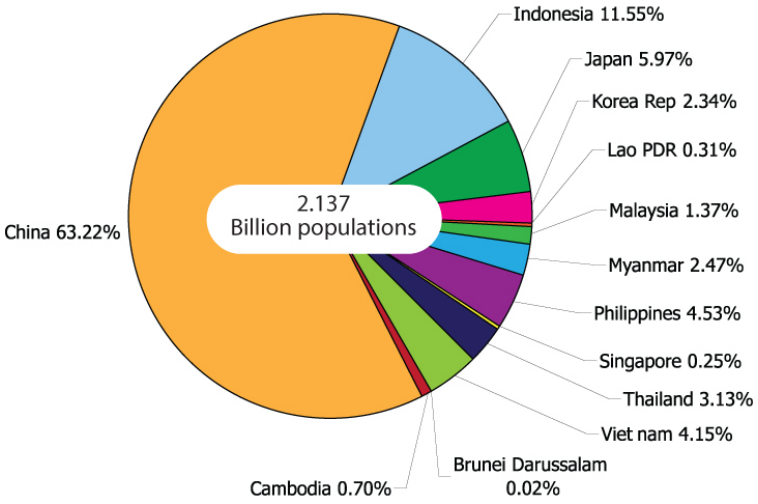
"Universal Health Coverage for 2.1 Billion Populations: Lessons Learned from ASEAN Plus Three Countries"

Key messages:

- Seven countries in ASEAN Plus Three have already achieved UHC, greater than 95% population coverage, while the rest of six are moving towards UHC.
- ASEAN Plus Three countries had proved UHC a feasible one given political and financial commitments by Countries; UHC can be possible anywhere in the World.

1. Population

The total population of ASEAN Plus Three is nearly one third of the world population. If all ASEAN Plus Three countries, the one third of the world, commit and achieve Universal Health Coverage, the whole world would be able to do the same.



Source: World Bank data, http://data.worldbank.org/country accessed on 7 May 2014

Figure 1 Population of 2.137 covered by ASEAN Plus Three Countries

2. Economic status

There are huge differences of economic status among ASEAN Plus Three countries which vary from very rich at 47,870 US$ to only 880 US$ per capita in 2012.

Table 1 ASEAN Plus Three Countries with different economic and UHC status

Country	GNI per capita, US$ 2012*	UHC Situation (UHC in terms of population coverage)
Japan	47,870	UHC Since 1961
Singapore	47,210	UHC since 1965 through universally available subsidies. National Programmes of Medisave, MediShield and Medifund were implemented in the 80s and 90s.
Brunei Darussalam	31,590	National welfare
Republic of Korea	22,670	UHC Since 1999
Malaysia	9,820	UHC using public providers and general government revenue achieved in 1980s
China	5,720	UHC 95% pop coverage
Thailand	5,210	UHC Since 2002
Indonesia	3,420	Stared in January 2014 and will achieve by 2019
Philippines	2,500	By 2016
Viet Nam	1,550	By Law, 100% population coverage in 2014 Practical target at 80% pop coverage by 2020
Lao PDR	1,270	By 2020
Cambodia	880	Strong commitment to move towards UHC
Myanmar	NA	Strong commitment to strengthen health system to support UHC

Source: World Bank data, http://data.worldbank.org/country accessed on 7 May 2014

3. UHC status

It can be observed that seven countries, including Brunei Darussalam, China, Japan, Republic of Korea, Malaysia, Singapore, and Thailand have already achieved UHC, greater than 95% population coverage. Interestingly, these countries did not start UHC when they obtained as rich countries. For example, Japan achieved UHC since 1961 when Japan was not as rich as today; Thailand started and achieved UHC when we had only 400 and 2,000 USD per capita per year respectively. We don't have to wait until we are rich to start and achieve UHC.

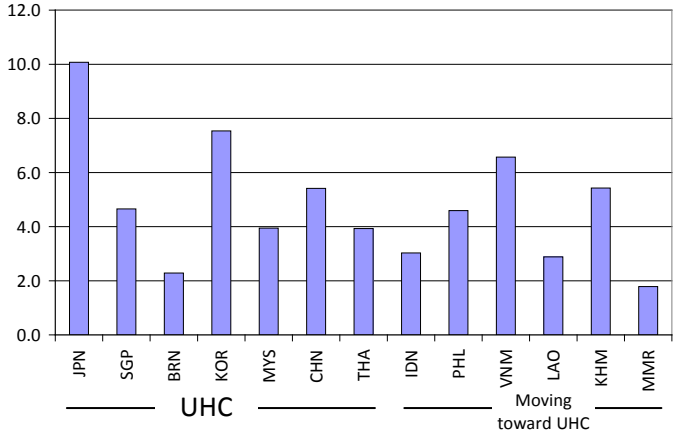
4. Health financing

4.1 Total Health Expenditure

Average total health expenditure (THE) among the ASEAN Plus Three Countries was at 4.8% of GDP (min 1.8 – max 10.1 % of GDP). There was huge variation on health spending per capita in 2012, see figure 3. Some countries spent quite large amount per capita on health while some spent too little.

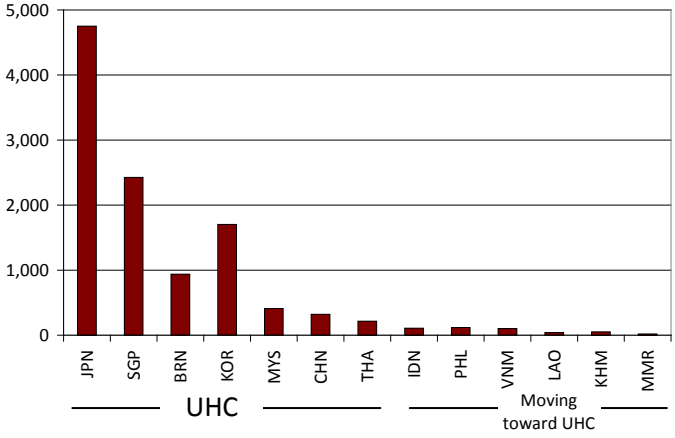
- High income groups like Japan, Singapore, Brunei Darussalam and Republic of Korea, spent nearly 1,000 to 4,752 US$ per capita on health.
- Interestingly, Malaysia, China and Thailand spent only around 215-410 US$ per capita for their population within the UHC situation.
- The rest spent less than 120 US$ per capita.

Therefore, both health financing issues of "money for health" and "more health for money" are essential for ASEAN Plus Three Countries.



Source: World Bank data, data of 2012

Figure 2 Total Health Expenditure as % of GDP



Source: World Bank data, data of 2012

Figure 3 Total Health Expenditure per capita (US$)

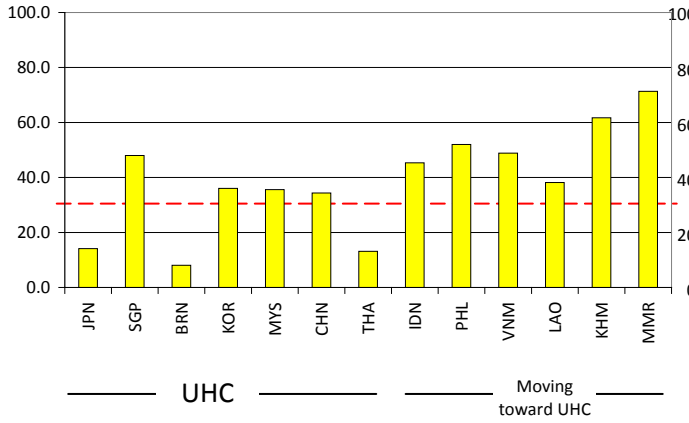
4.2 Out-of-pocket payment versus public spending on health

Out-of-pocket payment in ten countries was higher than 30% of total health expenditure. Even though some countries already achieved UHC, they still had high level of out-of-pocket payment. This depends very much what health services are provided under the UHC (figure 4).

Information from a study of 89 countries around the World shows "The higher out-of-pocket expenditure, the higher percentage of household catastrophe and impoverishment". Importantly, it clearly indicates that when out-of-pocket payment on health is less than 20% of total health expenditure, the incidence of financial catastrophe falls significantly to only negligible levels.

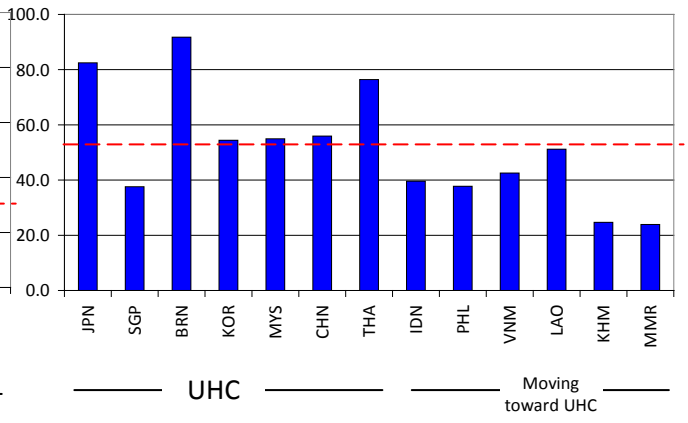
Japan, Brunei Darussalam and Thailand were able to achieve this level, out-of-pocket payment at 14.1, 8.1 and 13.1% of total health expenditure, respectively. Republic of Korea, Malaysia and China had the level of out-of-pocket at around 35%. Note that Singapore out-of-pocket of 48% includes third party payers such as private medical insurance, employers' benefits for employees, civil service medical benefits and charitable donations. It is not the same of "out-of-pocket actual cash outlay from individuals". Additionally, the Singapore government provides regular top-ups to Medisave accounts (especially for the low and elderly) to help defray their healthcare cost.

ASEAN Plus Three Countries collectively aims to further reduce out-of-pocket spending on health to protect households from health financial burden.



Source: World Bank data, data of 2012;
Except Singapore National data

Figure 4 Out-of-pocket payment as % THE



Source: World Bank data, data of 2012

Figure 5 Public spending on health as % THE

Interestingly, countries who already achieved UHC (Japan, Brunei Darussalam, Republic of Korea, Malaysia, China and Thailand) except Singapore used public spending on health at the minimum of 54% or above, up to 91% of total health expenditure. In contrast, among Countries moving toward UHC, public spending on health was equal to or less than 50% of total health expenditure. Governments should continuously assess their share of spending on health, preferably not less than 50% of total health expenditure, for moving towards UHC.

4.3 Innovative on health financing

Examples of Malaysia and Viet Nam using Goods and Services Tax and Philippines and Thailand applying Sin-Tax.

Malaysia:

Malaysia has achieved impressive health gains for its population funded through general revenue that provides universal health and comprehensive services. Nevertheless, the current system may not be sustainable and thus we are in a stage of planning to reform the healthcare system. Malaysia is looking into several options and studying on various models of health financing. At the same time, the country is also moving towards implementation other sources of revenue such as Goods and Services Tax (or Value Added Tax, VAT) in April 2015 which is believed to strengthen the income status of the nation which in return will bring about better services to the population, including healthcare. In addition to this, Malaysia is looking into better financing mechanism to ensure that resources are better targeted. Malaysia does not use sin-tax as a mechanism to fund the healthcare.

Philippines:

Approximately 85% of the Incremental Revenues from Sin Tax are earmarked for health - wherein 80% will be allocated for universal health care under the National Health Insurance Program, the attainment of MDGs and health awareness programs while 20% will be for medical assistance and health enhancement facilities program.

Singapore:

Singapore has applied Medical Savings Accounts, Catastrophic Illness Insurance and Endowment Fund for the needy. To ensure the fiscal sustainability of the government-financed UHC system and empower people to choose appropriate medical services, Singapore introduced the 3Ms – Medisave, MediShield and Medifund. Complementing the tax-financed UHC provided by government subsidies, the objective of introducing 3Ms was to strengthen the protection afforded by tax-financed UHC as well as its long-run sustainability. Medisave – a health savings account that is mandatory for all workers was set up to ensure that Singaporeans have sufficient resources for their healthcare expenditures. Savings in these accounts can be used not just for individual expenditures but also for family members. MediShield – a catastrophic illness insurance designed to work with Medisave ensures that individuals are protected from very high expenditures by risk pooling these expenditures in a national government-run insurance scheme. Medifund – was set up as a government-financed endowment fund to support copayments for financially needy families. As the capital sum of Medifund is preserved and only interest income can be used, Medifund provides a stronger guarantee of support then annual general tax-based expenditures. Together, the 3Ms and government subsidies reflect and support the shared responsibility of families, communities, healthcare providers, insurers and government to keep healthcare affordable and sustainable.

Thailand:

ThaiHealth Promotion Fund was established in 2001, just a year before an introduction of UHC in Thailand. A 2% additional tax on tobacco and alcohol was pooled at ThaiHealth Promotion Fund for the purpose of empowering civil society and promote the well-being of Thai citizens. This sin tax is used to support programs and activities related to health and social determinant of health. The main portfolios were broad based community and civil society campaigns against health risk factors like alcohol, tobacco, obesity, physical inactivity and actions to promote healthy life style, active living, sexuality and HIV/AIDS prevention. It plays a supplementary role to health promotion and disease prevention activities by healthcare providers under the UC scheme in Thailand.

5. Outputs related to UHC-examples of Malaysia, Thailand and Viet Nam

5.1 Malaysia

Malaysia has achieved UHC in the public system which has extensively geographical coverage as shown in figures below. Primary Health Care has been further strengthened. Secondary and tertiary care levels are extensive in Malaysia.

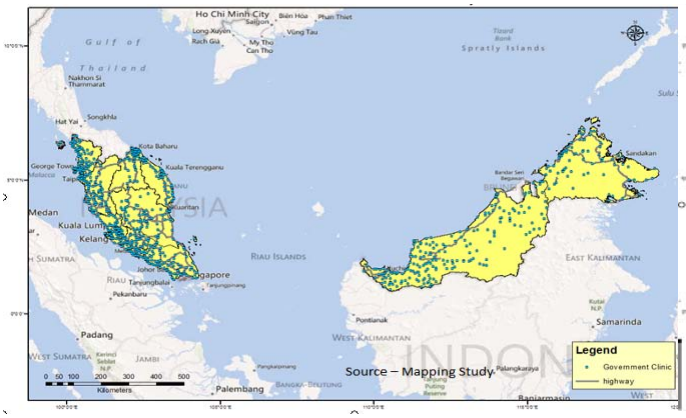


Figure 6 Distribution of government clinic

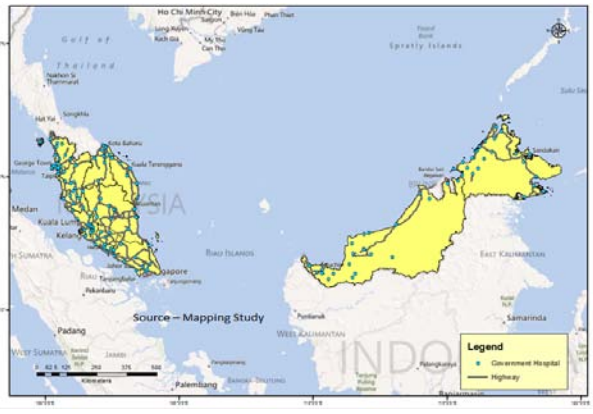


Figure 7 Distribution of government hospital

Data from National Health Morbidity Survey (1986, 1996, 2006 and 2011) in Malaysia show increasing trends of healthcare utilization of both out-patient and in-patient services in the past 20 years in Malaysia.

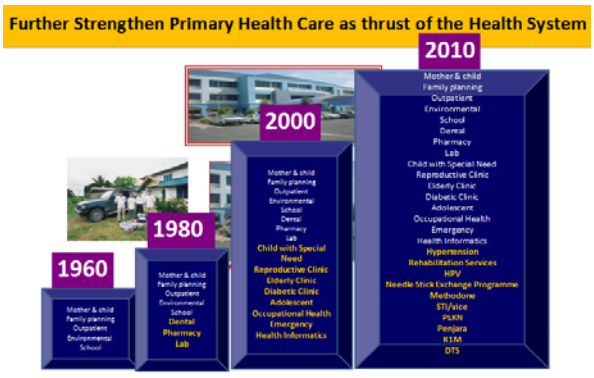


Figure 8 Primary Health Care Strengthening

Figure 9 Secondary and tertiary care services

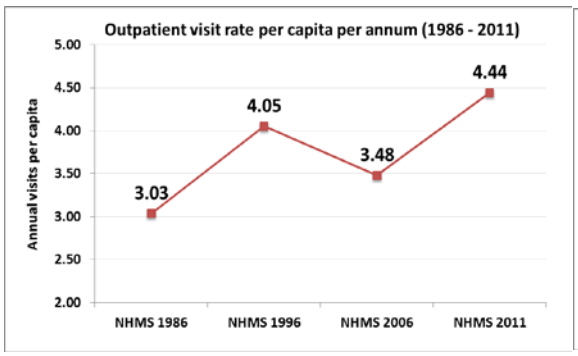


Figure 10 Use rate of outpatient visit in Malaysia

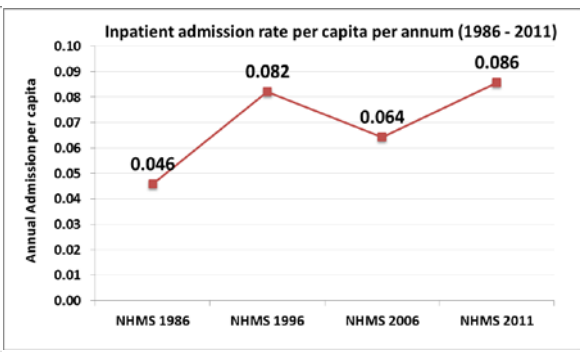
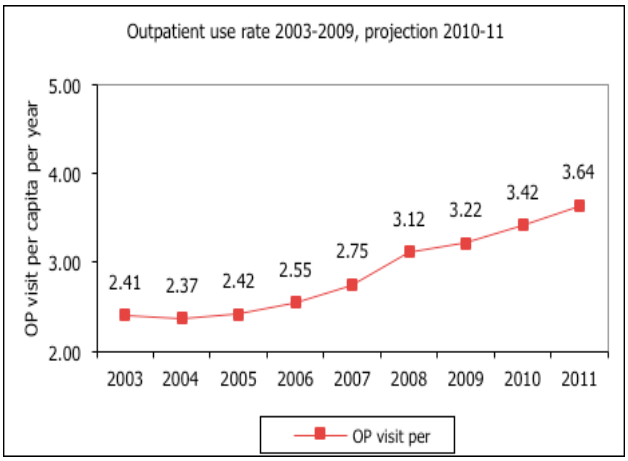


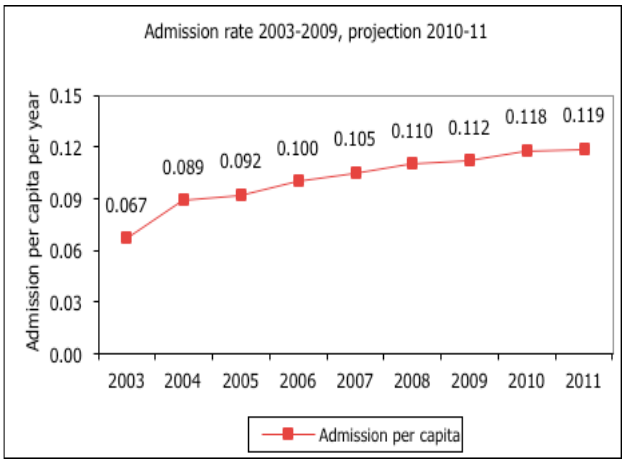
Figure 11 Use rate of admission in Malaysia

Note: the "dip" in the outpatient visit and admission in NHMS 2006 is due to a change in methodology used in the survey compared to the year 1986, 1996 and 2011.

5.2 Thailand[†]

UHC increased access to health services both out-patient and in-patient services and households can be prevented by medial impoverishment.





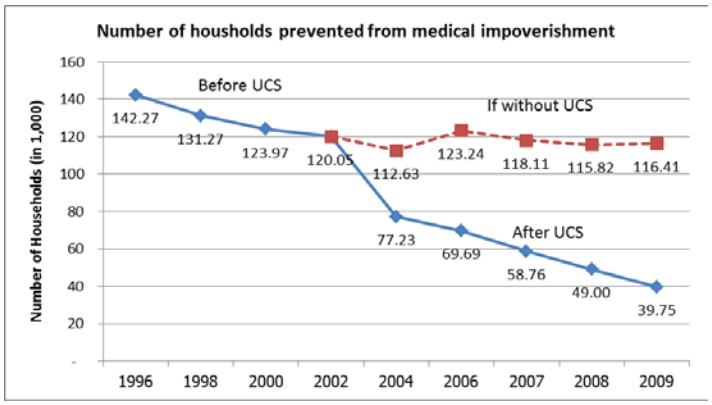
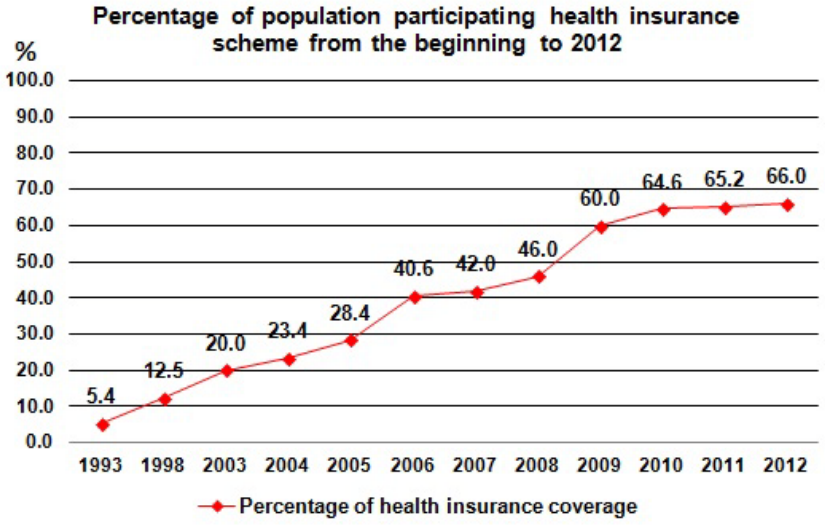


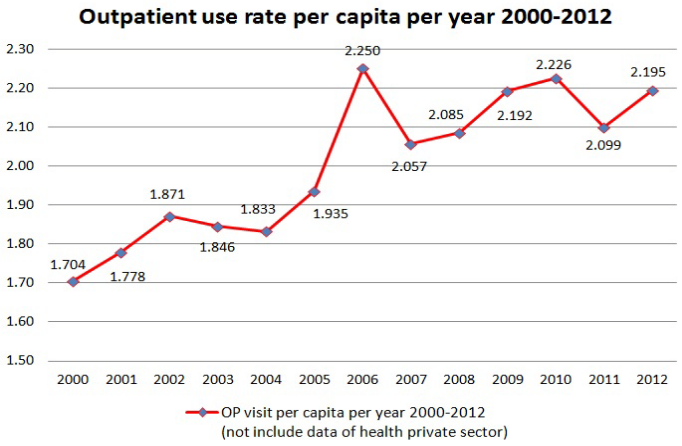
Figure 12 Use rate of outpatient and admission rate and households prevented from medical impoverishment in Thailand

[†] Thailand's Universal Health Coverage Scheme: An independent assessment of the first 10 years (2001-2010)

5.3 Viet Nam

Population coverage by health insurance in Viet Nam increased from 5.4% to 66.4% of total population between 1993 and 2012. In addition, use rate of outpatient services and hospital admission in public health facilities increased.





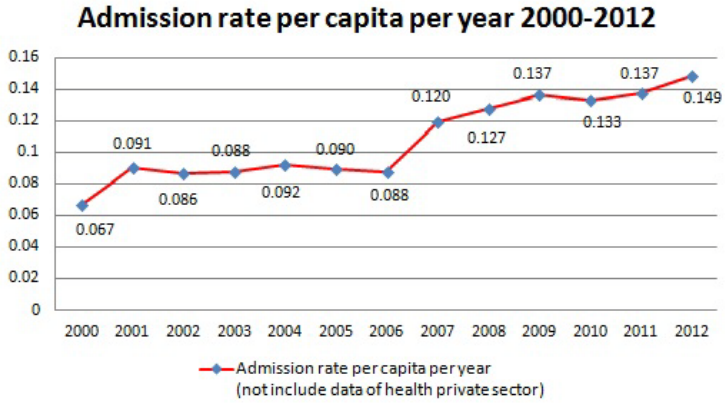


Figure 13 Percent of population coverage by health insurance and use rate in Vietnam

6. Highlights from the UHC Roundtable of ASEAN Plus Three Health Minister Meeting, 6 July 2012[‡]

The Meeting on 6 July 2012 appreciated and noted the statements by all Health Ministers of ASEAN Plus Three countries. The Meeting well endorsed the direction of moving towards UHC of the ASEAN Plus Three and greed to support the ASEAN Plus Three UHC Network.

Brunei Darussalam

Health Minister of Brunei Darussalam, H.E. Pehin Dato Adanan Yusof discussed the key challenge AMS were the limited resources such as human resources, infrastructures and health care financing. The strong government commitment in the provision, regulation and financing of health systems is very crucial. Clear National health policy objectives with a focus on values and principles of primary health care with particular target in women and children and those living in remote areas were essential. Priorities of improving health outcomes of the people and putting balance between tertiary, secondary, primary health care provision and health promotion should be addressed. Key major success factors of UHC include i) to create supportive and enabling environment, gain strong commitment and active engagement from all multi-sectoral stakeholders; ii) to strengthen institutional capacity for generation of information and formulation of policy and iii) to continue implementing MDGs indicators and having a guidance from WHO on relevant indicators including ratio of health professionals to populations.

[‡] Report of the 5th ASEAN Plus Three Health Ministers Meeting. *Theme: ASEAN Community 2015: Opportunities and Challenges to Health,* 6 July 2012, Phuket, Thailand.

Cambodia

Health Minister of Cambodia, H.E. Dr. Mam Bunheng shared the view on the UHC covered three dimensions of population coverage, health service provision and financial protection. The Ministry of Health of Cambodia has developed and implemented the strategic framework for health financing 2008-2015 to guide the development of health care financing system. He emphasized the need of more domestic resources. To reach the target, the equity fund and community financing schemes were needed to identify. The gap and weakness in health service delivery should be determined. In summary, the government of Cambodia has a strong commitment to achieve UHC.

Indonesia

Health Minister of Indonesia, H.E. Dr. Nafsiah Mboi informed that Indonesia has a strong commitment and political wills to achieve UHC by 2019 through social health insurance system. This includes integrating the existing health protection schemes into a single scheme, expanding the benefit package, covering the existing uninsured population, and subsidizing premiums for the poor by the government. Indonesia also focuses on health promotion and prevention aiming not only to improve the population health status but also reducing the health care cost in the long run. Besides the supply gap has to be fulfilled especially addressing the shortage of human resources for health in the remote areas. However there are challenges that need to be tackled in order to achieve UHC which are the geographical and demographic situation, and a considerable variety of existing health insurance schemes. In this regard, Indonesia would like to ask the ASEAN plus Three members to consider raising UHC as part of sustainable development indicator. In conclusion, Indonesia fully supports the initiative that ASEAN Plus Three formulate appropriate mechanism for capacity building and collaboration, as well as monitoring the progress of Universal Health Coverage.

Lao PDR

Health Minister of Lao PDR, H.E. Prof. Eksavang Vongvichit mentioned that health for all policy is to ensure all citizens to access to health services. They concern that equity is an important dimension in health financing. Previously, Lao PDR has 4 health insurance schemes managed by two ministries, the civil servant scheme and social security scheme by Ministry of Labour and community based health insurance and health equity fund by Ministry of Health. The Government has just approved new policy to merge these four schemes to be managed by Ministry of Health and aim to provide 50% subsidization for self-employees and 100% for vulnerable groups and the poor. He proposed that ASEAN and the Plus Three to work in collaboration and continue to strengthening the UHC by sharing lessons learn among countries.

Malaysia

Health Minister of Malaysia, H.E. Dato' Sri Liow Tiong Lai Liow presented that the health expenditure was 5% of GDP in Malaysia. Malaysia already achieved UHC through public healthcare providers. He raised the challenges to sustain and provide the accessible and effective health care services for all people. The health system needs to be designed to deal with the increasing trends and burden of NCDs. This leads to the need of proactive actions on the health system transformation/reform, including health financing reform. The focus will be more on public health services, the accountability of the system, and the quality of health services. In conclusion, Malaysia supports the moving towards UHC and highlights that the collaboration among ASEAN Plus Three will be benefit the countries and their population.

Myanmar

Health Minister of Myanmar, H.E. Dr. Pe Thet Khin shared the current situation in Myanmar and showed the commitment to strengthen the health systems financing to increase the accessibility to health services of the people, in particular the poor. He shared the situation of Myanmar that out-of-pocket is still high at 80% of total health expenditure and the government spending on health is still low at 3% of total government budget, although it increased four times from the previous year. Myanmar confirmed to strengthen the existing health system. Myanmar is

implementing pilot projects of many health insurance schemes. In summary, Myanmar confirmed its support on UHC concept and Myanmar is interested to collaborate and support the ASEAN Plus Three UHC Network.

Philippines

Dr. Enrique Tayag, Assistant Secretary, Cluster Head, Support to Service Delivery and Director IV, National Epidemiology Center, Department of Health, Philippine on behalf of H.E Dr. Enrique T. Ona, Secretary of Health Philippines informed the situation of health insurance and health financing in the Philippines, including the initiative on 'no balance billing' policy. The Philippines support the concept of moving towards UHC by reducing out-of-pocket expenditure on health and at the same time to increase domestic resources e.g. sin tax. In addition, the Philippines proposed that UHC should be monitored at least three points which are equitable access, affordable health system and quality services by measuring utilization rate, out-of-pocket as % of total health expenditure (less than 30%), patient satisfactory, respectively.

Singapore

Health Minister of Singapore, H.E. Mr. Gan Kim Yong shared the same concern in the affordable and sustainable system. Singapore provides broad based subsidies for healthcare, especially in acute healthcare, as the public sector caters to about 80% of hospitalisation workload. This, together with compulsory health saving accounts (Medisave), basic national healthcare insurance known as MediShield catered for large hospital bills, and lastly the social safety net of Medifund, no one in Singapore is denied of basic healthcare due to an inability to pay. Going forward, Singapore has said in 2012 that it will double its annual budget over the next five years to ensure the sustainability. He urged to look beyond insurance scheme, and shared experience of the integrated multi-tier health care systems in Singapore.

Thailand

H.E. Wittaya Buranasiri, the Minister of Public Health of Thailand shared Thai experience on UHC that Thailand has implemented UHC for a decade. One main observation is that it is not necessary to wait until we are rich and implement UHC. UHC needs the development in two strands, health system development and financial health protection. He emphasized the capacity building on health system research which will provide evidence based policy decision. Thailand is happy to share our experience on UHC and to learn from other countries for the improvement of Thai health system. Thailand fully supports the ASEAN Plus Three countries to move towards UHC and the ASEAN Plus Three UHC Network. Finally, Thailand is ready to be the focal point of the ASEAN Plus Three UHC Network.

Viet Nam

Health Minister of Viet Nam, H.E. Thi Kim Tien Nguyen, shared the concern the out of pocket spending of the poor, the vulnerable group, and other sub group population. The government committed to cover UHC to meritorious and the vulnerable groups, and improve and strengthen the system of preventive medicine and primary health care at the grassroots level. However the challenges are there for further works, for example, out of pocket expenditure on health as % of total health expenditure is still high. Viet Nam will reform the provider payment methods which focus on capitation method and diagnosis related group method. She sincerely thanked to ASEAN Plus Three countries for a kind technical support and experiences sharing, and Viet Nam strongly supports the ASEAN Plus Three Network on UHC.

China

H.E Prog Huang Jiefu, Vice Minister of Health China, informed that China launched the health care system reform in 2009. It aims to establish basic health care system which can provide safe, effective, convenient and affordable health service to all people both in urban and rural areas by 2020. It also reflects the "prevention-oriented" policy. In 2011, the out-of-pocket expenditure of China health system was at 35.88 % of total health expenditure. He expressed the importance of Universal Health Coverage. He suggested that international community should establish coordination mechanism on health research and financing at the global level to reduce the price of drugs and vaccines for better accessibility. He also emphasized the solidarity among developed and developing countries. Finally, he confirmed that China will continue to insist the concept of providing basic health care services as public goods to all people and China is willing to further promote the communication and share experiences with ASEAN, Japan and Republic of Korea, and work together for the well-being of people in this region.

Japan

H.E. Kazue Fujitaof Parliamentary Secretary for Health, Labour and Welfare of Japan, shared the experiences how to establish health universal coverage in Japan, laws were revised to support the system. The goal of the system is to provide free access to all with good quality of health care service. With limited resources, it is a challenge for the government to achieve the goal. Japan plans to increase tax and mobilize the expected budget into the system in order to strengthen and sustain the system. She highlighted the importance of learning experiences from each other among ASEAN Plus Three on how to establish and sustain UHC, and Japan is willing to share the experiences, technical supports to all countries. She has an opinion that the strategies depend on the countries context. Japan is willing to work more in collaboration and share the experiences with ASEAN Plus Three with some concerned issue like aging society.

Republic of Korea

Republic of Korea delegate, Mr. Tae Han Lee, Assistant Secretary of Health Care Policy, Ministry of Health and Welfare, Republic of Korea shared Korea's experience in relation to universal health coverage. He presented the efforts to expand benefits by setting principles, criteria and priority in adjusting benefits based on social consensus, considering improvement of co-payment schemes and working to reform the payment system. He also mentioned about effort to increase investment in health promotion to sustain the Korea's health system.

7. Conclusion

In summary, ASEAN Plus Three countries commit to actively accelerate the progress toward UHC in all countries and agree to share and collectively build up the national and regional capacity to assess and manage the equitable and efficient health systems to support UHC.

Seven countries in ASEAN Plus Three have already achieved UHC, greater than 95% population coverage, while the rest of six are moving towards UHC with specific targeted year.

Health financing indicators are undoubtedly developed, accessible and comparable worldwide. Data speaks itself that more "money for health" is urgently required in many countries and "more health for money" is not less important issue to be concerned in many countries of ASEAN Plus Three. Mobilizing more domestic resources is the priority. The government commitment to spend on health at equal or greater than 50% of total health expenditure can be a significant indicator for accelerate UHC achievement. An innovative health financing in many countries is applied such as "VAT" and "Sin Tax" which can replicate elsewhere, as appropriate. It aims that out-of-pocket payment would reduce to less than 20% of total health expenditure.

UHC outcome indicators like increased access to health services and financial risk protection are limited and not easy for cross-country comparison. As agreed by the Steering Committee of the ASEAN Plus Three UHC Network, three important works indicated in the action plan of the Network during 2014-2016 are measuring UHC baseline, strengthening data systems and monitoring UHC progress. The Network aims for comparable indicators of UHC outcomes in the near future.

With the diversity among ASEAN Plus Three countries, experience sharing, learning together and support each other are worth strategies for pursuing UHC together through the ASEAN Plus Three UHC Network. An ultimate goal of UHC is not for the health sector itself but its main purpose is for the better health of the populations.

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ASEAN Plus Three UHC Network

"A trust-based network"

Republic of Korea

Brunei Darussalam

Japan

Cambodia

We

commit to collectively accelerate the progress towards UHC in all countries

China

Indonesia

concur and will collectively move the issue of UHC to highest regional and global development forum

Viet Nam

Lao PDR

agree to collectively build up the national and regional capacity to manage the equitable and efficient health systems to support UHC

The Joint Statement, 5th ASEAN Plus Three Health Ministers Meeting
6 July 2012

Thailand

Malaysia

Singapore

Myanmar

Philippines

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ASEAN (the Association of Southeast Asain Nations) and Plus Three Countries (China, Japan and Republic of Korea)