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Health in the Post-2015 Development Agenda for Asia and the Pacific

Yanzhong Huang, Patricia Moser, and Susann Roth
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Abstract

The paper discusses the key health challenges in the post-2015 development agenda for Asia and the Pacific, a highly populated, diverse region of countries with different health needs and priorities. However, common to most countries are the emerging health challenges of an aging population, increasing prevalence of noncommunicable diseases, financing and strengthening health systems to ensure basic services, climate change, population mobility, rapid economic growth, and environmental pollution. At the same time, the unfinished business of the Millennium Development Goals is still very much relevant for Asia and the Pacific—especially in low- and middle-income countries where child and maternal mortality goals have not been achieved. Drawing on the regional, thematic, and subregional consultations and on expert views in and outside of the Asian Development Bank (ADB), this paper argues that the post-2015 development agenda needs to address health in a more systematic way in one global goal, and in more specific national goals that focus on country-specific health needs in and outside the health sector. The paper also provides entry points for ADB to support a post-2015 health agenda in its developing member countries, and highlights the importance of strengthening regional cooperation and integration to tackle emerging health challenges.

Background

The period of 15 years that was given to fulfill the promises of the unique Millennium Declaration of September 2000 is coming to a close soon. It raised great hopes of a world without poverty and deprivation. Some of those promises have indeed been fulfilled. The Asia and Pacific region, for instance, has led the world in halving the incidence of extreme poverty. However, the majority of the world's poor still live in the region. This reflects the challenges of Asia and the Pacific: the region with the fastest growing economies, the largest private sector investments compared to Africa and Latin America, the fastest widening inequalities, the most disaster-prone and climate change-affected countries, and the most rapid reduction in biodiversity worldwide.

These extremes can only be tackled through a more integrated approach to development, one that supports a global development vision and at the same time addresses the needs of the region and each of its countries. In order to support the region in developing a more holistic approach to the development agenda that will go beyond the Millennium Development Goals (MDGs)—the “post-2015” agenda—the Asian Development Bank (ADB) has supported consultations and expert dialogues within the region, and has led internal discussions with the wide range of experts in its internal communities of practice. ADB is also drawing on its regional partnerships with national and regional development partners to build a regional approach to the post-2015 setting of goals and targets. ADB has supported its developing member countries in achieving the goals, and monitored, reported on, and advocated for MDG achievement. Much of this work has been accomplished through a partnership established in 2004 with the United Nations Economic and Social Commission for Asia and the Pacific and United Nations Development Programme, which has published the 2012–2013 regional MDG report containing Asian and Pacific perspectives on the post-2015 development agenda.

This paper aims to summarize global and regional discussions on health in the post-2015 development agenda.

1. Introduction

Health has rightly been at the center of the international development agenda since the adoption of the Millennium Declaration in 2000, which underlines human rights and equality as fundamental values.¹ Among the eight Millennium Development Goals (MDGs), there are three health-specific goals—for child health (MDG4), maternal health (MDG5), and combating HIV/AIDS, malaria, and other diseases (MDG6). In addition, the goal for reducing poverty (MDG1) includes income and nutrition targets, both of which directly impact health; and three other goals address social dimensions critical for improving health—education (MDG2), gender equality (MDG3), and environmental sustainability (MDG7).²

Given slow progress in achieving some of the above goals, they will remain relevant beyond 2015 in Asia and the Pacific. However, articulation of goals for the post-2015 era must also take into consideration the emerging health challenges of the region. These include the increasing prevalence of noncommunicable diseases (NCDs) and injuries, aging populations, increasing health threats from emerging communicable diseases, increasing vulnerabilities due to climate change, and rising inequities in health outcomes.

1.1 Progress on the Health-Related Millennium Development Goals

Key message: Asia and the Pacific still accounts for the majority of the global disease burden, measured by disability-adjusted life years (DALYs), (footnote 1). For that reason alone, the perspective of Asia and the Pacific on how health should continue to be addressed post-2015 is relevant for the global agenda. Although Asia and the Pacific has made considerable progress in achieving the MDGs, the region lags in reaching the health-related goals.

Developing countries in Asia and the Pacific have made tremendous progress in meeting the MDG targets. However, progress toward meeting some of the health-related targets is lagging:

- The trend in the proportion of underweight children, a target under MDG1, is slowly improving across much of South and Southeast Asia, but regressing in the Pacific.³
- Achievement of infant and maternal mortality goals (MDG4 and MDG5) is slow in all subregions.⁴
- While most countries in the region have made good progress in reducing the incidence of HIV, a target under MDG6, rates have risen by more than 25% in seven of the countries.⁵

¹ United Nations. 2000. United Nations Millennium Declaration. Available at <http://www.un.org/millennium/declaration/ares552e.htm> (accessed 20 May 2013).

² United Nations Economic and Social Commission for Asia and the Pacific (UN ESCAP), Asian Development Bank (ADB), and United Nations Development Programme (UNDP). 2012. *Accelerating Equitable Achievement of the MDGs: Closing Gaps in Health and Nutrition Outcomes, Asia-Pacific Regional MDG Report 2011/2012*. Bangkok.

³ In addition, stunting (or chronic malnutrition), measured by height for age, remains a problem, with some countries registering more than 40% of children under 2 in this category. The majority of stunted children live in the region, with a very large proportion of these in South Asia.

⁴ Subregions of Asia and the Pacific as per ADB definition: Pacific, Southeast Asia, South Asia, Central Asia and Caucasus, and East Asia.

⁵ Joint United Nations Programme on HIV/AIDS (UNAIDS). 2012. *Global Report: UNAIDS Report on the Global AIDS Epidemic 2012*. Geneva. Available at http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/2012_1120_UNAIDS_Global_Report_2012_en.pdf (accessed 23 April 2012).

Table 1: Progress toward Achieving the Millennium Development Goals in Asia and the Pacific

Goal	1	2	3	4	5	6	7
	\$1.25 per day poverty Underweight children	Primary enrollment Reaching last grade Primary completion	Gender primary Gender secondary Gender tertiary	Under-5 mortality Infant mortality	Maternal mortality Skilled birth attendance Antenatal care (≥1 visit)	HIV prevalence TB incidence TB prevalence	Forest cover Protected area CO ₂ emissions ODP substance consumption Safe drinking water Basic sanitation
Asia and the Pacific	● ■	▶ ■ ■	● ● ●	■ ■	■ ■ ■	● ● ●	● ● ●
Excluding PRC and India	● ● ▶	■ ■ ■	● ● ●	■ ■ ■	■ ■ ■	● ● ●	▲ ● ●
Southeast Asia	● ● ▶	▶ ■ ■	● ● ●	■ ■ ■	■ ■ ■	● ● ●	▲ ● ●
South Asia	■ ■ ■	▶ ■ ■	● ▶ ■	■ ■ ■	■ ■ ■	● ▲ ●	● ● ●
Pacific Islands			▲	■ ■ ■	■ ▲ ■	● ● ▲	▲ ● ●
North and Central Asia	■	▲ ● ●	● ● ●	■ ■ ■	■ ● ■	● ● ●	● ▲ ●
Asia and the Pacific LDCs	■ ■	■ ■ ■	● ● ▲	■ ■ ■	■ ■ ■	● ● ●	▲ ● ●

● = Early achiever ▶ = On track ■ = Slow ▲ = Regressing/No progress

CO₂ = carbon dioxide, LDC = least developed country, ODP = ozone depletion potential, PRC = People's Republic of China, TB = tuberculosis.

Source: Asian Development Bank, United Nations Economic and Social Commission for Asia and the Pacific, and United Nations Development Programme. Forthcoming. *Regional MDGs Report 2012/2013: Asia-Pacific Aspirations for a Post-2015 Development Agenda*. Bangkok.

MDG4 and MDG5 are the only goals in which all indicators are progressing slowly across the region. This warrants further analysis and action. Similar is the case with the region's failure to provide adequate maternal health care. While countries are making slow progress on provision of antenatal care and delivery by skilled birth attendants—the two targets for MDG5—evidence now suggests that these will not be sufficient to achieve the maternal mortality ratio reductions targeted in MDG5 (footnote 2). Rapid access to lifesaving hospital services will be essential to further reducing maternal mortality. This will require well-trained and responsive health professionals, compliance with good operating procedures, and availability of needed medications, among other inputs, all of which require specialized health services and physical and financial access at the time of need. While hospital care is expensive, the social and economic costs of preventable maternal death can be far higher.

Progress on reducing HIV/AIDS, malaria, and other diseases (MDG6) is varied. Many countries were able to reduce HIV incidence after 2009 with targeted prevention efforts and expanded access to antiretroviral drugs. For instance, Nepal and Cambodia reduced new HIV infections in the past decade by 91% and 88% in the general population, respectively. Four countries that account for a large number of people living with HIV in the region—India, Myanmar, Papua New Guinea, and Thailand—reduced new HIV infections by more than 50% from 2001 to 2011. New infections in Malaysia dropped by 34% during the same period.

However, while the rate of new infections has remained steady or decreased, the number of people living with HIV significantly increased in Bangladesh, Indonesia, and Sri Lanka. In addition, the rate of new HIV infections continues to rise in Central Asia and the Caucasus. In

Georgia, Kazakhstan, and the Kyrgyz Republic, the rate of new HIV infections rose by more than 25%, largely driven by increased transmission in high-risk populations, such as injecting drug users.⁶ This requires action; however, most HIV/AIDS financing comes from external aid, which is declining for HIV/AIDS in the region, although huge resource gaps persist (footnote 6).

Overall, the incidence and prevalence of tuberculosis has declined in Asia and the Pacific, with some exceptions in Central and West Asia and the Pacific Islands, where multidrug-resistant tuberculosis is becoming a major challenge. Malaria deaths have dropped by nearly 75% in the region, due to active national programs promoting diagnostic testing, bednets, and chemotherapy. However, the incidence of malaria is still high among high-risk groups such as populations in Myanmar, and artemisinin drug resistance is a major emerging problem in the Greater Mekong Subregion, for which the World Health Organization (WHO) announced an emergency response in April 2013.⁷

Given large populations and the unfinished MDG agenda, it is not surprising that the region still accounts for the majority of the global disease burden, measured by disability-adjusted life years (DALYs).⁸ For that reason alone, the perspective of Asia and the Pacific on how health should continue to be addressed post-2015 is relevant for the global agenda.

2. Post-2015 Health Challenges

According to WHO, NCDs and injuries, including cancer, cardiovascular diseases, chronic respiratory diseases, diabetes, and road traffic-related death are now the most frequent causes of death in Southeast Asia and the Western Pacific.

2.1 Noncommunicable Diseases and Injuries

Key message: Healthy years of life are mostly lost to cardiovascular disease in Asia and the Pacific. Risk factors—such as tobacco smoking, high blood pressure, and obesity—contributing to NCDs are substantially increasing in the region calling for more attention to preventive health care and health promotion.

WHO projects that Asia and the Pacific will have the greatest total number of NCD deaths among all global regions by 2020.⁹ Most developing countries of Asia and the Pacific face the double burden of communicable and noncommunicable diseases. For the region, NCDs are the predominant cause of mortality. According to World Bank research, the share of total deaths attributable to NCDs in South Asia will increase from 51% in 2008 to 72% in 2030.¹⁰ Indeed, NCDs are not just the leading cause of mortality, but also the primary contributor to DALYs in the region. Among the 25 leading causes of DALYs in 2010, cardiovascular disease is ranked first in high-income Asia and the Pacific, East Asia, and Southeast Asia, while ischemic heart

⁶ UNAIDS. 2012. *World AIDS Day Report 2012*. Geneva.

⁷ World Health Organization (WHO). 2013. WHO Launches Emergency Response to Antimalarial Drug Resistance. Press release of 24 April. Available at http://www.who.int/mediacentre/news/releases/2013/world_malaria_day_20130424/en/ (accessed April 2013).

⁸ According to the recently released Global Burden of Disease (GBD) study, all subregions (high-income Asia and the Pacific, East, Central, Southeast, and South Asia) combined made up 51.1% of the global burden in 2010; calculated from *The Lancet*. 2012. Disability-Adjusted Life Years (DALYs) for 291 Diseases and Injuries in 21 Regions, 1990–2010: A Systematic Analysis for the Global Burden of Disease Study 2010. 15 December. Vol. 380, Issue 9859, p. 2213.

⁹ WHO. 2011. *Global Status Report on Noncommunicable Diseases 2010: Description of the Global Burden of NCDs, Their Risk Factors and Determinants*. Geneva. Chapter 1: Burden: Mortality, Morbidity and Risk Factors. Available at http://www.who.int/nmh/publications/ncd_report_chapter1.pdf (accessed January 2013).

¹⁰ For the subregion of East Asia and the Pacific, the share will grow from 76% to 85%. See Irina A. Nikolic, Anderson E. Stanciole, and Mikhail Zaydman. 2011. Chronic Emergency: Why NCDs Matter. *World Bank Health, Nutrition and Population Discussion Paper*.

disease is ranked first in Central Asia, second in East Asia, and third in high-income Asia and the Pacific and Southeast Asia.¹¹

NCDs take a heavy toll on economic development, not only because treating them can quickly drain household resources, but also because they often prevent people from working or seeking employment.¹² While part of the increase in proportion of deaths is due to progress in reducing maternal and child mortality, and another to aging populations having more people at risk, it is also a result of rising rates for NCDs at younger ages due to increasing tobacco use and changes in diet, lifestyle, and environmental factors. As a result, people are affected at a younger age with NCDs, impacting the working-age population and increasing the economic burdens posed by these diseases in the region.

A trend is also visible in the risks, which contributes to the burden of disease and to injuries. In 2010, the three leading risk factors for global disease burden were high blood pressure (7.0% of global DALYs); tobacco smoking, including secondhand smoke (6.3%); and alcohol use (5.5%). In Asia and the Pacific, the rise of risk factors for NCDs is shown by the substantial increase in the burden attributable to tobacco smoking (including secondhand smoke), high blood pressure, and obesity. While household air pollution (HAP) from solid fuels remains the leading factor in South Asia, high blood pressure and tobacco smoking (including secondhand smoke) were among the three leading risk factors in all the subregions, including South Asia.¹³

When it comes to injuries, rapid motorization and expansion of road infrastructure has led to a rapid increase in traffic fatalities, with more than half of global traffic fatalities happening in Asia and the Pacific. Given poor road traffic oversight in many countries, traffic-related deaths and injuries per kilometer far exceed rates in Organisation for Economic Co-operation and Development countries, and most often affect the poor. Throughout the region, road traffic-related deaths are the major cause of death for young adults.¹⁴

2.2 Undernutrition

Key message: Asia and the Pacific is home to the largest share of the world's hungry and undernourished. Undernutrition threatens children's survival, health, growth, and intellectual development.

An important contributor to NCDs is early stunting, which occurs when children are deprived of the proper nutrients from undernourished mothers at the time of conception through the first 2 years of life (the "first 1,000 days") and is measured by height for age. Stunting is often strongly correlated with poverty and social exclusion. Asia and the Pacific is home to the largest share of the world's hungry and undernourished, and undernutrition threatens children's survival, health, growth, and intellectual development, as well as hinders national progress toward development goals. More than a third of children under 5 in Asia have moderate to severe stunting. In India and Nepal, stunting affects almost half of all children under 5.¹⁵

¹¹ Christopher J. L. Murray et al. 2012. Disability-Adjusted Life Years (DALYs) for 291 Diseases and Injuries in 21 Regions, 1990–2010: A Systematic Analysis for the Global Burden of Disease Study 2010. *The Lancet*, 15 December. Vol. 380, Issue 9859, p. 2216.

¹² Note 9, p. 35. Available at http://www.who.int/nmh/publications/ncd_report_chapter2.pdf

¹³ *The Lancet*. 2012. A Comparative Risk Assessment of Burden of Disease and Injury Attributable to 67 Risk Factors and Risk Factor Clusters in 21 Regions, 1990–2010: A Systematic Analysis for the Global Burden of Disease Study 2010. 15 December. Vol. 380, Issue 9859, p. 2248.

¹⁴ UN ESCAP. 2006. Road Safety in Asia and the Pacific. Meeting of Senior Government Officials in preparation for the Ministerial Conference on Transport, 6–8 November, Busan, Republic of Korea. Available at http://www.unescap.org/ttdw/common/TPT/GettingStarted/3-Link/MCT_SGO_9E.pdf

¹⁵ United Nations Children's Fund. 2012. The State of the World's Children 2012: Children in an Urban World. New York, NY, pp. 94–95. Available at http://www.unicef.org/sowc2012/pdfs/SOWC%202012-Main%20Report_EN_13Mar2012.pdf

Stunted children are less likely to complete schooling, join the workforce, or have future household incomes equivalent to children who are not stunted. They are more likely to suffer later in life from NCDs, such as heart and kidney disease, obesity, and diabetes. Stunted girls are also themselves likely to be mothers to underweight babies, potentially transmitting ill health and poverty across generations. MDG1 includes reduction of undernutrition as a specific target, measured by weight for height and indicates acute malnutrition. Stunting is evidence of less visible chronic malnutrition, and impairs children's lifelong abilities and impacts their future health by increasing risks for NCDs. Stunting is compounded by diarrhea and enteric diseases resulting from low levels of sanitation and hygiene and unsafe water.

At the same time, rising levels of both childhood and adult obesity are of growing concern across the region. Consequent rising rates of hypertension and diabetes affect health, productivity, and public finance—for example, in the Philippines in 2007, about 20% of adults aged 30 and above are estimated to be diabetic, compared to 3.9% in 1998.¹⁶

2.3 Communicable Diseases

Key message: Communicable diseases remain a serious concern in the region. Communicable diseases remain the leading causes of mortality for children in South and Southeast Asian countries.

While the regional disease burden continues to shift away from communicable to noncommunicable diseases, it is important not to ignore the threat of communicable diseases in the region. Based on the Global Burden of Disease Study 2010, communicable diseases remain the leading causes of premature mortality—measured by years of life lost (YLLs) in 2010—for certain South and Southeast Asian countries. Diarrheal disease is ranked the third largest cause of YLLs for South Asia and sixth for Southeast Asia, and HIV/AIDS is ranked ninth for Southeast Asia, while tuberculosis is ranked second for Southeast Asia, eighth for South Asia, and tenth for Central Asia.¹⁷ In addition, malaria, dengue and other neglected tropical diseases (e.g., filariasis, schistosomiasis) remain challenges in some areas.

It is important to keep in mind that NCDs mainly affect the elderly and adults; however, children who enjoy longer remaining life expectancy, will continue to suffer and die from communicable diseases, adding disproportionately to YLL. In addition, even if communicable diseases are contained, this is achieved at considerable costs, and continuing investment is needed to sustain this.

2.4 A Graying Population

Key message: Globally, most people aged 60 and above will live in Asia and the Pacific by 2050. Forward-looking planning is required to manage the health service needs of this wave of aged people with mostly noncommunicable diseases.

The impacts of increasing longevity on poverty incidence and health expenditures raise important issues for the region. Life expectancy at birth has continued to rise for both sexes and for all countries. In addition, fertility has been falling in most countries. As a result, the proportion of the elderly (aged 65 and above) in the total population has been steadily increasing, going from 6.1% in 2000 to 7.0% in 2010. While the magnitude of change is not as significant as that

¹⁶ Maria Luz B. Soria et al. 2007. Philippine Cardiovascular Outcome Study on Diabetes Mellitus. *Philippine Journal of Internal Medicine*. 45 (5): 211–217.

¹⁷ *The Lancet*. 2012. Global and Regional Mortality from 235 Causes of Death for 20 Age Groups in 1990 and 2010: A Systematic Analysis for the Global Burden of Disease Study 2010. 15 December. Vol. 380, Issue 9859, p. 2118.

in Europe (from 15.3% in 2000 to 17.0% in 2010), it is larger than in other emerging regions and rapidly rising.¹⁸

At the subregional level, the proportion of those over 65 has risen most rapidly in East and Northeast Asia—from 7.9% to 9.5%. In these countries (including the People’s Republic of China [PRC] and Japan), an estimated one-third of the population will be over the age of 60 by 2050.¹⁹ This will also pose huge challenges to the countries’ pension systems.²⁰ Population aging is highly associated with the rise of NCDs. Indeed, between 1990 and 2010, aging was responsible for nearly 40% of the increase in NCD deaths.²¹ Many of these diseases are chronic and expensive to treat, placing new burdens on households and health systems. Therefore, it is critical that countries take aging into account in national fiscal and social protection planning, and develop health services’ capacities to address the health needs of older persons. In particular, the “silver tsunami” may exacerbate gender issues, as women typically have longer life spans than men but earn less over their working lives and often have depleted their wealth as they reach older ages.

2.5 Urbanization

Key message: Little attention is paid to health care needs of low-income groups in Asian cities, who are often exposed to poor living conditions, pollution, and unhealthy diets, and have little awareness about preventive health measures.

In 2010, the number of people living in urban areas surpassed that of people living in rural areas globally. In Asia and the Pacific, 42.7% of the population lived in urban areas in 2010. While the level of urbanization is only higher in Africa, the region’s urban proportion rose by 13% during 2000–2010, more than any other region.²² Rapid and unplanned urbanization causes problems of urban crowding, slum development, and lack of access to basic services. Hygiene, access to safe drinking water, and sanitation are major issues for urban dwellers across the region. For example, most urban dwellers in major population centers, including Manila, Jakarta, Dhaka, and New Delhi, lack access to modern sanitation, making them more vulnerable to waterborne diseases. Diet and lifestyle changes associated with urban living, as well as increased exposure to air pollution from vehicle traffic and power generation, also increase the risks for NCDs.

Crowded, impoverished living conditions in urban areas also provide opportunities for diseases such as tuberculosis and other communicable diseases; diarrhea-causing viruses and bacteria, including rotaviruses and cholera; and fungal and bacterial skin infections. Unsafe and impoverished urban conditions can also result in vulnerability to violence, crime, and abuse, particularly for women and children. Urbanization raises concerns about the health care needs of socially marginalized populations, such as migrant workers, and poses challenges to local and national governments to provide health care services for large, often mobile populations, including those living in informal settlements or not registered with local authorities.

¹⁸ International Labour Organization. *Labour Migration in Asia and the Pacific*. <http://www.ilo.org/asia/areas/labour-migration/lang-en/index.htm>

¹⁹ Population data for UN ESCAP. 2011. *Statistical Yearbook for Asia and the Pacific 2011*. Bangkok. See <http://www.unescap.org/stat/data/syb2011/I-people/population.asp>

²⁰ Donghyun Park. 2009. Ageing Asia’s Looming Pension Crisis. *ADB Economics Working Paper Series*. No. 165. Manila: ADB.

²¹ Rafael Lozano et al. 2012. Global and Regional Mortality from 235 Causes of Death for 20 Age Groups in 1990 and 2010: A Systematic Analysis for the Global Burden of Disease Study 2010. *The Lancet*, 15 December. Vol. 380, Issue 9859, p. 2102.

²² Urbanization data for UN ESCAP, *Statistical Yearbook for Asia and the Pacific 2011*. See <http://www.unescap.org/stat/data/syb2011/I-People/Urbanization.asp>

2.6 Health Impacts from Climate Change and Degraded Environments

Key messages: Infectious diseases, for example malaria and dengue, will increase with climate change and affect populations beyond borders. More work is needed to mitigate negative health impacts from climate change.

Many countries in Asia and the Pacific are highly vulnerable to climate change and natural disasters that negatively impact health. Climate change challenges the public health community at the global, regional, and national levels with emerging diseases and expansion or reintroduction of existing diseases. One example is the increasing spread of dengue in Southeast Asia and South Asia. Climate change–related health impacts range from disease to changing atmosphere that affects water, livestock, and agriculture. These include increased health risks from extreme weather, such as fatal heat waves, floods, and storms, to less dramatic but potentially more serious effects of changing climate on infectious disease dynamics. Shifts to long-term drought conditions in many regions, melting of glaciers that supply freshwater to large population centers, and sea-level increases leading to salination of water sources for agriculture and drinking water can be observed.

Second, the health impacts of climate change are potentially huge. Many of the most important global killers, such as malaria, dengue, and waterborne diseases, are highly sensitive to climatic conditions, and an increase in incidences can already be observed.^{23,24}

Models predict that malaria prevalence in Asia and the Pacific could be 1.8 to 4.8 higher in 2050 than in 1990. The share of the world’s population living in malaria-endemic zones could also grow from 45% to 60% by the end of the century.²⁵

To address the climate change–related health impacts in the region, WHO endorsed the Regional Framework for Action to Protect Human Health from the Effects of Climate Change in the Asia-Pacific Region (2008) as a guide for planning and implementing actions to protect health from the effects of climate change, which include strengthening the existing health infrastructure and human resources, as well as surveillance, early warning, and communication and response systems for climate-sensitive risks and diseases. More support, particularly through regional cooperation, is needed to assist countries in the implementation of this action plan.

2.7 Internal and External Migration

Key message: Increasing intraregional migration calls for subregional and regional approaches to universal health coverage. This requires collaboration, information sharing, and harmonization of policies and practices among countries, including social protection for people moving within the region.

In 2010, there were 53 million documented migrants (one-quarter of the world’s total) and a large number of undocumented ones in Asia and the Pacific. Each year, more than 3 million people in the region leave their countries to work abroad.²⁶ The trend will continue in part because population aging and the drop in total fertility rate (TFR)—in 2010, TFR dropped to the replacement level in Asia and the Pacific—generate growing demand for migrant workers in

²³ ADB. 2011. *Accounting for Health Impacts of Climate Change*. Manila.

²⁴ United Nations Environment Programme. Climate Change. <http://www.unep.org/roap/Home/tabid/roap/Activities/ClimateChange/tabid/6834/Default.aspx>

²⁵ Sarah Potter. 2008. The Sting of Climate Change: Malaria and Dengue Fever in Maritime Southeast Asia and the Pacific Islands. Policy Brief, November. Lowy Institute.

²⁶ UN ESCAP. <http://unescapsdd.org/international-migration>

some countries in the region. Another contributing factor to migration is climate change, which impacts livelihoods.²⁷ In addition, the Association of Southeast Asian Nations (ASEAN) Economic Community (AEC) will be fully established by 2015, which will lead to increased international labor mobility since free flow of skilled labor is one of AEC's key objectives.

A healthy migrant workforce benefits the social and economic development of its communities of origin and destination. Yet, migrant workers often work and live in hazardous conditions and tend to be marginalized by society. While the health risks they face are relatively high, they are often excluded from local public health systems. This is especially the case for migrants without legal status, who tend to incur higher out-of-pocket payments than nationals when seeking care due to lack of social protection schemes. This is not just a violation of their rights; it is also counterproductive from a public health and development perspective (footnote 27).

While the limited access to public health and health care increases the risk of the spread of communicable diseases, higher out-of-pocket payments prevent the full development potential of migration from being achieved. It is therefore in the interest of the countries in the region to recognize the need for health coverage of international migrants, regardless of their legal status, and to incorporate it in the universal health coverage (UHC) agenda. As shown in Europe and Latin America, cooperation and integration at the regional level over this issue would not only contribute to achieving UHC as an overarching health goal, but can also create important opportunities for collaboration, information sharing, and harmonization of policies and practices among states, including social protection for people moving within the region.²⁸ In order to include coverage for international migrants in the UHC agenda, countries in the region should work toward collecting and harmonizing health data by gender, age, and socioeconomic status, as well as migrant type and legal status.

2.8 Increasing Threats to Health Security

Key message: The region is a hot spot for emerging communicable diseases, such as new seasonal influenza viruses and extraordinary diseases, like severe acute respiratory syndrome (SARS), avian influenza A (e.g., H5N1, H7N9), and Nipah virus. Such outbreaks can have huge economic impact beside the public health concern and can impair regional development.

Increasing economic growth in the region also comes with increasing cross-border trade, investments, and expanding transport corridors. This leads to growing threats to regional health security. The region is historically an epicenter of emerging communicable diseases, for example new seasonal influenza viruses and extraordinary diseases, such as severe acute respiratory syndrome (SARS), avian influenza A (H5N1), and Nipah virus. Such outbreaks can compromise regional development in a way that is disproportionate to the actual number of cases. SARS, for example, led to an immediate economic loss of an estimated 2% of gross domestic product (GDP) in East Asia in the second quarter of 2003 and close to \$40 billion in global economic loss in 2003, even though only about 800 people ultimately died from the disease.²⁹

²⁷ ADB.2013. *Addressing Climate Change and Migration in Asia and the Pacific*. Manila.

²⁸ International Organization for Migration. n.d. Health in the Post-2015 Development Agenda. Available at <http://www.iom.int/files/live/sites/iom/files/What-We-Do/docs/Health-in-the-Post-2015-Development-Agenda.pdf> (accessed January 2013).

²⁹ Mike Moffat. n.d. The Economic Cost of a Flu Pandemic. Available at http://economics.about.com/od/healthcareconomics/a/flu_pandemic.htm (accessed January 2013); Jong-Wha Lee and Warwick J. McKibbin. 2004. Estimating the Global Economic Costs of SARS. In Stacey Knobler, Adel Mahmoud, Stanley Lemon, Alison Mack, Laura Sivitz, and Katherine Oberholtzer, eds. *Learning from SARS: Preparing for the Next Disease Outbreak – Workshop Summary*. Washington, DC: National Academy of Sciences, pp. 92–109. Available at <http://www.ncbi.nlm.nih.gov/books/NBK92473/> (accessed January 2013).

Globalization and growing economic interdependence means that even countries with few to no cases have to deal with the economic shocks caused by the spread of disease in the region. Economic development in Cambodia and Myanmar, for example, suffered in 2003 even though they were spared by SARS.³⁰ In 2013, the region is watching closely the H7N9 infections in eastern PRC, which are assumed to originate from poultry; however, the mode of transmission is to date still uncertain but limited and non-sustainable transmission from humans to humans appears to be possible.³¹ Although the negative health impact with limited infections and deaths so far has not reached a large scale, the economic impact is visible, especially for the poultry industry in the PRC.

Over the past decades, notable strides have been made in slowing or even reversing the spread of major communicable diseases that were considered leading threats to global and regional health security such as HIV, tuberculosis, and polio. However, new health security threats are rising. Many of the emerging diseases dangerous to human health arise from animal diseases that impact human health (zoonosis). The region is traditionally a hot spot for the emergence of new diseases due to extensive human–animal interactions and large, mobile populations. With increasing incomes and populations, these risks are rising as demand for animal protein for food increases, leading to growing animal production, extensive animal trade, and cross-border human and animal movements. These interactions lead to the emergence of new and reemergence of old zoonotic diseases that can spread quickly between countries and are economically costly to control.

Rapid economic development and integration into the global economy increase the health threats of countries in the region, passing novel pathogens from and to other countries and other regions with negative impacts on development and security.

Antimicrobial resistance (AMR) is also a growing challenge, largely due to inappropriate, counterfeit and irrational use of anti-infective drugs in humans and animals, which has contributed substantially to the emergence and spread of resistant microorganisms. AMR is particularly a concern in Asia and the Pacific, where, according to the Study for Monitoring Antimicrobial Resistance Trends (SMART), the levels of resistance are the highest worldwide.³² This impacts the ability to treat many illnesses and serves to create new, powerful, and dangerous infectious agents. The region's serious epidemic of multidrug-resistant tuberculosis (MDR TB) and growing artemisinin-resistant malaria bear witness to these problems (Box 1).

High level political leadership was expressed at the Malaria2012 conference to address the challenges of malaria artemisinin resistance and ultimately eliminate malaria from the region. To translate political leadership into action the Asia-Pacific Leaders Malaria Alliance (APLMA) was established with ADB providing the APLMA secretariat. The APLMA's role is to unite countries to invigorate the fight against malaria and to promote regional political leadership and collaboration to drive progress and accountability to achieve the goals of a 75% reduction in malaria cases and deaths by 2015 and contain the spread of drug-resistant malaria and undertake high-level policy advocacy in Asia and the Pacific to keep malaria high on the region's agenda. The APLMA will oversee two streams of regional policy action: (i) improving access to quality malaria medicines and technologies and (ii) financing the gap between

³⁰ Yanzhong Huang. 2010. Pursuing Health as Foreign Policy: The Case of [the People's Republic of] China. *Indiana Journal of Global Legal Studies* 17 (1): 130.

³¹ James W Rudge and Richard Coker. 2013. Human to Human Transmission of H7N9. *British Medical Journal*. Vol. 347, *BMJ2013;347:f4730*.

³² Po-Ren Hsueh. 2012. Study for Monitoring Antimicrobial Resistance Trends (SMART) in the Asia-Pacific Region, 2002–2010. *International Journal of Antimicrobial Agents* 40(S1).

available domestic and global resources for sustained malaria control. The APLMA is the starting point for a high-level regional alliance and regional cooperation for other communicable diseases and public health threats. The alliance will promote partnership and mutual accountability across countries in the region for ensuring evidence-based, effective action on malaria and drug-resistant malaria.

Resurging or reemerging vectorborne diseases, including dengue, chikungunya, and Japanese encephalitis, are also a health security problem. These diseases are spreading, driven partly by urbanization, land-use changes, and climate change. Dengue is the fastest emerging arboviral infection. WHO estimates that 1.8 billion people in the region are at risk for the disease, which is more than 70% of the global at-risk population.³³ In 2012, the number of people in India sickened with dengue saw a more than 59% jump from the 2011 level.³⁴ However, a recently published study states that WHO-estimated dengue infection is triple the current estimates.³⁵

Natural disasters in the region also impact emerging and resurging diseases. The region is globally most prone to tsunamis, typhoons, and other natural disasters. Flooding often contaminates drinking-water facilities, increasing the transmission of waterborne diseases such as cholera, diarrhea, and hepatitis A. The cholera that killed more than 6,000 people in Haiti was believed to be brought by UN peacekeeping forces from Nepal.³⁶

Box 1: Emerging Health Threats in Asia

Avian influenza (H5N1): Asia has been most affected so far, with 75% of outbreaks of avian influenza in poultry notified to the World Organization for Animal Health (OIE) from the end of 2003 to 15 February 2013 in the region.^a In 2003 and 2004, highest poultry losses from avian influenza were suffered in Viet Nam, with 44 million birds, amounting to approximately 17.5% of its poultry population; and in Thailand, with 29 million birds or 14.5% of its poultry population. This was equivalent to up to \$450 million for Viet Nam and the loss of 1.5% of gross domestic product growth over a year for Thailand.^b As of March 2013, globally 622 cases were officially reported and 371 deaths of which 83% and 91%, respectively, were reported in Asia and the Pacific.^c

Multidrug-resistant tuberculosis (MDR TB): Accounting for a quarter of the cases worldwide, the People's Republic of China has the highest annual number of MDR TB* in the world—a third of new tuberculosis cases and half of patients with previously treated tuberculosis are found to have drug-resistant forms.^d It is estimated that around 180,000 cases of MDR TB reside/occur annually in the World Health Organization (WHO) Southeast Asia region, with more than 80% in Bangladesh, India, Indonesia, Myanmar, and Thailand.^e

Multidrug-resistant malaria: *Falciparum* malaria parasites resistant to artemisinin, the last line of effective drug therapy, have been detected in four Southeast Asian countries—Cambodia, Myanmar, Thailand, and Viet Nam.^f Combating the spread of this resistant strain has become a global good given that no new powerful drug class is expected for the next 5 years. The doom scenario is that artemisinin resistant *P. falciparum* parasites are carried to by infected people westward and eventually reach Africa, where the burden of *falciparum* malaria is much higher. The emergence of chloroquine (and pyrimethamine) resistance in Southeast Asia and subsequent spread to Africa and is thought to have contributed to the death of millions of African children.^g WHO launched an Emergency Response to Artemisinin Resistance in early 2013 to bring full attention to this public health threat.^h

continued on next page

³³ WHO. Dengue in the Western Pacific Region. http://www.wpro.who.int/emerging_diseases/Dengue/en/index.html

³⁴ Gardiner Harris. 2012. As Dengue Fever Sweeps India, a Slow Response Stirs Experts' Fears. *The New York Times*. 6 November. Available at http://www.nytimes.com/2012/11/07/world/asia/alarm-over-indias-dengue-fever-epidemic.html?pagewanted=all&_r=0 (accessed January 2013).

³⁵ Samir Bhatt et al. 2013. The Global Distribution and Burden of Dengue. *Nature* 496 (7446): 504–507. Available at <http://www.nature.com/nature/journal/vaop/ncurrent/full/nature12060.html> (accessed January 2013).

³⁶ Martin Enserink. 2011. Whole-Genome Study Nails Haiti-Nepal Cholera Link. *Science*. 23 August. Available at <http://news.science mag.org/sciencenow/2011/08/whole-genome-study-nails-haiti-n.html> (accessed January 2013).

Box 1 *continued*

Other MDR infections: Resistance to community-acquired infections including gonorrhea, diarrheal diseases, and streptococcus pneumonia is now widespread across the region. According to WHO, a high proportion of penicillin (37.0%) and quinolone antibiotic (59.2%) resistance was detected among isolates tested in the WHO West-Pacific region and Southeast Asia region.¹ A remarkable increase in the prevalence of highly resistant bacteria such as methicillin-resistant *S. aureus* (MRSA) in health facility-acquired infections has been observed in the region, with the percentage of MRSA among *S. aureus* isolates as high as 62.9% in the People's Republic of China and 64.0% in the Republic of Korea.¹ More recently, the New Delhi metallo-beta-lactamase-1 (NDM-1), a super drug-resistant microbe, was found in almost every continent within a year of its emergence in India in 2011.

Security risk from biological innovation: The dropping barriers to entry and costs of bioengineering increase the risks of accidental or intentional release of dangerous pathogens. Moreover, "gain-of-function" research on certain organisms could create a pathogen that is more virulent, drug-resistant, vaccine-evading, and transmissible. In 2011, news emerged that a group of scientists created a genetically modified version of the H5N1 avian flu virus that could theoretically wipe out all humanity. This new development highlights the need to address the dual-use research dilemma; that is, scientific studies with potential public health benefits are also growing biosafety and biosecurity concerns. The risk is brought higher in Asia and the Pacific, which houses numerous bio-research labs and facilities as well as a rapidly expanding pharmaceutical sector.

* Defined as tuberculosis resistant to at least isoniazid and rifampin.

^a Animal Health Information Department. 2013. Outbreaks of Highly Pathogenic Avian Influenza (subtype H5N1) in Poultry Notified to the OIE. Available at http://www.oie.int/fileadmin/Home/eng/Animal_Health_in_the_World/docs/pdf/graph_avian_influenza/graphs_HPAI_15_02_2013.pdf (accessed January 2013).

^b Anni McLeod, Nancy Morgan, Adam Prakash, and Jan Hinrichs. n.d. Economic and Social Impacts of Avian Influenza. Available at <http://www.fao.org/avianflu/documents/Economic-and-social-impacts-of-avian-influenza-Geneva.pdf> (accessed January 2013).

^c WHO. 2013. Cumulative Number of Confirmed Human Cases for Avian Influenza A(H5N1) Reported to WHO, 2003–2013. Available at http://www.who.int/influenza/human_animal_interface/EN_GIP_20130312CumulativeNumberH5N1cases.pdf (accessed January 2013).

^d Yanlin Zhao et al. 2012. National Survey of Drug-Resistant Tuberculosis in [the People's Republic of] China. *New England Journal of Medicine* 366:2161–2170. 7 June.

^e Rajesh Bhatia and Jai P. Narain. 2010. The Growing Challenge of Antimicrobial Resistance in the South-East Asia Region – Are We Losing the Battle? *Indian Journal of Medical Research* 132 (5): 482–486. November.

^f WHO. 2012. *World Malaria Report 2012*. Geneva. Available at http://www.who.int/malaria/publications/world_malaria_report_2012/en/index.html (accessed January 2013).

^g Eline L. Korenromp et al. 2003. Measurement of Trends in Childhood Malaria Mortality in Africa: An Assessment of Progress toward Targets Based on Verbal Autopsy. *The Lancet Infectious Diseases* 3: 349–357.

^h See http://www.who.int/mediacentre/news/releases/2013/world_malaria_day_20130424/en/

ⁱ Monica M. Lahra. 2012. Surveillance of Antibiotic Resistance in Neisseria Gonorrhoeae in the WHO Western Pacific and South East Asian Regions, 2010. *Communicable Diseases Intelligence* 36 (1): 95–100. March. WHO. Available at [http://www.health.gov.au/internet/main/publishing.nsf/content/cda-cdi3601-pdf-cnt.htm/\\$FILE/cdi3601d.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/cda-cdi3601-pdf-cnt.htm/$FILE/cdi3601d.pdf) (accessed January 2013).

^j Yu-Tsung Huang and Po-Ren Hsueh. 2010. Antimicrobial Drug Resistance in Asia. In Anibal de J. Sosa, Denis K. Byarugaba, Carlos F. Amabile-Cuevas, Po-Ren Hsueh, Samuel Kariuki, and Iruka N. Okeke, eds. *Antimicrobial Resistance in Developing Countries*. Springer, pp. 322–323.

What we see in Asia and the Pacific is the need to address the unfinished business of the MDGs while simultaneously finding solutions for emerging health issues that are interlinked with regional integration, poverty, lifestyle, climate, and demographic changes. In essence, the post-2015 development agenda has to address social, economic, and environmental dimensions of health concerns and find regional and national solutions to address interlinked and cross border problems.

3. Key Actions to Address Remaining Millennium Development Goal Health Challenges and the Post-2015 Development Agenda

3.1 Strengthen Health Systems

Key message: The post-2015 development agenda needs to address noncommunicable diseases since they significantly contribute to out-of-pocket-related impoverishment and their prevention cuts across sectors. Holistic cross-sectoral approaches, which include health system strengthening, sustainable financing for universal health coverage, and improving living standards and dietary habits, are necessary.

The shifting health and development landscape point to the limits of the existing MDG approach, which focused on “single diseases” or outcomes. The implementation of the MDGs led to increased commitment in tackling disorders related to maternal and child health, as well as HIV/AIDS, tuberculosis, and malaria. As a result, the burden of related disorders has dropped by nearly 32% over the past 2 decades and is expected to drop further by 2015.³⁷ This is a great success story.

Yet, at the global level, more than two-thirds of DALYs today arise from disorders not targeted in the MDGs. In Asia and the Pacific, only South Asia has the burden of MDG-related disorders exceeding one-third of DALYs. For East Asia and high-income Asia and the Pacific, DALYs related to MDG4, MDG5, and MDG6 as a proportion of the total burden have dropped to below 10% of total DALYs.³⁸

Given the burden of diseases, addressing NCDs and their risk factors needs to be an important element of the post-2015 agenda, especially given the chronic and debilitating nature of many NCDs and the consequent negative impacts on household incomes and poverty through out-of-pocket payments for health care.³⁹ The distribution and impacts of NCDs and their risk factors are highly inequitable. Indeed, the impact of NCD morbidity falls disproportionately on those of lower socioeconomic status.⁴⁰ In low- and middle-income countries, where comprehensive social health insurance systems and other types of social safety nets are underdeveloped, NCDs impose a disproportionately large burden and impede poverty reduction initiatives. The overall numbers are large, posing challenges for households, health systems, and economies. A study of eight countries in Southeast Asia estimated that in 2008 there were over 700,000 new cases of cancer and 500,000 cancer deaths in the region, leading to about 7.5 million DALYs lost in 1 year.⁴¹

Addressing NCDs and at the same time maternal and child health requires moving away from disease-driven initiatives to an approach that focuses on strengthening health systems in Asia and the Pacific.⁴² Dealing with the burden of NCDs requires a two-pronged, system-wide approach that involves proactive public health interventions to address the risk factors (e.g.,

³⁷ Note 1; note 11, p. 2217.

³⁸ Note 11, p. 2217.

³⁹ See note 2, chapter 2: NCDs and Development. Available at http://www.who.int/nmh/publications/ncd_report_chapter2.pdf (accessed January 2013).

⁴⁰ National Public Health Partnership. 2001. *Preventing Chronic Disease: A Strategic Framework*. Melbourne: Australian Health Ministers' Advisory Council.

⁴¹ Stephen Jan. 2012. Assessing the Burden of Cancer in South-East Asia: Understanding the Epidemiological, Social and Economic Impact. Presentation at the Second Global Symposium on Health Systems. Beijing. 2 November. Available at <http://hsr2012.abstractsubmit.org/presentations/5674/> (accessed January 2013).

⁴² ADB. 2013. *Impact of Maternal and Child Health Private Expenditure on Poverty and Inequity*. Manila.

tobacco use) on the one hand, and continual, well-coordinated medical services for those with chronic conditions or at high risk of developing such conditions, on the other.⁴³

Over the past decade, the surge in international funding and interest aimed at improving maternal and child health and combating specific communicable diseases, especially HIV/AIDS, tuberculosis, and malaria, has led to rapid proliferation of disease-driven programs. Such “vertical” initiatives play an important role in tackling targeted health challenges. Yet, they tend to operate outside the existing general health care system and are often characterized by fragmentation, duplication, competition, and disorder. Furthermore, sustainability of these programs relies heavily on the continuous supply of external donor resources and actually often decreases national spending on MDG-related health issues. This approach therefore cannot provide a sustainable solution to the new challenges, nor to the unfinished business of the MDGs, which requires system-wide responses.

For the same reason, weak and fragmented health systems in resource-poor settings are unable to provide well-designed, cost-effective, and mutually reinforcing prevention and treatment interventions. Indeed, health targets of current MDGs have floundered where health systems are inadequate to simultaneously meet the needs of health campaigns and everyday medicine. The lack of robust health systems in part explains why NCDs, which are typically associated with population aging, kill at younger ages in low- and middle-income countries, where 29% of such deaths occur among people less than 60 years old (the proportion is 13% in high-income countries).⁴⁴

Different from the disease-driven programming, which examines a particular issue through a linear, one-directional framework, health system strengthening (HSS) tackles health issues by emphasizing the underlying infrastructure to effect change that may transcend a particular issue area, as well as social norms, politics, or other mediating factors that may support or distract from the intended outcomes. While it can still examine a particular issue, such as HIV prevention, it “starts by bounding the system by identifying all of the relevant actors, activities, and settings within the given country that are related to HIV prevention.”⁴⁵

Certain principles may be followed in order to achieve successful HSS. These principles include, but are not limited to, the following (footnote 40):

- (i) build multidisciplinary and multi-stakeholder involvement to ensure adequate representation of all parts of the system;
- (ii) focus on local infrastructure that supports system-wide capacity for health workforce development;
- (iii) engage in whole-government approaches to leverage resources and reduce duplication in health system financing;

⁴³ NCD Alliance. 2011. Tackling Non-Communicable Disease: What Can Health Systems Do? Briefing Paper.

⁴⁴ Other Health Risks data for UN ESCAP, *Statistical Yearbook for Asia and the Pacific 2011*. See <http://www.unescap.org/stat/data/syb2011/I-People/Other-health-risks.asp> (accessed January 2013).

⁴⁵ United States Agency for International Development (USAID). 2012. Complexity and Lessons Learned from the Health Sector for Country System Strengthening. Background paper for the USAID experience summit on strengthening country systems. November. p. 9.

- (iv) ensure local country ownership (i.e., political leadership and stewardship, institutional and community ownership, capabilities, and mutual accountability, including financing) while building partnerships with development partners, civil society, and the private sector; and
- (v) build evidence-based monitoring and evaluation systems and link resources to results.

Among these principles, engaging multi-stakeholder involvement is essential to improve the performance of the health system. For most developing countries in the region, the government alone does not provide the resources or the capacity to provide quality and affordable health care: people often first seek diagnosis and treatment from private sector providers (PSPs) because they are perceived to be more accessible and efficient than their public sector counterparts. Working with PSPs is a critical part of HSS. It entails enacting and enforcing legal and regulatory rules that work to control escalation in treatment costs, limit malpractice, and improve technical quality care. It is equally important, however, to lower the barriers to entry of the private sector and encourage competition. Similar to their public sector counterparts, PSPs can be contracted for packages of essential health care and can be financed through prospective payment mechanisms.

Strengthening health systems does not exclude the existing disease-driven programs. Rather, the idea is to promote a synergy between the two. Health systems should be strengthened at the primary health care (PHC) level to handle both MDG-related challenges and NCD prevention and detection. The public sector needs to retain responsibility for ensuring access to quality services for priority health goals. At the same time, one might best expect innovation and focus on cost-effective “best buy” interventions on NCDs to be a strength of the private sector.⁴⁶

Existing “vertical” models and programs can be integrated into NCD control programs or “scaled up” for handling NCDs as well. Staff at clinics or hospitals focusing on treating HIV/AIDS, for example, can be retrained to address challenges of NCDs, including diabetes, hypertension, and other metabolic disorders. Programs devoted to reproductive and maternal and child health can play a more active role in detecting cervical cancer and breast cancer while in the meantime helping to prevent the spread of MDG-related communicable diseases, such as HIV/AIDS.⁴⁷

3.2 Sustainably Finance Essential Health Services

Key message: More and more governments in Asia and the Pacific have made a commitment to provide universal health coverage (UHC). However, UHC needs to be strengthened also at the regional level through shared commitments and knowledge. UHC should be a subtheme of the global post-2015 health goal and should be highlighted as a necessary means to achieve better and equal health outcomes for all population groups.

A global momentum is developing around universal health coverage (UHC) as a priority of the post-2015 agenda, defined by WHO as “ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services.”⁴⁸

⁴⁶ WHO. 2011. *Global Status Report on Noncommunicable Diseases 2010: Description of the Global Burden of NCDs, Their Risk Factors and Determinants*. Geneva.

⁴⁷ Jonathan D. Quick. 2012. On the Road to Universal Health Coverage: The Vital Role of the Essential Package for Health Impact. *Management Sciences for Health*. 31 October. Available at <http://blog.msh.org/2012/10/31/on-the-road-to-universal-health-coverage-the-vital-role-of-the-essential-package-for-health-impact/> (accessed January 2013).

⁴⁸ WHO. Universal Health Coverage. http://www.who.int/topics/universal_health_coverage/en/index.html

UHC is also part of the Social Protection Floor (SPF), which was introduced by the International Labour Organization (ILO) and which was endorsed by ILO member states in 2012.⁴⁹ The Rio+20 outcome document also stressed the need to provide social protection to all members of society and encourages national and local initiatives aimed at providing a social protection floor for all citizens, as well as supports global dialogue and best practices for social protection programs.⁵⁰ The SPF calls for the provision of essential guarantees (essential health care, education, water and sanitation, housing) and basic income security for children, persons in active age unable to earn sufficient income, and people in old age.

In Asia and the Pacific, all countries have committed to UHC goals. High-income countries (e.g., Australia, Japan, Republic of Korea) have some form of universal coverage, while middle-income countries, including Thailand, have established UHC programs. The Philippines and Viet Nam have also adopted UHC strategies and are working toward it. It is particularly encouraging that two of the most populous nations, the PRC and India, are making progress toward UHC. More than 95% of the population in the PRC is officially covered by some form of health insurance. However, the benefit package is still limited, with the average inpatient reimbursement rates in 2011 being as low as 48% for urban residents and 44% for rural residents.⁵¹ Considering the PRC's health challenges—a growing aging population with more NCDs that require long-term treatment—there is a need to develop more effective coverage; for instance, by increasing the reimbursement rate and covering more cost-effective services for all PRC citizens.

India, meanwhile, intends to provide easily accessible and affordable health care to all Indians by 2022 by offering an essential health care package and free choice of medical care facility. India chose a bottom-up design for expansion of health coverage, starting with coverage of the rural and the poorest segments of the population first, and the rapid scale-up of population coverage in a short period of time.⁵² There is debate whether expansion on both the supply and demand sides in the long term is sustainable, how to prioritize investments between primary and inpatient care, and between the extension of population coverage versus expansion of the benefits package, especially when resources are limited.⁵³

In May 2011, the World Health Assembly formally adopted a resolution calling for worldwide UHC, which WHO Director General Margaret Chan later described as “the single most powerful concept that public health has to offer.”⁵⁴ In January 2012, health ministers worldwide gathered in Bangkok committing to raising universal health coverage on the national, regional, and global agendas. In December 2012, the UN General Assembly approved a critical resolution, which recognizes the need for health care as a human right and supports UHC for people everywhere.⁵⁵

⁴⁹ See Global Extension of Social Security. The Social Protection Floor (SPF). <http://www.socialsecurityextension.org/gimi/gess/ShowTheme.do?tid=1321>

⁵⁰ UN General Assembly. 2012. Sixty-Sixth Session, Agenda Item 19: The Future We Want. Available at <http://sustainabledevelopment.un.org/futurewewant.html> (accessed January 2013).

⁵¹ Yuanli Liu. 2011. Great Progress, but More Is Needed. *The New York Times*. 1 November.

⁵² Somil Nagpal. 2013. Expanding Health Coverage for Vulnerable Groups in India. *Universal Health Coverage (UNICO) Studies Series No. 13*. Washington, DC: The World Bank. Available at <http://documents.worldbank.org/curated/en/2013/01/17207220/expanding-health-coverage-vulnerable-groups-india> (accessed January 2013).

⁵³ Note 51.

⁵⁴ WHO. 2012. 65th World Health Assembly Closes With New Global Health Measures. 26 May. Available at http://www.who.int/mediacentre/news/releases/2012/wha65_closes_20120526/en/index.html (accessed January 2013).

⁵⁵ UN General Assembly. 2012. Sixty-Seventh Session, Agenda Item 123: Global Health and Foreign Policy. Available at http://www.un.org/ga/search/view_doc.asp?symbol=A/67/L.36 (accessed January 2013).

Consultation feedback stresses that UHC should be one of the health goal subthemes of the post-2015 agenda.⁵⁶ UHC not only offers a systemic and sustainable solution to the major global health challenges of the 21st century, but also meets the five guiding principles for the post-2015 agenda as laid out by UN Assistant Secretary-General Robert Orr in a speech at the Council on Foreign Relations.⁵⁷

First, UHC capitalizes on the MDGs' focus on poverty, with a fundamental goal to reduce impoverishment due to health care costs. The most robust cross-country empirical evidence so far suggests that broader health coverage leads to better access to essential care and improved population health, particularly for poor people.⁵⁸

Second, as part of the health system strengthening efforts, UHC programs seek to build upon efforts to meet the present health-related MDGs and provide an integrated and sustainable solution to health-related development challenges.

Third, although there are not yet consistent definitions to measure coverage depth and breadth, countries are rapidly developing the financial and population data systems that will be needed to measure UHC.

Fourth, different from current MDGs for health, UHC focuses on providing affordable care for everyone and applies to every nation in the world, rich and poor alike. The agenda therefore meets the requirement of universal applicability.

Last, as enshrined in the UN resolution in December 2012, UHC is anchored in the right to health and raises the bar for improving health care overall.

UHC can also address some other major concerns as highlighted at the Economic and Social Council (ECOSOC) meeting in April 2012. First, the targets of UHC as an integrated part of HSS efforts reflect and address broader health needs, including the need to address the rising challenges of population aging and NCDs. Second, it can address sustainable development, inclusive growth, inequalities, and governance simultaneously. Last but not least, in recognition that "one size does not fit all," UHC is defined in a way that allows country ownership of health targets and implementation.

While many countries have traditionally taken a public sector approach to provision of services and health services coverage, these systems have remained weak, underfinanced, and inaccessible for much of the population in most countries in Asia and the Pacific. Strong growth in private health services, as well as increased access to information and communication technologies, is providing opportunities for innovations in coverage through demand-based programs, including micro-health insurance, conditional cash transfers (CCTs), and extensions of national social health insurance programs.

⁵⁶ UN. 2013. *A New Global Partnership: Eradicate Poverty and Transform Economies through Sustainable Development*. Report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda. New York. May.

⁵⁷ Orr laid out five guiding principles for the "post-2015" development agenda: (i) it should capitalize on the MDGs' focus on poverty; (ii) its legitimacy stems from building on the MDGs' considerable achievements; (iii) it should be measurable and reviewable; (iv) it should apply to all nations or poor people everywhere (including in the developed world); and (v) it should be a rights-based approach. CFR Workshop on the Post-MDGs Agenda for Global Health, 17 November 2012. See <http://www.cfr.org/projects/world/sustaining-healthy-development-a-workshop-on-the-postmdgs-agenda-for-global-health/pr1627>

⁵⁸ Rodrigo Moreno-Serra and Peter C. Smith. 2012. Does Progress towards Universal Health Coverage Improve Population Health? *The Lancet*. 8 September. Vol. 380, Issue 9845, p. 917–923. Available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)61039-3/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61039-3/abstract) (accessed January 2013).

These demand-based programs are also being used to change the allocation of funding from public facilities to clients, particularly for directly subsidizing health insurance coverage for the poor. Examples of pilot demand-based programs exist in Pakistan, India, and also in the Philippines, and a nationwide rollout was implemented in Georgia. In addition to promoting health services usage by the poor, such systems change the incentives for the public providers and reduce the ability-to-pay constraint to private provision. As countries approach UHC with unique histories and health infrastructure, such innovations will be needed to expand coverage in each setting. However, experiences with the demand-based approach also show the need for strong capacity development and implementation of public sector regulations to ensure continuous evaluation of the quality of care delivered.

By targeting poor and underserved populations, these demand-based UHC programs are consistent with the rights-based SPF approach, which promotes the implementation of social and labor policies that provide a basic set of social rights, services, and facilities that everyone should enjoy, including universal access to health care services. The demand-side programs open opportunities for new tools. Since the service providers do not have to be from the public sector, they allow the private sector to play a larger role in health service delivery.

Also, by allowing for competition among providers and linking the delivery of services to targeted performance-related subsidies, these client-centered programs can help ensure quality services and improve performance from the supply side. Service users can be more involved in providing feedback on service quality and thus can be empowered as “clients” of services rather than only beneficiaries. Measures such as CCTs and vouchers place purchasing power and the choice of provider directly in the hands of the recipients, which encourages the utilization of underused services (e.g., immunization, reproductive health) among the needy and underserved populations.

However, UHC bears numerous challenges, especially in large populations. The issue is not just about scalability, but also sustainability. While affordably reaching large numbers of informal sector and poor clients poses challenges for both public providers and demand-based programs, sustaining those gains is also difficult. Increased resources are needed to cover service expansion to the poor. Among other mechanisms to pay for expanded coverage, countries are using small, formal co-payments (controlled user fees) for health insurance or for using health services; allocating more general tax revenues to pay for CCTs and to subsidize insurance membership or re-insurance mechanisms for demand-based UHC plans covering the poor; and raising new finances and improving health through special taxes on alcohol and tobacco.

UHC needs collaboration between the public and the private sector, and it is important—especially in the long run—that risks are pooled. This is especially important when trying to address the issue that many programs offer limited benefits only and often do not provide for catastrophic coverage, leaving the poor better off to use more services, but still vulnerable to impoverishment from major illness. Another challenge is to ensure that demand-based financing does not result in cost escalation and inefficiency.

Programs must be carefully designed to ensure incentives for better service quality, good health results, and cost containment. In Sri Lanka, for example, there is concern about the government’s ability to continue to publicly provide free health services as NCDs and chronic illnesses become a larger portion of needed care. In the PRC, the pooled funds for the New Cooperative Medical Scheme (NCMS) are projected to be used up in 3 years if full coverage is extended to catastrophic illness. In Taipei, China, the national health insurance system is

increasingly underfunded and there is a shortage of doctors. Evidence from many countries indicates that given inappropriate incentives and medical markets, private medical providers can create unnecessary demand for health services and can quickly escalate health care pricing.

As a recent Council on Foreign Relations/Dalberg report noted, no substantial and sustainable improvements in health can be achieved without addressing coverage, care, and quality of personnel and/or supplies.⁵⁹ There must also be systems in place for ensuring the sustainability and affordability of services.

While it is ultimately the national government's responsibility to promote UHC programs, UHC can be strengthened at a regional level through shared commitments and knowledge. Taking regional perspectives into account when developing UHC is particularly important with respect to intraregional migration, which often leaves migrant workers without any health coverage. The UHC momentum is already building in Asia and the Pacific. In July 2012, the Fifth ASEAN+3 (PRC, Japan, and Republic of Korea) Health Ministers Meeting adopted a UHC commitment, pledging their cooperation on this issue.⁶⁰ Now it is time to include other countries in the region to scale up cooperation on UHC. Given the breadth of developed and developing country experience in UHC represented in the Asia-Pacific Economic Cooperation (APEC), it might be a good forum to discuss UHC among political leaders and health officials in order to hammer out a workable proposal for regional cooperation on the topic.

As a first step, regional leaders need to agree on the definitions, targets, and measurements for a common framework against which to discuss regional achievements, commitments, and knowledge. From there, specific regional issues can be developed. These might include sharing knowledge on fiscal sustainability, catastrophic coverage, and containing costs; coverage of migrant labor; regional accreditation and benchmarking of health service performance; and enabling and engaging the private health sector.

3.3 Maximize Health Outcomes of Public Policy

Key message: The post-2015 development agenda needs an integrated approach to health, in which social determinants of health such as water and sanitation, education, poverty, and inequality are all taken into account when planning for better health outcomes.

Asia and the Pacific has boosted economic growth and made huge strides in poverty reduction; however, health for all is not improving at the same speed. Many factors plan into good health. Notable are the social determinants of health, such as education, gender, income level, access to water and sanitation, and living condition, to name a few. All contribute to a person's health status. These social determinants of health are often underpinned by inequality, meaning that unequal access to these social determinants of health aggravates health outcomes.⁶¹ For example, in India, Indonesia, the Philippines, and Viet Nam, the under-5 mortality rate among the poorest quintile of the population is three times higher compared to that of the richest quintile. It is also proven that the health outcomes of children improve with the mother's educational attainment (footnote 57). With increasing unplanned urbanization, the poor are also

⁵⁹ Oren Ahoobim, Laurie Garrett, and Yanzhong Huang. 2012. *The New Global Health Agenda: Universal Health Coverage*. New York, NY: Council on Foreign Relations Press. Available at <http://www.cfr.org/global-health/new-global-health-agenda/p27998> (accessed January 2013).

⁶⁰ Pongphon Samsamak. 2012. Universal Healthcare Essential, ASEAN+3 Health Ministers Say. *The Nation*. 7 July. Available at <http://www.nationmultimedia.com/national/Universal-healthcare-essential-Asean+3-health-mini-30185681.html> (accessed January 2013).

⁶¹ WHO. 2008. *Health in Asia and the Pacific*. Bangkok/Manila: WHO Regional Offices for South-East Asia and the Western Pacific.

the ones suffering from exposure to outdoor air pollution and overcrowded, unsanitary housing in underserved slum or shantytown settlements, which contributes to waterborne and respiratory diseases and skin infections.

The report on social determinants of health to the World Health Assembly in 2009 confirmed that health inequities are increasing both within and between countries. However, the report also emphasized that these inequalities in social determinants of health are evitable through adequate policy actions that promote improving daily living conditions, tackle the inequitable distribution of power, money, and resources, and build evidence of bottlenecks outside the health sector, which, if addressed, accelerate health outcomes. A good example is the water/sanitation–food–health–education nexus, promoted by the United States Agency for International Development (USAID), which reflects the linkages between the four sectors and how achievements in one sector affect development outcomes in the others.⁶²

The Pacific recognized the social determinants of health in 1995—even before the MDGs—and developed the “healthy Island” approach, which provides comprehensive packages for policy actions in water and sanitation, food security, waste management, human resource development, prevention and control of communicable and noncommunicable diseases, reproductive health services, and primary health care. Recently, there have been calls to reposition this approach as a broader development initiative that would incorporate other elements, such as food security and climate change, in the healthy island approach.⁶³

Other initiatives such as the “Healthy Settings Approach” promoted by WHO in 2011 were brought forward to promote health in a holistic matter and work across sectors. The post-2015 agenda provides opportunities through an integrated development framework to work on development outcomes across sectors. This would also need to include strengthening policy between different government departments, which should complement rather than contradict each other in relation to health promotion. For example, trade policies that actively encourage the production, trade, and consumption of processed foods high in fat and sugar or soft drinks to the detriment of fruit and vegetable production are contradictory to health policy; the same is true for milk formula products, which in the Philippines, for example, belong to the most bought consumer products. In the Philippines, the rate of exclusively breast-feeding for the first 6 months of life was below 40% in 2008.⁶⁴ The United Nations Children’s Fund estimated in 2008 that 16,000 deaths of children under 5 in the Philippines are caused by inappropriate feeding practices, including the use of infant formula.

Moreover, labor laws, including provision of adequate maternity leave, and adhering to core labor standards are important policy actions to not only promote breast-feeding and promote child health but also improve the health status of the population in general. Very little of this action sits within the capabilities or responsibilities of the health sector. Positive advances have been made—for example, bans on advertisements for foods high in fat, sugar, and salt during television programs aimed at children.

⁶² USAID. n.d. Water and Development Strategy 2013–2018. Available at http://www.usaid.gov/sites/default/files/documents/1865/USAID_Water_Strategy_3.pdf (accessed April 2013).

⁶³ See <http://www2.wpro.who.int/southpacific/sites/pi/hi/> (accessed April 2013).

⁶⁴ OECD/WHO. 2012. Health at a Glance in Asia and the Pacific. http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/health-at-a-glance-asia-pacific-2012/breastfeeding_9789264183902-18-en#page1

However, a significant challenge remains, which is to engage with the multiple sectors outside health in areas such as trade, agriculture, employment, and education to support a comprehensive approach to good health for all.

3.4 Minimize Transnational Health Threats

Key message: The region needs to strengthen regional health security by improving regional cooperation and integration also in the health sector. Disrupting trade and travel as well as impacting international markets due to disease outbreaks need be prevented as much as possible. The rising health threats and the capacity gaps need to be addressed through the regional post-2015 process and under a goal for improving global and regional partnerships.

Meet International Health Regulation Requirements: Revised in 2005 and entered into force in 2007, the International Health Regulations (IHR) are a legally-binding international instrument for all member states of WHO. IHR aims to strengthen global public health security by providing a framework for the coordination of the management of public health emergencies of regional and international concern. Under IHR, all governments have to develop core capacities to detect, assess, notify, and respond to public health threats.⁶⁵ With improved domestic political engagement in the post-SARS period, there is strong political commitment to tackling public health security threats. Governments have also increasingly realized the need to adopt a “whole-of-government”–“whole-of-society” approach to protect against health security threats. Great progress has been made in strengthening disease surveillance capacities. In the PRC, the government has not only amended its domestic laws and regulations to be compliant with IHR, but also invested tremendously in building core surveillance and response capacities to tackle public health emergencies. By 2008, it had already built a multilevel disease surveillance and disease reporting system, allowing hospitals (including township health care centers) to directly report suspected outbreaks to the Chinese Center for Disease Control and Prevention.

Other countries, such as Viet Nam, have explored innovative arrangements for implementing IHR by engaging the services of nongovernment organizations in the event-based surveillance system. In addition, there is closer and more frequent exchange of information among countries in the region. Regional surveillance networks, such as the Mekong Basin Disease Surveillance (MBDS), the Southeast Asian Infectious Disease Clinical Research Network (SEAICRN), and the Emerging Infections Network (APEC EINet), have been created to enhance surveillance and response capacities at the regional level.

However, most countries in the region have not met the IHR requirements in core capacity building. In Southeast Asia, seven countries thus far have requested and been granted extensions to achieve IHR core capacities. Capacity building in the region tends to focus on surveillance capacity building (e.g., information sharing), with less emphasis on building capacities in terms of human resources, laboratories, and responses. A problem is also that capacity development for IHR implementation is mainly led by technical health agencies, such as WHO, which are focused on the health sector and are not able to follow a multisectoral approach to IHR implementation.

Despite the recognition of the importance of a multisectoral approach in managing health security threats, there is still inadequate national and regional support and coordination for response activities. To some extent, the increasingly demanding international health rules and norms regarding response to public health emergencies highlight the capacity gap in the region.

⁶⁵ WHO. Health Topics: International Health Regulations. http://www.who.int/topics/international_health_regulations/en/

By June 2009, for example, Thailand only had 5% of the population covered by government antiviral stockpiles, which was far below the recommended stockpile (covering 20% of the population). Most other Asian countries only had 1% of their population covered. This is certainly a major concern in politically decentralized states, but even in countries that embrace the approach, such as the PRC, efficient capacity building remains a problem.⁶⁶

The capacity gap has important implications for regional and global development. Lack of core response capacities could encourage countries to react defensively to disease outbreaks, disrupting trade and travel as well as international markets. In contrast to the responses of countries in Europe and North America—and against WHO’s advice—many countries in the region adopted a very costly containment-centered approach in combating the 2009 H1N1 pandemic, despite the limited benefit of the approach in stopping the spread of the virus.⁶⁷ Some countries used the fear of disease spread to practice trade protectionism by banning pork imports from Mexico and North America despite the lack of any evidence that the virus could be transmitted through pigs or pork products.

The rising threats and the capacity gap can and should be addressed through the regional post-2015 process.

Build multisectoral capacities and responses: Strengthen regional and global health security networks: An effective regional post-2015 agenda needs to also address capacity building to strengthen regional health security as a public good. For that, investing in effective global and regional partnerships is crucial. This approach would entail sustaining and improving the existing regional surveillance networks, such as MBDS, SEAICRN, and APEC EINet, and also knowledge-sharing platforms such as the Asia Pacific Observatory on Health Systems and Policies. Equally important is the use of the intergovernmental processes and forums (e.g., APEC, ASEAN+3, Asia–Europe Meeting, East Asia Summit) more frequently to

- (i) bring to attention the vulnerabilities of capacity building in areas that fall short of IHR requirements;
- (ii) ask government leaders and international donors to invest more directly in regional, multilateral initiatives aimed at capacity building; and
- (iii) push for the formation of regional or coordinated positions on preparation for and response to transnational disease threats.

4. Improve Monitoring for Key Actions

Key message: Adequate indicators for assessing health systems performance need to be identified at the national, regional, and global level to increase evidence-based decision making and to increase accountability at the national, regional, and global level.

4.1 Health System Strengthening Needs Better Monitoring

Given its importance in addressing new health challenges, there is a need to better measure and monitor progress in HSS. A number of tool kits and indicators have been developed.

⁶⁶ Yanzhong Huang. 2013. *Governing Health in Contemporary [People's Republic of] China*. London and New York: Routledge.

⁶⁷ Yanzhong Huang. Forthcoming. The 2009 H1N1 Flu Pandemic and the Policy Response in East Asia. In Robert M. Hathaway and Michael Wills, eds. *New Ways of Thinking about Security in Asia*. Washington, DC: Wilson Center Press.

In 2010, WHO identified six building blocks for HSS: governance, health financing, health workforce, information systems, medical products and technology, and service delivery.⁶⁸ Based on these building blocks, WHO's Handbook on Monitoring the Health Systems Building Blocks (2010) proposed information for concerned stakeholders who wish to know which indicators work best and under what circumstances. These core indicators enable policy makers to track health progress and performance, evaluate impact, and ensure accountability at the country and global level. This is particularly important for the design and implementation of health projects funded by development partners, which are increasingly interested in the delivery of actual results that have a positive impact on health outcomes. A recent study of five different countries highlights the strengths and weaknesses of applying selected indicators and their ability to monitor the success of HSS interventions on improving health outcomes, which is useful analysis for the development of health projects and programs.⁶⁹

4.2 Determine Quality of Coverage Indicators for Universal Health Coverage

UHC has two fundamental goals: maximizing health and reducing impoverishment due to health care costs. If it becomes one of the post-2015 health goals, it is essential that there be solid indicators and targets for health outcomes and health system performance, in addition to coverage, since coverage alone is not necessarily linked with improved health outcomes. WHO has developed a two-component approach to measuring progress toward UHC, focusing on health service coverage and financial risk protection, and selected health system determinants of health service coverage.⁷⁰ The strength of this approach is that it builds on the health impact of the existing MDGs and seeks to achieve the broad, flexible goal of UHC.^{71, 72}

4.3 Monitor International Health Regulation Compliance at the Country and Regional Level

To strengthen health security, IHR requires states parties to develop, strengthen, and maintain certain core capacities. It lays out core capacity requirements for surveillance and response at the community, intermediate, and national levels.⁷³ Based on these requirements, a comprehensive list of 28 indicators has been developed by WHO, focusing on core capacities. These core capacities need to be monitored at the national level, while strengthening regional core capacities for surveillance is a key objective of IHR and could be addressed under a goal on regional and global partnerships in the post-2015 development agenda.

When identifying indicators for the post-2015 development agenda, it is of utmost importance to look at existing indicators and build on the experience using and analyzing them.

⁶⁸ WHO. 2010. *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies*. Geneva. Available at http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf (accessed January 2013).

⁶⁹ Itamar Katz. 2012. Measuring and Monitoring Health Systems from Inputs to Impacts: Lessons Learned from Applying a Standardized Set of Indicators in Five Countries. Presentation at the Second Global Symposium on Health Systems. Beijing, 2 November. Available at <http://hsr2012.abstractsubmit.org/presentations/4337/> (accessed January 2013).

⁷⁰ WHO. n.d. Universal Health Coverage: Five Questions. Available at http://www.who.int/health_financing/universal_health_coverage_5_questions.pdf (accessed January 2013).

⁷¹ See Jonathan D. Quick. 2012. On the Road to Universal Health Coverage: The Vital Role of the Essential Package for Health Impact. *Management Sciences for Health*. 31 October. Available at <http://blog.msh.org/2012/10/31/on-the-road-to-universal-health-coverage-the-vital-role-of-the-essential-package-for-health-impact/> (accessed January 2013).

⁷² Core indicators related to NCDs and their risk factors are adapted from a WHO discussion paper by Timothy Armstrong. 2012. Available at http://www.who.int/nmh/events/2012/4November2012_PPT_RevPaper_TA.pdf (accessed January 2013).

⁷³ See Part A of Annex 1 of the Regulations in WHO. 2008. *International Health Regulations (2005)*. Second edition. Available at http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf (accessed January 2013).

4.4 Monitor Health-Related Development Outcomes

In order to strengthen and assess monitoring of health-related development outcomes, it is essential to improve the availability, quality, and use of the data needed to make health reporting possible, effective, and efficient. This would require strong national capacity to maintain routine administrative records on the health system performance (e.g., through a routine health facility reporting system and disease reporting system). The information should be validated and adjusted against data obtained from census and other population-based surveys and assessments on a regular basis. This requires investments in civil registration and vital statistics, which are weak in many countries in the region. UN ESCAP reported in December 2012 that the births of one- to two-thirds of children, depending on the country are not registered in Asia and the Pacific, leading to an average of one-third unregistered children in the region.⁷⁴

There is also the need to continuously invest in the country's disease surveillance system so that it can effectively detect, assess, notify, and respond to public health threats. In case of public health emergencies, the government needs to have the "surge capacity" to effectively utilize available technologies and information systems (e.g., phones, computers, and internet-enabled tools) to formulate reports to local and higher-level health authorities and other relevant government agencies in a timely and accurate manner.

Since the impact of an outbreak is often felt by almost every sector of society, it is important for the state to increase open and effective communication between multidisciplinary groups (clinicians, researchers, epidemiologists, public health and other government officials, and civil society) in multiple sectors (civilian vs. military, prevention vs. treatment, government vs. nongovernment, national vs. international) that involve various key operational areas (e.g., hospitals, clinics, airports, ports, ground crossings, laboratories, government ministries).

5. Invest in Information and Communication Technology for Health

Key message: Better use of information and communication technology (ICT) in the health sector is needed to meet the data needs for monitoring and evaluation of health services and health outcomes for all population groups and for improving disease surveillance across borders. Moreover, ICT provides valuable opportunities to provide cost-efficient solutions for health service delivery.

The state-centric facility reporting model tends to be passive and does not work well on private facilities when no registration or reporting system is enforced. Indeed, the state-centric model is becoming increasingly inappropriate in the current move toward institutional autonomy and privatization for hospital and clinics. Information technology may be a game changer facilitating the monitoring of health-related development outcomes. New measurements, for example, could be developed to encourage the shift to electronic medical records or other e-vital statistics and also to leapfrog new technological application in mobile and e-health. Many initiatives exist and there is the Asia e-Health Information Network⁷⁵ since 2012, which aims to promote better use of information and communication technology (ICT) to achieve better health in Asia and the

⁷⁴ UN ESCAP. 2012. UN Makes Every Life Count on Human Rights Day. 10 December. Available at <http://www.unescap.org/news/un-makes-every-life-count-human-rights-day> (accessed April 2013).

⁷⁵ See <http://www.aehin.org/>

Pacific. ADB supports ICT for development⁷⁶ through investments and by supporting regional networks and knowledge platforms such as the ICT for Development Initiative for Asia and the Pacific, e-health being one of its priority thematic areas.

Strengthening monitoring of health-related outcomes is primarily country-focused, but for those countries in the region that do not have the domestic means or resources to strengthen the financing or administrative capacities, such capacities have to be imported from outside, including regional and global partnerships. Existing surveillance networks at the global, regional, or subregional level (e.g., Global Outbreak Alert and Response Network, APEC EINet, MBDS) could be fully utilized to supplement national surveillance capacities. Internationally supported specific programs, such as those for immunization and malaria, should also be integrated into a national health information system.

Stakeholders, including civil society, labor unions, private sector, UN agencies, bilateral donors, multilateral development banks, global health partnerships, and academic institutions, need to be involved in investing in and monitoring post-2015 health-related objectives. Among them, WHO would play its role as a “knowledge broker”—collecting, analyzing, and disseminating information and evidence for policy making and capacity building related to the post-2015 process. In a recent discussion paper on the post-2015 development agenda, it supports the use of UHC as a way to track progress in health, because UHC allows countries themselves to monitor coverage in areas most important to them, incorporating existing MDGs and the new health agenda.⁷⁷

Due to the predominance of the government-centric approach in dealing with the region’s common challenges, non-state actors have not played a major role in monitoring health-related development outcomes. Civil society organizations, ranging from health-promoting nongovernment organizations to faith-based organizations, however, can play a constructive role in collecting health data, disseminating health-related information, and reporting and monitoring disease outbreaks. To ensure that the post-2015 agenda is relevant and effective, the voices of patients, elderly people, and marginalized populations, such as migrant workers, should be heard in the monitoring process.

6. Mobilize Innovative Financing

Key message: Considering the enormous health challenges and the global financial crisis, it is important to leverage more public–private partnerships that can be sustained under local conditions or to find ways to engage private sector resources to fill critical resource gaps in the public sector.

Successful implementation of health-related development goals cannot be achieved without adequate and sustainable financing. Unlike the funding of many disease-driven programs, the goal of health system financing is not only to mobilize sufficient funds for the delivery of public health and medical services, but also to protect against financial risk through reduced reliance on out-of-pocket payments. Political commitment from the top leadership is essential to earmark sufficient resources for health care.

⁷⁶ ADB. 2003. *Toward E-Development in Asia and the Pacific: A Strategic Approach to Information and Communication Technology*. Manila. Available at <http://www.adb.org/documents/toward-e-development-asia-and-pacific-strategic-approach-ict>

⁷⁷ WHO. 2012. *Positioning Health in the Post-2015 Development Agenda*. Discussion paper. Available at http://www.who.int/topics/millennium_development_goals/post2015/WHOdiscussionpaper_October2012.pdf (accessed January 2013).

Thailand is able to sustain its UHC program because of strong political commitment: for 5 consecutive years, the Thai government decided to freeze all new capital investments of urban health facilities and shift the budget to build up rural facilities, including extensive construction of community health facilities to reach also rural population groups. Increased efficiency in revenue collection and distribution will also generate funds to be used for health. This requires the government to give NCDs more priority status when allocating budgets. It also means that governments need to put more efforts in reducing corruption in the health sector and prevent government health investment from becoming another “income-transfer program” benefiting primarily health care providers.

Given the enormous health challenges and the global financial crisis, it is unrealistic to expect another donor-funded response (similar to the one with HIV/AIDS) that is robust enough to deal with the NCDs effectively. Therefore, it is necessary to set up public–private partnerships that can be sustained under local conditions or to find ways to engage private sector resources to fill critical resource gaps in the public sector. The private sector therefore should be allowed to play a much bigger role in comprehensive health financing.

For countries in the region, especially least developed countries that are unable to mobilize sufficient domestic resources to fulfill the post-2015 health goals, they will continue to need support from development partners. Global and regional development partners are already moving to focus on funding post-2015 health priorities. However, many of the health inequities and most of the world’s poor are now in middle-income countries, with reduced access to development assistance for health.⁷⁸ Thus, these countries must shoulder an increasing domestic fiscal burden to meet global health goals. It also requires careful consideration of assistance targets and rules, as well as a relook at potential donor sources of funds. For example, while the Global Fund to Fight AIDS, Tuberculosis and Malaria, out of the \$23 billion approved portfolio funding, is already investing more than 37% in HSS and disease control appropriate for the post-2015 agenda, new rules may limit funding available to middle-income countries.⁷⁹

Innovative financing mechanisms are needed, including public–private partnerships and health microinsurance schemes (HMI) for poor communities. Development of social enterprises in health can be part of the solution to address financing gaps. Public–private partnerships in health require governments to design and implement policy and regulatory frameworks to ensure affordable high-quality service delivery. Microinsurance schemes are valuable, especially for poorer communities. However, it is often challenging for microinsurance in the health sector to create sustainable mechanisms, which can also be brought to scale. Most health microinsurance products cover catastrophic risks which occur with low frequency, are often unpredictable, and result in a need for high-cost services. These catastrophic events are more easily insured than routine health care needs, so insurers have focused on them, often designing inpatient only coverage and not outpatient services, which are important for health promotion and public health activities. For social enterprises in health, recent developments in Asia and the Pacific are promising; however, one has to note that development of social enterprises is still in its infancy in Asia and the Pacific and not as progressed as in Latin America, for example.

⁷⁸ See note 2.

⁷⁹ Interview with a Global Fund official, Geneva, 22 February 2012.

The post-2015 development agenda has to consider the changing geo-economic landscape, with middle-income countries emerging, and the private sector economies playing a more active role in providing financial and technical support.

There is an urgent need for new global health resources and advocates. Compared to the traditional donors' growing focus on health issues, there is tremendous unrealized potential for the emerging economies to engage in health-related development assistance. Given shared interest in mitigating the threat of the next major disease outbreak (e.g., pandemic flu) in the region, building a regional health security fund and strengthening the health of the increasing number of migrant workers would allow these middle-income powers or emerging economies to play a more significant role in ensuring regional health security.

7. Summary

In summary, the MDGs were remarkably successful in forging a common purpose and in drawing attention to key human development issues. However, in its simplicity of articulating development challenges as single problems or in the case of the health MDGs as “single diseases,” the MDGs did not capture the synergies and links between goals. Health is a striking example where least progress has been made in Asia and the Pacific, despite the high economic growth and great success in poverty reduction. The multidimensional aspects of development have to be integrated in the post-2015 development agenda, and root causes of development challenges need to be addressed.

Health systems have to be strengthened jointly with investments in basic infrastructure, which, for example, in water and sanitation bring huge health outcomes. At the same time, changing health needs will need to be tackled in the post-2015 development agenda to mitigate the economic impact of increasing NCDs and of a changing climate. Health provides an excellent opportunity for ADB to build on existing regional and global partnerships, leverage regional cooperation and integration, transfer knowledge and technology to provide the best possibility environment for health for all, and show commitment toward public goods (Box 2).

The often cited quote “health is wealth” remains valid and calls for continued investment to achieve health outcomes in a region where focus on economic growth and wealth has often missed the core reason for development—improving the lives of all people.

Box 2: What Does This Mean for a Regional Development Bank Like ADB?

The Asian Development Bank (ADB) is the regional development bank in Asia and the Pacific, with a strong focus on regional cooperation and infrastructure investment. It facilitates cofinancing and innovative financing solutions for its developing member countries (DMCs) with an emphasis on linking public and private investments for development. ADB is also building its leadership role as a knowledge bank and aims to support its DMCs in identifying the best approaches to inclusive and sustainable growth.

The need for inclusive and sustainable growth was highlighted in many consultations on the post-2015 development agenda in Asia and the Pacific, as was the need to address root causes of poverty and deprivation. This requires recognizing and addressing the linkages of social, economic, and environmental dimensions of the development challenges. Health plays an important role in the intersection of these three dimensions. Investing in health through intersectoral approaches, therefore, is a must for a regional development bank that promotes inclusive and sustainable growth for Asia and the Pacific.

ADB Can Play an Important Role in Health Sector Policy Dialogue to Strengthen Health System Strengthening

ADB is well positioned to play a key role at the macro level and within the health sector. An important role for ADB is engaging in policy dialogue with ministries of finance—the natural counterparts of ADB—and senior government leaders to support countries in developing strong roles for the public sector in financing and overseeing health services, as well as in developing the policy framework for multisector and private sector participation. This includes working with ministries of finance to increase government spending in the health sector. ADB can support governments in creating fiscal space and identifying tax reforms that allow internal resource mobilization to finance increased coverage under UHC commitments. ADB is also providing capacity development to DMCs on results-based public sector management, which can be extended to improve governance and management as well as establishing enabling environments for public–private partnerships in the health sector.

Another avenue for ADB support would be through additional work on improving efficiencies in health services and expanding health personnel training. This could include working to improve the quality and affordability of hospital services, a major area for public and private expenditure. For personnel, ADB can work with public and private education sectors and professional societies to improve quality and affordability of training, as well as with health ministries to determine options for task shifting and contracting to meet health personnel needs. To support information and monitoring, ADB could also scale up support for civil registration and vital statistics (CRVS).

In particular, information and communication technology investments are needed to improve the reach, reliability, and affordability of CRVS systems. ADB already provides technical assistance to strengthen CRVS and also collaborates with development partners on regional knowledge sharing and capacity development events, such as the High-Level Meeting on the Improvement of Civil Registration and Vital Statistics held in December 2012. In addition, ADB can play a role in supporting countries to develop knowledge about and responses to regional health system issues, including regional benchmarking of health system performance, managing issues of migrant health, and supporting ASEAN in its goals of regional integration for all sectors from 2015.

ADB Well Positioned to Support Developing Member Countries in Strengthening Health Financing

As a financial institution, ADB has supported countries in developing financing schemes for many types of services, including UHC. In health, ADB has worked in public finance at central and decentralized levels, supported improvements in social insurance schemes, and assessed alternative instruments such as national health savings plans. ADB brings to this work a unique poverty/inclusive growth lens that is appropriate for the needs of the region. ADB is also well positioned to bridge its public sector work with its experience in the private sector to link public health financing schemes with private insurance models and support new infrastructure investment models for both the public and the private health sector.

continued on next page

Box 2 *continued***ADB Should Play a Critical Role to Support and Facilitate Development of Strong Regional and Subregional Health Security Systems**

ADB's long-term strategic framework Strategy 2020 recognizes that health is an important aspect of social and economic development, with impacts beyond the individual, household, or national level, and that it affects the whole region. Strategy 2020 highlights that ADB should mitigate the adverse health impacts of all its infrastructure and trade facilitation projects and should use its comparative advantage to support regional public goods and address cross-border health issues such as mobility-related spread of communicable diseases. ADB is therefore prepared to provide leadership and assistance for regional public goods, in particular strengthening of regional health security. The SARS crisis and avian influenza events provide extensive evidence that DMCs look to ADB to provide leadership in regional approaches; advise on risk mitigation, preparedness, and capacity building; and, where necessary, respond to emergencies and longer-term preparedness, partly through its capacity for interdisciplinary approaches as well as through its regional cooperation mechanisms. ADB is also well positioned to play an increasingly important role in promoting health security in partnership with other agencies that have an acknowledged technical leadership role, such as the World Health Organization (WHO), and in facilitating cross-sectoral and cross-country collaboration to strengthen regional health security. DMCs in the region agree that a "regional approach with local actions", and with focus on risk populations (whatever nationality) and risk areas ("no border barrier"), with development of regional strategies, standard of practice and monitoring/information systems, and use of "regional resources from all countries" is needed. ADB—as the regional development bank—is in an excellent position to provide support to drive the regional cooperation and integration on health as a public good forward and supports the initiative. For that reason, ADB was tasked to function as the secretariat for the Asia Pacific Leaders Malaria Alliance and to develop a regional financing mechanisms for regional public goods on health with a special trust fund for malaria. ADB will mobilize funding from the public and private sectors for this trust fund. The trust fund will invest in regional activities that support the elimination of malaria and control of drug-resistant malaria.

ADB Can Leverage Partnerships and Financing for the Post-2015 Health Goal

ADB can play a strong role in leveraging innovative financing modalities. It has long-standing experience in mobilizing funds for regional themes such as HIV/AIDS, supported by the Cooperation Fund for Fighting HIV/AIDS, which delivered remarkable results and spearheaded ADB's work on mitigating negative effects of transport and mobility of people across the Greater Mekong Subregion. ADB also accessed bilateral funds such as the Japan Fund for Poverty Reduction (JFPR) for health projects, for example in Papua New Guinea, or the People's Republic of China Regional Cooperation and Poverty Reduction Fund for a communicable disease project in Central Asia to build capacity for implementation of the International Health Regulations. With minor additional investments, ADB could also increase positive health impacts from its infrastructure developments, such as water and sanitation or road projects, if partnerships with other development partners are strengthened and project links leveraged.

ADB is also exploring opportunities to leverage financing of private health care investors through its capital market investment work and to link private financing investments with public needs. It recognizes that there is enormous scope to work with regional health care investors. ADB can leverage its health and private sector expertise to enable greater efficiency for health care provision while meeting the needs of underserved patient populations. The projected growth in the health care sector in Asia and the Pacific related to the rising middle class, the aging population, and the increasing awareness of health and preventive care is exceeding 15% per year, attracting more and more private capital in Asia and the Pacific's health care sector.

ADB has great potential to play a role as a financial broker and assist DMCs in attracting private capital into health care systems to increase efficiencies, meet increasing capital requirements to upgrade health care services, and reduce the growing strain on public resources.

It is increasingly clear that the post-2015 development agenda needs new approaches to financing and that the private sector plays an increasing role in this regard in Asia and the Pacific with growing engagement in the health sector.

Health in the Post-2015 Development Agenda for Asia and the Pacific

Countries in the diverse Asia-Pacific region are facing common emerging health challenges such as aging populations, increasing prevalence of noncommunicable diseases, and population mobility. The region is also yet to achieve the targets for the Millennium Development Goals on reducing child and maternal mortality. Drawing on the regional and subregional thematic consultations in and outside of the Asian Development Bank (ADB), this paper argues that the post-2015 development agenda needs to address health in a more systematic way—in one global goal, and in more specific national goals that focus on country-specific health issues in and outside the health sector. The paper also provides entry points for ADB's support of the post-2015 health agenda in developing member countries.

About the Asian Development Bank

ADB's vision is an Asia and Pacific region free of poverty. Its mission is to help its developing member countries reduce poverty and improve the quality of life of their people. Despite the region's many successes, it remains home to two-thirds of the world's poor: 1.7 billion people who live on less than \$2 a day, with 828 million struggling on less than \$1.25 a day. ADB is committed to reducing poverty through inclusive economic growth, environmentally sustainable growth, and regional integration.

Based in Manila, ADB is owned by 67 members, including 48 from the region. Its main instruments for helping its developing member countries are policy dialogue, loans, equity investments, guarantees, grants, and technical assistance.

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