Ensuring Access to Affordable Healthcare for All:

The Role of Health Finance in G20 Countries

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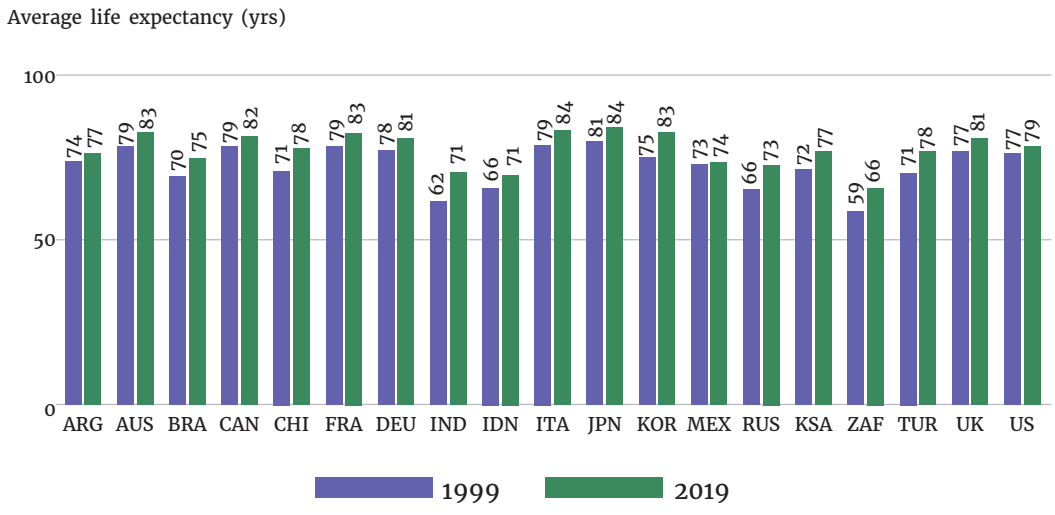
The G20 countries, individually and collectively, have made strides in improving human health since the group's inception in 1999. Average life expectancy across the member states has shown remarkable progress, increasing from 73 years to 78 years over the past two decades, well above the global average of 67 years.[1]

Figure 1: Average Life Expectancy in G20 Countries

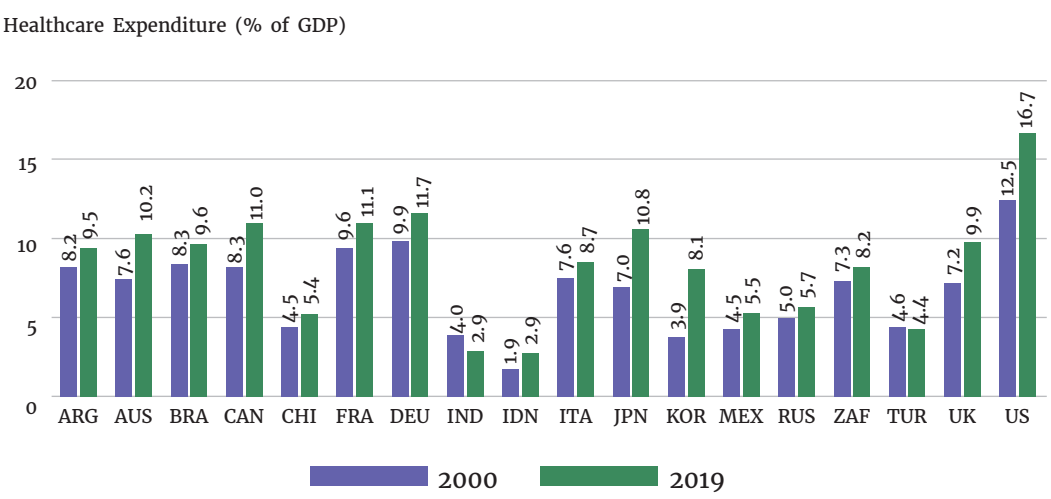


Source: WHO data

This achievement demonstrates the potential of the G20's collective commitment towards enhancing public health outcomes and underscores the importance of continued efforts to prioritise health equity between countries. There is still much to be done: within the group, there is an 18.2-year difference in life expectancy between the highest and lowest achieving members. Imagine the life and health gains if all G20 countries levelled up.

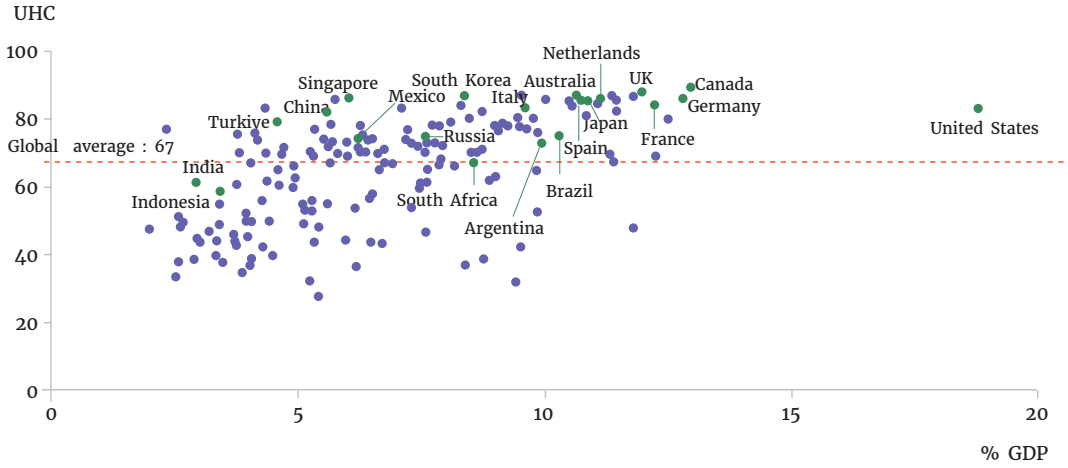
The improvements in human health have been accompanied by an increase in healthcare spending in absolute terms. With the exception of India and Turkey, G20 nations saw a rise in the average healthcare expenditure as percent of GDP, from 6.8 percent to 8.5 percent between 2000 and 2019, or just above US$3,000 per capita.

Figure 2: Healthcare Expenditure as % of GDP for G20 countries



Source: WHO data[2]

Figure 3: Higher % GDP Spending in Healthcare and Increase in UHC Coverage



Source: WHO Data[3]

There is recognition that investments in healthcare, overall, runs parallel to expansion in coverage of Universal Health Care (see Fig. 3). However, this coupling between healthcare spending and health outcomes is a topic of intense interest when discussing health finance in G20 countries. While increased healthcare expenditure often leads to improved health outcomes, this is not always the case and it is crucial to ensure that investments are directed effectively and efficiently. By adopting innovative financing mechanisms, G20 countries can optimise the impact of healthcare spending and achieve desired health outcomes for their populations.

Persisting Out-of-Pocket Expenses

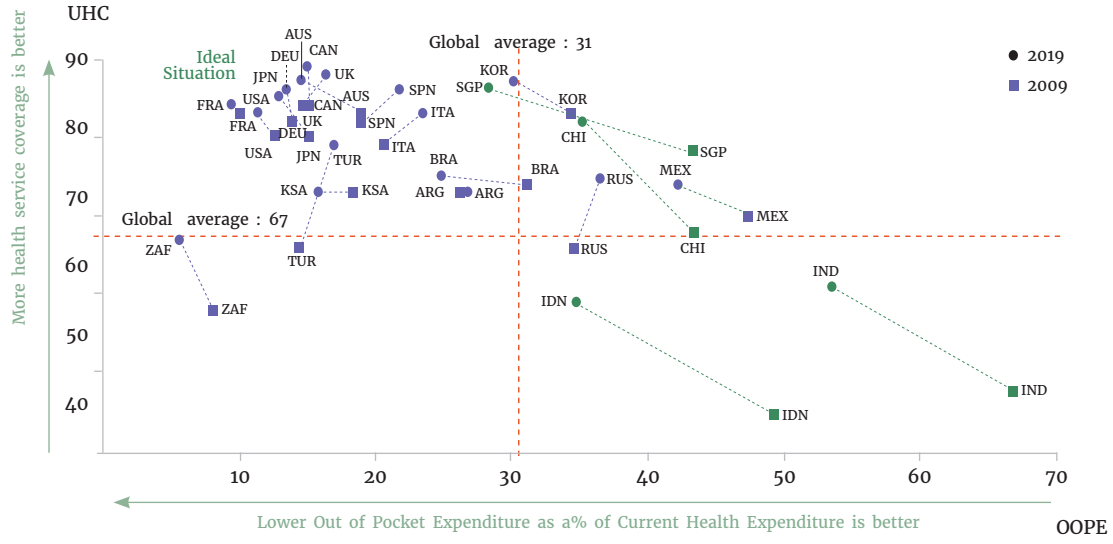
Despite progress, the issue of high out-of-pocket (OOP) expenses remains a significant concern in many G20 countries. OOP expenses often place a disproportionate burden on vulnerable populations, leading to financial hardships and limited access to healthcare.[4] Embedded in the advocacy for health equity is the recognition that health disparities exist among different populations due to various factors such as socioeconomic status, race, ethnicity, gender, geographic location and access to healthcare services.[5] Thus, achieving health equity requires interventions and policies targeted towards those who are most disadvantaged and have the greatest needs. This may involve redistributing resources, implementing targeted healthcare programs, improving access to quality healthcare services, addressing social and economic inequalities, and promoting health education and prevention

initiatives. As the COVID-19 pandemic has illustrated, no one is safe until everyone is, and even if primarily motivated by self-interest, there is an economic case (if not for reasons of equity) for uplifting the most vulnerable populations.

The efficiency of healthcare systems also varies greatly among G20 countries. While some economies have successfully implemented efficient and effective healthcare models, others continue to face challenges in delivering equitable care. The authors of this article examine the relationship between universal healthcare service coverage (UHC) and Out-Of-Pocket Expenses (OOPE) as a proportion of Current Health Expenditure for G20 countries (Fig. 4), reflecting targets 3.8.1 and 3.8.2 of the UN Sustainable Development Goals for Universal Health Care.

UHC measures coverage of essential health services that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access among the general and the most disadvantaged populations. Meanwhile, 3.8.2 highlights catastrophic OOP healthcare spending, usually defined as populations with household expenditure on health >10 percent or 25 percent of total household expenditure. The authors used data from previous decade to sift out which countries of the G20 had shown the most recent improvements, and also included Spain and Singapore to the analysis as both these countries are permanent or recurring guest nations to the G20 dialogues and could offer lessons to emulate.

Figure 4: Changes in UHC Service Coverage with OOPE in the Past Decade for G20 Countries



Source: WHO data[6]

From the chart, directional movement to the upper left quadrant or North-West direction would be ideal as it highlights increased UHC with lower OOPE, i.e. better coverage at greater affordability. The most significant improvements are highlighted in green (China, India, Indonesia, Singapore). This article discusses efforts in Indonesia and Singapore that have contributed to these remarkable achievements. By examining diverse strategies, readers can gain insights into potential pathways towards achieving health equity within different national contexts, be they in developing or developed nations.

Best Practices

Indonesia

Indonesia's journey to UHC is a textbook case of adherence to expanding health insurance coverage and implementing social protection mechanisms. The landmark JKN National Health Insurance was implemented in 2014 to provide access to healthcare for its population and today covers approximately 250M people.[7] The JKN program covers all Indonesian citizens, including formal and informal sector workers, and those categorised as poor and near-poor, ensuring that everyone has access to essential healthcare services. It consolidates more than 300 risk pools and operates under a single-payer system, managed by the Social Security Agency for Health (*Badan Penyelenggara Jaminan Sosial Kesehatan* or BPJS). BPJS collects contributions, manages the insurance fund, and coordinates with healthcare providers. Participation for all eligible individuals is mandatory, and contributions are based on income and employment status, with the government subsidising the premium for the poor and near-poor. The insurance scheme entitles every Indonesian to the same medical benefit package, decreasing OOPE from 47 percent to 34 percent in just four years.[8]

Within this OOP spending, in LMICs (low- and medium-income countries) such as Indonesia, medicines typically account for 20-60 percent of total healthcare expenditure with nearly 90 percent of the population purchasing medicines through OOP payments.[9] Managing drug pricing and procurement is thus a key lever for further managing costs and affordability. Indonesia

has implemented a generic medicine pricing policy where the retail price of generics cannot exceed the maximum retail price set by the MOH.

A 2010 study across nine public hospitals, 64 private pharmacies, and nine NGO hospitals in four provinces in Indonesia, showed that the prices of Lowest Price Generic (LPG) and Innovator Brand (IB) medicines was lower in 2010 than in 2004, with declines ranging from 40 percent to 2200 percent.[10] This showed that generic medicine pricing policies have succeeded in lowering the price of medicines. Despite this success, however, there is wide variation in implementation as exemplified by the excess paid by patients compared to MOH set prices varying widely from 2 percent to 600 percent. Even within countries, there is substantial opportunity to narrow the differences. More recently, the government has also embarked on working through state-owned enterprises (SOEs) to centralise drug procurement and leverage purchasing power, negotiating lower prices to further ensure availability of medications across facilities.

On the demand side, Indonesia has promoted the use of generics with public awareness campaigns to educate the public about their benefits. These campaigns aim to dispel misconceptions and increase confidence in the quality and efficacy of generic medications. Additionally, the government has provided incentives for healthcare professionals to prescribe and dispense generic medications. These incentives may include financial incentives or recognition for healthcare providers who prioritise generic prescribing. Again, implementation has been varied. In an observational study at Kalisat District Hospital, doctor's compliance in prescribing generic drugs reached 68 percent while the national standard in April 2013 reached 90 percent.[11]

Overall, in Indonesia, BPJS and various national policies have forged significant steps in achieving UHC. However, as highlighted above, uniform and consistent implementation remains a challenge. Beyond these, there are also additional efforts that Indonesia can undertake to improve UHC further. Whilst JKN has an extensive network of healthcare providers, including public and private hospitals, clinics and facilities, challenges exist due to disparities in healthcare infrastructure across the vast island archipelago, and despite co-payments by beneficiaries, the JKN also faces a

significant deficit. To raise funds, Indonesia has room to raise Public Health Expenditure and contribution compliance. At the same time, Indonesia can also improve primary care and manage spending and governance.[12]

Singapore

Whilst Indonesia is rightly lauded as having the fastest growing insurance program in the world (with BPJS covering close to 91 percent of its population in less than 10 years),[13] Singapore has had its 3M approach (Medisave - a compulsory health savings account, Medishield – catastrophic illness insurance and MediFund – a social security net for the indigent) initiated 30 years prior, in 1984. What has Singapore done in the past decade to continue to move the needle in improving UHC and affordability?

Expanding capacity has been a priority. In 2009, there were approximately 8,000 acute hospital and 9,000 nursing home beds in Singapore. Today, those numbers have grown to 12,000 and 17,000 beds, respectively, or a combined 70-percent increase in institutional places. With healthy economic and GDP growth, the Singapore government has been assiduously increasing healthcare infrastructure, particularly in the eldercare sector as it prepares to become the 2nd fastest aging economy in Asia outside of Japan. By 2030, one in every four Singaporeans will be above 65, and along with changing societal and family patterns, will require massive capacity to cater to the elderly who mostly live independently and require support with their daily activities. Singapore has tried to keep costs manageable for the eldercare sector by footing high land and building costs of residential nursing homes and then offering concessions through competitive bids for operators. Eligible seniors are means tested and substantial subsidies of up to 80 percent of monthly fees are extended.

Widening coverage to become truly universal has been a highlight of the last decade. In 2015, MediShield was replaced by MediShield Life, a more comprehensive and universal health insurance scheme that extended coverage to all Singaporeans, including those with pre-existing conditions and older individuals who were previously excluded or had difficulty obtaining coverage. All citizens and permanent residents were automatically enrolled in the scheme with lifetime coverage. Whilst MediShield Life helps

to pay for large hospital bills and selected costly outpatient treatments such as dialysis and chemotherapy, Singaporeans also have access to CareShield Life, which is a long-term insurance targeted at severe disability, providing cash payouts for long-term care costs for life (and applicable towards nursing home fees). Both MediShield and CareShield premiums can be paid using Medisave, with needier beneficiaries able to benefit from top-ups by family members or occasionally, one-off government disbursements.

Prudent and rational use of limited funds is a priority in Singapore, especially with increased investment. The visible, frontline expansion of services aside, the Ministry of Health has also been actively shoring up decision-making and support services for better health economics. The Agency for Care Effectiveness (ACE) was set up in 2015—subsuming the prior Pharmacoeconomic and Drug Utilization Unit (PEDU)—as an expanded health technology assessment (HTA) unit to support the MOH's Drug Advisory Committee in making evidence-based recommendations for the public funding of drugs. Standardised HTA methods and processes have been developed in line with international best practices and since ACE's establishment, subsidised medications are provided earlier within a drug's life cycle and value-based pricing has led to more cost-effective prices being negotiated with pharma.[14] However, bandwidth limitations and lack of skilled HTA practitioners impact ACE's capacity to achieve greater impact.

The cost positioning for Singapore was further improved when the public healthcare clusters banded together in 2018 to centralise procurement through the setting up of ALPS Healthcare. Touted as a supply chain partner, ALPS consolidates, negotiates and manages logistics for supplies for all public healthcare players—from primary to quarternary care and including the eldercare sector. ALPS's coverage goes beyond pharmaceuticals to include consumables and even support services such as housekeeping and laundry. This is especially important given the small size of the domestic Singapore market and consolidation improves efficiency and more cost-effective procurement.

Despite these cost-saving measures, Singapore has not escaped the worldwide dilemma of rising healthcare costs. 'Healthier SG', set to go live in July 2023, advocates the signing up of every citizen with

a dedicated GP/family physician. The GP then serves as continuing and continuous partner in managing each individual's healthcare needs more holistically—from simple needs to acute referrals to chronic diseases. The focus will progressively shift from a hospital-centric healthcare system to a preventive model and right-siting care to the most appropriate (and cost-effective) modalities, which translates to more care within community settings and providing care that is most appropriate for the individual and not necessarily just what is most advanced medically.

As this article highlights the examples of Indonesia and Singapore, broad themes emerge in the approaches used in achieving universal health care. Expanding financial coverage is critical and with this, widening service accessibility, especially in primary care and judicious purchasing and effective procurement. Implementation is paramount and there is opportunity here for countries to learn and work better together.

Particularly in Southeast Asia, where government procurement is significant and yet not entirely efficient, the region lacks cross-country learning opportunities. In the vein of RESYST (Resilient and Responsive Health Systems) and SPARC (Strategic Purchasing for Africa Resource Centre), international consortia focused on strategic purchasing, the South East Asia Regional Collaborative for Health (SEARCH)[15] hosted by the National University of Singapore aims to review existing health purchasing mechanisms of all ASEAN countries and provide national and regional-level policy recommendations. This will be a meaningful step to educate policymakers and help countries overcome roadblocks to strategic purchasing.

Beyond risk pooling, pricing and procurement, more efforts can be poured into strengthening primary care provision; there are additional opportunities from technology and digital modalities. Telehealth and insurtech, if devised and regulated appropriately, could allow the next step-change in improving access to healthcare, both within a dense urban city state like Singapore or a dispersed island nation such as Indonesia. The COVID-19 pandemic has shown the need and case for such services, and particularly for a developing nation like Indonesia, the vast proliferation of mobile services could pave the way for micro-insurance and insurtech to further improve affordability of healthcare services.

The journey to UHC and improving health equity is an ongoing endeavour. While G20 countries have made remarkable progress in improving human health and increasing healthcare spending, more can be done to ensure access to affordable healthcare for all. By prioritising health equity and implementing innovative approaches to health finance, G20 countries can accelerate progress in transforming public health systems. It is hoped that some of the learnings shared in this chapter may inform and support continued commitment to addressing the complex and interconnected public health challenges faced by societies worldwide.

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