Background Paper 3B

Health Services Improvement in the Greater Mekong Subregion

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November 2020

This chapter should be cited as

Nguyen, D.C. and Vu, T.T.H. (2020), 'Health Services Improvement in the Greater Mekong Subregion', in Kimura, Fukunari (ed.), *Subregional Development Strategy in ASEAN after COVID-19: Inclusiveness and Sustainability in the Mekong Subregion (Mekong 2030).* Jakarta: ERIA, pp.BP93–BP116.

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1. Introduction

The health service system refers to healthcare professionals or organisations that provide healthcare activities to the population. It plays an important role in ensuring the well-being of the people and contributing to the growth and development of an economy. Health service system reforms are needed to accelerate the development of a country (Berman and Bitran, 2011).

The Greater Mekong Subregion (GMS) covers a geographical area consisting of Cambodia, the Lao People's Democratic Republic (Lao PDR), Myanmar, Thailand, Viet Nam, and China (Yunnan Province and Guangxi Zhuang Autonomous Region). It is home to about 300 million people. Regional cooperation and integration have facilitated population movement within the region either legally or illegally, and created a unique set of public health challenges. The collective challenges threaten the GMS countries' Sustainable Development Goals (SDGs), particularly universal health coverage (UHC).

According to the World Health Organization (WHO), 'UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care' (WHO, 2020). To measure UHC progress, the World Bank and WHO have developed a framework consisting of 16 essential health services in four categories: (i) reproductive, maternal, newborn, and child health; (ii) infectious diseases; (iii) non-communicable diseases; and (iv) service capacity and access.

This chapter aims to provide a comprehensive analysis of the status of health services in the GMS, propose regional targets, and provide recommendations to improve health services in the region. It is organised as follows. The next section presents the status of health services in the GMS. The following sections describe the challenges and opportunities for the improvement of health services in the GMS, and cooperation mechanisms and targets for the future of health services in the GMS. The final section concludes the paper.

2. Status of Health Services in the GMS

2.1. Health Service Systems in the GMS

The health systems in GMS countries differ in terms of structure, operational history, coverage, and quality. The Thai healthcare system is considered the most advanced in the region and consists of government health services, non-profit health organisations, and the private medical sector. In total, Thailand has 17,013 healthcare facilities,[29] of which about 70% are public (Oxford Business Group, 2016). The ratio of doctors, nurses, and midwives per 1,000 population in Thailand was 3.1, lower than the WHO recommendation of 4.45 health professionals/1,000 population – indicating human resources shortages in health services (Pagaiya et al., 2019).

In Viet Nam, a system of mixed public–private health services is evolving. The country's healthcare delivery system is organised into central, provincial, district, and commune levels. The central health services providers are managed directly by the Ministry of Health (MOH), and village health workers are at the bottom of the system, working in commune healthcare stations (Le at al., 2010). Since 2008, with the adoption of Resolution No. 18/2008/NQ-QH12 by the National Assembly, Viet Nam has stepped up the socialisation of health services, including services provided by public health facilities. In 2018, the number of hospitals in Viet Nam reached 1,063 (of which 12% are private). There is an average of 8.6 doctors and 28 hospital beds per 10,000 people (General Statistics Office of Viet Nam, 2018). Compared with the global average of 15 healthcare workers and 30 beds per 10,000 population, this is much lower (Pham, 2016).

Health services in the Lao PDR are mainly provided by the public system, which is organised into three administrative levels (central, provincial, and district) (USAID, 2019). The MOH manages the system at the central level and oversees the professional operation at other levels of the health service system. The fourth level of the health service system in the Lao PDR consists of health centres, village health volunteers, community health committees, and traditional birth attendants. In 2016, 1,233 health service facilities were operating in the Lao PDR, including 43 central hospitals, 17 provincial hospitals, 137 district hospitals, and 1,026 health centres (Masaki et al., 2017). Meanwhile, the private health sector consists of 1,050 clinics, 29 hospitals, and three specialisation hospitals under construction (ASEAN–Japan Centre, 2019).

In Cambodia, basic health service delivery was restored in the 1990s through health reforms, with a network of public health facilities and a growing private sector. The private sector and informal providers account for 61% and 26%, respectively, of all health service provision in Cambodia (WHO, 2015).

Myanmar's healthcare system reflects the country's seven decades of conflict. It includes the system managed by the Ministry of Health and Sports and another system operated by a collective of community-based organisations and the health departments of ethnic armed organisations (Latt et al., 2016). This differentiates Myanmar's healthcare system

[29] As of October 2015.

from others in the GMS in terms of service delivery, human resources, and political affiliations (IPSOS, 2013).

2.2. Basic Healthcare Services in GMS Countries

Basic healthcare service coverage is generally quite high in GMS countries (Table 1), especially in protecting reproductive, maternal, and infant health. Table 1 also shows that the indicators on universal immunisation and reproductive health are high in many GMS countries (except the Lao PDR).

Table 1: Basic Healthcare Services in the GMS

Indicators	Viet Nam	Lao PDR	Cambodia	Thailand	Myanmar	China
Percentage of births delivered by skilled medical workers (%)	93.8% (2014)	40.1% (2012)	89% (2014)	99.1% (2016)	60% (2016)	99.9% (2015)
Percentage of women with antenatal care insurance – at least four visits (%)	73.7% (2014)	62.2% (2017)	75.6% (2014)	90.8% (2016)	58.6% (2016)	
Percentage of family planning demand by modern methods (% of married women in need of family planning)	70% (2014)	61% (2012)	56% (2014)	89% (2016)	75% (2016)	97% (2001)
Percentage of children who received the DPT vaccine in 2018 (% of children aged 12–23 months)	75%	68%	92%	97%	91%	99%
Percentage of children who received hepatitis B vaccine (HepB3) in 2018 (% of children 1 year old)	75%	68%	92%	97%	91%	99%
Percentage of children who received measles vaccine in 2018 (% children aged 12–23 months old)	97%	69%	84%	96%	93%	99%
Rate of HIV drug treatment (% of people infected with HIV) in 2018	65%	54%	81%	75%	70%	
Rate of effective tuberculosis treatment (% of people who received treatment) in 2016	75%	37%	58%	47%	63%	82%

DPT = diphtheria, pertussis, tetanus; GMS = Greater Mekong Subregion; Lao PDR = Lao People's Democratic Republic.
Sources: World Bank (n.d.) DataBank. (https://data.worldbank.org/indicator?tab=all; and WHO (n.d.), Data Collections. https://www.who.int/data/collections (accessed 15 May 2020).

For example, the percentage of children who have received vaccines for measles is 84%–99% in most GMS countries, but only 69% in the Lao PDR. In Viet Nam, more than 1.70 million children were registered in the national immunisation management information system at 11,183 (or 99%) of medical stations across the country – storing personal vaccination information and facilitating the management of vaccinations at the local level (VNA, 2019). In terms of reproductive health, the percentage of women with antenatal care insurance is highest in Thailand (90.8%), followed by Cambodia (75.60%), Viet Nam (73.70%), the Lao PDR (62.20%), and Myanmar (58.60%). The ratio for Thailand is equivalent to or higher than the average in the Asia-Pacific region (except developed countries).[30] However, access to effective tuberculosis treatment services are quite low in the Lao PDR and Myanmar, at only 37% and 47%. Apart from the Lao PDR and some component indicators in Cambodia and Myanmar (Table 1), the access to basic healthcare services of residents in GMS countries is generally higher than that of other countries in the Association of Southeast Asian Nations (ASEAN). This improved considerably during 2015–2017 in universal immunisation, reproductive health, and infant health. Table 2 shows that the scores regarding access to healthcare services of residents in GMS countries are higher than the ASEAN average, except Singapore. According to the WHO evaluation, in terms of reproductive, maternal, and infant health in 2017, Thailand's scores of 90 were better than those of the other GMS countries and are higher than those of some developed countries such as Japan, the Republic of Korea, and the United States.

[30] In the Asia-Pacific region (except developed countries), the rate of children being delivered by skilled health workers/midwives in 2015 reached 95%. The vaccination rates for diphtheria, pertussis, tetanus (DPT), hepatitis B, and measles in 2018 were 91%, 91%, and 92%, respectively.

Table 2: WHO Country Score of Basic Healthcare Services Coverage

Country or region	Reproductive, maternal, and infant health		Infectious diseases		Non-infectious diseases	
	2017	**2015**	**2017**	**2015**	**2017**	**2015**
Viet Nam	82	82	73	66	64	63
Thailand	90	90	74	62	69	68
Cambodia	73	73	66	61	68	67
Myanmar	71	69	62	57	65	64
Lao PDR	59	61	54	43	61	59
China	86	86	69	61	65	64
Philippines	69	65	53	45	64	63
Malaysia	76	76	68	60	62	62
Brunei Darussalam	92	92	77	75	71	71
Indonesia	79	79	36	28	58	59
Timor Leste	65	63	49	44	46	44
ASEAN average score (except Singapore, calculated from average points of countries)	**76.5**	**76.0**	**61.9**	**54.7**	**63.0**	**62.2**
Singapore	**90**	**90**	**77**	**76**	**78**	**78**
Japan	**85**	**84**	**79**	**69**	**71**	**70**
Republic of Korea	**89**	**89**	**84**	**82**	**72**	**71**
United States	**90**	**90**	**81**	**79**	**68**	**68**

ASEAN = Association of Southeast Asian Nations, GMS = Greater Mekong Subregion, Lao PDR = Lao People's Democratic Republic, WHO = World Health Organization.
Source: WHO (n.d.), Data Collections. https://www.who.int/data/collections (accessed 15 May 2020).

2.3. Health Service Capacity and Accessibility in GMS Countries

WHO measures health service capacity and accessibility based on hospital access, health worker density, access to essential medicines, health security, and compliance with the International Health Regulations (IHR). Table 3 shows the differences in the medical infrastructure of the GMS countries. For instance, the number of beds per 1,000 people is quite high in Viet Nam (2.51) – far above Cambodia (0.80), Myanmar (0.97), and the Lao PDR (1.23) but less than Yunnan, China (4.08). Indicators on the number of doctors and midwives per 1,000 people show the same trend. The number of nurses per 1,000 people in Viet Nam is lower than that of Thailand and Yunnan and Guangxi Zhuang, China. This figure is equivalent to 1.15 in Viet Nam, above the Lao PDR at 1.07, but about half of Thailand's rate of 2.32. According to the World Bank, the number of nurses and midwives per 1,000 people in Viet Nam in 2016 was only 1.40, which is considerably lower than the Asia-Pacific average (except developed countries) of 2.70, and numbers in other ASEAN Member States such as Malaysia (3.50) and Indonesia (2.40) in 2018 (World Bank, 2020).

Table 3: Health Services Statistics of the GMS Countries

Indicators	Cambodia 2014	Guangxi Zhuang, China 2016	Yunnan, China 2016	Lao PDR 2016	Myanmar 2016	Thailand 2016	Viet Nam 2016
Doctors (1,000)	2.19	77.8	122.6	4.33	10.48	31.48	77.5
Number of doctors/1,000 people	0.14	1.39	2.57	0.64	0.2	0.46	0.84
Nurses (1,000)	9.1	122.6	106	7.25	21.6	159.79	106.7
Number of nurses/1,000 people	0.6	2.2	2.22	1.07	0.41	2.32	1.15
Pharmacists (1,000)	0.62	16.7	10.4	1.76	-	12.66	33
Number of pharmacists/ 1,000 people	0.04	0.3	0.22	0.26	-	0.18	0.36
Midwives (1,000)	5.48	-	-	1.52	13.81	-	28.8
Number of midwives/1,000 people	0.36	-	-	0.22	0.26	-	0.31
Number of hospital beds (1,000)	12.41 (2015)	209.02	194.7	8.34	51.46	-	232.3
Number of beds/1,000 people	0.8 (2015)	3.75	4.08	1.23	0.97	1.72 (2015)	2.51

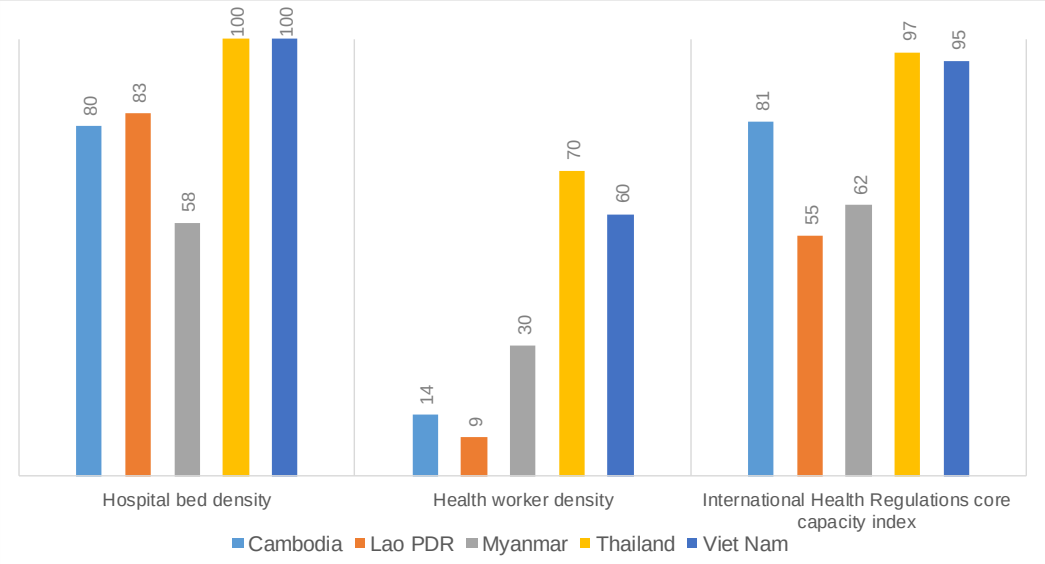
GMS = Greater Mekong Subregion, Lao PDR = Lao People's Democratic Republic.
Source: http://www.greatermekong.org/stats/index-static.php (accessed 15 May 2020).

In GMS countries, healthcare services are mainly supplied by public hospitals. The public medical systems supply services at a lower cost than private medical hospitals. The ratio of public hospitals is significantly higher in Viet Nam (81%) and Thailand (70%) than in the Lao PDR (32%) and Cambodia (20%). Therefore, the livelihood of people, especially the poor and informal workers, accessing affordable health services is higher in Viet Nam and Thailand. However, amongst GMS countries, the level of provision of public services in the hospital systems of Thailand and the Lao PDR is higher than in Viet Nam and Cambodia (Phanphairoj and Loa, 2017).

In terms of medical infrastructure in 2017, according to the WHO evaluation, Viet Nam's ability to receive and serve patients was lower (score of 83) than that of Thailand (score of 88). In relation to IHR, core capacity indicators are fully implemented, such as human resources, surveillance, laboratory, and response for limiting the spread of public health emergencies. According to this, Viet Nam and Thailand have significant points, at 95 points and 97 points, respectively.

The effectiveness of using the basic medical system in Viet Nam has many limits. It also generates pressure on hospital systems, especially central and provincial hospitals. About 31% of medical examinations at central hospitals can be resolved at provincial hospitals, while 41% of medical examinations at provincial hospitals can be resolved at district hospitals. In Viet Nam, a large number of district hospitals/medical centres have lacked investment and missing facilities, while about 40% of commune health stations do not meet national standards (Social Affairs Committee of the National Assembly, 2018).

Figure 1: WHO Evaluation of Infrastructure and Ability to Provide Healthcare Services in GMS Countries



GMS = Greater Mekong Subregion, Lao PDR = Lao People's Democratic Republic, WHO = World Health Organization.
Source: WHO (2019).

2.4. Finance for Medical Activities in GMS Countries

The different health care spending levels in Mekong countries in 2017 are shown in Table 4. Overall, the social expenditure on medical activities in GMS countries is high. Except in the Lao PDR and Thailand, the rate of healthcare expenditure/gross domestic product (GDP) in 2017 in GMS countries was higher than the Asia-Pacific average (except developed countries). The rate of Yunnan Province (China) was 8.04% (in 2015), about 1.6 times the Chinese average.

Table 4: Healthcare Expenditure in GMS Countries, 2017

Indicators	Viet Nam	Lao PDR	Cambodia	Thailand	Yunnan, China (2015)	Guangxi Zhuang, China	Myanmar	Asia-Pacific (except developed countries)
Social expenditure on health as percentage of GDP in 2017 (%)	5.53	2.53	5.92	3.75	8.04	5.15	4.66	**4.91**
Social expenditure on health per capita ($)	129.58	62.12	82.08	247.04	370.88	440.83	58.04	**313.64**
State budget spending on health (% of total budget expenditure)	9.48	4.04	6.08	15.03	-	9.07	3.49	**-**
State budget spending on health (% of GDP)	2.69	0.89	1.41	2.85	-	2.92	0.69	**2.74**
Budget spending on health per capita ($/person)	63	21.84	19.54	188.06	-	249.83	8.59	**177.95**
Private expenditure on health (% of total social spending on health)	49.38	48.2	61.13	20.91	-	43.33	76.23	42.99

GDP = gross domestic product, GMS = Greater Mekong Subregion, Lao PDR = Lao People's Democratic Republic.
Source: https://data.worldbank.org/ (accessed 15 May 2020).

Public finance is the main source of healthcare spending in most countries of the GMS. Viet Nam and Thailand spent a large share of their government budgets on health in 2017 (9.48% and 15.03% of total budget expenditure, respectively). As a percentage of GDP, Viet Nam's budget spending on health is higher than the Asia-Pacific average (except developed countries). The Lao PDR and Cambodia have received a large amount of sponsorship for the medical system from non-governmental organisations (NGOs) and foreign sponsors (Phanphairoj and Loa, 2017). The percentage of out-of-pocket payments on health is the highest in Cambodia and Myanmar, at 61.13% and 76.23% respectively.

There is a significant gap in the level of private expenditure on health amongst GMS countries. Thailand has the lowest rate, at about 20% of private spending on health, which is only half the regional average. This partly reflects the effectiveness of public expenditure on health in Thailand as well as the success of the global healthcare programme reaching 98% of residents (against 65% in Viet Nam, 24% in Cambodia, and 15% in the Lao PDR) (Phanphairoj and Loa, 2017). The level of private expenditure on healthcare services in the Lao PDR is lower than in Viet Nam thanks to NGOs and external development partners. In Cambodia, the MOH manages the healthcare system under a centralised model, which increases management costs and raises the burden of payments on the private healthcare system.[31]

[31] In Viet Nam, the Lao PDR, and Thailand, the health system is managed in a decentralized manner, helping to enhance the role of local governments in planning, financing, and providing health services. This makes it suitable for local conditions, contributing to reducing the management costs of the health system (Phanphairoj and Loa, 2017).

Table 5: Effectiveness of Medical Cost on Households in GMS Countries

Indicator	Viet Nam (2016)	Thailand (2017)	Lao PDR (2017)	Cambodia	Myanmar (2015)	China (2013)
Incidence of catastrophic expenditure (%)						
At 10% of household total consumption or income*	9.40%	2.20%	3%	15.3% (2014)	14.40%	19.70%
At 25% of household total consumption or income	1.90%	0.40%	0.30%	5.2% (2014)	2.80%	5.40%
Rate of poverty due to people's own health spending (% poverty line)						
$1.90/day (price comparison in 2011) (PPP)	0.25%	0%	0.40%	2.99% (2009)	0.63%	1.48%
$3.20/day (price comparison in 2011) (PPP)	1.16%	0.01%	0.99%	6.15% (2009)	2.92%	
60% daily expenditure/total household expenditure	2.36%	0.62%	0.44%	4.55% (2009)	2.27%	4.19%
Poverty gap increased due to people's self-expenditure on health (% poverty line)						
$1.90/day (price comparison in 2011) (PPP)	0.05%	0%	0.09%	1.48% (2009)	0.14%	0.38%
$3.20/day (price comparison in 2011) (PPP)	0.27%	0%	0.39%	2.76% (2009)	0.80%	
60% daily expenditure/total household expenditure	0.70%	0.18%	0.11%	1.96% (2009)	0.63%	1.63%

GMS = Greater Mekong Subregion, Lao PDR = Lao People's Democratic Republic, PPP = purchasing power parity.

* Within the Sustainable Development Goal monitoring framework, catastrophic health spending is defined as out-of-pocket health spending exceeding 10% or 25% of the household's total consumption or income (budget). These payments include the part not covered by a third party such as the government, health insurance fund, or private insurance but exclude insurance premiums as well as any reimbursement by a third party. They might be financed by income, including remittances, savings, or borrowings.

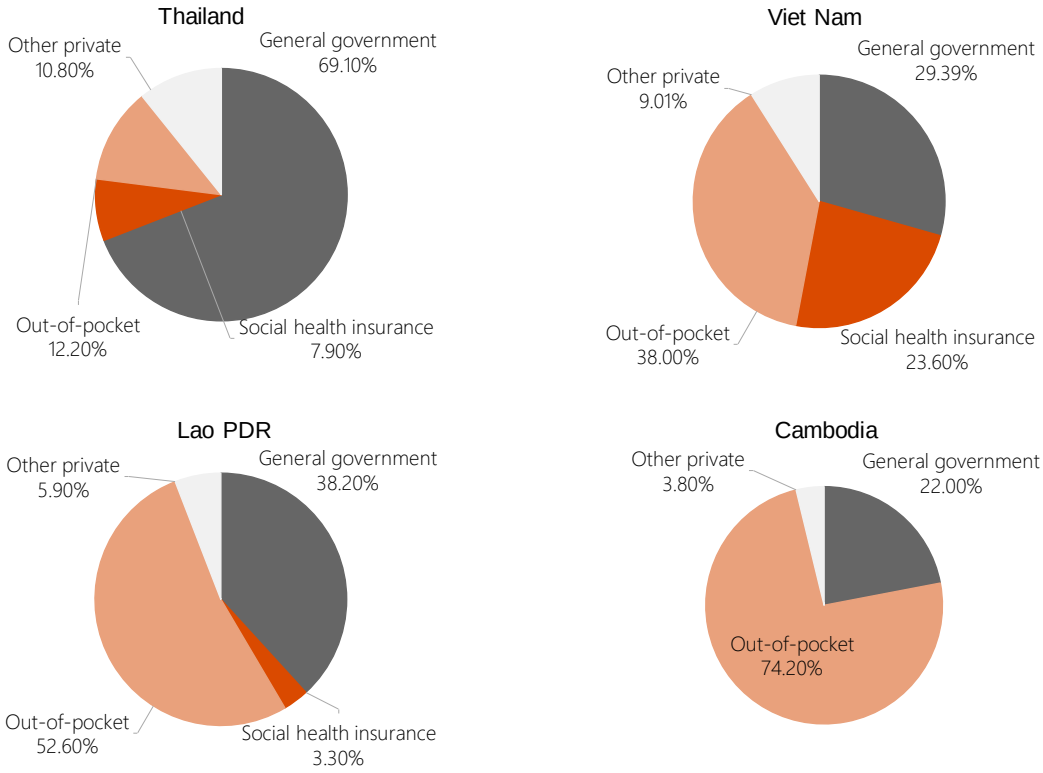
Source: WHO (2019).

Apart from Thailand, households in GMS countries spend a large share of their total household expenditure or income on healthcare. In Viet Nam, 9.4% of households spend at least 10% of their expenditure or income on healthcare services, rising to 15% or more in Cambodia, Myanmar, and China (about 20%).

To go into the details of the structure of medical expenses in GMS countries, there is a remarkable gap between medical insurance coverage and social security. Thailand has the best coverage, with widening of the poverty gap due to basic medical expenses under 0.5%. The rate of widening of the poverty gap due to medical expenses in Viet Nam is maintained at a low level, but the rates of impoverishment due to people's medical expenses (% poverty line) are quite high (the rate of poverty caused by using up to 60% of daily expenditure income on health ranks second amongst GMS countries). This reflects a constrained level of UHC and limited support from the government budget for medical

expenditure. Until May 2019, medical insurance had covered 89% of Vietnamese people (Ha, 2019). In the Lao PDR and Cambodia, medical insurance coverage was 15% and 24%, respectively, in 2014. There was some improvement in using health equity funds (HEFs)[32] to pay for the poor in Cambodia, but employees in the private sector are not totally insured, and vulnerable groups (e.g. the elderly and people with disabilities) are excluded from the free insurance programme (Van Minh et al., 2014).

Figure 2: Structure of Medical Expenses in GMS Countries



GMS = Greater Mekong Subregion, Lao PDR = Lao People's Democratic Republic.
Sources: WHO (2019).

Insurance is another important resource for healthcare expenditure. Thailand introduced the Universal Coverage Scheme (UCS) in 2002 and since then has improved healthcare access and utilisation. The UCS covers Thai citizens who are not protected by any other public scheme. It replaces all previous health insurance schemes (Glassman and Temin, 2016).[33] In 2017, about 48.80 million people or 72% of the population were registered under the UCS. Other insurance schemes in Thailand include the social security scheme (SSS) and the Civil Servant Medical Benefit Scheme (CSMBS). The SSS provides mandatory

[32] A government-funded subsidy whereby public health facilities provide services free of charge to poor patients, financed through a transfer from the national budget. The schemes are managed directly by operational districts and hospitals.

[33] These include the low-income card scheme for the poor; the medical welfare scheme; a medical welfare scheme for indigent people; and the voluntary health card for the disabled, the elderly, and children aged under 12 years.

coverage for private sector employees but not their dependents who are covered under the UCS. The SSS is mandatory for firms with more than one worker and for the self-employed. The CSMBS covers civil servants and their immediate family members, including spouses, parents, and up to three children under the age of 20 years. It also covers retirees and their dependents. The SSS covers 14 million of the population, while the CSMBS coverage is 5 million. Thai citizens also have access to private health insurance, which covers 6–9 million employees and employers. Private insurance companies provide this insurance (Witoolkollachit, 2018).

Viet Nam has four main types of social insurance: health insurance, compulsory social insurance, unemployment insurance, and voluntary social insurance. Since 2008, enrolment in health insurance has been mandatory under the Law on Health Insurance, 2008. As of 2019, Viet Nam has the highest proportion of people enrolled in health insurance, at 85.95 million, while the voluntary social insurance is the lowest, at only 570,000 people. The number of participants in compulsory social insurance and unemployment insurance is medium, at 15.77 million and 13.43 million, respectively (VNA, 2020).

Myanmar's social security scheme is run by the Social Security Board (SSB) under the Ministry of Labour, Immigration and Population. The scheme requires a contribution of 2% of workers' salaries and is open to regular workers in the formal sector. Although it has been active since 1956, the scheme only covers about 1,400,000 employees (around 2.5% of the population) out of 54.7 million citizens. Only certain groups of state-owned enterprise employees, civil servants, and employees of public and private firms with five or more employees can enrol in this programme (Van Rooijen et al., 2018). Formal private sector workers are covered by a contributory social security scheme. The SSB does not cover workers in the private and informal sectors.

The Lao PDR had six health protection schemes as of 2017: the National Social Security Fund; the National Social Security Fund; national health insurance (NHI); community-based health insurance (CBHI); HEFs; and the free maternal, newborn, and child healthcare programme. The CBHI covers only 2.2% of the population, while the NHI covers 1.7%. HEFs target the poor and cover only 5% of the population. The MOH aims to achieve UHC by 2025, but the current health insurance programmes only cover 20% of the population (Alkenbrack, Jacobs, and Lindelow, 2013).

In Cambodia, the National Social Security Fund provides basic insurance (employment injury and health) to workers in the formal sector to ensure their welfare and secure their livelihoods in case they encounter hardships. The employment injury insurance scheme had more than 1.6 million registered members in 12,513 registered businesses as of 2018, with 156 contracted hospital facilities. The health insurance scheme had nearly 1.6 million registered members in 9,200 registered businesses, with 1,349 contracted hospitals. The government, through the MOH, has established a HEF to subsidise the healthcare fees of

low-income people who hold an 'IDPoor' card.[34] The programme benefits about 3 million people or 92.70% of the poor population (MOH (Cambodia), 2017). Voluntary health insurance is provided in two forms: CBHI and private health insurance for consumers and informal sector workers. However, CBHI schemes provide only moderate financial protection and access to essential healthcare for those enrolled, through the support of a small number of NGOs. Since 55% of the population is either poor or vulnerable, the level of contributions in the scheme will not be stable (OECD, 2017). At the same time, only a small number of the non-poor informal sector has the capacity to pay into a contributory system. Thus, CBHI tends to fail in encouraging enrolment and it is not able to cover a large section of informal sector labour.

In terms of insurance policies for informal workers or the unemployed, a voluntary social security system for informal sector workers was set up in 2011 under the Social Security Act, 1990 (amended in 1994 and 1999). Thailand is the first country in the GMS to provide access to a universal insurance scheme. In 2012, 69.00% of informal workers who suffered an injury and required hospital treatment used UCS; 6.70% used private health insurance; 2.40% used insurance available to family members of government officers; 19.00% paid for themselves; 1.10% paid with the help of parents, relatives, and/or friends; and 0.80% were covered by employers. Therefore, it is obvious that informal sector workers have benefited from the UCS (Kongtip et al., 2015).

In Viet Nam, only 24.0% of the labour force in 2016 was covered by compulsory and voluntary social insurance schemes. 97.90% of informal workers worked without social insurance, and only 0.2% had compulsory social insurance (ILO, 2020b).

In Cambodia, most people are not fully or partly covered by insurance. The National Social Security Fund covers 1.2 million private sector workers. They are protected by injury insurance, maternity benefits, and, health insurance. However, they are mostly workers of large enterprises (ILO, 2020a).

Similarly, most people in the Lao PDR are not protected by social insurance. Less than 20% of the labour force, mostly in the formal sector, benefits from comprehensive social protection coverage. The government has been supporting NGOs to achieve comprehensive social protection within the next decade and to promote voluntary coverage for self-employed workers (ILO, 2020a).

In Myanmar, it is estimated that 51.50 million people or 97% of the population does not have access to adequate social protection, leaving them to rely on themselves and their communities to cope with life risks (ILO, 2020b).

2.5. Effectiveness of Health Services Provision in GMS Countries

The effectiveness of health services in GMS countries is illustrated through the outcomes of the longevity and health of people in these countries. In general, the health and

[34] The Identification of Poor Households Programme (IDPoor), established in 2006 within the Ministry of Planning, is part of the Government of Cambodia's ongoing efforts to reduce poverty and support socioeconomic development throughout the country (Ministry of Planning of Cambodia, 2020).

longevity of people in GMS countries (except Viet Nam) improved significantly during 2010–2018, with a greater change than the average of the Asia-Pacific region (except developed countries). The longevity and health of people is lower in the Lao PDR, Cambodia, and Myanmar than in Viet Nam, Thailand, and the Asia-Pacific average (except developed countries). However, the difference narrowed considerably in most of the indicators during 2010–2018, especially in the mortality rate of children under 5 years old/1,000 births (Table 6).

Table 6: Selected Life Expectancy and Health Indicators of GMS Countries

Item	Viet Nam	Lao PDR	Cambodia	Thailand	China	Myanmar	Asia-Pacific countries (except developed ones)
Mortality rate of children under 5 years old/1,000 births							
2010	23.10	68.10	44.30	13.30	15.80	63.30	23.10
2018	20.70	47.30	28.00	9.10	8.60	46.20	15.70
Change	−2.40	−20.80	−16.30	−4.20	−7.20	−17.10	−7.40
Stunting rate (% of children under 5 years old)*							
2010	22.70	44.20	39.80	16.40	9.40	-	-
2018	23.80	33.10	32.40	10.50	8.10	29.40	-
Change	1.10	−11.10	−7.40	−5.90	−1.30	-	-
Expected longevity (years)**							
2010	74.80	64.30	66.60	74.20	74.40	63.50	73.10
2018	75.30	67.60	69.60	76.90	76.70	66.90	75.00
Change	0.50	3.30	3.00	2.70	2.30	3.30	1.90
Rate of survival to 65 years for females (%)***							
2010	86.20	68.40	72.50	84.20	86.30	69.60	83.90
2018	86.80	73.80	77.60	87.60	89.00	74.70	86.40
Change	0.60	5.40	5.10	3.50	2.80	5.00	2.40
Rate of survival to 65 years for males (%)***							
2010	71.40	60.70	63.70	71.00	80.20	55.20	76.40
2018	72.00	66.20	67.90	74.40	83.30	61.60	78.90
Change	0.60	5.60	4.20	3.40	3.10	6.30	2.50

GMS = Greater Mekong Subregion, Lao PDR = Lao People's Democratic Republic.
* The stunting rates were taken as follows: Viet Nam (2010, 2017); Lao PDR (2011, 2017); Thailand (2010, 2013); China (2010, 2013); average of the lower middle-income countries (2010, 2017); and Myanmar (2016).
** The average expected longevity from birth in the Asia-Pacific region (except for developed countries) and lower middle-income countries are according to 2010 and 2017 data.
*** The rate of survival until age 65 for women and men in lower middle-income countries and Asia-Pacific countries (except developed countries) are from 2010 and 2017 data.
Source: World Bank (n.d.), World Bank Open Data. https://data.worldbank.org/ (accessed 15 May 2020).

Nevertheless, the quality of the grassroots healthcare system and private medical examination and treatment services in Viet Nam, the Lao PDR, and Cambodia are generally limited. In Viet Nam, the private medical system is fragmented and has many operating difficulties.[35] Grassroots healthcare systems are limited in terms of facilities, the quality of health workers, and healthcare services. Almost all medical stations have a shortage of medicines, including for the treatment of chronic and common diseases, and traditional medicine (Nguyen, 2018). Moreover, the level of antibiotic abuse in Viet Nam is alarming, increasing the risk of antibiotic resistance in the community (APSIC, 2019). Training for medical workers and private health infrastructure in the Lao PDR and Cambodia are limited. In Thailand, the quality of healthcare services is higher, but the best healthcare services in private hospitals are only accessible to the high-income population (Arunanondchai and Fink, 2007).

3. Cooperation and Challenges for Providing Healthcare Services in GMS Countries

3.1. Medical Cooperation in GMS Countries

Medical cooperation is a priority strategy for GMS countries. It is identified in the GMS Economic Cooperation Program Strategy Framework, 2012–2022 and integrated into other cooperation programmes such as the Strategic Framework and Action Plan for Human Resource Development in the GMS, 2013–2017. Demand for medical cooperation is based on medical issues in the region, such as protecting community health, controlling cross-border diseases, providing healthcare for migrants and vulnerable groups, and upgrading the quality of healthcare services.

Medical cooperation is one of the most effective collaborative actions amongst GMS countries (ADB, 2017). It is implemented through annual conferences between the health authorities of the GMS countries. The Third Meeting of the GMS Working Group on Health Corporation took place in Thailand in December 2019. The target was strengthening medical cooperation in GMS countries to address regional issues such as health insurance for immigrants, responding to pandemics, developing medical infrastructure, and promoting the application of information technology in the health sector in the context of the Fourth Industrial Revolution. Regarding the health protection of migrants, representatives of the GMS countries signed a memorandum of understanding in 2004 to cooperate in tackling human trafficking. The Mekong Migration Network, established in 2008 to recognise and protect rights of migrants, is a subregional support network for NGOs, migrant grassroots groups, and research institutes (ADB, 2013). In addition, there are bilateral collaborations and memoranda of understanding between Thailand and neighbouring GMS countries on the migration of workers.

Numerous regional and subregional initiatives have been established to ensure cross-border cooperation on migrant health.[36] With the help of the Asian Development Bank

[35] Resolution No. 20-NQ/TW.

[36] These include the Mekong Basin Disease Surveillance Network; the Joint United Nations Initiative on Mobility and HIV/AIDS; the WHO Mekong Malaria Elimination Programme; and the WHO Regional Action Framework on UHC.

(ADB) and the Ministry of Labour and Vocational Training of Cambodia, the Lao PDR, Myanmar, Thailand, and development partners organised the Roundtable Discussion on Regional Investment Framework for Migrant Health in the GMS on regional migrant healthcare and financing solutions (ADB, 2018). The 'Vientiane Declaration on Transition from Informal Employment to Formal Employment towards Decent Work Promotion in ASEAN' specified the rights of informal workers in ASEAN and requires the members to 'foster research and information sharing amongst ASEAN Member States on best practices in promoting the transition from informal employment to formal employment towards achieving decent work that promotes employment creation, rights at work, social protection, and social dialogue' (ASEAN, 2020).

Although various cooperation programmes protect migrant labour – such as mapping of social protection regimes, establishing social insurance systems to cover the informal sector, and building UHC in all countries – they have not yet been fully implemented. Thus, mutual recognition of migrants' rights, in terms of access to healthcare, has not been achieved.

3.2. Challenges to the Healthcare Systems in GMS Countries

Healthcare systems in the GMS generally produce varying degrees of success in reducing risk pooling, standardising contributions and benefits, and reducing direct payments that help consolidate distinctive features of the health systems as well as ensuring health for all. In Viet Nam, Thailand, the Lao PDR, and China, insurance systems have become more firmly ensconced in the hands of the state, while a combination of government and community-based organisations, religion-based societies, and NGOs provide health services in others.

All the GMS countries have a social insurance scheme to improve the quality of life of their citizens. The programmes cover pensions for employees (both private and public), benefits for survivors, disability, work injuries, and unemployment. One of the most prominent schemes is a UHC provided for all people in Thailand. Other countries are also implementing pro-poor insurance schemes, such as the health fund for the poor in Viet Nam, 'IDPoor' in Cambodia, and HEFs in the Lao PDR.

Improving health systems in the GMS involves several challenges. The first challenge is improving UHC in GMS countries. There is a considerable difference amongst GMS countries in the level of UHC in three groups of indicators: (i) access to health services, (ii) medical infrastructure, and (iii) medical expenses. Support from the state budget and insurance to healthcare in the Lao PDR and Cambodia is low, so the proportion of people paying for healthcare is high. All GMS countries aim to achieve the SDGs on healthcare by 2030, but the level of drug resistance and infectious diseases remains high.

The second challenge is mobilising resources and effective investment to improve the quality of the healthcare system, especially medical infrastructure in GMS countries. This is particularly important in responding to an acute public health threat, protecting health for vulnerable groups from regional integration, and responding to other priority health issues in the GMS. The GMS is a global hotspot for susceptible diseases and recurrent

diseases (ADB, 2019). Therefore, it is necessary to enhance the capacity of supervision, risk assessment, diagnostic capacity in laboratories, communication, and effective response of the public health system.

The third challenge is about enhancing cooperation amongst GMS countries in addressing regional health issues, especially the mechanism of sharing information, harmonisation of legal frameworks and policies on controlling infectious diseases, limiting disease spread, food safety, and protecting immigrant labourers and other vulnerable groups. A common challenge for GMS countries in implementing the SDGs on healthcare is health coverage for immigrants and groups of travelling people. This is most evident in border areas, where people often live and travel across borders, in ethnically diverse areas, with poor health infrastructure compared with other regions (ADB, 2019).

4. Cooperation Goals and Programmes in the GMS, 2020–2030

The GMS countries have a collective vision for GMS health cooperation – that health and well-being are shared by all in an integrated, prosperous, and equitable subregion. Medical cooperation programmes during 2020–2030 in GMS countries mainly aim to achieve three goals: (i) improving the effectiveness of responding to contagious disease and global health crises, (ii) strengthening the protection of vulnerable groups from the health effects of the integration process, and (iii) enhancing the quality of management and human resources to solve healthcare issues in GMS countries. The implementation of these targets is measured by a set of indicators for UHC in the GMS. On the basis of individual country situations, GMS countries have set their own goals to improve their healthcare systems. National health targets run parallel to the implementation of cooperation goals.

According to the 12th National Health Development Plan, 2017–2021, the Thai targets are as follows: (i) people, communities, local administrations, and networks have better knowledge of health, leading to a reduction in preventable mortality and morbidity; (ii) all age groups enjoy quality of life, with a reduction in premature mortality; (iii) the capacity of services is strengthened at all levels; (iv) an appropriate number of health personnel is in place to take care of people; and (v) the health governance system is efficient and effective (Ministry of Public Health (Thailand), 2017).

Meanwhile, Viet Nam, the Lao PDR, Cambodia, and Myanmar aim at UHC for all. These countries are implementing various policies to ensure that their residents receive health services without suffering financial hardship (WHO, 2020). The implementation of these goals is feasible, based on each government's efforts to commit to increasing levels of investment in health and developing policies to encourage the private sector to provide care services. The governments are also developing national and regional health programmes as well as implementing the major strategic health commitments that have been signed.

To achieve UHC, member countries must use multiple approaches. Thailand's UHC experience has shown that UHC requires long-term planning and continuous efforts to advance step by step when windows of opportunity exist at points along the route of policy development. An early step is improving healthcare infrastructure, then the arrangement of healthcare expenditure, and improving and extending public healthcare and the preventative healthcare system. Thailand's government developed the National Health Sector Plan, 2016–2020 to support UHC (WHO, 2015).

For Viet Nam, the government's Agenda for Moving toward Universal Coverage requires the assistance of central and provincial health facilities to strengthen the capacity of district and community health facilities. The aim is to shift the health service delivering burden to lower-level primary healthcare facilities (Somanathan et al., 2014).

For Myanmar, the government enhanced collaboration amongst the different types of providers at the various administrative levels, through the engagement of ethnic health organisations, NGOs, and private for-profit providers. Currently, the country has four health development strategies: (i) health promotion, disease prevention, and consumer and environmental protection excellence; (ii) fostering fair treatment and reducing inequality; (iii) developing and creating a mechanism to increase efficiency in managing human resources for health; and (iv) developing and strengthening the health governance system (Ministry of Health and Sports (Myanmar), 2016).

For Cambodia, the government aimed to improve equity, efficiency, and sustainability in access healthcare services and financing; improve the quality of healthcare services; and strengthen effective use of information, evidence, and research (WHO, 2016). The government has increased its healthcare expenditure and subsidised specific groups such as the poor, mothers, and children through HEFs.

For the Lao PDR, the government has progressively scaled up the coverage of the Social Security Fund, and streamlined and consolidated the national social protection strategy to attain the country's goal to achieve UHC by 2025 (ILO, 2020a).

To achieve these goals and targets, GMS countries need to implement the following activities. The priority activities to achieve goal 1 are as follows:

- Enhancing the indicator of core ability following the IHR standards. This activity aims to improve the ability of GMS countries to respond to potentially contagious diseases, including a system of medical laboratory facilities.
- Enhancing the capacity for cooperation; sharing information about healthcare amongst GMS countries; and building an integrated, multi-area information system to reflect the potential disease risks. This activity is integrated into other cooperation frameworks amongst GMS countries, to make the most of available resources.
- Cross-border and subregional cooperation on health security. This activity aims to harmonise the health regulations in GMS countries, design policies, and build the collective capacity of GMS countries in responding to public health issues (such as supervising contagious diseases, risk assessment, and information sharing).

Priority activities to achieve goal 2:

- Enhancing the capacity of the healthcare system in border areas, towards the goal of synchronising the quality of healthcare in border areas between countries; through this, enhancing the capacity of management and the access to healthcare services of residents in border areas, especially people who travel frequently across borders.
- Enhancing the access of vulnerable groups to healthcare services, by expanding health insurance and furthering access to UHC in GMS countries for immigrants, people travelling frequently across borders, and other vulnerable groups (with or without documents). Improved linking of health systems in departure and destination countries will improve cross-border patient management and referral. Programming will follow a multi-sector approach, with civil society organisations and other non-state actors engaged in intervention design and delivery.
- Improving the integration of the healthcare system development in association with urban and transportation development in GMS countries. It is necessary to minimise the negative effects on health and increase the positive effects of transportation and urban development to improve the living standards and access of people to the healthcare system. This activity requires cooperation amongst many sectors – urban development, transportation, trade, and healthcare – as well as investment partners, including the private sector.

Priority activities to achieve goal 3:

- Enhancing the capacity for high-level cooperation and exchange on healthcare amongst GMS countries, including organising annual conferences and exchanging information. This helps to unify the priority for medical cooperation amongst GMS countries within an annual unified framework.
- Enhancing the quality of human resources in the healthcare sector, through cooperative training, experience, and skill-sharing programmes, or academy programmes amongst GMS countries.

5. Conclusion

The GMS countries are determined to achieve the SDGs. Thailand has completed most of the Millennium Development Goals and contributed to the global development process by helping to strengthen its neighbours to enhance their capacity and to fulfil their Millennium Development Goal commitments (Ministry of Foreign Affairs (Thailand), 2016). While the rest of the countries do not yet have access to full UHC, they mostly meet the targets on improving healthcare through the goals of the UHC programme. In Viet Nam, Thailand, the Lao PDR, and China, insurance systems have become more state-centred, while Myanmar and Cambodia have a combination of government and community-based organisations, religion-based societies, and NGOs providing health services. Governments are improving national healthcare systems to aim at health service equity for all.

The pursuit of sustainable development in the GMS is still a challenge. Significant differences remain between countries and between different groups within countries. Changing climate patterns have caused the reappearance of old diseases such as malaria, chikungunya, Zika, and Avian flu; and the emergence of new diseases such as coronavirus disease (COVID-19). The rise in the incidence of non-communicable diseases (cancer, cardiovascular disease, chronic respiratory diseases, and diabetes) due to unsustainable lifestyles has also become an increasingly significant source of premature deaths. Additionally, various health insurance schemes offer limited coverage (ADB, 2019). In the 1990s, most GMS countries received finance from civil society, NGOs, the United Nations Development Programme, ADB, and the World Bank, to implement the Millennium Development Goals as low-income countries. As the countries move towards middle-income country status, external development funding has been reduced. That is one of the explanations for high out-of-pocket expenditure, leading to a significant separation between public and private healthcare providers.

First, in terms of cooperation principles, GMS cooperation focuses on the principle of equality and mutual respect. At the same time, enhancing solidarity in the subregion through consensus building in decision-making is a priority of GMS cooperation.

Second, at the national level, GMS members differ in terms of prioritisation: the Lao PDR, Myanmar, and Cambodia may focus more on developing their own health infrastructure, human resources, and social insurance schemes, while Thailand or Viet Nam may work towards supporting sustainable development in regional capacity. The countries should promote mechanisms for phased cooperation and long-term goals, such as a region-wide insurance system, regardless of nationality.

Third, at the regional level, medical cooperation programmes during 2020–2030 in GMS countries mainly aim to achieve three goals: (i) improving the effectiveness of responding to contagious disease and global health crises; (ii) strengthening the protection of vulnerable groups from the health effects of the integration process; and (iii) enhancing the quality of management and human resources to solve healthcare issues in GMS countries. To do this, eight activities are proposed. To maximise the effectiveness of healthcare, GMS governments need to fulfil their commitments regarding health services. In supporting the implementation of the SDGs, the GMS should assist its member countries by providing policy guidance; assisting with building capacity; and serving as a platform for information exchange, follow-up, and review.

In conclusion, externally funded programmes need to be integrated into a well-functioning health system. To tackle health spending issues, support from multilateral development banks, such as the Asian Development Bank and the Asian Infrastructure Investment Bank, are particularly important. These institutions play a significant role in enabling member countries to implement the SDGs. Bilateral aid from countries such as China, Japan, the Republic of Korea, European Union member states, and the United States also plays a significant role in the GMS. Since health issues are a great public challenge – affecting not only health systems but also socio-economic and political security status – cooperation between countries should be not only in the field of health but also in sharing social solidarity values and social welfare actions.

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