

The background is a vibrant blue with a textured, slightly grainy appearance. It is decorated with various abstract elements: a large yellow cross in the top left, a red curved bar at the top right, a yellow hand icon pointing right, a white cloud with a lightning bolt, a yellow pill, a blue pill, a green pill, a red checkered pattern, a blue hand icon pointing left, a yellow rectangle, a green circle, and several white dashed lines and dots. In the top left, there is a small yellow cross with the binary code '01110', '10110', and '01101' next to it. In the bottom center, there is a small white icon of a hand with fingers spread.

Chapter 3

The need for Universal Health Coverage

The COVID-19 pandemic is a stark reminder that health is not to be taken for granted and has put the spotlight on social determinants of health and many existing gaps and challenges in the region's health care systems. Over 40 per cent of all countries globally reported disruptions in availability and quality of services.⁹² Major challenges have included a lack of health care resources and an entrenched distrust of certain services. In addition to being important in its own right,^{93, 94} good health is central to human capital formation.⁹⁵ Recent simulation results suggest that additional investments in health would increase GDP per capita and significantly decrease poverty in low-income countries. There is also a wealth of empirical studies that link good health to positive economic growth, including in South Asian countries.^{96, 97}

When the workforce is healthy and has access to healthcare, everyone wins.⁹⁸ When workers' basic rights are upheld, their wellbeing and productivity increases, opening a range of opportunities for workers and their households. Firms enjoy increased productivity, lower absenteeism, a larger pool of qualified jobseekers and higher levels of staff retention. Governments would see higher output and tax revenues. When workers' need for healthcare is not met, access bars many working-age adults from participating in the labour force. This comes with a plethora of social and economic costs to individuals, families and society, including loss of income, productivity and premature death. Each year, the lack of affordable health care results in catastrophic health expenditures and high out-of-pocket payments that push millions of households into poverty.⁹⁹ Achieving a healthy workforce is a tangible measure that generates a virtuous cycle, underpinned by solidarity.

Shielding the workforce from financial hardship as a result of individual health emergencies as well as global health shocks requires Universal Health Coverage (UHC).¹⁰⁰ This is a crucial goal to attain inclusive and sustainable development. Providing social health protection (SHP) is the main demand-side policy instrument that can help countries progress toward UHC.¹⁰¹ As a rights-based approach, SHP provides all people, irrespective of whether they work or not, with effective access to quality health care without financial hardship. It also provides income security to compensate for loss of earnings due to sickness. It can therefore improve workers' health and well-being and lower premature deaths.

More than one third of the population in Asia and the Pacific is not effectively protected by a healthcare scheme, leaving behind about 1.6 billion people.¹⁰² This exclusion means that close to 6 in 10 workers have to finance their own healthcare costs in times of illness.¹⁰³ Lacking income protection means no salary when absent from work. Health insurance, financed privately or through contributions, is only extended to one in five people in the region.¹⁰⁴ Except for Central Asia, universal health coverage slowed in all ESCAP subregions during 2010–2019, relative to 1990–2010. It is estimated that by 2023, nearly one third of the global population without universal health coverage will be residing in South Asia.¹⁰⁵

Within the workforce, certain population groups including women, youth, rural residents, persons with disabilities, migrants and refugees are disproportionately disadvantaged, often as a result of their informal and precarious working arrangements. Extending social health protection to all would leave no one behind, irrespective of people's demographic, socioeconomic and employment situation. Such

92 World Health Organization (WHO) (2022). Third round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic: November–December 2021. Interim report. WHO.

93 Gary S. Becker, Tomas J. Philipson and Rodrigo R. Soares (2005). The Quantity and Quality of Life and the Evolution of World Inequality. *American Economic Review*, 95 (1).

94 Dean T. Jamison, Lawrence H. Summers et al (2013). Global health 2035: a world converging within a generation. *Lancet* 2013, 382, p. 1898–1955.

95 Gary S. Becker (2007). Health as Human Capital: Synthesis and Extensions, *Oxford Economic Papers* 2007.

96 David E. Bloom, David Canning, Jaypee Sevilla (2004). The Effect of Health on Economic Growth: A Production Function Approach, *World Development*.

97 Seema Narayan, Paresh Kumar Narayan and Sagarika Mishra (2010) Investigating the relationship between health and economic growth: Empirical evidence from a panel of 5 Asian countries, *Journal of Asian Economics*. Elsevier, vol. 21(4), p. 404–411.

98 Chris Orchard (2015). The Business Benefits of a Healthy Workforce. Op-ed Harvard Business School.

99 Sirag Abdalla and Norashidah Mohamed Nor (2021). Out-of-pocket health expenditure and poverty: Evidence from a dynamic panel threshold analysis. *Healthcare* (Basel). May 2021, 9 (5), p. 536.

100 The Report follows the WHO definition of UHC. This requires a full spectrum of essential and quality health services to be provided to all individuals throughout their life whenever necessary, without recipients suffering financial hardship as a consequence. This definition is also embedded in 2030 Agenda on Sustainable Development, particularly in Sustainable Development Goal 3.8 which is monitored over time by WHO.

101 See Bayarsaikhan, Tessier and Ron (2022) for a discussion of UHC and SHP.

102 International Labour Office (ILO) (2021). *Extending social health protection: Accelerating progress toward universal social health protection in Asia and the Pacific*. ILO, Geneva.

103 Ibid.

104 ESCAP elaborations based on DHS StatCompiler accessible at <https://www.statcompiler.com/en/> accessed in April, 2022.

105 Global Burden of Disease 2019 Universal Health Coverage Collaborators (2020). Measuring universal health coverage based on an index of effective coverage of health services in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet* 2020; 396: 1250–84.

a comprehensive and inclusive approach is imperative to address the social determinants of health and improve the health and productivity of the current workforce, particularly in the face of rapid population ageing in the region. This approach is also ideal for the future workforce as it ensures that all children and youth have access to basic healthcare needed to thrive in their early years as they build their human capital.

3.1 The state of health among the workforce in Asia and the Pacific

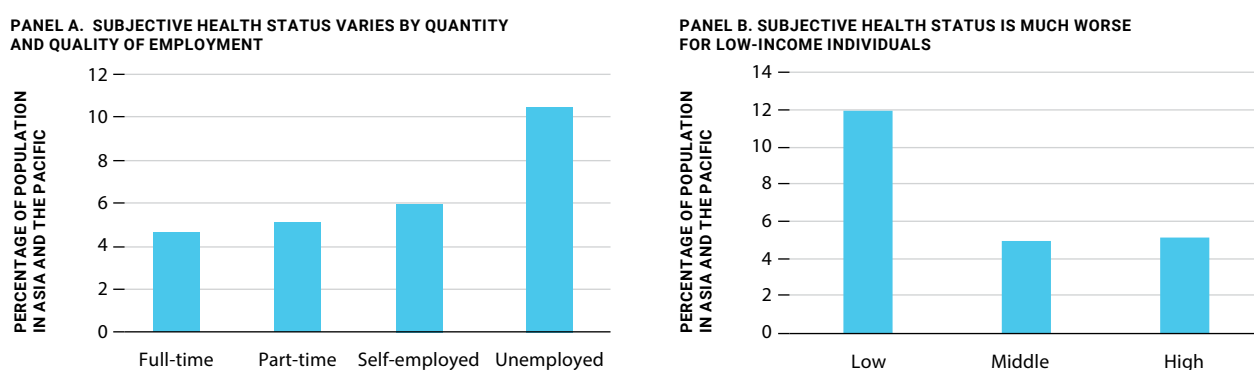
Poor health continues to widen inequalities within the workforce.¹⁰⁶ Recent data on subjective health status¹⁰⁷ affirm these problems. Poor health appears less common among full-time employees relative to part-time or self-employed workers, while the unemployed reports highest levels of poor health (figure 3.1, Panel A). Income status is a major factor determining health deficits among people (figure 3.1, Panel B). On average, 12 per cent of low-income earners in the region report poor health, compared to 5 per cent among high-income

individuals. Outside the labour force, poorer health is disproportionately reported by persons with disabilities and older persons.

While the health of employed people may be better than that of the unemployed, deficits in occupational safety and health can be very high in Asia and the Pacific because of low levels of decent employment. Globally, 2.9 million workers die every year as a result of preventable accidents and diseases.¹⁰⁸ When the burden of disease attributable to 19 occupational risk factors is considered, the global death toll in 2016 was 1.9 million, with Asia and the Pacific accounting for 1.2 million deaths. This implies almost 90 million disability-adjusted life years (DALYs) globally where one DALY is the loss of the equivalent of one year in full health. In Asia and the Pacific, DALYs reached 55 million in 2016.¹⁰⁹ Exposure to long working hours is the leading occupational risk factor for attributable death, followed by occupational exposure to particulate matter, gases and fumes. The burden of disease falls disproportionately among males and older age groups.¹¹⁰ The death tolls and injuries vary across sectors by each risk factor. Fatal injuries occur most in the construction, manufacturing and transportation and storage sectors.¹¹¹ Women at work often face different and additional risk factors

FIGURE 3.1 Poorer health among vulnerable workers in the Asia-Pacific region

Share of population with poor health by employment status and level of income



Source: WVSA (2022). World Values Survey, Wave 7. Available at <https://www.worldvaluessurvey.org/> (accessed in January 2022).

Note: Weighted results from 27 countries in Asia and the Pacific directly obtained from WVS interactive tool. Figures exclude those reporting “do not know” or “no answer”. Poor and very poor health are bundled together for space brevity. Full-time employment assumes at least 30 hours of work per week. Income status and highest level of education is recoded as per WVS guidelines.

106 Quamrul H. Ashraf, Ashley Lester and David N. Weil (2009). When Does Improving Health Raise GDP? National Bureau of Economic Research (NBER) *Macroeconomics Annual* 2008, vol. 23. University of Chicago Press.

107 The subjective nature of evaluating one's own health status is open to various biases. Differences among specific groups should therefore be interpreted with caution and only descriptively.

108 International Labour Office (ILO) (2022). *Enhancing social dialogue towards a culture of safety and health: What have we learned from the COVID-19 crisis?* ILO, Geneva.

109 World Health Organization and International Labour Office (WHO) (ILO) (2021). *Joint Estimates of the Work-related Burden of Disease and Injury, 2000–2016: global monitoring report*. World Health Organization and International Labour Office, Geneva.

110 Ibid.

111 ESCAP elaborations based on ILOstat data on SDG target 8.8 which calls for the protection of labour rights and promotion of safe and secure working environments for all workers, including migrant workers, in particular women migrant workers and those in precarious employment. Indicator 8.8.1 measures this target partly by frequency of fatal and non-fatal occupation injuries.

and hazards. Given the importance of prevention at work and the need to invest in a systems approach, the ILO Centenary Declaration for the Future of Work in 2019 raised the importance of including safe and health working conditions. ILO Declaration on Fundamental Principles and Rights at Work was then amended accordingly in 2022.

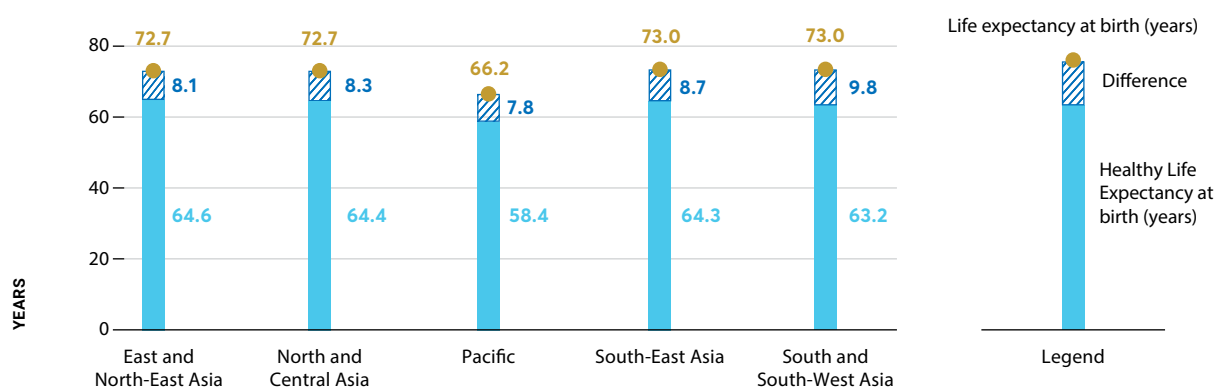
The latest data on key health indicators illustrate increasing gaps in life expectancy at birth, survival to age 65 and child mortality rates. The situation is particularly dire for workers in low- and lower-middle income countries, where the majority of informal and vulnerable workers live and have lower levels of productivity.

Access to basic health care should start from early childhood and continue throughout a person's life. This is crucial to build a strong functional ability needed in older ages to meet basic needs, such as being mobile, contributing to society and ageing with dignity. A complementary indicator for overall health status is healthy life expectancy at birth which measures the number of years of good health that a newborn can expect. The health gap between healthy and standard life expectancy represents the number of years lost to disease, injury or disability. Across Asia and the Pacific, there is on average almost a decade lost in healthy years. Even more concerning is that there has been virtually no progress since the early 2000s.¹¹² The health gap remains high in 45 countries across the region, particularly in South and South-West Asia (figure 3.2).

The burden caused by disease comes increasingly from non-communicable diseases (NCDs) and injuries. Chronic illnesses are becoming more prevalent. Their financial implications are concerning not only for the workers but also for their dependents. SDG target 3.4 calls for the reduction in premature mortality from NCDs through prevention and treatment, and promotion of mental health and wellbeing. Indicator 3.4.1 measures part of this target, focusing on the probability of death between the ages of 30 and 70 from cardiovascular disease, cancer, diabetes or chronic respiratory disease. This indicator is therefore closely related to health risks in the workforce. Data from 2019 across 47 countries in the region indicate the threat of NCDs for the workforce, particularly in the Pacific (excluding Australia and New Zealand). The probability of death from NCDs in this subregion is on average 38 per cent. East and North-East and North and Central Asia follow with an average of 24 per cent probability of death from NCDs. Across the region, men are particularly susceptible to NCDs. In Georgia, Mongolia and the Russian Federation, men's risk of dying from a NCD is 20 percentage points higher compared to women. While social determinants of health extend beyond employment status, precarious and informal work can increase disease burden on the workers. A recent study found that working longer hours particularly in the informal economy can lead to higher likelihood of developing cardiovascular diseases.¹¹³

FIGURE 3.2 Healthy ageing at risk across the Asia-Pacific region

Average years of healthy and standard life expectancy at birth, by subregion, 2020



Source: WHO (2022), The Global Health Observatory. Available at <https://www.who.int/data/gho> (accessed on 12 March 2022).

Note: Data are available for 45 countries in 2020. Simple averages are presented following ESCAP subregional classifications. High-income countries including Australia, Japan, the Republic of Korea and New Zealand are excluded from the graph.

112 World Health Organization (WHO) (2008). *Health in Asia and the Pacific*. WHO, Geneva, Switzerland.

113 Frank Pega, Bálint Náfrádi, Natalie C. Momen, Yuka Ujita, et al. (2021) Global, regional, and national burdens of ischemic heart disease and stroke attributable to exposure to long working hours for 194 countries, 2000–2016: A systematic analysis from the WHO/ILO Joint Estimates of the Work-related Burden of Disease and Injury, *Environment International*, Volume 154, 2021, 106595.

3.2 Universal Health Coverage remains an ambition in Asia and the Pacific

Throughout Asia and the Pacific, significant gaps in UHC remain. Legal health coverage does not always translate into effective health coverage. The average UHC service coverage index (SDG indicator 3.8.1) for the region stands at 64 (0 indicating no coverage and 100 indicating universal coverage) but ranges from 33 in Afghanistan to 86 in Australia (figure 3.3). Countries with values below the regional average are largely found in South and South-West and South-East Asia.

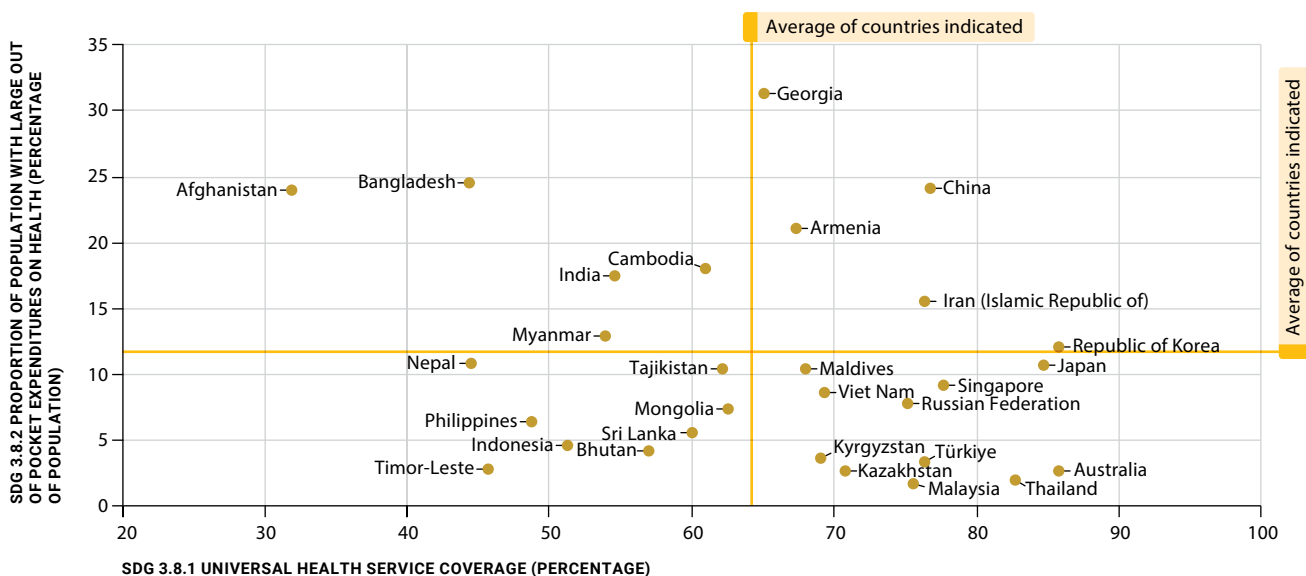
Another measure of great importance is out-of-pocket expenditures on healthcare. Catastrophic out-of-pocket health expenditures are defined as when a household spends more than 10 per cent of total household expenditures on healthcare (SDG indicator 3.8.2). This indicator shows large variation across the region, from below 2 per cent of the population in Malaysia to over 30 per cent in Georgia (figure 3.3). About half of the countries have less than 10 per cent of their population exposed to catastrophic out-of-

pocket expenditures. In Afghanistan, Armenia, Bangladesh, China and Georgia, the population share exceeds 20 per cent.

Figure 3.3 illustrates country groupings of achieving universal health coverage. In the top-left quadrant, a few countries in South and South-East Asia can be seen with a substantial room to broaden both service coverage and financial protection. In the top-right quadrant, only upper-middle-income countries are seen with a need to prioritize the financial protection of their citizens. In the bottom left quadrant, countries need to prioritize service coverage, while maintaining financial protection. Many countries in the bottom-right quadrant are close to achieving UHC. These are also countries that have introduced important healthcare reforms in the early 2000s, notably Maldives, Thailand, Türkiye and Viet Nam.

ESCAP estimates that over the past two decades the annual growth rate in UHC service coverage index in the region was on average 2 per cent, with a maximum of 6 per cent in China.¹¹⁴ If countries could sustain their average long-term growth rate in UHC service coverage index each year up to 2030, only seven countries (i.e., Cambodia, China, Indonesia, Islamic Republic of Iran, Malaysia, Singapore and Thailand) would reach the maximum

FIGURE 3.3 Large variation in Universal Health Coverage in the Asia-Pacific region



Source: WHO (2022), The Global Health Observatory. Available at <https://www.who.int/data/gho> (accessed on 29 March 2022).

Notes: The Universal Health Coverage (UHC) service coverage index on the x-axis is a composite index covering 14 tracer indicators of health service coverage including reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases. As a unitless index, it ranges between 0 and 100 with higher values representing higher service coverage. Financial protection, on the y-axis measures the share of households with over 10 per cent of their total household expenditures or income devoted to health.

¹¹⁴ The results are based on a simple linear projection for 51 countries in. Countries are likely to follow a non-linear path. To avoid further assumptions, only a linear projection was carried out.

score in the index by 2030. A few countries would come close to universal health coverage, including Japan,¹¹⁵ Myanmar, the Republic of Korea, the Russian Federation and Viet Nam. For some countries like the Philippines and Timor-Leste, this would require much faster growth in coverage expansion than what has previously been observed. Accelerating the expansion of universal health coverage must therefore be a priority for most countries in the Asian and Pacific region.

In 13 of 32 regional countries, financial protection has improved, especially in Kyrgyzstan, Maldives, Thailand, Türkiye and Viet Nam, where the share of population with catastrophic health expenditures more than halved. Conversely, the share of the population with exposure to catastrophic health expenditures more than doubled in Afghanistan, Bhutan, China, Georgia, India, Mongolia, the Philippines and the Russian Federation.¹¹⁶ Consequently, the region is now home to the highest number of people globally who could be impoverished as a result of falling ill. This is not only detrimental for the workforce but also inconsistent with the principles of solidarity and equity and requires effective cost-sharing within societies and between generations.

Digital technologies can play a significant role in helping countries progress toward UHC, especially when fiscal space is limited.¹¹⁷ While they have long penetrated the health sector, their potential to empower beneficiaries through transparency and accountability, improve the quality of healthcare, detect disease outbreaks and support payments has not yet been reached in developing countries in the region. Some countries are increasingly making use of digital technologies in rapidly expanding coverage to wider populations. India's Aadhar program integrates health data of over 1.2 billion citizens to improve the management of health insurance programmes.¹¹⁸ The COVID-19 pandemic accelerated the adoption of digital technologies and led some local health governments to pilot

online care delivery and virtual health. The private sector has also increasingly been filling the service delivery gaps governments leave. Large platforms such as AliHealth and Ping An Good Doctor (China), Practo and 1MG (India) and Halodoc or Alodokter (Indonesia) have brought health care providers closer to some 1.5 billion users.¹¹⁹

3.3 The impact of health care reforms

To build a productive, healthy and protected workforce, health reforms towards UHC need to be integrated with other sectors, most notably social protection and decent employment. Türkiye is one of few regional developing countries that has substantially extended UHC.¹²⁰ Between 2003 and 2013, Türkiye implemented the Health Transformation Program (HTP) and ensured access to health services for all. The HTP was complemented with reforms in social security and universal health insurance in 2008. The single purchaser model and unified approach in HTP gave full responsibility to the Social Security Institution in Türkiye which collected revenues, pooled resources and expenditures and purchased relevant goods and services. Results-based management and regular monitoring and evaluation were critical. The results of HTP were overwhelmingly positive.¹²¹ Life expectancy at birth increased by 6 years between 2002 and 2014 and child- and infant mortality dropped significantly. The reform increased the share of the population satisfied with health services by over 90 per cent. Despite these advances, health expenditures only increased from 5.4 per cent in 2000 to 6.7 per cent of GDP in 2011. During the same period, out-of-pocket expenditures almost halved. The HTP did not leave the poorest behind, but expanded coverage widely from 24 to 85 per cent in the lowest income decile. Türkiye achieved legal coverage for all and approached effective UHC which improved population health, financial risk protection and user satisfaction,¹²² although there

115 UHC is legally achieved in Japan thanks to the statutory health insurance system which together with public social assistance program covers the entire population.

116 In many developing countries it is the rich who incur large out-of-pocket health expenditures as they can afford higher quality services that are easily accessible through the private sector.

117 United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) (2022). *Economic and Social Survey of Asia and the Pacific (2022): Towards post-COVID-19 resilient economies*. ESCAP, Bangkok.

118 World Bank (2018). *Business Unusual: Accelerating Progress Towards Universal Health Coverage*. World Bank, Washington, DC.

119 McKinsey and Company (2022). *The future of healthcare in Asia: Digital health ecosystems*.

120 The selection of Türkiye is partly driven by the availability of the Income and Living Conditions Survey which offers a rich set of data on health care. Health care reforms in Thailand, Viet Nam, China and Malaysia are equally important good practices with substantial positive impact.

121 World Bank (2018). *Turkish Health Transformation Program and Beyond. Results Brief*. World Bank.

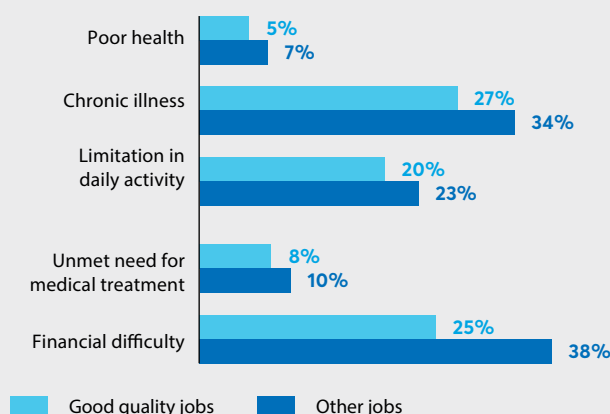
122 Rifat Atun (2015). Transforming Turkey's Health System – Lessons for Universal Coverage. *The New England Journal of Medicine*, 373, p. 1285–1289.

BOX 3.1 Health care reforms in Türkiye

Half a decade after HTP's full implementation, the Household Income and Living Conditions Survey of Türkiye before the pandemic (2019) can help elucidate the health status of the workforce along with access to health care. First, only 4 per cent of the labour force reported poor health at the time of the survey even though about a quarter had a long-standing chronic illness or condition such as diabetes, hypertension, asthma, renal failure or rheumatic diseases. While about 16 per cent of the overall labour force reported limitations in daily activities because of physical or psychological health problems in the past six months, over 60 per cent among those with chronic illness reported limitations in daily activities. Estimating aggregate economic cost due to such limitations is beyond the scope of this Report. However, it is important to recognize that such limitations can have economically meaningful productivity and welfare effects at the individual, household, and national levels.

When asked about unmet need for medical examination or treatment during the last 12 months, only 8 per cent reported that in at least one occupation they had unmet need. Among this group, three main reasons were reported including financial (30 per cent), inability to take time off due to work or care for children or others (25 per cent), wanted to wait and see if the problem got better on its own (23 per cent) and late time for appointments (12 per cent) and distance to health facility (5 per cent). There are some gendered differences in these reasons with men being more likely to wait and see while women are more likely to report that they could not take time off due to work or care of children or others.

Formal regression analysis controlling for individual and household circumstances such as sex, age, education, location and household income continue to find statistically significant differences among the employed within the labour force particularly when the quality of employment is taken into consideration. As shown in figure 3.4, workers with access to good quality jobs^a are less likely to report poorer health, chronic illnesses, limitations in daily activities in the past six month and unmet need for medical examination or treatment in the past 12 months. Among those who report unmet needs, financial difficulty is much less likely to be reported as the main reason among workers with good quality jobs.

FIGURE 3.4 Health and decent employment in Türkiye

Source: ESCAP elaborations based on Income and Living Conditions Survey (2019), Türkiye obtained from the Turkish Statistical Institute (TURKSTAT).

Note: Predicted probability for selected indicators based on ILC Türkiye. Total number of observations is 27,524 individuals in the labour force.

Even after controlling for quality of employment, differentials emerge across individual circumstances. Notably, women are more likely to report poorer health and chronic illnesses than men in the labour force. Older people and people with no education and primary education are also more likely to report these negative health outcomes relative to youth and adults as well as people with secondary and tertiary education, respectively. Such differentials in outcomes are also observed in access to health care. The disadvantaged groups are more likely to report unmet need for health care, particularly due to financial difficulties. It is important to note that these results should not be interpreted as causal relationship between decent employment and health of the workforce since they are likely to be simultaneously determined by unobserved factors and reinforce one another over time. Further analysis is needed to isolate the exogenous impact of good quality jobs on health outcomes.

^a The quality of jobs is determined by the availability of variables in the survey including status of employment, status of registration in social security and type of contract. This is in a similar vein to Section 2.3 although here the Income and Living Conditions Survey is used as opposed to the Labour Force Survey.

is still room for improvement for disadvantaged groups. Supporting the workforce during the green transition to access decent employment would further improve health outcomes and access to health care in Türkiye.

In Maldives, the introduction of the UHC scheme called 'Aasandha' in 2012 was a milestone in boosting access to health care services. Services that used to be out of reach for some segments of the population became available and free of charge overnight, albeit with a capped limit. This cap was subsequently removed in 2014 with the introduction of a new UHC scheme called "Husnuvaa Aasandha", which meant unlimited health coverage for Maldivian nationals.¹²³ The Maldives' experience exemplifies how the introduction of UHC has improved access to services, even as service availability concerns are being replaced by ease of access concerns. Nevertheless, access has had a positive impact on the health of women of working age. Earlier studies have also shown a positive correlation between births attended by skilled health care professionals and the share of the population protected by a health care scheme.¹²⁴

An examination of over time progress across countries, using skilled birth attendance (as a common proxy of access to health care) indicates that countries with more established UHC schemes stand out (figure 3.6, Panel A). While all countries above the diagonal line have seen some progress, the Maldives have made the most dramatic jump from a coverage of 1 in 3 to 100 per cent in less than one decade. Inequality in access follows a similar pattern: the gaps between groups furthest ahead and furthest behind in access to skilled birth attendance have fallen across most countries in the region (countries below the diagonal line, figure 3.6, Panel B). The case of the Maldives is again exemplary as UHC elevated access of the majority of women by leaving no one behind.

Despite this promising progress, gaps in access to health care linger across the region. The furthest behind groups often consist of poorer and low educated women with two or more children. Among

these factors, being poorer is the most common factor. These women often choose to forego the cost and challenges of accessing professional help during childbirth.¹²⁵ The gaps are also more acute in countries with higher shares of informal employment. In Bangladesh, Indonesia and Nepal, more than three quarters of total employment was informal in 2016–2017, compared with less than half in the Maldives and Mongolia, and less than a quarter in Armenia and Türkiye.¹²⁶ Informal workers in countries without UHC are particularly exposed as they are rarely covered by any employers' liability schemes. UHC, along with the universal social protection floor, would be an ideal policy response to ensure a healthy, protected and productive workforce, now and in the future, particularly in light of the region's rapidly ageing population.

3.4 Population ageing and the future of health care

Population ageing will undoubtedly affect accessibility, availability and affordability of health care services. In the context of implementing the 2030 Agenda for Sustainable Development, population ageing will also have major implications for fiscal pressures from health care expenditures, a key variable that summarizes the interaction between demand for and supply of health care services. Since large out-of-pocket expenditures on health care impose a substantial financial burden on the workforce, it is important to anticipate the evolution of total health care expenditures in the region while addressing the social determinants of health over the course of a person's life and investing in the health of the workforce from an early age.

Projecting increases in health care expenditures (HCEs) as percentage of GDP up to 2060 with and without healthy ageing adjustment follows an empirical model inspired by the latest considerations on the determinants of future health care expenditures (see Box A1 in Appendix for technical details). The healthy ageing adjustment is implemented by allowing the age profile of health care expenditures for age groups over 50 to shift downwards at least one five-year age group.¹²⁷

123 Aasandha Company Ltd. (2022). Husnuvaa Aasandha Scheme Overview. Aasandha Company Ltd.

124 International Labour Office (ILO) (2021). *Social Health Protection: Accelerating progress towards Universal Health Coverage in Asia and the Pacific*. ILO, Geneva.

125 United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) (2022). Leaving No One Behind (LNOB) Platform. ESCAP, Bangkok.

126 ESCAP elaborations based on ILOSTAT Explorer. Available at https://www.ilo.org/shinyapps/bulkexplorer30/?lang=en&segment=indicator&id=EAP_2WAP_SEX_AGE_RT_A (accessed on 18 April 2022).

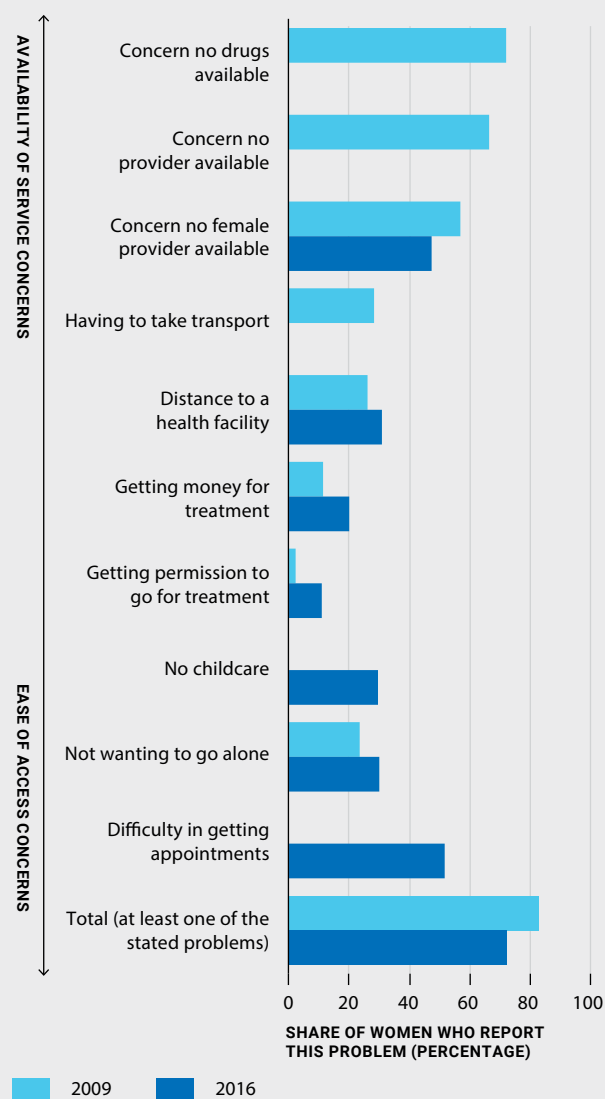
127 This means that the per capita health care expenditures for individuals aged 50 to 55 can fall to the level of health care expenditures for individuals aged 45 to 50 following the method of Maisonneuve and Martins (2015).

BOX 3.2 Health care reforms in the Maldives

The Maldives had the highest rates of labour force participation among women ages 15 and above in South and South-West Asia, at almost 40 per cent in 2016.^a Universal access to health care has been essential for these women's wellbeing. After the introduction of the two health care reforms in 2012 and 2014, key health outcomes improved rapidly. A case in point: women's access to skilled birth attendance increased from 33 per cent in 2009 to 100 per cent in 2016.^b Access to skilled birth attendance is a critical proxy for access to health care in general, as it appears as a reliable indicator in many relevant indices including the UHC Service Coverage index of SDG 3.8 reviewed in Chapter 2.2.

Even though not all health areas saw a drastic improvement (mortality rates attributed to non-communicable diseases only slightly decreased from 13 to 12 per cent during the same period), women of working age in the Maldives benefitted to some degree. Data from Demographic and Health Surveys (DHS) indicate that the percentage of women who reported having a serious problem with accessing health care fell from 83 per cent in 2009 to 72 per cent in 2016 (figure 3.5). The problem reported as most important also changed: In 2009, the main concerns were availability of drugs or a health care provider. In 2016, the availability of appointments was the biggest hurdle. This change in the problems women faced in accessing health care also reflects a continuum in demand for health services, as access improves. Clearly, not all problems have been resolved since the introduction of the Universal Health Coverage, and continuous feedback, openness and accountability to improve the quality of service and ease of access are important elements going forward.

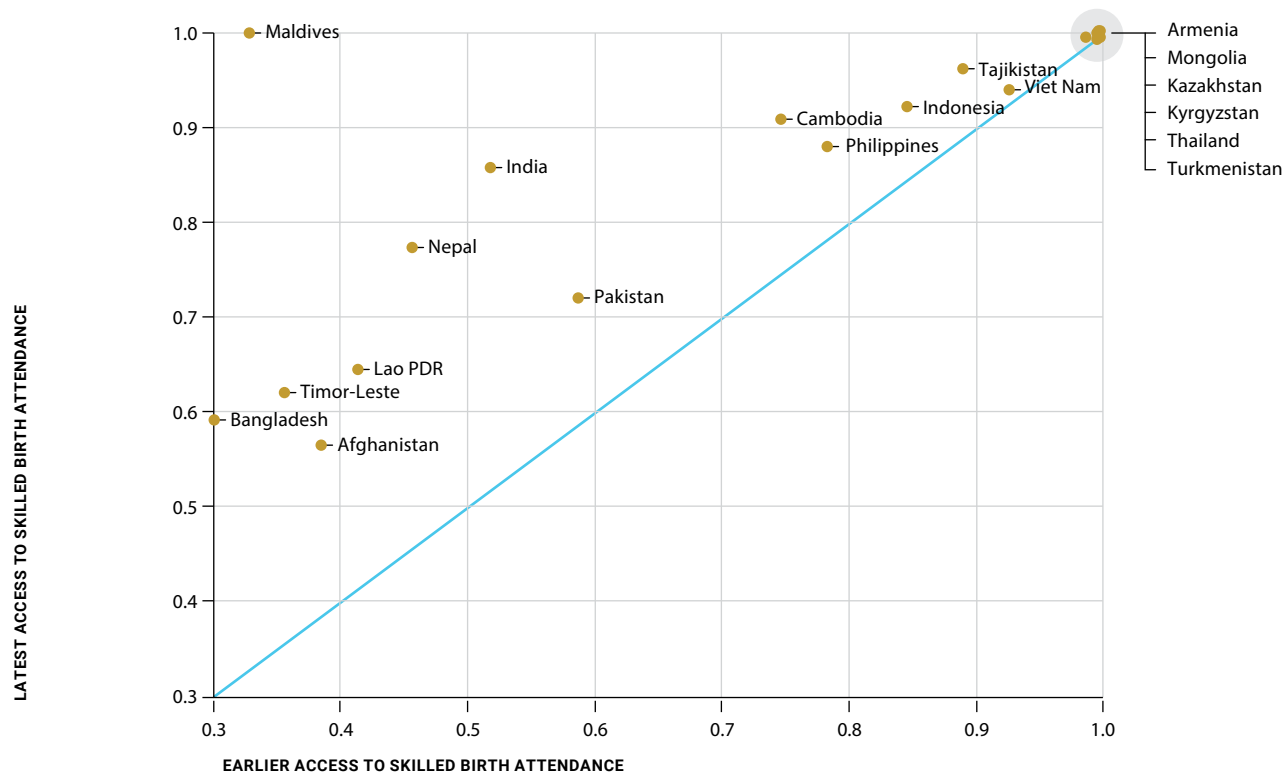
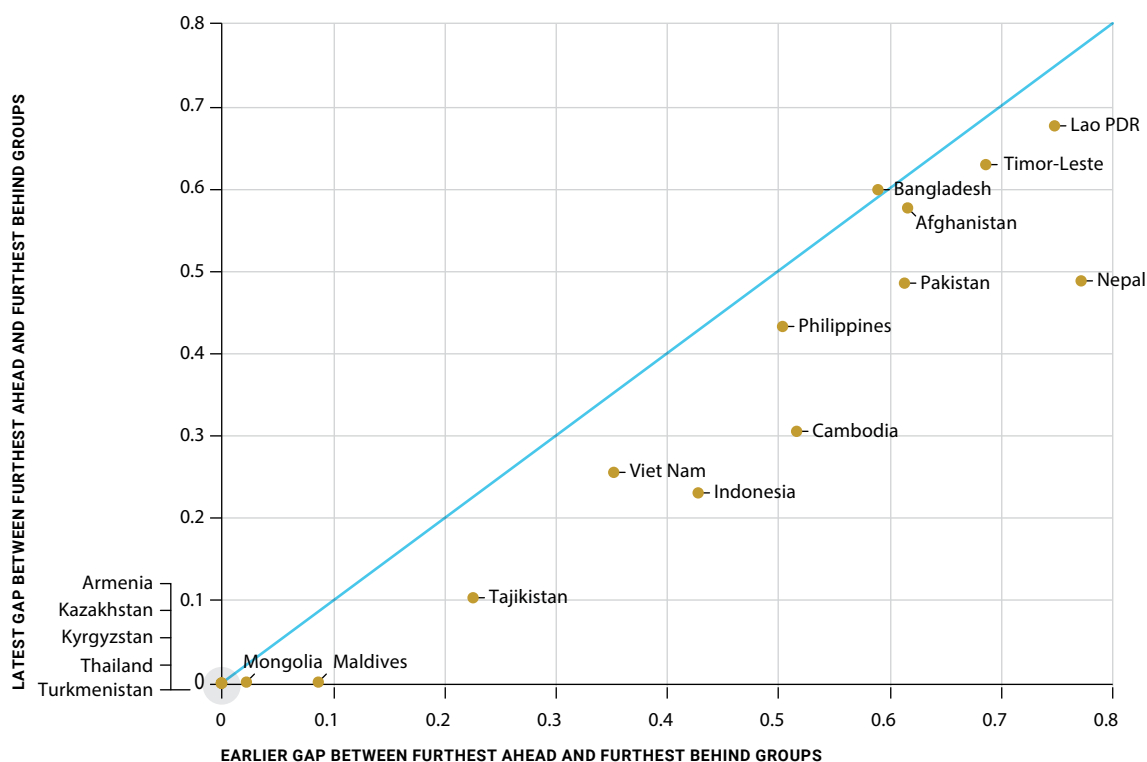
FIGURE 3.5 Change in self-reported serious problems of women (ages 15–49) accessing health care in the Maldives



Source: ESCAP analysis based on DHS 2009 and DHS 2016, Maldives.
 Note: Different answer options were presented in the two surveys. In 2009 (before the introduction of the UHC programme) the 'serious problems' in accessing health care were: a) getting permission to go for treatment, b) getting money for treatment, c) distance to health facility, d) having to take transport, e) not wanting to go alone, f) concern no female provider is available, concern no provider is available, concern no drugs are available. In 2017, the 'serious problems' were: a) getting permission to go for treatment, b) getting money for treatment, c) distance to health facility, d) not wanting to go alone, e) no female health provider, f) no childcare, e) difficulty in getting an appointment.

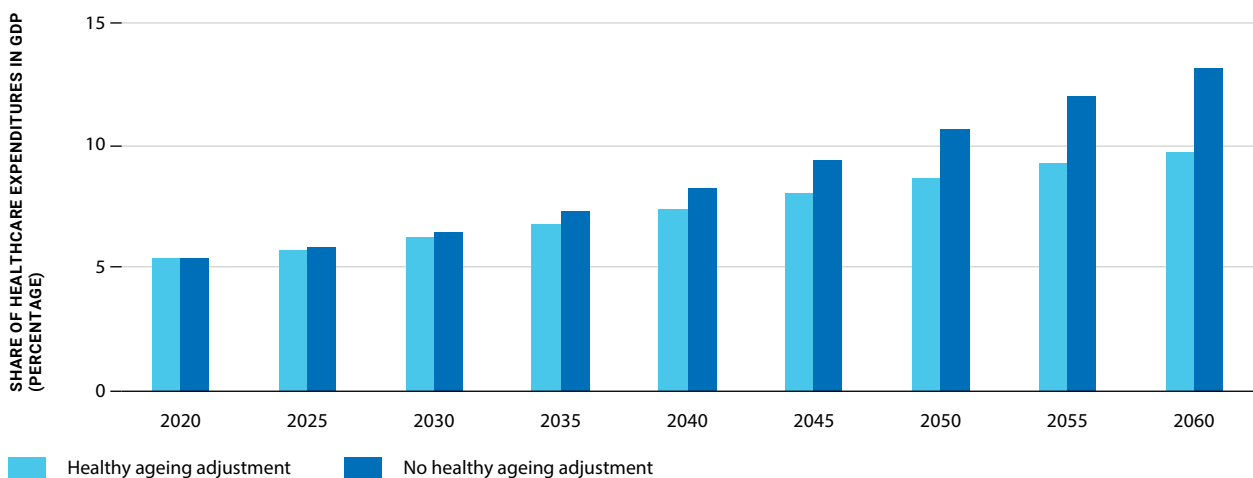
a International Labour Organization, Labour Force Participation Rate by Sex and Age Database. Available at https://www.ilo.org/shinyapps/bulkexplorer40/?lang=en&segment=indicator&id=EAP_2WAP_SEX_AGE_RT_A (accessed on 18 April 2022).

b United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) (2021). *Reducing Inequality in FEALAC member countries*. ESCAP, Bangkok.

FIGURE 3.6 Progress and gaps of access to skilled birth attendance for women**PANEL A. INCREASING ACCESS TO SKILLED BIRTH ATTENDANCE FOR WOMEN, SELECTED COUNTRIES, EARLY 2010s–LATE 2010s****PANEL B. FALLING GAPS IN WOMEN'S ACCESS TO SKILLED BIRTH ATTENDANCE, SELECTED COUNTRIES, EARLY 2010s–LATE 2010s**

Source: DHS and MICS from the period 2009–2018, selected Asia-Pacific countries.

Note: In red are countries that have a score above the regional average of 64 in the UHC service coverage index (see figure 3.3). Latest data for Viet Nam (2013) and for Lao People's Democratic Republic (2017) do not capture recent vast expansion of their respective schemes. Access and composition of the furthest behind and furthest ahead groups in figure 3.6 is calculated using the Classification and Regression Tree Analysis (CART) and available on ESCAP LNOB platform (<https://lnob.unescap.org/>).

FIGURE 3.7 Projected total health care expenditures by year in the Asia-Pacific region as a share of GDP

Source: Howdon and Pasali (2022).

Estimations from this model reveal that between 2020 and 2060, overall health care expenditures are set to increase by 80 to 144 per cent, with and without healthy ageing (figure 3.7).¹²⁸

There are important nuances within the region. First, HCEs in high-income countries peak in 2050 and stabilize from thereon, while there is a monotonic increase among middle-income countries. This result can partly be explained by differences in healthy ageing between high-income countries and middle- and low-income countries. Healthy ageing can thus put the brakes on the growth of health care expenditures or provide sufficient headroom to countries transitioning to an aged society.

While some developing countries in the region are projected to face particularly high health care costs by 2060, the difference is mainly a result of whether the population will follow a trajectory with or without healthy ageing (figure 3.8). This is captured by the standard ageing premium in dark blue in figure 3.8 and could reach as much as 55 per cent of the costs in the Maldives and Islamic Republic of Iran. In Cambodia, China, Indonesia, Mongolia, Nepal, and Tajikistan, the differential amounts to over 40 per cent. Given that out-of-pocket expenditures (OOP) are considerably higher in low- and middle-income countries than in high-income countries, the burden of OOP would disproportionately fall on groups in already vulnerable situations, such as older persons and workers in informal jobs.

Accelerating progress toward universal health coverage (UHC) in Asia and the Pacific is the single most important policy priority for building a healthy workforce. Expanding social health protection is the key policy instrument to achieve this goal. The pandemic provided the right incentives for member States to make headway toward UHC during the UN Decade of Health Ageing, but there is a need to move beyond ad hoc measures and introduce health reforms for stronger and resilient health systems. At the global level, the commitment to UHC was solidified prior to the COVID-19 pandemic by the political declaration included in the United Nations General Assembly Resolution A/RES/74/2 where Member States agreed to implement the most effective, high-impact, people-centred gender and disability responsive interventions to meet the health needs of people throughout their life and to reverse the trend of catastrophic out-of-pocket expenditures. The Bangkok Declaration adopted at the conclusion of the 78th session of the Economic and Social Commission for Asia and the Pacific (ESCAP) in May 2022 also calls for achievement of universal health coverage by 2030 in Asia and the Pacific.

The experience of the COVID-19 pandemic clearly showed the centrality of UHC, not only during a health crisis, but to also achieve healthy ageing and thereby control future health expenditures. Healthy ageing can keep out-of-pocket expenditures in check and avoid them increasing significantly above the currently high levels observed today at above

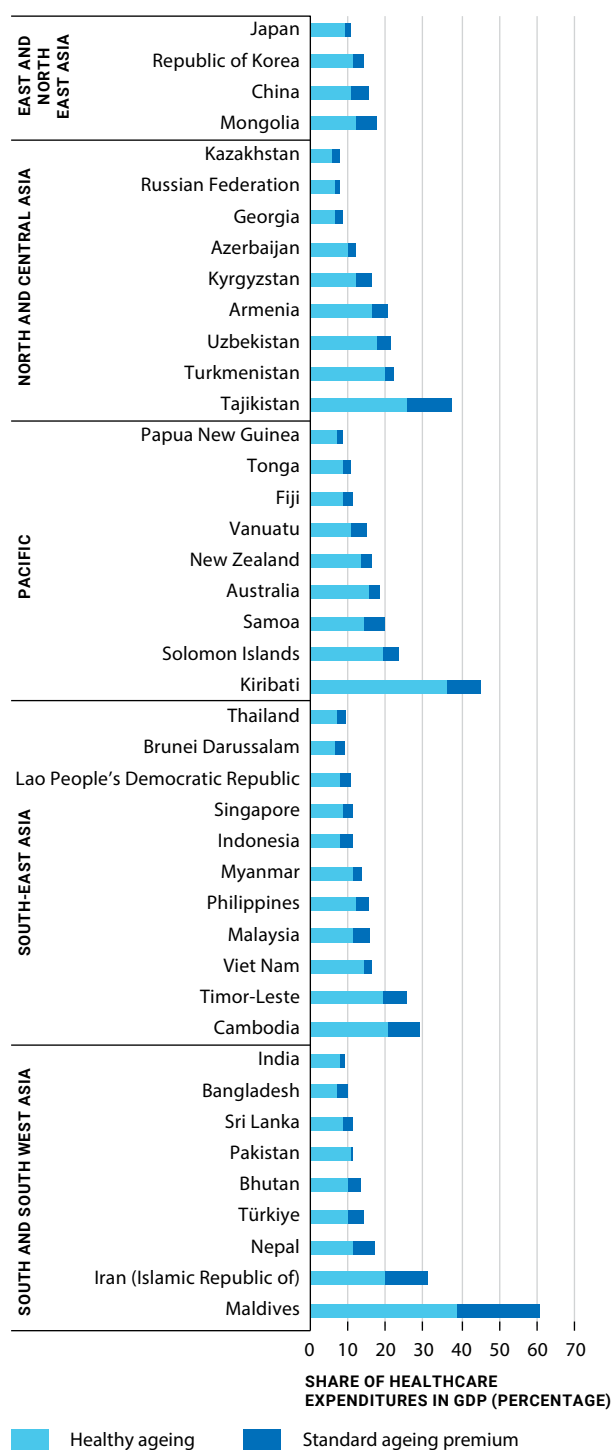
¹²⁸ A healthy ageing adjustment allows the age profile of health care expenditures for age groups over 50 to shift downwards at least one five-year age group. This implies that over time the per capita HCE for individuals aged 50 to 55 can fall to the level of HCEs for individuals aged 45 to 50.

60 per cent in Afghanistan, Armenia, Bangladesh, India, Myanmar and Tajikistan. Already, millions are being pushed into poverty across the Asian and Pacific region annually due to out-of-pocket expenditures. Latest estimates from WHO indicate over 50 million people in the Asian and Pacific region were pushed into extreme poverty while over 90 million people were pushed into moderate poverty in 2017.

The challenges ahead are formidable as the number of health care workers, who are also ageing¹²⁹ and emigrating, is insufficient.¹³⁰ For each 1,000 people in the region there is less than one doctor in low-income and lower-middle income countries compared to 2.6 doctors in high income countries.¹³¹ There is also an uneven distribution within countries, even in high-income countries, where rural areas are increasingly left behind.¹³² Expanding service coverage ultimately entails building a strong and resilient health care workforce. The barriers to a strong health care workforce are not only financial. They also include inadequate training systems and pressures from labour migration.¹³³ The care economy, which includes the long-term care sector for ageing societies, is expected to generate over 270 million jobs in the region over the next eight years.¹³⁴ To attract workers to these jobs, decent working conditions, including social protection coverage, will be essential.¹³⁵ There is an important gender dimension to this issue as long-term care is provided largely informally by women, which negatively affects their participation in and attachment to formal labour markets. Such exclusion inevitably results in women's underrepresentation in adequately funded old-age pension schemes and increases their vulnerability at older ages, as discussed more at length in the next chapter.

Countries are also facing significant resource constraints with direct implications on investments in programmes to expand health coverage. Addressing the resource constraint entails careful evaluation of resource allocation within the health sector as well as health versus other sectors; governance and human resource challenges and sequencing of health benefits.

FIGURE 3.8 Projected Health Expenditures in 2060 by country as a share of GDP



Source: Howdon and Pasali (2022).

129 Sornwit Osothisinlp and Arnon Warrayingyong (2020). Aging healthcare workers. *Chulalongkorn Medical Journal*, 64 (4), December 2020, pp. 453–458.

130 Kanchan Marcus, Gabriella Quimson and Stephanie D. Short (2014). Source country perceptions, experiences and recommendations regarding health workforce migration: A case study from the Philippines. *Human Resources for Health* 12 (1), 62.

131 Organization for Economic Cooperation and Development (OECD) (2021). *Health at a Glance: Asia-Pacific 2020. Measuring Progress Towards Universal Health Coverage*. OECD, Paris.

132 Short, S.D., Marcus, K. and Quimson, G. (2014). Source country perceptions, experiences and recommendations regarding health workforce migration: A case study from the Philippines. *Human Resources for Health* 12 (1), 62.

133 United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) (2020). *Asia-Pacific Migration Report 2020*. ESCAP, Bangkok.

134 International Labour Office (ILO) (2022). *Care at work: Investing in care leave and services for a more gender equal world of work*. ILO, Geneva.

135 United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) (2021). *COVID-19 and the Unpaid Care Economy in Asia and the Pacific*. ESCAP, Bangkok.