International Health Policy Program -Thailand

Health in Asia Beyond 2015

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Outline

- Health as well-being
- Important health and health-related problems in Asia beyond 2015
- Movements on Health in Post 2015/SDGs and the role of Asian countries
- ASEAN Community 2015 and Health
- Response to challenges

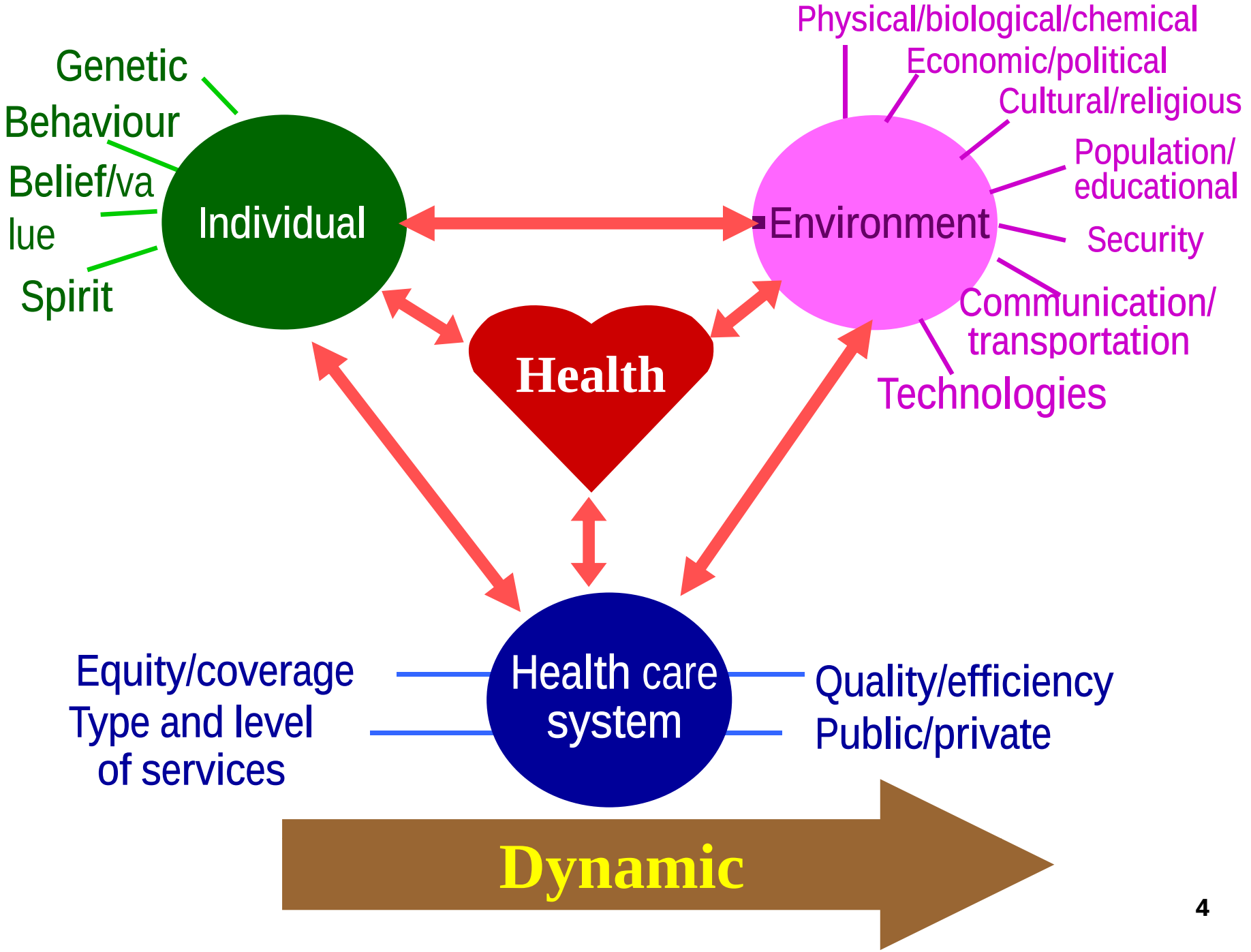
Health

"A state of complete physical, mental, and social (and spiritual) well-being, not merely the absence of diseases and infirmity"

How do we measure 'health' – morbidity and mortality – composite index of BOD?

Can **Asia** measure 'well-being'?

Health and related factors



Challenges of Asian Health Beyond 2015

- Rapid population ageing – LTC and NCDs
- Epidemiological Transition – Double Burden
- Technological development – increasing cost
- Social and Political changes – SDH
- Rising trade and economic growth – FTAs, Asian Community/AEC, TPP – IP, Food safety, HCS etc.
- Rapid expansion of UHC and health expenses
- More active players on Global n National Health

Health in Post 2015/SDGs

- Two parallel movements of Post 2015 development agenda and Rio+20 SDGs
- Well-being for all was proposed as the overarching development goals and **UHC as the overarching health goals**
- Successes and sustainability and challenges
- The Roles of Asian Countries to put UHC as the post 2015 and the SDGs

Two parallel movements for post 2015 and Sustainable DGs

- The UNSG High Level Panel of Eminent Persons co-chaired by President of Indonesia, Liberia and PM of UK for post 2015 – reported in June 2013
- The UNGA established a ‘member states’ driven processes with 30 members working group on Rio+20 SDGs – started March 14th 2013.
- The possible congruent of the two movements in 2014 or 2015
- The official negotiation period Sept 2014 – 2015 – several movements regionally and globally

Post 2015 development agenda: well-being for all

The contributions of the health sector and other sectors

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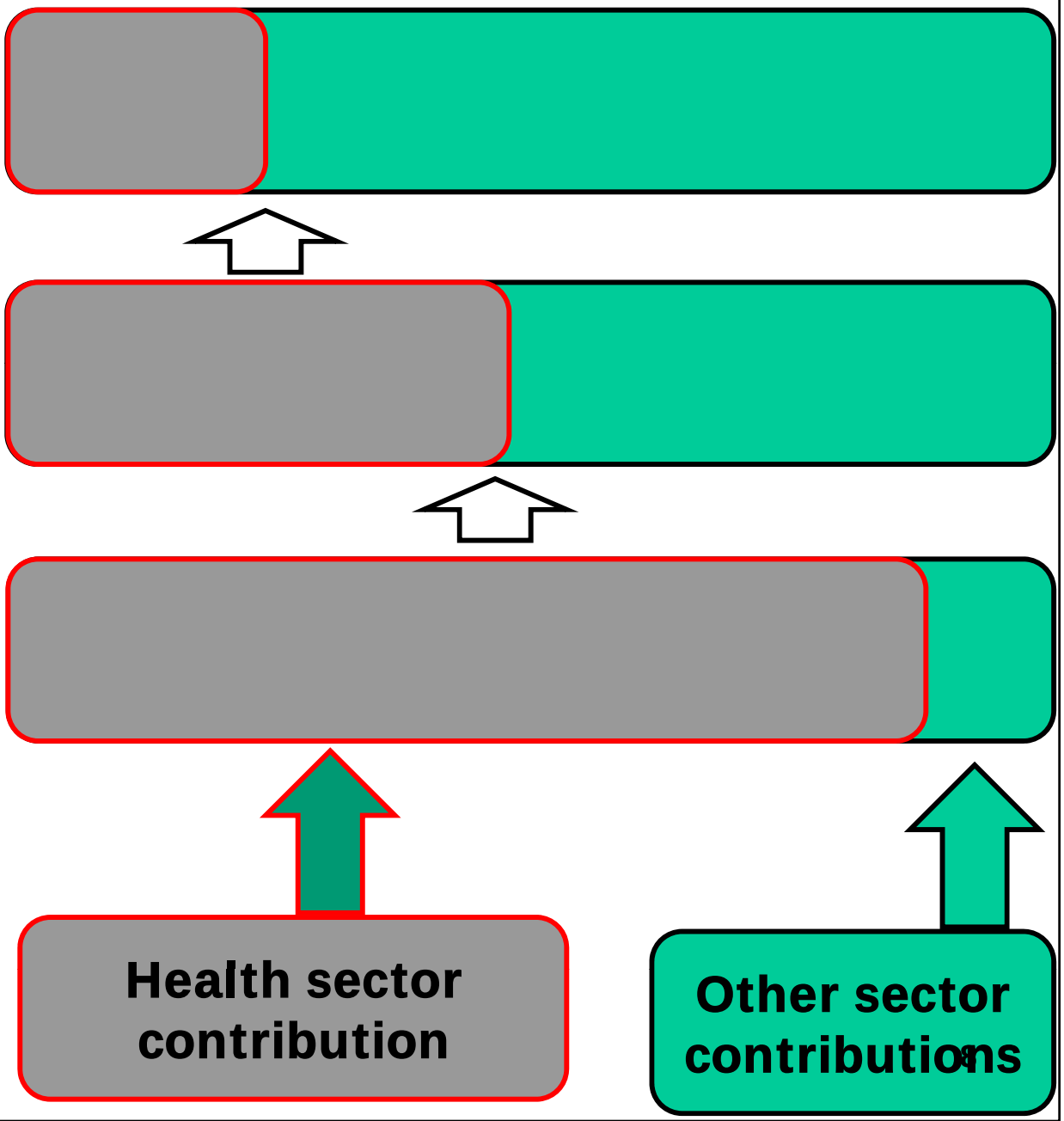
Sustainable wellbeing for all
Poverty eradication, health, education, nutrition, environment, security etc.

Healthy lives at all stages
Child survival, maternal survival, MDG6, adolescent health, NCD burden reduction

Universal health coverage (UHC)
Health promotion, prevention, treatment, financial risk protection



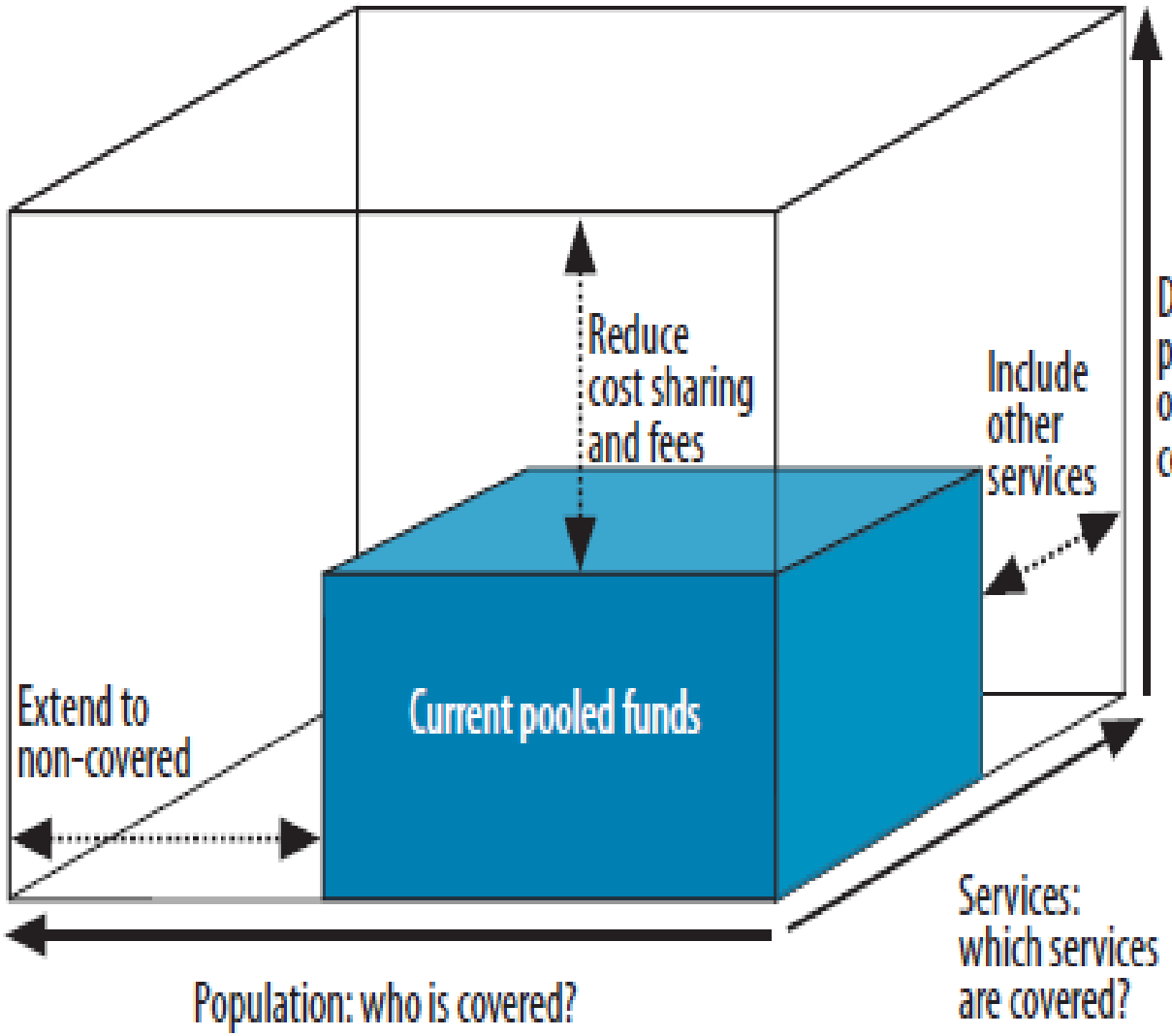
The UHC – Thai's experiences

- Universal access to **quality comprehensive essential** health services **without financial barriers** – services, population, financial protection coverage – three dimensions

- Possible targets - access to qualified and motivated primary care health workers and essential technologies; financial protection

- Cover the issue of 'right based' approaches, health equity, and all the MDGs++ targets.

Thai UC – three dimensions of UC cube



Free at point of services
Low incidence of catastrophic health expenditure and medical impoverishment

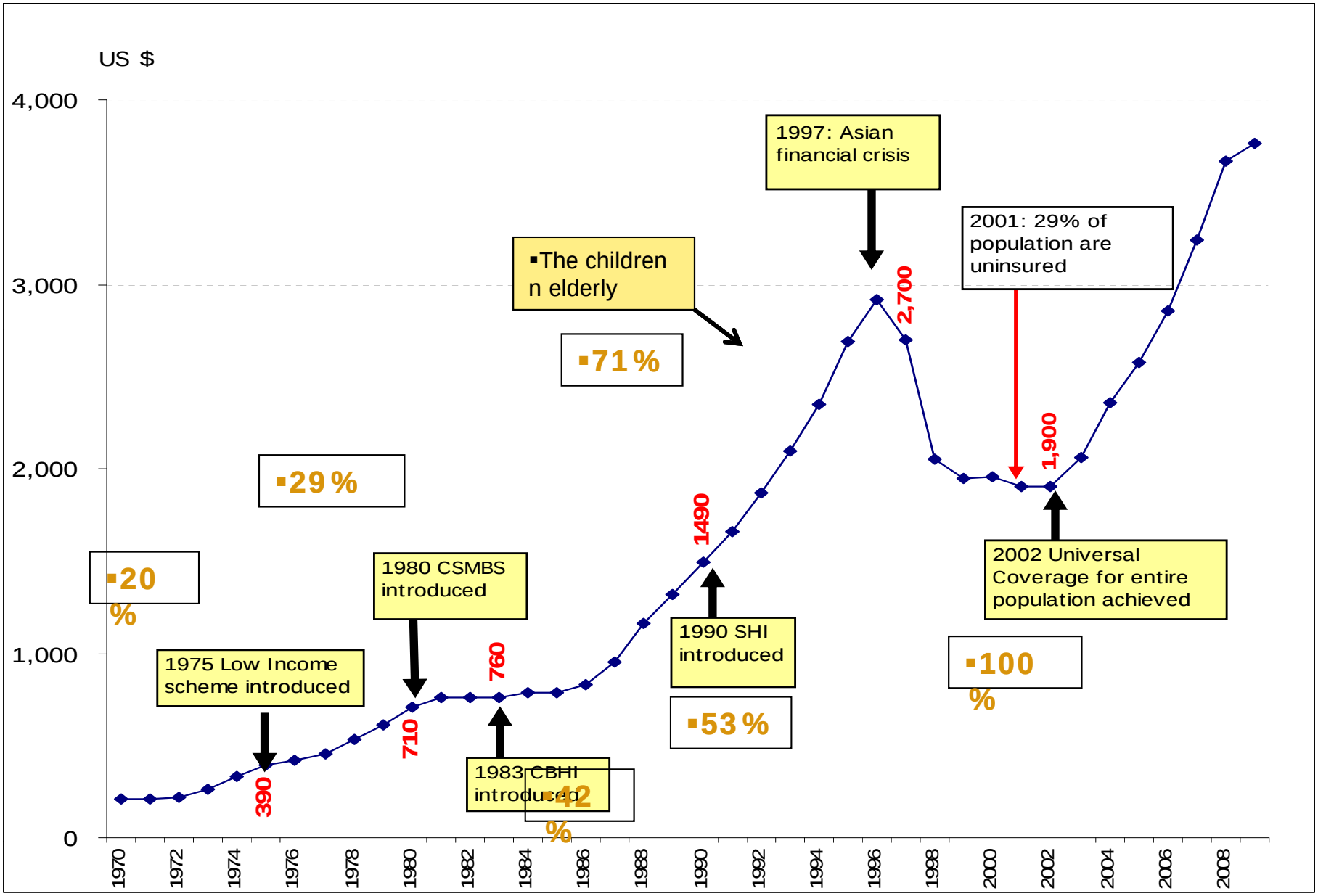
Universal (100%) Coverage by 3 public schemes

Essential comprehensive services and drugs
High cost services are covered e.g. Renal Replacement Therapy, chemotherapy, ARVs, etc

UHC is feasible and sustainable

- UHC can be started and achieved **at low level of income** – financial protection and quality services**.**
- UHC is effective for **poverty reduction**
- Fiscal spaces and innovative financing are possible for **additional resources** mobilization
- Mechanisms are there to ensure value for money, sustainable financing and meeting the emerging challenges

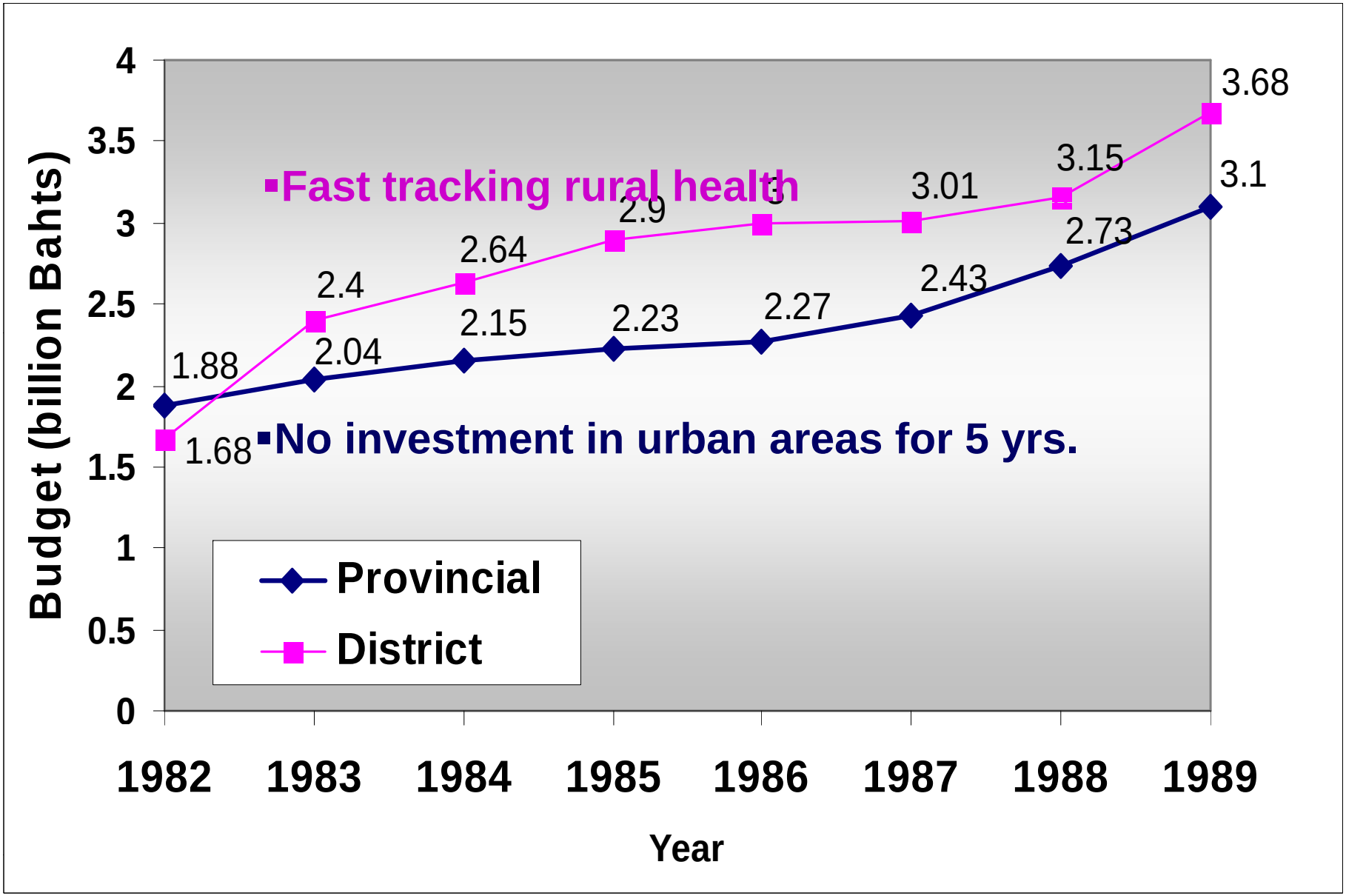
UHC can be started and achieved at low level of income – Economic Crisis is an opportunity not a threat



Ensuring universal quality health services

- Extensive expansion of rural health services in early 80s **– in spite of economic crisis**
- How? – Budget shifting - **Freeze** new capital investment in urban health facilities for 5 years and reallocate to rural health facilities.
- Extensive production of motivated Rural Health Workers with **compulsory public services and incentives**
- Establishment of Hospital Accreditation Institute

Building up quality rural health facilities - Reallocation of budget to rural facilities and HRH



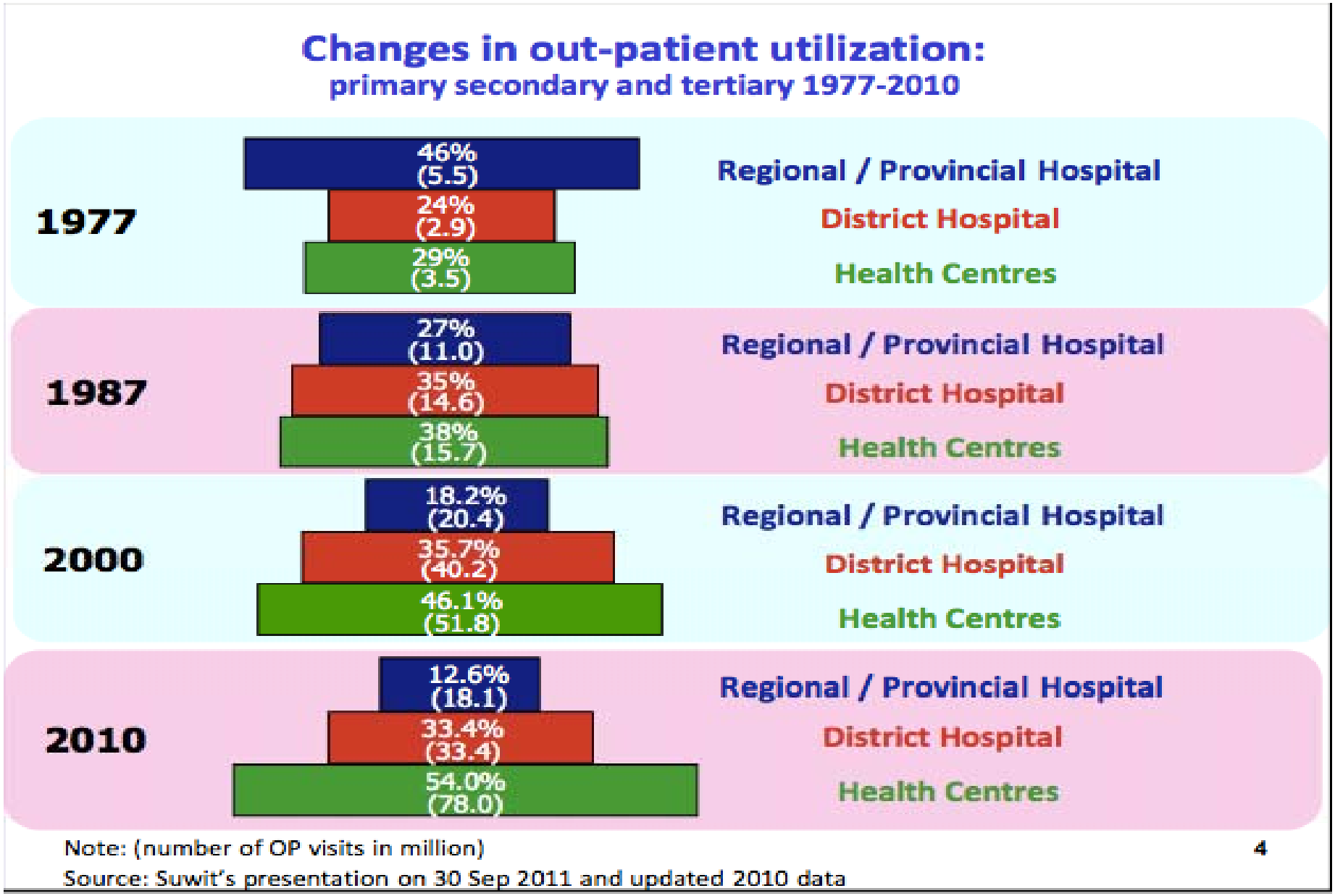
▪Adequate and appropriately manned rural health facilitieis

Rural health centers with 3-6 nurses n CHWs cover 2,000-5,000 population

▪***Extensive production of appropriate cadres and motivated health personnel with mandatory public works and adequate support are essential.***

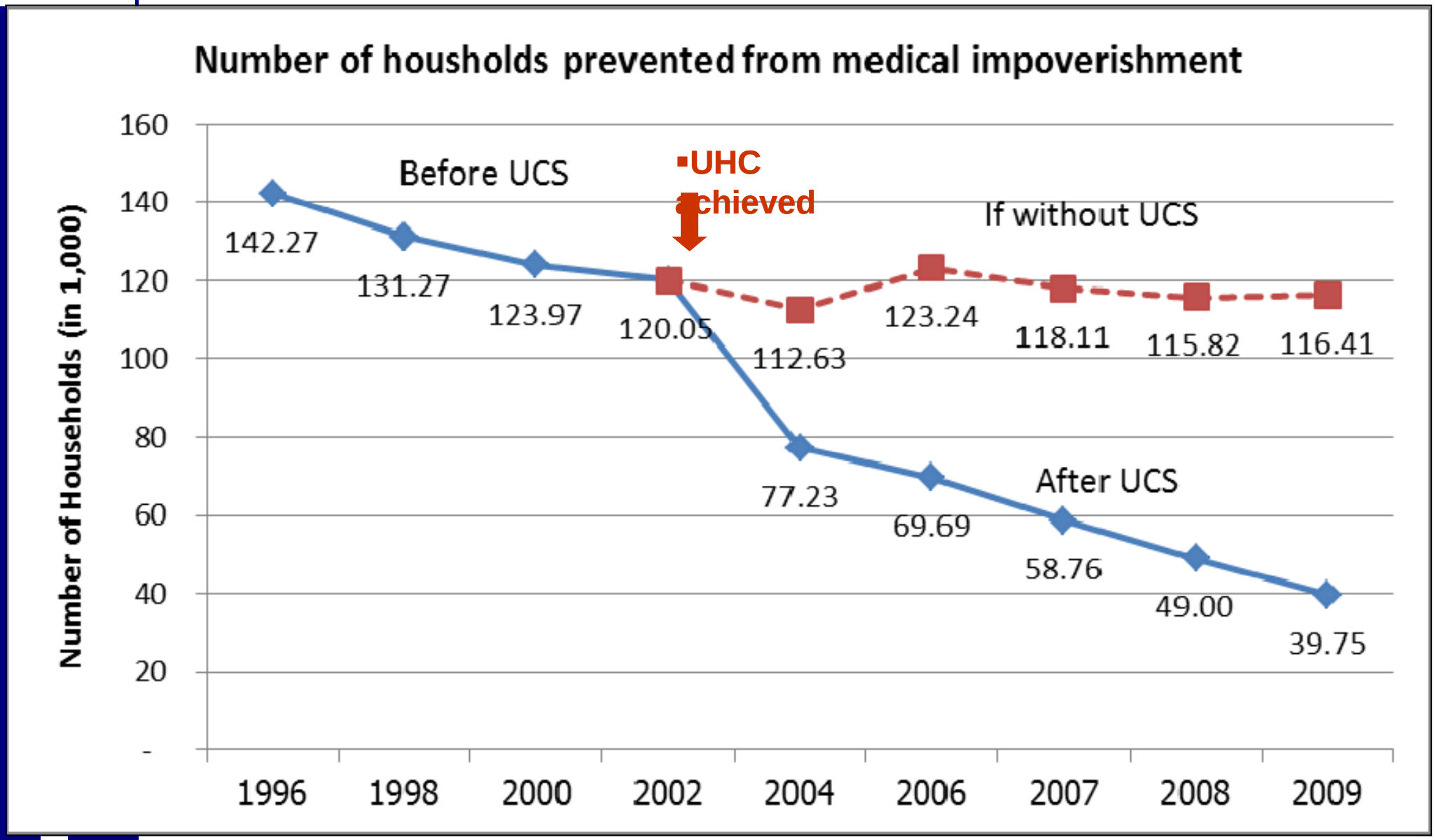
▪Rural community hospital with 2-8 doctors cover 30-100,000 population

From reverse to upright triangle: PHC utilization (OP visits)



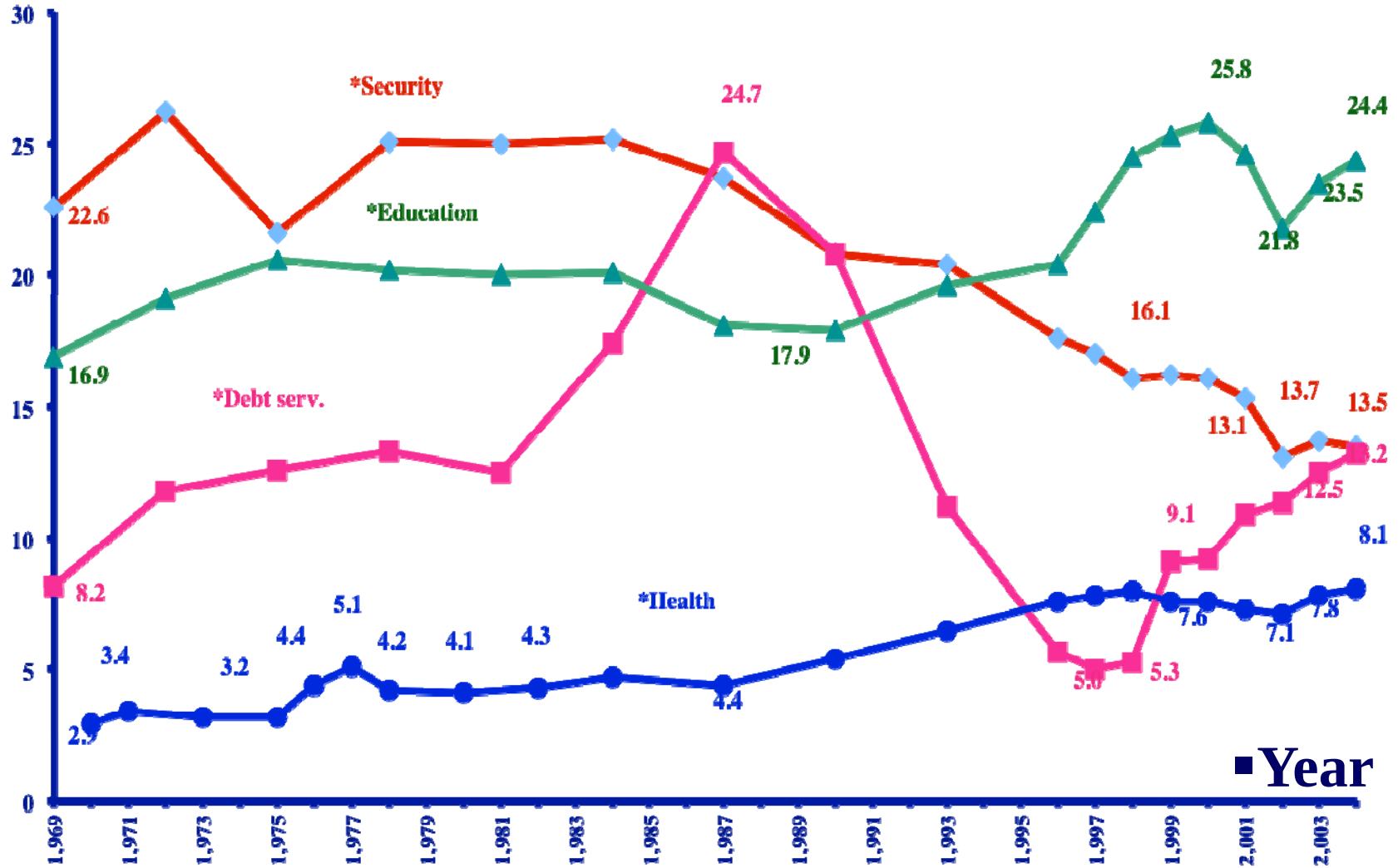
Dr. Suwit Wibulpolprasert, IHPP, Thailand

UHC is effective for poverty reduction



Source: Viroj Tangcharoensathien

Fiscal Space to health from peace and economic growth



Source: Bureau of Budget

Innovative Financing for Health

- **Sin tax -** 2% **additional levy** on top of tobacco and alcohol excise tax, since 2001 – Thai Health Promotion Foundation managed by independent board chair by the PM – $US 120 millions in 2012 – *support works on H1N1*

- **Community Health Development Fund** and provincial rehabilitation fund – 50% from UC and 50% from local government - $US 200 millions in 2012

Mechanism to ensure Better Value for Money and Cost Control for Sustainable Financing

- **20%** of UC budget to P&P & comm H fund
- **Cost-effectiveness studies** of health technologies – ***IHPP, HITAP, etc -*** determine *National Essential Drug List (800 items) and benefit package*
- Strategic purchasing – PPP, Central purchasing with VMI and use of TRIPs flexibilities
- **Close end capitation** budget with mixed payment mechanisms and PC gate keeper
- Adequate capacity on HS/HP and management

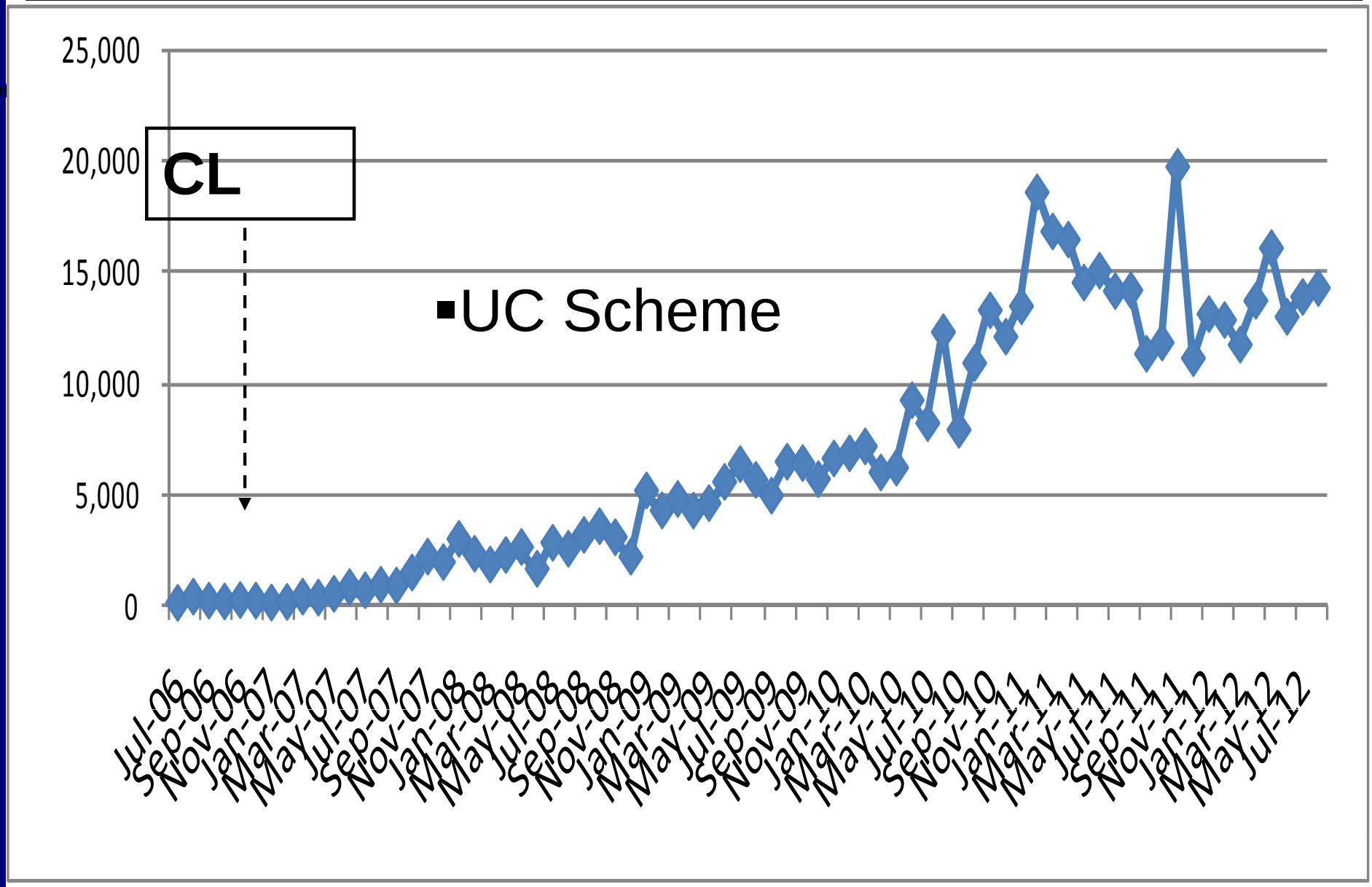
Central purchasing and bargaining of drug and instrument

Items	Unit cost (Baht)			Saving (Baht)
	Before	After	Number (unit)	
1.Instrument				
Folding lens	4,000	2,800	64,100	76,920,000
Unfolding lens	4,000	700	7,197	23,750,1o0
Balloon stent	20,000	10,000	26,655	266,550,000
Coronary stent	30,000	5,000	10,575	264,375,000
Drug elutent stent	85,000	17,000	33,794	2,297,992,000
DES Alloy stent	55,000	25,000	343	10,290,000
2. Drug (sample)				
ARV (AZT 300 mg caps.)	1201.22	891.23	47,000	14,569,530
ARV (EFV 600 mg tabs.)	304.89	149.51	400,000	62,152,000
ARV (LPV/RTV 200/50 mg (CL)	2139.82	1481.91	170,000	111,844,700
Botulinum toxin type A 100 IU	10,750.00	7977.74	946	2,622,557.96
Docetaxel 80 mg inj	25654.32	4716.26	2,700	56,532,747.31
IVIG 5% 100 ml	9,649.62	5,479	19,200	80,075,904
Peg-interferon alpha	11,000	3,150	77,000	604,450,000
Influenza vaccine	200	150.28	643,319	31,985,820
Erythropoietin	671	229	1,634,239	722,333,638
CAPD fluid	200	105	19,095,657	1,814,087,415
Saving				**6,440,531,412.27**

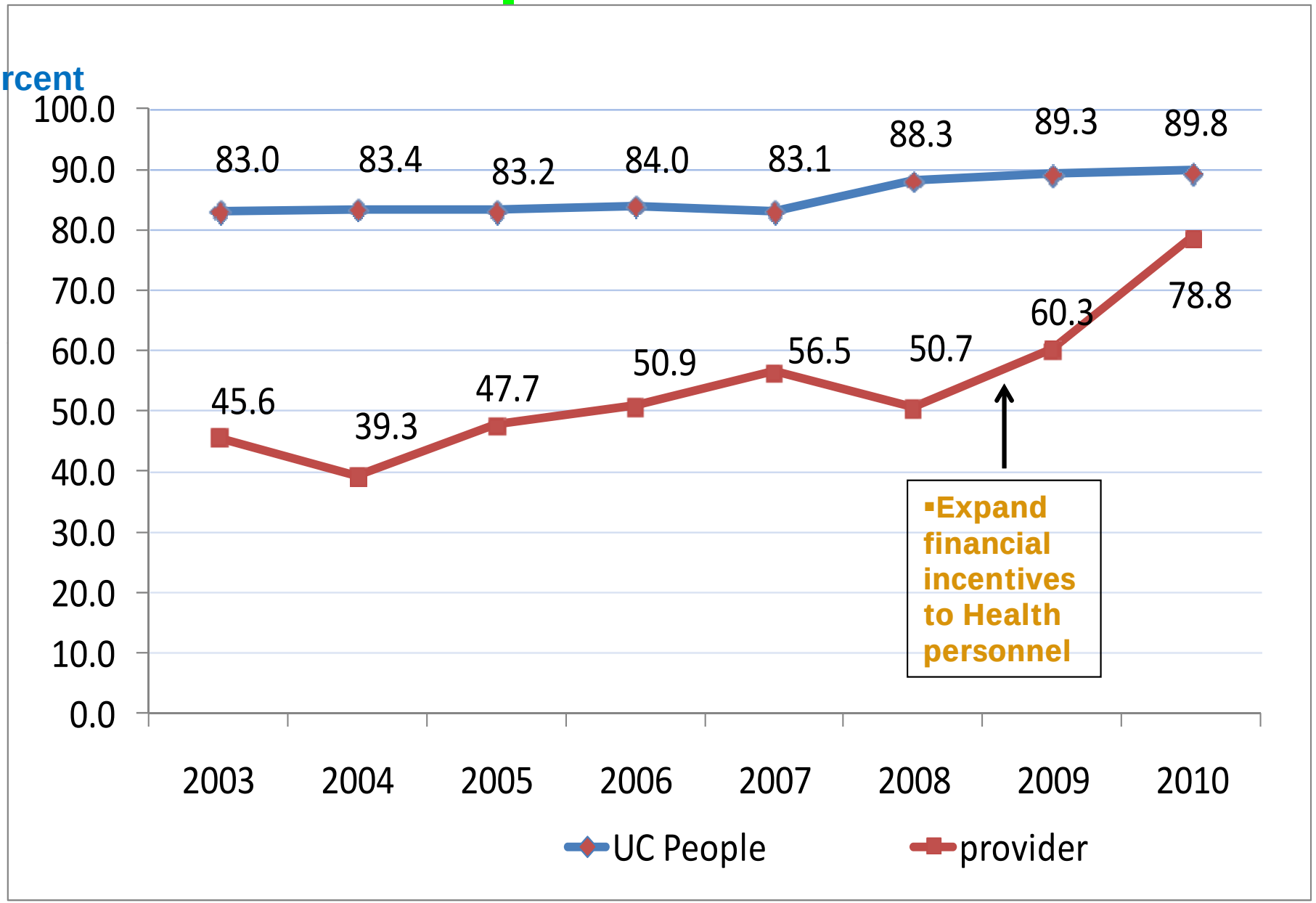
Suwit Wibulpolprasert, IHPF, Thailand

From: NHSO 2012

Rate of use of Lopinavir/Ritonavir (200/50mg)



Satisfaction of UC beneficiaries & providers



Adequate capacity to generate evidences for decision and manage UHC

- 1992 – Health Systems Research Institute **(HSRI)**
- 1995 – Health Care Reform Project - EU
- 2000 – International Health Policy Program and later on foundation **(IHPP)**
- 2002 – National Health Security Office **(NHSO)** and sin-taxed based Thai Health Promotion Foundation and Hospital Accreditation Institute **(HAI)**
- 2005 – Health Insurance Systems Research Office **(HISRO);** Claim and **case mix** (DRG)
- 2006 – establish Health Intervention and Technology Assessment Program **(HITAP)**
- 2012 – all partners establish **CAP UHC** to support south-south collaboration – workshops and on site consultation and advocacy

Challenges and possible solutions

- Inequitable access : harmonization/ unification and special financial incentives (P4P)
- Ageing society, NCD and chronic diseases – community and home based care and NCD funds for 2ry prevention
- International trade – medical tourism n TRIPs plus
- Technology explosion – HITA and TRIPs flexibilities
- Increasing expectation/demand – regular surveys, social motivation/financial incentives, NFCF

The regional and global movements

- Asian countries with UHC - Brunei, China, Japan, Korea, Malaysia, Singapore, Sri Lanka, Thailand
- Asian countries committed – Bangladesh, India, Indonesia, Laos PDR, Maldives, Philippines, and Vietnam
- Joint Statement ASEAN plus three HMM – July12
- UNGA resolution on UHC - December 2012
- UHC in the post 2015 and SDGs and ECOSOC 13
- Many global and regional meetings on UHC – EMRO/Dubai, JP-WB/Tokyo in December 2013!!
- Capacity building supports – JLN, JP-WB trust fund, CAP UHC/Thailand, etc.

Asean +3 Joint Statement of HMM

- Recognize significant role of UHC on **poverty reduction and support the achievement of MDGs**
- Commit to accelerate the progress on UHC in all countries and support the establishment of the **ASEAN plus three UHC networks on UHC**
- Share and **build capacity** to assess and manage equitable and efficient health systems to support UHC
- **Concur and collectively move the UHC to be discussed and committed at the highest regional and global development forum, including ASEAN plus three summit, and the UNGA**

The UNGA resolution on UHC

- Include UHC in the discussion on the post 2015 development agenda
- ECOSOC consider UHC as part of its 2013 work programs with WHO n WB
- Continue consultation on UHC and possibility of a **HLM in UNGA**
- UNSG and UN agencies to give high priority to UHC **– WB and WHO are very clear**

The Role of Asian Countries to move UHC

- Move concretely and actively to achieve UHC
- Global advocacy movement – to put UHC as the post 2015 and the Sustainable Development Goals – several regional meetings
- Capacity building thru Knowledge management – the Japan-WB trust fund on UHC, the ASEAN plus three UHC networks, the AAAH, the HTAsiaLink, and the **Thai UHC CAP program**

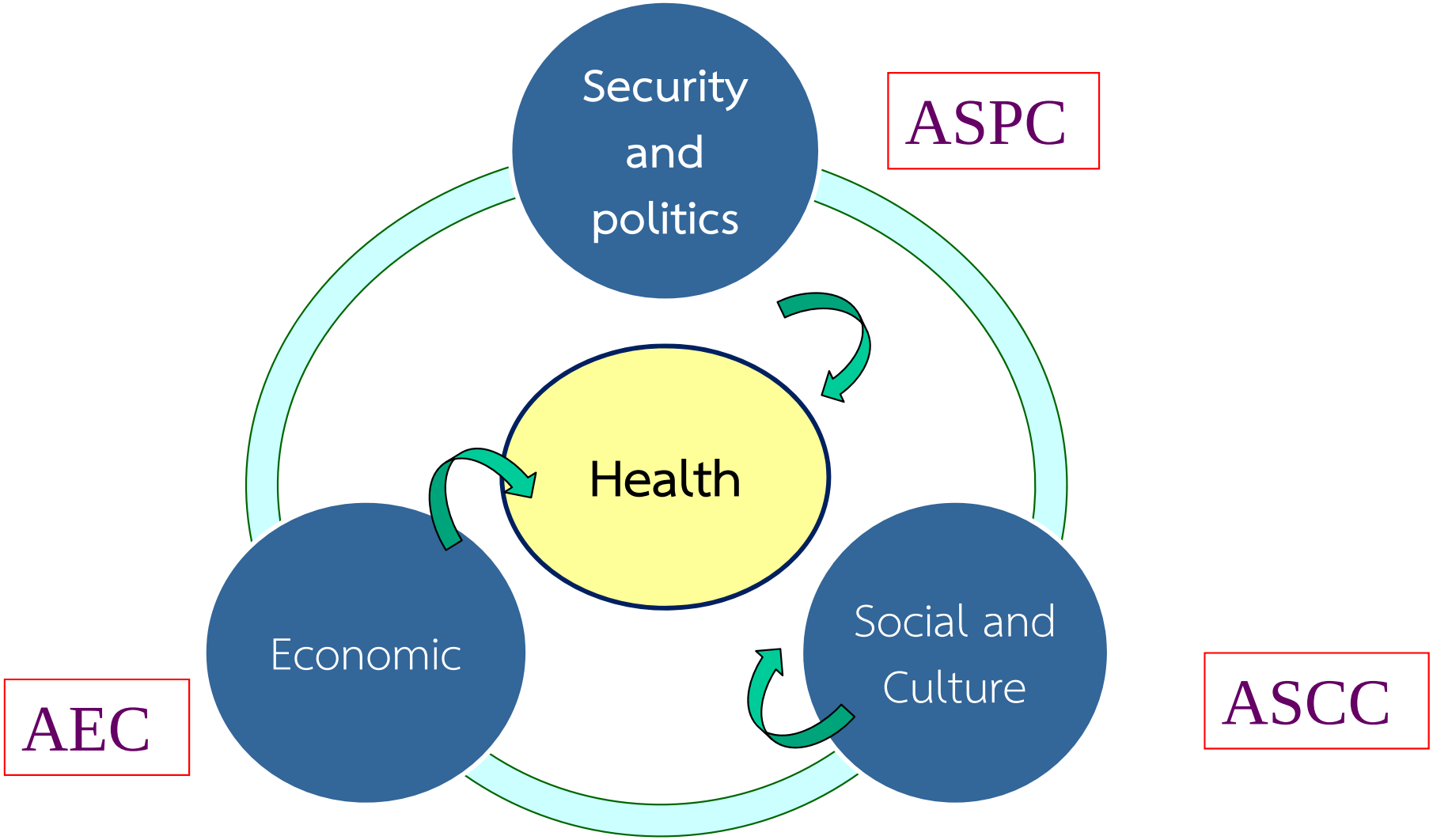
The Association of Southeast Asian Nations (ASEAN Community)

ASEAN is the microcosm of the world

Political – Absolute Monarchy to Democracy
Religious – Buddism, Christian, and Islamic
Economy – LIC, LMIC, UMIC, HIC
Geography – islands and mainland
Population – small, medium, and large
Climate – equator to temperate
Colonization – non and used to (UK, France, Dutch, US) with China and Russian Influence

- ***Anything that can be agreed in consensus in ASEAN is likely to be agreed in the whole world***

ASEAN Community and Health



Challenges to ASEAN Community

PEACE : Political – Military Security

Non-traditional threats : Disaster

Democracy, Good Governance and Human Rights

PROSPERITY : Economic Security

Food Security

Energy Security

PEOPLE : Socio-Cultural Security

Human Security

Security and Identity

CoMMUNITY

Community-building is an on-going process; beyond 2015

CONNECTIVITY

Connecting within and to the world; beyond ASEAN connectivity

CENTRALITY

Central in the regional architecture; in the 'driving seat'

CREDIBILITY

Credible to the peoples and the world

Interests of ASEAN members in regional trade in health services

Mode	Export	Import
1 **Cross border supply**	Thailand	Singapore
2 **Consumption abroad**	Singapore, Malaysia, Thailand, Philippines	All ASEAN members
3 **Commercial presence**	Singapore, Malaysia, Thailand	All ASEAN members
4 **Movement of natural person**	Philippines, Indonesia, Myanmar	Singapore, Brunei, Thailand

Challenge - Will the medical tourism drain limited human resources from developing countries?

Why Mutual Recognition Arrangement (MRAs)?

- Pursuant to the AFAS and the ASEAN Economic Community (free flow of good, services & investments)
- 12th ASEAN Summit, 13 January 2007- *ASEAN Economic Community by 2015* [free movement of professionals]
-
- To facilitate movement of health professionals to further facilitate provision of health services

ASEAN MRAs on Health Professionals

- Nursing Services
  - Negotiated during 2004 - 2006
  - Signed on 8 December 2006 by ASEAN economic health ministers
- Medical Practitioners
  - Negotiated during 2006 – 2009
  - Signed in 2009
- Dental Practitioners
  - Negotiated during 2006 – 2009
  - Signed in 2009

MRA on Nursing Services

ARTICLE III

RECOGNITION, QUALIFICATIONS AND ELIGIBILITY OF FOREIGN NURSES

3.1 Recognition of a Foreign Nurse

3.1.3 Minimum practical experience in the practice of nursing of not less **than three (3) continuous years** prior to the application;

3.3 Undertaking of a Foreign Nurse

3.3.1 Local codes of professional conduct in accordance with the policy on ethics and conduct on the Practice of Nursing established and enforced by the Host Country;

3.3.2 Prevailing domestic laws and regulations of the Host Country,...

Any ASEAN members that are not ready to implement this MRA can defert is required to implement it by **1 January 2010**.

The effect is still far away from 'real' movements of HRH

Barriers to the MRAs

- Different definitions and scope of nursing practices
- Different education standards/curriculum/continuing education
- Regulatory system and work permit/VISA
- Language and cultural barriers

Unilateral recognition has been implemented!!!

Strategies for H in Asia beyond 2015

- Invest more on Health and get the best health for the investment
- Long term sustainable capacity building especially on HS/HP research and management based on INNE (Individual, Node, Network, and Environment) model
- Triangle that moves the mountain – combination of Social power, power of wisdom and political power

Summary

- Asia is progressing fast in economic and social development and is microcosm of the world
- Challenges include ageing, epidemiological transition, globalization especially global trade, politico-economic-socio/cultural difference
- Asian countries are moving fast to achieve UHC and can play significant roles at global level
- ASEAN Community 2015 opens a new era of collaboration but it will take more time to really affect any significant changes in H
- Combing the power of wisdom, society and policy supported by long term capacity building and more investment in health are essential responses