Editorial

Universal health coverage in an era of rising costs: Prevention and quality must move together

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Advancement in science, especially in medicine, is occurring at remarkable speed. New drugs and diagnostic tools are constantly introduced, bringing the promise of better outcomes. Yet research on the development of medical interventions or the validation of new diagnostic tools requires cost. This contributes to higher costs for medical management and burdens the healthcare budgets. For health systems with finite resources, this creates a persistent tension between expanding access to more medical services and maintaining the quality of those quality of the services.

This tension is often framed as a choice between quantity and quality. In universal health coverage (UHC), however, the principle of quantity is not negotiable. UHC is universal by definition and intended for everyone. The real challenge is therefore not whether to include people, but how to keep people healthier so that fewer of them need costly treatment in the first place. Hence, prevention is not an optional addition to UHC. Refocusing on value for money with prevention programs is the core strategy that makes universal coverage sustainable.[1]

A prevention-centered approach begins with the epidemiological triad. Disease risk can be reduced through action on the host, the agent, and the environment. If the host is healthier, the risk of illness is lower. If the agent is controlled, exposure is reduced. If the environment is safer and more supportive, health outcomes improve. World Health Organization (WHO) has endorsed the empowerment of primary health care-oriented health systems to address health promotion and prevention.[2]

Among host factors, knowledge, attitudes, and behavior are especially important. In the digital era, however, the public is exposed to a flood of health information, much of which is unreliable. WHO describes an infodemic as "too much information, including false or misleading information," that can create confusion, encourage false behavior, undermine trust in health authorities, and weaken public response. For that reason, health professionals must continue to educate the public. Health education is not a one-time intervention; it is a continuous implementation.[3]

This also means that governments must take a more active regulatory role. Health information should not be left entirely to the media, including social media and television channels. Oversight is needed to ensure that public health messages are delivered by qualified professionals and that health-related advertising does not overclaim or mislead. In Indonesia, BPOM, as the national drug and food regulator has a regulatory role to prevent harm to patients and distortions in health-seeking behavior.

Promoting healthy lifestyles is also essential, but it must be done carefully. Encouraging physical activity, balanced nutrition, smoking cessation, and other healthy behaviors should empower people rather than stigmatize those who are already sick. A good health promotion strategy does not blame patients; it builds the conditions that make healthy behaviors accessible and sustainable. The same prevention logic applies to the agent component. In the context of food and drugs, BPOM supervision is necessary to reduce harmful exposure and protect the public. In the context of chemical risk, governments must address pollution, waste management, and unsafe waste disposal. In the context of physical risks, road safety policies, traffic regulation empowerment, and accident prevention are equally important public health measures. These interventions may not always be perceived as "health policy," but they directly affect morbidity and mortality.

The environment is equally decisive. Health does not improve in isolation from social welfare. Education, incomes, housing, transportation, sanitation, and employment influence whether people can be wealthier, they can be healthier. It requires cross-sector collaboration, not only the Ministry of Health

but also other ministries responsible for education, transportation, environment, finance, and so on.

An ideal UHC would provide the best possible care to everyone, everywhere, and whenever needed, without financial constraint. In reality, no system has unlimited resources. This is where the distinction between evidence-based medicine, value-based medicine, and evidence-based policy becomes important. Evidence-based medicine answers whether an intervention works. Value-based medicine assesses whether the cost is worth the benefit. Evidence-based policy determines whether public resources are directed toward interventions that yield the greatest health impact for the population.[4] Together, these principles offer a more realistic foundation for health policy in an environment of constrained budgets. WHO has provided "best buys" policies to tackling non-communicable diseases.[5] By investing 1 USD in safe and cost-effective policies, there is a yield of 7 USD per person through productivity improvement and health expenditure reduction.[6]

Quality also requires a robust health workforce and infrastructure. This has direct implications for Indonesia. As preventive programs expand, including the introduction of free annual health check-ups, the health system must be ready to accommodate increased service utilization. The program is important because it can improve early detection and shift the focus from late-stage treatment to timely prevention. At the same time, the rapid expansion of hospital infrastructure, including large-scale construction in many regions, should be accompanied by proportional improvements in service quality. Hence, as health facilities expand in capacity and service, the system (particularly BPJS *Kesehatan*) must be prepared for higher costs.

The sustainability of UHC ultimately depends on society's willingness to recognize that resources are finite. With limited contributions and increasing healthcare expenditure, BPJS *Kesehatan* cannot be expected to provide maximum services, because no insurance system can cover every possible intervention without limits. This should not automatically be interpreted as a failure of the health system, but rather reflects the reality that healthcare resources must be allocated to maximize health benefits for the greatest number of people. In the context, transparent communication regarding coverage decisions becomes essential to align public expectations with the principles of sustainable UHC. At the same time, health workers should not be placed in a position where they are perceived as refusing care when the real issues are financing design and benefit-package limitations.

The more constructive path is alignment: stronger prevention, clearer communication, better regulation, and careful policy prioritization. If quality improves, the care that is delivered will have greater value. And if policy is guided by evidence rather than optimism alone, the health system will be better able to balance quantity, quality, and sustainability.

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