CHAPTER – 1

ABSTRACT

BACKGROUND:

Southeast Asia is a region with a lot of diversity. In some nations, social, political, and economic growth has resulted in significant health improvements, while in others, smaller changes have occurred. Such health threats cannot be ignored by public policy in these countries, since they can have significant social and economic implications. As a public health policy, regional collaboration in emergency preparedness, disease surveillance, and health system response to disease outbreaks has clear benefits. If the remarkable health achievements of the past few decades in most countries in the region are to be repeated, greatly improved health promotion and disease prevention strategies are an urgent priority. The growing demands for high-quality healthcare by an increasingly educated and affluent population amplify the stresses put on national healthcare systems by recent demographic and epidemiological transformations. Many conventional clinical practices coexist with the use of emerging medical technology and pharmaceutical products, posing safety and quality concerns for regulators.

Southeast Asian countries and their health-care reforms can thus be classified based on their healthcare systems' stages of growth. For the diverse mix of health systems at various stages of socioeconomic growth, a typology of common problems, challenges, and priorities is created.

Most countries have improved social security systems and basic health services as a result of the lessons learned from the previous financial crisis. Many creative pro-poor funding programs have been introduced in the country, including Thailand's Health Card and 30-baht Schemes, Vietnam's Health Fund for the Poor, Cambodia's and Laos' Health Equity Funds, and even Singapore's Medifund, a voucher system for indigent patients.

Because of the strong position of governments and efficient controls by health authorities to solve inequity issues, healthcare systems that rely heavily on tax revenue have remained relatively stable so far. However, rising prices, the potential viability of centralised tax-financed schemes, the reliability and quality of public services, and rising public standards are all critical concerns. As a result, several governments have passed legislation establishing national health care programs and mandating universal coverage, despite implementation challenges. With current decentralization and liberalization policies, equity issues and weak infrastructure will continue to stymie the health sector's growth.

Aims & Objective:

• To determine the equity effect of the Southeast Asian countries' package of UHC reforms to promote universal coverage.

• To recognize the health-care system's problems, opportunities, and next steps for the UHC's implementation.

Methogology:

Study Design: Descriptive study, Review based

Time Duration: 3 Months (March 2021- May 2021)

No. of Articles reviewed: 25 out of which 15 fall under criteria.

Data Collection:

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- Conceptual definitions, frameworks, and methods for analyzing health equity and equity in access
- Policy analysis of issues relating to equity of access to health services
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Exclusion criteria

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Keywords: Healthcare Systems, Socioeconomic, Health Equity, Universal Health Coverage.

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INTRODUCTION

The World Health Organization (WHO) proposes the concept of Universal Health Coverage (UHC) as a 'single overarching health goal' for the next iteration of the Millennium Development Goals (MDGs). UHC is described as a condition in which all persons who require health services (prevention, promotion, treatment, rehabilitation, and palliative care) have access to them without experiencing undue financial hardship. The beneficiary who is covered (population coverage or breadth coverage), the type of services covered (service coverage or depth coverage), and the coverage degree of financial contribution are all important features of UHC (financial coverage or height coverage). UHC is an essential component of long-term development and poverty reduction, as well as a fundamental component of any effort to address social inequity. The health and wellbeing of a people are directly affected by UHC. When sick people and their families have to pay for health care out of their own pockets, financial risk protection protects them from falling into poverty. UHC is a symbol of a government's commitment to improving the lives of its citizens. Health systems must be functional and successful in order to provide services that are both widely available and of high quality, according to the UHC. Every country is making different progress toward UHC. Over 3 billion people worldwide, many of whom are in the world's poorest half, must pay for health services out of pocket (OOP). Direct OOP payments account for more than half of overall health expenditures in 33 predominantly low-income countries, including many of the world's most populous nations. Around 150 million people worldwide face financial ruin each year, with another 100 million being forced into poverty as a result of unsustainable health-care spending. Each year, up to 11% of the population in some nations endures extreme financial hardship as a result of catastrophic health spending, with up to 5% of the population plunged into poverty. For the past 45 years, the Association of Southeast Asian Nations (ASEAN) has been the most major multilateral group in Asia, comprising ten countries: Brunei, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar (Burma), the Philippines, Singapore, Thailand, and Vietnam. ASEAN has made a number of major successes in the areas of economics and non-proliferation since its founding in 1967. In terms of demography, geography, society, economic growth, political systems, and health outcomes, ASEAN is characterized by a great deal of variation. These factors have contributed not just to the region's different people' differing health statuses, but also to the region's distinct health systems, which are in various stages of development. As a result, progress on UHC in various countries varies. The desire to establish the ASEAN Economic Community (AEC) by 2015 stems from the region's growing multilateral engagement. The goal of this regional economic integration is to create a single market and manufacturing base that is competitive, equitable, and well-integrated into the global economy. Integration has the potential to have both beneficial and bad consequences for a country's efforts to achieve universal health coverage.

	Total population (000s), 2012[a]	Median age of population (years), 2012[a]	Population aged >60 years (%), 2012[a]	Population living in urban areas (%), 2012[a]	Crude birth rate (per 1,000 population), 2012[a]	Crude death rate (per 1,000 population), 2012[a]	NCDs age-standardized mortality rate (per 100,000 population) both sexes, 2012[a]	Literacy rate among adults aged ≥15 years (%), latest year[b]	Gross national income per capita (PPP int. $), 2012[a]
Brunei	412	30.1	7.0	76	15.9	3.5	475.3	95 (2012)[c]	No data
Cambodia	14,865	24.1	7.7	20	25.9	5.7	394	74 (2009)	2,330
Indonesia	246,864	27.5	7.9	51	19.2	5.3	680.1	93 (2011)	4,730
Lao PDR	6,646	21.0	5.8	35	27.3	7.0	680.0	73 (2005)	2,690
Malaysia	29,240	27.0	8.2	73	17.6	5.0	563.2	93 (2010)	16,270
Myanmar	52,797	28.6	8.2	33	17.4	8.3	708.7	93 (2012)[c]	No data
Philippines	96,707	22.7	6.2	49	24.6	5.9	720.0	95 (2008)	4,380
Singapore	5,303	37.9	15.1	100	9.9	4.4	264.8	96 (2012)[c]	60,110
Thailand	66,785	36.4	14.0	34	10.5	7.5	449.1	96 (2010)	9,280
Vietnam	90,796	29.4	9.3	32	15.9	5.7	435.4	94 (2009)	3,620

[a]World Health Statistics 2014; [b]UNESCO Institute for Statistics 2014; [c]UIC estimation.

Table 1: Selected socio-demographic and health indicators in the ASEAN countries

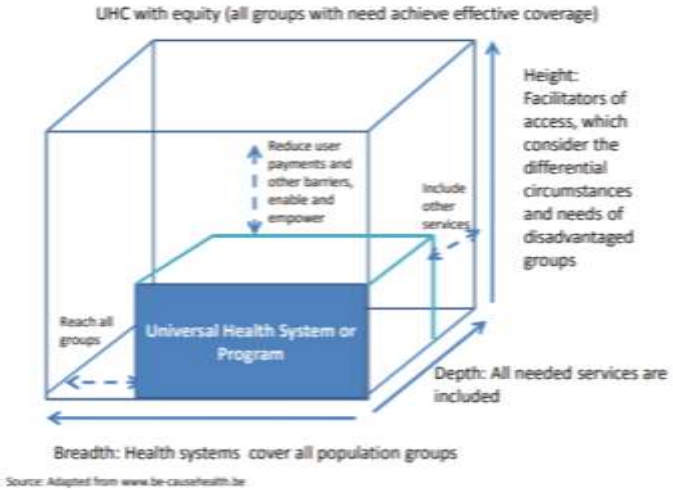
CHAPTER- 3

REVIEW OF LITERATURE

The WHO defines Universal Health Coverage (UHC) as a basic idea that ensures that "all individuals have access to the health services they require without facing financial difficulty in paying for them." As a result, UHC delivers two benefits: first, everyone is covered by a bundle of high-quality health services, and second, UHC provides financial protection against health-care expenditures. UHC is supported by several key elements, including: • An efficient, resilient health system • Affordable care and a system of financing health care that does not impoverish users • Access to essential medicines and technologies • Health workers who are motivated and have sufficient numbers and skills • Efficient, functional administrative and governance arrangements • Transparency in tracking progress to achieve UHC, governments must improve health services in three ways. To begin, the fraction of the population covered should be increased to include all citizens of a country (universal population coverage). Second, as resources allow, the range of services covered by UHC policies should grow, including adequate investment in vital public health tasks. To be effective, services must also be available and of sufficient quality. Third, a growing share of the funding needed to deliver services should come from pooled funds acquired through compulsory prepayment methods such as general or special taxation or public social insurance.

THE BENEFITS OF UHC

The global health agenda is increasingly focusing on universal health coverage. The WHO World Health Report in 2010 focused on the path to universal health coverage, outlining how nations should structure their health-finance systems to pay for it. More than 70 nations have requested WHO assistance in moving on with their own programs since then. Margaret Chan dubbed Universal Health Coverage (UHC) "the single most potent notion that public health has to offer" in 2012. Adopting and maintaining a UHC system is thus a political as well as a technological undertaking. Although there are significant aspects to getting the system right, UHC originates with and is sustained by political decision-makers' commitment to guarantee that the entire population has access to high-quality health services without fear of financial hardship, frequently in response to citizen demand. In each country's circumstances, the best way to achieve universal coverage varies, but countries who have made success with UHC have seen a variety of benefits.



UHC is not a new priority for the region. In 2012, a regional UHC plan was created, and UHC has been a regional focus area, or "flagship" since 2014. Health services cannot be provided without health personnel and medicines, and they have been identified as major roadblocks to UHC advancement in the region. As a result, the regional UHC flagship places a special emphasis on developing human resources for health and increasing access to high-quality pharmaceuticals. WHO South-East Asia Member States committed to a Decade for Strengthening Human Resources for Health from 2015 to 2024 in 2014, recognizing the need for long-term support to accomplish reforms in the health workforce. UHC is increasingly represented in regional national health policies and initiatives. There is general agreement that regular progress tracking is necessary to keep the momentum going. The WHO South-East Asia Regional Committee determined last year to evaluate progress on UHC and SDG 3 every year until 2030. Every two years, progress on the Decade for Strengthening Human Resources for Health is assessed; the first review was in 2016, and a fresh report will be released later in 2018. All of this implies that there is governmental commitment to UHC, with some clear priorities. UHC monitoring tools have also been created and are currently being deployed.

A preliminary assessment of how well people in this region are getting the treatment they need was released in 2016 and will be updated annually using a new WHO-developed essential health services coverage index. A rising number of countries in the region are providing analyses of their financial protection levels. Overall, the questions today are less about “whether UHC is possible,” and more about how to make progress toward it, and – in the case of SDG goal 3. for UHC – how to do so more quickly. Experience has also shown that a country does not need to be wealthy to make development: development may be made from any point. Thailand has made strides toward UHC in this region during the previous three decades, beginning with the introduction of free medical treatment for the poor in 1975, when the GDP per capita was barely $390.

When the GDP per capita was still relatively low at US$ 1900 in 2002, only a few years after the Asian financial crisis of 1997, full population coverage was introduced. Given that all countries are dealing with changing health needs as a result of epidemiological and demographic shifts, some

argue that countries can't afford not to take a more holistic approach, because all health interventions use the same limited resources, and UHC provides a platform to do so more efficiently. It is widely stated that progress on UHC will be impossible without progress in noncommunicable disease care. What is becoming increasingly evident is that today's health systems must make significant changes in the way health services are staffed, structured, and paid for. With the increasing number of people over 65, who are more likely to have chronic and often several health disorders at the same time, this is becoming more pressing. Originally created for acute and time-limited health issues, service delivery paradigms are no longer adequate.

The region's health-care system is already changing. Many cost-effective health interventions can be administered safely at this level of care, and they are generally closer to vulnerable populations, therefore there is a rising focus on front-line services. In several nations in this region, the private sector accounts for up to 70% of all consultations. New approaches to harnessing the potential of this enormous, diversified, and rapidly increasing sector in ways that promote public health and improve UHC are required. The history of poor utilization and frequent bypassing of public front-line health services has a number of issues, including how to revive these services so that they are more trusted, used by more people, and responsive to changing health needs and expectations. According to regional data, health workers have been trained in greater numbers in recent years. When compared to the WHO SDG index criteria of 4.45 physicians, nurses, and midwives per 1000 population, health personnel are still in insufficient supply in many of the region's Member States. Inefficient skill-mix imbalances still exist; for example, numerous countries report having more doctors than nurses. In many nations, doctors and nurses are still concentrated in metropolitan areas, and practically all health workers are asked to perform activities other than those for which they were trained. Within the region, there is still a scarcity of data and evidence on the efficacy of human resources for health policies. The good news is that in 2016, a global set of metrics on human resources for health was agreed upon, as well as instruments to improve data. A subset of these indicators will be used in the second WHO South-East Asia review of progress on the Decade for Strengthening Human Resources for Health, which will be published later this year. Of fact, a substantial and well-performing health personnel is insufficient to ensure that everyone receives the treatment they require. They require the instruments of their trade, which include guidelines, diagnoses, medications, information, and clean, safe work environments. National health workforce policies must be aligned with evolving service delivery models and backed up by sound financial policies.

Bhutan, Indonesia, Maldives, Myanmar, and Thailand are the only five countries to have done so since the year 2000. Despite the fact that certain countries, such as Myanmar, had a poor start, they have made great progress. There are also ways to make better use of existing resources. The World Health Report 2010 listed ten primary reasons of inefficiency, three of which were related to the management of drugs. 16 This emphasizes the region's focus on medicine. A future edition of the WHO South-East Asia Journal of Public Health will focus on access to pharmaceuticals.

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AIMS & OBJECTIVE

• To determine the equity effect of the Southeast Asian countries' package of UHC reforms to promote universal coverage.

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CHAPTER – 5

METHODOLOGY

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RESULTS

The advancement of UHC in ASEAN countries

The ASEAN countries have made significant progress toward UHC in general. Many ASEAN countries have increased their availability of healthcare services, both preventive and curative. Most preventive care services are offered separately through vertical national programs in some countries, including Cambodia, Lao PDR, and Vietnam. Social health insurance (SHI) has been proposed as a means of obtaining UHC coverage in ASEAN countries. Despite the gaps in insurance coverage that persist throughout these countries, significant progress has been achieved in expanding health insurance coverage (Fig. 1). SHI now covers the whole population of Thailand, as of 2012.

In Malaysia, the entire population can access public health services, which are funded by general taxes and moderate user fees, whereas in Singapore, MediShield, the mandatory government-run health insurance plan, covers 93 percent of the population. In Indonesia, over 60% of the population has health insurance. On January 1, 2014, the Indonesian government launched the Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan, with the goal of achieving national coverage of UHC by January 2019. The Social Security Administration (BPJS), a national agency under the auspices of the President of the Republic of Indonesia, is in charge of coordinating this project. However, in Lao PDR (15%) and Cambodia, health insurance coverage is still insufficient (24 percent). The government of the Lao People's Democratic Republic is proposing establishing a national health insurance body by combining the four social health protection programmes. Universal coverage is expected by 2020 as a result of a unified institutional setup. Cambodia has made significant success in utilizing health equity monies to help the poor. However, governmental servants and private-sector employees are not protected by insurance, and the user fee exemption plan excludes certain vulnerable populations such as the elderly and disabled.

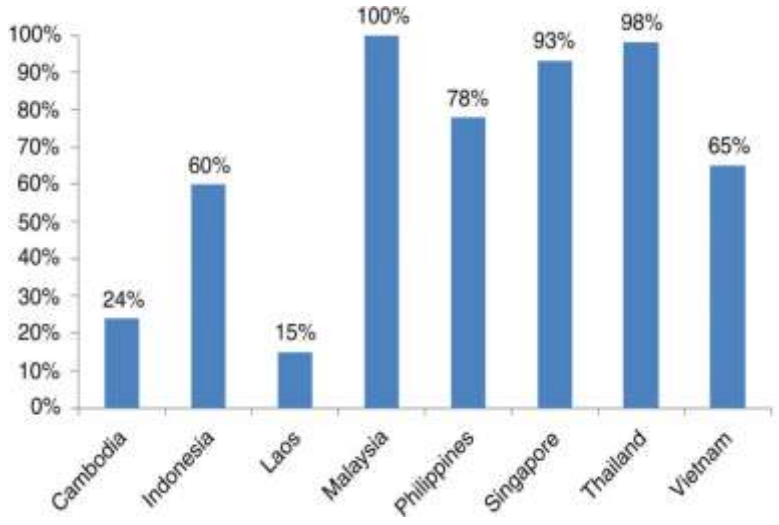

Fig. 1. Coverage of health insurance in ASEAN countries 2012

The percentage of people in ASEAN countries who have access to certain vital health services. The majority of health MDG interventions (such as vaccination, prenatal care, and births attended by qualified medical workers) were available in ASEAN countries. With the exception of Indonesia, Lao PDR, Myanmar, and the Philippines, the region's coverage of diphtheria, tetanus, toxoid, and pertussis (DTP3) immunization among 1-year-old children was over 90%. With the exception of Lao PDR, Malaysia, and Myanmar, the region's antenatal care coverage for expecting mothers was also fairly high (above 90%). In some nations, the percent of newborns attended by trained medical workers was quite low.

Political commitments of ASEAN countries to UHC

At first glance, the ASEAN countries' political commitments to support UHC appear to be substantial. Many policies and strategies have been devised and implemented in these countries, some to a greater extent than others, to help them get closer to UHC. For example, Thailand's governmental commitment to universal healthcare has been stressed since 2002 in the National Health Security Act, which declares that "the Thai population should be entitled to a health service of such quality and efficiency." The Presidential Bill No. 40/2004 on National Social Security System was enacted in Indonesia in 2004 to safeguard Indonesian residents from catastrophic household expenditures due to illness and death. A Master Plan for SHI was developed in Cambodia in 2005, marking an important first step toward the establishment of a unified health protection system. In 2012, the Prime Minister of Vietnam adopted the Master Plan on Universal Health Care, which included a timeline for reaching 70 percent UHI coverage by 2015 and 80 percent by 2020, as well as a reduction in out-of-pocket payments to 40 percent by 2020. Myanmar's government approved the objective of obtaining universal health coverage by 2030 in 2012, with the goal of improving the health of the poor and vulnerable, particularly women and children. In the Philippines, the president signed Republic Act 10606 in 2013, amending the National Health Insurance Act of 1995 to require the government to cover the premiums for indigent and informal sector insurance, so helping many Filipinos. Singapore recently announced the extension of MediShield, a health insurance program that aims to prevent catastrophic out-of-pocket expenses and already covers 93 percent of the population. MediShield Life would be the new name for the extended program. It will be mandatory, with 100 percent population coverage and the declared goal of lowering co-insurance prices from 10-20% to 3-10%. In Malaysia, arguments are presently concentrated on whether the government should shift to a SHI model, 1Care, which would allow insured people to utilize private institutions.

	Total expenditure on health as % of GDP, 2012	General government expenditure on health as % of total expenditure on health, 2012	General government expenditure on health as % of total government expenditure, 2012	Social security expenditure on health as % of general government expenditure on health, 2012	OPP as % total expenditure on health, 2012	Incidence of catastrophic medical expenditures (>10% of household spending), 2011
Brunei	2.3	91.8	6.0	No data	8.1	No data
Cambodia	5.4	24.7	6.7	No data	61.7	17.0
Indonesia	3.0	39.6	6.9	17.6	45.3	5.0
Lao PDR	2.9	51.2	6.1	4.9	38.2	9.0
Malaysia	4.0	55.0	5.8	0.9	35.6	2.0
Myanmar	1.8	23.9	1.5	3.0	71.3	No data
Philippines	4.6	37.7	10.3	28.3	52.0	5.0
Singapore	4.7	37.6	11.4	12.7	58.6	No data
Thailand	3.9	76.4	14.2	10.1	13.1	3.5
Vietnam	6.6	42.6	9.5	37.0	48.8	15.1

World Health Statistics 2014.

Table: 2 Financial coverage of UHC in ASEAN countries

Major barriers to achieving UHC in ASEAN countries

Financial constraints, supply side constraints, and the ongoing epidemiological transition at various stages, characterized by increasing burdens of NCDs, persisting infectious diseases, and re-emerging potentially pandemic infectious diseases, are all common barriers to achieving UHC in ASEAN countries.

Low levels of government expenditures and overall health costs are the main financial restraints. With the exception of Cambodia (5.4 percent) and Vietnam (5.4 percent), most ASEAN countries spent less than 5% of their GDP on health in 2012. (6.6 percent). The government's health spending as a percentage of overall health spending varied from 23.9 percent in Myanmar to 91.8.1 percent in Brunei. According to the World Health Organization, achieving UHC is extremely difficult if OOP is equal to or greater than 30% of total health expenditures, and the aim for UHC might be set at 100% protection for the population as a whole from both impoverishing and catastrophic health costs. The proportion of total government spending spent on health varies, from 1.5 percent in Myanmar to 14.2 percent in Thailand. With the exception of Brunei and Thailand, private spending on health is higher than public expenditures. With the exception of Malaysia, the Philippines, Indonesia, and, to a lesser extent, Cambodia, government health expenditures appears to be increasing gradually over time

A household with catastrophic health spending is defined by the WHO as one with total OOP health payments equal to or surpassing 40% of a household's capacity to pay. When a non-poor household becomes poor below the poverty line after paying for health services, it is impoverished by health payments. In 2010, 3.9 percent of households in Vietnam had catastrophic expenditure, and 2.5 percent of households were pushed into poverty as a result of OOPs. In 2007, Cambodians spent 4.3 percent of their income on catastrophic health care and 2.5 percent of their income on poverty. In 2008, catastrophic health spending and poverty rates in Lao PDR were 1.7 and 1.1 percent, respectively. In the Philippines, catastrophic health expenditure and poverty rates were 1.2 and 1.0 percent, respectively, in 2009.

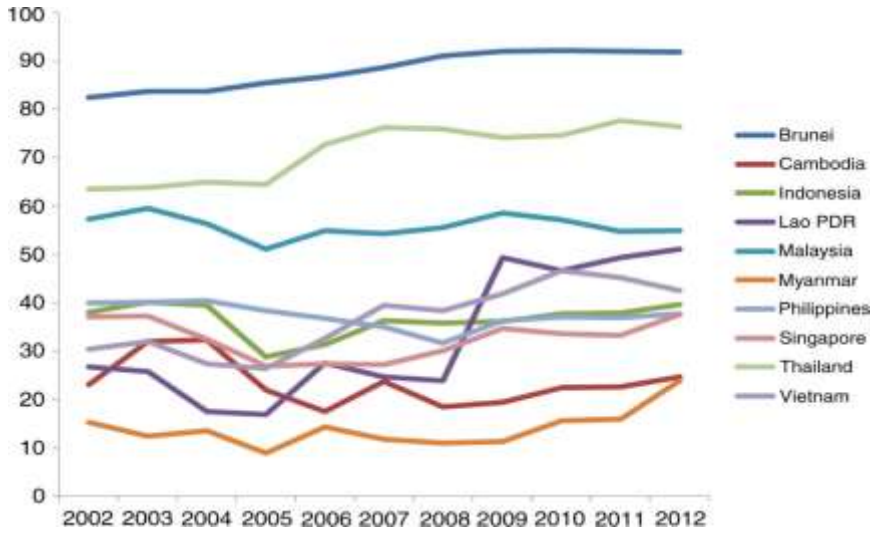

Fig.2. Trends in general government expenditure on health as % of total expenditure on health, 2002-2012

In the ASEAN countries, insufficient healthcare providers and unequal distribution of health professionals have remained major issues due to supply side constraints .The number of doctors per 10,000 people varied from two in Cambodia, Indonesia, and Lao PDR to 14 and 19 in Brunei and Singapore, respectively. Except in Vietnam, where there were 12 doctors and only 10 nurses/midwives per 10,000 people, all ASEAN countries had more nurses and midwives than doctors. Except in Singapore and the Philippines, there were only about four pharmacists per 10,000 people in the ASEAN countries. According to recent study, all Southeast Asian countries experience challenges with health professional maldistribution, with rural and isolated areas frequently understaffed. In most nations, there is a lack of coordination between health worker output and employment capacity.

ASEAN Countries	Doctors per 1,000 population, latest year	Nurses and midwives per 1,000 population, latest year	Pharmacists per 1,000 population, latest year
Brunei	1.4	7.0	0.1
Cambodia	0.2	0.8	0.04
Indonesia	0.2	1.4	0.1
Lao PDR	0.2	0.8	No data
Malaysia	1.2	3.3	0.4
Myanmar	0.5	0.9	No data
Philippines	1.2	6.0	0.9
Singapore	1.9	6.4	0.4
Thailand	0.3	1.5	0.1
Vietnam	1.2	1.0	0.3

Table 3: Health workforce in ASEAN countries

Essential health care coverage for UHC is influenced by supply side restrictions, with immunization rates serving as a critical indication. In the previous decade, DTP3 immunization coverage among 1-year-olds has increased dramatically in Lao PDR and consistently in Indonesia

and Cambodia, as shown in Fig.3. Although rates in Cambodia, Myanmar, and Brunei have fluctuated and fallen in recent years, with a sharp drop in DTP3 vaccines seen in Vietnam last year (from 97 percent in 2012 to 59 percent in 2013). During this time, Thailand has continuously had the highest immunization rates of 98 percent or higher, followed by Singapore and Malaysia (95 percent or higher), the three countries with the highest health insurance rates.

ASEAN is a hotspot for new infectious illnesses, especially those with pandemic potential, when it comes to epidemiological transition. Infectious diseases have taken a tremendous toll on public health and the economy. The tourism sector in the region was quickly ravaged by severe acute respiratory syndrome (SARS). The poultry business has been devastated by influenza A (H5N1). Southeast Asia is vulnerable to developing infectious illnesses for a variety of reasons. The region is home to dynamic systems that integrate biological, social, ecological, and technological activities in ways that allow bacteria to exploit new ecological niches. Simultaneously, the ASEAN countries are undergoing an epidemiological change, with increased morbidity and death due to NCDs. NCDs currently account for 60% of all deaths in the region. The problem is caused by population aging, lifestyle choices (tobacco, alcohol, poor food, and lack of physical activity), and environmental factors. The triple burden of diseases — persistent and new infectious diseases, noncommunicable diseases, and injuries – poses a serious threat to the people of this region. However, in ASEAN, a considerable amount of NCD mortality occurs early - in 2012, NCDs were responsible for 50.9 percent of fatalities among those aged 70 or younger, compared to 31.2 percent in the WHO Europe area. At the 65th World Health Assembly in 2012, the WHO agreed to set a global goal of a 25% reduction in premature mortality from NCDs by 2025, which we hope would be aggressively pursued in ASEAN.

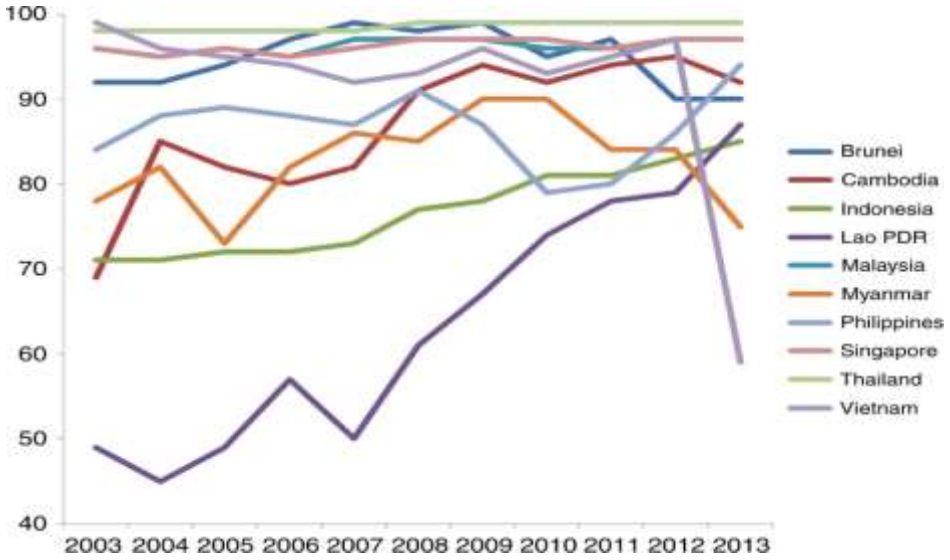

Fig.3. Trends in Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%), 2003-2013

ASEAN is also undergoing a demographic shift, with a higher proportion of the elderly as a percentage of the total population. In 2015, the percentage of people aged 65 and up in ASEAN countries was predicted to be 7.1 percent, with Singapore (13.7 percent) and Thailand (7.1 percent) having the greatest proportions of the elderly (12.0 percent). By 2030, the proportion of aged people in the population is predicted to nearly double, reaching a regional average of 12.3%.

Population aging has consequences for financing UHC and how benefits packages will evolve in the next 20 years, given that healthcare consumption grows with age.

Each ASEAN country's primary obstacles and impediments to UHC can also be contextualized. The single most significant impediment to achieving UHC in Cambodia is the lack of a responsive health finance framework for both the formal and informal sectors. Because of low government salary and health-care expenses, there is no financial program for public employees. Furthermore, because to the lack of a SHI funded by payroll taxes, the concept of health insurance is very new. In Cambodia, OOP for health was predicted to be 61.7 percent in 2012. In Indonesia, insufficient infrastructure (human resources, facilities, and equipment) has hindered progress toward universal coverage for the population, which policymakers aim to achieve by 2019. Indonesia has one of Asia's lowest physician-to-population ratios (only two for every 10,000 population in 2010, compared to an average of 5.5 per 10,000 population for countries in the WHO South East Asian region). Furthermore, the hospital bed-to-population ratio is extremely low (six beds per 10,000 people, compared to an average of 11 beds per 10,000 people in the WHO South East Asian area). Despite efforts to raise it, public health spending in Lao PDR is still too low, and it is currently insufficient to meet the population's health needs. Geographically dispersed social security programs and restricted population coverage are both important impediments to getting care, resulting in large OOP expenditures and poverty; a government subsidy could help to alleviate the high burden of OOP payments. In Lao PDR, health services are underutilized due to the country's isolated mountainous terrain and poverty.

In Myanmar, insufficient and uneven health investments, a shortage of health workers, and catastrophic health costs are among the key obstacles to achieving universal health coverage. Despite the fact that the government's total health spending has more than quadrupled in recent years, it was only 2% of GDP in 2011. OOP payments, which fell from 100% in 2000 to 71.3 percent in 2011, still contribute for nearly all healthcare costs. The greatest impediment to establishing UHC in the Philippines is the expansion of PhilHealth's insurance coverage without corresponding budgetary increases. In addition to underfunding, the Local Government Code of 1991 resulted in inefficient referral services due to the devolution of health services. Richer Local Government Units are more likely to sustain and maintain their buildings and services, exacerbating regional health disparities.

In Vietnam, over two-thirds of the population is insured. However, among workers in the informal sector, health insurance coverage is still extremely low. Vietnam need a more efficient enforcement mechanism for the official sector, as well as effective measures and encouragement for the informal sector to join the plan. Although provider payment methods for healthcare expenditures of national health insurance have altered in recent years, fee-for-service payments continue to dominate the system. OOP payments have traditionally represented a large percentage of total health expenditure in Vietnam, ranging from 50% to 70

High and upper-middle income nations confront similar challenges in achieving universal health coverage. The availability of service delivery, notably health workers, in Thailand limits access to healthcare. Despite having broad networks of healthcare providers, issues remain in terms of healthcare supply in remote rural areas where trained health personnel are difficult to attract and retain. Due to a prolonged period of restricted training capacity, the country has a low doctor-to-population ratio — lower than comparable countries with similar levels of economic development. The largest roadblocks in Singapore are not financial or technical, but ideological. The government is unprepared to embrace UHC in the spirit of other industrialized countries due to concern of

moral hazard leading to overconsumption and overservicing, as well as eventual financial insolvency. Furthermore, there is a genuine sense that money and financial success must transfer into improved quality of life, especially healthcare — a typical motto promoted by government officials is "Work for reward, Reward for work." In Malaysia, a split healthcare system has formed, with private services for the wealthy and public services for the others, with the private sector's quality seen to be superior than the public sector's. As a result, patients who use public services are sicker and poorer. To meet rising demand, ensuring that public sector service quality improves and service capacity develops (particularly in metropolitan areas) will be a barrier to achieving UHC.

CHAPTER- 7

DISCUSSION

UHC and ASEAN integration.

By 2015, the AEC has been established as the goal of regional economic unification. Healthcare has been highlighted by ASEAN leaders as a high-priority industry for regional integration. The ASEAN Trade Ministers adopted a roadmap in November 2004 to enhance trade in healthcare commodities such pharmaceuticals and medical equipment. Furthermore, two service sub-sectors in the healthcare industry have been targeted for progressive liberalization: 1) health services, which includes hospital services (including psychiatric hospitals) as well as medical laboratories, ambulances, and non-hospital residential healthcare; and 2) medical laboratories, ambulances, and non-hospital residential healthcare and medical experts, such as doctors, dentists, midwives, nurses, physiotherapists, and paramedics, are all available to help. The liberalization of healthcare markets promises significant economic benefits, but it also exacerbates existing obstacles in promoting equitable healthcare access inside countries. In terms of UHC specifically, the April 2014 meeting of the ASEAN plus 3 (China, Japan, and South Korea) UHC network (convened by ASEAN Health Ministers) demonstrates that serious conversations concerning UHC and ASEAN integration have only recently begun. The AEC's aspirations for service sector integration pose the region's most difficult difficulties as well as its most promising potential. Some ASEAN countries, such as Singapore and Thailand, have already established themselves as major exporters of modern services in fields like professional services and information and communication technology (ICT), such as business processing outsourcing (BPO), higher education, and health tourism. The Medical Tourism Association (MTA), a non-profit organization located in the United States that aims to define global standards for the medical tourism business, is catalyzing the business in Asia. Services related to health In Singapore, Thailand, and Malaysia, tourism has grown to be a significant sector, integrating health services for wealthy visitors with recreational packages to increase healthcare consumption. Medical tourism, on the other hand, has taken on a variety of forms in different countries. The Malaysian Healthcare Travel Council, created in 2009 as a promotional arm and subsidiary of the ministry, is working to expand high-end private hospital treatment to cater to medical tourists. In 2010, some of the 35 hospitals that took part were government-owned corporations (e.g; National Heart Institute). As with Singapore's corporatized public system, doctors in public hospitals with private wards can keep a portion of the cost for treating private patients. In comparison to Thailand, where medical tourism is mostly delivered and driven by private hospitals, the MOH in Singapore does not make as much of an effort to recruit overseas patients. Other obstacles to the openness of healthcare markets exist in other countries. Multinational healthcare corporations, for example, have exhibited a lukewarm response to investing in Indonesia despite the wonderful chance to tap into the vast market of Indonesia's people. To facilitate knowledge transfer, multinational healthcare corporations must also create local manufacturing plants. The President of the Republic of Indonesia signed amendments to the negative investment list by Presidential Decree Number 39, which was enacted on April 23, 2014. In order to prepare for the AEC, this amendment aimed to increase foreign investment in Indonesia. In order to prepare for the AEC, this amendment aimed to boost foreign investment in Indonesia. The highest degree of capital ownership of international pharmaceutical businesses has climbed

from 75 to 85 percent, illustrating certain changes in the economic situation. Health fairness within and between countries is jeopardized by the progressive liberalization of health professional services. Physicians, nurses, and dentists are among seven professional categories permitted to work freely between member countries under the AEC's Mutual Recognition Arrangement (MRA). Although the financial benefits of this technique appear to be substantial, questions of equality within UHC have arisen as a result of the potential for health workers to flee poorer regions already struggling to provide UHC. There is a significant risk that the liberalization of trade policy in health will benefit exclusively the wealthy, either through regional outmigration of health professionals or intra-country mobility of health professionals to private institutions, which tend to be located in urban regions.

Another problem for UHC policies offered by regional integration is the increased number of migrant workers whose mobility will be unrestricted as a result of liberalization. Migrant workers are unlikely to be automatically enrolled in national health insurance plans, and as a result, they may lack proper access to and benefits from health care. Each country, and possibly ASEAN as a whole, must have a clear policy that provides adequate healthcare coverage and benefit packages for migrant workers.

How can ASEAN countries fully implement UHC?

Adopting UHC is essentially a political issue, not a technical one, according to research and nation experiences, with incremental progress made over long periods of time. Effective leaders, social movements, strong moral arguments about appropriate levels of coverage, as well as economic cycles and policy changes in other sectors, can all play a role in achieving UHC. Even in low- and middle-income nations, UHC can be achieved through strengthening the health system, obtaining long-term and fair funding, choosing the correct benefit package, and structuring domestic health expenditures to be spent more efficiently (2, 49-51).

As evidenced by policy reforms in Indonesia and Singapore, there must be an express governmental commitment to expanding healthcare coverage while also assuring affordability for healthcare users. Select health services could be organized regionally to increase efficiency even further. In order for ASEAN countries to achieve regional economic integration by 2015, UHC should preferably be addressed. In the next years, regional cooperation in health system operations in support of UHC will need to be bolstered, particularly given growing population movement between nations. Simultaneously, regional collaboration on critical global health challenges such as growing universal health coverage in ASEAN infectious disease outbreaks, disaster preparedness, NCDs and migration, capacity building, and the development of the health workforce in the area is required. These countries should share and duplicate lessons and experiences in the prevention and control of NDC.

In the face of ASEAN liberalization and the broader rise of private health providers and transnational healthcare firms, it is more critical than ever that UHC is given express priority to ensure access to health services, especially for disadvantaged people. We regret that, because to a data limitation, we were unable to present a comprehensive picture of UHC in each nation and across ASEAN. We also didn't have enough longitudinal data to talk about time patterns beyond a few UHC and related metrics.

CHAPTER – 8

CONCLUSION

ASEAN countries face enormous hurdles in achieving universal health coverage. In most ASEAN countries, out-of-pocket costs are frighteningly high, and countries have been unable to secure enough human resources for health (HRH) and health facilities, as well as their distribution to more disadvantaged province and district areas. The region's health services must be flexible and adaptable in light of the triple illness load and increased inter- and intra-country migration. Given the magnitude of some of these problems, and despite apparent political commitments to UHC in most countries, real implementation and action have been slow or delayed (e.g. integrating SHI schemes and stepwise recruitment to a unified UHC scheme in Indonesia).

In the medium term, we believe that capacity building and technical exchange of expertise on UHC, HSS, and health services is both achievable and desirable. HRH mobility can be exploited in two ways in the medium term. First, HRH's medical missions to low-income nations may be broadened to help those nations' health systems grow by providing technical skills, such as training on medical equipment, new technology, or health-care delivery methods. HRH who travel to higher-income nations (for short-term training or migration) may be able to offer their knowledge on how to deliver health services in less-resourced situations. In the near run, governments should develop a policy that provides free or low-cost emergency health care to short-term ASEAN travelers who have been injured or become ill in the destination country, as well as a baseline package of health services for labor migrants. Country MOHs might agree on an Essential Health Package (EHP) of public health initiatives and health services that each individual should get in their own country, if they have not already done so, as suggested by the WHO. Such EHPs can aid in promoting national debate on health priorities and improving accountability by tracking progress toward EHP objectives. Similarly, in ASEAN-wide standards/agreements, MOHs and relevant ministries should consider specifying basic safety standards for services and products, such as food and medications (e.g. permissible additives/ingredients). Disease surveillance by each nation, as well as timely information sharing during outbreaks, will aid ASEAN's health. In the long run, we believe that social protection might be incorporated into a variety of ASEAN-wide packages, such as health insurance and senior care, so ensuring regional health coverage. Disease outbreaks and surveillance could be aided by a regional health fund to which ASEAN countries contribute based on their national economic levels. However, we believe that ASEAN has the potential to formalize some of these actions within an ASEAN-wide framework. These could be designed as multilateral ASEAN-wide MRAs first, before considering whether to implement legal frameworks, such as a basic package of emergency health services that countries are required to provide for short-term ASEAN travelers. We also acknowledge that each country's implementation capacity, as well as its ability to enforce policies, varies significantly (e.g. food safety standards). However, we believe that ASEAN has enormous potential to become a driver for greater health in the region given political will and increased investment in public health systems. Finally, we expect that all ASEAN people would benefit from enhanced health and safety standards, as well as comprehensive social protection.

CHAPTER- 9

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