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Universal Health Coverage for ASEAN: Is it possible?

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ABSTRACT

Geography, society, economic development, and health outcomes vary much among the Association of Southeast Asian Nations (ASEAN). The health systems, structure and services vary considerably. As a consequence, the development for a Universal Health Coverage (UHC) in these countries also diverges. The objective of this article is to study the development toward the UHC in ASEAN countries and the barriers that hinder the progress. Online and manual search methods were used to gather the information and ‘snowball’ further data. It is found that, in general, ASEAN countries have made good progress toward UHC. However, there are major barriers to all the countries in achieving UHC, namely 1) financial restrictions; 2) supply side limitations; and 3) the increasing problems of non-communicable diseases, continuing infectious diseases, and recurrence of potentially pandemic infectious illnesses. Whereas the minor obstacles are the divergence of 1) language; and 2) cultures. The ASEAN Economic Community’s (AEC) aim of regional economic incorporation and a single market by 2015 grants both prospects and tasks for UHC. Healthcare services have become more accessible but health and healthcare inequities will likely go downhill as better-off citizens of member countries might have more benefits from the liberalization of trade plan in health. ASEAN has noteworthy prospective to become a power for better health in the region. It is hoped that all ASEAN populations can enjoy greater health and safety standards, complete social security, and enhanced health status.

Keywords: We would like to encourage you to list your keywords in this section (3-5 words).

INTRODUCTION

The Association of Southeast Asian Nations (ASEAN), a home to about 600 million people. It was formed on Aug 8, 1967 by Indonesia, Malaysia, the Philippines, Singapore and Thailand during the Cold War when there was a strong aspiration by these countries for neutrality, peace and social as well as economic development. Its membership has since expanded to 10 to include Brunei, Cambodia, Laos, Myanmar and Vietnam. The motto of ASEAN is "One Vision, One Identity, and One Community" (Minh, 2014).

ASEAN is categorized by much diversity in terms of economic development, health outcomes, society, and geography. The health systems as well as healthcare structure and provisions vary considerably. Therefore, the advancement toward Universal Health Coverage (UHC) in these countries also differs. UHC has been proposed by WHO as single health goal for the Millennium Development Goals (MDGs) and it is defined as a “situation where all people who need health services (prevention, promotion, treatment, rehabilitation, and palliative) receive them, without unnecessary financial hardship. It has a direct impact on a population’s health and welfare. UHC is the hallmark of a government’s pledge to advance the welfare of all its citizens. This requires health systems to be functional and effective, offering services that are widely available and of good quality. Progress toward UHC is unequal in all countries (WHO, 2013).

METHODS

Data reported in this paper were obtained from published literature, reports, and gray literature available in the ASEAN countries. Both online and manual search methods were used to collect the data.

RESULTS

Globally, over 3 billion people, numerous of them in the poorest half of the world’s population, must pay out of pocket (OOP) for health services. In 33 mostly lower income countries, comprising many of the world’s most populous nations, direct OOP expenses account for more than 50% of total health costs. Worldwide, about 150 million people suffer financial catastrophe annually while 100 million are pushed below the poverty line as a result of catastrophic health spending (WHO 2010).

In some countries, up to 11% of the populace undergoes severe financial destitution each year as a result of terrible health spending and up to 5% is forced into poverty. ASEAN is characterized by much diversity in terms of economic development, health outcomes, society, and geography. The health systems as well as healthcare arrangement and supplies vary considerably. Thus, the advancement toward Universal Health Coverage (UHC) in these countries also differs (WHO, 2013).

The increasing all-party teamwork between countries in the ASEAN region has led to a determination to create the ASEAN Economic Community (AEC) by 2015. The AEC can

possibly bring both positive and negative effects to a country's effort in attaining UHC. The objective of this article is to describe the progress of UHC in each member country, political commitments of each country and major and minor barriers in achieving UHC in ASEAN.

1. Progress of UHC. Coverage of Health Insurance in ASEAN Countries by 2012 (Guinto, Zuwasti, Suphanchaimat, Pocock, 2014; Presiden of Indonesia, 2011; WHO, 2010)

Thailand. The entire population is covered with social health insurance (SHI)

Malaysia. Theoretically the entire populace can use public health services funded via general taxation and low user payment.

Singapore. The 93% of the population of Singapore is covered by Medi-Shield, the compulsory government organized health insurance scheme.

Indonesia. Around 60% of the populace is protected by health insurance. The Indonesian government rolled out the Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan on January 1, 2014, with a motivation to attain national coverage of UHC by January 2019. This move is under the supports of the President of the Republic of Indonesia.

Lao PDR. The coverage of health insurance in Lao PDR is however, still low, 15% of the population. Laotian government is now bearing in mind the establishment of a national health insurance authority through the incorporation of four different social health protection schemes leading to universal coverage by 2020.

Cambodia. The coverage of health insurance in Cambodia is still low also, 24% of the population. Worthy improvement has been made in using health equity funds to cover the poor. However, civil servants and private sector workforces are not protected at all by insurance, while certain susceptible groups such as the elderly and disabled are disqualified from the user fee exemption scheme.

Philippines. Coverage of 51% of the population.

Brunei. No data available

Myanmar. No data available

Vietnam. No data available

2. Political Commitments

During the 11th ASEAN Health Ministers Conference hosted by the Thailand Ministry of Public Health in 2012, a joint statement highlighting five key health topics, including establishing a UHC. The political pledges to ratify UHC have at face value been solid in the ASEAN countries (Anuar, 2012; ASEAN, 2012; Chanel News Asia, 2014; Yow, 2012,)

Thailand. Since 2002, the political assurance to universal access to healthcare was stressed in the National Health Security Act that declares that ‘Thai population shall be entitled to a health service with such standards and efficiency’.

Indonesia. In 2004, the Presidential Bill No. 40/2004 on National Social Security System to safeguard Indonesian citizens from appalling household spending due to illness and death was decreed.

Cambodia. In 2005, a Master Plan for SHI was approved, demonstrating an essential first step toward launching a unified health protection system.

Vietnam. In 2012, the Prime Minister ratified the Master Plan on UHC with a roadmap to attain universal health insurance (UHI) coverage levels of 70% by 2015 and 80% by 2020, and to reduce OOP payment to 40% by 2020.

Myanmar. In 2012, the government has authorized the goal of achieving UHC by 2030 with targets to advance the health status of the poor and susceptible, especially women and children.

Philippines. In 2013, the president modified the National Health Insurance Act of 1995 by signing Republic Act 10606 which dictates the government to assume the premiums for the insurance of the impoverished and informal sectors thus aiding many Filipinos.

Singapore. The government recently declared the growth of MediShield that has covered 93% of the populace to MediShield Life that will be compulsory with 100% population coverage and a definite aim of decreasing co-insurance levels from the current 10-20% to 3-10%.

Malaysia. The profile of UHC remains to be debated, with negotiations currently addressed on whether the country should change to a SHI model, 1Care, which would allow the insured to have access to private services. Civil society and trade unions have voiced concerns that 1Care will support private providers at the expense of the public, and debates have since been hindered.

Although, there seems to be a political commitment articulated for UHC, the truth is, it is tough for policymakers to balance opposing interests of the rising for-profit private sector (in most countries) and the necessity to warrant equal access to healthcare.

3. Major Barriers for UHC

All ASEAN countries are facing some shared barriers to achieving UHC such as financial restrictions, supply side limitations, the increasing problems of NCDs, continuing infectious diseases, and recurring of potentially pandemic infectious diseases, language as well as culture (Coker, Hunter, Rudge, Liverani & Hanvoravongchai, 2011; Kanchanachitra, Lindelow, Johnston, Hanvoravongchai, Lorenzo & Huong, 2011; Minh, Kim, Saksena, James & Xu, 2013; Minh, 2014; Phua, Yap, Schwanke & Lee, 2015; Tangcharoensathien, Patcharanarumol, Ir, Aljunid, Mukti & Akkhavong, 2011; WHO, 2005; WHO 2011; WHO 2011a; WHO 2011b; Xu, Evans, Kawabata, Zeramdini, Klavus & Murray, 2003).

The key financial restraints are low levels of government expenditure and overall expenses on health. Most countries in the ASEAN region allotted less than 5% of the gross domestic product (GDP) as spending on health in 2012, with the exemption of Cambodia (5.4%) and Vietnam (6.6%). To guarantee UHC, particularly assumed economic liberalization on the path to AEC, governments should protect health budgets and rank not only achievement but also preservation of UHC. This is especially vital among ASEAN's middle-income countries. WHO describes households with tragic health expenditure as a family with a total OOP health payments equal to or beyond 40% of a household's ability to spend. A non-poor family is made poor by health payments when it becomes poor below the poverty line after spending for health services.

Thailand. Access to healthcare is restricted by the accessibility of service delivery, mainly health workforce. Notwithstanding having widespread networks of healthcare providers, challenges still occur in terms of healthcare delivery in far-flung rural areas where it is tough to attract and retain qualified health personnel.

Malaysia. A dual healthcare system has developed, with private facilities for those who have enough money to spend and public services for the rest, with quality alleged to be higher in the private than in the public sector. To guarantee that public sector service quality increases, and service capacity enlarges (especially in urban areas), to keep up with bigger demand is a challenge to Malaysian government.

Singapore. The reservations on moral risk leading to overconsumption and over-servicing, as well as ensuing financial unsustainability are the key causes why the government is unprepared to adopt UHC match other developed nations.

Indonesia. Indonesia faces numerous obstacles such as inadequate infrastructure (human resources, facilities, and equipment), the ratio of hospital beds to the populace is very low (six beds per 10,000 population) and the large geographical archipelagic area. A huge task is to deliver equal right of entry to healthcare, including for populations in remote areas and islands of Indonesia.

Lao PDR. The level of public spending on health, regardless of efforts to increase it, is still too low, and is presently inadequate to meet the health necessities of the people.

Cambodia. The reactive health financing system for both formal and informal sectors is the single prime barrier to achieving UHC. There is no financial arrangement for public servants due to low government wages and low government expenditure on health.

Phillpines. The surge in the coverage of insurance of PhilHealth without corresponding funding increases.

Brunei. No data available

Myanmar. Insufficient and unpredictable investments in catastrophic health payments, lack of health workforce, and health. Though the government has augmented its total expenditure four times on health in recent years, this was only 2% as a percentage of GDP in 2011.

Vietnam. Nearly two thirds of the populace is covered by health insurance. The coverage of health insurance is still quite small among informal sector workers.

4. Minor Barrier

4.1. Language Barrier

The diversity of languages spoken in Southeast Asia is an evidence to the variety of the region. Each country has numerous native and regional languages. These languages range from the Sinitic languages spoken by the Chinese populaces to the Tai languages, which contain the national languages of both Thailand and Laos. Colonial languages, including French, Dutch, Portuguese, Spanish and English are also spoken.

There are three major languages that are spoken in ASEAN e. g. Bahasa Indonesia, Thai language as well as English.

Bahasa Indonesia is spoken by 240 million Indonesians, 26 million Malaysians, and many Southern Thais, Singaporeans, Bruneians, and East Timorese. That's at the very least 260 million speakers of Bahasa Indonesia, or Bahasa Melayu as it is called in Malaysia, in ASEAN (Saksith, 2015).

Thai is spoken apparently by at least 65 million Thais, plus maybe about 20 million in nearby neighboring countries like Lao, Cambodia and Myanmar (Saksith, 2015; Dorhs, 2015).

English is extensively spoken in Malaysia, Phillipines, Singapore a total of about 130 million people. English is commonly spoken in all the ASEAN countries. This can assist to solidify ASEAN relations with the newly developing economies of the East, especially China and India, with whom they have had profound interaction since early times. The diversity can also help as a bridge with Western countries with whom they have had more recent historical ties _the British in Brunei, Malaysia, Myanmar and Singapore, the Dutch in Indonesia; the Spanish and the Americans in the Philippines; and the French in Cambodia, Laos and Vietnam. The Philippines owe the Americans for English proficiency. Singapore still has English listed as one of four official languages. In Myanmar, English has only just endured, because of that country's colonial past. Cambodia has made enormous strides in learning the language, sparked by the interference there by the United Nations in the early 1990s. Elsewhere, English is still struggling (Hunt, 2014). This language barrier can be a problem for the health personnel who want to work in other country that does not speak their language and migrant workers to work in other country that does not speak their own language (Chang, Feller & Nimmagadda, 2009).

4.2. Cultural Barrier

ASEAN is known not only for its vast economic clout but also for its cultural variety. Can this be measured an asset in today's globalized and diverse world, where variety is seen as a source of strong point in terms of UHC for ASEAN? Beside language, culture may become a barrier because some cultures may be very open to foreign health-care personnel, whereas others may be unenthusiastic, distrustful or even unaccepting. Furthermore, Southeast Asian cultural approaches toward suffering, such as beliefs that suffering is unavoidable or that one's life span is predetermined, can cause Southeast Asians not to seek health care (Clough, Lee, & Chae, 2013).

While foreign cultural stimuli have assisted much change, the region's own culture still sparkles through. The region has a native culture that is thriving to date. Common

characteristics can still be traced back to the similar cultural roots of the many nations in the region, which retained a variety of animist cultures. The growing combination of the region's economies, primarily facilitated by ASEAN, is causing the merging of cultures as well. The world view of each country is shaped by deeply believed cultural and religious beliefs. The lesser developed ASEAN countries such as Cambodia, Laos, Myanmar and Vietnam practise Buddhism, which practices acceptance of one's fate helped in overcoming adversity (Clough, Lee, & Chae, 2013). These countries have survived well in times of uncertainty as compared to the more developed ASEAN countries like Brunei, Malaysia and Singapore.

Despite the differences, there is a clear merging of cultures too. Almost all ASEAN countries have experienced the same wide-ranging influences from China, India and Europe. Similarities within the region include a forward-looking attitude, willingness to work together and seek agreement for the common good, and a conviction that "any human activity takes place in a broader context where causality plays a major role" (Singleton & Krause, 2009).

DISCUSSION

Conclusion

As a conclusion, is universal health coverage for ASEAN possible? Yes, it is possible if each member country would take time and effort in making political efforts to achieve it, and to overcome the major and minor barriers.

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