Strengthening Strategic Health Purchasing in Southeast Asia:

Progress, Opportunities and Recommendations

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Executive Summary

1. BACKGROUND

- **Health systems worldwide have been hit hard by the COVID-19 pandemic.** ASEAN has particularly felt the effect of the pandemic due to its high out-of-pocket health spending and its health systems at different levels of maturity.

- In recent years, **government health spending in ASEAN has been on an upward trend**. This reflects the region's shared commitment to achieving Universal Health Coverage (UHC) and strengthening social health protection.

- However, **health financing mechanisms are still in their developing stages** in many ASEAN countries. Fragmented financing schemes are common across the region, with spending divided among government bodies, health insurers (public and private), donors and households.

- **The COVID pandemic also highlighted the need to allocate limited resources effectively** if UHC targets are to be met. Indeed, more money alone cannot achieve UHC. Countries can achieve good coverage and health outcomes even with modest spending through efficiency in their resource allocation.

- In this context, **health purchasing** – identified as one of the three core pillars of health financing by the WHO – **becomes an important tool to help governments set priorities and use data to inform their funding decisions**. Purchasing refers to the allocation of funds to healthcare providers to obtain services on behalf of a population. This process can be passive – driven by historical averages or line-item budgets – or strategic.

2. DEFINING STRATEGIC PURCHASING

- **Strategic health purchasing features a constant search for the most efficient, impactful and cost-effective purchasing decisions.** It is driven by data on a country's health needs at the national and sub-national level; on provider performance; and on other information relevant to decision-making on resource allocation.

- The concept of strategic purchasing has gained increasing international attention through WHO publications and research consortia. Yet, while various pilots have been implemented across Southeast Asia, **there is little consolidated information on the region's health purchasing practices and progress toward strategic purchasing**. Due to the complexity and diversity of ASEAN health systems, there has also been limited collaboration in knowledge-sharing and capacity-building on the topic.

- This policy report provides an **overview of the current health purchasing strategies of the ten ASEAN member states** – Brunei Darussalam, Cambodia, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Vietnam – by evaluating their progress across seven key functions: *governance, financial management, benefits specification, contracting arrangements, provider payment, performance monitoring*. Challenges, areas of progress and national-level opportunities to advance strategic purchasing are highlighted for each country.

3. COMMON NEEDS AND RECOMMENDATIONS

- The report then delves into higher-level recommendations to assist ASEAN member states in strengthening their health purchasing systems. These cover: **i) common national recommendations,** highlighting shared challenges and opportunities across ASEAN countries; **ii) common recommendations on purchasing for primary care**, recognising that primary care is the cornerstone for UHC; **iii) regional-level recommendations**, highlighting areas where the ASEAN bloc might act collaboratively to increase capacity for strategic purchasing.

- Ultimately, countries will need a range of tools and capabilities to implement fully-strategic purchasing. These include:

  i) data analytics and technological capacity to assess provider performance, identify unmet health needs and inform future purchasing decisions;

  ii) human and technical capacity for purchasers, policymakers and other decision-makers to understand the benefits of strategic purchasing and implement its key functions;

  iii) governance frameworks to define the public mandates and objectives of health purchasers and to ensure accountability among all stakeholders involved.

4. STRENGTHENING REGIONAL COLLABORATION FOR STRATEGIC PURCHASING

- While **ASEAN countries are at different stages along their journeys toward UHC**, strengthening strategic purchasing can be a tool for all to make the best use of limited resources. Some countries have already developed expertise in strategic purchasing; some have begun implementing pilot programmes or raising their capacity for specific functions; others have only newly introduced the concept to their health systems.

- **Expanding regional collaboration will allow ASEAN governments to learn from the best practices and challenges of their neighbours.** By working collectively to overcome these challenges and align on best practices, ASEAN countries can make significant progress in strengthening their strategic purchasing capabilities and ensuring equitable access to quality healthcare for their populations.

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Table of Contents

Abbreviations

ADB – Asian Development Bank

AIC – Agency for Integrated Care

ASEAN – Association of Southeast Asian Nations

BPJSK – Badan Penyelenggara Jaminan Sosial Kesehatan

CBHI – Community Based Health Insurance

CDMP – Chronic Disease Management Programme

CGD – Comptroller General's Department

CHAS – Community Health Assist Scheme

CHC – Community Health Centre

CHD – Centre for Health Development

CHE – Current Health Expenditure

CPF – Central Provident Fund

CSMBS – Civil Servant Medical Benefits Scheme

DHC – District Health Centre

DHO – District Health Office

DILG – Department of Interior and Local Government

DJSN – Dewan Jaminan Sosial Nasional

DOF – Department of Finance

DOH – Department of Health

DOI – Deed of Indemnity

DRG – Diagnostic-Related Group

EHO – Ethnic Health Organisations

EML – Essential Medicines List

FMCH – Free Maternal and Child Health

GP – General Practitioner

H-EQIP – Health Equity and Quality Improvement Program

HEF – Health Equity Fund

HFSC – Health Financing Steering Committees

HIV – Human Immunodeficiency Virus

HMIS – Health Management Information System

HPO – Healthcare Performance Office

HPV – Human Papillomavirus

HTA – Health Technology Assessment

ILO – International Labour Organization

IDR – Indonesian Rupiah

IRAS – Inland Revenue Authority of Singapore

JKN – Jaminan Kesehatan Nasional

KPI – Key Performance Indicator

LAK – Laotian Kip

LCE – Local Chief Executive

LGU – Local Government Unit

LHE – Local Health Board

LPA – Local Procurement Agency

MAC – Medifund Advisory Board

MAS – Monetary Authority of Singapore

MCAF – Medical Claims Authorisation Form

MFC – Medifund Committee

MFI – Medifund Institutions

MHO – Municipal Health Office

MLSW – Ministry of Labour and Social Welfare

MLVT – Ministry of Labour and Vocational Training

MNCH – Maternal, Newborn and Child Health

MOD – Ministry of Defence

MOH – Ministry of Health

MOHE – Ministry of Higher Education

MOF – Ministry of Finance

MOL – Ministry of Labour

MOPH – Ministry of Public Health

MOPI – Ministry of Planning and Investment

MYR – Malaysian Ringgit

NCD – Non-communicable Diseases

NHA – National Health Accounts

NHI – National Health Insurance

NHIB – National Health Insurance Bureau

NHG – National Healthcare Group

NHP – National Health Plan

NHSO – National Health Security Office

NIMU – NHP Implementation Monitoring Unit

NPCA – National Payment Certification Authority

NSSF – National Social Security Fund

NTA – National Tax Allotment

NUHS – National University Health System

OD – Operational Districts

OOP – Out-of-pocket

PCPN – Primary Care Provider Network

PHC – Primary Healthcare

PHI – Public Healthcare Institutions

PHD – Provincial Health District

PHP – Philippine Peso

SHI – Social Health Insurance

SGD – Singapore Dollar

SLA – Service Level Agreement

SSB – Social Security Board

SSO – Social Security Office

SSS – Social Security Scheme

TB – Tuberculosis

UCS – Universal Coverage Scheme

UHC – Universal Health Coverage

USD – United States Dollar

VSS – Vietnam Social Security

WHO – World Health Organization

Introduction

This report was prepared by the **Southeast Asia Regional Collaborative for Health (SEARCH)** at the Saw Swee Hock School of Public Health, National University of Singapore. It examines the progress, current status and future opportunities for strategic health purchasing in Southeast Asian countries.

Strategic purchasing is a core component of health financing, which in turn is a core function of health systems that can improve financial protection and service coverage and quality (WHO). Therefore, strategic purchasing and health financing are essential elements of Universal Health Coverage (UHC) in enabling populations to receive high-quality health services when needed, without financial hardship.

The WHO has identified three core functions of health financing. These include revenue generation (determining sources of funds to finance a health system); pooling of funds (accumulating existing funds on behalf of a population or group); and lastly, purchasing of services, which is the focus of this policy report.

The purchasing of health services refers to the allocation of funds to healthcare providers to obtain services on behalf of identified population groups (Kutzin 2001). In this context, a purchaser is any agency within a country that finances healthcare providers. The main purchaser(s) may be the Ministry of Health, an independent government body, sub-national government authorities or health insurance agencies.

Effective resource allocation and strong healthcare purchasing systems can enable UHC by freeing up fiscal space, thus increasing the cost-effectiveness of services and resulting in a larger funding base to cover a population's health needs. Therefore, purchasing health services strategically, effectively and transparently is crucial to health system development.

We hope that this Report will enable more informed conversations about strategic purchasing in Southeast Asia, and support the continuing development of strategic purchasing capacity, capabilities and expertise in Southeast Asian health systems.

Passive and Strategic Health Purchasing

There are two types of health purchasing behaviours: **passive purchasing** and **strategic purchasing.**

PASSIVE PURCHASING occurs when healthcare providers are given a predetermined budget or automatic reimbursement for goods and services they provide, without strategic criteria for resource allocation. In passive purchasing, payment is independent of the performance of health providers and the needs of the population, and does not involve efforts to minimise inefficiencies. Passive purchasing thus disincentivizes quality service provision, because the budget allocated to a provider remains fixed regardless of patient outcomes and efficiency metrics.

STRATEGIC PURCHASING involves an evidence-driven allocation of funds to healthcare providers in order to achieve efficient purchasing and high quality, equitable healthcare. Purchasers set a budget for providers based on information on population health needs, health service provider performance and other relevant data. Strategic purchasing involves an active purchaser which uses data and resource allocation to influence health service provision for different reasons. This is intended to cut waste in health expenditure, to increase equity in healthcare services, to promote quality of healthcare and other health system objectives. Due to the importance of linking payment to information and outcomes, information management systems and performance monitoring are important aspects of strategic purchasing.

Scope of strategic purchasing

There are three core questions at the heart of strategic purchasing:

WHAT TO BUY? This involves a critical assessment of which health services, interventions and medicines should be purchased based on population needs and preferences. Directing funds towards priority interventions, setting benefit package terms and deciding on appropriate cost-sharing and referral arrangements can direct resources where they are most needed and free up fiscal space for more targeted health expenditure.

FROM WHOM TO BUY? This involves a strategic selection of which health service providers to buy services from. Defining contracting criteria (e.g. safety, quality, financing and information systems criteria that a provider must meet) can ensure a minimum standard of care for patients and efficiency for the overall health system. Selectivity can also incentivise health service providers to perform at a higher standard and produce better outcomes with their given budget. This reduces expenditure waste and promotes patient interests.

HOW TO BUY? This involves a series of strategic decisions on the payment methods, contract obligations, and other mechanisms which link the actions of purchasers to the behaviour of providers. This may involve pre-contracting considerations (e.g. provider payment mechanisms, contract lengths and terms) and post-contracting considerations (e.g. reporting obligations, performance monitoring, incentives and disincentives, enforcement mechanisms).

Strategic purchasing functions

The path from passive to strategic purchasing is a continuum, whereby countries may have developed certain strategic purchasing functions but still need to develop others. Therefore, looking at specific sub-functions of strategic purchasing to track countries' progress is a worthwhile effort to map their journey.

The Strategic Purchasing Africa Resource Center (SPARC) has identified elements of Strategic Purchasing that nations can focus on to develop more effective health financing practices. SPARC is a resource hub in sub-Saharan Africa that provides information and support for strategic purchasing through a network of government agencies, academic institutions and NGOs. It serves the region by assisting countries to implement better strategic purchasing practices.

The five key purchasing functions in SPARC's proposed framework are: financial management, benefits specification, contracting arrangements, provider payment and performance monitoring. Governance is another consideration in SPARC's framework which acts as an overarching background factor.

GOVERNANCE: The systems and structures in place to provide strategic direction, oversight, accountability mechanisms and decision-making processes in the health system, as well as the institutional arrangements surrounding purchasing functions.

FINANCIAL MANAGEMENT: The purchaser's management of revenues and expenditures that will be used to pay providers and purchase the services in the benefit package.

BENEFITS SPECIFICATION: Defining the services and medicines to be covered by a health protection scheme, as well as where and how they can be accessed.

CONTRACTING ARRANGEMENTS: Decisions on how and which public and/or private providers enter into contracts for delivering services in the benefit package. The enforcement of the contracts, as well as the terms and conditions in the contracts, are included in this function.

PROVIDER PAYMENT: The design and implementation of payment systems between purchasers and providers. This includes setting the payment rates to providers for goods and services.

PERFORMANCE MONITORING: The systems in place for assessing provider performance, giving feedback on performance, and analysing a provider's utilisation rates, quality and other areas for improvement.

Strategic purchasing in the international sphere

While still a relatively new term, strategic purchasing has been an increasing focus of international meetings, WHO reports and research consortia.

The **World Health Organization** has published materials for strategic purchasing, such as strategic purchasing case studies and frameworks for implementing strategic purchasing functions in health systems. A policy brief from the WHO published in 2019, "Purchasing health services for universal health coverage: how to make it more strategic?", has provided direction for countries aiming to make their purchasing more strategic. The WHO has also acted as a global convenor for strategic purchasing capacity-building. In 2017, the organisation hosted a conference in Geneva entitled "Strategic Purchasing for UHC: Unlocking the Potential", where researchers, national health authorities and health financing experts met to discuss five key focuses within strategic purchasing: benefit design, mixed provider payment system, governance for strategic purchasing, information management systems and payment for performance.

Since 2018, the **Strategic Purchasing Africa Resource Center (SPARC)** has produced policy tools, resources and research on strategic purchasing in Sub-Saharan Africa. This includes a strategic purchasing progress tracking framework which will be adopted in this policy report.

The **Resilient and Responsive Health Systems (RESYST)** research consortium — based at the London School of Hygiene and Tropical Medicine — produced research on health financing (including strategic purchasing) between 2010 and 2019. RESYST published an assessment of health purchasing functions across several countries in Africa and Asia: China, India, Indonesia, Kenya, Nigeria, the Philippines, South Africa, Tanzania, Thailand and Vietnam. This was a significant step in comparing purchasing practices across Low- and Middle-income countries.

The **ThinkWell Institute** has focused its research and advocacy efforts on strategic purchasing for primary healthcare. Its Strategic Purchasing for Public Health (SP4PHC) project investigated the purchasing of primary health care services with a focus on family planning and maternal, newborn and child health. Its initiatives target six core countries: Burkina Faso, Indonesia, Kenya, Pakistan, the Philippines and Uganda.

Strategic purchasing in Southeast Asia

Despite increasing attention on strategic purchasing in such international and cross-national forums, strategic purchasing remains a nascent field — especially in Southeast Asia.

SOUTHEAST ASIA HAS A CLEAR NEED FOR STRATEGIC PURCHASING FOLLOWING THE FINANCIAL IMPACTS OF THE COVID-19 PANDEMIC.

As a region composed of many Low and Middle Income Countries (LMICs), Southeast Asia is feeling the strain of limited funding for its healthcare systems. In 2020, the Southeast Asia region suffered an almost 4% contraction of its economic growth due to the pandemic. Strategic purchasing could be an effective tool to optimise scarce resources, but many countries in the region face significant obstacles in implementing it.

For one, many countries in Southeast Asia have fragmented healthcare systems, making it a challenge to implement strategic purchasing across financing mechanisms. Health financing mechanisms are often split across out-of-pocket payments, government spending, national health insurance schemes and personal health insurance schemes. Social health protection schemes are still developing in many countries; these may have low population coverage or poor data collection capabilities, making it challenging to gather data for policy change. Lack of political commitment and, in some countries, political uncertainty also act as barriers for policymakers trying to introduce strategic purchasing practices in their countries.

MANY COUNTRIES IN SOUTHEAST ASIA ARE TRYING TO CREATE MOMENTUM TOWARD STRATEGIC PURCHASING, AND THERE IS A PREVAILING REGIONAL COMMITMENT TOWARD IMPROVING UHC.

A joint statement that included a commitment to building UHC was signed at the 11th ASEAN Health Ministers Meeting in 2012. In view of this commitment, several Southeast Asian countries have implemented health system reforms over the past decade. In 2019, the Philippines passed its UHC Bill and shifted its efforts towards strengthening the primary healthcare system. Singapore has made great progress in expanding its national health insurance scheme, MediShield, in order to curb its out-of-pocket health expenditure. Indonesia established a national health insurance scheme called Jaminan Kesehatan Nasional in 2014, and Lao PDR merged its various schemes into a National Health Insurance scheme in 2019.

These national reforms create a promising scenario for a regional shift toward strategic purchasing. Highlighting strategic purchasing as a high-potential and cost-effective health financing tool to Southeast Asian policymakers could help countries further accelerate their health system reforms and their journeys toward UHC.

The Southeast Asia Regional Collaboration for Health (SEARCH)

The **Southeast Asia Regional Collaboration for Health (SEARCH)** is a knowledge-sharing network based at the Saw Swee Hock School of Public Health, National University of Singapore. SEARCH was instituted with the aim of enhancing UHC uptake and understanding in Southeast Asia. Strategic purchasing has been selected as a key focus area for SEARCH due to its high potential to address Southeast Asia's health resource constraints.

In early 2023, SEARCH launched an online registry mapping the state of health purchasing in the ten ASEAN member states. Data on health purchasing mechanisms, public spending regulations and other relevant aspects of healthcare financing was gathered through desk-based research and interviews with expert policymakers and academics. This registry was the first Southeast Asia-focused, cross-country consolidation of information on strategic purchasing. The registry will be regularly updated as the health financing landscape in each country develops and as new strategic purchasing initiatives are piloted and implemented.

SEARCH also actively engages policymakers and other health financing stakeholders in capacity-building activities. This involves organising events, workshops, trainings and policy dialogues within and across countries to promote the value of strategic purchasing. The aim of SEARCH is to become a platform for cross-country collaboration and knowledge-sharing among stakeholders involved in healthcare financing. Southeast Asian countries are at different stages in developing their strategic purchasing practices, and SEARCH can act as a bridge for resource-sharing and cross-country initiatives.

This policy report consolidates SEARCH's 2022-2023 research on the state of strategic purchasing in ASEAN.

It supports SEARCH's efforts to inform relevant stakeholders on the potential of strategic purchasing, by demonstrating what has already been accomplished and what gaps remain. We aim to facilitate the translation of knowledge into action by making this knowledge readily available at the regional level.

Following SPARC's strategic purchasing progress tracking framework, our report describes each country's progress across the core functions of strategic purchasing. Recent initiatives, successes and challenges for each ASEAN country in strategic purchasing are also highlighted. Finally, country- and regional-level recommendations to make purchasing more strategic are shared at the end of the report.

Country Briefs

Brunei Darussalam

Health Financing Schemes in Brunei

Brunei Darussalam is a high-income country located on the island of Borneo that provides Universal Health Coverage for all citizens and residents. Healthcare in Brunei is financed mainly through government funding. Private health insurance and out-of-pocket payments also contribute to the overall health expenditure in smaller proportions.

The Ministry of Finance and Economy is responsible for managing the country's finances, including funding for healthcare. Through a consolidated pool, the Ministry raises funds for healthcare in Brunei through a variety of sources, including government revenues (taxes, customs duties, and fees) and revenues from natural resources.

The government provides comprehensive healthcare services at all levels of care with a strong emphasis on primary healthcare. Most healthcare services are provided by the Ministry of Health. Specialised care, outpatient and dental care is also provided in private hospitals and clinics.

The main health financing schemes in Brunei are:

GOVERNMENT FUNDS: Healthcare is primarily funded by the government through a single pool of consolidated funds collected by the Ministry of Finance and Economy via different revenue streams and general taxation. Government funds account for 96% of total health expenditure. This financing scheme covers a comprehensive range of health services provided in both public and private health facilities including consultations, laboratory tests, hospitalisation and medications for all citizens and permanent residents in Brunei Darussalam. Expatriates and foreigners can still access public health facilities but are charged according to a standard tariff set in the Ministry of Health Scheme of Charges.

PRIVATE FUNDS: This includes out-of-pocket payments and private health insurance and accounts for 4% of health expenditure. Citizens and permanent residents can opt to access care in private facilities where OOP payments are expected. This is primarily used for specialised outpatient care (cardiology, neurology), individual screening, dental care and outpatient care provided by private GP clinics. For complex care at private facilities, citizens and permanent residents can receive subsidised care through government funds by obtaining referrals from doctors in a government health facility.

OVERVIEW

Population (2022): **0.45 million**

GPD per capita (2022): **US$37,152**

Poverty headcount at national poverty line: **No data**

Life expectancy (2021): **75 years**

Infant mortality rate per 1,00 live births (2021): **9.6**

DALYs per 100,000 (2019): **27,814**

Current health expenditure as % of GPD (2020): **2.39%**

Domestic government expenditure as % of CHE (2020): **94.04%**

Out-of-pocket expenditure as % of CHE (2020): **5.96%**

UHC Service Coverage Index score (2021): **78**

Physician density per 1,000 people (2019): **1.80**

The Primary Healthcare System in Brunei

Primary healthcare is provided through a network of publicly funded health centres and clinics, private clinics and outpatient care in private hospitals. The Ministry of Health is responsible for the planning and implementation of publicly funded primary healthcare services in the country.

Primary healthcare services in Brunei aim to provide comprehensive, accessible, and affordable healthcare to the population. This includes preventive care, dental care, health education and promotion, and disease surveillance and control.

Comprehensive healthcare services offered in Primary Health Centres include:

1. General medical consultations and selected specialist clinics, e.g. ophthalmology
2. Maternal and child health services, including antenatal care, child immunizations and well-baby clinics
3. Chronic disease management, including diabetes and hypertension management
4. Dental services, including oral health education and preventive measures
5. Mental health services, including counselling and referrals to specialist care
6. Outpatient rehabilitation services including physiotherapy and occupational therapy
7. Nurse-led health screening and health promotion activities, such as health fairs and health talks
8. Diagnostic services including phlebotomy and x-ray services (selected health centres)
9. Outpatient pharmaceutical services

Publicly funded primary healthcare is mainly funded by the government, and the services are provided free-of-charge to citizens and permanent residents. Privately funded GP clinics also provide primary healthcare services where patients are charged fully OOP.

Purchasing Functions in Brunei's Healthcare Schemes

	GOVERNMENT BUDGET SCHEME
% of Total CHE	94% (2020)
Coverage	0.34 million (100% of citizens / 74.1% of the total population) **Citizens can access public healthcare services free-of-charge. Most non-citizen residents are ineligible for subsidised rates.*
Purchaser(s)	Ministry of Health (MOH), Ministry of Finance and Economy (MOHE)
Governance	The purchasing of healthcare services, pharmaceuticals, medical devices and medical consumables is centrally planned and coordinated. Decision-making rules for purchasing (budget, priority setting, procurement processes, payment processes) are set nationally by the MOFE; their implementation is managed by the MOH. In addition, the role of the MOH is to provide oversight of both purchasers and providers for public facilities. The MOH's Department of Health Services is responsible for providing public health services for the population.
For PHC:	The above governance aspects apply. The MOH's Department of Health Services is responsible for providing public health primary care services for the population.
Financial Management	The MOH and Local Procurement Agency (LPA) conduct technical evaluation and financial governance, following national financial regulations. For example, the MOH budget committee ensures that annual budget proposals submitted to the MOFE meet the financial regulations and reflect the public interest. The MOH also oversees programme-based budgeting and fiscal consolidation programmes.
For PHC:	The above financial management aspects apply.
Benefits Specification	There is no explicit listing of the benefit package. Benefits provided in the public healthcare system are comprehensive and cover all citizens and permanent residents. Nominal co-payment is set to access public facilities at the point of care. Services in selected private facilities are covered if a patient is referred by a public facility. Foreign workers employed under government service are eligible for subsidised (though not free) services, while other foreigners can access public facilities at a charge set by the Ministry of Health Scheme of Charges.
For PHC:	Public primary health centres provide comprehensive healthcare services including outpatient services, maternal, new-born and child health (MNCH), dental care services and more.
Contracting Arrangements	Public facilities in Brunei do not need accreditation and automatically provide free health services for the population. Health facilities include health centres/clinics for primary care and dental services, hospitals for secondary and tertiary care and mobile health clinics and flying medical teams as needed. In addition, the MOH contracts several private providers to run haemodialysis services where the contract is managed by the Department of Renal Services, MOH. All public facilities (including government contracted services to private providers) are funded by the government.
For PHC:	Public primary care facilities do not require accreditation and are funded by the government directly to provide free services for the population.
Provider Payment	An annual budget is allocated to different public health facilities. This is based on historical trends of spending and anticipated projected spending. Public facilities are therefore paid on a global budget basis. Private facilities contracted by the government to provide referral services are paid on a fee-for-service basis.
For PHC:	Public primary care facilities are paid on a global budget basis from the government.
Performance Monitoring	There is no explicit system to monitor the performance of individual providers. Internally, performance is monitored using several data sources such as customer complaints, surveys and data extracted from electronic medical records. Overall, health system performance in Brunei is monitored using a set of indicators recommended by the World Health Organization and is outlined in the MOH Strategic Plan. Health system outcomes (i.e. life expectancy) are also monitored nationally as part of the multi-agency national development planning.
For PHC:	The above performance monitoring aspects apply.

Recent Progress in Strategic Purchasing

- Strategic purchasing is a nascent topic among health policy actors in Brunei. Nonetheless, foundational components to support the implementation of strategic purchasing are in place. For example, governance arrangements such as decision-making processes and public interest mandates to allocate resources strategically have been applied by the MOH.
- Progress toward strategic purchasing has focused on structural reforms to enhance financial sustainability, efficiency and quality of health service delivery. For example, processes of international accreditation of primary healthcare centres (Joint Commission International) and laboratories (International Organisation for Standardisation) have increased the efficiency and quality of health services in public facilities. Through quality improvement projects, priority areas of concern and service gaps have been identified and addressed. However, such accreditation activities are voluntary and there are no service level agreements between the MOH and providers.

KEY HIGHLIGHT: A NEW PURCHASER-PROVIDER SPLIT IN PROCUREMENT

A Local Procurement Agency (LPA) was established in end-2020 to strengthen the supply chain of medical products, medicines and consumables. The LPA assists the MOH with procurement activities by designing individual contracts with facilities and suppliers for pharmaceuticals and consumables. These contracts are based on technical requirements set by MOH drug advisory and procurement committees.

Challenges for Strategic Purchasing

- **Governance:** The centrality of structure, policies and processes is a key feature of health governance in Brunei. Centrality offers benefits such as a clear lines of communication, a central vision and cost control. However, such benefits can only be reaped with good data and information to guide policy decisions, leadership and managerial capacity and effective relations between governance actors, purchasers and other stakeholders.
- **Governance:** Data to support policy decisions, including strategic purchasing, is rudimentary. Information used to identify, prioritise and plan for health needs (i.e., budget submissions) is based on historical trends and routine statistics. Due to the recency of Brunei's provider-purchaser split in procurement, the respective roles and responsibilities of the MOH and LPA are still blurred and fluid. The organisational capacities of both actors to execute purchasing and regulatory functions are yet to be determined and planned.
- **External factors:** The principles of UHC are embedded in all policy and resource allocation decisions. This ensures that quality healthcare is accessible to all. Similarly, public financial management rules are set nationally by the Ministry of Finance and Economy. This ensures the credibility of public finances and fiscal sustainability of healthcare. A key challenge for Brunei is its market structure. As a centralised planned economy, it runs as a monopsony

where there is only one buyer and very few suppliers. This limits its potential access to markets and, with lack of competition, this allows purchasing actors to set high prices.

Opportunities to Improve Strategic Purchasing

1. **Brunei could continue to develop existing health reforms which aim to enhance the quality of service delivery, efficiency and financial sustainability.**

   Some successful reforms have been introduced by the MOH (regulator/purchaser) and MOFE (payer). Their output measures are aligned to meet the national health policy of sustaining UHC for all. Improving strategic purchasing functions and capabilities of purchasers will further enhance this.

2. **Existing initiatives to enhance the effectiveness of procurement, budgeting and priority-setting could be consolidated under one strategic initiative to introduce a more systematic health financing policy.**

   A comprehensive health financing policy reform that includes capacity-building programmes that aim to enhance the organisational capacity of providers and purchasers (e.g., data-informed procurement, contract management, negotiation skills, etc.) will provide better clarity on the roles and responsibilities of purchasers and providers. This in turn will provide an opportunity to build the trust needed for the implementation of an effective oversight system.

3. **Brunei could consider equity in strategic purchasing to assist vulnerable groups.**

   A potential area of improvement is the equity component of strategic purchasing where the needs of vulnerable/high-risk populations (e.g., elderly, special needs, foreign workers not covered under insurance / financial protection) can be identified, planned and incorporated into the new health financing policy.

Opportunities to Improve Strategic Purchasing for Primary Care

Accessibility to primary healthcare is the strength of the Brunei health care system. As service planning, budgeting and procurement are planned centrally, opportunities to improve strategic purchasing in primary healthcare should follow a similar path to the enhancement of strategic purchasing in general.

Cambodia

Health Financing Schemes in Cambodia

The Kingdom of Cambodia is a lower-middle income country with a population of 16.77 million. Its health system is characterised by high out-of-pocket payments – the second highest in East Asia & the Pacific after Myanmar.

In recent years, Cambodia has made significant improvements to its health outcomes (particularly regarding maternal and child health). Cambodia also has ambitious strategies to expand its social health protection and provide the population with Universal Health Coverage. Challenges such as wealth inequality, rapid urbanisation and an increasing burden of non-communicable diseases will have to be overcome in order to meet this target.

OVERVIEW

Population (2022): **16.77 million**

GPD per capita (2022): **US$1,787**

Poverty headcount at national poverty line (2012): **17.7%**

Life expectancy (2021): **70 years**

Infant mortality rate per 1,00 live births (2021): **21.3**

DALYs per 100,000 (2019): **37,507**

Current health expenditure as % of GPD (2020): **7.51%**

Domestic government expenditure as % of CHE (2020): **27.69%**

Out-of-pocket expenditure as % of CHE (2020): **60.60%**

UHC Service Coverage Index score (2021): **58**

Physician density per 1,000 people (2014): **0.19**

The main health financing schemes in Cambodia are:

HEALTH EQUITY FUND: Established in 2000, the Health Equity Fund (HEF) is one of the major health financing schemes in Cambodia. It is under the direction of the Ministry of Health (MOH). Its function is reduce financial barriers to health service utilisation by the poor, and it covers about 2.5 million poor Cambodians. Beneficiaries of the HEF can access treatment at all public facilities. The HEF uses case-based payments to providers, according to the Guidelines For the Benefit Package and Provider Payment of the Health Equity Fund for the Poor (2018). Provider payment rates are set by the MOH. The HEF is co-funded by the Cambodian government through taxation revenues and by overseas development partners.

NATIONAL SOCIAL SECURITY FUND: The National Social Security Fund (NSSF) implements a Social Health Insurance (SHI) programme which includes the civil servant scheme and the private sector scheme. The SHI is designed to provide health insurance to Cambodian citizens in the formal sector. In 2020, SHI covered about 1.4 million formal private sector workers and 416,000 civil servants, public pensioners, and veterans. The SHI is financed by employer contributions and uses a mix of case-based and fee-for-service payments to providers.

The Primary Healthcare System in Cambodia

The primary healthcare system in Cambodia is organised into Operational Districts (OD).Each OD contains health centres, referral hospitals and health posts, which serve remote areas. This structure is outlined in Cambodia's Health Coverage Plan, which was adopted by the Ministry of Health (MOH) in 1995. Health Centres form the foundation of Cambodia's primary healthcare system and act as gatekeepers to secondary and tertiary care. There is a large and growing private medical sector in Cambodia, and private providers are currently delivering a major proportion of primary health care, with Cambodia's Strategic Health Plan 2016-2020 reporting a 1:8 ratio of public to private healthcare providers across Cambodia. Typically, private clinics and practitioners deal with curative health services, while preventative care, such as tuberculosis control and immunisations, are under the public sector.

The Cambodian government has been making efforts to expand primary healthcare access and increase equity in health financing. The government has chosen to prioritise maternal, newborn and child health services within primary health care through an increase in funding and the expansion of social protection mechanisms However, many health centres in remote regions currently face shortages of quality staff, restricting their provision of health services. The government has pushed funding towards primary healthcare and social protection programmes such as the Health Equity Fund, and as a result, utilisation rates at health centres and referral hospitals have increased. The World Bank found that from 2015 to 2018, the number of outpatient visits per HEF beneficiary per year increased by 40%.

Purchasing Functions in Cambodia's Healthcare Schemes

	HEALTH EQUITY FUND
% of Total CHE	1.5% (2016)
Coverage	2.8 million (16.7% of the total population) **The HEF covers households enrolled into the IDPoor system, identifying poor households.*
Purchaser(s)	Ministry of Health, Royal Government of Cambodia
Governance	The national HEF program is managed by the MOH. It is technically and financially supported by the Health Equity and Quality Improvement Program phase 2 (H-EQIP II). Within the HEF system, Health Financing Steering Committees (HFSC) play a significant role in governance at the district and provincial levels. They review HEF utilisation reports, finance summaries and other documentation to identify issues and look for solutions. The Health Equity Fund Operation Manual (2016) is used as a framework for implementing HEFs.
For PHC:	At the local level, Health Centre Committees provide oversight of HEF implementation at primary care clinics.
Financial Management	The Ministry of Economy of Finance provides the budget for the HEF. The Department of Budget of Finance under the MOH oversees financial management capacity at all contracted health facilities. The department produces quarterly and annual financial management reports on disbursement rates of government and pooled donor funds for the HEF.
For PHC:	The above financial management aspects apply.
Benefits Specification	The benefit package is explicitly defined in MOH's Guidelines for the Benefit Package and Provider Payment of the Health Equity Fund for the Poor (2018). It covers the cost of user fees for access to services at health centres and referral hospitals, and associated costs such as transport, food and funeral expenses.
For PHC:	For primary healthcare, HEF provides eligible individuals with services such as consultations, diagnosis and treatment of common illnesses.
Contracting Arrangements	In the past, the HEF was managed by NGOs in Cambodia and contracts were set between participating health facilities and the NGOs themselves. As the HEF has scaled up and is now managed by the MOH, it automatically covers all public health facilities (including hospitals and health centres).
For PHC:	The above contracting arrangements aspects apply.
Provider Payment	The HEF uses primarily case-based provider payment. Payments are transferred directly from the MOH to providers so that poor individuals do not have to pay fees out-of-pocket. Payment rates are somewhat performance-based, as they are subject to change based on quality-of-care scores determined quarterly for hospitals and semi-annually for health centres. The NPCA verifies and approves all claims before payments are made by the MOH. While there are plans to strengthen the NPCA's purchasing functions, there is currently no purchaser-provider split as the NPCA does not make payments directly.
For PHC:	The above provider payment aspects apply.
Performance Monitoring	The HEF system has an independent monitoring process to verify that services are correctly delivered and accurately reported by health facilities. H-EQIP II involves an updated National Quality Engagement Monitoring (NQEM-II) Process and Tools, Intended to improve quality monitoring through indicator lists and accreditation standards for facilities. Ex-ante assessments are carried out by assessor teams from different provinces and ex-post assessments are carried out by PCA staff, both on a semi-annual basis. Provincial health departments also have rosters of technical experts to support health facilities in achieving quality standards. Performance-based Service Delivery Grants (SDGs) are disbursed semi-annually according to facilities' quality enhancement scores, as measured through the NQEM process.
For PHC:	The above performance monitoring aspects apply.

Purchasing Functions Cambodia's Healthcare Schemes

	SOCIAL HEALTH INSURANCE – NATIONAL SOCIAL SECURITY FUND
% of Total CHE	2.21% (2020)
Coverage	1.8 million (10.8% of the total population) **The NSSF covers all formal sector employees, including civil servants and the private sector.*
Purchaser(s)	National Social Security Fund
Governance	The NSSF as a whole is governed by a tripartite Board of Directors composed of representatives from employers, employees and the government (Ministry of Economy and Finance, Ministry of Health, Ministry of Labour and Vocational Training). This board deals with major decisions concerning NSSF operations. The Social Security Law (2002) and the 2019 Law on Social Security Schemes provide a legal framework for the operation of the NSSF and its SHI.
For PHC:	The use of SHI for primary healthcare is overseen by the NSSF.
Financial Management	The NSSF prepares a budget that outlines its expected expenses and income for the year. Once it is approved by the Ministry of Economy and Finance, the NSSF adheres to this budget and monitors its financial performance throughout the year to submit to the MOEF. A department under the NSSF is responsible for budget allocation, reporting finances and auditing processes specifically for SHI.
For PHC:	The above financial management aspects apply.
Benefits Specification	The NSSF's social protection scheme includes medical benefits and income replacement benefits during absences from work due to illness or maternity. The medical benefit package is defined in Prakas 109 on Health Care Benefit (2016) and updated in Prakas No. 184 (2018). It includes curative services (rehabilitation, treatment), essential medicines, and some primary care services.
For PHC:	The SHI benefit package provides coverage for outpatient services (medications, diagnostic tests, consultations), preventative services (vaccinations, screening for common illnesses), maternal and child health services, emergency services, and referral services.
Contracting Arrangements	The NSSF signs annual contracts with healthcare providers based on a standard template outlined in the Prakas on Health Provider Payment Methods from the MLVT (2017). All public facilities must have a contractual arrangement with the NSSF. Health facilities under contract must comply with the following conditions: health facilities must be licensed by the MOH; materials and equipment used in the hospital must comply with all regulations set by the MOH; health facilities must have appropriate qualification and number of medical staff; health facilities must accept the provision of an NSSF agent or a service centre.
For PHC:	Contracting terms and provisions are laid out in the joint MOH-MLVT prakas, which allows the NSSF to make individual contracts with health facilities according to the approval of a governing body within the NSSF. All public facilities are required to have a contract with the NSSF.
Provider Payment	The NSSF uses case-based and fee-for-service provider payment mechanisms. The NSSF has established a 15-member Provider Payment Mechanism Committee to agree on proposed provider payment rates.
For PHC:	Capitation is the main provider payment mechanism for services included as health insurance benefits at the primary care level.
Performance Monitoring	A quality assurance program was established by the Prakas on Health Provider Payment Methods (2010). In accordance with sub-decree No. 01 on the Establishment of the Social Security Scheme (2016), the service quality of health facilities will be inspected and monitored by the Medical Committee of NSSF. The composition and roles of the Medical Committee of NSSF is regulated jointly by the Minister of Ministry of Labour and Vocational Training and the Minister of MOH with the proposal of the NSSF governing body.
For PHC:	The NSSF implements a standard quality assurance programme for all health care providers, including primary health care providers.

Recent Progress in Strategic Purchasing

- Cambodia has taken initiatives towards health system strengthening and strategic purchasing. The most recent Health Strategic Plan, HSP3, set Health Development Goals for 2016-2020. Its priority areas were maternal and child health, communicable diseases and non-communicable diseases. It covered key action items for strategic purchasing, including strengthening health system governance, improving health information systems and developing health infrastructure. The MOH has drafted another Health Strategic Plan (HSP4 2021-2030) providing a framework for the next ten years. The purpose of these plans is to move towards UHC by addressing weaknesses in the health system.
- The Health Information Master Plan 2016-2020 was developed to strengthen Cambodia's health information systems in harmony with other health sector plans, particularly the Health Strategic Plan 2016-2020. The Department of Planning and Health Information is expected to ensure that all health sector players follow the Master Plan. Strategic interventions outlined for the period 2016-2020 included developing and using data kits and data quality assurance tools, improving the coverage of Health Management Information System reporting and implementing standards and data sharing arrangements.
- The MOH has successfully laid out an accreditation roadmap for healthcare providers, following its Master Plan for Quality Improvement in Health (2010-2015) and Health Facility Accreditation System (2015). A set of 365 Cambodian hospital accreditation standards was developed and approved by the Quality Improvement Working Group of the MOH. The Cambodian healthcare quality monitoring system for public providers was strengthened at the same time, considering structure, process and outcome indicators.
- The National Payment Certification Agency (NPCA, previously PCA) was established in 2017 through the Cambodia Health Equity and Quality Improvement Project (H-EQIP), a donor- and government-funded partnership providing technical support to the Cambodian government to improve health coverage. The NPCA is intended to gradually become an independent purchasing verification agency. It already carries out some strategic purchasing functions by verifying HEF benefits and monitoring the quality of health centres, hospitals and health administrations at the provincial and district level. The role of the NPCA was further defined and strengthened in the July 2023 "Sub-Decree on Transformation of Health Payment Certification Agency to National Payment Certification Agency".
- The NPCA has also taken over the Cambodian Patient Management Registration System (PMRS) — Cambodia's early electronic medical record (EMR) — to monitor the HEF and other health system data, aiming to take an expanded role in strategic purchasing. The PMRS is used by public health facilities to manage individual patient data by creating a system of unique patient identifiers. It collects data on patient details, service utilisation and service fee and allows for aggregate reporting of financial data by facilities.
- Service delivery grants (SDGs) have been implemented as part of H-EQIP since 2017 and include elements of performance-based financing. Co-funded by the Cambodian government and development partners, these grants are given to all public facilities based on assessments of financial management, infection control, hygiene, waste disposal, client satisfaction and HEF management. Facilities have already shown improvement across various indicators measured.

KEY HIGHLIGHT: PRO-POOR SOCIAL HEALTH PROTECTION

In its progress toward Universal Health Coverage, Cambodia has taken a distinctive path by expanding its coverage primarily for the poor rather than prioritising civil servants and private sector employees. The Health Equity Fund (HEF), Cambodia's largest social health protection scheme, is a pro-poor insurance scheme which covers about 2.8 million individuals (16.7% of the total population). The HEF reimburses public health facilities for the user fee exemptions they provide to the poor for health services. The HEF has eased the burden of out-of-pocket expenditure and increase health service utilisation, especially for poorer households using public providers.

One key component to the success of the HEF is Cambodia's Identification of Poor Households Programme (IDPoor) System, which was launched in 2007 as a way of identifying and confirming poor households. The identification of poor households is led by Commune/Sengkat Working Group members. Villagers are made aware of the IDPoor system; lists of poor households in a village are reviewed and compiled each year, and new households wishing to register in IDPoor do so by submitting a request for interview to the Working Group, village chief or via the IDPoor app. When households are enrolled into the IDPoor system, they receive an equity card granting them access to social protection schemes, including free healthcare in public facilities covered by HEF.

IDPoor has become an invaluable tool in Cambodia's journey towards UHC. Using IDPoor data, HEF has been able to target its support to poorer households. The poor are vulnerable to rising user fees and catastrophic out-of-pocket expenditures at health facilities, and those living in rural areas even more so. While Cambodia still has work to do in improving the reach of its HEF protection scheme, its pro-poor programmes can be an example for other lower-middle income countries.

Challenges for Strategic Purchasing

- There is a lack of health insurance coverage for the "missing middle" in Cambodia — specifically non-formal workers who are not identified as poor households by the IDPoor programme, and are therefore ineligible for both the HEF and NSSF schemes. Currently, 54% of the population has no legal basis for health insurance coverage. This limits the financial protection and purchasing capacity of the schemes, as they cover relatively small segments of the population and do not represent a majority of health expenditure. Risk-pooling among providers is insufficient, and patients bear most of the risk where there are limited funds. Indeed, out-of-pocket (OOP) expenditure remains high despite the expansion of social health insurance schemes; in 2020, Cambodia's OOP expenditure on health was at 60%.
- Cambodia's Information and Technology infrastructure ranks low (155th out of 190) when compared to other countries, despite efforts to integrate IT systems into the health sector. Health outcomes between urban and rural populations remain unequal, and many remote health centres do not have access to IT systems due to lack of access to electricity and Internet connectivity.
- Cambodia faces low human capital and poorly trained professionals. Greater governance of human resources for health is foundational for strategic purchasing, which seeks to respond to patient needs. The MOH is becoming concerned with improving patient care through the regulation of training activities rather than simply the provision of professional training.
- Even among HEF-eligible Cambodians, there is low enrolment in and low utilisation of the scheme. This may be due to poor public awareness of scheme eligibility and low satisfaction with public healthcare facilities. While the HEF contracts only with public facilities, as many as 86% of HEF patients still seek care in the private sector as it is perceived to be superior to public facilities. This limits the financial protection capabilities of the HEF and retains high out-of-pocket spending among poor Cambodians.

Opportunities to Improve Strategic Purchasing

1. **Cambodia could consider expanding the coverage of its HEF and NSSF schemes to catch the "missing middle" of the population.**

   For the HEF, this may involve extending coverage to the near-poor. The NSSF could be expanded to include dependents of formal sector workers and specific groups of informal workers. Challenges may arise with the expansion of both schemes — namely a need to collect employee contributions for the NSSF, beyond current employer contributions, and a need to ensure the financial sustainability of the HEF. These challenges should be considered in advance and a health financing strategy should be prepared as enrolment in the respective schemes increases.

2. **The quality of public health facilities should be improved to meet greater social security enrolment and increased utilisation.**

   While there has historically been low satisfaction with public healthcare facilities, new quality and accreditation standards have been laid out. Public facilities should be supported in achieving these quality goals — for example, ensuring sufficient cleanliness, essential medicine availability and staff training. This might help to increase utilisation of the HEF scheme and prevent patients bypassing to the private sector. Existing performance-linked financing activities, such as H-EQIP's performance-based SDG, can be further expanded as quality standards are fully implemented.

3. **Cambodia could gradually integrate, or at least harmonise, the HEF and NSSF schemes**

   Doing so would provide more equitable coverage and increase the purchasing power of the national health insurer(s). Special attention could be paid to benefit package design and claims processing (currently managed under two different systems, creating duplicate work).

Opportunities to Improve Strategic Purchasing for Primary Care

1. **Cambodia could consider expanding programmes to incentivise care-seeking at the primary level.**

   Some programmes incentivising primary care already exist, such as the government midwifery incentive scheme and the HEF's transportation allowance eligibility. While there are no strict referral systems to ensure gatekeeping, other similar incentives could be designed to encourage the population to seek care at primary health centres.

2. **Cambodia could invest further in access to medicines and trained staff in primary care.**

   Specifically, the MOH may wish to monitor the availability of items from the National Essential Drug List at local health centres — currently only 15 items from the list are monitored for stock-out — and build up a stronger supply chain for pharmaceuticals to reach all levels of the health system.

Indonesia

Health Financing Schemes in Indonesia

Indonesia is an upper-middle income country with a population of 275.50 million — the most populous in Southeast Asia and the fourth-most populous in the world. Its large population and archipelagic geographic features have historically made it challenging to implement integrated health financing schemes.

Prior to 2014, various fragmented and largely ineffective social health protection schemes existed. Since 2014, Indonesia has centralised these into a single-payer health insurance system. This system, known as Jaminan Kesehatan Nasional, is one of the largest single payer systems in the world and has made significant improvements to Indonesia's health system efficiency.

JAMINAN KESEHATAN NASIONAL: Since 2014, Indonesia operates a single-payer national health insurance fund called Jaminan Kesehatan Nasional (JKN). JKN covers 92.8% of the population, or as 257.40 million persons, and offers generous healthcare benefits. It is managed by the National Social Security Agency for Health (BPJS Kesehatan, or BPJSK), the government agency whose task is to operate JKN. JKN is regulated by stakeholders like the Ministry of Health and supervised by the National Social Security Agency.

Financing for JKN originates from different sources, with the majority coming from mandatory contributions and government revenues. Government revenues are targeted towards subsidies for informal workers and the poor. Mandatory contributions are cut directly from employee salaries. All funds are collected and pooled into a single source account called the Dana Jaminan Sosial (DJS). After this pooling, BPJS is tasked with purchasing services from contracted providers.

SUPPLY-SIDE FINANCING: The supply side financing scheme is a typical top-down financing from the central government to regional governments. It is funded from tax and general government revenues and follows annual public cycles of budgeting and disbursement, whereby the central government channels health funds to the Ministry of Health and Ministry of Home Affairs. The fund is segregated into different channels: 1) the special allocation fund (*Dana Alokasi Khusus*), funding public health activities and infrastructure; 2) the general allocation fund (*Dana Alokasi Umum*), funding the acceleration of decentralised services and the improvement of capital and infrastructure (with a component earmarked fund for health – the *Dana Alokasi Umum Kesehatan*); 3) the deconcentration fund (*Dana Dekonsentrasi*, or block grant) funding public health delivery services. This last fund is channelled from the central government to provincial government and allocated directly for public healthcare providers, such as primary health centres.

OVERVIEW

Population (2022): **275.50 million**

GPD per capita (2022): **US$4,788**

Poverty headcount at national poverty line (2022): **9.5%**

Life expectancy (2021): **68 years**

Infant mortality rate per 1,00 live births (2021): **18.9**

DALYs per 100,000 (2019): **33,996**

Current health expenditure as % of GPD (2020): **3.41%**

Domestic government expenditure as % of CHE (2020): **55.05%**

Out-of-pocket expenditure as % of CHE (2020): **32.5%**

UHC Service Coverage Index score (2021): **55**

Physician density per 1,000 people (2020): **0.62**

The Primary Healthcare System in Indonesia

Primary Health Care (PHC) has been a priority in Indonesia since the 1980s. At the time, the government launched the Village-Based Health Services (Posyandu) and Primary Health Center (Puskesmas) programs, which provided essential health services and education to mothers and children under five. This program was a successful example of community-based healthcare and significantly improved health outcomes. Following this success, Indonesia has been improving the infrastructure development of Puskesmas and Posyandu over decades by building more community health centres and upgrading existing facilities to meet national standards.

Currently, primary healthcare in Indonesia is more accessible than ever before. The country has approximately 10,500 community health centres (Puskesmas) across the archipelago, providing primary healthcare services to millions of people. The infant mortality rate has decreased from 34 deaths per 1,000 live births in 2000 to 19 deaths per 1,000 live births in 2017. Similarly, the maternal mortality rate has decreased from 390 deaths per 100,000 live births in 1995 to 126 deaths per 100,000 live births in 2015. The JKN has played a critical role in improving access to healthcare services, with more than 220 million Indonesians covered by the scheme as of 2021. Additionally, the government has increased investment in digital health technologies, such as telemedicine and health information systems, to improve the efficiency and effectiveness of primary healthcare services.

Purchasing Functions in Indonesia's Health Financing Schemes

	JAMINAN KESEHATAN NASIONAL (JKN)
% of Total CHE	23.1% (2019)
Coverage	257.40 million (92.8% of the total population) **JKN enrolment is open to all citizens and the vast majority of foreigners residing in Indonesia.*
Purchaser(s)	BPJS Kesehatan (BPJSK)
Governance	BPJSK acts as single purchaser and reports to the President of Indonesia, while being supervised by the National Social Security Agency. The Ministry of Health sets the tariffs, regulation and benefit packages. The National Social Security Board (DJSN, or Dewan Jaminan Sosial Nasional) creates policies and oversees the national social security system.
For PHC:	Primary healthcare is fully covered by BPJSK. Facilities report to MOH for quality of care purposes.
Financial Management	BPJSK collects data from multiple revenue sources, both public and private. The public revenues come from mandatory contributions (or premium) as well as subsidies. The private contributions come from out-of-pocket contributions from JKN users, as well as cost sharing for certain services. The subsidies come from the MOH and are credited directly to the pooled fund.
For PHC:	Primary care services, either private or public, collect revenues from the public fund and the JKN fund. Public primary care institutions are entitled to receive public health funds, channelled through the deconcentration and physical funds from the central and regional government.
Benefits Specification	The benefit specification is conducted by the MOH. The MOH implements all benefit packages through cost-effectiveness assessments. As JKN deals with individual health services, all benefits are tailored to medical treatment and individual-level interventions, except for vaccination for HPV (other mandatory vaccines fall under the preventive health population scheme).
For PHC:	The benefit specification for primary care under JKN includes non-communicable disease screening as well as vaccinations (e.g., HPV).
Contracting Arrangements	BPJSK conducts credentialing for providers based on predetermined indicators, covering supply-side and process readiness. MOH also conducts regular quality reviews of care in the form of accreditation for facilities contracted under JKN, both public and private.
For PHC:	Contracting agreements for primary care take place similarly between public and private facilities. Once credentialing is completed and enrolment into JKN is confirmed – both for Puskesmas or private clinics — primary care facilities must undergo accreditation.
Provider Payment	Provider payment follows capitation, case-mix payments and retrospective claims. Performance-based capitation is used for primary care, alongside retrospective line-item payments for certain services. Case-mix payments are given retrospectively in a bundled system per each diagnosis, particularly to referral care providers. Claim payments, also retrospective, are made to special facilities for each delivery of a specific service (e.g, maternity clinics for each normal delivery).
For PHC:	Capitation payments are made to accredited primary care providers monthly according to the number of registered users under each establishment. The value of capitation payments is subject to certain indicators being obtained each month (performance-based capitation). Retrospective line-item payment are accepted for maternal care services (e.g. normal childbirth).
Performance Monitoring	JKN implements performance monitoring and links it to provider payment. Monitoring is generally conducted on cost and quality indicators by the Cost and Quality Control (*TKMTB)* committee. In primary care, performance-based capitation is applied to incentivise providers to increase their standards of care. At a system level, the aggregate progress of JKN is supervised and controlled by the DJSN. An accreditation committee (KARS) as well as Hospital Supervision Board (BPRS) carries out quality assurance. KARS regularly conducts accreditation and re-accreditation for hospitals based on quality standards.
For PHC:	Performance-based capitation requires primary care providers to meet monthly targets for full disbursement relating to 1) contact rate, 2) managed chronic care patient ratio and 3) ratio of non-specialist referrals. A performance monitoring platform, SATUSEHAT, is also being developed to connect all health information systems for users and providers within one digital application.

Purchasing Functions in Indonesia's Health Financing Schemes

	SUPPLY SIDE SCHEME
% of Total CHE	29% (2019)
Coverage	275,500,000 individuals (100% of the total population) **The supply-side scheme focuses on health promotion & prevention and therefore covers the entire resident population.*
Purchaser(s)	Ministry of Health, regional governments
Governance	The supply-side financing scheme follows the annual public budget cycle. As Indonesia practises decentralisation, fiscal transfers are conducted from the central government to regional governments (provincial and municipality/district) which then allocate their internal funds. The Ministry of Finance (MOF) transfers a dedicated budget to the Ministry of Health and disburses it through different channels.
For PHC:	The above governance aspects apply.
Financial Management	The financial management of fiscal transfers for health is conducted by the MOF. These are based on the medium-term development plan (*Renstra*) prepared by the MOH, Parliament and other stakeholders such as the Ministry of Development and Planning. Once the annual budget is agreed upon, the MOH divides it into central and regional funds for health. The health allocation fund is disbursed to provincial health offices, while block grants are transferred directly to the district office and primary care system.
For PHC:	Funds for primary care are disbursed through the MOH or through fiscal transfers to regional governments. Their use is based on channelling: the special allocation fund and physical allocation fund are used for infrastructure improvement and procurement; the deconcentration fund and non-physical allocation fund are used for public health activities.
Benefits Specification	The supply-side scheme is directed toward public health activities. These are conducted within public health centres (*Puskesmas* and *Posyandu*) or regional health offices.
For PHC:	The supply-side scheme finances primary care activities including training, health promotion and population-based screening and prevention (e.g., mandatory vaccination). Benefits include activities conducted within *Puskesmas* public health centres (e.g. chronic disease management) or outside the centres (e.g. home or school visit). Some activities are also conducted within community centres (*Posyandu*), such as nutrition management programmes.
Contracting Arrangements	All public health providers are included in the government's supply-side financing scheme. There are no contracting arrangements with private providers or practices.
For PHC:	As all health facilities are managed directly by the government, all public primary care facilities are included in the government's supply-side financing scheme.
Provider Payment	Public Financial Management processes are followed. Providers are not paid based on specific services but receive funding allocated towards population-based public health interventions.
For PHC:	Payments to primary health centres are based on their operating budget, as set by provincial health office planning. District health offices and *Puskesmas* create annual "plannings of activity fund" (*Rencana Kegiatan Anggaran*), collated at the provincial level and submitted before the annual budget cycle. Provincial health offices receive fund transfers from the central government accordingly and disburse these to providers. From 2022, the MOH has assigned special incentives for PHC public health programmes known as the *Insensitif Upaya Kesehatan Masyarakat*.
Performance Monitoring	Performance monitoring is conducted solely by the MOH for public providers who receive government funding. This focuses on key priority areas such as HIV/AIDS, TB and stunting.
For PHC:	Performance monitoring for public health activities is based on the vertical division of programmes. Different monitoring systems are used for priority programmes (e.g. HIV/AIDS and Tuberculosis), since different information systems are deployed for the relevant vertical programme. The MOF often monitors the effectiveness of budget spending across different government programs, even though this is not specifically institutionalised for the health budget.

Recent Progress in Strategic Purchasing

Indonesia has made great progress toward strategic purchasing in recent years. Ever since the founding of the JKN in 2014, Indonesia has established a more integrated primary care system while linking financing decisions to outcomes (performance-based financing). Moreover, Indonesia has also started piloting strategic purchasing in certain target areas to improve access to care.

- Performance-based financing has been introduced in Indonesia. The birth of single-payer insurance in Indonesia has allowed innovative payment systems to emerge. Aside from the main payment systems within JKN — capitation and case-mix payment — Indonesia has successfully piloted global budget approaches and implemented performance-based capitation as part of its national payment system for care providers.
- Indonesia has piloted strategic purchasing for tuberculosis and maternal care as priority target areas. The clear design of funding flows and channels, as well as incentives for providers for specific services, are currently being developed by the MOH.

KEY HIGHLIGHT: ESTABLISHING A NATIONAL HEALTH INSURANCE

Indonesia has been pursuing UHC to ensure equal access to healthcare. Since 2014, all public health insurance was merged into a single-payer national health insurance scheme, JKN. This was marked by the birth of Bylaw 40/2004 of the National Social Security System. Subsequently, an implementing agency — BPJSK — was appointed to manage the social health security fund and pay contracted healthcare providers under Bylaw 24/2011 on the Social Security Agency for Health.

The arrangement of Indonesia's health financing scheme has allowed the channelling of resources for both health services (funded by JKN) and public health programs (funded by the public budget). Alongside it, Indonesia also reformed its PHC system to allow the equal distribution of access to primary care and community health centres (Posyandu). Despite the progress, gaps have been identified, such as ensuring monitoring practices and the sustainability of the health system.

Strategic purchasing is an important tool to alleviate health financing problems, particularly in the JKN. This has been highlighted in Indonesia's implementation of innovative healthcare payment systems, such as performance-based capitation. Progress has also been made in piloting strategic purchasing, with several areas identified for target interventions — particularly for vertical programs such as maternal health and tuberculosis.

Challenges for Strategic Purchasing

- BPJSK is limited in its role as sole purchaser. Currently, the role of BPJSK as sole purchaser is limited. For example, BPJSK is given the mandate to operate under certain service delivery and quality standards but does not have the power to change or set its own quality standards. Moreover, BPJSK does not have the flexibility to choose effective payment systems, but must instead implement payment systems agreed upon by associations and regulators (i.e., MOH).
- Indonesia has limited cost and quality control mechanisms. Directly linked with the limited role of BPJS as the sole purchaser, the limited cost and quality control for healthcare utilisation might be a setback for implementing strategic purchasing. The heightened demand for healthcare due to the existence of JKN — accelerated by COVID-19 — led to over-utilisation of services. Since there is no cap in the benefits package (e.g., with cost-sharing and/or utilisation controls), the quality of care may be compromised as users over-utilize services.
- There is a lack of adequate incentives for primary care providers, leading to the over-utilisation of specialist services. Since primary care practitioners are not incentivised, financially or otherwise, there are limited gatekeeping functions in the primary care system. This leads to a high number of referrals, either vertical or specialist. In the long term, this adds to the cost of healthcare.
- There is limited knowledge of and capacity for strategic purchasing among health system stakeholders. Health system practitioners, academics and policymakers need to not only understand the concept but also the application of strategic purchasing in the health system. Currently, there is limited evidence around strategic purchasing and its potential in global literature and in Indonesia specifically.

Opportunities to Improve Strategic Purchasing

1. **Indonesia could gradually build a strategic role for BPJSK to improve efficiency.**

   As BPJSK becomes the single operator of the national health insurance, it should be given the authority to implement efficient policy options without sacrificing the quality of care. Quality standards, alternative payment system choices and evidence-based allocation of resources should gradually be placed under the jurisdiction of BPJSK. Healthcare regulators such as MOH should conduct regular monitoring of the health system to keep BPJSK accountable in the process. Moreover, over, BPJSK should be given a greater role to leverage the private sector. Especially for curative care, BPJSK should be able to set clear roles for and be inclusive of private providers, so that access to care for the population can be improved. Moreover, by taking a more strategic role, BPJSK could search for alternative financing beyond domestic or public sources (e.g., private sector or non-domestic source) to sustain its operation. Moreover, BPJSK should be given a greater role to leverage the private sector. Especially for curative care, BPJSK should be able to set clear roles for and be inclusive of private providers, so that access to care for the population can be improved. Moreover, by taking a more strategic role, BPJSK could search for alternative financing beyond domestic or public sources (e.g., private sector or non-domestic source) to sustain its operation.

2. **Indonesia could use data to enforce cost and quality controls for services to avoid wastage and improve outcomes.**

   Currently, the quality and control team (Tim Kendali Mutu Kendali Biaya/TKMKB) is only authorised to monitor cost and quality, but with little support from MOH and other stakeholders and not in an institutionalised manner. The institutionalisation of cost and quality will increase the accountability of the implementer (BPJSK) and limit any conflicts of interest between the current TKMBKB and BPJSK. This is important as currently, TKMKB is composed of stakeholders (academia, professionals and experts) operating under BPJSK, which is prone to having conflict of interest. Moreover, BPJSK should operate quality control beyond credentialing (the initial quality check before contracting providers). Having its own quality of care matrix and assurance system would allow BPJSK to monitor care independently, and without compromising quality between public and private sector providers.

3. **JKN could carefully select and monitor provider payment systems that reward efficiency.**

   Currently, JKN implements case-mix based group (CBG) payment, which allows hospitals to be paid for a sum per diagnosis treated. CBG incentivises cost-control, as fixed payments are set. However, this scheme incentivises providers to accept patients needing low-cost treatments and to refer or reject those of high-cost. There are also multiple occasions where CBG payment systems introduce fraud, such as upcoding (hospital submitting diagnoses with higher claims to receive more payment). A combination of proper monitoring of the payment system, as well as an introduction of new payment systems that reward efficiency, can be implemented to tackle this issue. Global budget payments for hospitals, for example, could manage volume and cost based on set prospective payments.

Opportunities to Improve Strategic Purchasing for Primary Care

1. **Indonesia could design benefit packages that prioritise a population and preventive health approach.**

   The current system does not fully incentivise public health interventions. The benefit package is designed based on primary care diagnoses (total of 144 diagnoses) and leaves out other essential public health functions, such as screening and vaccinations. Vaccination and screenings have a high return of investment (ROI). Currently, public health programmes such as vaccinations are under the MOH budget rather than JKN as they target population health; however, funding for these is limited and only mandatory vaccinations are covered. Adding vaccinations and similar services to the JKN's benefit package could better prioritise public health and allow the better management of diseases which cannot be eradicated through treatment alone. Active case finding in tuberculosis, for example, would benefit the community once inserted in the benefit package.

2. **Indonesia could consider introducing payment systems that incentivise appropriate primary care provider behaviour, thus improving outcomes and reducing cost.**

   The current payment system potentially punishes primary care providers rather than rewarding them for improvement. For example, JKN currently implements performance-based capitation based on selected indicators that encourages better performance. However, the implementation tends toward disincentivising, since the system punishes providers if target indicators are not met. This may encourage the manipulation of indicator data in order to meet capitation income targets and to avoid punishment or payment cuts. On the other hand, at times when target indicators are already met within a month, this may discourage providers from performing further. Incentive systems which motivate better primary care performance and public health programmes are warranted. A payment system should be implemented to allow for extra incentives as metrics of success for interventions are achieved — both for clinical care and public health initiatives. For example, for Tuberculosis, the allocation of incentives for successful Active Case Finding (ACF) should be set.

3. **Indonesia could invest in capacity building for strategic purchasing in primary healthcare.**

   Primary care providers are often limited in capacity and understaffed. This could be improved by introducing an understanding of strategic purchasing principles — for example, how to manage different information and reporting systems and how to optimise limited resources amidst the abundant responsibilities of primary care. Building strategic purchasing capacity for primary care implementers would enhance the potential of primary care settings. For example, clinic managers could increase uptake if they knew how to efficiently allocate funds for public health activities. Moreover, within each centre, incentives could be designed to compensate allied health workers (e.g., community healthcare workers) to accelerate public health or out-of-building activities.

Lao PDR

Health Financing Schemes in Lao PDR

Lao PDR is a landlocked lower-middle income country. Despite limited resources, it has made great progress toward implementing better digital health infrastructure and merging its social health protection schemes into one. Thanks to the National Health Insurance scheme, social health protection coverage increased from 10% to 94.5% in under 10 years.

However, Lao remains lagging in terms of health outcomes globally due to low accessibility and quality of services. Its mountainous terrain and poor supply-side readiness, among other factors, pose challenges to further strengthening Lao PDR's health system and implementing strategic purchasing.

The main health financing schemes in Lao PDR are:

NATIONAL HEALTH INSURANCE: The National Health Insurance (NHI) scheme was introduced in 2016 as a universal health protection scheme. In 2019, the NHI successfully merged Lao's separate health protection schemes: the NSSF for the formal sector, and the Health Equity Fund (HEF) and Community Based Health Insurance (CBHI) for the poor and informal workers. The NHI relies primarily on tax-based financing with low co-payments and exemptions for specific groups. It is supplemented by mandatory contributions from the formal sector; these are channelled through the National Social Security Fund (NSSF-SASS for civil servants and NSSF-SSO for the private sector). Health contributions to the NSSF are split between employers and employees. The NSSF transfers 1.25% of its collected contributions to the NHIB.

GOVERNMENT BUDGET: Beyond contributing to NHI revenues, the government of Lao allocates annual budgets to the health sector through the Ministry of Health. Government expenditure in Lao made up 42.9% of health expenditure in 2020 (including NHI contributions and other MOH spending). This was the first year that government expenditure overtook out-of-pocket payments. The public health system in Lao is divided among three administrative levels (central, provincial, and district) and four service provider levels (central, provincial, district, and health centre). Beyond participating in the NHI scheme, these public facilities receive input-based financing via the MOH.

OTHER SCHEMES: Vientiane Capital is not yet included in the NHI. The CBHI (a voluntary scheme for informal workers) still exists in the capital, covering approximately 3% of the population. Vertical donor-funded programmes also contribute significantly to the health sector, focusing on nutrition, infectious diseases and maternal & child health.

OVERVIEW

Population (2022): **7.53 million**

GPD per capita (2022): **US$2,088**

Poverty headcount at national poverty line (2019): **18.3%**

Life expectancy (2021): **68 years**

Infant mortality rate per 1,00 live births (2021): **34.2**

DALYs per 100,000 (2019): **26,886**

Current health expenditure as % of GPD (2020): **2.69%**

Domestic government expenditure as % of CHE (2020): **42.85%**

Out-of-pocket expenditure as % of CHE (2020): **41.76%**

UHC Service Coverage Index score (2021): **52**

Physician density per 1,000 people (2020): **0.35**

The Primary Healthcare System in Lao PDR

Public healthcare services in Lao PDR are provided across three administrative levels: tertiary (provincial and central hospitals, secondary (district hospitals) and primary (health centres). Primary care is also available at private, military and police facilities. However, the private sector accounts for under 10% of health spending in the country and is not included in nationally-funded programmes such as the National Health Insurance. Services provided at primary health centres are relatively comprehensive, and include outpatient and inpatient care with a co-payment of LAK5,000 for most citizens.

Free maternal and child health services have been provided since 2010, including primary as well as inpatient care. This was significant in helping Lao PDR achieve improved maternal and child health outcomes. These FMCH programmes have been merged into the consolidated NHI from 2016 onward.

The primary care system is Lao is challenged by supply-side limitations. These include an insufficient and poorly-trained workforce; low availability of basic equipment and medicines; and delayed reimbursement from the NHI to health centres. Since primary health centres and secondary district hospitals especially suffer from resource limitations, patients may bypass primary care and directly seek services at provincial or regional hospitals. This is made possible because, while referral systems are technically in place in Lao, they are not effective due to the lack of gatekeeping functions in primary care. Substantial investment from the government will be necessary to improve quality and utilisation in primary care.

Purchasing Functions in Lao PDR's Health Financing Schemes

	NATIONAL HEALTH INSURANCE
% of Total CHE	7.53% (2017 – NHI and NSSF schemes combined)
Coverage	7.12 million (94.5% of the total population) **The NHI covers the entire Lao PDR population with the exception of Vientiane capital.*
Purchaser(s)	National Health Insurance Bureau
Governance	The implementation of the NHI scheme is based on Decree 470/PM (2012). The scheme is implemented by the Ministry of Health (MOH) and managed by the NHI Management Committee and its Secretariat, the National Health Insurance Bureau (NHIB). The NHIB at the central level is a department of the MOH and is responsible for all NHI management functions. While the Ministry of Labour and Social Welfare (MLSW) historically ran the National Social Security Fund (NSSF) schemes, these were integrated into the NHI in 2019 and are now managed by the NHIB.
For PHC:	The above governance aspects apply.
Financial Management	The NHIB is responsible for NHI financial management, including accounting and transfers to Provincial and District Health Insurance Bureaus (P/DHIB). Decree 470/PM outlines the principle of "[ensuring] the right, transparent and auditable manner concerning the transaction of the NHIF." However, financial management is challenging in practice due to manual record-keeping.
For PHC:	PHIB and DHIB receive funds from the national-level NHIB. Funds for primary care are jointly managed by the NHIB nationally and P/DHIB for their respective jurisdictions.
Benefits Specification	The NHI covers formal sector employees and their families through NSSF enrolment, and automatically covers the rest of the population. It includes a comprehensive benefit package covering most public sector health services, with a low co-payment (LAK 5,000-30,000) at point of care. The poor, expectant mothers, children under 5, monks, village heads and contributing NSSF members are exempt from co-payments. The NHI benefit package is proposed by the NHI Management Committee and stated in the Law on Health Insurance through a combination of negative and positive definitions. There are differences in the benefits package for NSSF members and other NHI beneficiaries, with the NSSF benefit package being less comprehensive.
For PHC:	The NHI benefit package covers comprehensive primary care services at public health centres. There is a co-payment of LAK5,000 (inpatient and outpatient) except for exempted populations.
Contracting Arrangements	The NHI covers treatment at all public health facilities. These include local health centres and district, provincial, central and specialised hospitals. One private hospital — Xaymangkorn hospital in Udomxay — is contracted with NHIB and part of the NHI network.
For PHC:	All public primary care health centres are automatically contracted by the NHI.
Provider Payment	NHI payment to service providers is in principle output-based, but performance-based formulas are not yet developed. Capitation is used at health centres and for most outpatient services at other facilities. Case-based payments are used for maternal and child health services and inpatient services. Capitation payments are made in advance; case-based payments are released 80% upon receipt of a quarterly report from the facility and 20% after verification. The NHIB uses a simple system based on ExcelView to make case-based payment calculations. Third-party reimbursement does not apply for referrals to central hospitals; patients must pay out-of-pocket and subsequently submit an NHI reimbursement claim.
For PHC:	Advance capitation payments are used to reimburse primary health centres.
Performance Monitoring	The NHI has low facility monitoring capabilities due to manual record-keeping practices. At the systems level, it collects data on utilisation and health outcomes and conducts an annual review to inform the following year's budget request, taking into account past spending and necessary funds for future improvements. The Lao Expenditure and Consumption Survey has been used to show improvements in health service accessibility and financial protection, but, this is conducted at 5 year intervals and does not include data on quality or other relevant indicators.
For PHC:	Performance monitoring for individual primary care facilities is limited.

Purchasing Functions in Lao PDR's Health Financing Schemes

	GOVERNMENT BUDGET
% of Total CHE	42.85% (2020)
Coverage	7.53 million (100% of the total population) **The government budget focuses on health promotion & prevention and therefore covers the entire resident population.*
Purchaser(s)	Ministry of Finance, Ministry of Health
Governance	The Ministry of Finance (MOF) is responsible for all budget planning, including for health. The Ministry of Planning and Investment (MOPI) is also involved in making capital investment decisions and giving guidance on funding from external donors. The Ministry of Health (MOH) is responsible for managing funds allocated to health, including the management or health services and human resources. District and Provincial Health Offices (DHOs and PHOs) are involved in budget planning: DHOs prepare budget plans through requests from health centres, and PHOs consolidate these plans for submission to the MOH and MOF.
For PHC:	The above governance aspects apply.
Financial Management	The Sam-Sang decentralisation policy has made provincial governments responsible for fund management at the provincial level. While a proposal has been submitted to prevent the reallocation of health and education funds, this has not yet been translated into legislation. Provincial governments have autonomy over health workforce planning, but the MOF restricts their ability to shift their budgets to meet emerging needs (e.g. equipment repair).
For PHC:	DHOs and PHOs are allocated budgets to implement public health programmes. While lower-level health centres should be consulted in budget planning, this is very limited in practice. Health centres therefore have low autonomy in budget planning and (re)allocation.
Benefits Specification	The government budget is intended to implement public health programmes, to assist health facilities in supply-side readiness and to complement resources generated through the NHI. While facilities should have access to basic equipment and medicines, these are sometimes unavailable to patients.
For PHC:	Primary care health centres receive government funding for human resources, amenities and equipment and medicines. However, health centres often lack the basic medicines and equipment necessary to treat patients.
Contracting Arrangements	MOF/MOH budgets for health are allocated to all levels of public facilities, including tertiary care (provincial and central hospitals), secondary care (district hospitals) and primary care (health centres).
For PHC:	The above contracting arrangement aspects apply.
Provider Payment	Annual budget allocations are currently not based on clear formulas. Budgets are prepared based on historic allocations or with no accounting mechanisms, and therefore vary considerably across provinces.
For PHC:	The above provider payment aspects apply.
Performance Monitoring	Each sector (including health) sets targets through five-year planning cycles. The National Assembly monitors the implementation of these sector plans. The Health Sector Reform Strategy 2015-2025 has set explicit objectives for the health sector, and HSR committees are in place to monitor the strategy's progress. A recently-released 5 Goods and 1 Satisfaction policy outlines 5 indicators that all health facilities must meet. Nonetheless, no specific indicators to track performance are given and performance monitoring capabilities remain limited.
For PHC:	All health facilities – including primary health centres – should meet Lao PDR's 5 Goods and 1 Satisfaction requirements. However, performance monitoring is limited in practice.

Recent Progress in Strategic Purchasing

- The Law on Health Insurance was promulgated in 2018 as the legal framework underpinning the NHI. In 2019, pre-existing formal sector (NSSF) schemes were merged into the NHI following pilots in the Vientiane and Sekong provinces. This completed the successful merging of all previous MOH and NSSF-operated social health protection schemes under the NHI.
- The National Health Insurance Strategy 2021-2025 was published as an update of the NHI Strategy 2017-2021. This retains the general direction and aim of the NHI to provide Universal Health Coverage, and calls for legislative changes to establish the NHIB as a semi-autonomous body with a reserve fund for an increased purchaser-provider split.
- Lao PDR is seeking to improve its public financial management across government and in the health sector. In 2019, Lao initiated a Public Financial Management Strengthening Program to improve the country's budgeting, taxation, accounting, reporting, public procurement and treasury practices. This programme is supported by partners including the Asian Development Bank, European Union, International Monetary fund and others. Within the health sector, an ADB-supported roadmap for financing health has been extended until 2030. This covers public financial management reforms as a collaboration between the MOH and the Department of Finance (DOF).
- Development partners are assisting Lao PDR to implement performance-based provider payment initiatives. The Health and Nutrition Services Access project (HANSA), supported by the World Bank and Global Fund among other partners, includes support for quality and performance monitoring and DHIS-2 data entry. USAID is also providing assistance to Lao PDR to expand its performance-based provider payment mechanisms. This includes providing assistance on the design of incentives to providers and testing output-based payment mechanisms.
- Lao PDR issued a 5 Goods and 1 Satisfaction (5G1S) policy in 2016 to improve treatment & diagnostic accuracy and increase patient satisfaction. The items include: 1) warm welcome, 2) cleanliness, 3) convenience, 4) accurate diagnosis, 5) good and quick treatment, alongside patient satisfaction. This guidance marks a foundational effort toward quality improvement but lacks specific indicators to track the intended areas of improvement.

KEY HIGHLIGHT: INTEGRATING FRAGMENTED HEALTH FINANCING SCHEMES

Lao PDR has seen great success in merging its various fragmented health financing schemes into a National Health Insurance. In 2012, Decree 470/PM was issued by the Prime Minister to create a legal basis for a national social health insurance fund. It also included provisions to establish an administrative body for this fund, now known as the National Health Insurance Bureau under the MOH.

The NHI was initially implemented in 2016 by merging the voluntary Community-Based Health Insurance (CBHI), the Health Equity Fund (HEF) for the poor and the Free Maternal, Newborn and Child Health (FMNCH) scheme for mothers and children under 5. In 2019, two formal sector schemes previously managed by the National Social Security Fund – the NSSF-SASS for civil servants and NSFF-SSO for the private sector – were successfully merged into the NHI.

This rapid progress raised social health protection coverage in Lao PDR from 10.5% in 2008 to 94.5% in 2018. Currently, only Vientiane capital is excluded from the NHI and continues to operate smaller health protection schemes. Though coverage is high, challenges remain in ensuring the adequate provision of benefits to reduce high out-of-pocket payments. The merging of fragmented schemes will be an important facilitator to expand national benefit packages.

Beyond successfully pooling internal resources, Lao PDR has focused on effectively integrating donor aid – which accounts for 15.36% of CHE – after passing the Vientiane Declaration on Aid Effectiveness in 2006. This aimed at the harmonisation of donor- and government- funded plans. A health Sector-Wide Coordination (SWC) mechanism provides a platform for the MOH and other stakeholders to effectively plan for aid distribution across health programmes.

Challenges for Strategic Purchasing

- Despite the NHI's relatively comprehensive benefit packages, high population coverage and low co-payments amount, its financial protection capacity remains limited. This is reflected in the continued high rate of out-of-pocket (OOP) payments in Lao PDR, as high as 41.76% in 2020. While OOP expenditure is on a downward trend, it remains a high proportion of total health expenditure. Indirect payments also remain a significant challenge at the facility level despite the existence of the NHI benefit package, as facilities may not feel that they receive sufficient NHI reimbursement.
- The lack of supply-side readiness among healthcare facilities hinders the effectiveness of the NHI in providing universal health coverage. Many facilities — especially local health centres — lack basic amenities, equipment and medicines. Funding and training for human resources are also limited and poses a further challenge to Lao PDR's health system capacity.
- Information systems are not sufficiently developed in the Lao PDR health system. The NHI, in particular, lacks an interoperable information management system. Some facilities (especially at the lower level) operate with only manual record-keeping. This prevents the NHI from carrying out effective monitoring and evaluation. The verification of claims and reimbursement to health facilities may also be set back. Moreover, data collected in the DHIS-2 cannot be used to inform the NHIB's purchasing decisions as there is no sufficient financing and patient-level data available.
- Lao PDR lacks gatekeeping mechanisms in primary care, and the system is geared disproportionately toward central rather than local levels of care. This leads to patients bypassing local health centres in favour of central and provincial hospitals. As a result, local and provincial facilities remain under-utilised and a higher burden is placed on the secondary and tertiary care system. Local health facilities are also at risk of not benefitting from national reforms, as service delivery bottlenecks can lead to national-level reforms having a limited impact at the local level. This is a particular challenge for poor, rural and otherwise underserved population groups who will find it challenging to access higher-level health facilities.

Opportunities to Improve Strategic Purchasing

1. **Lao PDR could work to establish the NHIB as a semi-autonomous body with a reserve fund, as outlined in the NHI strategy 2021-2025.**

   This would grant the NHIB more independence in decision-making and budgeting. A reserve fund would act as a financial buffer, ensuring the continuity and sustainability of the NHIB in spite of inflationary pressures. Proper accountability mechanisms should be developed among the NHIB, MOH and other health system stakeholders on the occasion of an increased purchaser-provider split.

2. **Lao PDR could consider developing National Health Accounts (NHA) on an annual basis to generate evidence and drive decision-making on public health spending.**

   NHA in Lao PDR have been previously prepared by the Health Financing Policy Division of the Department of Finance, Ministry of Health (MoH). Increasing the regularity of these accounts will provide updated data to identify areas with greater health needs and allocate resources accordingly. This could be achieved with support from the WHO or other relevant partners. Policymakers and bureaucrats should also be trained to make use of NHA data in strategic purchasing decision-making.

3. **The NHIB could focus on improving the timeliness of its reimbursements to health facilities.**

   This could be achieved through improved Information Technology or medical claims verification systems. Reducing delays in provider payments will help raise satisfaction among participating facilities, decrease indirect payments at the facility level and increase financial protection for NHI beneficiaries.

4. **Information management systems could be improved for the NHI and across the health system.**

   Data quality checks should be used on a more systematic basis, and facilities relying on manual record-keeping should be identified and supported in transiting to IT systems through improved infrastructure and staff training. Data collected across the health system should follow interoperability best practices. To translate these information systems gains to health system improvements, a culture of using data to guide evidence-driven policy-making and health purchasing should be encouraged at the MOH level.

Opportunities to Improve Strategic Purchasing in Primary Care

1. **Supply-side readiness at the primary care level could be strengthened, with a particular focus on access to basic equipment and essential medicines.**

   This will ensure that health needs of poor and remote communities are well-served and that unnecessary referrals to district or central hospitals do not take place. Improving supply-side readiness may also include investing in training for primary care providers (including doctors, nurses, allied health and community health workers) on medical skills, IT skills and gatekeeping practices.

2. **Lao PDR could improve its gatekeeping systems to discourage bypassing of primary care services among patients.**

   This could be achieved through NHI reforms, including strengthening referral systems and providing performance-based incentives for primary care providers to engage in gatekeeping practices. Broader initiatives could be considered at the community level, such as public awareness campaigns to educate the population on the importance of primary care.

3. **Lao PDR should invest in improving information systems in primary care.**

   Currently, national health reforms may not translate at the local health centre level due to low information capacity and service delivery bottlenecks. Helping primary care facilities collect better-quality, digital data can ensure that health sector improvements in Lao PDR reach all levels of care. Primary care data can also assist in identifying the varying health needs of provinces and villages, and planning for resource allocation according to these needs.

Malaysia

Health Financing Schemes in Malaysia

Malaysia is an upper-middle income country situated on the Malaysian archipelago and the island of Borneo. The Malaysian health system is split between the private sector (1/3) and public providers (2/3) who providing free or high-subsidised services at point-of-care. In 2019, almost 35% of Malaysia's total health expenditure came from OOP payments.

Healthcare reforms have been in the making since 1985 to reduce the strain on the health system and to sustain universal healthcare coverage. While there is no national health financing scheme to date, progress has been attempted to ensure equity in healthcare service delivery for vulnerable populations.

The main health financing schemes in Malaysia are:

TAX-FUNDED SCHEME: Health financing in Malaysia has been mainly funded from government revenues since independence, providing highly-subsidised healthcare services for the general population and legal residents at public healthcare facilities. General government revenues come from direct taxation (60%) and indirect taxation via the Goods & Services Tax (GST).

PEKA B40: PeKa B40 is a government initiative via the Ministry of Health to meet the healthcare needs of Malaysian citizens in the bottom 40% of household income (the B40 group). Citizens who receive financial aid for households in the poverty range (Sumbangan Tunai Rahmah) and their spouses are automatically eligible for this programme. No prior registration is required. PeKa B40 benefits include health screenings at MOH or registered private GP clinics; the purchase of medical equipment required in procedures/treatments not subsidised in MOH hospitals, capped at MYR 20,000; and financial assistance and transportation reimbursements while undergoing cancer treatment. In 2021, this scheme benefited 101,673 participants (14.9% of the B40 group) with services provided by 2589 private GPs, 897 MOH clinics, 181 private diagnostic labs and 145 MOH hospitals.

OTHER SCHEMES: Health protection schemes for specific subgroups and voluntary/employer health insurance schemes are available in Malaysia. The largest of these is PERKESO (Social Security Protection), a scheme for employees and their dependents (including the self-employed and foreign domestic workers). Medical and recovery services include care at the PERKESO Rehabilitation Centre, Return to Work services, panel clinics providing medical treatment for employment-related injury for insured persons, Dialysis Centres and a Health Screening programme (SEHATI).

OVERVIEW

Population (2022): **33.58 million**

GPD per capita (2022): **US$11,972**

Poverty headcount at national poverty line (2019): **8.4%**

Life expectancy (2021): **75 years**

Infant mortality rate per 1,00 live births (2021): **6.1**

DALYs per 100,000 (2019): **26,886**

Current health expenditure as % of GPD (2020): **4.21%**

Domestic government expenditure as % of CHE (2020): **52.75%**

Out-of-pocket expenditure as % of CHE (2020): **35.89%**

UHC Service Coverage Index score (2021): **76**

Physician density per 1,000 people (2020): **2.29**

The Primary Healthcare System in Malaysia

Malaysia has a strong primary healthcare (PHC) network that has been in place since independence in 1957. The country has a two-tier healthcare system, with public and private services coexisting without formal integration. The public sector is government-funded and provides almost free primary care, while the private sector is fee-for-service. The public PHC network is operated and managed by the Ministry of Health (MOH) and is designed to provide comprehensive and universal access to basic healthcare services to all citizens. The majority of Malaysians (64.3%) use the public sector, which includes a network of health clinics and community health centres staffed by healthcare professionals offering a range of services.

The PHC system in Malaysia incorporates a community-based approach to healthcare delivery. This includes community participation in health promotion and disease prevention programmes, as well as outreach services to remote and underserved communities. Studies have shown that public primary care services were better than private providers in serving primary care-sensitive conditions, had better informational continuity and had a better skill-mix and inter- and intra- professional relationships. Meanwhile, the private sector was stronger in the referral decision-making process, specialist feedback and greater out-of-hours facilities access.

The MOH has established various programs and initiatives to improve the quality and accessibility of PHC services in Malaysia, such as:

- Increasing the availability of Family Medicine Specialists at community health centres to guide the clinical team.
- The implementation of the Family Doctor Concept, which encourages continuity of care.
- The use of an Electronic Medical Record (EMR) system to facilitate the sharing of medical information among healthcare providers within the public healthcare facilities.

However, the public PHC system still faces challenges, such as:

- A shortage of healthcare professionals and EMR coverage, particularly in rural and remote areas.
- Limited access to specialised services for certain medical conditions.
- The increasing burden of primary care’s gatekeeper role to tertiary care services (e.g., long waiting times and shortage of drugs, especially for chronic Non-Communicable Diseases).
- Despite these challenges, Malaysia's PHC network is a vital part of the country's healthcare system and plays an important role in improving the health of the population.

Purchasing Functions in Malaysia's Healthcare Schemes

	TAX-FUNDED SCHEME
% of Total CHE	46.1% (2020)
Coverage	33.58 million (100% of the total population) **Highly-subsidised public healthcare is available to all legal residents in Malaysia, citizen and non-citizen.*
Purchaser(s)	Ministry of Health
Governance	The Ministry of Health is the main purchaser of public healthcare services in Malaysia. Its Procurement and Privatisation Division (PPD) is responsible for procurement, privatisation, asset and store programmes – including for pharmaceuticals, medical equipment, services and ICT. The MOH follows procurement guidelines set by the Ministry of Finance (MOF) for all ministries. The Auditor General audits the financial health of the MOH annually and presents the report to the Parliament for public scrutiny.
For PHC:	The public primary care system is fully covered by the MOH (accounting for 25.9% of health expenditure in 2021). Public providers report to the MOH on quality of care indicators. Private primary care services are privately-owned and therefore do not report to the MOH.
Financial Management	Public providers collect revenues from all patients (Malaysian citizens & non-citizens) based on a standardised fee schedule. The Government Trust Fund (under section 10, Financial Procedures Act 1957) is available to help those unable to pay finance the costs of medical treatment.
For PHC:	A nominal fee of MYR 1 is paid per primary care visits (including consultations, lab investigations as and one-month supply of prescribed medications). A fee of MYR 5 is paid by patients receiving treatment from a Family Medicine Specialist. Non-citizens are charged using different rates, except for communicable diseases where treatment is free of charge.
Benefits Specification	Benefit specification at all public healthcare facilities is determined by MOH directly. It covers comprehensive benefits at all levels of care (primary to tertiary), and includes medical care, dental care and health prevention/promotion.
For PHC:	Benefits at the public primary care level include integrated health services such as health promotion, disease prevention and curative, rehabilitative and supportive care.
Contracting Arrangements	Agreements are set between all providers (primary, secondary and tertiary) directly with the MOH. Contracts with the National Heart Centre (IJN SB) cover patients who require specialised cardiac management not available at tertiary public hospitals.
For PHC:	Public primary care clinics are financed by the MOH to provide comprehensive services for the population.
Provider Payment	Provider payment follows generally fee-for-service methods. Case-mix and Diagnostic-Related Groups (DRGs) are used for several MOH tertiary centres.
For PHC:	Public primary care facilities are paid on line item budgeting basis from the government.
Performance Monitoring	The MOH implements performance monitoring for all services across public facilities. For hospital-based services, this is monitored by the Clinical Performance Surveillance (CPSU) of the Medical Care Quality Section at the Medical Development Division.
For PHC:	Performance monitoring for primary care is conducted by the Family Health Development Division of the MOH.

Purchasing Functions in Malaysia's Healthcare Schemes

	PEKA B40
% of Total CHE	0.17% (2020)
Coverage	5.90 million (19.4% of citizens / 17.4% of the total population) **PeKa B40 covers the bottom 40% of Malaysian citizen households only.*
Purchaser(s)	ProtectHealth Corporation, Ministry of Health
Governance	All governance aspects follow general MOH and corporate governance processes. The ProtectHealth Corporation was established as a private company fully owned by the Malaysian government in 2016. ProtectHealth is led by a Board of Directors comprising representatives from the Ministry of Health, Ministry of Finance and Independent Members. It was established to play the role of purchaser and has autonomy on choosing providers, with defined processes for ensuring quality performance as well as measures to penalise non-performers.
For PHC:	As PeKA B40 is a primary care-focused scheme, all governance aspects above apply.
Financial Management	The financial management of PeKa B40 is conducted by the MOH via ProtectHealth. The government and MOH allocate funding for ProtectHealth to carry out its intended activities.
For PHC:	As PeKa B40 is a primary care-focused scheme, all financial management aspects described above apply.
Benefits Specification	The PeKa B40 scheme is offered to Malaysian citizens in the bottom 40% household income range (the B40 group). Recipients of the Sumbangan Tunai Rahmah (STR) cash assistance programme and their spouses aged 40 and above are automatically eligible. Benefits include free health screenings (physical examination and laboratory tests) at public or registered private clinics. The scheme does not yet include treatment or medication benefits. Recipients who require treatment post-screening are referred to government clinics for free treatment or, if treated at a private clinic, must bear the cost themselves. Recipients who require any non-MOH subsidised medical equipment (e.g. intraocular lenses, intracardiac stents) are eligible for financial aid up to MYR 20,000. The PeKa B40 scheme also provides cash incentives for recipients who complete cancer treatment (up to MYR 1,000) and transportation cost support (up to MYR 500-1,000).
For PHC:	As PeKa B40 is a primary care-focused scheme, all benefits specification aspects described above apply.
Contracting Arrangements	ProtectHealth contracts public and private primary care clinics to provide health screening services for beneficiaries. Screening tests at private primary care clinics are contracted to private diagnostic laboratories, while public primary care facilities use in-house diagnostic laboratory services. ProtectHealth selects its providers based on set criteria for primary care practitioners; providers must be registered with the Malaysian Medical Council, clinics must have IT facilities for patient data transfer and diagnostic laboratories must be accredited and meet industry quality standards.
For PHC:	As PeKa B40 is a primary care-focused scheme, all contracting arrangement aspects described above apply.
Provider Payment	ProtectHealth pays providers through fee-for-service payments with set payment rates — e.g. MYR 60 per client recruited for health screening, which includes consultation and laboratory test fees. Capitation and other forms of provider payment mechanisms are being considered and may be adopted in future benefit packages.
For PHC:	As PeKa B40 is a primary care-focused scheme, all provider payment aspects described above apply.
Performance Monitoring	Regular medical audits and performance reviews of PeKa B40 providers are conducted at both the ProtectHealth and MOH level. Under- or non- performing providers will be issued reminders to improve, and procedures are in place for penalties or the withdrawal of contracts.
For PHC:	As PeKa B40 is a primary care-focused scheme, all provider payment aspects described above apply.

Recent Progress in Strategic Purchasing

- The COVID-19 pandemic highlighted gaps in health procurement practices and regulations set by the Ministry of Finance. Strategic purchasing principles were employed to purchase vaccines and accelerate public-private partnerships for healthcare services.
- To enhance efficiency and quality, Malaysia has adopted contracting and performance-based financing since July 2022. Contracts established between the Ministry of Health and healthcare providers follow general Procurement Procedures set by the Ministry of Finance, focused on service delivery targets, quality indicators and payment mechanisms.
- To strengthen hospital payment systems, Malaysia introduced Diagnostic-Related Groups (DRGs) in 2018. DRGs classified patients with similar diagnoses and treatment profiles, enabling fairer reimbursement to hospitals. This initiative aligned financial incentives with patient needs, promoting efficiency and cost containment. To date, ten public tertiary hospitals under MOH have implemented case-mix payments and DRGs.
- The Malaysian healthcare system has recognised the important contribution of Health Technology Assessments (HTAs) to inform strategic purchasing decisions. Specifically, the input of the Malaysian Health Technology Assessment Unit at the Ministry of Health was set up in 1995 to evaluate the clinical and cost-effectiveness of healthcare technologies, ensuring that resources are appropriately allocated to yield the greatest impact. This evidence-based approach improved the value and appropriateness of healthcare investments.
- Malaysia has focused on strengthening its PHC in recent years. The government has introduced initiatives to enhance primary care services, including the provision of comprehensive care packages, capacity building for primary care providers and venturing into public-private partnerships (PPP) with various types of provider payment mechanisms. For example, the provider payment for the PeKa B40 scheme is based on capitation. These efforts have aimed to improve health outcomes, reduce unnecessary hospitalizations and contain costs. While significant progress has been made, several challenges persisted.
- In June 2023, the government announced a new pilot initiative scheme for acute treatment at private medical clinics. Eligibility includes recipients who are from households registered for welfare aid, senior citizens (without spouses) and singles. The beneficiaries are able to use this scheme for the treatment of minor acute conditions such as upper respiratory tract symptoms, diarrhoea and vomiting, sprains and strains, headache and mild trauma. The treatment is capped at a specific amount for each category: MYR 75 for singles, MYR 125 for senior citizens to MYR 250 for households on welfare aid. This scheme does not cover health screening or treatment for NCDs.

KEY HIGHLIGHT: WORKING TOWARD HEALTH FINANCING REFORMS

Malaysia has been seeking to adopt healthcare reforms for some time, in particular addressing the need for a national healthcare financing scheme. Although attempts have been made to adopt strategic purchasing and procurement practices, improvements are required in separating provider and purchaser roles and setting clear mechanisms for performance monitoring and governance. Currently, there are social assistance programmes (i.e. the PeKa B40 scheme and Skim Perubatan Madani) which targets vulnerable populations — namely the B40 group, households who receive social welfare aid and the unemployed.

A Health White Paper presented in the Parliament on 16th June 2023 lists plans for major restructuring of the MOH over the next 15 years. This whitepaper targets 4 pillars: transforming healthcare service delivery, enhancing health promotion and disease prevention at all levels; ensuring sustainable and equitable healthcare financing; and strengthening the foundation and governance of the healthcare system. In the initial five years, there will be two main areas of focus. Firstly, establishing the fundamental building blocks necessary for implementing complex and long-term systemic or structural reforms, which may involve legislative changes. Secondly, implementing further stages of ongoing initiatives or pilot programmes to bring about improvements that more people can directly witness, thereby generating momentum for broader reform.

Challenges for Strategic Purchasing

- There is no national health financing scheme in Malaysia which can be a catalyst to wider strategic purchasing practices in the healthcare system.
- Currently, the Ministry of Health plays a dual role as purchaser and provider in the pilot social assistance scheme PeKa B40. This situation raises potential Issues of conflict of interest in the purchasing process as well as in governance practices.
- Data on provider performance and evidence-based recommendations provided by Malaysian Health Technology Assessment (MaHTAs) are administratively under MOH. Access to data should not be restricted to MOH alone, but should be accessible to other parties such as other providers, researchers and the general public upon request.

Opportunities to Improve Strategic Purchasing

1. **Malaysia could gradually work to introduce a national health financing scheme as part of the Health White Paper Reforms.**

   The Malaysian healthcare system faces significant challenges in implementing strategic purchasing practices due to the absence of a national health financing scheme. Without a comprehensive and unified funding system, the effective implementation of strategic purchasing becomes difficult. Strategic purchasing involves procuring healthcare services and products based on their quality, cost-effectiveness, and alignment with healthcare goals. However, the lack of a national health financing scheme hampers the ability to allocate resources strategically and may result in inefficient procurement practices.

2. **Malaysia could gradually introduce elements of active strategic purchasing to complement "passive procurement".**

   Procurement practices in the Malaysian healthcare system are undergoing a transition from passive purchasing to incorporating some elements of strategic purchasing. While certain sectors have started adopting strategic purchasing, overall procurement practices remain in flux. The Ministry of Finance (MOF) has advocated for the implementation of procurement procedures that provide a certain level of uniformity and structure. However, there are still areas within the procurement process that lack proper governance, such as the absence of transparent and detailed specifications for procurement selection or rejection.

3. **Malaysia could gradually build a system to collect data for efficiency and effectiveness, and to make this data transparent.**

   There is a pressing need to share and consolidate data on product performance, including drugs, devices, high-value technologies, and traditional and complementary medicine (TC&M). Access to such data would enable purchasers to make informed decisions and guide the implementation of strategic purchasing. To ensure the success of strategic purchasing, it is also crucial to have a clear separation between the roles of the purchaser and provider to enhance accountability and transparency. Furthermore, good governance would play a vital role in instilling confidence in strategic purchasing practices, ensuring fair and efficient allocation of resources in the healthcare system.

4. **Malaysia should establish its Health Technology Assessment unit (MaHTAS) as an independent Health Technology Assessment agency.**

   Overcoming the lack of data to support strategic purchasing practices could be achieved by establishing the MaHTAS as a separate and independent entity, rather than keeping it under the Ministry of Health (MOH). By separating MaHTAS, the agency can focus solely on conducting rigorous assessments of health technologies and generating evidence to inform purchasing decisions. It would provide the government with access to evidence-based recommendations and economic evaluation for medicines, devices and healthcare services.

Opportunities to Improve Strategic Purchasing for Primary Care

1. **Malaysia could better integrate primary healthcare with secondary care in a new national health financing scheme.**

   Malaysia could work to build a national health financing scheme to ensure the sustainability of public healthcare delivery. This new scheme should better integrate primary healthcare to secondary care, providing comprehensive and coordinated care as patients transition between healthcare environments. Clear gatekeeping roles and shared care initiatives after diagnosis should be key features in the design of benefit packages.

2. **Malaysia should gradually separate the roles of purchaser and provider by strengthening ProtectHealth Corporation.**

   ProtectHealth should act as an independent third party purchaser, featuring good governance mechanisms and employing centralised procurement practices for medicines and vaccines, medical devices and healthcare support services for not only MOH, but also for other providers of healthcare services (MOHE, MOD).

Myanmar

Health Financing Schemes in Myanmar

Myanmar is a low income country with an average annual income of USD1,210. Out-of-pocket expenditure is high, making up 78.2% of health spending in 2020. Health financing in the country does not yet appear to be consolidated or comprehensive, and there are no significant health insurance systems in place.

Unable to rely on contributions from a low-income population, the government may need to consider funding a majority of health financing schemes if it wishes to implement stronger social health protection mechanisms. This will require freeing up fiscal space to support higher spending on health.

The main health financing schemes in Myanmar are:

NATIONAL BUDGET SCHEME: The Ministry of Health (MoH) is responsible for health expenditure in the public sector, including providing preventive and curative health services at different levels. The MoH distributes funds to its various departments, including the Department of Public Health and especially, the Department of Medical Services which are responsible for providing public health, preventive and curative services. Annual budgets are distributed to health facilities at the township and district level.

SOCIAL SECURITY SCHEME: A contributory Social Security Scheme was established in 1956 by the Ministry of Labour to cover formally-employed private sector employees. The scheme is managed by the Social Security Board and provides free healthcare and income protection benefits for members. It is financed by 2% contributions from members' monthly salaries and 3% contributions from employers. In 2018, this scheme covered only 1,450,00 workers (approximately 2.5% of Myanmar's population). There appears to be no evidence of the scheme having been developed or improved over the years.

OVERVIEW

Population (2022): **54.18 million**

GPD per capita (2022): **US$1,096**

Poverty headcount at national poverty line (2019): **24.8%**

Life expectancy (2021): **66 years**

Infant mortality rate per 1,00 live births (2021): **33.7**

DALYs per 100,000 (2019): **33,863**

Current health expenditure as % of GPD (2020): **4.62%**

Domestic government expenditure as % of CHE (2020): **15.95%**

Out-of-pocket expenditure as % of CHE (2020): **78.20%**

UHC Service Coverage Index score (2021): **52**

Physician density per 1,000 people (2019): **0.74**

The Primary Healthcare System in Myanmar

In the past, Myanmar had focused its healthcare investment on urban areas and tertiary facilities and granted less attention to primary healthcare and rural areas, as recognised in the government's National Health Plan 2017-2021. Myanmar's primary health care system has struggled with human resource shortages for nurses, midwives and general practitioners.

Poverty in Myanmar could be a significant limiting factor in funding services at the primary health care level, such as antenatal care and preventative care. According to the Myanmar Health Financing System Assessment (2018), in 2015, at least 20% of the population lived under the poverty line and 40% remained poor or extremely vulnerable to poverty. This may prevent many households in Myanmar from being willing or able to contribute to national coverage schemes, and makes out-of-pocket expenditure a significant barrier for patients in need of care.

The most recent National Health Plan (NHP) 2017-2021 laid out plans to invest in primary healthcare. The NHP included plans to develop an Essential Package of Health Services (EPHS) that prioritised primary health care and was accessible to the whole population through service delivery at the township/village level and below. However, there appears to be no evidence on whether the NHP's plans were implemented amidst changing political conditions.

Purchasing Functions in Myanmar's Healthcare Schemes

	NATIONAL BUDGET
% of Total CHE	15.81% (2020)
Coverage	54.18 million (100% of the total population) **Free or subsidised public healthcare services should be accessible to the whole population.*
Purchaser(s)	Ministry of Health
Governance	The Ministry of Health (MOH) is responsible for oversight on the entire public healthcare system. It is divided into seven departments. The Department of Public Health is responsible for some public health service delivery including maternal and child health. The Department of Medical Services is responsible for all other service delivery, including preventive and curative care.
For PHC:	The MOH's Department of Medical Services oversees primary care delivery in the public health sector. However, many primary care services are provided by private clinics and Ethnic Health Organisations (EHOs) not managed by the government.
Financial Management	The MOH is responsible for national health planning, financing and budgeting. It allocates funds to its component departments and to regional and township health facilities, which are responsible for implementing their allocated budgets. The MOH's financial management capacity is low and its financial management system is almost entirely paper-based. Its financial reporting each year focuses on audit requirements and historic allocations, rather than measuring outputs and needs to aid decision-making for the following year.
For PHC:	The MOH's Department of Public Health is responsible for budget implementation for public maternal and reproductive health services, child health services and school health services. The Department of Medical Services is responsible for budget implementation for all other preventive and curative services, including at the primary care level.
Benefits Specification	Since 2012, public facilities theoretically provide the whole population with free access to emergency services, maternal and childhood illnesses and essential medicines. However, Myanmar lacks an explicit benefit package and there are uncertainties regarding which services are to be provided freely and which should involve cost-sharing.
For PHC:	The benefit package at the primary care level is not well-defined. The National Health Plan (NHP) 2017-2022 set out plans to focus an Essential Package of Health Services (EPHS) strongly on primary care. Various services relevant to primary care (including maternal & child health, nutrition, NCDs and minor illnesses) were listed as part of this plan. However, the EPHS was not implemented, possibly due to changing political conditions.
Contracting Arrangements	All public healthcare institutions are funded by the MOH to provide free or subsidised services. These include curative, rehabilitative, preventive and public health services at primary care health centres, station hospitals, township hospitals, district hospitals and specialist hospitals.
For PHC:	Primary care health centres (including rural health centres and sub-rural health centres) are funded by the MOH to provide primary care interventions.
Provider Payment	Budget is allocated annually to providers without a clear formula. This may be done based on population-to-facility ratios, number of hospital beds and bed utilisation rates from the previous year, or sometimes, with no allocation criteria at all. Provider payment is therefore largely based on historical averages, structured around a line-item system and not linked to population needs.
For PHC:	The budget for primary rural and sub-rural health centres is allocated without a clear formula.
Performance Monitoring	The MOH does not gather data on provider performance. For broader systems-level analysis, a Monitoring & Evaluation Plan for the NHP was published in 2018 listing outcomes and outputs to be measured. The NHP Implementation Monitoring Unit (NIMU) was established as the responsible body for monitoring implementation of the NHP. However, it is unclear whether this performance monitoring mechanism has been implemented.
For PHC:	There is no performance monitoring conducted for primary care. The NHP Monitoring & Evaluation Plan 2018 listed various primary care indicators to be measured for systems-level analysis, but it is unclear whether this has been implemented.

Purchasing Functions in Myanmar's Healthcare Schemes

	SOCIAL SECURITY SCHEME
% of Total CHE	0.85% (2020)
Coverage	1.45 million (2.5% of the total population) **All citizens and foreign residents working in the formal sector are eligible for SSS enrolment.*
Purchaser(s)	Social Security Board, Ministry of Labour
Governance	The Social Security Scheme is administered by the Social Security Board (SSB) according to the Social Security Law 2012. The SSB is managed by the Ministry of Labour (MOL). Its committees include an Executive Committee, a National Welfare Society and a Medical Advisory Council.
For PHC:	The SSB oversees all governance matters relating to the Social Security Scheme, including for primary care.
Financial Management	Financial management is conducted by the SSB with supervision from the MOL. No financial management is done at the facility level. The SSB releases public financial reports on a regular basis.
For PHC:	The SSB oversees all financial matters relating to the Social Security Scheme, including for primary care.
Benefits Specification	SSS members can access free treatment at SSB facilities. These medical benefits include primary care, specialist and laboratory services, x-rays, hospitalisation, physical therapy, prostheses and medicines. Benefits also include income security in case of sickness, maternity, death of a worker or work-related injury. The SSB maintains a yearly-updated list of authorised benefits under the Social Security Scheme, with the latest being released for the FY 2023-2024. The benefits extend to all formal workers as well as others who voluntarily register, including students, informal workers, those working abroad and other groups.
For PHC:	Primary care services at SSB facilities can be accessed freely by members.
Contracting Arrangements	SSB facilities provide the majority of care for the Social Security Scheme. These include 3 Worker's Hospitals, 96 clinics, 58 enterprise clinics and some mobile units. A pilot project was established to contract private facilities to supplement the work of SSB facilities. Currently, the SSB contracts with some private clinics on a purchaser-provider split basis.
For PHC:	SSB facilities including clinics, enterprise clinics and mobile units are contracted to provide primary care services.
Provider Payment	SSB facilities are funded by the SSB in collaboration with the MOH; they receive a bi-annual line-item budget allocation. 21 contracted private clinics are paid on a capitation basis, whereas 11 contracted private clinics are paid on a fee-for-service basis (specifically for maternity services).
For PHC:	Provider payment for primary care at SSB facilities is done biannually based on historical budget estimates. Contracted private clinics providing primary care services are paid either on a capitation basis or on a fee-for-service basis for maternity services.
Performance Monitoring	The SSB relies on a largely paper-based information system, making performance monitoring challenging. A new information system was introduced to maintain information on the characteristics of each enrolled member. An accounting system produces information on income, expenditures and balance sheets. Nonetheless, risk and performance monitoring systems can be further digitised and improved.
For PHC:	The SSB oversees all performance monitoring matters relating to the Social Security Scheme, including for primary care. As of now, performance monitoring capabilities are limited.

Recent Progress in Strategic Purchasing

Since 2016, the Myanmar government has laid out some plans to improve the efficiency and coverage of its health financing schemes. However, no information appears to be available on the progress of these plans.

- The National Health Plan 2017-2021 was created in 2016 to target healthcare service accessibility for geographic areas with the greatest need. It laid out a vision for increasingly strategic purchasing of health services in the public sector. As a step towards achieving Universal Health Coverage, the National Health Plan intended to create a Basic Essential Health Package for the entire population and gradually scale up financial protection for health. The National Health Plan 2017-2021 especially focused on service delivery at the primary care level at the Township level and below. As an extension of the National Health Plan, the Ministry of Health and Sports (MOHS) [reconstituted as the Ministry of Health in 2021] developed a Strategic Action Plan for Strengthening HIS as a guide for improving its Health Information System and eHealth tools.
- A pilot project to evaluate the outcomes of strategic purchasing was conducted by Population Services International (PSI) Myanmar between 2017 to 2019. PSI Myanmar simulated the role of purchaser, contracting 5 selected clinics through a capitation payment scheme and performance-based incentives. These clinics provided primary care service packages to 2,506 poor households in their designated areas. The project data indicated that out-of-pocket expenditure for health in poor households was successfully reduced through this health financing scheme, and that similar initiatives could be piloted across the broader health system.
- In 2018, the government launched a Public Financial Management Reform Program Strategy. This strategy aimed to modernise public financial management in Myanmar, distribute expenditures equitably and increase spending and financial management capacity for the health sector.
- Between 2017 and 2022, the International Labour Organization and Grand Duchy and Luxemburg implemented a project to “Support the extension of Social Health Protection in South-East Asia”, with Myanmar as a country of focus. This project sought to improve the administration and capacity of the SSB. As part of this project, ILO experts began an actuarial analysis to understand the feasibility of expanding the Social Security Scheme to members’ dependents.

Challenges for Strategic Purchasing

Myanmar faces gaps in its governance and healthcare system that should be addressed before the country can build the infrastructure necessary for strategic purchasing.

- The issue of insufficient resources is a major barrier to accessible health service delivery and quality care. The government's chronically low level of public spending on health (1% of GDP over the last 20 years, according to World Bank Data) may impact care for patients and limit the ability to improve existing health financing systems. Fiscal space must be cleared up to improve health purchasing and healthcare access, but this has been difficult in recent years with military expenditure crowding out social spending.
- Myanmar still lacks a clearly defined benefit package, despite recent commitments in the NHP 2017-2021. This appears to cause widespread uncertainty on which health goods and services are provided freely for the population and which services are not.
- Myanmar faces the challenge of outdated and underdeveloped Information Technology (IT) and Health Information System (HIS). The MoH currently lacks the technical capability to develop and manage the more complex instruments of IT systems.

Opportunities to Improve Strategic Purchasing

1. **Myanmar could revisit progress plans laid out in the National Health Plan 2017-2021.**

   This would first involve gathering information on progress that has been made (if any). The government should then commit to an updated timeline and strategy to achieve UHC, including how to improve purchasing mechanisms.

2. **Myanmar could follow up on plans to implement a semi-autonomous health purchasing agency.**

   This entity should have a sustainable revenue source, information management systems and a mandate to independently allocate funds across providers. Myanmar could look to the experiences of neighbouring countries in considering the functions of strategic purchasing.

3. **The government could consider improving Public Financial Management (PFM) measures.**

   For health, this would include centralising budget planning cycles and setting clear, adequately flexible guidelines on funding flows to public health facilities.

4. **The government could consider expanding the coverage of the Social Security Scheme.**

   The SSS could operate beyond the formal employment sector, beginning with members' dependents. A bigger pool of members would not only extend social health protection to more vulnerable populations, but also give the SSB increased negotiating power in terms of provider payment mechanisms and payment rates when contracting with private facilities.

Opportunities to Improve Strategic Purchasing for Primary Care

1. **Myanmar could recognise primary care as the cornerstone of UHC by expanding the primary care workforce and building up supply-side capacity, especially in remote areas.**

   In doing so, the country could move away from its focus on specialist and tertiary care. Primary care would ideally be the point of focus for managing chronic diseases, common illnesses and Non-Communicable Diseases (NCDs), among other conditions. Development should include a wide range of healthcare providers including MOHS providers, private clinics, Ethnic Health Organisations (EHOs) and NGOs. GPs, nurses, midwives and voluntary health workers should be leveraged in building up capacity. This would help ensure that the health system is ready for increased utilisation once financing reforms are implemented.

The Philippines

Health Financing Schemes in the Philippines

The Philippines is a lower middle-income country consisting of over 7,000 islands and islets. The Philippines recognised health as a human right in its 1987 constitution, and significant steps have been taken toward increasing Universal Health Coverage– most notably the passing of the UHC Law in 2019. Funds for health primarily come from government revenues. A national health insurance programme covers a majority of the population, but challenges to social health protection remain due to low accessibility and quality of care and high out-of-pocket fees.

The main health financing schemes in the Philippines are:

DEPARTMENT OF HEALTH – NATIONAL HEALTH PROGRAMMES: The Department of Health (DOH) was established after World War II. Accountability for health services was decentralised under the Local Government Code in 1991, and the DOH's functions shifted primarily to standards setting, stewardship and technical and financial assistance. However, due to the variable financial capacity of Local Government Units (LGUs), the DOH continues to allocate budget to financing health personnel services, capital expenditures, supplies and commodities. The DOH submits an annual budget for consideration and approval by the National Government.

NATIONAL HEALTH INSURANCE PROGRAMME: The establishment of the National Health Insurance Program in 1995 and the creation of the Philippine Health Insurance Corporation (PhilHealth) became an additional mechanism to collect and pool revenues for health and to purchase services. Although these were initially collected from premiums by the enrolled workers, the government covers the premiums of vulnerable populations (e.g. indigents & senior citizens) from sin tax revenues and other sources. The creation of PhilHealth diversified payment for health services from one that was purely budget-financed and publicly delivered to one that is demand-driven including private and public providers.

LOCAL GOVERNMENT UNITS – LOCAL HEALTH SERVICES: Devolution in 1991 granted fiscal and administrative autonomy for Local Government Units (LGU) in health matters. This included responsibility for local health facilities and direct service provision, such as public health programmes and promotive and preventive care. Each level of government has its own geographical and technical scope for health. Although LGUs have the authority to generate their own resources, most are highly dependent on their national tax allotment (NTA) to finance their spending (including for health). The funds allocated to health are subject to variability in budgeting because the NTA does not set specific conditions and/or allocations for programmes or expenditures.

OVERVIEW

Population (2022): **115.56 million**

GPD per capita (2022): **US$3,623**

Poverty headcount at national poverty line (2021): **18.10**

Life expectancy (2021): **69 years**

Infant mortality rate per 1,00 live births (2021): **20.5**

DALYs per 100,000 (2019): **33,798**

Current health expenditure as % of GPD (2021): **5.61%**

Domestic government expenditure as % of CHE (2021): **44.40%**

Out-of-pocket expenditure as % of CHE (2021): **41.49%**

UHC Service Coverage Index score (2021): **58**

Physician density per 1,000 people (2021): **0.77**

The Primary Healthcare System in the Philippines

The Local Government Code charges municipalities to manage rural health units (RHUs) and barangay health stations to deliver Primary Health Care (PHC) services, including preventive and promotive health. Primary health care delivery is intended to start with these local rural health units and barangay health services. However, patients can choose their health service providers and may opt to proceed directly to higher-level public or private facilities. High out-of-pocket spending ratios (47.6% as of 2019) may be why most Filipinos defer seeking primary care services.

Aside from LGU and DOH funding, PhilHealth has benefit packages to purchase services and augment funding for primary care in public facilities. The latest attempt was the rolling out of the Konsulta package from 2020. This package aims to provide Filipinos with financial access for services at an assigned Primary Care Provider, who will deliver basic essential services at every life stage. This package also accredits private PHC facilities and covers diagnostic services and medicines. It is based on an annual capitation rate of Php500 for public and Php750 for private facilities per individual (not per household or family).

Aside from Konsulta, Sustainable Development Goals (SDG) Benefit packages also include some primary care services. SDG coverage includes treatment for malaria, HIV/AIDS, Tuberculosis, family planning, animal bites and maternity care. No Balance Billing policy is applied to these benefits in all government and private facilities for TB, FP and maternity care.

Purchasing Functions in the Philippines' Healthcare Schemes

	DEPARTMENT OF HEALTH – NATIONAL HEALTH PROGRAMMES
% of Total CHE	23.60% (2021)
Coverage	115.56 million (100% of the total population) **National health services cover all residents (citizen and non-citizen).*
Purchaser(s)	Department of Health
Governance	The National Government, through the Department of Health (DOH), is tasked with implementing population health services and support the financing of capital investments, human resources for health and health systems development to complement local government resources. The government also allocates funding for DOH-retained and other public hospitals and supports the financing of services for local governments that cannot cover their province's health expenditure. The DOH is led by a Secretary for Health. It reports to the president and to Congress, especially during the budget process and in deliberations of legislation for health. Centres for Health Development (CHDs) assist the operations of provinces within their area of responsibility.
For PHC:	The provision of primary care is devolved to the respective local government units and administered within their provider networks.
Financial Management	National budgets for all government programmes and activities, including health, are enacted annually through legislation as general appropriations. Across all national agencies, a Performance Informed Budgeting (PIB) approach was introduced by the Aquino Administration (2010-2015) and implemented in 2018. The execution of DOH funds follows a standard process of appropriation, allotment, obligation and disbursement and is subject to universal procurement and financing policies. All public funds are subject to audit by the Commission on Audit. Budget ceilings are determined in the annual general appropriations hearing held by Congress.
For PHC:	Local chief executives at the provincial level are responsible for implementing primary care services through the National Health Insurance Programme. A sandbox implementation of contracting public and private PHC networks, as part of the mandate of the UHC law, has also been initiated in 7 provinces.
Benefits Specification	The DOH lacks an explicit benefit package. However, all population-based national health interventions (including surveillance, health literacy and maternal interventions) are under its purview. The Department also oversees the management of the rise and spread of water-borne and communicable diseases. Patients can access secondary and tertiary DOH services without referrals from primary care providers, but there is an intention to introduce referral systems.
For PHC:	The above benefits specification aspects apply. The DOH budget may be used to support LGUs that need additional resources to implement primary care services in their provinces.
Contracting Arrangements	Contracting follows procedures specified by the Government Procurement Policy Board. Providers submit bids within the purchaser's specifications in portals provided by the agency. A Bid and Awards Committee composed of key officers and technical person(s) reviews the bids.
For PHC:	The above contracting arrangement aspects apply.
Provider Payment	Payment terms depend on the contract with the provider. Usually, this involves an initial or tranche payment with the total amount given upon completion. Payments are based mainly on input-based line items. Hospitals under the DOH's purview are also paid via a line-item budget.
For PHC:	The above provider payment aspects apply.
Performance Monitoring	The Department of Health has no set of incentives for good performance, but only punitive provisions including blacklisting, sanctions and penalties and criminal or civil charges. LGUs are monitored via an LGU scorecard published by the Department of Interior and Local Government (DILG), but incentive mechanisms need to be strengthened. There is a strong drive with the newly appointed Secretary of Health to utilise technology, digitalisation and analytics for better service delivery and monitoring at the systems level.
For PHC:	LGUs are monitored by the DOH through an LGU scorecard, including for their success in implementing primary care at the provincial level.

Purchasing Functions in the Philippines' Healthcare Schemes

	NATIONAL HEALTH INSURANCE PROGRAM
% of Total CHE	12.89% (2021)
Coverage	115.56 million (100% of the total population) **All citizens and foreign residents must enrol into the NHIP.*
Purchaser(s)	Philippine Health Insurance Corporation (PhilHealth)
Governance	The UHC Law mandates PhilHealth's responsibility to pay for individual health services. The agency establishes provider networks allowing patients to benefit from primary, secondary and tertiary care. The President of the Philippines appoints the President of PhilHealth. A Board oversees the agency, chaired by the Secretary of the Department of Health. Board members are elected by the President in consultation with the Chair and relevant key stakeholders.
For PHC:	PhilHealth is mandated by the UHC Law to provide individual health services, including PHC.
Financial Management	PhilHealth has more flexibility in its financial management compared with the DOH. With revenues collected from premiums, it is allowed to have a reserve fund under certain conditions: a) the accumulated revenues are not needed to meet the current year's expenditures; b) the fund does not exceed the ceiling equivalent to the amount of actuarial estimated for two years' projected expenditures; c) if reserve funds exceed the required ceiling, the excess shall be used to increase benefits or decrease members' contributions; d) any unused portion of the reserve fund shall be invested to earn an average annual income at prevailing rates of interest and shall be referred to as the "Investment Reserve Fund". A maximum of 7.5% of the actual total premiums collected from member contributions can be used for administrative expenses.
For PHC:	The above financial management aspects apply.
Benefits Specification	Through the 2019 UHC Law, the NHIP covers all Filipinos – both direct contributors (employed individuals who pay premiums) and indirect contributors who receive full subsidies. It has explicit benefit packages through which PhilHealth can purchase services from providers. This includes inpatient benefits, conditions linked to catastrophic expenditure (e.g. cancer care), primary care and outpatient benefits (e.g. TB care, HIV/AIDS treatment, family planning, maternity care).
For PHC:	PhilHealth's primary care package, Konsulta, covers initial and follow-up consultations, health screening and assessment; 13 select diagnostics services; and 21 drugs and medicines. Currently, outpatient primary care benefits are only available for poor beneficiaries.
Contracting Arrangements	PhilHealth accredits public and private facilities. These must follow rigorous standards on service quality, co-payment/co-insurance and data submission to become part of a PhilHealth provider network. Maternity care, anti-TB and PHC providers are accredited separately. PhilHealth is moving to contract its provider networks through service level agreements.
For PHC:	PhilHealth contracts with private and public providers for PHC. Non-hospital facilities are eligible to deliver the Konsulta benefit package, and must apply for accreditation through a local health insurance office. Approximately 877 Konsulta providers were accredited as of August 2022.
Provider Payment	PhilHealth pays providers through case-based payments for hospitals, including secondary and tertiary care. It pays for primary care services through capitation. Contracted networks and apex hospitals will be paid via performance-driven, closed-end, prospective payments based on Diagnostic-Related Groups. Some incentives are also available to PhilHealth providers, such as the ability to keep fund surpluses resulting from cost-efficiency.
For PHC:	For Konsulta, PhilHealth releases annual capitation funds based on the numbers of registered members and performance at per capita rates of PHP500 (public) or PHP750 (private).
Performance Monitoring	PhilHealth incentivises health facilities to perform well by rating them according to set standards. Surveillance and audit mechanisms are also in place to compliance. The UHC Law mandates that differential payment schemes be developed with consideration to service, quality, efficiency, equity and public health outcomes. Currently, systems-level performance monitoring for PhilHealth is limited but there are plans to implement this in the future.
For PHC:	The above performance monitoring aspects apply.

Purchasing Functions in the Philippines' Healthcare Schemes

	LOCAL HEALTH SERVICES
% of Total CHE	16.68% (2021)
Coverage	115.56 million (100% of the total population) **Local health services cover all residents (citizen and non-citizen) within their jurisdiction.*
Purchaser(s)	Local Government Units (LGUs)
Governance	Elected Local Chief Executives (LCEs) govern each LGU. Each local government has a Local Health Board (LHB) chaired by with representatives from the DOH's regional offices (Centres for Health Development). The LHB acts as an advisory board on health-related matters. The UHC Law mandates that the DOH, Department of Interior and Local Government (DILG), PhilHealth and LGUs integrate local health systems into province-wide health systems. A strengthened Provincial Health Board will exercise administrative and technical supervision over health resources within their jurisdiction (gradually starting in July 2023). It will set health policy directions, including developing and implementing strategic and investment plans for provincial and city health systems. It will also coordinate the integration of health services across the healthcare continuum and manage the Special Health Fund, a pool of financial resources intended to finance population-based and individual-based health services.
For PHC:	Currently, LGUs are responsible for implementing primary care in their jurisdictions, but Provincial Health Boards are expected to take increased management responsibility to ensure care integration. Rural health units (RHUs) are the facilities responsible for delivering public primary care programmes. They are within the managerial accountabilities of their city/municipality, and are not linked with any secondary/tertiary facilities in terms of governance.
Financial Management	Each LGU currently manages its funds for health. LGUs aggregate funds from all sources (including Internal Revenue Allotment local revenues, DOH funds, PhilHealth payments, grants and loans from donors) and allocate these according to prioritised programmes (determined by legislative councils and LCEs). Priority areas for health spending are autonomously determined by each LGU at the start of the year in consultation with its public health facilities.
For PHC:	The above financial management aspects apply.
Benefits Specification	LGUs have no explicit benefit packages. Per the Local Government Code of 1991 (RA 7160), municipalities are mandated to provide primary care while provinces are mandated to provide secondary and tertiary care. Per the UHC Law, LGUs are mandated to fund population-based programmes for the DOH and manage local health networks for individual-based healthcare.
For PHC:	The above benefits specification aspects apply.
Contracting Arrangements	PhilHealth accreditation requirements are used to contract providers for LGU networks. These include an assessment of their health offices, facilities and services, human resources and other operations. Community-based healthcare facilities operated by LGUs are considered part of the system. The private sector can participate through contractual arrangements with the province-wide or city-wide health system.
For PHC:	The above contracting arrangement aspects apply.
Provider Payment	LGUs provide input-based, line-item budgets on an annual basis to public providers under their purview. They may also engage in selective contracting with private providers (laboratory works, diagnostic and therapy).
For PHC:	Public primary care providers are paid through input-based line-item budgets.
Performance Monitoring	The performance monitoring for LGU networks follows guidelines set by the DOH and PhilHealth. Each LGU is mandated to develop audit mechanisms to ensure networks' compliance with contractual obligations and standards. While this should be carried out annually, it is unclear how regularly audits are conducted at the moment.
For PHC:	The above performance monitoring aspects apply.

Recent Progress in Strategic Purchasing

- The Philippines hit a significant milestone in moving toward Universal Health Coverage (UHC) with the passage of the UHC Act in 2019. Relevant policies and operational details are currently ongoing development. Under this Act, all citizens are automatically entitled to PhilHealth benefits, including comprehensive outpatient services. The Act aims to strengthen PhilHealth by transforming it into a national purchaser of individual-based health goods and services (including all individual-based services, supplies, medicines, commodities and operating expenses of health facilities part of PhilHealth networks). To support this more prominent role, premium contributions to PhilHealth will be complemented with increased government contributions from sin taxes, annual appropriations and revenues.
- PhilHealth's provider payment systems will be reformed towards global budgets for contracted Health Care Provider Networks (HCPN). This will begin with a sandbox implementation in 7 provinces starting in July 2023, whereby provinces will be contracted by PhilHealth to provide primary care services through a network arrangement. The DOH will maintain responsibility for population-based services and salaries for government healthcare workers.
- The new UHC Law will impact financing at the Local Government Units level. It mandates LGUs to establish a Special Health Fund (SHF), required by DOH and PhilHealth to contract with a province- or city-wide health system. DOH and PhilHealth are mandated to maintain an SHF utilisation tracking system to allow real-time collection, consolidation and analysis of data. Guidelines for the allocation and utilisation of SHF funds will be made by DOH and PhilHealth, with input from the Department of Budget and Management (DBM), Department of Finance (DOF), Commission on Audit (COA), DILG and LGU. This will begin through a a sandbox implementation in 7 provinces starting in July 2023.

KEY HIGHLIGHTS: UHC SANDBOXES AND DIGITAL TRANSFORMATION

There are now 7 provinces out of the 82 provinces who will be piloting UHC under a sandbox implementation of the law. This will provide lessons on how best to implement different models in the creation and management of health care provider networks as well as the health financing side. This will provide opportunities to improve on strategic purchasing for UHC and primary healthcare services.

In line with the Department of Health's efforts to leverage Technology, Digitalization and Analytics in the Universal Health Care implementation a partnership and formal agreement is being created in order to institutionalise the private sector's support through the League of Corporate Foundations. This public-private partnership will provide technical support and resources to the DOH to augment their personnel and capacity for their digital transformation.

Challenges for Strategic Purchasing

- Current policies and guidelines for the DOH and PhilHealth should be reviewed and continuously enhanced as the UHC Law is implemented. This would allow the health system to become more responsive to the needs of patients and inclusive in the participation of network providers.
- The current requirements used to evaluate the accreditation of clinics borrow requirements for accreditation from outpatient or emergency units of hospitals. As such, very few private clinics qualify to become part of the PhilHealth network, leading to a loss of crucial skills.
- It would be necessary to review the drugs listed in the government's approved formulary. The formulary is currently generic and excludes crucial drugs dealing with debilitating NCDs like hypertension and cancer.
- There are challenges relating to information systems, including limited integration. Current systems are stand-alone, making it difficult to monitor, evaluate and identify needs for the whole population. This is especially true with the involvement of the local governments, as LGUs currently have individual and non-interoperable IT systems which make the implementation of national programmes challenging.
- The Philippines currently faces a limited portability of electronic medical records, limited capability to harvest big data and limited capability to generate analytics to guide policy and strategic purchasing.

Opportunities to Improve Strategic Purchasing

1. **The Philippines could generate a stronger evidence base to support resource allocation.**

   This will be particularly important in light of a high disease burden and finite healthcare resources. A stronger evidence base would enable the systematic prioritisation of conditions; rational benefit planning and designing; and investment planning. This could be conducted through health technology assessments, burden of disease and cost of illness studies, health demographic survey and other means.

2. **The DOH's and PhilHealth's prioritisation frameworks for health could be harmonised.**

   Currently, the two entities have separate but overlapping prioritisation frameworks. Evidence-based planning and integration would help ensure that the most relevant and impactful health services are provided. In turn, this would contribute to improved health outcomes, lower burdens of the top diseases and lower mortality rates.

3. **The DOH's governance and oversight capacity could be strengthened, and opportunities to for continual and meaningful engagement with PhilHealth could be expanded.**

   The DOH will need to build a comprehensive set of health guarantees, including unified and systematic clinical practice guidelines that would define service-level allocations. Resulting comprehensive health guarantees will provide insight into which diagnostic and other capacities should be increased and which capital investments should be made by the DOH. They will also help guide the strategic purchasing of medicines, and allow for consolidation and bulk purchasing to have better leverage in pricing negotiations.

4. **The capacity of PhilHealth to monitor performance could be strengthened, focusing on ICT developments to link provider payments to performance.**

   PhilHealth should identify collaborative arrangements for monitoring contracted providers alongside the DOH. The application of technology, digitalisation and analytics could facilitate the monitoring of provider performance within the Health Care Provider Network (HCPN), and thus ensure compliance with contracts or service agreements. A stronger performance monitoring system would be helpful in designing incentives to reward good performance. Such a system should also be able to flag sub-par performance to the HCPN management and ensure that issues are addressed in a timely manner.

Opportunities to Improve Strategic Purchasing for Primary Care

1. **PhilHealth could to consider making improvements to its current PHC package, "Konsulta".**

   There have already been attempts to expand the initial Konsulta design, making it more comprehensive in scope and increasing incentives for providers; however, these improvements have yet to be fully implemented.

2. **PhilHealth could pilot the expanded PHC package on the ground before full implementation.**

   Pilot implementations would allow the capture of initial lessons on how funds are downloaded, utilised and monitored. Based on these learnings, PhilHealth can start improving and refining the PHC package. In a positive step, some provinces have already been identified for this "sandbox" style implementation of the Konsulta, wherein Primary Care Provider Network (PCPN) contracting will be done.

3. **The Philippines could build the capacity of primary care providers through training, IT systems and resource investments.**

   This may involve frontloading investments to stimulate service delivery through feasible tranches of capitation/global fund payments. These trainings should ensure that there is absorptive capacity within the network so that they can effectively marshal resources that will be made available. It will also be important for PhilHealth to invest in stakeholder engagement processes — for example, setting up local management structures that exclusively perform governance and management for health care provider networks.

Singapore

Health Financing Schemes in Singapore

Singapore is a high-income city-state located at the Southern tip of the Malay peninsula. Singapore's healthcare system has been identified as one of the most efficient in the world, and the country enjoys excellent health outcomes alongside relatively low spending on health. Singapore has a mixed payer system for healthcare based on principles of personal responsibility, market competition and government oversight.

Singapore has multiple social health protection schemes designed to complement each other to provide affordable care. These schemes target primarily Singapore citizens and to an extent, Permanent Residents. Out of Singapore's 5.64 million population, 1.56 million foreign residents are therefore excluded from national health protection schemes and rely on employer or voluntary insurance or out-of-pocket payments. Recently, some smaller health protection schemes have been developed for low-income migrant workers in the country.

OVERVIEW

Population (2022): **5.64 million**

GPD per capita (2022): **US$82,808**

Poverty headcount at national poverty line: **No data**

Life expectancy (2021): **83 years**

Infant mortality rate per 1,00 live births (2021): **1.7**

DALYs per 100,000 (2019): **15,045**

Current health expenditure as % of GPD (2020): **6.05%**

Domestic government expenditure as % of CHE (2020): **52.41%**

Out-of-pocket expenditure as % of CHE (2019): **28.44%**

UHC Service Coverage Index score (2021): **89**

Physician density per 1,000 people (2021): **2.70**

The main health financing schemes in Singapore are:

NATIONAL BUDGET: The Ministry of Health (MOH) receives an annual budget allocation from the Ministry of Finance (MOF). Within this budget, the MOH purchases services from three public healthcare clusters: Singapore Health Services (SingHealth), the National Healthcare Group (NHG) and the National University Health System (NUHS). Each cluster is responsible for a geographical area and comprises public healthcare institutions (PHIs) including hospitals, primary care polyclinics, rehabilitation hospitals and specialty centres. While these can be used by all residents, subsidised services are only accessible to citizens and Permanent Residents. Capitation rates from the MOH to the three clusters are set according to the number of eligible residents in their geographical area.

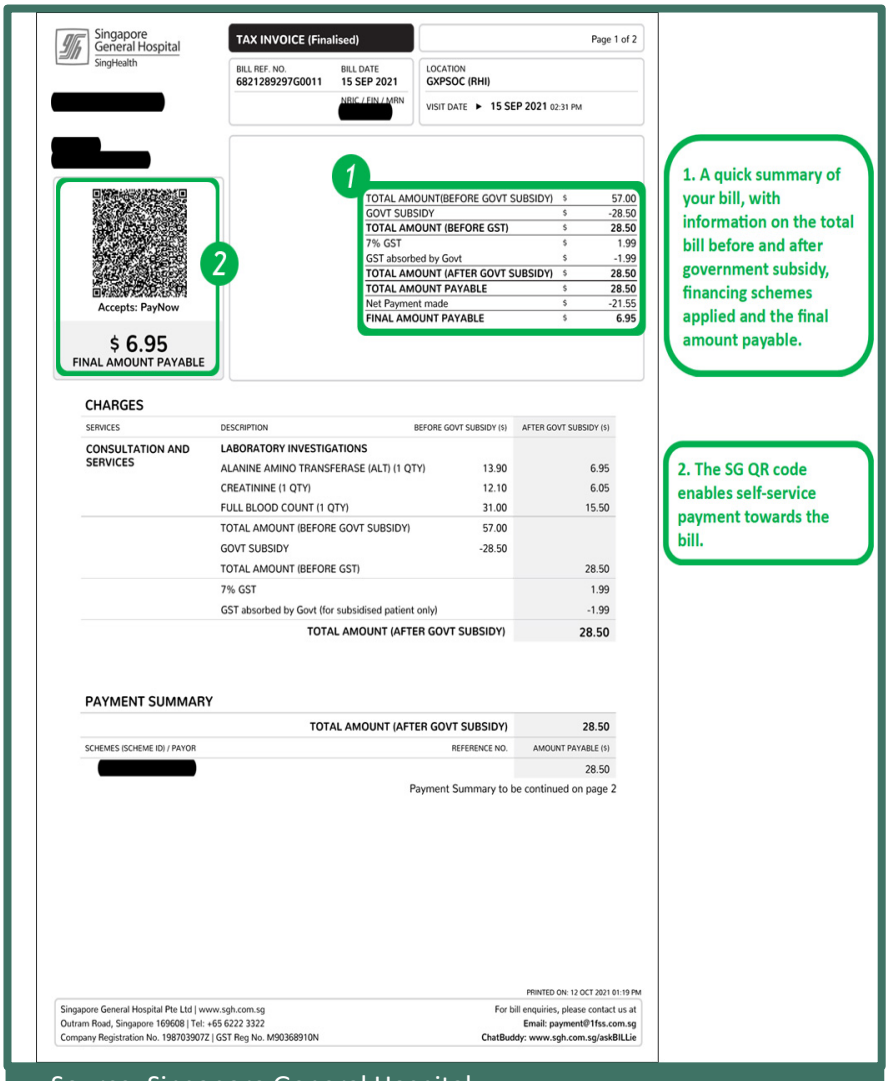
MEDISAVE: Singaporeans and Permanent Residents participate in a mandatory personal health savings scheme called MediSave. Participants contribute between 8 and 10.5% of their income to their MediSave accounts. Funds from these accounts can be used to pay for inpatient treatment and many outpatient treatments (including chronic disease treatments, preventative care, children's health, cancer and kidney treatment and others, within annual caps). MediSave funds can be used for the account owner or close family members (spouse, children, parents, grandparents, siblings).

MEDISHIELD LIFE: Singaporeans and Permanent Residents are enrolled in MediShield Life, a compulsory national health insurance scheme. MediShield Life funds can be used to offset the costs of large hospital bills and limited high-cost outpatient treatments (e.g. kidney dialysis and cancer treatment). Premiums can be paid directly out-of-pocket or through one's MediSave account.

MEDICAL ENDOWMENT FUND: Medifund is a government assistance fund providing support to low-income Singaporean citizens to cover outstanding medical bills, even after MediSave and MediShield Life avenues have been exhausted. Medifund grants are given by the government to Medifund-approved Institutions (MFIs), who have discretion over applications from patients to receive benefits. Medifund can be used to cover most healthcare services including inpatient, specialist, long-term, primary, antenatal and dental care.

COMMUNITY HEALTH ASSIST SCHEME: CHAS is a government scheme that subsidises private primary and dental care services for Singaporean citizens. The value of CHAS benefits depends on one's household income; these cover chronic condition management for all Singaporeans and dental care and common illnesses (e.g. flu) for the lowest-income Singaporeans.

OTHER SCHEMES: Other health financing schemes include private insurance schemes (employer or individually-sponsored), schemes for specific Singaporean populations (e.g. ElderShield for the elderly) and schemes for migrant workers.



Source: Singapore General Hospital

The Primary Healthcare System in Singapore

The primary healthcare system in Singapore is divided between public polyclinics and private General Practitioner (GP) clinics. Polyclinics are part of Singapore's public healthcare clusters; there are currently 23 polyclinics, with plans to raise the number to 32 by 2030. Polyclinics are financed through the relevant healthcare cluster's budget, set by the MOH using capitation rates. While private GPs provide 80% of primary care services in Singapore, polyclinics manage 45% of all patients with chronic diseases.

GP clinics are financed through out-of-pocket payments and private health insurance schemes. While they generally do not receive government funding, there are certain Public-Private financing schemes in place whereby clinics receive a budget from the MOH to provide set services. These include the Community Health Assist Scheme (CHAS), granting subsidies to citizens (especially the low-income) for GP visits; the Chronic Disease Management programme (CDMP) providing chronic disease management to citizens; the Public Health Preparedness Clinic Scheme covering primarycare responses to health emergencies; and Healthier SG, enrolling citizens (starting with the elderly) to a GP to provide holistic lifelong care.

Purchasing Functions in Singapore's Healthcare Schemes

	NATIONAL BUDGET
% of Total CHE	43.08% (2019)
Coverage	4.07 million (100% of citizens and Permanent Residents / 72% of the total population) **Subsidy coverage differs among citizens and PRs. Foreign residents are not eligible for subsidised public healthcare.*
Purchaser(s)	Ministry of Health
Governance	The public healthcare clusters operate under MOH Holdings, the holding company for Singapore's public healthcare assets. MOH Holdings is 100% government-owned and falls under the MOH. A "Standing Policy Agreement" defines the roles & responsibilities of the public healthcare clusters.
For PHC:	Each cluster contains one 'arm' dedicated to primary care services: National Healthcare Group Polyclinics, National University Polyclinics and SingHealth Polyclinics. These bodies oversee the services provided by individual polyclinics and collaborate with other members of their respective cluster (e.g. hospitals and specialty centres) to coordinate care. The MOH sets price caps for the range of services provided by polyclinics; this pricing cannot change without MOH approval.
Financial Management	The Ministry of Finance (MOF) sets annual budgets for each Ministry (including the MOH) based on previous year and projected data. The MOH collects data on each cluster's operations (e.g. clinical data, utilisation, quality, financial data) to guide annual budgeting decisions.
For PHC:	The financing of polyclinics is internally managed by the relevant cluster (NHG, SingHealth, NUHS). Each cluster has the mandate and flexibility to decide on their internal resource allocation across member institutions.
Benefits Specification	The MOH, in its Service Level Agreements with public healthcare institutions, outlines the expected medical benefits to be provided to the population. In public institutions, 10 to 80% of the costs of medical care are subsidised through government funding depending on a patient's income and residency status.
For PHC:	The MOH collaborates with the public healthcare clusters to define the services to be provided by polyclinics. Service Level Agreements may be set with the MOH at either the cluster or the individual polyclinic level.
Contracting Arrangements	Public healthcare institutions are managed by MOH Holdings (the holding company for public healthcare assets). Public hospitals were corporatised ("restructured") from 1985 and have autonomy over their workforce, fees and funding, but they are ultimately owned by the government.
For PHC:	The government and MOH, as owners of all public healthcare institutions, have the mandate to centrally plan polyclinics (e.g. the development of new polyclinics, the allocation of polyclinics across clusters). Each cluster must work with its allocated member polyclinics but has flexibility in internal resource allocation.
Provider Payment	The MOH is shifting to capitation-based payment for the healthcare clusters as of April 2023. Capitation rates are set according to the regional boundaries of each cluster, though users can access services across all three clusters regardless of their area of residence within Singapore. Capitation rates are set according to historical average care costs and service utilisation rates.
For PHC:	The recent shift to capitation is intended to incentivise primary and preventive care across public healthcare. However, healthcare clusters have flexibility on their internal resource allocation and payment mechanisms, and do not need to pass on cluster-level capitation funding to their member institutions (including polyclinics).
Performance Monitoring	Healthcare Performance Offices (HPOs) within public institutions report on clinical indicators to MOH regularly. The MOH maintains a Public Hospital Scorecard on clinical, satisfaction and other indicators. Based on this data, the MOH's Service Level Agreements with the public healthcare clusters include annual performance targets which are annually reviewed.
For PHC:	Each cluster monitors the performance of its primary care polyclinics. The MOH also carries out overall monitoring of its clusters and their sub-units. Annual review processes at the polyclinic level may track clinical, patient safety, quality and other data for performance monitoring.

Purchasing Functions in Singapores' Healthcare Schemes

	MEDISAVE
% of Total CHE	4.83% (2019)
Coverage	4,070,000 individuals (100% of citizens and Permanent Residents / 72% of the total population) **MediSave applies to all citizens and PRs but excludes foreign residents.*
Purchaser(s)	Individuals, within the framework provided by the Central Provident Fund Board
Governance	MediSave is overseen by the Central Provident Fund (CPF) Board, a statutory board under the Ministry of Manpower (MOM). The CPF Board includes representatives from the government, employers and workers. It is responsible for the administration, management, stewardship and regulation of MediSave according to the Central Provident Fund Act 1953, the Central Provident Fund (MediSave Account Withdrawals) Regulations and related regulations.
For PHC:	The CPF Board is responsible for managing all MediSave contributions, accounts and disbursements, including those relating to primary care services.
Financial Management	While MediSave accounts are personal health savings accounts, these are managed by the CPF Board rather than by patients themselves. The CPF board is responsible for financial management including interest accrual, account management, financial reporting and budgeting and reserves.
For PHC:	The CPF Board is responsible for the financial management of all MediSave funds, including those relating to primary care services.
Benefits Specification	The MOH and CPF Board jointly set eligibility criteria for the utilisation of MediSave funds. These include benefits eligible for MediSave usage, reimbursement limits and other conditions. Benefits eligible under MediSave are outlined in the Central Provident Fund (MediSave Account Withdrawals) Regulations and published on the CPF Board website. Benefit entitlements are designed to complement public healthcare subsidised rates, so beneficiaries who seek care in private facilities will pay more out-of-pocket as private facility fees are unsubsidised.
For PHC:	Limited primary care services are eligible under MediSave. These are jointly set by the MOH and CPF Board, and include approved screenings, vaccinations and chronic conditions.
Contracting Arrangements	MediSave funds can be used at all public healthcare institutions and accredited non-public institutions. Institutions must submit an accreditation application to the MOH; they must sign a Deed of Indemnity (DOI), submit required documents and meet set accreditation criteria. Both the institution where a procedure is performed and the doctor/dentist performing a procedure must be accredited under MediSave in order for claims to be submitted.
For PHC:	MediSave funds can be used for all primary care at polyclinics and for chronic disease care at accredited General Practitioner (GP) clinics. Private GPs wishing to participate in MediSave must submit an accreditation application to the MOH through the Chronic Disease Management Programme (CDMP), submitting required documents and meeting pre-established criteria.
Provider Payment	Singapore does not have a single-payer system for healthcare, hence only a portion of patient's bills will be eligible for MediSave payment/reimbursement. Claims are reimbursed to institutions directly through case-based and fee-for-service payments. After a patient signs a Medical Claims Authorisation Form (MCAF), institutions will apply for MediSave payment on their behalf. The approved amount will be deducted from the patient's MediSave fund and transferred directly to the institution to settle outstanding fees.
For PHC:	MediSave provider payment for primary care follows the same procedures as for all other MediSave-eligible services. Specifically, fee-for-service payments are used for polyclinics.
Performance Monitoring	The CPF Board collects and analyses data on MediSave contributions, withdrawals and utilisation to monitor financial sustainability and performance. MediSave-accredited institutions are required to report on financial and clinical data to the MOH. The MOH monitors the effectiveness of MediSave in meeting health system objectives — particularly affordability metrics according to the MOH's annual Key Performance Indicators (KPIs).
For PHC:	Compliance and performance monitoring for primary care under MediSave is done in conjunction with performance monitoring of the MediSave scheme as a whole.

Purchasing Functions in Singapore's Healthcare Schemes

	MEDISHIELD LIFE
% of Total CHE	8.62% (2019)
Coverage	4,070,000 individuals (100% of citizens and Permanent Residents / 72% of the total population) **MediShield Life covers all citizens and PRs but excludes foreign residents.*
Purchaser(s)	Central Provident Fund Board
Governance	MediShield Life is overseen by the Central Provident Fund (CPF) Board, a statutory board under the Ministry of Manpower (MOM). The CPF Board includes representatives from the government, employers and workers. It is responsible for the governance of MediShield Life with the support of the MediShield Life Council. Comprising representatives from the MOH, CPF Board, healthcare sector and insurance industry, the MediShield Life Council oversees the operations of MediShield Life and gives recommendations to the MOH on improvements to the scheme.
For PHC:	Not applicable.
Financial Management	The MediShield Life Fund is designed to be self-sustaining and follows principles from the Monetary Authority of Singapore's (MAS) Risk Based Capital (RBC) Framework for private insurers. Premiums are adjusted every 3 to 5 years by the MOH and CPF Board. Benefit entitlements are reviewed regularly by the MOH. This is intended to ensure that premiums are priced on a sound actuarial basis and that the Fund remains sustainable. The Inland Revenue Authority of Singapore (IRAS) and the CPF Board are responsible for the recovery of any outstanding premiums.
For PHC:	Not applicable.
Benefits Specification	The MOH is responsible for decision-making on MediShield Life benefits, with input from the MediShield Life Council. Benefits under MediShield Life are limited to large hospital bills including day ward, inpatient surgery and select outpatient services (e.g. cancer drug treatment, radiotherapy, kidney dialysis). Patient co-payment levels range from 3 to 10%. Benefit entitlements are designed to complement public healthcare subsidised rates, so beneficiaries who seek care in private facilities will pay more out-of-pocket as private facility fees are unsubsidised. Details on the MediShield Life benefit package are published on the MOH website.
For PHC:	As MediShield Life is intended to cover high-cost interventions, primary care benefits are excluded from the scheme.
Contracting Arrangements	MediShield Life contracts with all public healthcare institutions and accredited non-public institutions. Institutions must submit an accreditation application to the MOH; institutions must sign a Deed of Indemnity (DOI), submit required documents and meet set accreditation criteria. Both the institution where a procedure is performed and the doctor/dentist performing a procedure must be accredited under MediSave in order for claims to be submitted.
For PHC:	Not applicable.
Provider Payment	Singapore does not have a single-payer system for healthcare, and only a portion of a patient's bills will be eligible for MediShield Life payment/reimbursement. After patient deductibles and co-payments are made, the remaining cost is borne by MediShield Life (within annual limits). The MediShield Life Fund directly reimburses public and accredited institutions for the relevant bill amount.
For PHC:	Not applicable.
Performance Monitoring	MediShield Life institutions submit clinical and financial data to the MOH and CPF Board, which monitor the performance of the scheme and adjust premiums/benefits accordingly to ensure its sustainability. The MOH collects data on affordability related to MediShield Life for its annual Key Performance Indicators (KPIs). It conducts regular revisions of MediShield Life (the latest having taken place in 2020) with input from the CPF Board, MediShield Life Council and the public.
For PHC:	Not applicable.

Purchasing Functions in Singapore's Healthcare Schemes

	MEDICAL ENDOWMENT FUND (MEDIFUND)
% of Total CHE	0.61% (2019)
Coverage	Varies year-by-year. **Low-income citizens and PRs are eligible to apply for Medifund on a case-by-case basis. 1,150,985 admissions, attendances and bed months were approved in FY2020 (may not correspond to the number of unique patients covered).*
Purchaser(s)	Ministry of Health
Governance	Medifund is governed according to the Medical and Elderly Care Endowment Schemes Act (Chapter 173A). Medifund is managed by the MOH. A Medifund Advisory Council (MAC), appointed by the Minister for Health, advises on fund administration and policy and recommends scheme improvements. Each Medifund-approved Institution (MFI) has a Medifund Committee (MFC) that evaluates applications and administers grants. Committee members are independent volunteers nominated by the institutions and appointed by the Permanent Secretary for Health.
For PHC:	The MFC of the relevant polyclinic group (National Healthcare Group Polyclinics, SingHealth Polyclinics) is responsible for decision-making on Medifund applications and has oversight of internal fund management. Currently, the National University Polyclinics group falls under the Ng Teng Fong General Hospital Medifund Committee (also a member of the NUHS health system).
Financial Management	The government is responsible for growing the endowment of Medifund, with an intended endowment size of $3 billion. A separate Medifund Silver is maintained for needy elderly patients. Top-ups to the fund are given by the MOF at the government's discretion when budget is available. The MOH disburses funds to MFIs annually, and MFCs conduct their own financial management by managing internal reserves, evaluating applications and administering grants. While each institution typically manages its own reserves, the Agency for Integrated Care administers Medifund for over 50 smaller institutions part of the scheme.
For PHC:	The MFC and medical social workers of each polyclinic group oversee the internal management of Medifund reserve,s including application outcomes, subsidy amounts and financial planning.
Benefits Specification	Medifund is intended as a safety net to cover low-income Singaporeans for outstanding medical bills after other subsidised and schemes are used. It covers inpatient, specialist, intermediate and long-term care and (more recently) primary, antenatal and dental care and medical consumables. Beneficiaries must be Singapore citizens who are receiving treatment at MFIs. As institutions have discretion over the approval of Medifund applications, medical social workers lead holistic evaluations of patients' needs, backgrounds and bill sizes to determine eligibility. The MOH provides guidelines to facilitate consistency in decision-making, but MFCs retain full discretion.
For PHC:	Patients can apply for Medifund for any service at polyclinics. Approval and fund disbursement is at the discretion of the relevant MFC, based on the patient's financial circumstances and bill size.
Contracting Arrangements	MFIs include all Public Healthcare Institutions (PHIs) — namely public hospitals, national speciality centres and polyclinics — and selected intermediate- and long-term care facilities.
For PHC:	Medifund can be used at PHIs in primary care, and therefore can only be utilised at public polyclinics (not private GP clinics). All polyclinics are automatically considered MFIs.
Provider Payment	The MOH provides MFIs with grants from the annual interest generated from the fund. The grant value is determined by a facility's projected needs and previous year spending/unutilised savings.
For PHC:	As for any MFI, polyclinics are provided an annual grant from the MOH to be used for their Medifund accounts. Grants are operated by the relevant MFC.
Performance Monitoring	Each MFC is required to maintain records of its Medifund transactions and submit financial statements for auditing. Auditors are appointed by MOH on a yearly basis. The Medifund Advisory Council (MAC) collects information on the performance of the fund and provides recommendations for improvement. The MAC is re-appointed regularly and includes representatives from the healthcare sector, eldercare and social services and legal sector.
For PHC:	Polyclinics' MFCs submit financial statements to the MOH yearly for auditing.

Purchasing Functions in Singapore's Healthcare Schemes

	COMMUNITY HEALTH ASSIST SCHEME (CHAS)
% of Total CHE	0.52% (2019)
Coverage	1,200,000 individuals (33.80% of citizens / 21.28% of the total population are cardholders) **Only Singapore citizens are eligible to apply to become CHAS cardholders.*
Purchaser(s)	Ministry of Health
Governance	The MOH and the Agency for Integrated Care (AIC), an agency under the MOH, are responsible for administering aspects of the CHAS scheme. These include enrolment (processing applications against eligibility criteria, maintaining CHAS patient databases, issuing CHAS cards to beneficiaries); contracting with healthcare providers; managing claims processing and reimbursements.
For PHC:	As CHAS is a primary care-focused scheme, all governance aspects described above apply.
Financial Management	The MOH is responsible for the financial management of CHAS.
For PHC:	As CHAS is a primary care-focused scheme, all financial management aspects described above apply.
Benefits Specification	CHAS was originally created to cover low-income Singaporeans and the elderly for primary care services at GP clinics and dental clinics. The MOH is responsible for benefit specification for CHAS. Benefits include consultation fees, medication and basic investigations/lab tests). In 2019, CHAS was expanded to cover all Singaporeans, but application to be a CHAS cardholder are necessary and benefits are tiered according to income. The amount of subsidy received will depend on one's household income or annual value of their home. Lower-income CHAS Blue and Orange cardholders can use the scheme for common illnesses, selected chronic conditions and selected dental services, whereas higher-income CHAS Green cardholders can use it for selected chronic conditions only. Elderly patients (Pioneer Generation and Merdeka Generation) are eligible for enhanced CHAS benefits regardless of their income status.
For PHC:	As CHAS is a primary care-focused scheme, all benefits specification aspects described above apply.
Contracting Arrangements	GP clinics, private dental clinics and Specialist Outpatient Clinics (SOCs) at public hospitals can participate in the CHAS scheme. To participate in CHAS, clinics and doctors providing treatment must be accredited under MediSave's Chronic Disease Management Programme (CDMP) framework, fill out an application form for CHAS and complete a CHAS e-learning training. Accredited clinics are assigned to a polyclinic administrator to sign the CHAS contract. Currently, over 1,000 private GPs and 700 dental clinics are enrolled in CHAS.
For PHC:	As CHAS is a primary care-focused scheme, all contracting arrangement aspects described above apply.
Provider Payment	Participating providers can check their patient's balance for their annual CHAS subsidy. If the subsidy cap has not been reached, they can produce an itemised bill indicating the CHAS subsidy amount. Clinics then have 30 days to submit a CHAS claim; claims are generally processed and reimbursed within one month by the MOH.
For PHC:	As CHAS is a primary care-focused scheme, all provider payment aspects described above apply.
Performance Monitoring	The AIC regularly reviews the performance and budget of the CHAS scheme, and collects feedback to identify areas of improvement. Polyclinics administrators of CHAS or MOH-appointed auditors also conduct regular audits on clinical and financial metrics. CHAS-participating clinics must maintain relevant documents for such audit purposes.
For PHC:	As CHAS is a primary care-focused scheme, all performance monitoring aspects described above apply.

Recent Progress in Strategic Purchasing

- In 2023, Singapore initiated Healthier SG, a significant healthcare redesign initiative. The Healthier SG scheme for primary care enables citizens and Permanent Residents to enrol to a private GP clinic for lifelong care, seeking to move the disproportionate chronic care burden away from polyclinics and to encourage preventive care.
- As part of Healthier SG, the payment of public healthcare clusters has shifted from a mixed-payment system (DRG for inpatient and day surgery, block grants for outpatient) to capitation funding.
- The MOH implemented a Pay for Performance framework from 2021 tracking cluster data on key priority areas and financially rewarding them for performing well. Priority areas are still in the process of being finalised, but may reflect the annual Key Performance Indicators of the MOH. In 2022 these included indicators on good health outcomes, quality, accessibility and affordability.
- Bundled payments were implemented starting in 2021 for specified conditions — for example, end-to-end care including surgery, inpatient care and outpatient rehabilitation for hip fracture patients. Through these bundled payments, a lump sum is paid for the management of a condition even where care may span across multiple healthcare institutions (e.g. acute hospitals and community/rehabilitation hospitals).
- To reduce spending on medical devices, equipment and pharmaceuticals across the public healthcare clusters, a joint procurement agency — ALPS Pte Ltd — was established from 2018 to centralise procurement across public institutions. ALPS is currently responsible for 65% of overall procurement for public healthcare and 90% of procurement for pharmaceuticals for public healthcare.
- In 2019, CHAS was expanded to cover Singaporeans of all incomes for selected chronic care conditions. Higher-income Singaporeans (over 2,000 SGD household monthly income per person) can receive limited subsidies for the management of chronic conditions at private GPs, thus reducing the burden of care for public polyclinics.
- Through the Value-Driven Care (VDC) programme launched in 2017, the MOH has identified 17 high-volume, high-cost conditions and is working with VDC workgroups across institutions to standardise cost and outcome indicators for these.

KEY HIGHLIGHT: HEALTHIER SG FINANCING AND IT REFORMS

Healthier SG is a comprehensive health system reform launched by the Singaporean government in 2022, with the aim of promoting a healthier population and focusing the nation's healthcare system on preventive care.

Healthier SG covers 5 key features: 1) mobilising **family doctors** to deliver preventive and holistic care; 2) developing holistic **health plans** for all residents (covering medications, lifestyle changes and screenings) in consultation with family doctors; 3) activating **community partners** to support residents in living a healthier life and integrate with the health system through social prescriptions; 4) launching a **national enrolment exercise**, whereby residents will register with one lifelong family doctor/private GP clinic for their health plan and holistic healthcare needs; 5) enhancing **system enablers** including IT, manpower development and financing to support a national shift toward preventive care.

The planned system enablers include strengthening mobile applications to track residents' health plans, physical activities and diets; shifting financing of the public healthcare system toward a capitation-based model, giving health clusters the incentive to improve preventive and population health; and improving the IT capabilities of private GP clinics by integrating their independent Clinic Management Systems with Singapore's National Electronic Health Record (NEHRS) system.

A Healthier SG whitepaper outlines short-term, medium-term and long-term aims and indicators for progress. These include operational outcomes (e.g. resident enrolment rates), utilisation outcomes (e.g. proportion of diabetes patients receiving appropriate screening) and health outcomes (e.g. incidence of stroke and cancer). This will assist the Ministry of Health in tracking the progress of Healthier SG and bridging remaining gaps in the health system as needed.

Challenges for Strategic Purchasing

- As users are free to access care at any of the public healthcare clusters, issues of 'transfer pricing' (i.e. patients going outside of their provider network) will have to be considered after the recent shift to capitation funding.
- Implementation challenges may emerge in the initial phases of Healthier SG for primary care at the private GP level. Sufficient enrolled GPs will be needed to ensure the success of the scheme and empower the private sector to provide chronic disease management. To do this, appropriate Healthier SG funding and other non-monetary benefits will have to be considered satisfactory by GPs to incentivise them to care for medically complex patients.
- Singapore's ageing population poses a challenge to the current MediShield benefit package, which will have to be revised continuously alongside evolving care needs and chronic diseases.
- Funding flows across Singapore's public healthcare are complex, and there may be challenges in ensuring that strategic purchasing practices are passed on at all levels involved. While capitation is being implemented from MOH to the health clusters, no set payment mechanism has been mandated from the clusters to their component institutions.
- Due to the complexity of Singaporean health financing schemes, there may be challenges in communicating the benefits and assistance schemes available to patients. Better coordination among GPs, medical social workers, institutions and the MOH are required to help patients navigate care seamlessly.

Opportunities to Improve Strategic Purchasing

1. **Singapore's public healthcare clusters could focus on growing their internal capacity to implement the new capitation framework.**

   This should involve collecting data on service utilisation and patient outcomes to make evidence-driven decisions (for example, determining how to allocate capitation shares among component institutions within a cluster). Developing high-level and granular data analytics platforms will be essential to this effort.

2. **Singapore could further track data on specific vulnerable populations in terms of health outcomes, service utilisation and financial needs.**

   This would help to identify the needs of vulnerable sub-groups and thus improve the equity of the health system. In the new capitated model, tracking the health outcomes and financial needs of vulnerable groups may also help the MOH set more data-driven capitation rates for the public health clusters.

3. **Singapore could expand on its existing public outreach and care integration efforts.**

   With the complex and fragmented nature of Singapore's health financing schemes, some patients may have poor understanding of available schemes and modes of assistance. Vulnerable patients may also face barriers to financial support, such as onerous means-testing processes. Greater public outreach across the different schemes (MediSave, MediShield Life, Medifund, CHAS) could educate the public on available assistance schemes and gather feedback on how to streamline administrative processes such as means-testing.

4. **Singapore could aim to encourage residents to seek care at their designated healthcare clusters to maximise the benefits of capitation funding.**

   In view of Singapore's ongoing shift to capitation, a standardised system of incentives should be implemented to encourage residents to seek care at their designated cluster. This would ensure that capitation funding amounts are accurately calculated. Alternatively, the MOH should consider gathering data on patients seeking care outside of their designated networks in order to guide funding decisions.

5. **The MOH could focus on regularly reviewing patient and financing outcomes in real time, allowing it to implement changes quickly if needed.**

   This real time monitoring will be increasingly necessary while Singapore is in the midst of implementing healthcare financing reforms. Gathering lessons from the ground rapidly and implementing changes accordingly will help ensure the success of these reforms.

Opportunities to Improve Strategic Purchasing for Primary Care

1. **Singapore could further empower primary care to support ongoing healthcare financing reforms.**

   The burden on the health system will grow alongside Singapore's shifting burden of disease toward NCDs and ageing-related conditions. The shift to capitation for clusters, the rollout of Healthier SG and the enrolment of residents to a lifelong private GP clinic may be an opportunity to ramp up manpower, including "lay extenders" in polyclinics and GP clinics to undertake non-medical tasks. This will empower primary care to better support national health financing efforts and preserve the sustainability of Singapore's health system.

2. **Fair pricing models could be developed for Healthier SG to encourage GP enrolment.**

   Pricing models should be developed alongside private GPs to ensure acceptability and understand their perceptions of the Healthier SG scheme. Pricing models should be reviewed every 3-5 years, as the patient load is expected to increase, to ensure continued satisfaction. Developing high-level data analytics platforms and collecting more granular data will be essential to this effort.

Thailand

Health Financing Schemes in Thailand

Thailand is an upper-middle income country with Universal Health Coverage (UHC) that provides access to healthcare services for all citizens and legal residents. The Universal Coverage Scheme (UCS), Civil Servant Medical Benefit Scheme (CSMBS) and Social Security Scheme (SSS) collectively function as the system of UHC in Thailand. Public expenditure (comprising UCS, SSS, CSMBS, the Ministry of Public Health and other public components) comprises approximately 70% of the current health expenditure. About 10% of current health expenditure comes from out-of-pocket (OOP) payments.

The main health financing schemes in Thailand are:

UNIVERSAL COVERAGE SCHEME: Established in 2002, the UCS targets individuals in Thailand not covered under the SSS or the CSMBS. It covers approximately 49.8 million people (74% of the population). The scheme is considered a citizen's right to receive social protection and is financed through the tax-based government budget. Health facilities are paid on a capitation basis for outpatient, preventive and health promotion services. Inpatient services are paid using diagnostic-related groups with a global budget approach. For specific high-cost procedures, a fee-for-service method with a ceiling is applied. The annual public budget allocated per capita was around 3,800 THB or 120 USD per person in 2020.

OVERVIEW

Population (2022): **71.70 million**

GPD per capita (2022): **US$7,090**

Poverty headcount at national poverty line (2021): **6.3%**

Life expectancy (2021): **79 years**

Infant mortality rate per 1,00 live births (2021): **7.1**

DALYs per 100,000 (2019): **24,227**

Current health expenditure as % of GPD (2020): **4.36%**

Domestic government expenditure as % of CHE (2020): **70.36%**

Out-of-pocket expenditure as % of CHE (2020): **10.54%**

UHC Service Coverage Index score (2021): **82**

Physician density per 1,000 people (2020): **0.95**

SOCIAL SECURITY SCHEME: Established in 1990, the SSS is intended for private employees in Thailand. It covers approximately 11.2 million people (17% of the population). It is a mandatory health insurance scheme that combines state subsidies and mandatory contributions from employees and employers. Health facilities are paid on a capitation basis for outpatient services, while inpatient services are paid using diagnostic-related groups within a global budget approach. The annual public budget allocated per capita was around 7,000 THB or 220 USD per person in 2020.

CIVIL SERVANT MEDICAL BENEFIT SCHEME: Established in 1980, the CSMBS covers civil servants in Thailand, as well as their parents, spouses and up to three children. The CSMBS covers approximately 6 million people (9% of the population). The scheme is considered a fringe, state welfare benefit and is financed through a tax-based, non-contributory governmental budget. Health facilities are paid using a fee-for-service approach for outpatient services, while inpatient services are paid using diagnostic-related groups with multiple cost bands. The annual public budget allocated per capita was around 12,000 THB or 400 USD per person in 2020.

The Primary Healthcare System in Thailand

Thailand has a well-developed primary healthcare system that serves as the first point of contact for patients seeking public healthcare services. The public primary healthcare system is operated by the Ministry of Public Health (MOPH) and covers the entire country.

The system is structured around a network of primary healthcare facilities, including health centres and community hospitals, or so-called District Health Systems (DHS). These facilities are staffed by trained healthcare professionals, including doctors, nurses and other medical and public health staff. They provide a wide range of medical and public health services, including preventive care, health promotion services, treatment of common illnesses, maternal and child health services and basic diagnostic tests.

One of the key features of the primary healthcare system in Thailand is its emphasis on community-based healthcare. The system places a strong emphasis on health promotion and disease prevention, and community health volunteers are often utilised to provide health education and basic medical care and public health services in their catchment areas.

Overall, the primary healthcare system in Thailand is a well-established and effective system that provides basic healthcare services to all people. The system's focus on community-based healthcare and health promotion has helped to improve equitable access to health services and the health of the population and reduce the burden of disease on the healthcare system.

Purchasing Functions in Thailand's Healthcare Schemes

	UNIVERSAL COVERAGE SCHEME (UCS)
% of Total CHE	18% (2019)
Coverage	49.80 million (74% of the total population) **The UCS covers all citizens not enrolled in the SSS and CSMBS schemes.*
Purchaser(s)	National Health Security Office (NHSO)
Governance	The UCS is governed by the Board of UCS, with the NHSO as the Secretariat of the Board. The NHSO is a government organisation responsible for managing the UCS. It was established in 2002 under the National Health Security Act to ensure that all Thai citizens have access to essential health services and financial protection against catastrophic medical expenses. The NHSO is responsible for managing the UCS budget, contracting providers and monitoring service quality.
For PHC:	The Ministry of Public Health (MOPHS) is the major provider of public healthcare services through Primary Care Units (PCUs). A system of Contracting Units for Primary Care (CUP) is used, with all MOPH facilities automatically enrolled. Other public and private providers can voluntarily register and be approved to serve as healthcare units for UCS beneficiaries within their local networks.
Financial Management	The UCS is funded by government budget allocation, which is managed by the NHSO.
For PHC:	The NHSO plays a crucial role in the financial management of primary care by implementing the UCS, which provides comprehensive primary care services to UCS beneficiaries and health promotion and disease prevention services for the entire Thai population.
Benefits Specification	The UCS covers comprehensive services including preventive care, common illnesses, maternal and child health, basic diagnostic tests, prescription drugs, medical equipment and laboratory tests. It also covers medicines from the National List of Essential Medicines (NLEM) for UCS beneficiaries and health promotion and disease prevention for all Thais (not only UCS members).
For PHC:	The benefits specification for primary care is clearly outlined by the NHSO, describing the services, procedures, medications, and interventions which the beneficiaries are entitled to receive. In January 2023, the NHSO upgraded the UCS benefits by including new free items for elderly people such as free eyeglasses, adult diapers, dentures and dental implants.
Contracting Arrangements	The NHSO is responsible for contracting healthcare providers and monitoring the quality of care. The contracted parties include both public and private providers. All public facilities are required to be contracted providers, but only accredited private facilities can be enrolled. A private hospital could be accredited either through the Joint Commission International (JCI) or Thailand Healthcare Accreditation Institute (HAI).
For PHC:	District health systems (DHS) are the main contractors for primary care under the UCS.
Provider Payment	The UCS uses a mix of capitation and Diagnostic-Related Groups (DRGs). Outpatient services and health prevention & promotions are paid through capitation; amounts are based on patient characteristics, provider locations and type of care provided. Inpatient services are paid under DRGs with a global budget approach. For high-cost or specific procedures, fee-for-service is used. Public and private providers are also eligible for performance-based payments based on quality and patient satisfaction, under the "Quality and Outcome Framework" (QOF) payment system.
For PHC:	Primary care is paid through capitation, with amounts based on patient characteristics (age, gender, health status), provider locations and type of care provided.
Performance Monitoring	The NHSO is responsible for monitoring the performance of the UCS. It collects and analyses microdata on services provided and reimbursement. The NHSO and the MOPH have used evidence-based research and theoretical concepts to monitor and improve health system performance. Therefore, strategic purchasing in Thailand can inform policy-making decisions by reporting to the Parliament and Cabinet on UHC in the country.
For PHC:	The indicators for primary care cover interconnected and updated HMIS, standardised health promotion, disease prevention, home visits to special care groups, laboratory diagnostic services and comprehensive care for patients and at-risk groups with diabetes/hypertension.

Purchasing Functions in Thailand's Healthcare Schemes

	SOCIAL SECURITY SCHEME (SSS)
% of Total CHE	12% (2019)
Coverage	11.20 million (17% of the total population) **The SSS covers all private sector employees in Thailand (citizen and non-citizen).*
Purchaser(s)	Social Security Office, Ministry of Labour
Governance	The Social Security Scheme (SSS) is governed by the Board of SS and managed by the Social Security Office (SSO). The SSO is responsible for collecting contributions from employers and employees, contracting healthcare providers and managing the scheme's budget. Under the overall direction of the Ministry of Labour, the SSO operates under the Social Security Act 1990 and is responsible for managing social security and welfare programmes, including healthcare coverage for the beneficiaries. As a government agency responsible for social security and welfare programmes of private workers, the SSO is dedicated to ensuring access to affordable and quality healthcare services for its registered beneficiaries.
For PHC:	The SSS holds a relatively minor role in the governance of health purchasing for PHC, as its main contractors are large hospitals while local health facilities function as sub-contractors.
Financial Management	The SSS is funded by tripartite contributions from the government, private employers and private employees. The SSO is responsible for collecting contributions and managing the scheme's budget.
For PHC:	The above financial management aspects apply.
Benefits Specification	The SSS covers common illnesses, hospitalisation and some dental services. A Medical Committee appointed by the Minister of Labour provides guidance to the SSO Board on medical coverage and benefits. The SSO pays main contractors through capitation. Price caps are set for private care (4,000 baht per month for inpatient and 2,000 baht per month for outpatient). Disabled individuals can receive ambulance/transportation coverage up to 500 baht per month. They are also covered for rehabilitation costs when meeting specified criteria.
For PHC:	With its main contractors being large hospitals, SSS beneficiaries are covered for full outpatient expenses at government hospitals, but are limited to a price cap of 2,000 baht per month for private outpatient care.
Contracting Arrangements	The SSO is responsible for contracting healthcare providers on a competitive basis through its provincial offices throughout the country as well as 12 branch offices in Bangkok. The main contracted providers are public and private accredited hospitals with at least 100 beds and with 12 clinical specialties. The SSO allows subcontracting by these main contractors.
For PHC:	There is a referral system among SSO clinics within the relevant contracting unit's network. There are work-related clinics that perform medical diagnosis, provide treatment, offer surveillance and preventive care, offer consultations and promote occupational health and safety among firms.
Provider Payment	The SSS uses capitation and Diagnostic-Related Group (DRG) payments with a global budget to reimburse providers. Fee-for-service is used for some high-cost services, based on a fee schedule set by the SSO. The SSO pays for inpatient care at government hospitals through a DRG method.
For PHC:	Provider payments for primary care follows the same mechanisms as above.
Performance Monitoring	The SSO conducts regular assessments and quality control audits, with the main contracting units assessed annually. Nevertheless, it does not have a clear performance monitoring and accountability framework. The SSO cannot regulate the quality of public and private hospitals in its hospital networks as it has no bargaining power over private hospitals.
For PHC:	The SSO does not have clear structures for performance monitoring specific to primary care.

Purchasing Functions in Thailand's Healthcare Schemes

	CIVIL SERVANT MEDICAL BENEFITS SCHEME (CSMBS)
% of Total CHE	28% (2019)
Coverage	6,000,000 individuals (9% of the total population) **The CSMBS covers all civil servants in Thailand.*
Purchaser(s)	Comptroller General's Department (CGD)
Governance	The CSMBS is managed by the Ministry of Finance (MOF)'s Comptroller General's Department, a major central agency responsible for monitoring, controlling and administering public expenditure. Even without a legal mandate of strategic purchasing, the CGD is responsible for managing the scheme's budget, contracting healthcare providers, monitoring the quality of services and conducting reimbursement of CSMBS medical expenses. However, the CGD does not have a legal mandate as a purchaser; it is only responsible for the reimbursement of expenses to public and contracted private providers or directly to CSMBS beneficiaries. The CGD does not supervise the quality of services provided.
For PHC:	The CGD is solely responsible for the financial management of the CSMBS, i.e. reimbursement to beneficiaries and payment to healthcare providers (including for primary care).
Financial Management	The CSMBS is funded by tax-based public budget allocation. The CGD is responsible for managing the scheme's budget.
For PHC:	The above financial management aspects apply.
Benefits Specification	The coverage of CSMBS is similar to that of the UCS, including outpatient and inpatient services with price caps for private facilities. The CSMBS covers the cost of primary healthcare, specialty care and hospitalisation. The use of non-essential medicines is usually not permitted, unless physicians confirm that these are clinically indicated. Through evidence-based literature and cost-effectiveness principles, a technical advisory committee decides what services should be included in the benefit package (beyond those in the National List of Essential Medicines). The health expenditure per capita of the CSMBS surpasses that of Thailand's other two schemes, reaching a value that is 3.15 times greater than the per capita expenditure of the UCS.
For PHC:	The CSMBS covers comprehensive primary healthcare services as part of its benefit package.
Contracting Arrangements	There is no legal mandate for the CGD to be responsible for contracting healthcare providers. The CGD is only responsible for reimbursing expenses to government officials (the scheme's intended beneficiares) and health facilities. Specifically, the CGD is only responsible for controlling the reimbursement process according to MOF rules and regulations.
For PHC:	There is no mandate for the CGD to contract primary care providers, but only to reimburse claims to health facilities and enrolled government officials when primary care services are utilised.
Provider Payment	Starting in 2007, the CSMBS shifted from a fee-for-service payment mechanism for hospitalisations toward Diagnostic-Related Group (DRG)-based payments. Outpatient services are paid to providers through direct disbursement from the CGD. Inpatient services are paid through DRGs. Co-payment is possible for medicines not indicated on the National List of Essential Medicines.
For PHC:	Primary care services are paid to providers through direct reimbursement from the CGD.
Performance Monitoring	There is no explicit performance monitoring system for the CSMBS.
For PHC:	There is no explicit performance monitoring system for the CSMBS.

Recent Progress in Strategic Purchasing

- The NHSO uses a variety of purchasing strategies, including closed-ended provider payment, gatekeeping functions at the primary care level, exercising collective purchasing power and engaging the views of stakeholders in the decision-making. A well-established legal and policy landscape allows the NHSO to be accountable to people, healthcare providers and the government. The National Health Security Board (NHSB) consists of members from various stakeholder groups, including five representatives from NGO constituencies.
- The NHSB and the Health Service Standard and Quality Control Board approved the National Health Security Office Action Plan (2018-2022), with the aim of providing every Thai citizen with access to quality healthcare without experiencing financial difficulties. The action plan is grounded in three fundamental principles: 1) providing accessible services; 2) ensuring financial sustainability; and 3) upholding good governance.
- There are relentless efforts to improve the quality, efficiency and accessibility of the UCS. In 2022, many new health benefits were introduced: free adult diapers, glasses for children with vision problems, outpatient telemedicine for 42 diseases and symptoms piloted in Bangkok, Lab Anywhere for free laboratory tests covering 24 items at medical technology clinics, and a 'pharmacy for common illness' initiative for medicines and consultations for 16 symptoms and diseases.
- There has been some progress in improving access to primary care in Bangkok. While Bangkok is renowned for its advanced healthcare services, there remains a disparity in primary care provision. Factors such as traffic, distance to primary care units and a preference for pharmacies or hospitals have contributed to lower primary care utilisation in the city compared to other provinces. The NHSO has expanded Public-Private Partnerships (PPP) to increase primary care entry points in Bangkok. Prior to April 2023, access to primary care was limited to registered health units based on individuals' home addresses; with the updated system, UCS beneficiaries can decide on their health units. It is estimated that over 500 private clinics will be necessary to bridge the healthcare gap in Bangkok; these clinics will offer free services to beneficiaries and claim the fees from the NHSO. The NHSO has made efforts to improve its reimbursement system and claims processing times.
- The NHSO is also working with the Bangkok Metropolitan Administration (BMA) to address access gaps in primary care services. Joint efforts between the NHSO and BMA include extending after-hour clinics and introducing health mobile vehicles.
- The NHSO is working on a policy proposal that will allow the UCS beneficiaries to get primary oral health services at any healthcare access point. This will mitigate a problem for beneficiaries that only receive dental care at the hospitals or clinics where they are registered, which has caused obstacles for those living far from their registered health units or those who have relocated.
- In a recent report to the Cabinet, the NHSO also improved its reimbursement system to speed up the e-claim process, empowering hospital operators with the necessary financial liquidity to deliver free services to Universal Health Coverage (UCS) beneficiaries.

KEY HIGHLIGHT: HMIS DEVELOPMENT OVER THE DECADES

One of the most notable highlights of the UHC development in Thailand is the remarkable success story of its Health Management Information Systems (HMIS) of the Ministry of Public Health (MOPH). The HMIS plays a vital role in improving healthcare services and outcomes in Thailand. It has been instrumental in enhancing healthcare delivery, monitoring disease trends, improving decision-making, and promoting public health interventions. HMIS in Thailand incorporates the use of electronic medical records to digitise patient health information into the Electronic Medical Records (EMRs) system which allows providers to access patient data, track medical histories and facilitate better coordination across facilities.

HMIS facilitates the collection of health data from public health facilities. This includes patient demographics, disease prevalence, treatment outcomes, and more. By standardising data collection processes, HMIS enables comprehensive reporting, analysis, and monitoring of health indicators at national, regional and local levels.

Telemedicine and remote health services are technically feasible through investing in digital transformation and telecommunication technologies, in which HMIS can facilitate structured and unstructured data exchange and ensures secure transmission of medical information. While HMIS has proven beneficial in Thailand, challenges such as interoperability, data privacy, and resource constraints may arise. It is essential to address these challenges by implementing robust data protection measures, fostering collaboration among stakeholders, and investing in infrastructure and human resources.

The implementation of ICT technologies has enabled many new services in Thailand, including Telemedicine, patient queue management, and patient information collection using Big Data analysis. Thanks to the well-established HMIS foundation, public hospitals could actively evolve to expand telemedicine services when the COVID-19 epidemic situation had been a catalyst to adopt the technology. As of December 2022, about 98 percent of the MOPH hospitals use the cloud-based Health Information System Gateway (HIS Gateway) for data integration and exchange.

Challenges for Strategic Purchasing

- There are inequality gaps in benefits, health coverage and contributions among the three UHC schemes in Thailand. There is currently no available information regarding strategic purchasing for the CSMBS and SSS schemes, and no ongoing efforts to harmonise the three schemes. Thus, Thailand could put more effort into synchronising benefit packages, financial contributions and payment mechanisms. The three schemes could similarly harmonise their efforts toward strategic purchasing mechanisms to improve budget efficiency for overall strategic health purchasing in Thailand.
- Health Management Information System (HMIS) in the governmental sector faces challenges in data integration and interoperability, data quality, human resource capacity, privacy and security, and governance. The lack of interoperability between different healthcare systems, inconsistent data quality and standardisation, limited advance-skilled personnel, privacy and data breach concerns, and fragmented governance hinder the effective management of health and financial data. Enhancing the integration and interoperability of HMIS would establish a strong foundation for the overall efficiency of UHC's strategic healthcare purchasing.
- Healthcare budget limitations and financial constraints can dissuade strategic purchasing efforts. The reliance of Thailand's public healthcare system on an annual government budget allocation poses a risk of slashed budgets during economic downturns and fiscal constraints. This mismatch between budget allocation and a growing demand for health services, as well as increasing costs of labour and medicine, can lead to limited quality and access of UHC.

Opportunities to Improve Strategic Purchasing

1. **Thailand could converge the legal frameworks, organisational arrangements and institutional capacity among its three health financing schemes, potentially through appropriate Parliamentary and legislative action.**

   This may involve appropriate Parliamentary and legislative action and/or the creation of a coordinating body that oversees the operations of the three schemes. Achieving this would require strong political will from the government. Establishing common organisational arrangements and institutional capacity would help to streamline consistent management across the three schemes and ensure that they are working toward the same outcomes.

2. **Thailand could implement a unified performance-based payment system for all schemes to incentivise healthcare providers to provide high-quality care and meet specific health outcomes.**

   This would help to improve the overall quality of healthcare services and encourage providers to make efficient use of resources. Payment mechanisms for the different health schemes should be harmonised to improve the efficiency of service delivery and reduce administrative costs. Establishing common information systems and data management tools across the three schemes would help to improve transparency, reduce administrative burdens and enhance monitoring and evaluation for the healthcare system's performance.

3. **A national centralised procurement system for medical supplies and equipment could bring significant benefits to Thailand.**

   Standardising the quality of medical supplies across facilities and streamlining supply chain management would also enhance efficiency and effectiveness. A national centralised procurement system could achieve cost savings and improve resource availability, though it may also introduce bureaucratic delays, reduced competition and limited flexibility.

4. **The three schemes could better work together to collectively develop and promote the goals of "value-based healthcare".**

   This model aims to maximise the value of care for patients by improving health outcomes while minimising cost. Through this approach, the success of healthcare delivery is measured not by inputs or volume of services provided, but by health outcomes achieved per every monetary unit spent. To achieve this, providers must prioritise patient outcomes and satisfaction by implementing cost-effective treatments that improve the patient experience.

Opportunities to Improve Strategic Purchasing for Primary Care

The primary healthcare system in Thailand faces the same challenges as the overall healthcare system — including fragmented healthcare delivery, limited financial resources and variability in service quality and benefits coverage across the schemes and administrative areas. Therefore, the above recommendations also apply to improving strategic purchasing for primary care in Thailand.

Vietnam

Health Financing Schemes in Vietnam

Vietnam is a lower-middle income socialist country on the Southeastern tip of continental Asia. Vietnam has seen significant economic growth and poverty reduction since the 1990s, coinciding with great improvements to health outcomes among the population. Despite Vietnam's socialist market orientation, it comprises a mix of public and private healthcare facilities.

The first social health insurance law was passed in 2008, regulating Vietnam's roadmap to universal health insurance. However, out-of-pocket payments remain high and the country's ageing population risks posing a challenge to the sustainability of the health system.

The main health financing schemes in Vietnam are:

SOCIAL HEALTH INSURANCE: The Social Health Insurance Fund (SHI) is one of the major health financing schemes in Vietnam. SHI coverage in Vietnam was about 91% in 2021. In general, SHI revenues are made from contributions from i) the formal economy sector (4.5% of employees' income, contributed by both employees (1.5%) and employers (3%); ii) households in the informal economy sector (4.5% of minimum wage); iii) the social security agency fund (primarily for citizens on monthly pensions); and iv) government revenue subsidies in place of contributions from the poor and ethnic minority households. The SHI benefit package covers curative services (including some primary healthcare services). Fee-for-service is the dominant provider payment mechanism under the SHI scheme.

STATE BUDGET: The state budget (including the central government budget and local government budget) for health is planned for every year and goes through a review process before funds are channelled directly to service providers via the Ministry of Health (for central hospitals and centrally-affiliated agencies) or provincial Departments of Health/Departments of Finance (for public providers in the provinces). The state budget is responsible for covering preventive care, including many primary healthcare services (e.g., vaccination, health promotion and education, and family planning services among others). The Vietnam National Assembly passes laws on the state budget and sets state budget estimates and central government budget allocations. Provincial People's Councils are responsible for local government budgets.

OVERVIEW

Population (2022): **98.2 million**

GPD per capita (2022): **US$4,164**

Poverty headcount at national poverty line (2020): **4.8%**

Life expectancy (2021): **74 years**

Infant mortality rate per 1,00 live births (2021): **16.4**

DALYs per 100,000 (2019): **27,543**

Current health expenditure as % of GPD (2020): **4.68%**

Domestic government expenditure as % of CHE (2020): **45.11%**

Out-of-pocket expenditure as % of CHE (2020): **45.12%**

UHC Service Coverage Index score (2021): **68**

Physician density per 1,000 people (2016): **0.83**

The Primary Healthcare System in Vietnam

The health system in Vietnam comprises four administrative levels: central, provincial, district and commune. At each level, the organisational structure can be divided into curative care and preventive care. The curative public health sector is structured vertically through the hospital system, consisting of approximately 624 district hospitals, 376 provincial hospitals and 44 central hospitals as of 2021. A number of 11,112 commune health centres (CHC) deliver primary healthcare, including curative and preventive care.

CHCs form the foundation of Vietnam's primary healthcare system. Each CHC comprises one general doctor and three to five health staff, generally providing care for 2,000 to 12,000 inhabitants (with some exceptionally large communes having a population of over 100,000 inhabitants). CHCs are responsible for implementing priority public health programmes, organising community-level preventative health services such as immunisations, water and sanitation and promoting various public health campaigns as necessary. CHCs provide examination and treatment for common diseases, health counselling, managing and distributing common medications and medications used in priority public health programmes, referrals for patients with serious illnesses, prenatal and postnatal care and common spontaneous vaginal deliveries. In addition to CHCs, outpatient polyclinics (operated by district health centres) and district health centres (DHC) themselves provide more complex curative services.

SHI members may seek health care services at their registered primary health facility, at their local CHCs or at nearby polyclinics or district health centres. They can then be referred to higher-level hospitals if needed. Although those with social health insurance generally have free or low-cost access to primary care services through the CHCs, many people believe the quality to be poor and so bypass their CHCs and choose to self-pay for services directly at private clinics or hospitals. The recent district-level and provincial-level referral policies (regulated in the 2014 amended SHI Law, effective since 2016 for district-level referral policies and 2021 for provincial-level referral policies) also allow SHI members to bypass their registered primary health facilities to go to higher-level facilities in the same districts or provinces without incurring higher co-payment expenditure.

Purchasing Functions in Vietnam's Healthcare Schemes

	SOCIAL HEALTH INSURANCE
% of Total CHE	27.95% (2020)
Coverage	90,590,500 individuals (91% of the total population) **The SHI is expanding to cover the entire population of Vietnam, including eligible non-citizens/ foreign workers.*
Purchaser(s)	Vietnam Social Security (VSS)
Governance	The Vietnam Social Security agency (VSS) works with social insurance agencies in 63 provinces in revenue raising, fund management and provider reimbursement for the SHI. The SHI Law defines the MOH's responsibility in setting SHI policies. The MOH oversees the scheme alongside other agencies, health authorities and the VSS. Provincial People's Committee are responsible for implementing SHI policies and regulations at the provincial level; ensuring adequate funds to subsidise premiums; and conducting inspection, supervision and complaints resolution.
For PHC:	The above governance aspects apply.
Financial Management	The VSS fund is operated as a single fund, with all provincially-raised revenues pooled centrally. Hospitals can request payments from their social insurance agencies quarterly; these are responsible for claims assessment and reimbursement.
For PHC:	All primary care fund management is conducted by the VSS. District health centres (DHCs) consolidate claims on behalf of their subordinate commune health centres (CHCs), as CHCs cannot directly request payments from their social insurance agencies. Health stations in schools or companies also receive fixed funds from provincial social security agencies to cover their expenses on essential medicines, medical supplies and other aspects of first aid and primary care.
Benefits Specification	The Law on SHI implies that the SHI fund is dedicated to curative care; the SHI benefit package thus includes all curative services. The MOH has issued a list of non- and conditionally-reimbursable services as a "negative" benefit package list. Importantly, reimbursement rates do not cover full healthcare costs; a 20% co-payment policy was introduced in 1988 and has since been frequently revised. The MOH revises a list of SHI-reimbursable medicines every 2-3 years and issues criteria for adding or removing medicines.
For PHC:	An additional SHI basic health services package (via Circular 39/2017/TT-BYT) was issued in 2017 to apply in CHCs and DHCs. The package includes 76 basic services (e.g. doctor's visit, basic first aid, common blood test, normal birth delivery) and 241 essential medicines for PHC.
Contracting Arrangements	All public providers are automatically enrolled as SHI members and receive reimbursement from the SHI Fund. First-time providers (both public and private) must grant the MOH's licence and show the VSS their lists of health services and medicines, approved by competent authorities.
For PHC:	CHCs cannot directly sign contracts with social security agencies; DHCs do this on behalf of their subordinate CHCs. Private facilities that contract with social security agencies can also provide PHC services according to the SHI package. The SHI fund reimburses them at pre-defined rates, similar to those for public hospitals. Any additional expenses must be covered out-of-pocket.
Provider Payment	Though the SHI Law covers three payment methods (capitation, fee-for-service and Diagnostic-Related Groups), fee-for-service remains dominant. The MOH aims to implement a payment reform consisting of capitation and DRGs, but is facing governance and technical difficulties.
For PHC:	Capitation was the prevailing payment method for primary care in the past, but fee-for-service has become the primary payment method at present. A novel capitation method was implemented in April 2021 but abandoned in December the same year.
Performance Monitoring	The MOH regularly releases lists of monitoring & evaluation indicators (most recently in Circular 20/201/TT-BYT in 2019) and promulgates the widely-adopted Vietnam Hospital Quality Standard (Decision 6858/QD-BYT in 2016). However, these are not linked to VSS purchasing decisions.
For PHC:	Some indicators related to primary care are defined in the above list – e.g. percentage of CHCs implementing preventive and non-communicable disease management (%), percentage of children under 1 year old fully vaccinated, etc. CHCs regularly submit reports to higher-level management units, and the aggregated reports are sent to the DOHs and MOH.

Purchasing Functions in Vietnam's Healthcare Schemes

	STATE BUDGET
% of Total CHE	17.17% (2020)
Coverage	98,200,00 individuals (100% of the total population) **The government budget focuses on health promotion & prevention and therefore covers the entire resident population.*
Purchaser(s)	Ministry of Health
Governance	The Vietnam National Assembly passes laws on the state budget and decides budget estimates and central government budget allocations. Provincial People's Councils decide on and approve the local government budget. The Ministry of Finance (MOF) manages overall state budget funds.
For PHC:	The above governance aspects apply.
Financial Management	Budgets for healthcare are planned every year. They go through a review process before being channelled directly to service providers via the MOH (for central hospitals and centrally affiliated agencies) or provincial Departments of Health (DOH) or Departments of Finance (DOH) (for public providers in the provinces)
For PHC:	The MOH, provincial DOH and DOF are responsible for all financial management of state-funded healthcare, including primary care.
Benefits Specification	The Vietnam Communist Party (VCP) defines the theory of development and sets major directions for the health sector (formally written in its Resolution, with the latest being Resolution 20 in 2017). To operationalise the VCP Resolution, the government issues legal documents providing guidance on the allocation of the government budget. However, it is unclear how the government selects which health problems to prioritise. The MOH's Department of Planning and Finance is responsible for regular budget planning and allocation, but this appears to involve primarily passive purchasing. For example, the state budget allocated for preventive healthcare activities is based on population size and geographical conditions rather than health needs or provider performance.
For PHC:	The Ministry of Health promulgated the list of essential services for primary healthcare, health prevention and promotion to be funded by the state in Circular 39/2017/TT-BYT in 2017. Essential primary care services funded by the state budget include consultation, health promotion and education, vaccination, family planning and more.
Contracting Arrangements	Public facilities receive funding from the state budget channelled through MOH/DOH and therefore, no contracting process is required.
For PHC:	CHCs receive funding from the local state budget and therefore, no contracting process is required. A social contract model between CDCs and community health workers is being piloted to provide HIV/AID primary healthcare services such as testing.
Provider Payment	Public health facilities receive subsidies from the state budget using global budget or line-item budget methods.
For PHC:	The above provider payment aspects apply.
Performance Monitoring	The MOH regularly releases lists of monitoring & evaluation indicators (most recently in Circular 20/201/TT-BYT in 2019). However, these are not linked to purchasing or funding decisions. Prioritised public health programmes such as HIV/AIDS and tuberculosis control have some mechanisms to collect and analyse performance indicators for service providers, but these are not closely linked to purchasing or funding decisions.
For PHC:	Similar to SHI scheme, some specific indicators related to primary health care are also defined in the above list, such as percentage of CHCs implementing preventive and non-communicable disease management (%), percentage of children under 1 year old fully vaccinated, etc. CHCs and DHCs implementing prioritised public health programmes (e.g., HIV/AIDS, tuberculosis control) also report on requested indicators (e.g., number of cases referred for HIV testing and treatment) to higher-level management units. The MOH also promulgated the National Benchmark for Commune Healthcare to monitor the performance of the commune healthcare system.

Recent Progress in Strategic Purchasing

- The most recent health strategic plan was approved by the Prime Minister in 2013 and includes a vision toward 2030. The Plan established the SHI and state budget as the primary financial sources for healthcare. It also set priorities for reforming the health financing system toward UHC, including: (1) to increase the annual budget allocation for healthcare; (2) to increase the coverage of social health insurance and enhance the use of information technology in health insurance management; (3) to strengthen the financial autonomy of public hospitals; (4) to reform provider payment methods; (5) to integrate financial indicators into a national Monitoring & Evaluation system.
- The SHI benefit package has been developed by the MOH toward a more explicit approach. The MOH revises the list of SHI reimbursable medicines once every two to three years. The MOH also issued a set of criteria (including criteria on effectiveness, safety, cost-effectiveness and budget-impact) for adding a specific medicine from the list in 2018. Additionally, the MOH issued a list of non-reimbursable and conditionally-reimbursable services by the SHI to limit the reimbursement of high-technology and expensive services to higher-level providers. The list was first introduced in 2016, updated in 2017 and 2020.
- The MOH prepared for the reform of the provider payment system in 2020 with the pilot of a new capitation method for outpatient services and DRG for inpatient services. These efforts aimed to replace the sole provider payment method of FFS with other suitable methods, intending to minimize the current level of out-of-pocket expenses for patients and encourage providers to restrain the use of resources while increasing the quality of care.
- Under the state budget, some prioritised public health programmes (e.g., the national HIV/AIDS control programme) have been utilising Monitoring & Evaluation information to make strategic budgets for the long- and medium-term as well as to advocate for the approval of local government budgets. Some output-based criteria were also applied to finance HIV/AIDS services. The national HIV/AIDS control programme has successfully transitioned its financing sources from heavily depending on external funding to more stable and predictable internal funding, in the form of the SHI and state budget.

Challenges for Strategic Purchasing

- Although some functions of strategic purchasing can be observed, there is no particular unit dedicated to oversee strategic purchasing functions. The issues to be overcome include the quality of important policies, such as the health benefit packages specification, lack of well-defined processes, criteria and evidence generation. Significant gaps also exist relating to health information systems. These include the absence of recording and reporting mechanisms for public spending on health at the provincial level; a lack of timely updates on the status of the SHI fund; a lack of information on hospital performance; and the fact that health information has not been regularly utilised to support resource allocation.
- Although alternative provider payment methods have been previously used (i.e., capitation) and piloted (i.e., DRGs), health services are still primarily purchased through line-item budgeting and fee-for-service payments. The enforcement of hospital autonomy policy (that allow autonomous hospitals to gain more control over their financial management), paired with the predominant fee-for-service provider payment methods, have resulted in various revenue-maximising practices (e.g., the provision of "patient-requested" services, the provider-induced supply of unnecessary services, the excessive use of high-tech services, the inappropriate prescription of drugs). Thus, out-of-pocket expenditure remains a high percentage of total healthcare expenditure (over 40%).
- Several challenges in the health service delivery system must be overcome to achieve efficiency gains in the health sector. One of the biggest challenges is the overuse of hospital-based care, which may stem from lower levels of care being insufficiently equipped (in terms of financing, infrastructure, equipment and human resources) to tackle people's health needs among a transitioning burden of diseases.

KEY HIGHLIGHT: VIETNAM'S NATIONAL STRATEGY TOWARD UHC

The most recent health strategic plan, known as the 'National Strategy for the Protection, Care, and Improvement of People's Health during the period 2011-2020', includes a vision toward 2030 and sets priorities for reforming the health financing system. The overall objective is to more Vietnam toward Universal Health Coverage. The state budget and social health insurance are considered the two primary financial sources for healthcare, creating a favourable foundation to progress toward the goal of strategic purchasing in upcoming years. Recent progress in strategic purchasing has been made under both schemes, including the formulation of a social health insurance benefit package and state-funded essential primary health care services, as well as the pilot of Diagnostic-Related Group (DRG) as a new provider payment method for inpatient services.

Opportunities to Improve Strategic Purchasing

1. **The government could establish a mechanism to coordinate between healthcare financing organisations.**

   This may involve issuing legal documents to encourage the functions of strategic purchasing for both the SHI scheme and state budget. A coordination mechanism should emphasise funding for not only curative care, but especially for preventive and primary healthcare.

2. **Vietnam could work to establish a comprehensive electronic health information system.**

   This system would collect data on health outcomes, service quality, etc. at local and national levels. It would ideally function within clear processes to use evidence for purchasing.

3. **The government could seek to enhance capacity for strategic purchasing among relevant individuals and organisations involved through knowledge-sharing and participation.**

   First, the government should develop mechanisms to enable the effective participation of stakeholders in strategic purchasing (including the state budget and SHI). Capacity-building would then raise an appreciation for strategic purchasing among stakeholders, including its functions of priority setting, benefit package design and service pricing.

4. **The government could tailor benefit package design and provider payment methods toward strategic purchasing.**

   It should establish mechanisms for developing and regularly reviewing an explicit benefit package. It should also extend provider payment reforms toward greater efficiency.

Opportunities to Improve Strategic Purchasing for Primary Care

1. **Advocating to systematically reform lower-level health facilities in terms of financing, infrastructure, equipment and human resources could greatly benefit Vietnam.**

   This may help address the is the excessive reliance on hospital-based care, partly due to lower-level healthcare facilities being inadequately equipped to address people's health needs in the context of a changing disease burden.

2. **The government could further invest in primary health care, as per existing commitments.**

   Clearer criteria for state budget allocation for primary health care should be developed to guide the budgeting processes toward a more strategic approach.

3. **Vietnam could work to create more appropriate provider payment systems and incentives.** In the reform of the provider payment system, the government should identify and implement appropriate provider payment methods to create suitable incentive mechanisms for healthcare facilities providing primary healthcare services.

Recommendations

1

OBJECTIVE

Countries have integrated different parts of national health systems in ASEAN at the national level, with strong coordination between strategic purchasing agencies.

The lack of integration between different parts of national health systems in ASEAN countries contributes to poor coordination among different purchasing agencies. This fragmentation results in suboptimal resource allocation and limited coordination across public and private sectors, primary and secondary care, curative and preventive services, payers and donors.

In Thailand, the three main health financing schemes (Universal Coverage Scheme, Civil Servant Medical Benefits Scheme, Social Security Scheme) provide universal health coverage to the entire population, yet purchasing mechanisms among the three are not integrated. Other countries, like Malaysia and Singapore, have a significant private healthcare sector yet low public-private integration in terms of purchasing, financing and procurement.

RECOMMENDATION

Countries should consider establishing either a centralised agency for strategic purchasing, or a coordinating mechanism across existing agencies, based on the current degree of centralisation and division of duties among their healthcare services and purchasing agencies.

Countries with a more centralised healthcare system may consider establishing a dedicated agency responsible for strategic purchasing. This agency should have the authority to harmonise purchasing policies and practices across elements of the health system. It could promote collaboration among different purchasers, streamline purchasing processes and drive efficient resource allocation.

Countries with a more decentralised healthcare system — e.g. those comprising a variety of healthcare financing schemes — could instead establish a coordinating mechanism among relevant agencies. This mechanism should facilitate integration among the purchasers for different schemes, sectors and levels of care. Areas of focus may include data sharing for performance monitoring across schemes; benefit package standardisation; strategic purchasing capacity building initiatives for healthcare professionals and policymakers; and stakeholder engagement with providers and patients to design integrated purchasing policies.

2

OBJECTIVE

Countries have clear legal, fiscal and administrative frameworks that specify clear roles, rights and accountability for healthcare purchasing agencies.

Most ASEAN countries lack regulation empowering purchasers to carry out purchasing strategically and to operate independently through a purchaser-provider split. This hinders the implementation of strategic purchasing and may lead to the duplication of efforts among health financing agencies.

Indonesia's BPJS Kesehatan does not have full power as an autonomous purchaser, limiting its intended role as strategic purchaser. Similarly, while Malaysia's ProtectHealth Corporation was established in 2016 to provide strategic purchasing services, its roles continue to evolve depending on events and leadership changes.

RECOMMENDATION

Countries should consider passing relevant legislation to empower strategic purchasing agencies that govern their roles, rights, accountability and relationships with other agencies.

Appropriate legislation should clearly define the rights and responsibilities of purchasing agencies and lay out their relationships with other agencies in the healthcare financing ecosystem. These may include Health Technology Assessment agencies, health financing planning departments or other. Defining the mandate of healthcare purchasers through legislation could assist them in taking on an increasingly strategic, independent role and prevent duplicate efforts across agencies involved in healthcare financing and/or resource allocation.

3

OBJECTIVE

Countries have systematic structures for engagement between health purchasing agencies and clinicians, policymakers, payers and patients.

Formal engagement mechanisms among different health financing stakeholders are currently lacking in ASEAN. This may hinder effective decision-making and equity in health financing policy at the national or subnational level. Without regular engagement mechanisms, the level of transparency of health purchasing decisions will also be diminished.

RECOMMENDATION

Countries should build systematic structures for engagement between agencies and individuals relevant to health purchasing.

Countries could set up common platforms for dialogue among purchasers, providers, insurers, policymakers and donors to discuss resource allocation priorities and share best practices on strategic purchasing. This may involve regular discussion sessions or formal budgetary and administrative processes. Where appropriate, setting up these engagement mechanisms may require local laws, regulations or administrative processes to be gradually changed to accommodate the involvement of different stakeholders in decision-making.

4

OBJECTIVE

Countries have systematic data collection mechanisms for priority setting and performance monitoring in healthcare purchasing.

Whilst some ASEAN countries have better-developed health information systems than others, in most cases, these are not used to inform purchasing decisions or may not be adopted by all purchasers/health financing schemes in a country. Collecting provincial- and national-level data could assist purchasers in setting priorities for the future and monitoring the performance of providers to inform future financing decisions. Such data will facilitate priority setting (national and subnational), performance monitoring and other forms of data-driven decision-making.

Lao PDR is a country that has made significant progress in its health information technology, with the adoption of the DHIS-2 from 2014 onward; yet the data collected is not always relevant to strategic purchasing and hence not often used to inform purchasing decisions. Myanmar, Cambodia and Malaysia are among other countries lacking proper data infrastructure or systematic, national-level data collection practices.

RECOMMENDATION

Countries should consider investing in strong data collection systems to enable strategic purchasing and to monitor its performance.

Integrated Electronic Health Records (EHRs) and other systematic data collection systems would allow countries to maximise the benefits of strategic purchasing and to monitor its performance. This data would ideally be collected at the national and subnational level, according to health systems' levels of decentralisation. Relevant data to guide strategic purchasing decisions would include clinical, financial and quality aspects as well as efficiency outcomes.

5

OBJECTIVE

Countries have strong capacity for strategic purchasing at the national level, and relevant healthcare financing stakeholders have adequate understanding of strategic purchasing processes.

Whilst some ASEAN countries have better-developed health information systems than others, in most cases, these are not used to inform purchasing decisions or may not be adopted by all purchasers/health financing schemes in a country. Collecting provincial- and national-level data could assist purchasers in setting priorities for the future and monitoring the performance of providers to inform future financing decisions. Such data will facilitate priority setting (national and subnational), performance monitoring and other forms of data-driven decision-making.

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RECOMMENDATION

Countries should initiate or expand capacity-building efforts for strategic purchasing agencies or professionals.

Comprehensive training programmes should cover negotiation skills, contract management, quality control analysis, performance monitoring and legal and regulatory aspects of health purchasing. Capacity-building efforts may also include encouraging pilot initiatives in specific districts or disease areas; supporting local ‘champions’ to share their knowledge at dedicated forums; and establishing cross-country learning programmes with experts across ASEAN.

6

OBJECTIVE

Countries have well-developed, explicitly-defined and regularly-reviewed benefit packages for health.

The development and implementation of benefits packages is relevant to countries that have a social health insurance component in its payer mix. Therefore, benefits packages are still in their early stages in many ASEAN countries. This contributes to inconsistencies in healthcare coverage, limited access to essential services and inefficiencies in resource allocation. Moreover, countries with explicitly-defined benefit packages may still lack formal processes for their development and revision.

For example, Myanmar lacks an explicit benefit package, contributing to confusion among healthcare staff and patients at point-of-care. Malaysia also lacks a clearly-defined benefit package, though its national health plan states an intention to define one in the future. Vietnam, among other countries, instead has an explicit benefit package but lacks formal processes to revise it or well-defined criteria for service inclusion or exclusion under the package.

RECOMMENDATION

Countries should create explicit benefit packages, if lacking, or expand on and revise existing benefit packages as appropriate.

Countries should implement a clear strategy for defining and revising benefit packages; this may involve stakeholder engagement, health system performance analysis, cost-effectiveness assessments or other processes. Benefit packages should be explicitly-defined and communicated to patients and healthcare providers. Countries revising their existing benefit packages should consider increasing their depth of coverage to provide more services and/or breadth of coverage to reach more beneficiaries.

1

OBJECTIVE

Benefit packages are designed to incentivise cost-effective preventive interventions and primary care.

ASEAN countries lack a strong emphasis on primary care or gatekeeping mechanisms to ensure that patients do not bypass primary care. As the necessity of primary care to achieve Universal Health Coverage (UHC) is increasingly recognised, ASEAN countries are investing in strengthening their primary care services. Yet, benefit packages in many countries are not strong or effective enough to incentivise cost-effective preventive and promotive care. Benefit packages may also be designed in favour of secondary- and tertiary-level interventions rather than promoting primary care as the gatekeeper of health systems.

RECOMMENDATION

Countries should consider building an Action Plan for benefit specification at the primary care level.

National Action Plans for benefit specification should consider decision-making processes, key decision-makers, governance processes and benefit specification or revision timelines. Such Plans should be designed to incentivize cost-effective, preventive interventions and primary care.

2

OBJECTIVE

Appropriate provider payment methods incentivise and empower primary care systems in ASEAN.

Many ASEAN countries have health systems that historically prioritise secondary- and tertiary-level care. Although primary care has been found to be cost-effective in managing common illnesses and chronic diseases, primary care systems continue to suffer from historical underinvestment in various ASEAN countries. The role of primary care should be foregrounded through a selection of appropriate provider payment methods to incentivise preventive, promotive and primary-level interventions.

RECOMMENDATION

Countries should identify the most appropriate provider payment methods for primary care to incentivise health prevention and promotion.

Countries should begin by studying their current provider payment methods at the primary and tertiary level. They should then identify the most appropriate provider payment methods to be used in primary care to incentivize health prevention, health promotion and primary care. Options may include capitation, fee-for-service or Diagnostic-Related Groups/case-mix payments, with appropriate methods to be selected based on the individual country's health system and the experiences and best practices of regional neighbours.

3

OBJECTIVE

Countries have strong data systems for benefits specification and performance monitoring for all levels of healthcare service delivery (from primary to tertiary care).

While ASEAN countries are working to improve their health data systems, primary care settings risk lagging behind larger hospitals or speciality centres due to their limited funding, lesser-trained staff and/or rural geographic locations. While hospitals may have digitised Electronic Health Records (EHRs) and other data systems to enable strategic resource allocations, primary care clinics in several countries still rely on paper-based systems. This makes it challenging to integrate primary care-level data into national purchasing decisions or regional health budget allocation processes.

RECOMMENDATION

Countries should specifically invest in infrastructure and capacity-building for information systems in primary care.

Countries should ensure that information system improvements are carried out at the primary care level, particularly focusing on IT infrastructure and data systems of rural clinics. Healthcare professionals at the primary care level and in rural settings should be trained in data collection and reporting mechanisms, and data generated from primary care providers should be used to inform national resource allocation and strategic purchasing decisions.

1

OBJECTIVE

ASEAN member states have implemented a regional coordination mechanism for strategic purchasing at the Ministerial and technical level.

There is currently a lack of regional coordination for strategic purchasing in ASEAN, both at the Ministerial and technical levels. Despite shared ASEAN commitments to Universal Health Coverage (UHC) and goals of improving healthcare access and quality, member states demonstrate limited collaboration and alignment on strategic purchasing practices. This impedes the exchange of best practices, joint learning and resource optimisation across countries. Countries with recent successes in strategic purchasing, such as Thailand, therefore lack avenues to support other ASEAN states and share their knowledge.

RECOMMENDATION

ASEAN countries and the ASEAN Secretariat should consider organising a strategic purchasing side-meeting on the occasion of the next ASEAN Health Ministers' meeting.

ASEAN would be the ideal convening body for cross-country, regional meetings on strategic purchasing. The next ASEAN Health Ministers' meeting may provide an avenue for countries to begin aligning on strategic purchasing goals and best practices, and to raise the profile of strategic purchasing as a high-potential health financing tool in the region.

Broadly, ASEAN countries should establish mechanisms for regular engagement and information sharing among health policymakers and relevant technical working groups. This will help countries capitalise on collective expertise and potentially pool resources for purchasing as needed.

2

OBJECTIVE

ASEAN has implemented systematic, regional capacity-building initiatives for strategic purchasing.

While some countries are independently implementing capacity-building initiatives for strategic purchasing, there is a lack of such initiatives at the regional level. ASEAN countries should aim to raise their collective skills and capabilities for strategic purchasing functions.

RECOMMENDATION

Countries should conduct regional capacity-building via existing networks in Southeast Asia, primarily the ASEAN University Network and its partners.

The ASEAN University Network and its partners, or similar already-existing networks, could provide a politically-neutral platform for capacity-building on strategic purchasing. This capacity-building should be targeted at policymakers, healthcare providers, insurers, diplomats or other relevant stakeholders. It may include support from international strategic purchasing networks or research centres, international procurement agencies or industry-specific procurement centres of excellence (health or non-health).

Summary & Conclusion

Strategic purchasing and healthcare financing are vital pillars of health systems.

They are essential for achieving UHC and ensuring access to high-quality healthcare for all without financial hardship. Strategic purchasing plays a crucial role by efficiently allocating resources, promoting cost-effectiveness and improving service delivery and quality.

This policy report has highlighted the importance of strategic purchasing and its potential to improve health systems in Southeast Asia. It assesses ASEAN countries' current health purchasing practices in across several strategic purchasing key functions: *governance, financial management, benefits specification, contracting arrangements, provider payment* and *performance monitoring.*

As countries may be more effective in some aspects of strategic purchasing than others, focusing on specific sub-functions will enable them to track their progress systematically.

ASEAN's regional commitment to improving UHC — as demonstrated by various healthcare reforms in member states — is a promising step toward enabling strategic purchasing.

The COVID-19 pandemic has challenged health systems in the region, but also provided an opportunity to re-orient toward greater efficiency. The need for resilient health systems and sustainable financing policies may encourage governments to make the most of their resources. Transparent, evidence-driven and equitable health purchasing practices will be key to achieving this.

However, while the concept of strategic purchasing gains increasing attention globally, it remains nascent in Southeast Asia. The region faces challenges due to fragmented health systems, limited data infrastructure and varying levels of political commitment. ASEAN health systems also operate independently of one another due to their diversity and values of non-interference.

COVID-19 has highlighted the importance of cooperation in global health. ASEAN could leverage this opportunity to take a greater role in health policymaking and to support member countries in their health system transitions.

Importantly, strengthening ASEAN health systems as a whole will be a crucial enabler of — and prerequisite for — stronger strategic purchasing.

This may include reforming health financing schemes to cover a larger share of the population; increasing transparency and multi-stakeholder engagement in decision-making; building up healthcare infrastructure and human resources; and establishing strong IT systems to support relevant data collection across all health facilities. These essential governance and infrastructural building blocks will facilitate countries' journeys from passive to strategic purchasing.

SUMMARY OF RECOMMENDATIONS

This report has provided specific recommendations that ASEAN countries could adopt to make their purchasing more strategic. These cover 1) individual, national-level recommendations given within each country chapter; 2) shared national-level recommendations highlighting common challenges across all or most ASEAN countries; 3) shared national-level recommendations with a specific focus on strengthening primary care and strategic purchasing; 4) regional-level recommendations where the ASEAN bloc, or other governing bodies and institutions, could play a role in strengthening strategic purchasing capacity.

Shared national-level recommendations

1. Countries should consider establishing either a centralised agency for strategic purchasing, or a coordinating mechanism across existing agencies, based on the current degree of centralisation and division of duties among their healthcare services and purchasing agencies.
2. Countries should consider passing relevant legislation to empower strategic purchasing agencies that govern their roles, rights, accountability and relationships with other agencies.
3. Countries should build systematic structures for engagement between agencies and individuals relevant to health purchasing.
4. Countries should consider investing in strong data collection systems to enable strategic purchasing and to monitor its performance.
5. Countries should initiate or expand capacity-building efforts for strategic purchasing agencies or professionals.
6. Countries should create explicit benefit packages, if lacking, or expand on and revise existing benefit packages as appropriate.

Primary care recommendations

1. Countries should consider building an Action Plan for benefit specification at the primary care level.
2. Countries should identify the most appropriate provider payment methods for primary care to incentivise health prevention and promotion.
3. Countries should specifically invest in infrastructure and capacity-building for information systems in primary care.

Regional recommendations

1. ASEAN countries and the ASEAN Secretariat should consider organising a strategic purchasing side-meeting on the occasion of the next ASEAN Health Ministers' meeting.
2. Countries should conduct regional capacity-building via existing networks in Southeast Asia, primarily the ASEAN University Network and its partners.

Our national and regional recommendations emphasise the need for coordination and collaboration in purchasing for health.

Individually, countries should consider establishing a centralised agency or coordinating mechanism for healthcare financing and strategic purchasing. Clear legal frameworks should specify the roles and responsibilities of purchasers and define their relationships with other health financing bodies. Regular engagement mechanisms should take place among relevant stakeholders, helping to align best practices and enhance transparency in policymaking.

Regionally, coordination and capacity-building initiatives will be essential to develop strategic purchasing. ASEAN, the ASEAN University Network and similar bodies can provide platforms for cross-country collaboration and knowledge-sharing at the technical and policy level. Governments will be able to share best practices with their neighbours, learn lessons from similar health systems and build expertise in strategic purchasing practices among decision-makers.

By working collectively to overcome challenges and align on best practices, ASEAN countries can make significant progress in strengthening their strategic purchasing capabilities and ensuring equitable access to quality healthcare for their populations.

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