UNIVERSAL HEALTH COVERAGE AMONG ASEAN COUNTRIES

THE FINANCIAL ASPECT

Dr. Ye Htut
Consultant, Senior Lecturer
Parkway College, Singapore
Senior Adjunct Lecturer
Faculty of Medicine, Flinders University
Adelaide, Australia
M.B.B.S (University of Medicine 1, Yangon)
Master in Public Policy (Lee Kuan Yew School of Public Policy, Singapore)
Master of Health Administration (Flinders University, Australia)
Certified Professional in Healthcare Quality (National Association of Healthcare Quality, USA)

Dr. Ye Htut (MBBS, MPP, MHA, CPHQ)

Senior Lecturer
School of Healthcare Management
Parkway College, Parkway Pantai, Singapore
Senior Adjunct Lecturer
Faculty of Medicine, Nursing and Health Sciences
Flinders University, Adelaide, Australia

Dr. Ye Htut is a Medical Doctor, Health Policy Analyst and Certified Professional in Healthcare Quality with 14 years of working experience in both private and public sectors of the healthcare industry. Dr. Ye's academic areas encompass Public Policy and Management of Healthcare Systems, Global Health Policies, Management of Healthcare Organizations, Patient Safety and Healthcare Quality Management.

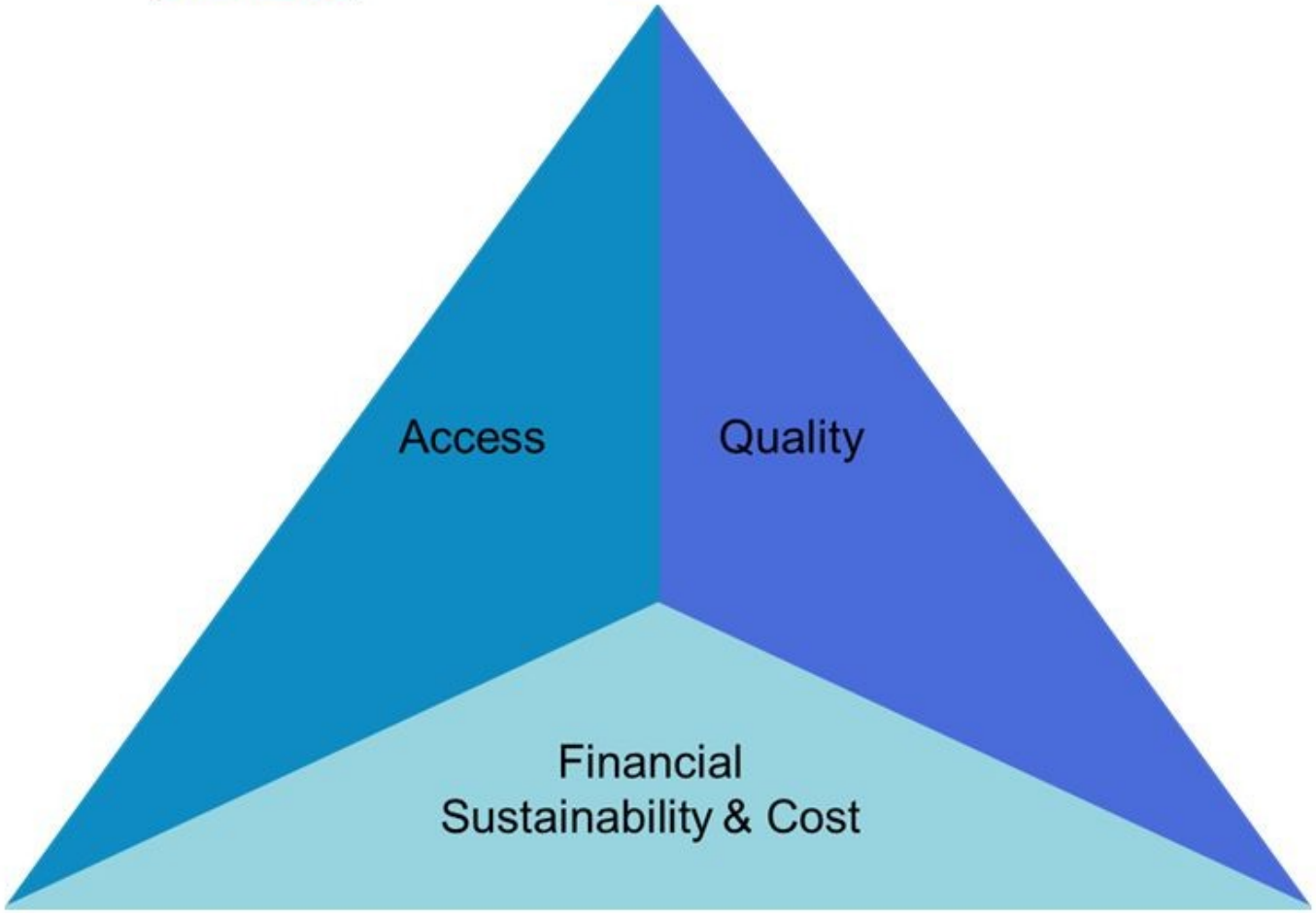
In addition to provision of healthcare to urban population, Dr. Ye provided policy consultancy for Singapore Action Group of Elders, established research policy and strategy for research institutes under Singapore Health Services, and organized health education campaigns to community and workplaces in Health Promotion Board, Singapore.

Dr. Ye is teaching Healthcare System Management, Healthcare Operations Management, Patient Safety, Proactive Risk Management and Clinical Governance and providing consultancy and trainings for Parkway Pantai Hospitals and Healthcare organizations in the region.

Dr. Ye is registered with Myanmar Medical Council and is a member of American College of Healthcare Executives which is a renowned international society for healthcare executives who lead hospitals and healthcare systems. In addition, Dr Ye is certified by National Association of Healthcare Quality, USA and he is an active executive member of Healthcare Quality Society Singapore

Dr Ye Htut's professional qualifications include:
•M.B.B.S (University of Medicine 1, Yangon)
•Master in Public Policy (Lee Kuan Yew School of Public Policy, National University Singapore)
•Master of Health Administration (Flinders University, Australia)
•Certified Professional in Healthcare Quality, (NAHQ, USA)

The IRON Triangle of Healthcare



Vancouver CoastalHealth
Promoting wellness. Ensuring care.

UNIVERSAL HEALTH COVERAGE

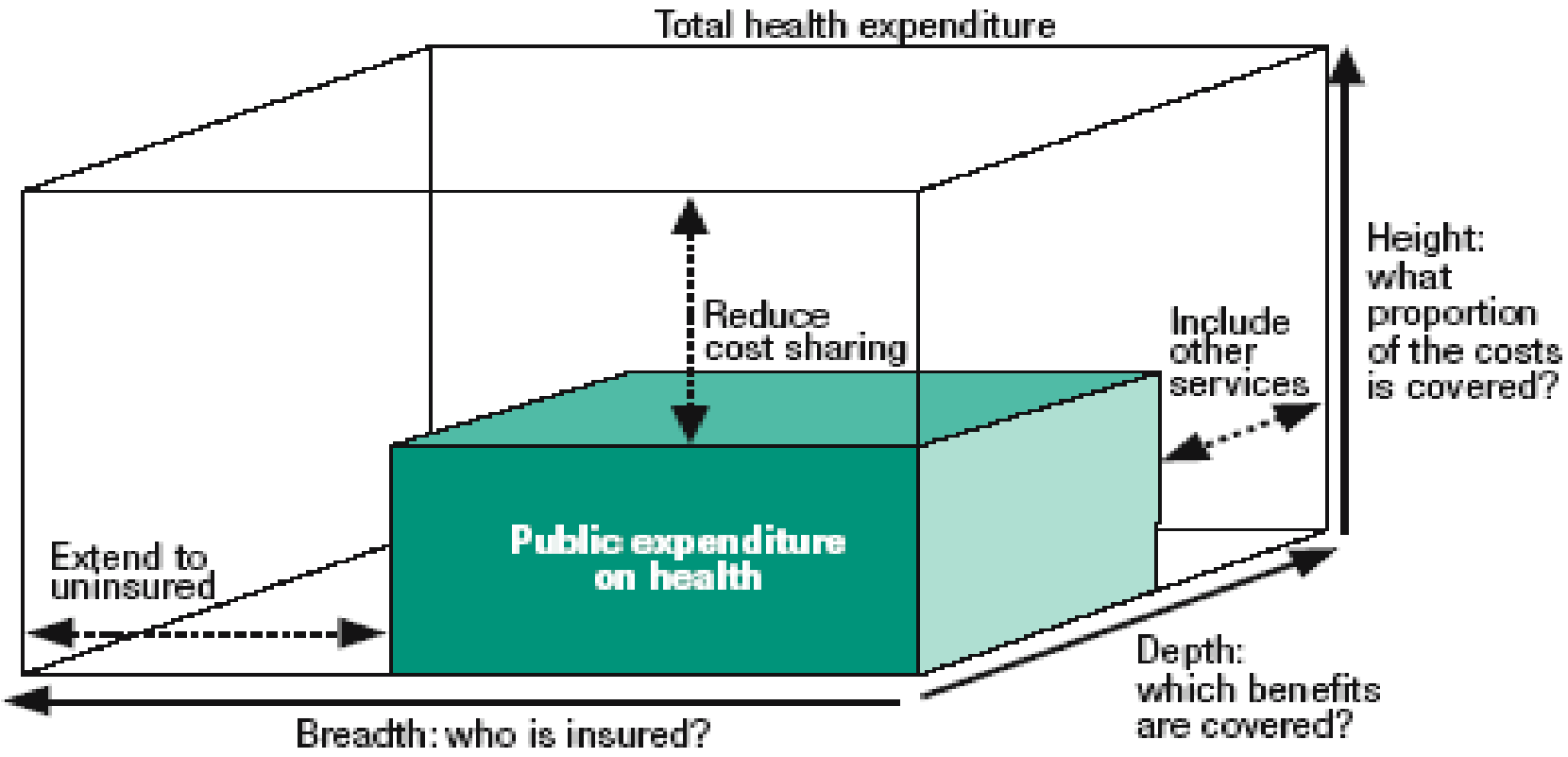
- Universal health care is **health care coverage that is extended to all eligible residents of a governmental region and often covers medical, dental and mental health care**

- These programs vary in their structure and funding mechanisms. Typically, most costs are met via a single-payer health care system or national health insurance or else by compulsory regulated pluralist insurance (public, private or mutual) meeting certain regulated standards

UNIVERSAL HEALTH COVERAGE

The World Health Report 2008

Figure 2.2 Three ways of moving towards universal coverage[17]



Reference: Universal Coverage, The World Health Report 2008

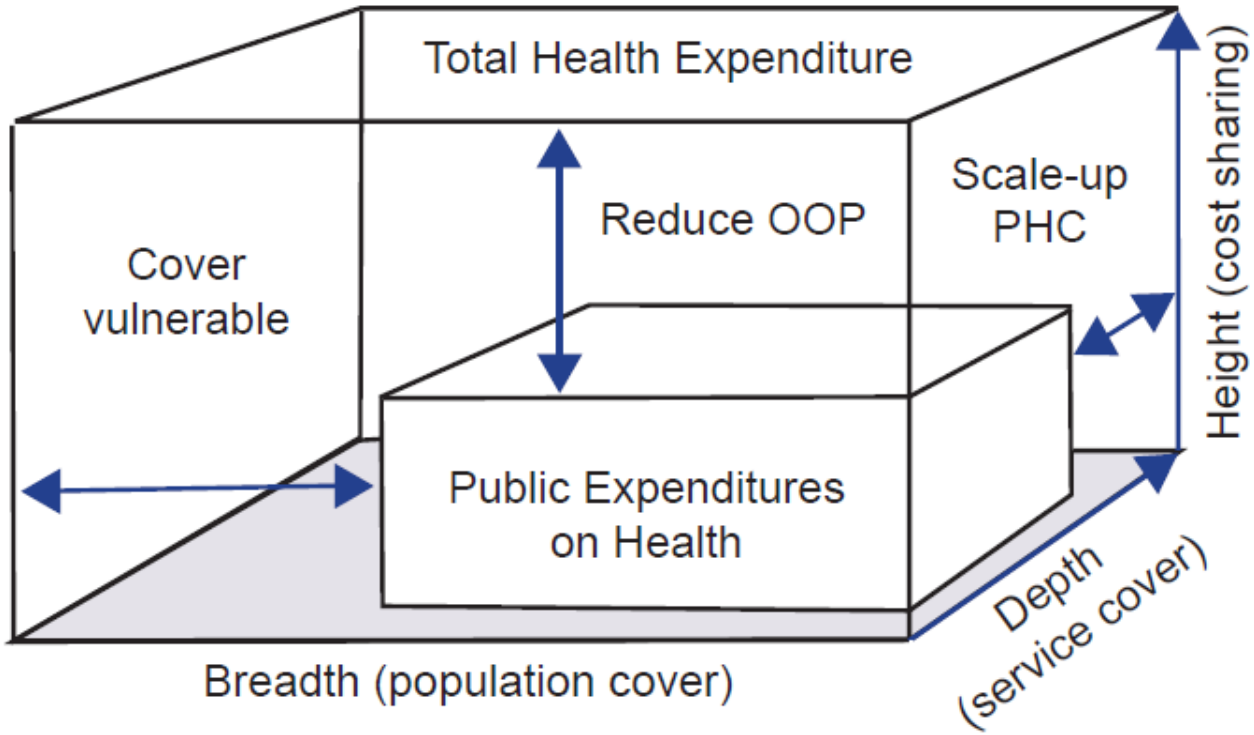
ASIA PACIFIC HEALTH FINANCING STRATEGY 2010-2015

These dimensions call for targeted interventions suited to each country in the following **eight strategic areas**:

1. Increasing investment and public spending on health
2. Improving aid effectiveness for health
3. Improving efficiency by rationalizing health expenditures
4. increasing the use of prepayment and risk-pooling
5. improving provider payment methods
6. Strengthening safety-net mechanisms for the poor and vulnerable
7. Improving evidence and information for policymaking
8. Improving monitoring and evaluation of policy changes

ATTAINMENT OF UNIVERSAL COVERAGE

Increased contribution in Public Expenditure



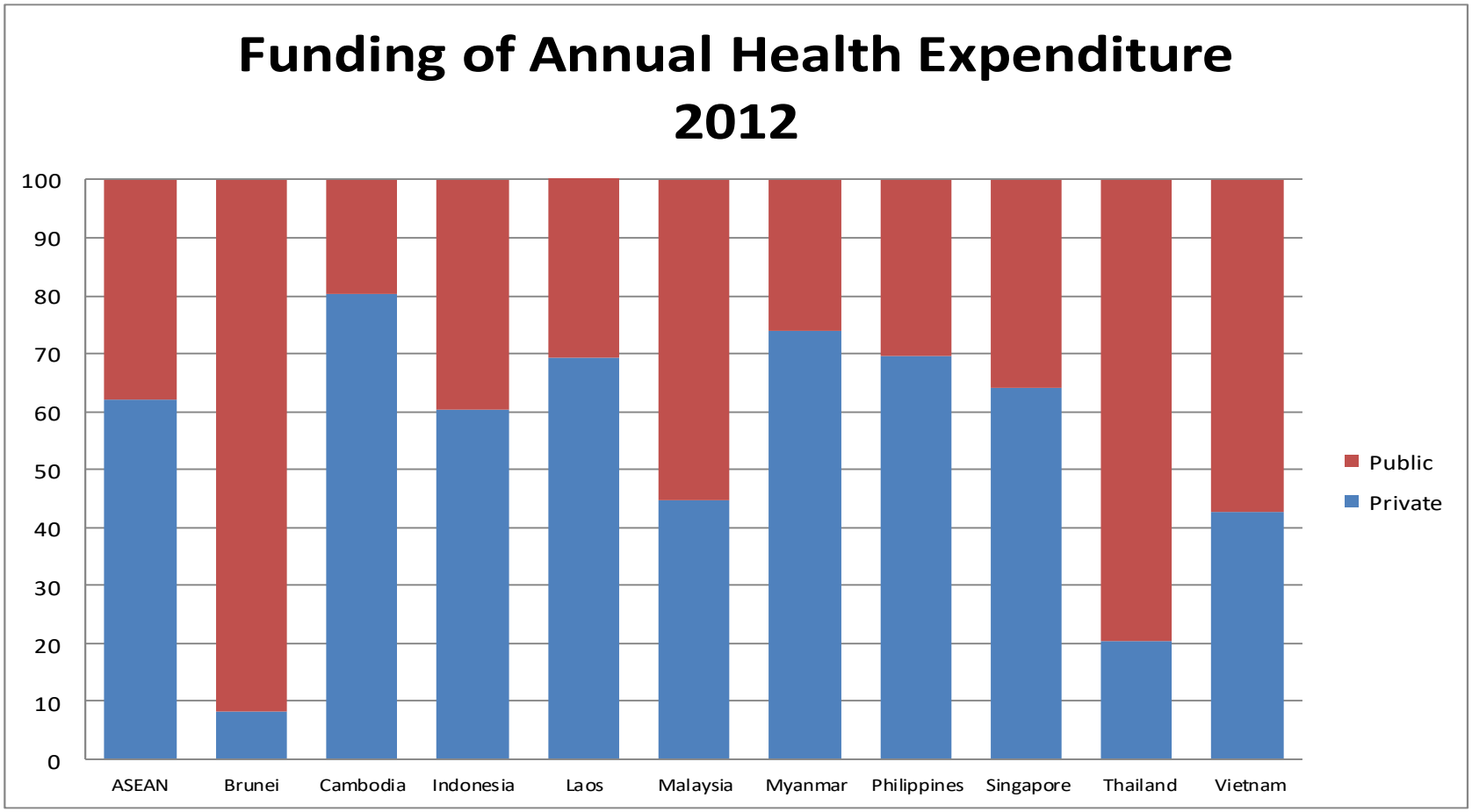
OOP = out-of-pocket
PHC = primary health care

Increase in Financial Resources

Greater efficiency in use of resources in Primary Care

Prepayment, Risk-pooling, Effective Social Protection

UNIVERSAL HEALTH COVERAGE PUBLIC AND PRIVATE EXPENDITURES



% GDP	3.7	2.3	7.3	3	1.9	4	1.8	4.4	4.2	4.5	6

Reference: World Health Statistics 2015, World Health Organization

Parkway College

A Social Science and Medicine Conference
ELSEVIER

Health Systems in Asia:
Equity, Governance and Social Impact
Lee Kuan Yew School, NUS, Singapore, 13 - 16 December 2013

NUS National University of Singapore

Increasing Healthcare Expenditure to improve Health outcomes and to reduce Health Inequities in Southeast Asia

Ye Htut, Aung Myat Oo

Introduction

- Southeast Asia region consists of ten countries Brunei Darussalam, Cambodia, Indonesia, Thailand, Malaysia, Myanmar, Laos, Philippines, Singapore and Vietnam with varying health inequities among populations.
- From 2000 to 2010, the per capita total health expenditure among member nations went up from 61 to 125 international dollar using purchasing power parity.

Purpose of the study

This paper attempts to establish relationship between increased healthcare expenditure and improvement in healthcare outcomes and to find out whether increased spending in healthcare can reduce health inequities.

Methods

The paper uses the following data from World Health Statistics 2005 to 2013 from World Health Organisation (WHO).

Indicators for Healthcare expenditures

- Per Capita total health expenditure

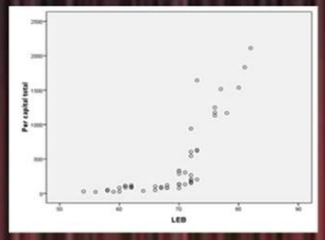
Indicators for Healthcare outcomes

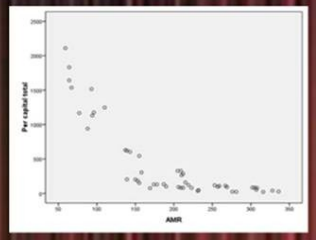
- Life expectancy at Birth (LEB)
- Adult Mortality rate (AMR)
- Infant Mortality rate (IMR)
- Under 5 Mortality Rate (U5MR)

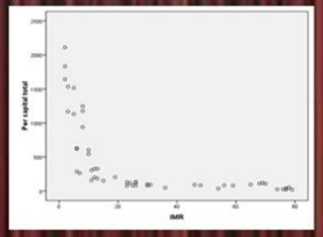
Indicators for Health Inequities based on residence, wealth and mother's education status

- Birth attended by skilled health personnel
- Under 5 Mortality Rate (U5MR)

Pearson Correlation test from Statistical Package for Social Science (SPSS) was used to establish correlation between healthcare expenditures and health outcomes.







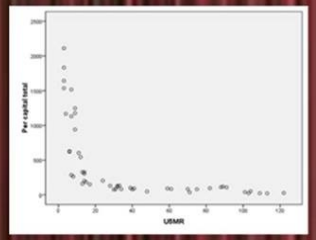


Diagram 1 Correlation between per capita total health expenditure and LEB, AMR, IMR and U5MR

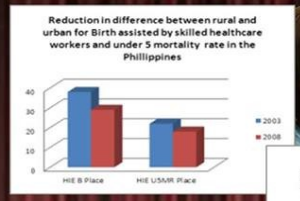
		Per capital total	LEB	AMR	IMR	U5MR
Per capital total	Pearson Correlation	1	.763**	-.810**	-.611**	-.590**
	Sig. (2-tailed)		.000	.000	.000	.000
	N	50	50	50	50	50

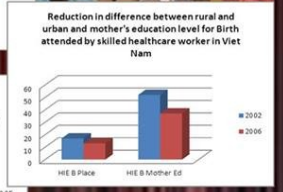
**. Correlation is significant at the 0.01 level (2-tailed).

Table 1 Correlation between per capita total health expenditure and LEB, AMR, IMR and U5 MR

Results

1. There is positive correlation between increased health expenditure and increase in life expectancy (R square 0.763, P<0.001).
2. A negative correlation was also found between increased healthcare expenditure and AMR, U5MR and IMR.
3. In Cambodia, Indonesia, Philippines and Viet Nam, increased spending reduced health inequities among urban and rural, different levels of wealth and mother's education status in two areas; Birth attended by skilled health personnel and U5MR. However, the reduction was not consistent among member countries.





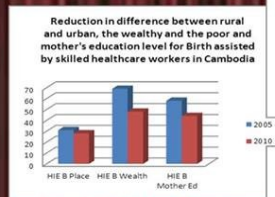


Diagram 2. Reduction in health inequities among members of ASEAN countries

Discussion

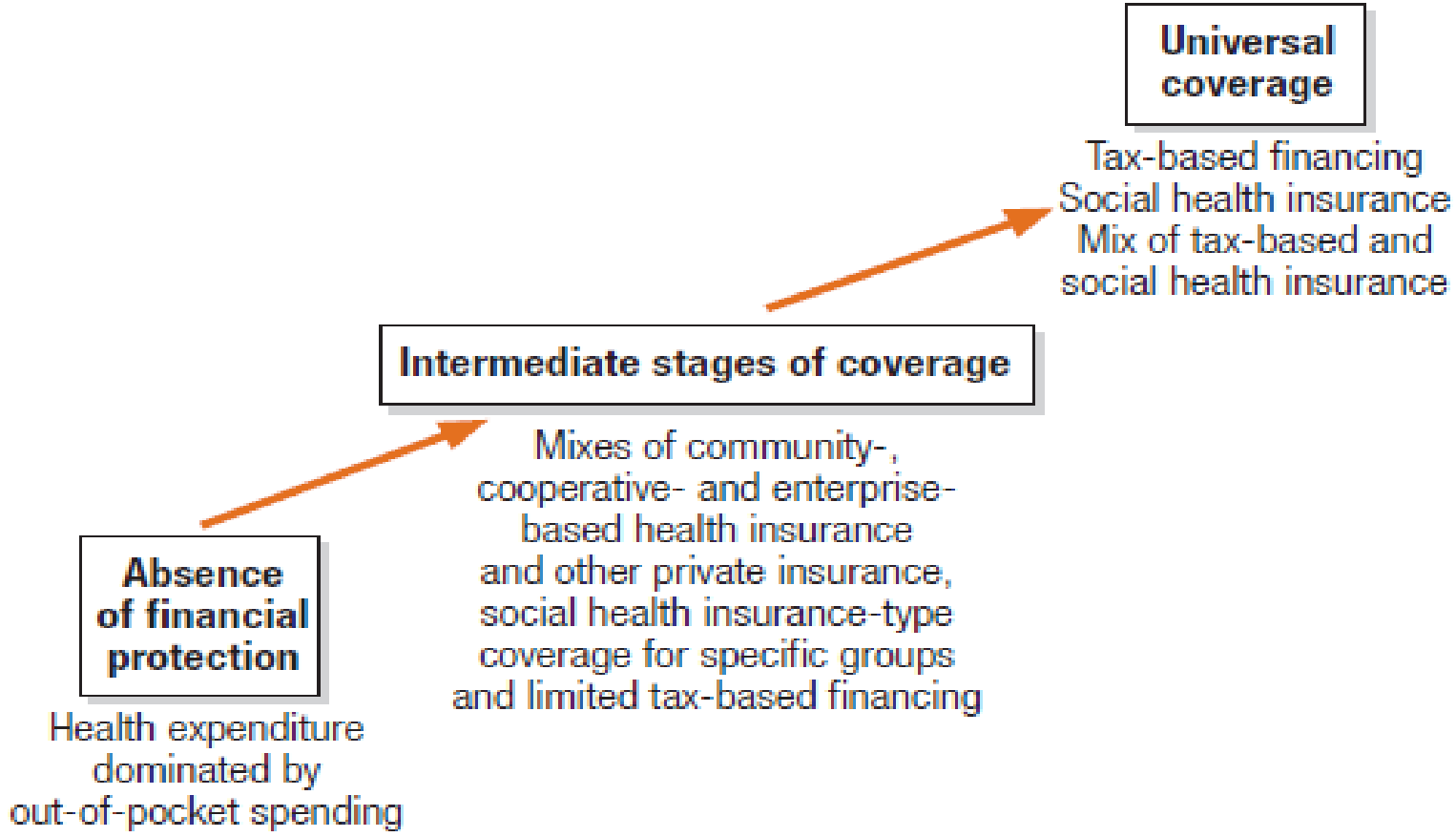
- For Southeast Asian countries, increased healthcare spending led to better health outcomes. In addition, some health inequities were found to be reduced by more healthcare expenditures.
- Inconsistency in reduction of inequities may be due to allocative inefficiency of healthcare resources among rural and urban, the wealthy and the poor, educated and illiterate populations which calls for further research.

Reference: World Health Statistics 2005-2013, World Health Organization

UNIVERSAL HEALTH COVERAGE FINANCING OPTIONS

Guy Carrin et al.

Fig. 1. **Key health financing options at different stages of the evolution towards universal coverage**[26]



UNIVERSAL HEALTH COVERAGE PROVIDER PAYMENT METHODS

Table 4. Advantages and disadvantages of alternative provider payment methods

Payment mechanism	Advantages	Disadvantages	Ways of minimizing disadvantages
Salary	Predictable expenditure Low administrative costs	Possible underprovision and/or poor quality of care Little incentive for efficient behaviour and productivity unless linked to performance	Peer review of provider practices Link part of payment to performance
Capitation	Incentive for technical efficiency and preventive care Administration costs reasonably low	Incentive for underservice Possible cream-skimming (attracting low-risk patients) Possible cost shifting (referral to another provider)	Adjust payments to risk Monitoring and peer review of provider practices (including referral patterns) Patient choice of provider
Fee for service	Incentive for technical efficiency (where fee schedules are fixed)	Incentive for overprovision and cost escalation High administrative costs	Global caps and/or adjusting fee to keep within resource limits
Budget allocation	Predictable expenditure and tight control Low administrative costs	Limited direct incentives for efficiency unless linked to performance Can lead to underservicing and cost shifting	Link part of payment to performance Monitoring and peer review
Per diem	Some incentive for technical efficiency	Incentive to extend length of stay and/or increase number of admissions	Global caps/budget limits Lower fees for longer stays
Case-based (includes diagnosis related group payments)	Strong incentive for efficient operation	Unpredictable expenditure Relatively high administrative costs Incentive for cream-skimming	Adjust for case mix, i.e. by grouping people according to their use of resources

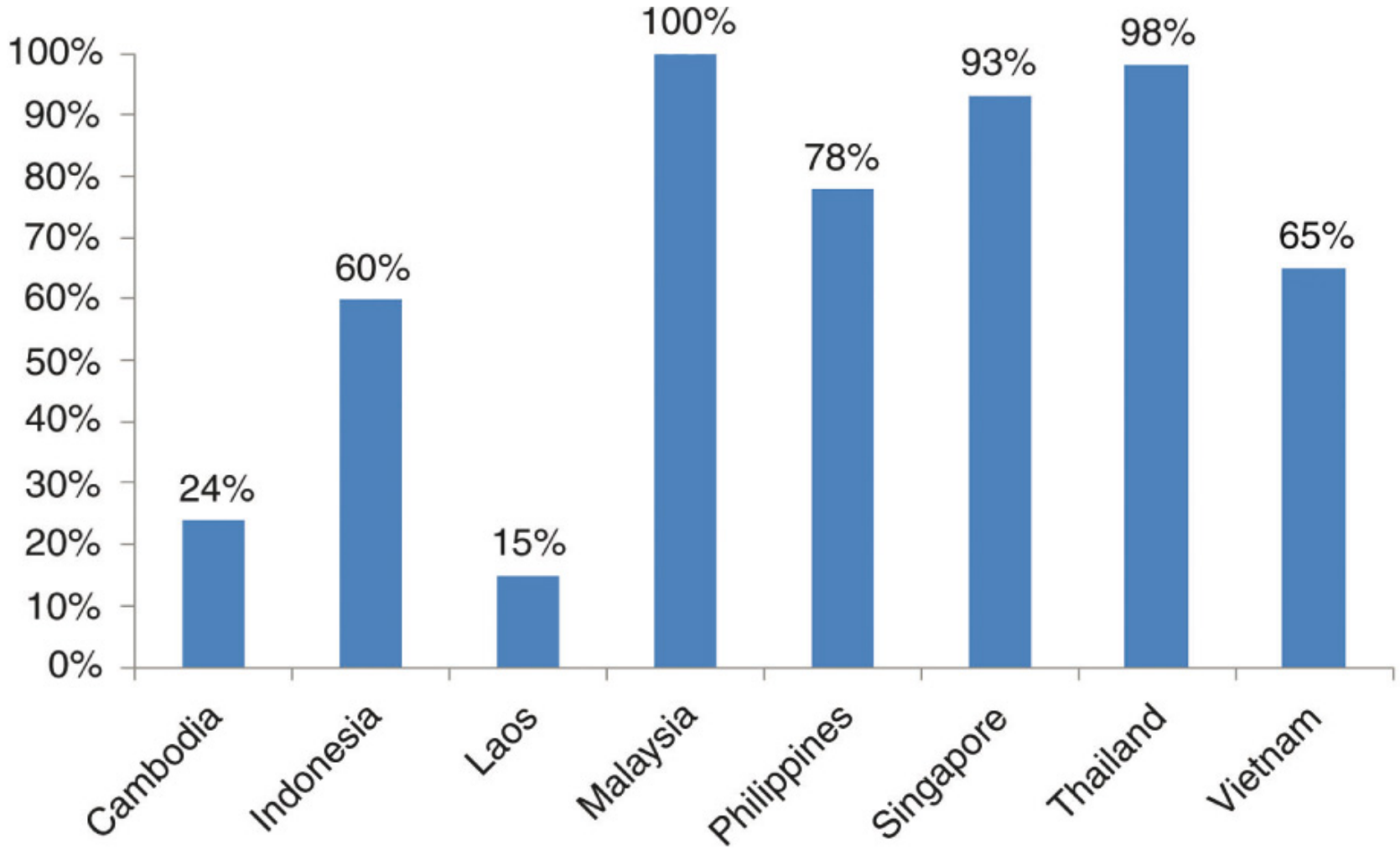
Source: Carrin and Hanvoravongchai, 2002.

Brunei

Cambodia, Laos Myanmar, Vietnam

Indonesia, Malaysia, Thailand Singapore

COVERAGE OF HEALTH INSURANCE AMONG ASEAN COUNTRIES



Reference: Progress toward universal health coverage in ASEAN, Global Heath Action

BARRIERS TO UNIVERSAL HEALTHCARE IN ASEAN COUNTRIES

Member Country	Barrier	Requirement
Cambodia	No financial scheme for public officials High OOP	Improve public expenditure Reduce OOP
Indonesia	**Insufficient infrastructure** **Lack of HIS with unique identifiers** **Unequal access due to geography**	More investment in infrastructure and technology
Laos	Low public expenditure	Improve public expenditure
Philippines	Increased in Philhealth coverage without commensurate increase in funding Health inequities	Step up funding to support Philhealth coverage Reduce health inequities by local government
Myanmar	Insufficient investment catastrophic health payments Lack of healthcare workforce	Increase government expenditure to reduce OOP Increase number of healthcare professionals
Malaysia	Shortage of healthcare professionals Appearance of dual healthcare system	Increasing production capacity Improvement of service capacity and quality of public hospitals
Singapore	**The fear of moral hazard and consequential financial unsustainability**	Incentives and policies for monitoring moral hazards
Thailand	**Availability of service delivery due to distributive inefficiency**	Attract and retain professionals in remote and rural areas
Vietnam	Low coverage (informal sector) High OOP Inadequate funding	Stronger enforcement systems More investment in infrastructure

Reference: Progress toward universal health coverage in ASEAN, Global Heath Action

UNIVERSAL HEALTH COVERAGE COMMON BARRIERS

- **Financial constraints** including low level of overall and government spending on health
- **Supply side constraints** including inadequate numbers and distribution of healthcare workers
- **Epidemiologic transition** increasing burden of non communicable diseases, persisting infectious diseases and reemerging potentially pandemic infectious diseases

Source; Progress toward Universal Health Coverage in ASEAN, Global Health Action

HOW TO OVERCOME THE BARRIERS TO UNIVERSAL HEALTH COVERAGE?

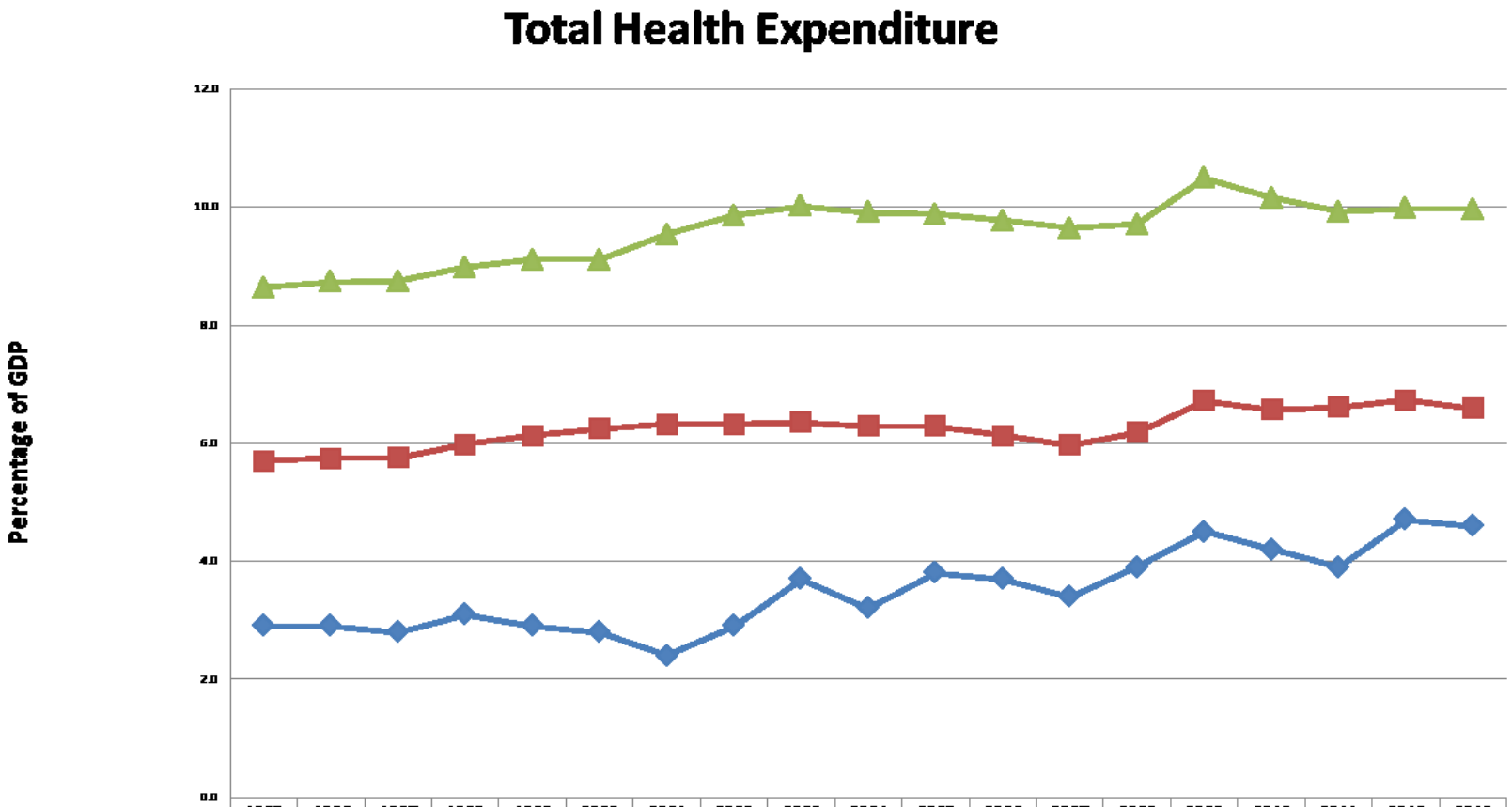
- **Political commitments to safeguard budgets and increase healthcare spending**
- **National strategies to reduce Out of Pocket expenditure**
- **Incentives to reduce allocative inefficiencies and improve efficiency of services**
- **Improving the quality of services from public hospitals**

Source; Progress toward Universal Health Coverage in ASEAN, Global Health Action

Singapore Healthcare System The Road To Universal Health Coverage

HEALTHCARE FINANCING

TOTAL HEALTH EXPENDITURE



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Singapore	2.9	2.9	2.8	3.1	2.9	2.8	2.4	2.9	3.7	3.2	3.8	3.7	3.4	3.9	4.5	4.2	3.9	4.7	4.6
Asia and the Pacific	5.7	5.7	5.8	6.0	6.1	6.2	6.3	6.3	6.4	6.3	6.3	6.1	6.0	6.2	6.7	6.6	6.6	6.7	6.6
World	8.6	8.7	8.7	9.0	9.1	9.1	9.5	9.9	10.0	9.9	9.9	9.8	9.6	9.7	10.5	10.2	9.9	10.0	10.0

HEALTHCARE FINANCING
PUBLIC AND PRIVATE CONTRIBUTION

Government Subsidies	1	**Pricing** We make good healthcare affordable for everyone.
Medisave	2	**Building up Savings** We help you save for the day should you fall sick.
MediShield	3	**Enhancing Protection** We protect you against the unexpected with insurance.
Medifund	4	**Assisting those in Need** We help out when things get rough.

Premiums?
Copayments?
Coinsurance?
Out of Pocket Payments?

Reference, Medishield Life, Ministry of Health, Singapore

GOVERNMENT HEALTH EXPENDITURE

	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14
• Operating Expenditure ($m)	1,840	2,020	2,379	2,920	3,258	3,489	4,066	5,044	**5,872**
• Development Expenditure ($m)	96	185	337	711	485	453	605	723	**1,147**
• Government Health Expenditure[1] ($m)	2,010	2,283	2,814	3,746	3,857	4,085	4,881	5,952	7,322
• Government Health Expenditure[1] (as % of GDP)	0.8	0.8	1.1	1.3	1.2	1.2	1.3	1.6	**1.9**
• Government Health Expenditure[1] (as % of Total Government Expenditure)	6.7	6.9	7.4	8.1	8.2	8.3	9.7	10.9	**11.9**

Notes:

1 - Includes expenditure from endowment funds

HEALTHCARE FINANCING

	2006	2007	2008	2009	2010	2011	2012	2013	2014
• **Medisave**									
No. of Accounts (m)	2.7	2.8	2.9	2.9	3.0	3.0	3.1	3.2	3.2
Total Medisave Balance ($b)	36.9	39.3	42.4	45.8	50.2	54.8	60.0	64.9	70.5
Average Balance per Account ($)	13,600	14,100	14,900	15,700	16,900	18,200	19,400	20,600	21,800
Amount Withdrawn for Direct Medical Expenses ($m)	445	517	558	601	678	722	767	799	852
• **MediShield & Integrated Shield Plans**									
No. of MediShield Policyholders ('000)	2,760	2,870	3,076	3,299	3,390	3,500	3,541	3,593	3,656
No. of MediShield Policyholders with Private Integrated Shield plans ('000)	1,510	1,660	1,790	1,930	2,068	2,200	2,318	2,404	**2,485**
• **ElderShield**									
No. of ElderShield Policyholders ('000)	748	786	835	872	921	977	1,013	1,019	1,167
No. of ElderShield Policyholders with Supplements ('000)	-	25	76	127	189	234	265	320	357

	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14
• **Medifund**									
No. of Applications Approved[1] ('000)	301	357	370	410	481	518	587	766	1,006
Grants Disbursed to Institutions ($m)	40.7	50.3	73.7	75.0	80.0	84.3	98.2	130.0	157.5

ACHIEVING UHC IN SINGAPORE FUNDAMENTAL SHIFT IN FINANCING

"Fundamental shifts" in healthcare financing system?

Added on: Thursday 21 March 2013
Total comments: **0**

Singapore Democrats

Healthcare systems expert Dr Jeremy Lim recently questioned Health Minister Gan Kim Yong's commitment to "fundamental shifts" in healthcare costs in Singapore.

During the recent Budget debate in Parliament Mr Gan said: "The review of our healthcare financing system will be extensive, and will involve fundamental shifts."

He added that the Government will "take on a greater share of national spending, from the current one third to about 40 per cent and possibly even further".

While the SDP applauds these steps which bring Singapore closer to where we were in the 1980s, we share with Dr Lim the concern that there is a need to go beyond incremental steps to real fundamental shifts.

As Dr Lim pointed out that the one important question to ask in the healthcare cost debate is whether healthcare in Singapore is affordable to the extent that it gives the people "peace of mind".

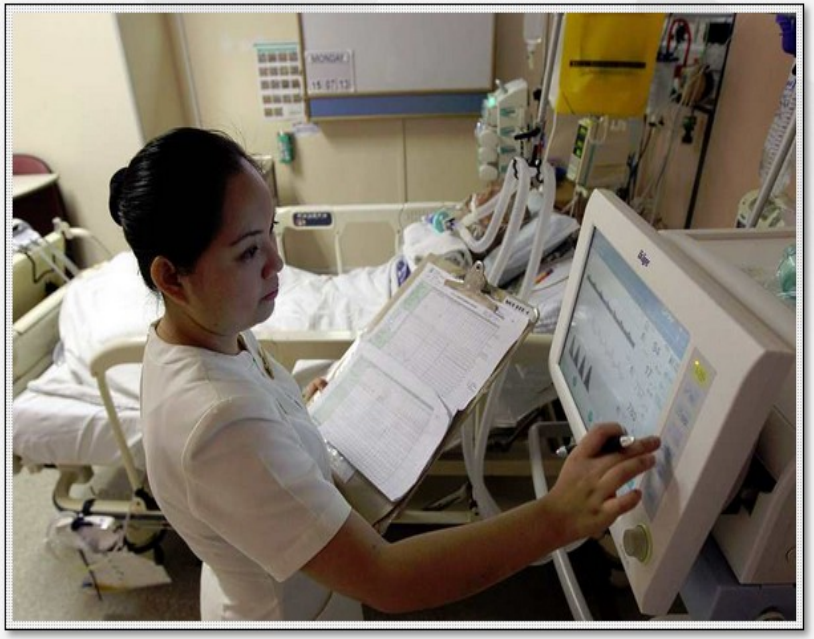
Unfortunately, the Minister for Health continues to miss the point by simply tweaking the fundamentally flawed 3M system (Medisave, Medishield and Medifund). He announced that Medisave would henceforth be allowed to be used for health screening and certain disease treatments.

Singaporeans should remember that Medisave funds are taken from our CPF savings. Even if its usage is liberalised, users continue to expend their own retirement income leaving them with insufficient savings for the future. Medisave is also used to pay for our children's and elderly parents' hospital bills when they fall ill.

All this adds to the financial burden of the people while the Government cuts back its share. This is not the way forward to a sustainable system where Singaporeans' healthcare needs

Problems with MediShield

Category: Current Affairs
Published on Thursday, 06 March 2014 00:00



One major criticism about MediShield that still dogs the national insurance scheme since it's inception 24 years ago in 1990, is that MediShield is not a truly inclusive national healthcare scheme. This is because despite the government's claim that MediShield is a national health insurance program, it still excludes providing coverage to certain population segments of Singaporean society.

The most glaring excluded segment of Singaporeans used to be newborns with congenital diseases, but this has been overcome with reforms to MediShield that were

ACHIEVING UHC IN SINGAPORE ENACTMENT OF MEDISHIELD LIFE

NO. 4] FRIDAY, MARCH 13 [2015

The following Act was passed by Parliament on 29th January 2015 and assented to by the President on 4th March 2015:—

MEDISHIELD LIFE SCHEME ACT 2015

(No. 4 of 2015)

I assent.

TONY TAN KENG YAM,
President.
4th March 2015.

Date of Commencement: 10th March 2015 Part 1, section 9, Parts 4, 5, sections 33 and 34

An Act to provide for the MediShield Life Scheme and matters related thereto, and to make consequential and related amendments to certain other written laws.

Be it enacted by the President with the advice and consent of the Parliament of Singapore, as follows:

PART 1

PRELIMINARY

Short title and commencement

1. This Act may be cited as the MediShield Life Scheme Act 2015 and shall come into operation on such date as the Minister may, by notification in the *Gazette*, appoint.

Interpretation

2.—(1) In this Act, unless the context otherwise requires —

"approved medical institution" means any medical institution approved by the Minister for the purposes of section 3;

"approved medical treatment or services" means any medical treatment or medical services approved by the Minister for the purposes of section 3;

"authorised person" —

ACHIEVING UHC IN SINGAPORE ENACTMENT OF MEDISHIELD LIFE

Benefit Parameter	MediShield	MediShield Life
Daily Limits	$450 / $900 (Normal / ICU Ward)	$700 / $1200 (Normal / ICU Ward)
Surgical Limits	$150 - $1,100	$200 - $2,000
Community Hospital Limit	$250 per day	$350 per day
Outpatient Cancer Treament Claim Limits	Chemo: $1,240 per 21/28 day cycle Radio: $80 - $160 per session	Chemo: $3,000 per month Radio: $140 - $500 per session
Deductibles (B2 / C)	80 and below: $2,000 / $1,500 Above 80: $3,000 / $2,000	No change
Co-Insurance	Inpatient: 10 - 20% Outpatient: 20%	Inpatient: 3* - 10% Outpatient: 10%
Annual Limit	$70,000	$100,000
Lifetime Limit	$300,000	Removed

8 THINGS YOU NEED TO KNOW ABOUT MEDISHIELD LIFE

1 It covers everyone

- All Singapore Citizens and Permanent Residents
- Even if you have pre-existing conditions
- Even if you were previously rejected by insurers

2 It protects you for life

3 It provides better benefits than MediShield

- MediShield Life will pay more of your hospital bill, and you will pay less

4 Premiums will be payable by Medisave

5 With better benefits, premiums will be higher than MediShield

6 Government will provide significant support

- Premiums Subsidies for the lower- to middle-income
- Pioneer Generation Subsidies
- Transitional Subsidies for all Singaporean Citizens for the first four years to ease the shift from MediShield to MediShield Life

7 The needy will not lose coverage

- Additional Premium Support for those who cannot afford premiums even after subsidies

8 No need to apply

- MediShield Life will replace MediShield in end 2015
- Automatic inclusion for Singapore Citizens and Permanent Residents

MEDISHIELD LIFE ONE YEAR LATER

More get help with medical bills under MediShield Life

Madam Yuen Soh Ying, 92, fell and fractured her hip in April. The total bill for surgery and rehabilitation was more than $10,000. But between MediShield Life and Medisave, her family only had to pay $100 in cash. PHOTO: COUTESY OF MADAM YUEN SOH YING

PUBLISHED 8 HOURS AGO

m/newsletter/regform

ST VIDEOS

Woman dragged away by tiger at China wildlife park seeking 2 million yuan compensation

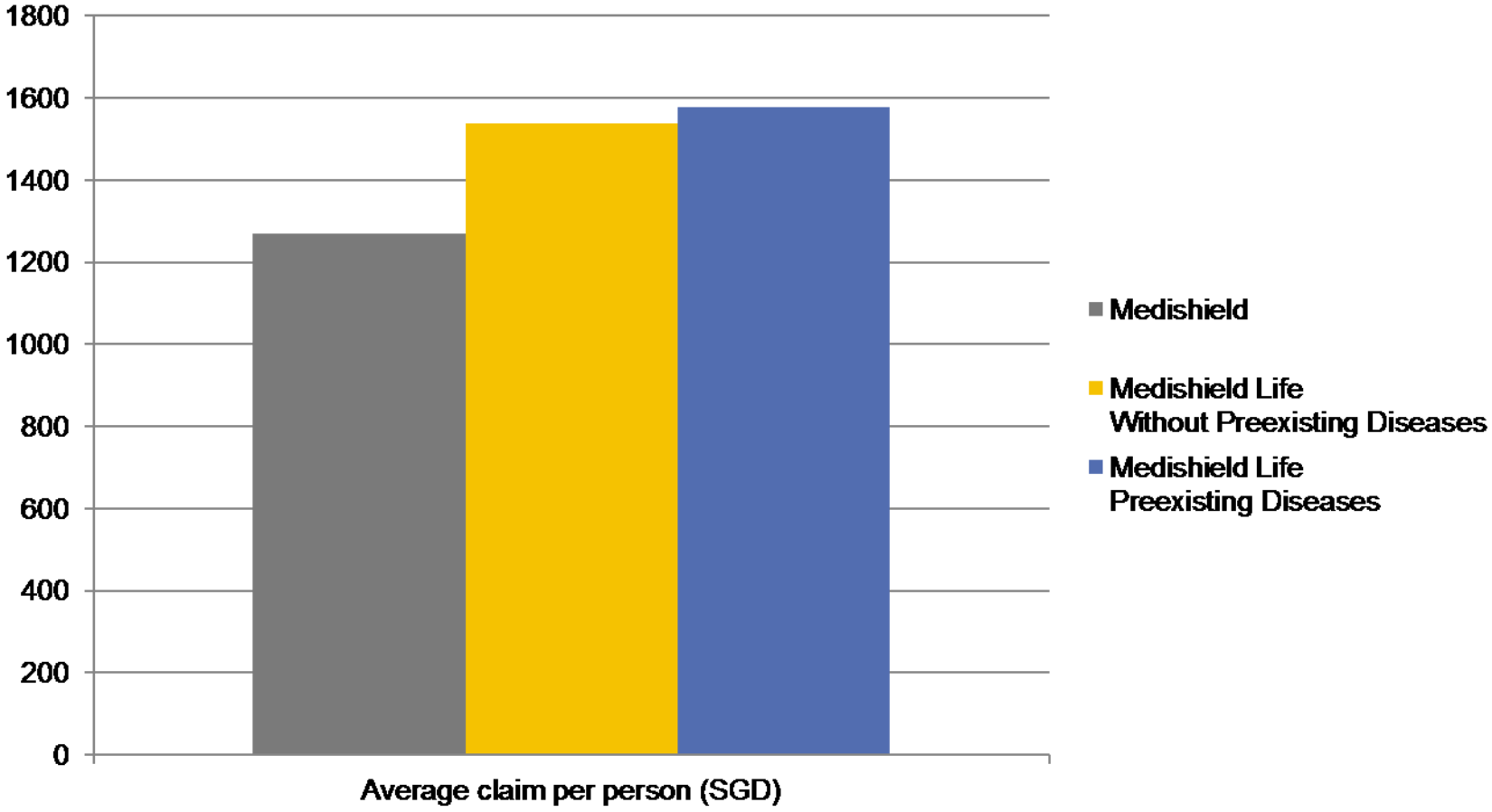
This school in South Korea has only three pupils

Sarawak mall dumps 1,500 bowls of 'unhealthy' laksa after setting national record

Clinton returns to centre; Trump's power is checked

Recommended by Outbrain

MEDISHIELD LIFE ONE YEAR LATER



- 307 Mio for 291,500 annual claims (Medishield)
- 600 Mio for 400,000 annual claims (Medishield Life)

MORAL HAZARD

Individual Mean Testing

- Based on means of **patient only**
- Pros: Can get consent and determine subsidies on the spot
- Cons: Unfair for some patients (e.g. high income but many dependents to support)
- Used for inpatient treatment as admissions are once-off and short

Household Mean Testing

- Based on **means of patient's household**
- Pros: Fairer than individual MT and easier to do than family MT
- Cons: Unfair for some patients (e.g. dependents such as parents not staying with patient)
- Used for ILTC services and outpatient treatment as care is long term (July 2012)

Family Mean Testing

- Based on means of **patient's family** (not just household)
- Pros: Fairest
- Cons: Labour intensive for staff and patient, only for small volume
- Used by Medical Social Workers for financial assistance such as Medifund

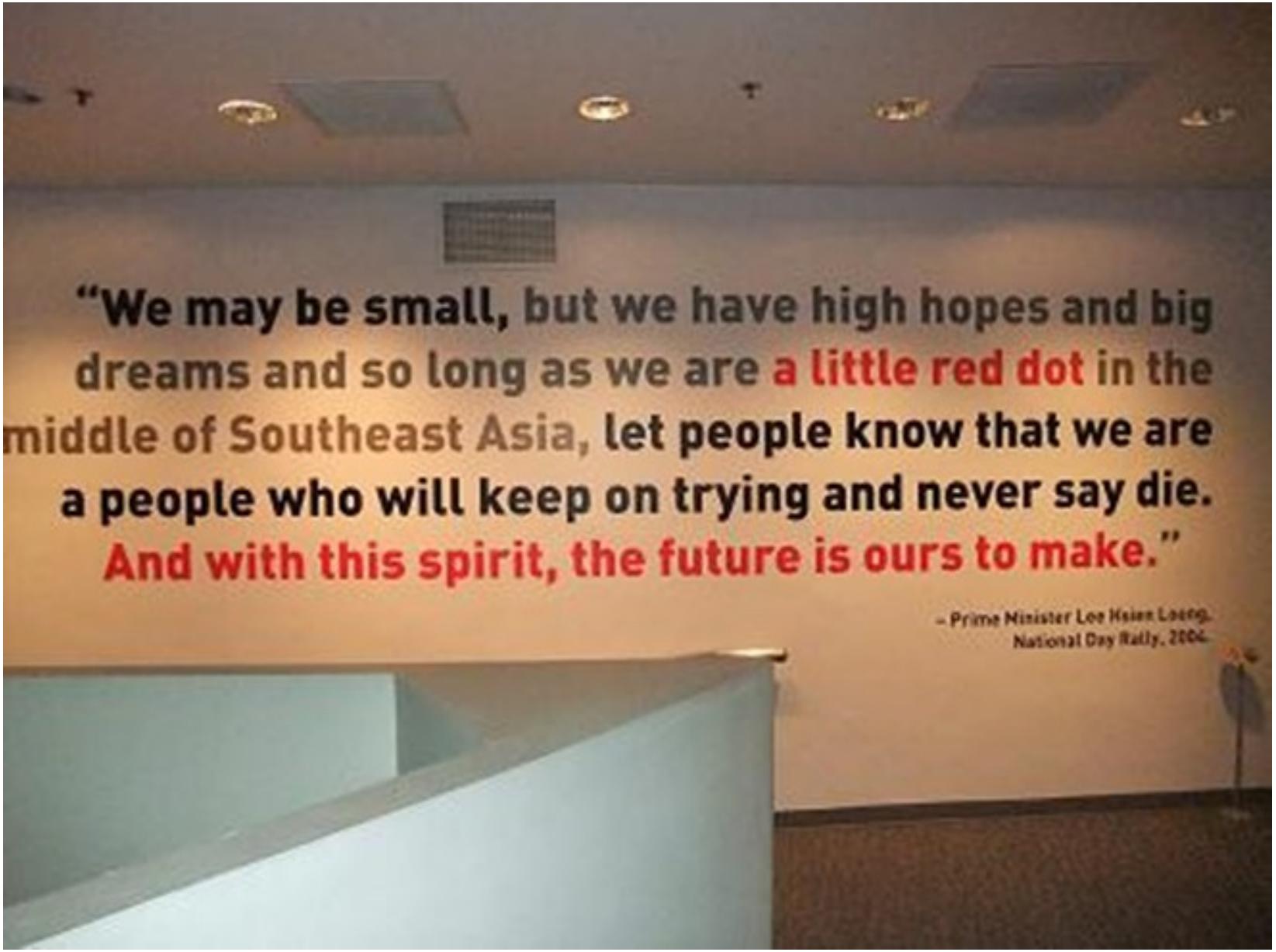
HEALTHCARE 2020

A GUIDE IN BUILDING AN INCLUSIVE HEALTHCARE SYSTEM FOR THE FUTURE

- Set up Regional Health System
- Support Primary Care via FMCs, CHCs, MC & Subsidies
- Support Palliative Care

- Build Capacity
- Engage Private Sector
- Build World-Class Public Healthcare Workforce

- Expand outreach of subsidies to outpatients (e.g. CHAS), ILTC
- Increase Subsidies in the RHs
- Enhance Medishield Coverage & Benefits
- Ensure Sustainable Healthcare Spending


"We may be small, but we have high hopes and big dreams and so long as we are a little red dot in the middle of Southeast Asia, let people know that we are a people who will keep on trying and never say die. And with this spirit, the future is ours to make."
– Prime Minister Lee Hsien Loong, National Day Rally, 2004.