Commentary

Health Systems for Aging Societies in Asia and the Pacific

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INTRODUCTION

The most recent statistics available suggest that the share of population aged 60+ years and over in the Asia Pacific will rise from 7.6% in 2015 to 17.8% by 2050.¹ The greying of populations in this region poses important and interlinked policy challenges for economies, families and especially the health sector.² The economic implications are well appreciated. The Asia Pacific region, particularly China, Southeast Asia and India (more recently), has enjoyed rapid economic growth, driven by a combination of growth-friendly policies and large increases in working-age populations, a phenomenon referred to as the demographic dividend.³ But as populations age, the demographic contribution to economies will fade, and tighter national budgetary constraints are likely to emerge.

A key driver of aging populations has been the so-called fertility transition, characterized by an overall trend toward smaller families. The fertility transition, itself an outcome of improved life spans due to public health interventions such as clean water, sanitation and vaccinations, and the advent of modern medicine, laid the foundation for rapid increases in working age populations and household investments in health and education. But the same forces underpin the decline of traditional family support systems, with fewer adult offspring to bear economic and social support responsibility for the elderly. Moreover, much of the economic growth in the Asia Pacific region has been concentrated in the informal sector, which is traditionally poorly served by social protection tools for families such as access to subsidized health services and pensions.

It is in the region’s health sector where the policy challenges associated with aging are likely the most acute. Rising numbers of the elderly has meant a growing prevalence of chronic non-communicable conditions (NCDs). The overall increase in the prevalence and mortality from these conditions has been driven by population aging, owing primarily to declining fertility rates and age-specific mortality rates,
and alongside increases in overall prevalence of NCDs. Unlike their counterparts in high-income countries in the region such as Japan, Korea and Australia, rising numbers of elderly in the rest of the Asia and Pacific region are occurring at a time when countries are at levels of economic development less likely to permit significantly higher shares of national incomes dedicated to health services or long-term support services. Public sector allocations to health sectors in many countries in the region have not kept pace with population needs, leaving the private sector to fill the gap with risks for efficiency, equity and cost inflation of health services. And health systems have traditionally been geared to infectious diseases and maternal and child health conditions, with the attendant challenges of reorienting health systems to cater to the growing burden of chronic conditions.

From a health sector perspective, the central challenges are:

- To understand the effectiveness of existing financing and health care delivery systems in serving the elderly and other populations with chronic conditions;
- To examine how aging populations and chronic conditions are affecting health systems, including health expenditures and fiscal systems;
- To assess the linkages between health services, old age support services and other social protection, including those provided by family members;
- To highlight policy lessons from the experiences of other countries, including from within the region.

The special issue is intended to explore many of these issues in the context of the Asia Pacific region. This region offers significant opportunities for learning due to the considerable cross-country variation that exists in health systems, economic circumstances, stage of demographic transition and political systems. Australia, Japan, Taiwan and Korea have higher shares of elderly, their demographic and economic transitions began much earlier, and they have invested more in health and long-term care services than low- and middle-income countries in the region. There is considerable variation also within the middle-income countries of the region. China is further along along the path of demographic transition than India and has invested more heavily in health. Thailand and Mongolia embarked on ambitious universal health coverage plans at the turn of the century that rely primarily on households for long-term care and often have inadequate social protection systems. And in contrast to the high-income countries in the region, the middle- and low-income countries rely primarily on households for long-term care and often have adequate social protection systems.

Overall NCD prevalence and mortality continue to increase in the region. The article by Ng et al. in this issue focuses on the management of hypertension in Malaysia, a middle-income country with rising numbers of elderly, but also high levels of premature mortality among middle-age adults. The authors report low levels of diagnosis of hypertension cases, a high proportion of diagnosed cases being treated, but then poor control of hypertension in treated cases. Although no single clear cause is identified, they discuss multiple plausible hypotheses for low levels of diagnosis. These include a public primary care sector that has, until recently, concentrated on rural areas while neglecting urban areas that have seen the bulk of the population growth, an underfunded health education and information strategy, a continued emphasis on maternal and child health services, and a screening strategy that emphasizes opportunistic testing. Malaysia’s rates of controlled hypertension are only about one-quarter those observed in high-income countries, which the authors attribute to inadequate availability of drugs in public facilities, the expense of drugs in private pharmacies and the poor quality of primary health care. Given the common practice of seeking care from multiple providers, a lack of electronic medical records that enable patients to be tracked may also be part of the explanation for poor management of treated patients.

The article by Yiengprugsawan et al. takes a close look at health care delivery services for diabetes and stroke in three countries, Thailand, Sri Lanka, and Malaysia. All three countries have begun reorienting their services to address NCDs, but there are important differences. NCD screening has been adopted, and there exist protocols for screening, prevention and management, along with efforts at training medical personnel in geriatric medicine in the three countries. But whereas Thailand has integrated NCD screening and management programs delivered through public sector primary care facilities, Malaysia lags in NCD services in urban primary care. NCD programs in Sri Lanka are mostly directed via local hospitals, because primary health clinics are inadequately equipped to handle NCDs. An increasing number of people consult both public and private providers (particularly in Sri Lanka and Malaysia) and this has adverse implications for continuity of care. Thailand appears to have moved further along, having recently introduced community-based programs involving social support and health services. In all three countries, hospital services remain tethered to a specialist model rather than the multidisciplinary framework needed
for NCDs. Overall, the authors conclude that there is a need to strengthen primary care, better integrate services for NCDs, upgrade staff skills and improve the numbers of ancillary health staff.

To address the challenges posed by long-term care needs of a rapidly aging population, China has recently piloted multiple long-term care interventions. The exploratory article by Lu et al. focuses on one such pilot on long-term care insurance, implemented in Qingdao city, in Shandong province. The pilot was motivated by the experience of large numbers of disabled elderly not being able to find affordable long-term care, the older population’s reliance on expensive hospital-based care as a proxy for palliative care services, and their medical care needs not being met by existing nursing homes and residential care facilities. Rural populations were particularly disadvantaged in this respect. Their study highlights the role of surplus funds in the existing medical insurance schemes in the establishment of long-term care insurance, and of funding and pricing practices in incentivizing the emergence of appropriate providers for long-term care. However, long-term care benefits vary across members covered under different medical insurance schemes and addressing these inequalities remains a concern.

Anderson and Irava use their long experience in the 15 Pacific island countries to point to constraints that influence elderly-focused policies in their health systems. The share of the elderly is expected to almost double by 2050 in the Pacific islands, but is currently quite low, so political support for elderly-related policy subjects is limited. There is an unfinished agenda related to maternal and child health services, and simultaneously, working-age adults are facing a growing NCD burden. Thus, policy focus and the limited financial resources available have been directed toward working age populations and the very young. There is some evidence of a trend in favor of urban hospital-based services, which are not well suited for elderly patients with chronic conditions. Important information gaps related to the needs of elderly people remain. Training for health and medical personnel related to geriatric and other support services is limited and adversely affected by emigration of health personnel to high-income countries such as Australia and New Zealand. Although some countries (e.g., Fiji) have taken steps toward formulating policies aimed at health and social support for the elderly, such initiatives are piecemeal, and the family remains the major source of support.

What can the middle-income countries learn from the experiences of their high-income counterparts? Doyle et al. present case studies of home-nursing and support services in Australia and Japan for people with dementia, a condition highly correlated with age. They observe a movement in both countries from institutional care to services provided in the community. This is not just a resource issue, but also what many elderly people want (although they are simultaneously concerned about the burden placed on family members). In both countries, financing mechanisms (long-term care insurance and medical insurance in Japan, and commonwealth-supported programs in Australia) have played an important role in the development of these services. There is a broad range of services that people with dementia receive in the two countries, including multiple types of social support and nursing services, with a key role for allied health professionals. Moreover, there is considerable heterogeneity of elderly needs, and relatedly increasing attention being paid to consumer-directed care. In turn, there have been concerns about the coordination of services such as linkage of support services to medical care when needed.

In contrast, the Republic of Korea presents a scenario of a high-income country that has only recently begun exploring the issues posed by long-term care needs of elderly populations. Korea’s share of elderly population has grown faster than most high-income countries. In their article on Korea’s policy experiences, Jeon and Kwon highlight the role of declines in family-based care and successive progressive governments in the introduction of long-term care insurance in 2008. Funded by a mix of taxes, government subsidies and co-payments, the Korean experience is instructive for low- and middle-income countries trying to set up long-term care systems. There has been a rapid uptake of services that has led to concerns about financial sustainability. Serious concerns have arisen over the inefficient use of scarce resources, such as an overreliance on hospital services, a mismatch of patients with required services and long-term care services that tend to disproportionately concentrate on home-help compared with nursing support. The authors analyze some of the historical drivers of coordination problems that drive these inefficiencies, but also crucially note the role of financial incentives underpinning provider and user behavior. In response to the introduction of long-term care insurance, Korea has also experienced a rapid growth of care providers, but that has been accompanied by problems of service quality and regional inequalities in the location of services.

Even as countries face a growing health and financial challenge associated with larger elderly and non-communicable conditions, new ways of treating and managing patients and of providing support to older individuals are emerging. While technological change is often a major driver of health system costs, Penno and Gauld focus on technological developments in information and communication technology (ICT) that could make services more convenient and cheaper to provide. Their article assesses the current state of ICT
application in the Asia Pacific region, the likely directions of development of ICT applied to health services and elderly care, existing evidence on its effectiveness, and some implementation challenges. They point to major advances in access to internet and mobile technologies in the region, and suggest gains from use of live-links as against “store and transfer” models, and from robotics and 3-D printing in the future. However, their review also underlines the limited evidence on the effectiveness and cost-effectiveness of such technologies in the health sector. Their article also explores funding-related issues of such innovations, their acceptability with the using public, and implications for equity in access to services.

In this issue’s final article, McPake and Mahal present the Australian experience with the financing and provision of health services and how it has sought to adapt to the changing needs and demands associated with an aging population structure. Australia’s relevance for the broader region stems from its mix of public and private providers of health services, and funding that comprises general revenues, private insurance and out of pocket payments. Australia has experimented with a variety of initiatives to address growing public and private health spending and the treatment and management of chronic conditions as its population has aged. Private health insurance (PHI) was considered a means to lower demand for public services by the rich, but increasing demand for services and associated adverse selection threatened its economic viability. That led the government to introduce a partial subsidy for health insurance premiums and age-loading of premiums, meaning individuals delaying purchase of private coverage to older ages were penalized by premium surcharges. However, PHI has failed to lower the burden on the public system. Recently there have been efforts to integrate services at the primary care level, across doctors, nurses and allied health practitioners and to provide the holistic care demanded by the multi-morbidity characteristics of an older population’s disease burden. However, existing funding arrangements have acted as a strong disincentive to these exercises. The authors draw attention to the challenge of coordinating care between primary care and hospital services, with lack of continuity of care reflected in repeat and preventable hospital stays. The government has responded with transition care programs but the effectiveness of such strategies often depends on availability of residential care facilities. The article concludes with potential lessons for health sector policies in middle-income countries in the Asia Pacific region.

The articles in this issue demonstrate the fast-developing transition for health systems across the Asia Pacific region. All countries, richer and poorer, are confronting major pressures on health systems that are still at the early stage of making themselves felt. If current trends in the burdens of non-communicable diseases, disability and mental ill health continue to track the growing proportion of populations above given age thresholds, it is unlikely that even the best resourced health systems will be able to offer an effective response on a universal basis. The potential for “healthy aging” on the other hand offers grounds for optimism. The critical issue is not chronological age, but biological age or age-related functional decline. An increasing proportion of the population with age-related functional decline is not an inevitability anywhere. But governments need to design and effectively implement the package of public policies to ensure this transition to healthy aging; this can be done, as illustrated by the experiences of some countries, but it does not happen always or easily.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflicts of interest were disclosed.

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