

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

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Background

ASEAN Plus Three Countries, Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand, Viet Nam, China, Japan and South Korea are diverse with regard to population size, social and economic conditions as well as health systems. The countries span two regions of WHO ie South East Asia Region (SEAR) and West Pacific Region (WPR) and cover 2.1 billion populations, with vast Universal Health Care (UHC) experiences and different stages of UHC development.

At this side event, the listed panelists shared country experiences on UHC.

China: Ms Chen Ningshan, Deputy DG of Dept of Law and Legislation, NHFPC

Indonesia: Prof Dr Akmal Taher, DG of Health Care, MOH

Japan: Dr Mitsuhiro Ushio, Assistant Minister, Minister's Secretariat, Ministry of Health, Labour and Welfare

Malaysia: YB Datuk Seri Dr S Subramaniam, Minister of Health Malaysia

Viet Nam: Prof Dr Le QuangCuong, Vice Minister of Health

World Bank: Dr Toomas Palu, Health Sector Manager for the World Bank's South East Asia and Pacific Region

WHO: Dr Marie-Paule Kieny, WHO Assistant DG for Health Systems and Innovation

Following introductions, the Chairperson of ASEAN Plus Three UHC Network, Dr Winai Sawasdivorn, informed the audience that of the countries represented in the panel, China, Japan and Malaysia had achieved up to 95% UHC coverage while Indonesia and Viet Nam are at different stages but moving towards full coverage. The audience would first hear the experiences of countries that are moving towards full coverage following which panelists from China, Japan and Malaysia, which had almost full coverage, would relate their do's and don'ts.

Dr Margaret Chan's address

In her brief address to the meeting, Dr Margaret Chan, DG of WHO, explained that when Member States (MS) first introduced the resolution on UHC many years ago, country focus at the time was on health financing. She added that feedback showed that countries did not object to the important principle of equity in UHC.

'WHO is clear in its support of UHC because it is equitable. How countries structure and finance coverage has to be context specific. For example Brazil staunchly supports that service provision should be public sector driven. In other countries, there may be a sharing between public and private sector providers. WHO plays the role of knowledge collector and sharer with MS. It is up to the country to determine whether it wants coverage to be totally public, totally private or a mix of both. WHO does not take any position on this,' she reiterated.

She asserted that WHO does not give priority to private sector health insurance but leaves each individual country to decide which system works best for it. 'Nobody should be denied access to care because they are poor, rural, female or indigenous. Lend your support to UHC. It is your decision on how the post 2015 Sustainable Agenda should be developed.'

Reports

Vietnam

Prof Dr Le Quang Cuong, the Vice Minister of Health, Vietnam, explained that most of the population in the country had social insurance coverage. The government placed priority on

preventive health care. The most vulnerable and poor were able to participate in the scheme through full government subsidisation. Provincial governments were encouraged by the central government to take responsibility for ensuring that the majority of the populations was fully covered.

Amongst the lessons learnt was that it was necessary to identify and specify marginal groups so that these groups did not fall through the cracks. Local government must play a lead role in ensuring that as many people as possible come on board the health insurance scheme. The shift from individual health insurance to family based schemes was another important learning.

Indonesia

Dr Akmal Taher explained that at present, 60% of Indonesians were covered by some form of health insurance. The Health Insurance Scheme in the country was formally adopted in 2014. There is a move to integrate the four different schemes in the country so that the lowest 30% of the health percentile is covered. The Ministry has targeted full integration of the four schemes by end of 2014. By this date, 121 million Indonesians would have been covered by the Scheme.

The Ministry has set itself the highly ambitious target of full coverage by 2019. People would have the options of selecting between government paid or worker premium schemes.

The country faced many challenges on the implementation in view of large health care inequities between rural and urban areas. Although 30% of the rural population is covered, between 20 – 30 million people remain uncovered. This is in fact the most difficult challenge for the government.

Malaysia

According to the Minister of Health, Datuk Seri Dr Subramaniam, all Malaysians by design are promised UHC by the government. 'Historically, Malaysia had inherited its health system from the days of British rule. This system has continued to function to date because it is a system that is funded by taxation, is sustainable and works through a good network of primary health centres, which the country has improved upon. From a three tier system we have restructured to a two-tier system,' he informed.

As a result, every Malaysian has access to a health facility within a 5km radius of the home. Infant mortality rate had decreased to 6.6 in 2011; life expectancy which was less than 60 years is now 77 years for women. Malaysians have a high level of risk protection – up to 97% - and catastrophic health expenditure is extremely low.

'Our main challenge is tertiary care, which has become very expensive and techno-centric. The public expects high quality care and our problem is difficulty in meeting those expectations,' stated Dr Subramaniam.

The country is seeing a rapid increase in the aging population; Non-communicable diseases are rising as are problems associated with these. 'The public health system is state funded while private health care is employer subsidized. The rate of out-of-pocket payments is rising, reaching 77% in some instances. The government's ability to fund this type of system is becoming burdensome,' he added.

In view of these challenges, there is now a renewed emphasis on preventive primary care which the government is actively and aggressively promoting. The push to maximize the utilization of manpower through re-engineering processes based on existing infrastructure is one strategy that is being pursued.

'Cost co-sharing is being explored but this is an explosive issue politically- there is strong public opposition and the government is trying to get the public to buy in to the proposals. Government health expenditure on health stands at RM50 billion and clearly the private sector has the capacity to assist. We are trying to build bridges between the public and private sectors,' he concluded.

Japan

Dr Mitsuhiro Ushio began his presentation by stating that Japan had 50 years of experience from having applied the national unified fee schedule. He indicated that UHC had historical links with Primary Health Care (PHC), stating 'After it was first introduced at Alma Ata, PHC became popular; currently UHC has succeeded PHC.' He stressed the importance of social determinants of health which, in his view, were addressed in UHC.

He indicated that preventive health must take priority over treatment. In Japan, the long term care system is vital in view of the rapidly aging population.

The National Health System in Japan was initiated in 1922 and covered only the employed. Currently the country has two schemes: for the employed and the non-employed.

He agreed that Japan's health insurance scheme was quite similar to Malaysia and Vietnam. However, in comparison, Japan has a very large middle income population and almost all its population could presently be classified as middle class. Medical care in Japan is free and most of the hospitals are occupied mainly by the aged. As a result long term care facilities for the aged population have been set up and concurrently there has been the introduction of a long term care insurance system. Because long term care to the aged population is generally very expensive, the preference was to provide this through community care.

The main health issues faced by the aged are dementia and loneliness; suicide is an associated factor.

China

According to the Deputy DG of Law, Ms Chen Ningshan, China is still undergoing health system reform and aims to achieve UHC. The government is taking full responsibility for ensuring health care coverage for all. From end of 1997 to date, up to 5% of the population has some form of coverage.

The delivery of PHC is being strengthened through the government's recruitment of qualified health care workers. China had benefitted from the experiences of various countries on what works and what does not, during this process of health systems reform. The following principles were clear:

Health is a basic human right and a priority. Everyone should have access to healthcare regardless of gender and where they lived, amongst other factors.

Prevention takes priority over treatment and it was important to establish free access to all.

Integrated health care delivery system is critical; a PHC system has been established and the focus was on improving quality of health services.

The provision of essential medicines and traditional medicines was assured.

Informed policy development based on country experience is necessary

In spite of its achievements, the country continues to face many challenges including a rapidly ageing population, Non-Communicable Diseases, lifestyle related expectation. Ms Chen stressed that evidence-based health policy makes a big difference to UHC.

World Bank

Dr Toomas Palu congratulated WHO for its strong leadership of UHC, adding that it had been a privilege to work with Asian countries who had shown a strong commitment to UHC. He indicated that there was clear momentum for international commitment on UHC.

Amongst the lessons learnt in the process were:

Governments must take responsibility for the poor and near poor for UHC.

- UHC is not just about raising money for health. Expenditure is also important. Services that are provided must prove value for money, as was efficiency.
- Supply side readiness of delivery also mattered. Service delivery was the emerging bottleneck and it was important that this was addressed as it relates to NCD.
- Affordability was a consideration; the Thai and Philippine experiences had demonstrated that it is possible to get UHC and good quality health care at low cost.

In her summing up, WHO's Dr Marie-Paul Kieny reiterated that availability, affordability and good quality were the basis for UHC. She indicated that even the richer countries struggle to meet changing health needs and demands. For example Japan is taking action to provide more community based health care in view of its rapidly aging population.

She asserted that UHC is not a vague concept; it was clearly defined. ASEAN countries had shown that UHC was feasible and that all countries can make measurable progress.

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