Chapter 1

Introduction

June 2023

This chapter should be cited as
ERIA (2023), 'Introduction', in Haruka Sakamoto and Haruyo Nakamura (eds.), *Towards Progress in Population Health and Health Equality in the Asian Region*. ERIA Research Project Report FY2023 No. 03, Jakarta: ERIA, pp.1-11.

Chapter 1

Introduction

In the report 'Tracking Universal Health Coverage: 2017 Global Monitoring Report' by the World Health Organization (WHO) and the World Bank (WHO and World Bank, 2017, p.v), Jim Yong Kim, the President of the World Bank at that time stated that 'universal health coverage….is an investment in human capital and a foundational driver of inclusive and sustainable economic growth and development'. As emphasised in this statement, improving population health, and building functioning healthcare systems are recognised as the foundation of economic growth. Whilst member countries of the Economic Research Institute for ASEAN and East Asia (ERIA) have shown remarkable economic growth in the past decades, further improvements in population health are necessary for continued economic development in the region.

In the past decades, people in the ERIA member countries have been able to lead healthier and longer lives. In most ERIA member countries, health-related Millennium Development Goals, including targets for maternal and child health metrics and infectious disease control, were met by 2015. However, ageing populations, an increased burden of non-communicable diseases (NCDs), increasing drug prices, and healthcare expenditures now pose tremendous challenges for all countries, regardless of economic status. In the face of these challenges, countries need to transform their healthcare systems.

In addition, health disparities, both within and between countries, have increased. For example, whilst life expectancy in Japan increased from 79.0 years in 1990 to 83.2 years in 2015, disparities in life expectancy across prefectures (difference between the prefecture with the highest vs the lowest life expectancy) increased from 2.5 years to 3.1 years (2.3 to 2.7 years for healthy life expectancy) (Nomura et al., 2015). Similar trends were observed in ERIA member countries (Sumriddetchkajorn et al., 2019; Han et al., 2019). Because health disparities are an important obstacle for continued economic growth, reducing disparities whilst facilitating continued growth is of great importance.

Although research addressing population health and health disparities meet ERIA priorities of (i) deepening economic integration, (ii) diminishing development disparities, and (iii) sustainable economic growth, ERIA research has previously not focused on health issues. The declaration from the Group of Seven (G7) summit in Ise-Shima, Japan in 2016 (G7, 2016) stated that 'health is the foundation of prosperity and security not only for individual but also for nations.' In the chairperson's statement of the 12th East Asia Summit in 2017 in Manila, the Philippines, it was further stated: 'We further welcomed ERIA's activities in new areas such as efforts to strengthen regional health services' (ASEAN Secretariat, 2017). Thus, addressing global health challenges and promoting global health research is of utmost relevance to ERIA's activities and to further contribute to sustainable economic growth in this region.

Against this background, this report outlines the health systems in each ERIA country, with particular focus on the characteristics of each country's health system and its progress in

achieving universal health coverage (UHC). Chapter 1 describes the basic indicators for each ERIA country. Chapter 2 describes the progress of each ERIA country, with a particular focus on UHC, followed by Chapter 3, which describes the health system characteristics of four selected countries within ERIA. Chapter 4 summarises the challenges to achieving UHC identified in light of the novel coronavirus disease (COVID-19) pandemic and the recommendations for achieving UHC. The COVID-19 pandemic, which has continued to spread since the end of 2019, has caused tremendous damage to the health systems of countries, and there is an urgent need to rebuild systems based on the lessons learned from COVID-19. We hope that the contents of this report will serve as a reference for countries.

1. Geography and Socio-demography

This report surveys and analyses 16 East Asian countries that are members of ERIA. They are Brunei Darussalam (Brunei), Cambodia, Indonesia, Lao People's Democratic Republic (Lao PDR), Malaysia, Myanmar, Philippines, Singapore, Thailand, Viet Nam (the 10 Association of Southeast Asian Nations [ASEAN] countries), Japan, China, the Republic of Korea, India, Australia, and New Zealand.

Table 1.1 summarises basic statistics for ERIA member states, covering a wide range of countries from those with very large populations, such as China, India, Indonesia, and Japan, to those with very small populations, such as Singapore. In relation to health care, the most notable trend is the ageing of the population. Whilst ERIA includes countries like Japan, which has the world's most aged population, ageing is not limited to high-income countries. Ageing is defined as the stage at which the percentage of the population aged 65 or older exceeds 7% of the total population. In light of this definition, Australia, New Zealand, Singapore, Thailand, Viet Nam, China, and India, in addition to Japan, already have ageing rates exceeding 7%, and Indonesia is expected to soon surpass this level. As populations age, the number of people living longer with chronic diseases such as hypertension and diabetes increases. Therefore, each country's healthcare system must be reformed to accommodate the needs of older adults with multiple chronic diseases. At the same time, as will be explained in more detail later in this report, a higher ageing population rate means a decrease in the percentage of the working population. In general, healthcare systems in each country are financed by taxes or insurance, and the proportion of the working population has a significant impact on the revenue portion. Therefore, when considering the relationship between population ageing and health systems, it is necessary to pay attention not only to the increase in demand for medical care, but also to the decrease in revenue that can be allocated to medical expenses to build a sustainable healthcare system.

Table 1.1. Demographic Indicators in 2021 (or latest available)

Indicators	Brunei	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philippines	Singapore
Population (in thousands)	440	16,950	276,360	7,380	32,780	54,810	111,050	5,450
								Population (% of total)
0–14 years	21.92	30.7	25.62	31.62	23.27	25.11	29.53	12.0
65 years and older	5.96	4.99	6.51	4.37	7.45	6.47	5.72	14.0
Annual population growth (%)	0.8	1.2	0.7	1.4	1.1	0.7	1.5	–4.2
Population density (2020)	84	93	145	32	101	82	376	7,919
Total fertility rate (per woman) (2020)	1.8	2.4	2.2	2.5	1.8	2.2	2.8	1.1
Crude birth rate (per 1,000) (2020)	14	20	17	22	15	17	22	9
Crude death rate (per 1,000) (2020)	5	6	7	6	5	9	6	5

Table 1.1. ***Continued***

Indicators	Thailand	Viet Nam	Japan	China	Republic of Korea	India	Australia	New Zealand
Population (in thousands)	69,950	98,170	125,680	1,412,360	51,740	1,407,563	25,688	5,122
								Population (% of total)
0–14 years	16.0	23.0	12.0	18.0	12.0	26.0	18.0	19.0
65 years and older	15.0	9.0	30.0	13.0	17.0	7.0	17.0	16.0
Annual population growth	0.2	0.8	–0.5	0.1	–0.2	0.8	0.1	0.6
Population density (2020)	140	308	346	150	531	470	3	19
Total fertility rate (per woman) (2020)	1.3	2.0	1.3	1.3	0.8	2.1	1.6	1.6
Crude birth rate (per 1,000) (2020)	9	15	7	9	5	17	12	11
Crude death rate (per 1,000) (2020)	7	6	11	7	6	7	6	6

Notes: Population density: people per square kilometre of land area. Dates other than 2021 are noted in brackets in the table.
Source: World Bank Open Data. https://data.worldbank.org (accessed 27 April 2023).

2. Economic Context

In general, as economic growth progresses, health-related outcomes such as life expectancy improve, and this trend is generally followed in the ERIA member states. Table 1.2 summarises the economic levels of the ERIA member states. In general, healthcare costs are rising year by year due to the ageing of the population and the advancement of medical technology, and the major issue is how to deal with such growing healthcare costs within the financial resources of each country. If the rate of economic growth was higher than the increase in medical expenses, such economic growth would be returned in the form of tax revenues and insurance premiums, and thus it would be possible to accept a certain level of increase in medical expenses. On the other hand, if economic growth is not as high as the increase in healthcare costs, it will be difficult to make up for the increase in healthcare costs within the existing framework (tax rates and insurance premiums). Therefore, the sustainability of health care, especially the sustainability of healthcare financing, is closely related to the economic growth of each country. As shown in Table 1.2, with the exception of some countries such as Myanmar, where the government is not stable, the ASEAN Member States are showing relatively strong economic growth (however the recent COVID-19 pandemic has also had a negative impact on countries' economies, making evaluation difficult). On the other hand, most high-income countries such as Japan and the Republic of Korea have already entered a period of economic stagnation, and in these countries, it is difficult to compensate for the growth in healthcare costs from economic growth, and healthcare financing is facing difficulties in its sustainability

Table 1.2. Macroeconomic Indicators in 2021 (or latest available)

Indicators	Brunei	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philippines	Singapore
Total GDP (current US$ millions)	14,006	26,961	1,186,092	18,827	372,980	65,091	394,086	396,986
GDP per capita, (current US$)	31,449	1,625	4,332	2,535	11,109	1,209	3,460	72,794
GDP average annual growth rate (%)	–1.6	3.0	3.7	2.5	3.1	–17.9	5.7	7.6
Value added in industry (% of GDP)	62.7	36.8	39.9	34.1	37.8	35.0	28.9	24.9
Value added in agriculture (% of GDP)	1.3	22.8	13.3	16.1	9.6	23.4	10.1	0.0
Value added in services (% of GDP)	37.6	34.2	42.8	38.8	51.6	41.5	61.0	69.4
Unemployment rate	4.9	0.5	3.8	3.3	4.5	1.5 (2020)	3.4	3.5
Gini coefficient	NA	NA	37.9	38.8 (2018)	41.1 (2018)	30.7 (2017)	42.3	NA

Table 1.2. *Continued*

Indicators	Thailand	Viet Nam	Japan	China	Republic of Korea	India	Australia	New Zealand
Total GDP (US$ million)	505,947	366,137	4,940,877	17,734,062	1,810,955	3,176,295	1,552.667	249,885
GDP per capita, (current US$)	7,066	3,756	39,312	12,556	34,997	2,256	60,443	48,781
GDP average annual growth rate (%)	1.5	2.6	1.7	8.1	4.1	8.7	2.2	3.7
Value added in industry (% of GDP)	34.8	37.5	29.0 (2020)	39.4	32.4	25.9	25.5	20.4 (2019)
Value added in agriculture (% of GDP)	8.5	12.6	1.0 (2020)	7.3	1.8	16.8	2.3	5.7 (2019)
Value added in services (% of GDP)	56.7	41.2	69.5 (2020)	53.3	57.0	47.5	65.7	65.6 (2019)
Unemployment rate	1.2	2.4	2.8	5.1	3.6	6.5	5.1	3.8
Gini coefficient	35.0	35.7 (2020)	32.9 (2013)	38.2 (2019)	31.4 (2016)	35.7 (2019)	34.3 (2018)	NA

Note: Dates other than 2021 are noted in brackets in the table.
GDP = gross domestic product, NA = not available.
Source: World Bank Open Data (https://data.worldbank.org) (accessed 27 April 2023).

3. Health Status

A comparison of basic health indicators for ERIA member states is summarized in Table 1.3 below. The world average life expectancy is 75 years for women and 70 years for men[7]. In comparison, some countries, such as Japan and Singapore, are much higher than the world average, while others, such as Laos and Myanmar, are more than 5 years below the world average. Healthy life expectancy is also summarized in Table 1.3. Healthy life expectancy (HALE), defined as "Average number of years that a person can expect to love in “full health” by taking into account years lived in less than full health due to disease and/or injury[8]", currently exists in all countries with a gap of about 10 years between average life expectancy and HALE for both men and women. A long gap means that people are living with some kind of physical disability, and it is a global challenge to reduce this gap from the perspective of curbing medical and long-term care costs.

Table 1.3. Life Expectancy at Birth and Health Indicators by Gender in 2021 (or latest available)

Indicators	Brunei	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philippines	Singapore
Life expectancy (in years) [a)]								
Female	77	73	71	71	78	70	74	86
Male	73	68	67	67	74	64	70	82
Healthy life expectancy (in years) [b)]								
Female	66.1	63.0	63.8	61.9	66.9	62.8	63.9	74.7
Male	65.2	59.8	61.9	59.2	64.5	58.8	60.1	72.4
Age-standardised mortality rate (per 1,000) [a)]								
Female	97	135	161	139	73	150	109	34
Male	141	201	220	194	144	252	153	59

Indicators	Thailand	Viet Nam	Japan	China	Republic of Korea	India	Australia	New Zealand
Life expectancy (in years) [a)]								
Female	84	80	88	81	87	72	85	84
Male	75	71	82	75	81	69	81	80
Healthy life expectancy (in years) [b)]								
Female	70.6	68.3	75.5	70.0	74.7	60.4	71.7	70.8
Male	65.9	62.4	72.6	67.2	71.3	60.3	70.1	69.6
Age-standardised mortality rate (per 1,000) [a)]								
Female	71	68	36	55	32	144	43	53
Male	174	163	64	109	72	202	73	81

Sources: [a)] World Bank Open Data (https://data.worldbank.org) (accessed 27 April 2023);
[b)] WHO Global Health Observatory (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/gho-ghe-hale-healthy-life-expectancy-at-birth) (accessed 27 April 2023).

In general, infectious diseases and maternal and child health-related diseases are the leading causes of death in many low-income countries. However, as economic growth progresses, an epidemiological transition occurs, and NCDs such as cancer and cardiovascular diseases become the leading causes. In many high-income countries, this epidemiological transition happened over a period of time, and NCDs began to increase after infectious diseases and maternal and child health-related diseases could be controlled to some extent. On the other hand, in many low- and middle-income countries, due to rapid urbanisation and dietary changes, the disease burden of NCDs is also increasing before the healthcare system is sufficiently established, i.e. when the disease burden of infectious diseases and maternal and child health-related causes are still high. This situation – in which both infectious diseases and/or maternal and child health-related diseases and NCDs need to be addressed – is referred to as the double burden of disease. The major causes of death in each country are discussed in detail in the case studies of Cambodia, Malaysia, Thailand, and Viet Nam (in Chapter 3), but many ERIA countries also face the challenge of the double burden of disease.

In this context, low- to middle-income countries s are also being pressed to respond to NCDs before their healthcare delivery systems can be strengthened, and the double burden of disease is placing a significant burden on their healthcare delivery systems. To overcome this situation, there is a need to establish a healthcare system that can respond to patient care in a more comprehensive manner rather than through individual disease control. For example, it often happens that patients with HIV/AIDS can be treated and medications are available, but patients with diabetes cannot be managed, and medications are not available. However, the goal is to create a system that can address basic primary healthcare needs at a community level, and investment in strengthening the overall health system rather than investing in individual disease control is urgently needed.

4. Sustainability in Healthcare Financing

Next, we review the sustainability of healthcare financing in ERIA member states. The Abuja Declaration adopted in 2001 (WHO, 2019) recommends that approximately 15% of each country's gross domestic product (GDP) be allocated to health care. Although the actual basis for this estimate is not clear, in any case, a certain amount of public funds is indispensable to provide adequate medical care to the people and protect their standard of health. If this public funding is insufficient, it will mean an increase in out-of-pocket payments. As explained in more detail in the next section, the larger the co-payment ratio, the greater the health inequality will widen as only the wealthy are able to receive medical care. Therefore, it is important to increase the investment of public funds and reduce co-payments so that even low-income households can receive medical care without undue financial burden.

Table 1.4 shows the breakdown of healthcare financing in ERIA member states. Public spending of around 10% of GDP is found only in high-income countries such as Japan, the Republic of Korea, Australia, and New Zealand. Most countries are only able to allocate less than 5%. Similarly, in terms of out-of-pocket payments, most countries have very high rates of 40% or more. Going forwards, a common challenge for the entire region is to increase the allocation of public funds to the healthcare sector and at the same time reduce the co-payment ratio by enhancing the public insurance system and other schemes.

Table 1.4. Trends in Healthcare Expenditure in 2021 (or latest available year)

Indicators	Brunei	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philippines	Singapore
Total health expenditure (THE) (% of GDP)	2.16	6.99	2.90	2.60	3.83	4.68	4.08	4.08
Government expenditure on health (% of THE)	94.32	24.31	48.94	36.93	52.2	15.76	40.60	50.20
Private expenditure on health (% of THE)	5.68	69.19	50.51	41.86	47.80	75.96	58.99	49.80
OOP payment (% of THE)	5.69	64.39	34.76	41.83	34.57	75.95	48.56	30.15

Indicators	Thailand	Viet Nam	Japan	China	Republic of Korea	India	Australia	New Zealand
Total health expenditure (% of GDP)	3.79	5.25	10.74	5.35	8.16	3.01	9.91	9.74
Government expenditure on health (% of THE)	71.66	43.80	83.86	55.98	59.53	32.79	71.68	75.56
Private expenditure on health (% of THE)	28.23	55.23	16.14	44.02	40.47	66.38	28.32	24.44
OOP payment (% of THE)	8.67	42.95	12.91	35.23	30.25	54.78	15.98	12.24

GDP = gross domestic product, THE = total healthcare expenditure, OOP = out-of-pocket.
Source: World Bank Open Data (https://data.worldbank.org) (accessed 27 April 2023).