Commentary

Aging and Universal Health Coverage: Implications for the Asia Pacific Region

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Abstract—Global population aging is the result of successes in public health, enabling longer life expectancy in many countries. The Asia Pacific region is aging more rapidly than many other parts of the world. The implications will be profound for every sector of society, requiring policy makers to reframe their thinking about the design of health and social systems to enable older populations to thrive. With increasing demand for more and different kinds of services, an imperative is shifting resources toward primary care for the prevention and comprehensive care of people with chronic conditions, and establishing linkages with community support. Major innovations are underway that accelerate progress in attaining universal health coverage for older populations. The renewed commitments under the Sustainable Development Goals to achieve universal health coverage offer a unique opportunity to invest in the foundations of the health system of the future.

Global population aging is the result of our successes in public health. Declines in infant mortality, fertility, and premature death have enabled longer life expectancy in many countries. By 2050, 2.1 billion people will be older (60 years of age or older), representing 21% of the world’s population.1 Population change will be apparent much sooner, however. Older people already outnumber children; by 2035, they will exceed the number of children 10 years and younger. And unlike just a few decades ago, it is not uncommon for people to live actively into their 80s and beyond.

A critical question is whether countries in the Asia Pacific region are ready for such profound change—and the implications of this change for health and social services. To address this question, we first discuss the demographics of aging, the relationships between aging and health, and the importance of public policies and disease prevention that enable healthy aging. We then focus on the opportunity in planning for universal health coverage (UHC)—in recognition that health systems of the future need to respond to older populations as a part of their global commitments to the Sustainable Development Goals.
Development Goals (SDGs). Lastly, the article discusses several neglected areas that require further research to inform policy.

The Asia Pacific region is among the most rapidly aging parts of the world, although it is highly heterogeneous. By 2050, it is projected that 80% of older people will be living in countries now categorized as low or middle income, and the Asia Pacific region will be home to 62% of older people—because of the sheer size of countries and the rapid aging underway. Older people in China and India alone will number nearly 800 million by 2050, larger than the total population of several countries in the region. Japan, South Korea, and Hong Kong are already old and advanced economically. These countries are preparing for rapid increases in the oldest old—those 80 years plus—as well as total population decline from reductions in fertility. Yet every country in the region, even relatively young nations, will experience a substantial growth in older populations in the coming decades. For example, the share of the older population in Bangladesh and Mongolia will triple between 2015 and 2050.1

Population aging is an important contributor to chronic disease prevalence, including heart diseases, chronic obstructive pulmonary disease, diabetes, depression, and dementia. But poor population health is not an inevitable consequence of aging. There is weak correlation between the share of the population 60 years or older and levels of disability.2 Take Japan as an example. Japan has the oldest population in the world but one of the lowest levels of older age disability in comparison with much younger countries. Japan has invested in primary, secondary as well as tertiary prevention—especially for hypertension and diabetes—and therefore has both high life expectancy and high healthy life expectancy even in old age. Japan’s health investments, however, were initiated in the 1960s, when the country was categorized as lower income and its population was relatively young. Partly because of these early investments, Japan continues to have the highest life expectancy globally, and people are able to remain healthy and active into their older years.

Such experience suggests that the health of the population in 2050 and the social and economic participation of older populations will be determined in part by current investments in public health policies. The probability of premature death from cardiovascular disease, cancer, diabetes and chronic respiratory disease ranges from 8.3% to 36.1% among countries in the Asia Pacific region.3 Some of this variation could be attributed to differing investments in public policies that promote healthy aging, such as tobacco control, prevention of the harmful use of alcohol, and promotion of healthy diets and reduction in consumption of salt, sugar, fat and edible oils. The implementation of these public policies has faced tough political resistance because of commercial interests in many countries—particularly those with local industries. Ultimately, however, the “cost” of waiting to implement such cost-effective public health policies is high. Premature mortality takes its toll on families, communities, and economies. Poor health in older ages, from diabetes and heart diseases, for example, will increase the demands on financing health and social services, health services utilization, and family caregivers. Without strong public policies to reduce the prevalence of risk factors for non-communicable diseases, health care expenditures will increase, including the need for long-term care.

The commitments under the SDGs offer an opportunity for countries in the Asia Pacific region to plan ahead for change and adaptation in light of these demographic and health challenges. Achieving UHC requires a shift from focusing on disease-specific programs to health system strengthening. This change emphasizes investing in the foundations for a health system that can be resilient in responding to dynamic health needs. In recognition that the population of the future will be older, the implications for access, equity and financial protection for older people should be explicitly identified in each step of the process. Given that older populations may face a decline in disposable income as well as an increase in health care utilization, their financial protection becomes crucial in the design of health care financing systems to protect them from catastrophic payments and from falling into poverty because of routine health expenditures. Moreover, many countries are considering the design of the benefits package under UHC; it would be important to determine whether the benefits packages will promote healthy aging and respond to the needs of older persons.

Determining the benefits covered under UHC is not a one-off activity, but rather a process and system to continually review and assess coverage and benefits, as done in Australia and Thailand, for example. The impact is particularly important for older populations. A great deal of research and development is underway—some of which could translate to products that could transform care management for older persons, such as technology to provide early warning for stroke or other events. Thus, infrastructure must be put into place for continually evaluating new cost-effective innovations as to whether they should be introduced into the health system. This implies that investments in evaluation infrastructure are needed, including information about utilization, prices, and expenditures as well as human capacities, to be able to continually inform and adjust policies. Such infrastructure may also include networks across countries and regions to enable...
countries to share information about safety, efficacy, and cost-effectiveness of medical products, so that research can be utilized across different settings as part of national decision-making processes.

Service delivery design is essential to improve care for the patients that use the system the most. Greater numbers of older persons will increase their demand for health services, particularly for the continuous management of non-communicable diseases. Older adults are also likely to have one or more chronic health conditions that require the expertise of different health care providers and access to allied health professionals such as physiotherapists, dieticians, and mental health professionals. The World Health Organization and other agencies have long advocated the people-centered health care approach. Yet, such changes require fundamental reforms in how health systems are financed and organized.

Implementing a strong primary care system requires shifting investments in infrastructure and deployment of human resources to primary facilities and health networks, and a determination of the appropriate technology at all levels of the health system aligned with clinical and referral pathways.

Key to the success of patient-centered models of care is the identification of workforce needs to achieve the right skills mix, including the recognition of the general practitioner as central to the system. Many older patients require routine rather than specialized support—for example, ensuring medication and appointment adherence, identifying early warning signs and symptoms, and ensuring appropriate nutrition and exercise. Such activities can be provided by allied health workers within a network of supportive care. At the other end of the health care spectrum, Japan, China, and Thailand have been experimenting with telemedicine to expand access to specialists. Limited experience in the use of such technologies exists in lower income countries; however, given very few specialists in geriatrics and gerontology, such innovations could play an important role in meeting health needs of older persons for specialized care.

The way in which health care providers are paid is crucial in driving changes and quality throughout the health system, thus creating the right balance through mixed ways of payment is important in aligning payment systems with the goals of promoting healthy longer lives vs. treating diseases. Fee for service—the payment method predominant in the region—pays for individual services; therefore, the main incentive is to deliver higher volumes of services, particularly where the fees are higher than the cost to the health care provider. In contrast, mixed payment systems incorporate case based payments and capitation, which provide stronger incentives to achieve health outcomes. Introducing and sequencing large-scale organizational and financing change is complex, requiring rules governing relationships among providers, payers, and policy makers and how public funds are managed, as well as quality assurance systems. Studies about how countries have undertaken such major institutional and payment changes and successfully shifted resources and infrastructure away from hospitals and toward primary care could provide important lessons learned in how to sequence large-scale systems reforms.

Governments are frequently concerned that aging will inevitably increase health care expenditures. While older people do tend to have higher demand and utilization for health services, evidence from high-income settings suggests that aging is not the primary driver of increases in health costs. Health expenditures directed towards averting mortality tend to be high at all ages, whether death occurs at 15 or 85 years, and thus the time to death is more important than aging. Moreover, time to death is a small contributor to increases in health care cost escalation relative to modifiable system factors and policies. Technology remains a primary driver of increasing health care costs—particularly where there is no systematic assessment of whether the cost of an additional technology outweighs its benefit.

In addition, the way in which health care is organized and paid for matters. A greater emphasis on primary care can lower the costs of care while improving health outcomes, and reduce health inequity. For example, routine health care procedures delivered in hospitals are likely to be far more costly than the same care delivered at primary care level at the same level of quality. Countries concerned about cost escalation could address this concern through different reforms, such as health technology assessments, changes in how health care providers are paid, controlling prices for medicines and services, integrating prevention into care programs, and building up primary care systems to ensure quality care at the most peripheral level of the system and to avoid preventable hospital admissions. Such reforms ensure that spending on health care translates to value and benefits for people.

Good health care for older persons goes beyond doctors and health facilities. Chronic disease management, in particular, requires patients and their families to actively manage their own health and health care. New technologies have the potential to inform, engage and empower older persons and their caregivers—where such technologies are well designed to address major health challenges and barriers, maintain functional ability and improve quality of life. This may include wearable technologies to monitor vital signs and falls, glucose levels, and medication adherence. Tools such
as decision aids may empower people faced with multiple treatment options, each with its own advantages and disadvantages and varying impact on quality of life. These tools may facilitate discussions with patients and family about their ability to comply with treatment recommendations, personal preferences, and impact on quality of life. These innovations have not widely been implemented in low- and middle-income countries in the Asia Pacific region and thus their success may be modified by cultural, social and economic factors. In Japan, South Korea, and China, with increasing income and levels of health awareness, such innovations are now being used more widely. These experiences could provide useful lessons to inform applicability elsewhere in the world, thus enabling countries in the Asia Pacific region to leapfrog progress in advancing care for older persons.

Older persons require not only health care but also social interaction, physical activities, and non-medical help such as cooking and cleaning to enable them to stay in their homes. Connections between health and social services are essential to promote quality of life among older people. As such, health care providers and facilities can also be incentivized to identify resources in their communities that can be involved in promoting health. Under models of social prescribing, for example, doctors “prescribe” social interaction and involvement in community groups. Further investigation is needed to demonstrate the impact of such innovations and the conditions under which they work. However, it is evident that employers, schools, city councils, and social associations have a critical role as resources for promoting health and social interaction, and ensuring that older people can fully contribute to the communities in which they live.

There are several areas where further investigations are needed to inform policy. One area is the role of the private health care sector. The private sector is increasing in size and scope in the Asia Pacific region, and is now engaged in providing health and social services for older people in many countries in the region. Services are provided to families who can pay, where demand exists for nursing home care, and the alternative is unpaid caregivers and family members. Older people may be poorer and also more likely to access private informal health care providers. Paying out of pocket for private care can be impoverishing for chronic conditions. The regulation of the private health care sector tends to be poor generally—and particularly so for informal health care providers and for institutions providing care for older people. It would be important for governments to better understand the nature and scope of private sector involvement in health care for older persons within their own countries, and establish a strong policy environment to enable their participation while ensuring quality and equitable access.

Another important area is the biomedical research that underpins clinical care. Clinical trials to evaluate medical products commonly exclude older adults and those with multiple medical conditions. This leads to a situation in which products may not have been evaluated in the very populations for which they are frequently intended. This is an important omission, given that aging can affect how medicines work. For example, older patients commonly experience reduced liver and kidney function, which affect the way medicines are absorbed, distributed, and removed from the body—possibly resulting in severe side effects. Basic biomedical research informs clinical practice guidelines, some of which may be inappropriate for patients with multiple morbidities, which in turn may also be used for developing quality metrics and payment systems. Training for physicians follows the same model, focusing on treating specific discrete diseases. Thus, a health care provider offering care to an older person with a combination of different conditions—depression, chronic obstructive pulmonary disease, and arthritis—faces a complicated task in developing a treatment plan in the absence of complete information and the right incentives to ensure quality. It is timely to reconsider traditional inclusion and exclusion criteria for clinical trials, particularly where no clinical justification exists. Moreover, countries can strengthen post-marketing studies of existing drugs, to evaluate their use in older populations and across diverse settings.

All countries in the Asia Pacific region are rapidly aging. The majority of older persons in the world will be living in Asia by 2050. The implications will be profound for every sector of society, requiring policy makers to reframe their thinking about health and welfare to enable older populations to thrive. A fundamental challenge is the disease-oriented nature of health systems, and the imperative to shift resources towards primary care for the prevention and comprehensive care of people with chronic conditions. Major innovations are underway that can help to leapfrog progress in attaining UHC for older populations, and improve the quality of their lives. Taking advantage of such innovations requires investments in planning and evaluation infrastructure. The renewed commitments under the SDGs to achieve UHC offer a unique opportunity to invest in the foundations for health systems of the future. Leadership and evidence from older and high-income countries in the region can provide models of comprehensive health and social programs that enable older people to remain active members of their communities.
DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

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