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Policy Forum Article

An Ounce of Prevention is Worth a Pound of Cure—Universal Health Coverage to Strengthen Health Security

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Abstract

The Sustainable Development Goal 3 targets aim to ensure that individuals achieve universal health coverage and that the capacity of countries, to identify early warnings, implement risk reduction plans and to respond and manage national and global health risks including emerging infectious diseases outbreaks is strengthened. Funding for the achievement of these outcomes can be erratic and weak healthcare systems do not cope well with the vagaries of fluctuating economies. Universal health coverage is achievable with formulated social health insurance programs that ensure consistent and predictable financial flows. This article deliberates the situation in the Asia Pacific region considering how funding the elimination of infectious diseases (specifically malaria) can facilitate a strengthening of weak health systems, which in turn will build economic potency and health security in the region.

Key words: Universal health coverage, social health insurance, malaria, Asia Pacific, health security

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1. Introduction

The influential Report *Global health 2035: a world converging within a generation*, published in 2013, highlighted that 'the returns on investing in health are impressive. Reductions in mortality account for about 11% of recent economic growth in low-income and middle-income countries as measured in their national income accounts ... Between 2000 and 2011, about 24% of the growth in full income in low-income and middle-income countries resulted from value of additional life years gained' (Jamison et al. 2013, p. 1898). Frenk and Ferranti (2012) purport that health is an economic driver, and they are inextricably linked. They conclude that not only is it ethically right for all people to have universal health coverage, it is also a sage move economically. They also state that the design of health coverage has to suit the country and be driven internally rather than by external forces. They categorically state '[A]id is not the answer' (2012, p. 863). Building coverage from within a country helps that country develop its own health strategies, which align with global targets. Frenk and Ferranti (2012) further note that putting the health dollar into prevention of infectious diseases is far more efficient than treating the disease once an outbreak has occurred.

Prevention requires strong systems. Many nations in the Asia Pacific inadequately prioritise efforts to strengthen the organisation of people, institutions, and resources that deliver healthcare services to meet the health needs of target populations—health systems.

Weak health systems in low-income and middle-income countries (LMICs) require bolstering to deal with future epidemics and to promote health. By investing in health, human development is also supported; active participation in economic development is promoted, and catastrophic risks avoided. Sands et al. (2016) reinforce the notion of a negative spiral of outbreaks of infectious diseases in countries where the health system is far from robust, creating costs that impede the economic prosperity of a country. Investment in health equates to investment in future proofing the economy.

Investing in healthcare systems can also lead to more efficiency. Governments and patients spend a considerable amount of money on health interventions that are irrelevant, duplicative, or excessive; provide very low or no benefits; or, in some cases, cause harm and through payment systems such as fee for service that offer incentives to over-service those people who can pay or who are covered from pooled funds. Ensuring that only health interventions that are effective and meet population needs and identifying the most cost-effective financing mechanisms facilitates the most efficient use of funds (WHO 2010).

A significant share of public health spending and measurable impact has to date come from external funding from the 'Global funds'. This has allowed targeting to country-led programs that often demand cross border involvement—the Global Alliance for Vaccination and Immunization is a notable example, as are regional initiatives such as the Regional Artemisinin Initiative through the Global Fund to Fight Aids, Tuberculosis, and Malaria (Sustainable Development Solutions Network 2015). Whilst global investments via funds such as Global Fund to Fight Aids, Tuberculosis, and Malaria have had an enormous impact on communicable disease burdens in many countries, it is also widely acknowledged that there has been insufficient regard paid to health systems strengthening (House of Commons 2014). As the availability of these funds decline and national governments take responsibility for financing, there is a unique opportunity to invest in public health and health

systems. Universal health coverage provides both the conceptual framework and the opportunity for this investment.

2. Universal Health Coverage

Universal health coverage (UHC) ensures that '... all people can access quality health services, to safeguard all people from public health risks, and to protect all people from impoverishment due to illness, whether from out of pocket payments for health care or loss of income when a household member falls sick' (Maeda et al. 2014, p. 1). Guaranteeing UHC has the potential to end life-threatening poverty by 2030 and enhance collective wealth in LMICs where the majority of the world's poor live (Maeda et al. 2014). Achievement of UHC can occur through a variety of means: national insurance schemes that purchase health services from public or private providers or the development of the public health system alone.

While the business case for investment in broad coverage of efficiently delivered preventative services is strong, financing UHC in the environment of Asia Pacific economies present challenges. This is particularly so as epidemiological and demographic trends are dynamic, and new curative treatments create new demands on finite budgets (WHO 2010).

Countries raise revenue for health in four substantive ways: increasing revenue collection, reprioritising government spending, innovative financing, and to a variable degree overseas development aid (WHO 2010). Increasing revenue means increasing taxes and/or insurance premiums, yet tax receipts in LMICs are often suboptimal both due to a large informal economy and weak government fiscal capacity.

To assist with financing healthcare, innovative means of raising funds have been mooted or trialed. A sin tax for instance, where a small amount of money is added to the price of cigarettes and alcohol and is earmarked for spending on health, has significantly increased revenues available to health in some countries. The Philippines passed Sin Tax Reform legislation that increased taxes on all tobacco

and alcohol products. This reform provided a new injection of funding that enabled the Philippine Government to enroll more people in universal healthcare and scale-up non-communicable disease prevention services in primary care (WHO 2015c). These ‘Sin Tax’ initiatives often have a twofold benefit: raising money from those who purchase the products and providing an incentive not to buy the products and therefore reducing potential future non-communicable disease costs.

Levies on air tickets as small as \$1 have also been used to raise significant funds for UNITAID, a global drug-purchase facility for the treatment of malaria and other diseases (Fryatt et al. 2010). This initiative rose in excess of US\$2.4 billion through to December 2014 and permitted UNITAID to finance aid to several countries (UNITAID 2014). Other taxes such as a sugar tax or a fast food tax have been debated (Holt 2010; Leonhardt 2010), while financial transaction taxes, such as on foreign currency exchange, have also been successful in generating funds from high-income countries (WHO 2010).

3. Social Health Insurance

Social Health Insurance (SHI) is a mechanism for raising and pooling funds to finance health services. It has a demonstrated ability to improve the health status of populations and to improve labour productivity and economic growth (Jamison et al. 2013).

SHI can be thought of as:

- (a) a way of mobilising additional domestic resources for health;
- (b) allowing organisational change for improved health system quality and efficiency that is easier to introduce through SHI (e.g. purchaser-provider splits, new provider payment mechanisms); and
- (c) extending financial risk protection to more people, or provide greater levels of protection to those already with coverage (e.g. replacing out-of-pocket spending with some form of prepayment, switching from private health insurance to SHI, at least for a basic package of health

services). This additional financial protection is seen as a way of allowing more people to use needed services without incurring high out-of-pocket payments, effectively moving closer to universal coverage (cited in Doetinchem et al. 2010, p. 3).

Financial risk protection is a key goal of any health financing modality. There are a number of variations on how SHI has evolved across countries. A common element of all systems however is the pooling of funds across all contributors to allow spreading of the financial risk associated with the need to use a health service. SHI also reduces the fear of financial hardship among individuals. Global evidence indicates that the greater the degree of reliance on out-of-pocket spending to finance healthcare, the greater the incidence of financial risk associated with medical care (van Doorslaer et al. 2006). Out-of-pocket expenditure is recognised as a key factor driving the near-poor into poverty with only 20–30 per cent of people from middle-income countries having coverage for loss of income in the event of illness (WHO 2010).

Transiting to a broad coverage of SHI however takes time. Some countries have taken in excess of 40 years to develop a system where the large majority of people are covered by SHI (Carrin & James 2005). There are some key facilitating elements that appear to allow for a speedier transition to broad coverage of SHI, and these can be summarised as: the level of national income, the structure of the economy, the geographic distribution of the population, the ability of the country to administer the scheme, and the level of political support in a country (Carrin & James 2005).

The contribution of SHI to UHC is to a large extent contingent on the modality of financing of SHI. This is in turn dependent on revenues available from the financing modality such as copayments, premiums, and government investment. What is evident from the literature is that SHI can be financed and that SHI can be an important part of ensuring UHC. While the experience of SHI to date has been mixed, there are clear lessons that can be gleaned from

understanding the successes and challenges of countries that have funded UHC through SHI. Two examples in the Asia Pacific region are Indonesia and the Philippines.

A health insurance scheme aiming to cover 260 million people—The Indonesian Story of Social Health Insurance

Indonesia's new health insurance scheme, launched just over three years ago in January 2014, already covers 134 million people—making it the largest in the world. By 2019 the scheme is to provide Universal Health Coverage (UHC) to the entire population—an estimated 260 million people (Republik Indonesia 2012).

Geographically Indonesia's large population is spread over 17,000 individual islands, in one of the most disaster-prone areas of the world. There are also stark inequalities both between geographic areas and income levels, and the country's healthcare system is decentralised, fragmented and segmented with a mixture of public and private provision (Republik Indonesia 2012).

Indonesia's fertility and population growth rates have been steadily declining with the total fertility rate in 2013 only 2.3. Indonesians have also become healthier over the past decade with life expectancy in 2013 being 71 years (The World Bank, 2017).

Since 1968, Indonesia has had a health insurance scheme that was only open to civil servants and government employees. Another scheme (Jamsostek) was introduced in 1992 for employees in the private sector, but the scheme was not compulsory so only covered 5% of employees. Following the passing of the Social Security Act of 2004, the government introduced Jamkesmas—a social security system aimed at protecting the poorest of the poor. Now these three separate schemes with their different benefit packages and insurance agencies have been brought together under one umbrella—Jaminan Nasional Kesehatan (JKN), a unified, contribution-

financed social health insurance scheme (Marzoeki et al. 2014). Fragmented financing schemes, inequitable distribution of resources, poor health outcomes and large out of pocket expenses for the poor provided impetus for the Indonesian government to establish a national health financing system for everyone. 'In 1999, the Indonesian Constitution was amended to include a right to social security and healthcare for all people (article 28H) and in 2002, under the fourth amendment, the State was instructed to develop a social security system for all Indonesians' (Marzoeki et al. 2014, np). This became law in 2004, making it compulsory for everyone with income above a certain level to contribute to social security. The aim was to bring down barriers to access of health services due to financial reasons, but also ensure further financial protection for the most vulnerable in society. However, for various political and other reasons, there was a ten-year delay before the National Security Law came into effect in January 2014. Financing for health in Indonesia comes from three sources. Out of pocket (OOP) expenditure, government budgetary spending (both central and subnational), and social health insurance expenditure. Despite relatively large increases in SHI expenditure in recent years, OOP expenditure remains the largest source of financing for health in Indonesia (The World Bank 2017). This is largely as a result of the relative low levels of public funding for health.

The Benefits Package

The benefits package under INA Medicare, while not clearly defined '... cover[s] all medically necessary services ... [meaning] if a doctor diagnoses a disease that must be treated, the most effective treatment will be covered by INA Medicare' (The World Bank 2017). The benefits package does not directly address preventive health services although the scheme allows access for all to health centres which '... are the front lines for providing various public health

programs ranging from health promotion, immunization, sanitation, and primary health care services to the community' (Thabramy 2008 in The World Bank 2017). Given the epidemiological transition in Indonesia towards non-communicable diseases and the increase in novel infectious disease outbreaks in the region, this lack of focus on prevention and public health is a lost opportunity for containing future health expenditure and minimising economic losses associated with disability and premature death.

Macroeconomic Rationale

Given the political forces that preempted the development of the Social Health Insurance scheme in Indonesia, there is no overt mention of the macroeconomic rationale for its development in Indonesian Government literature. Other commentators however have noted that improving the health of Indonesians would promote economic growth (Rokx et al. 2008; WHO 2006).

Future Challenges

While there are challenges ahead in implementation of INA Medicare including insufficient human resources for health, health infrastructure, a weak regulatory structure that provides limited oversight over quality of health care, and potential fiscal capacity issues, the overall design and institutional arrangements for health financing aspects of Indonesia's UHC program are largely consistent with UHC recommendations. The system has the potential to address health inequities and protect the poor from catastrophic costs; however, the scheme has already exhibited a rather large financial deficit with a medical claim ratio of 115% in 2014 (Hidayat 2015). This raises the question of the long-term financial viability of JKN. A further significant risk is that the health system will be skewed by JKN towards curative care in urban areas and public health and the rural population will be marginalised. Therefore, it is vital

for Indonesia's health security—and that of the region—that adequate investment is maintained in preventive and primary health care services.

Funding universal health coverage with a 'Sin Tax'—the Philippines Experience.

The Philippines is a large, diverse country with over 100 million inhabitants. It is a lower middle-income country, which has seen steady economic growth for several decades, and is one of the fastest growing economies in South-East Asia (Asian Development Bank and Philippines 2017). However, poverty and inequality have been recurrent challenges with over 25% of the population classified as poor (The Philippine Statistics Authority), and until recently with limited financial access to health services.

In common with many developing countries, the Philippines faces a double burden of disease: increasing rates of non-communicable diseases and high levels of risk factors (particularly alcohol and tobacco use and a rapidly growing epidemic of obesity) are accompanied by continued high rates of communicable disease. Many health indicators have shown little or no improvement in the past decade. Levels of public funds allocated to social services, including health, have been low, and although public health spending has been rising slowly as a percentage of GDP, budget allocations and per capita expenditures for health in the Philippines have remained low compared to other comparable countries in the region: per capita expenditure in 2014 was \$135 (of which 34.3% was public funding) compared to expenditure of \$360 in Thailand (86% public funding) (World Bank 2017).

The Government of the Philippines has included poverty reduction as a key development objective, and has identified UHC as a priority strategy to support this (National Economic and Development

Authority 2017). In common with much of the region, many Filipino households have been vulnerable to economic shocks and risks, including the catastrophic expenditure, which can accompany serious illness. To address this, the National Health Insurance Act of 1995 established the Philippine Health Corporation (PhilHealth) to ‘... provide all citizens with the mechanism to gain financial access to health services, in combination with other government health programs’ (The National Health Insurance Act of 1995 n.d., np). Formal sector workers and the self-employed contribute to a social health insurance fund managed by PhilHealth. The maximum premium is Pesos 10,500 (approx US\$225) for the formally employed (50% of this is paid by the employer). The premium (currently Pesos 2,400) for those classified as ‘indigent’ (identified by the Department of Social Welfare and Development based on specific criteria), those aged over 60, and retirees are fully subsidised by the government. Beneficiaries have access to a nearly comprehensive package of services, including inpatient care, catastrophic coverage, ambulatory surgeries, deliveries, and outpatient treatment for malaria and tuberculosis. The indigent are also entitled to outpatient primary care (PhilHealth 2017). Provider payment methods differ based on the type of care delivered. Fee-for-service reimbursements are used for inpatient care, while primary care providers are reimbursed based on a capitation system. No formal system sets deductibles or co-payments for beneficiaries, but health care providers are allowed to ‘balance bill’, charging patients the balance between what PhilHealth pays and the total cost of care. However, until recently many in the informal sector, a very large segment of the population, were yet to be covered by social health insurance.

In response to these issues, the Philippines ‘Sin Tax’ Law was enacted in 2012 (House Bill 5727 (the Sin Tax Bill) 2012). This significantly increased excise taxes on alcohol and tobacco, and earmarked the increased

revenue to the Department of Health (DoH). The results have been dramatic: Within two years of passing the law, the Philippine Department of Health’s budget increased from US\$1.25 billion to nearly US\$2 billion (WHO 2015c) and over 15 million poor and near poor families are now enrolled in the National Health Insurance Program, compared with just over 5 million three years ago.

There is also evidence that the sharp increase in the price of cigarettes has led to a reduction in smoking levels. According to the most recent Social Weather Stations survey commissioned by the DoH in 2015 smoking prevalence has fallen to 25%, from 30% in 2011 before implementation of the law began. However, outcomes in areas such as smoking prevalence, access to health services and levels of chronic disease are subject to both ‘an effect lag and a measurement lag’ and ‘the impact will only be fully captured by the results framework in later years’ (Kaiser et al. 2016).

The success of the Philippines in introducing this new tax regime has some important lessons for other countries that might consider similar measures. There was significant opposition from powerful vested interests; these were eventually overcome by a combination of technical analysis (clearly setting out the health, financing and equity implications of the proposed new law), and the development of broad coalitions for reform (involving law-makers and civil society, led by the President and supported by a well-designed communications strategy). The process took over ten years of sustained political commitment. Monitoring and public disclosure of the use of revenues, with the involvement of civil society organisations on the ground, has been important to sustain support for the new taxes. Introduction of the sin tax has shown that revenue earmarking for health can be an effective way of ensuring that health programs are scaled up and better targeted, and that it can also be politically popular.

4. An Opportunity

Where optimally implemented, SHI will not only pool risks for acute and chronic care but will also invest in prevention and infectious disease control. Investing in infectious disease control has the dual benefit of investing in priorities that disproportionately affect the poorest, and increase overall system efficiency by reducing the demands for expensive curative services. Malaria, in Asia Pacific, is largely a disease of the rural poor and presents a particular opportunity.

Since 1997, when the World Health Organisation suggested that malaria was a major public health dilemma, there have been some remarkable improvements in the control of transmission of the disease (Remme et al. 2001; Huszar et al. 2015; WHO 1997). The World Malaria Report of 2015 anticipated there were 262 million cases, most of which were in Africa (WHO 2015a). In the Asia Pacific region, however, there were 8 million cases (Huszar et al. 2015), and 61 per cent of the population of the Asia Pacific live in malaria-infected areas.

Malaria is geographically specific, largely confined to the subtropical regions of the world (WHO 2015b). Climatic conditions and the regions ecology are the main factors that affect the severity of the malaria burden.

Elimination of malaria in the Asia Pacific region is however a realistic target within the next 14 years (to 2030) and has been agreed to by Heads of Government in Asia and the Pacific (APLMA 2015). By eliminating malaria, over \$300 billion of economic benefit could be directed towards more pressing health targets (APLMA 2015; Huszar et al. 2015). Countries in the region with malaria that have little or no fiscal growth would also find that elimination of malaria could assist with strengthening agriculture and tourism in land that was once infested by mosquitos and thus further contribute to economic growth (Huszar et al. 2015).

Countries seeking to eliminate malaria however face a number of challenges in reaching the 2030 goal. The Greater Mekong Subregion in particular face the ubiquitous challenges of

reducing the incidence in high transmission areas and preventing reintroduction into areas that were deemed malaria free. In addition, there is the challenge of multidrug resistant (MDR) malaria that threatens to undermine global malaria efforts. As WHO has recommended, an urgent move to elimination is the only solution to tackle the MDR malaria crisis (WHO 2015b). What has also become clear is that effective health systems are a critical prerequisite for progress in many areas (Huszar et al. 2015).

A fully functioning healthcare system is a necessary requisite to eliminating infectious diseases more broadly. This system must be adequately funded and resourced with high quality commodities and qualified effective staff to manage a diversity of healthcare including public health initiatives and emerging infectious diseases. The health and economic impacts of recent outbreaks of Ebola and Zika virus underscore the issue. They have also demonstrated that emerging infectious diseases require a strong collective response from the Government for rapid containment and that failing to ensure this response is costly. The World Bank estimates that Guinea, Liberia, and Sierra Leone lost at least US\$2.2 billion in forgone economic growth in 2015 as a result of the epidemic. The World Bank further projects that the annual global cost of a moderately severe to severe pandemic is roughly \$570 billion, or 0.7 per cent of global income (The World Bank 2017). Strong health systems that support the elimination of malaria would also see the Asia Pacific region build its International Health Regulation core capacity so that countries in the region have the capacity to assess, detect, and respond effectively to public health emergencies.

Strengthening health systems (including prevention) is also vital to managing tuberculosis—another disease that threatens the Asia Pacific region. The World Health Assembly has declared drug resistant tuberculosis (DR-TB) a ‘global public health threat’ (World Health Assembly, 2009). The epidemic of DR-TB is increasing because of weaknesses in health systems and subsequently national TB programs. The Asia Pacific region carries the

bulk of the global TB burden (58 per cent), including the majority of all estimated MDR cases (54 per cent) (Majumdar et al. 2014). Visionary political leadership has been called for to champion a comprehensive regional strategy that draws on novel and creative solutions, similar to the Asia Pacific Leaders Malaria Alliance created to spearhead malaria elimination and to contain the emergence of drug-resistant malaria (Majumdar et al. 2014). 'TB control is intimately linked to health system development and socioeconomic factors ... and that [f]ailure to specifically address DR-TB will result in major long-term human and economic costs, and ultimately may pose a major threat to regional development' (Majumdar et al. 2014, p.241).

As many Asia Pacific nations consider further development and expansion of SHI, a unique opportunity presents to ensure that the financial reforms implemented under a shift to SHI adequately fund UHC, including the benefits package covering malaria and TB, and coverage of the rural poor. This will facilitate countries in the Asia Pacific region to protect their own economic interests while cooperating to secure regional prosperity. It is time for the Asia Pacific region to 'grasp the nettle' and use healthcare funds through SHI to target elimination of malaria through a strong and viable health strengthening program that will not only eliminate malaria but strengthen health security for the region.

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