ANNEX

DRAFT

Regional Action Framework for Health Financing to Achieve Universal Health Coverage and Sustainable Development in the Western Pacific

World Health Organization
Western Pacific Region

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Abbreviations

DALY	disability-adjusted life year
GDP	gross domestic product
HIC	high-income country
IMF	International Monetary Fund
MIC	middle-income country
NCD	noncommunicable disease
OOPS	out-of-pocket spending
PFM	public financial management
PHC	primary health care
PPP	purchasing power parity
SCI	service coverage index
SDG	Sustainable Development Goal
SHI	social health insurance
UHC	universal health coverage
VHI	voluntary health insurance
WHO	World Health Organization

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Glossary

Benefit/service package	The health services and goods that are funded, either fully or partially, from pooled revenues, and the conditions under which they can be accessed *(1)*.
Catastrophic health expenditure	Out-of-pocket health expenditure constituting a large share (10% and 25% being the most common thresholds) of household income or expenditure *(2)*.
Climate change	Long-term changes in the world's temperatures and weather patterns. These changes contribute directly and indirectly to humanitarian emergencies, epidemiological changes, and disruption of food systems and livelihoods. It affects the physical environment as well as all aspects of both natural and human systems including health systems *(3)*.
Financial hardship	Out-of-pocket health expenditure that negatively affects the welfare of people, most commonly measured by catastrophic health expenditure or impoverishing health expenditure *(2)*.
Financial protection	A dimension of universal health coverage, which is achieved when there are no financial barriers to accessing needed health services and goods, and out-of-pocket health spending is not a source of financial hardship *(2)*.
Fiscal space	Room in the government budget that allows it to provide resources for desired purposes without jeopardizing the sustainability of its financial position *(4)*.
Funding pool/pooling	The accumulation of prepaid revenues on behalf of a population to spread financial risk across the population so that no individual carries the full burden of paying for health care *(5)*.
Governance	The processes, structures and institutions that are in place to oversee and manage a country's health-care system. It manages the relationship between different actors and stakeholders involved in health care, including government agencies, health-care providers, patients and their families, people and communities, civil society organizations and private sector entities *(6)*.
Impoverishing health expenditure	Out-of-pocket health expenditure that pushes people below a poverty line *(2)*.
Political economy	The study of both politics and economics, which focuses on power and resources, how they are distributed and contested in different country

	and sector contexts, and the resulting implications for development outcomes *(7)*.
Primary health care (PHC)	A whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment *(8)*.
Prioritization of health	Government spending on health as a share of total government spending across all sectors within the fiscal year.
Public financial management (PFM)	The set of rules and processes that govern how public resources are collected, allocated, spent and accounted for *(9)*.
Public spending on health	Health spending using domestic public sources of revenue − that is, government budgets and/or social health insurance contributions *(10)*.
Purchasing	The allocation of pooled funds to health-care providers for the delivery of health services on behalf of certain groups or the entire population *(1)*.
Strategic purchasing	Purchasing is considered strategic when allocations to health-care providers are linked, at least in part, to information on provider performance and the health needs of the population they serve, with the aim of realizing efficiency gains, increasing equitable distribution of resources and managing expenditure growth *(11)*.
Universal health coverage (UHC)	All people have access to the full range of good-quality health services they need, when and where they need them, without financial hardship *(12)*.

Executive summary

The goals of universal health coverage (UHC) – ensuring that all people have equitable access to good-quality health services without financial hardship – are central to improving health and human development. Adequate, equitable, efficient and sustainable financing, particularly from public sources, is critical to attain these goals.

In the World Health Organization (WHO) Western Pacific Region, economic growth, combined with efforts to raise additional public revenue, has enabled a rapid increase in public spending on health. Still, spending levels in many countries remain insufficient to meet the growing health needs of their populations, leading to inadequate access and a rise in financial hardship from out-of-pocket spending (OOPS) on health. The future macroeconomic outlook suggests a slowdown in the growth of fiscal space for health in many countries, which poses challenges to sustain or increase the level of public spending on health.

Meanwhile, the use of available funds for health is often not optimized, resulting in inequitable and inefficient spending. Many countries have made progress in merging and harmonizing funding pools for health, but many cases of fragmentation remain within budgets, between schemes and across various funding streams. This situation is compounded by the lack of integration of many private health-care providers with publicly funded service delivery systems. In addition, resources are often not allocated to health-care providers in ways that incentivize equity, efficiency and quality of care. Importantly, primary health care (PHC) has not been sufficiently prioritized, which again has led to unsatisfactory UHC performance.

The Western Pacific Region is experiencing multiple transitions that impact the health sector, such as ageing populations, a growing burden of noncommunicable diseases, emerging health security threats, and health risks associated with climate change and other environmental problems. If unaddressed, these transitions could challenge the financial sustainability of the health sector and risk reversing improvements seen in population health outcomes.

Health financing systems need to respond to these challenges through a renewed commitment to PHC with an emphasis on preventive efforts. In light of the growing evidence of the interrelationship between health, the economy and well-being, the health sector will need to be increasingly proactive in promoting Health for All as a policy goal of the sustainable development agenda that goes beyond the health sector.

These ongoing and emerging health system and societal challenges are a call for action to improve the design and performance of health financing according to country priorities and contexts. The *Regional Action Framework for Health Financing to Achieve Universal Health Coverage and Sustainable Development in the Western Pacific* proposes five broad strategic action domains, as shown in the figure below, to ensure that financing for health addresses bottlenecks holding back UHC progress, supports the resilience of the health sector to emerging challenges, and facilitates holistic, multisectoral collaboration to address upstream determinants of health.

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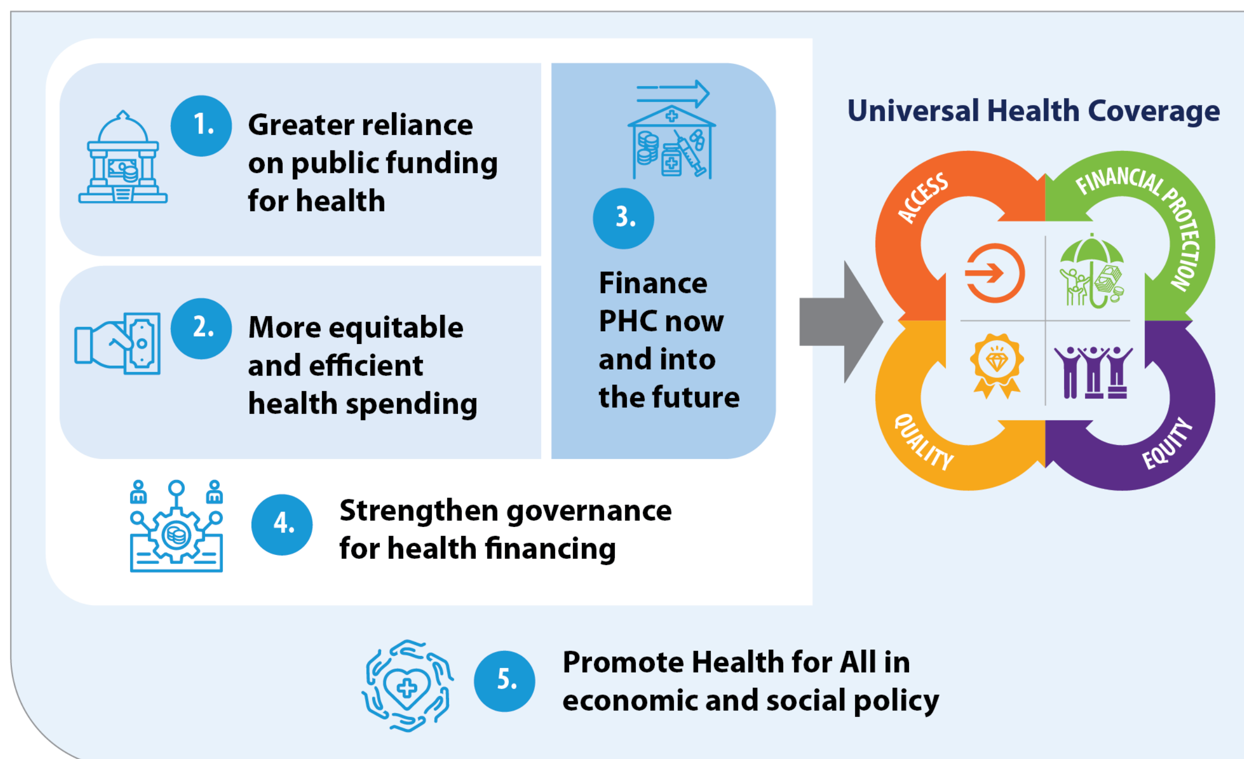
Action Domains in the Regional Action Framework for Health Financing



1. **Greater reliance on public funding for health**: Public financing of the health sector, particularly from government budgets, is crucial for advancing towards UHC. Many countries in the Region need to increase per capita public spending on health through more effective revenue collection and greater prioritization of health in budget allocations. Private sources of funding, such as voluntary health insurance and OOPS, should be limited to a supplementary role in financing UHC. Countries that rely heavily on external assistance should, together with development partners, improve the effectiveness and predictability of such assistance and ensure that it does not result in unintended reductions in domestic financing for essential service provision.

2. **More equitable and efficient health spending**: It is equally important to spend available public funds for health more wisely. This may be achieved by reducing the fragmentation of available resources, merging and harmonizing public funding pools, as well as incentivizing efficiency, equity and quality when allocating resources to health service providers. Further, the design of service packages, including conditions to access and co-payment policies where applicable, should be evidence- and value-informed, and minimize financial hardship and barriers to accessing care. Additionally, procurement, logistics and asset management can be made more efficient to reduce input costs of service provision.

3. **Finance PHC now and into the future**: PHC will be essential for addressing the Region's current and emerging health challenges, and it is crucial to an equitable and efficient health system. Both individual and population-based PHC services should be prioritized within public spending on health. Furthermore, financing mechanisms need to incentivize the reorientation of service delivery towards integrated, people-centred PHC, and PHC funding should be

directed to cost-effective interventions that best address current and emerging population needs, in particular essential public health functions and health preventive and promotive activities.

4. **Strengthen governance for health financing**: Governance systems, including public financial management (PFM) and data management, are critical to ensure that health financing policies are appropriately designed and effectively implemented. Accordingly, countries need to strengthen governance functions and institutional capacity to promote more transparent, accountable and inclusive health financing systems. PFM bottlenecks and rigidities that impede service delivery need to be systematically addressed in collaboration with ministries of finance and other relevant institutions. Finally, better quality and more timely data are required to inform health financing policy development and implementation, as well as to build the case for increasing public funding for health.

5. **Promote Health for All in economic and social policy**: Health systems are intricately woven into the fabric of economic, environmental and social aspects of society. Given this interconnectedness, there is significant potential for developing co-benefits that support the goals of UHC and sustainable development between health and other sectors. Countries are encouraged to develop and adopt whole-of-government approaches to financing health and well-being for all − for example, using cross-sectoral financing approaches to address the social determinants of health, and exploring the use of financial instruments to promote healthier behaviours. Finally, investments and incentives to strengthen climate change mitigation and adaptation in the health sector will be critical, given the impact of climate change on health and health systems.

All countries – regardless of income level, size, demographic context and health system maturity – can improve their health financing systems. Considering that health financing is highly context-dependent, countries need to tailor the implementation of these strategic actions to their local priorities and needs. Importantly, health financing reforms require careful planning. They should be designed, implemented and monitored within the context of wider health sector reforms and processes. Consideration of political dynamics and dialogues with communities and other key stakeholders throughout the process are also critical success factors.

The attainment of UHC through strong PHC and ensuring that health systems are prepared for future challenges are at the heart of WHO's vision for its work in the Western Pacific Region. Hence, critical priorities for WHO will be to secure and strengthen political commitment to health financing for UHC and Health for All, foster dialogues between health ministries and other ministries, produce high-level technical guidance and resources, provide tailored country support, facilitate peer learning and knowledge exchange, and promote the alignment of development partners to domestic health financing priorities.

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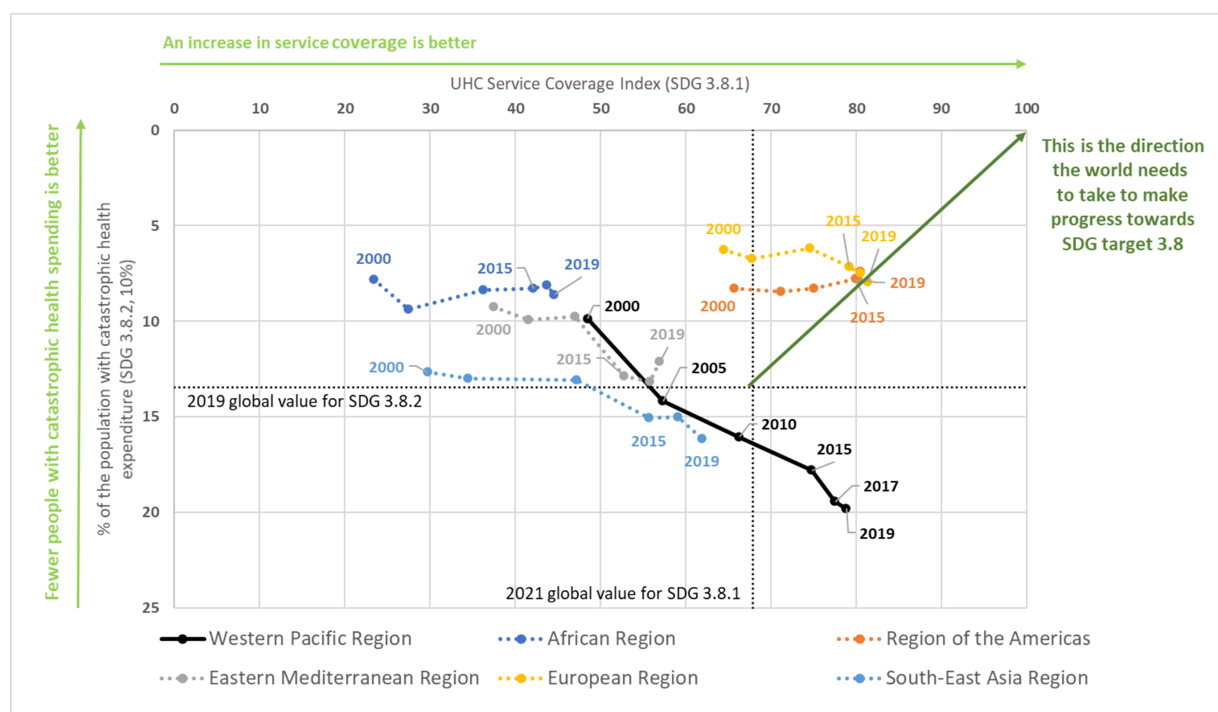
1. INTRODUCTION

The universal health coverage (UHC) goals of ensuring that all people have equitable access to good-quality health services without financial hardship are central to improving health and human development in the World Health Organization (WHO) Western Pacific Region. Adequate, equitable, efficient and sustainable health financing is key to attaining these goals. Over the past two decades, a combination of strong economic growth and policy choices have enabled many countries in the Western Pacific Region to increase public spending on health and strengthen their health financing systems, which has contributed to the rapid improvement in service coverage, as measured by the regional average of Sustainable Development Goals (SDG) indicator 3.8.1 (UHC Service Coverage Index), compared to the other five WHO regions (Fig. 1) *(13)*.

Despite these gains, significant challenges persist across the Region. Critically, the regional average of the incidence of catastrophic health expenditure, as defined by SDG indicator 3.8.2 (population with household expenditures on health greater than 10% of total household expenditure or income) *(14)*, has risen considerably to be among the highest in the world (Fig. 1). Moreover, health systems across the Region continue to face immense challenges in meeting population needs. At the same time, a weaker economic environment, combined with demographic, socioeconomic, climate and other transitions, will likely affect the amount of resources governments have at their disposal for health and the types of health spending required. These outstanding and emerging challenges are at risk of negatively affecting the financial sustainability of the health sector, population health outcomes and UHC more generally, unless countries develop robust and powerful policy actions to address them.

Fig. 1. Joint progress on SDG 3.8.1 and SDG 3.8.2 by WHO region (2000–2019)



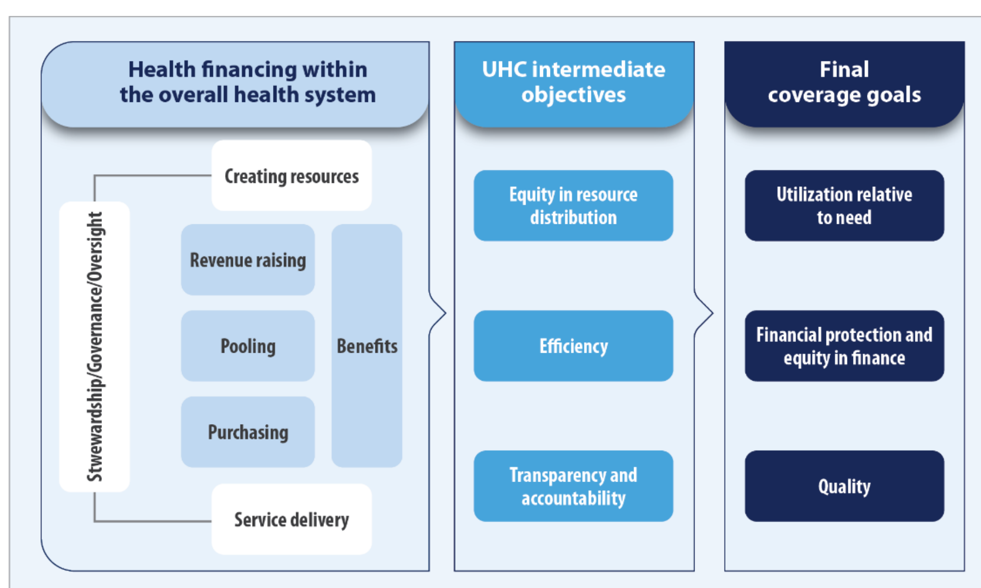
SDG: Sustainable Development Goal; UHC: universal health coverage.

Source: WHO and International Bank for Reconstruction and Development, 2023 *(2)*.

Against this backdrop, this *Regional Action Framework for Health Financing to Achieve Universal Health Coverage and Sustainable Development in the Western Pacific* has been developed to present a set of priority domains and strategic actions that Member States in the Region should consider implementing to address both old and new challenges.

The Framework also builds on WHO's existing health financing analytical framework *(1)* (Fig. 2) and presents the most up-to-date analysis of the progress and challenges of core health financing functional arrangements in the Region. It consolidates global evidence and experience accumulated over the past decades and provides updated technical guidance that is tailored to countries' needs and priorities in the Region.

Fig. 2. WHO's analytical framework for health financing and UHC



UHC: universal health coverage

Source: Adapted from Kutzin et al., 2017 *(1)*.

Further, the Framework highlights the need to take a systems approach to health financing for UHC, and incorporates new ideas on financing for population health outcomes and well-being beyond the health sector, as emphasized under the emerging paradigm of *Economics for Health for All (15),* which seeks to elevate health as a central goal of economic policy and sustainable development. To that end, there is a focus in the Framework on critical enabling systems, including essential institutional enablers within and across government systems, and on the links between health systems and economies, societies and the environment.

Lastly, the Framework is anchored in the broader vision of the WHO Regional Director for the Western Pacific as outlined in *Weaving Health for Families, Communities and Societies of the Western Pacific Region (2025−2029): Working together to improve health and well-being and save lives (16).* It also draws on existing regional action frameworks and strategies, notably those on primary health care (PHC) *(17)*, the health workforce *(18)*, noncommunicable disease (NCD) prevention and control *(19)*, healthy ageing *(20)*, health security *(21)* and transitioning to integrated financing of public health services *(22)*.

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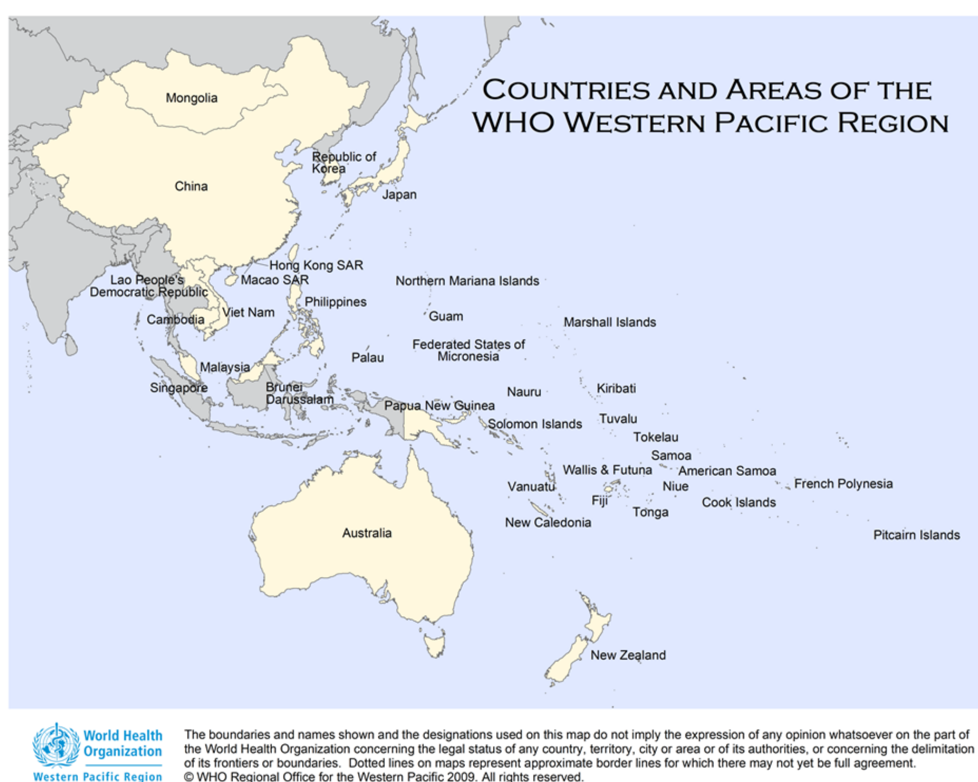
In summary, this Regional Action Framework is intended to support Member States as they consider how to adapt or reform health financing arrangements to make greater progress on health, well-being and the SDGs. The recommended strategic actions outlined in this document are primarily directed towards leaders and policy-makers involved in health financing policy design and implementation within and beyond the health sector.

2. OVERVIEW OF THE REGIONAL CONTEXT

2.1 A diverse and dynamic Region with changing health needs

The Western Pacific Region is defined by its extreme contrasts. The Region is home to an estimated 1.92 billion people – nearly one quarter of the world's population – spread across 37 countries and areas of considerable geographic and demographic diversity. At one end of the spectrum sit the many populous countries on the Asian continent, such as China with a population of more than 1 billion, and at the other end of the spectrum sit the many small island states scattered across the Western Pacific Ocean with populations of a few thousand or less (Fig. 3).

Fig. 3. WHO Western Pacific Region map



Among the 27 sovereign countries in the Region with available health expenditure data for analysis, nine are high-income countries (HICs), as classified by the World Bank, with the rest in the middle-income category, split between seven upper-middle-income countries and 11 lower-middle-income countries. Alongside the income diversity of the Region, there is considerable heterogeneity in socio-political systems, with varying implications for economic structure, government revenue-raising capacity, health expenditure patterns and the government's role in health financing. With such a rich and diverse set of countries, it is impossible to represent the Western Pacific Region's health financing arrangements in a single metric. Instead, it is intuitive to group countries within the Region into those with similar characteristics relevant to their health financing regimes (Box 1).

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Box 1. Grouping of the countries of the Western Pacific Region

The analysis in this Regional Action Framework is based on three country classifications: 14 Pacific island countries, six non-Pacific high-income countries (HIC) and seven Asian middle-income countries (MIC) (Table 1). These classifications are based on a combination of economic and geographic factors. Pacific island countries are treated as a distinct group regardless of income level due to their unique and largely shared geographical and demographic characteristics. They tend to experience similar challenges due to a relatively small scale of economy and geographical remoteness, which impact how health service delivery and financing are being organized in these countries. The remaining countries are grouped according to their income status at the time of writing, with the HIC group comprising countries in Oceania and Asia that are not Pacific island countries, and the MIC group comprising both lower- and upper-middle-income countries located in and around continental Asia.

Table 1. Grouping of 27 countries in the situational analysis in the Western Pacific Region – International Organization for Standardization country codes appear in parentheses*

Pacific island countries	**HICs** (that are not Pacific island countries)	**MICs** (that are not Pacific island countries)
Cook Islands (COK)	Australia (AUS)	Cambodia (KHM)
Fiji (FJI)	Brunei Darussalam (BRN)	China (CHN)
Kiribati (KIR)	Japan (JPN)	Lao People's Democratic Republic (LAO)
Marshall Islands (MHL)	New Zealand (NEZ)	Malaysia (MYS)
Micronesia (Federated States of) (FSM)	Republic of Korea (KOR)	Mongolia (MNG)
Nauru (NRU)	Singapore (SGP)	Philippines (PHL)
Niue (NIU)		Viet Nam (VNM)
Palau (PLW)		
Papua New Guinea (PNG)		
Samoa (WSM)		
Solomon Islands (SLB)		
Tonga (TON)		
Tuvalu (TUV)		
Vanuatu (VUT)		

* Note that tables and graphs of health expenditure data are limited to these 27 countries.

In recent decades, the economies of the Western Pacific Region countries have been among the most dynamic in the world, with profound social impacts. In 2021, the economic output in the Region, as measured by aggregate gross domestic product (GDP), was nearly triple the level in 2000 in real terms *(23)*.[1] The substantial increase in incomes has helped lift millions out of poverty,

[1] Unless otherwise stated, health expenditure data used throughout this document is from WHO's Global Health Expenditure Database (GHED) – see reference 23.

particularly among the Region's middle-income countries (MICs), and substantially increased the spending capacity of governments and households *(24)*. Strong economic growth has also transformed people's day-to-day lives by accelerating urbanization rates and increasing the availability of formal jobs. By 2021, 63% of the Region's population lived in cities, up from 42% in 2000. Alongside growth and urbanization, impressive gains have been made in reducing infectious diseases such as HIV, malaria and tuberculosis, as well as infant and maternal mortality. Accordingly, people in the Region now live longer and healthier lives than they did at the beginning of the millennium, and fewer women, men, girls and boys are dying of avoidable diseases.

However, there are many outstanding health challenges. Wide disparities remain in life expectancies, with a staggering 21-year difference between the highest and the lowest country *(25)*. Significant disparities in health outcomes also exist within countries, with morbidity and mortality rates generally higher in poorer, less educated rural communities and among vulnerable groups *(26)*. There remain critical gaps in the numbers of health workers, their skill mix and geographical distribution that limit the capacity of health systems *(18)*. Moreover, while growth and urbanization have brought benefits, the Region is now home to several of the world's largest megacities, and overcrowded neighbourhoods and housing are key mechanisms through which social and environmental inequality translates into health inequality *(27)*. Rapid industrialization and the transfer of basic and manufacturing industries to Asian MICs have also led to considerable issues with ambient air pollution, causing 73 deaths per 100 000 population in the Region in 2019 – much higher than the global average of 54 *(28)*. It has also exposed people to occupational injuries and diseases; hazardous physical, chemical and biological exposures; long working hours; inequalities; and psychological stress *(29)*. Given their more vulnerable positions within labour markets and society more generally, women tend to be more adversely affected by these challenges than men.

The challenges of growth are also compounding a host of environmental determinants of health that are responsible for more than one quarter of the burden of disease in the Region, causing an estimated 3.5 million deaths annually *(30)*. Excessive consumption patterns and unsustainable food production models contribute to ecosystem degradation and heighten the risk of antimicrobial resistance build-up. It is estimated that some 86 million people still do not have access to improved drinking-water sources, and more than 300 million people lack access to improved sanitation facilities, which directly contributes to the disease burden and impedes the development of human capital.

Rapidly ageing populations, urbanization and changing lifestyles are fuelling an epidemiological transition within countries. The percentage of the population older than 64 years has risen sharply as a share of the working-age population, from 8.5% in 2000 to 13.3% in 2022 *(25)*. These demographic trends set to continue, with half of the countries in the Region expected to be classified as aged societies by 2030 *(20)*. Preventable NCDs, such as cardiovascular disease, diabetes, chronic respiratory disease and cancer, have rapidly emerged as critical public health challenges in terms of mortality and morbidity (Fig. 4), with diabetes as a particular challenge for Pacific island countries and areas *(31,32)*. Increasingly, preventable NCDs are occurring in lower age groups, indicating that risk factors other than ageing – such as lifestyle and the environment – are at play. Already, NCDs are by far the biggest killers in the Region, responsible for nearly 87% of deaths – much higher than the global average (73.6%) *(19)*. Critically, if the burden of NCDs is not addressed, it is expected to grow in magnitude in almost all countries in the coming years (Fig. 5).

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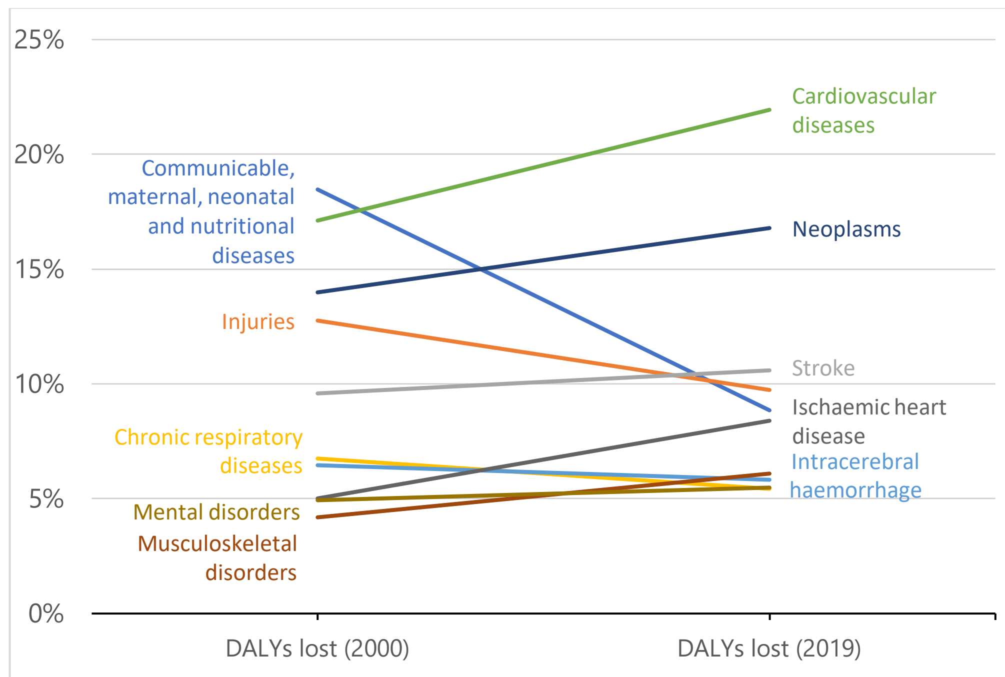
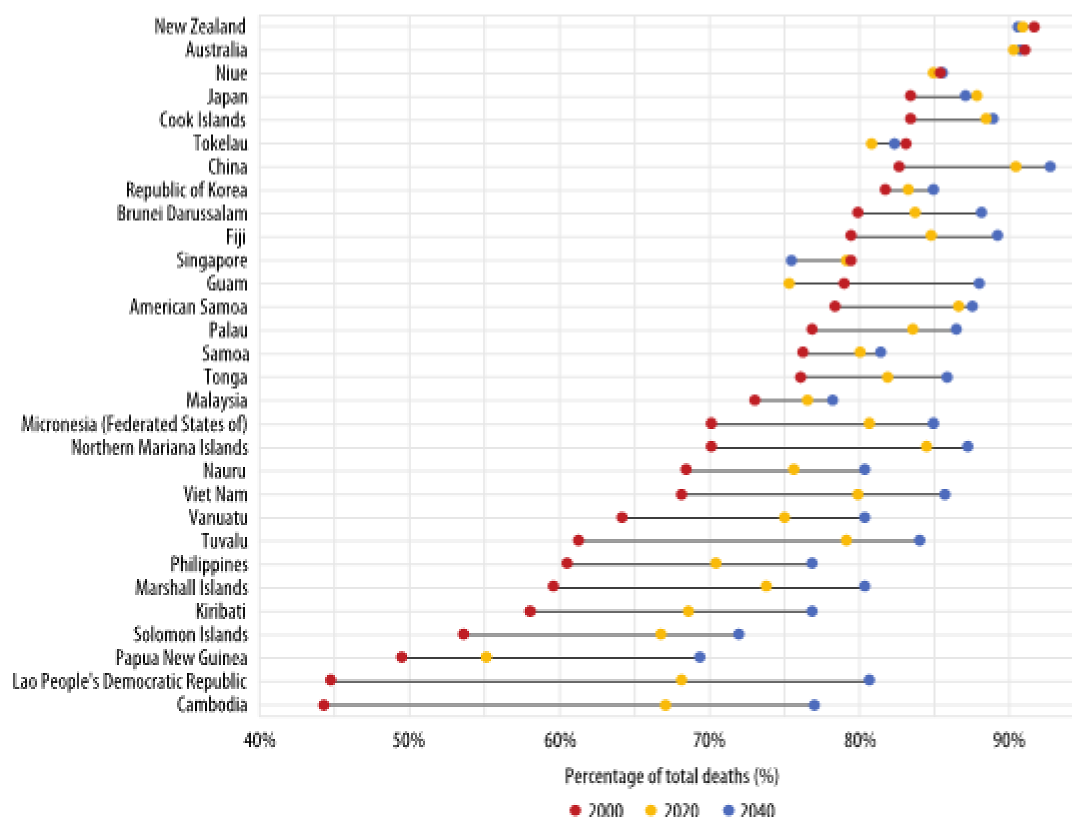
Fig. 4. Contribution of top 10 disease conditions to disability-adjusted life years (DALYs) lost in the Western Pacific Region, 2000–2019



DALY: disability-adjusted life year

Source: Adapted from WHO Regional Office for the Western Pacific, 2023 *(17)* and updated with more recent data from the Global Health Observatory, WHO (accessed 4 March 2024).

Fig. 5. Percentage of NCD burden in select countries and areas in the Western Pacific Region



Source: WHO Regional Office for the Western Pacific, 2023 *(18)*.

2.2 Progress towards UHC, while impressive, has been mixed

The goal of UHC is to ensure that all people receive the health services they need without facing financial hardship due to health-care costs. These two dimensions of UHC are generally tracked using two indicators. The first indicator (SDG 3.8.1) measures access to health care using a service coverage index (SCI), which is the average score of 14 tracer indicators organized into four domains: (1) reproductive, maternal, newborn and child health; (2) infectious diseases; (3) NCDs; and (4) service capacity and access. The second indicator (SDG 3.8.2) assesses incidence of catastrophic health expenditure by measuring the share of the population with large OOPS on health. In this Regional Action Framework, household out-of-pocket expenditures for health greater than 10% of total household expenditure or income is referred to as catastrophic health expenditure (SDG indicator 3.8.2 at the 10% threshold) *(2)*.

The general trend in the Region has been towards better service coverage (SDG 3.8.1), but the pace of improvement has stagnated in recent years (Fig. 6). It is also important to note that progress is uneven across the Region, with Pacific island countries (average SCI score of 51 in 2021) lagging significantly behind the SCI of those countries that are not Pacific island countries (85 and 65 for HICs and MICs, respectively) (Fig. 7).

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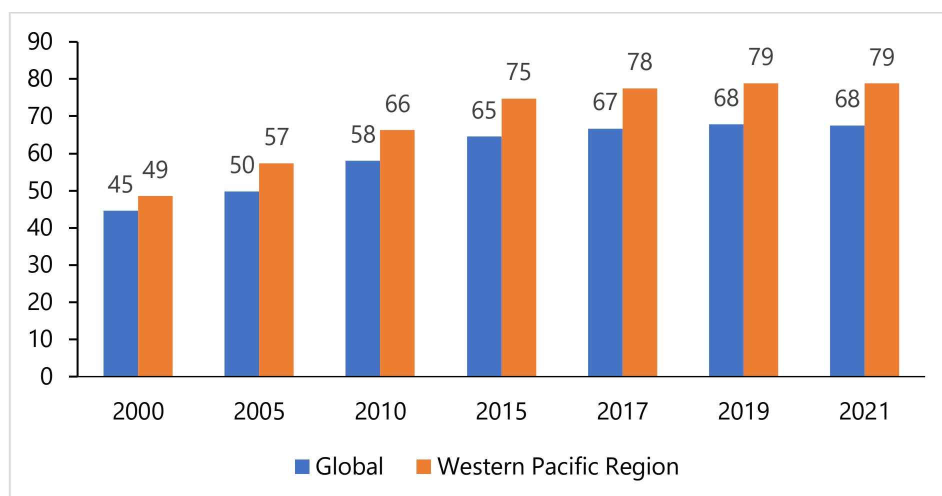
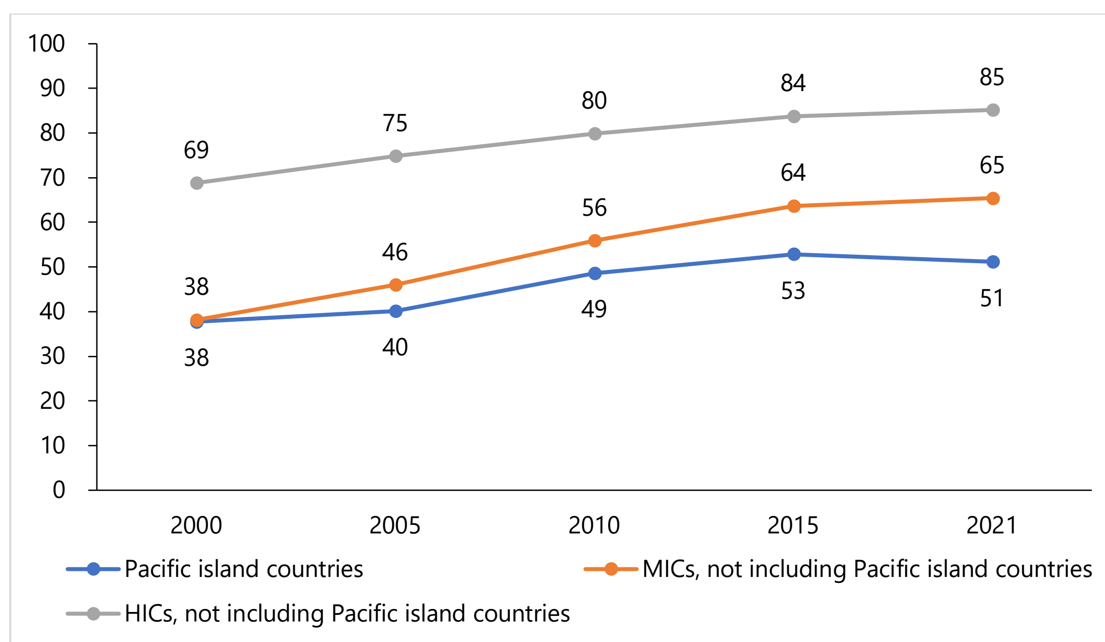
Fig. 6. UHC SCI (SDG 3.8.1), Western Pacific Region and global, 2000–2021[2]



Source: Global Health Observatory *(13)*.

Fig. 7. Average (unweighted) UHC SCI by Western Pacific Region country group, 2000–2021



HICs: high-income countries; MICs: middle-income countries.

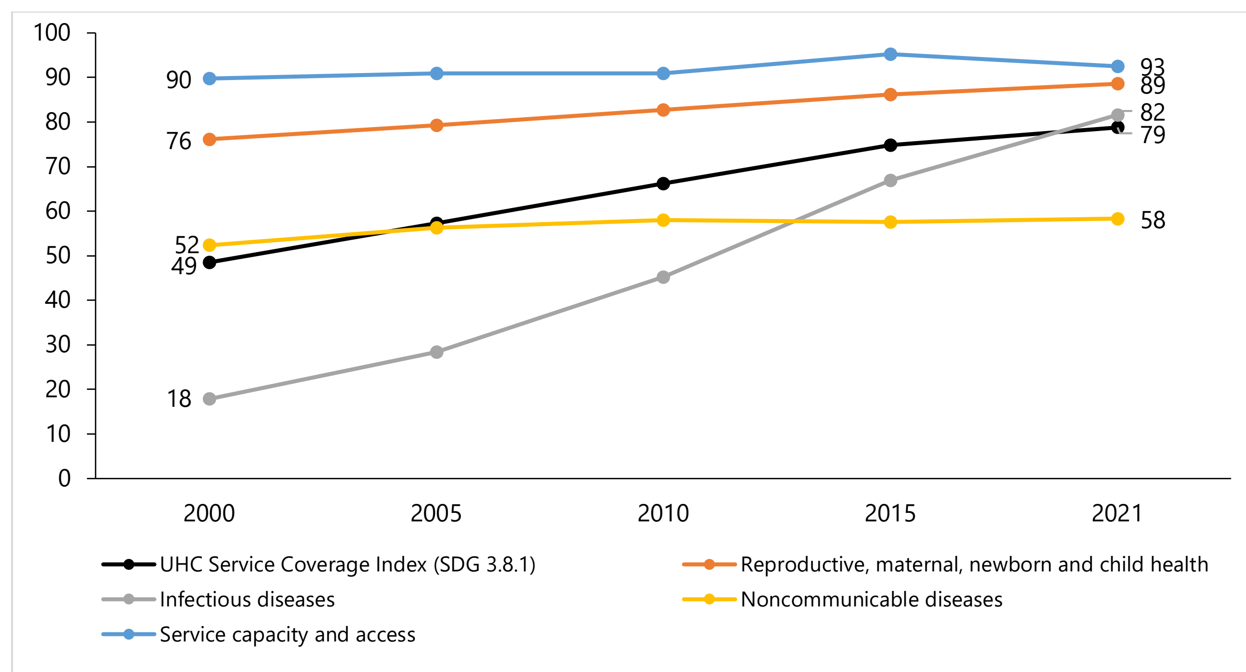
Source: Authors' calculations based on Global Health Observatory *(13)*.

Improvements in service coverage have been driven mainly by improved access to services for infectious diseases and reproductive, maternal, newborn and child health, for which the sub-index scores increased from 18 to 82 and from 76 to 89, respectively, between 2000 and 2021 (Fig. 8). However, these improvements were mainly seen between 2000 and 2015, and progress has levelled off

[2] Unless otherwise stated, averages for UHC performance indicators are population-weighted.

and only improved slightly during the past six years. Further, the sub-index for NCDs only increased marginally during this period and remains relatively low at 58.

Fig. 8. Average score for UHC SCI and its sub-indices in the Region, 2000–2021



SDG: Sustainable Development Goal; UHC: universal health coverage.

Source: Global Health Observatory *(13)*.

In contrast to service coverage, financial protection has deteriorated. Despite progress in reducing the incidence of extreme impoverishing health spending – at the purchasing power parity (PPP) $2.15 per day extreme poverty line – across the Region, which was largely due to national efforts on poverty reduction, there has been a trend, particularly evident among the Asian MICs in the Region, towards increased catastrophic health expenditure (Fig. 9). The share of the Region's population experiencing catastrophic health spending increased from one in 10 in 2000 to one in five in 2019. In 2019, an estimated 376 million people experienced catastrophic health spending, with most of these cases occurring in the country groups that are not Pacific island countries. Meanwhile, evidence of financial protection is currently lacking in the Pacific.

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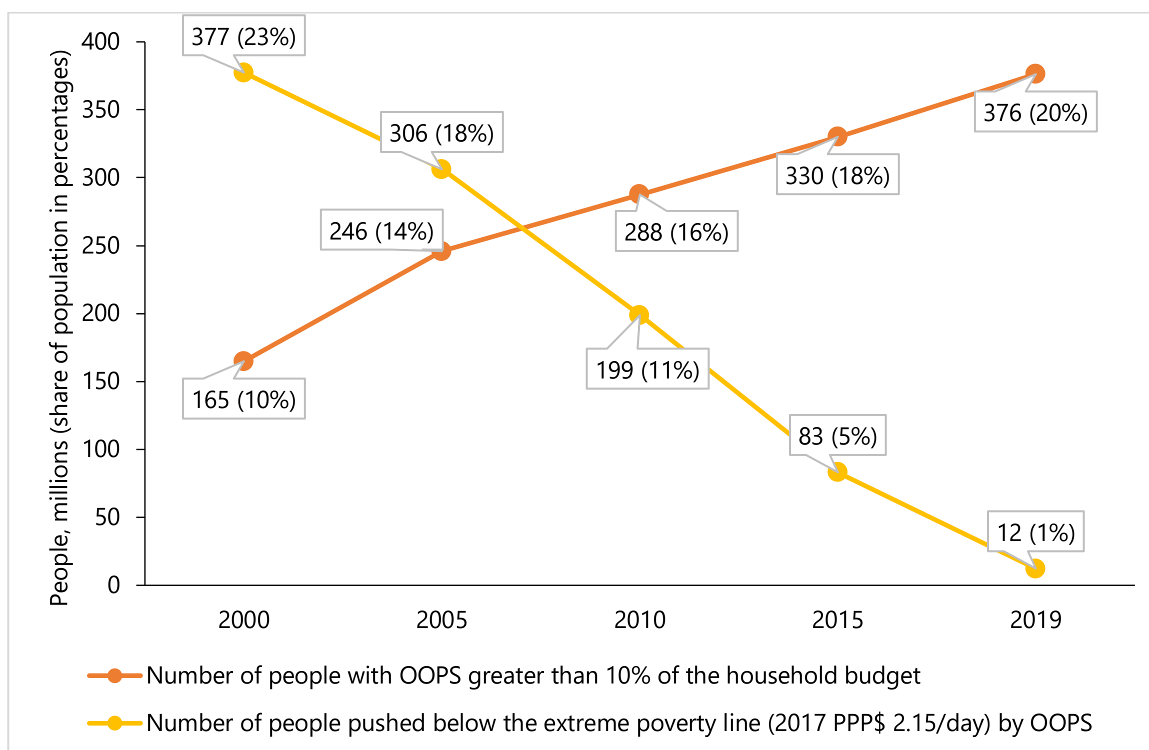
Fig. 9. Measuring financial hardship in the Western Pacific Region, 2000–2021

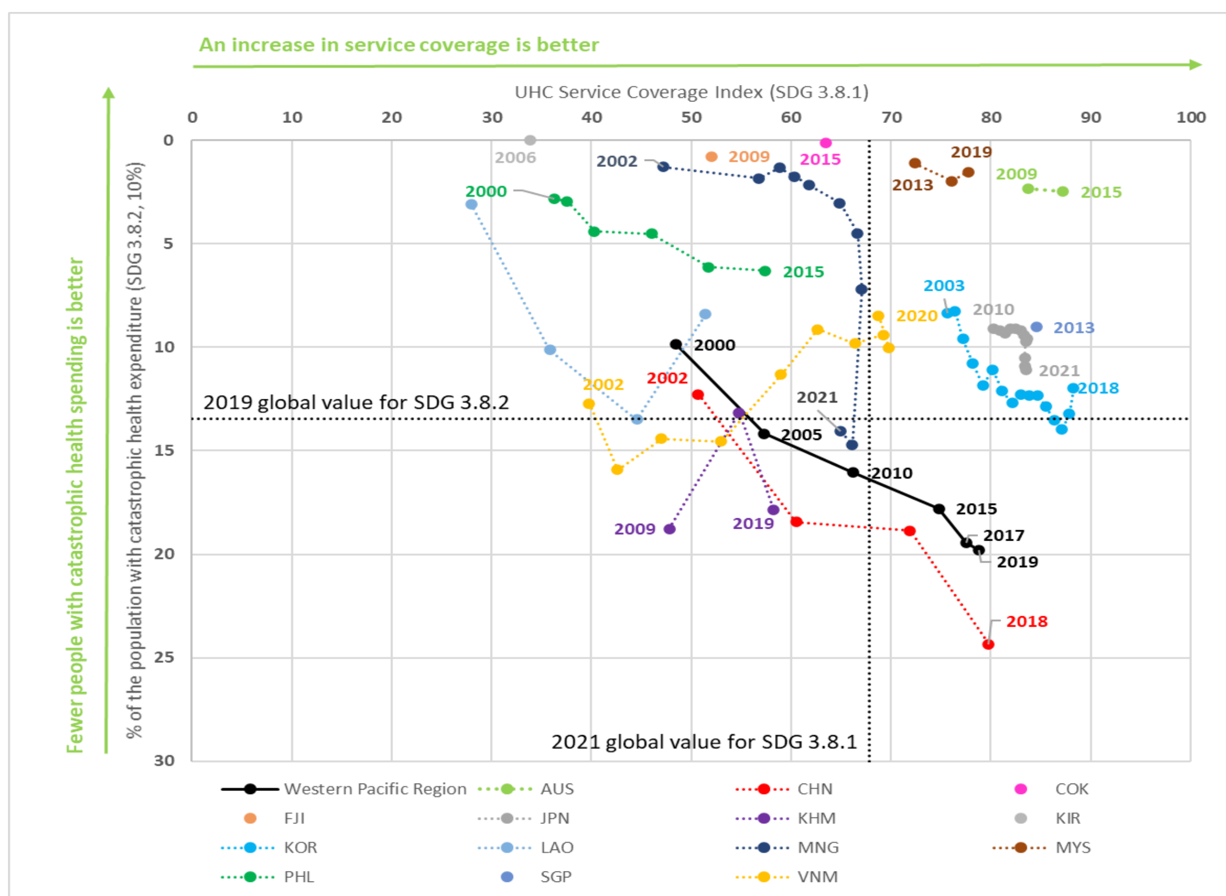


OOPS: out-of-pocket spending; PPP: purchasing power parity.

Source: Global Health Observatory *(14)*.

At an individual country level, UHC progress has also been mixed. Fig. 10 illustrates this by showing the joint progress of UHC service coverage (SDG 3.8.1, with increased coverage towards the right-hand side of the horizontal axis) and the incidence of catastrophic health expenditure (SDG 3.8.2, reductions moving up the vertical axis). For most countries where both SDG 3.8.1 and 3.8.2 data were available, there appears to be a trend towards the bottom right-hand quadrant over time − that is, improving coverage but deteriorating financial protections.

Fig. 10. Trends in UHC service coverage and catastrophic health expenditure in the Western Pacific Region by country, 2000–2019



Shows time trends of the two main dimensions of UHC – access to services (SDG 3.8.1) and the incidence of household expenditures on health greater than 10% of total household expenditure or income ("catastrophic expenditure") (SDG 3.8.2) – in the countries for which data are available for both indicators, as well as the population-weighted average for the Region.

SDG: Sustainable Development Goal; UHC: universal health coverage. (A key to the country abbreviations in this figure can be found in Table 1.)

Source: WHO, Global Health Observatory *(13,14)*.

The mixed results on UHC are despite efforts to expand population coverage within national schemes. Many countries have made impressive progress in expanding population coverage with their national financing schemes, especially with the establishment of social health insurance (SHI) systems, largely by making enrolment mandatory or automatic and by using government budgets to subsidize vulnerable groups, such as people in poverty and informal workers *(33)*. While this may have contributed substantially to the improvement of service coverage, the worsening trend of financial protection highlights that population coverage does not automatically translate into UHC progress; instead what really matters is "effective coverage" – the proportion of the population that receives health services at a sufficient level of quality to yield the intended health benefits, without financial hardship. Key to this is not only the availability, affordability and accessibility – including financial accessibility – of health services, but also the quality and efficacy of those services *(34)*. Current UHC monitoring

does not capture situations where financial barriers lead to unmet needs and foregone care, which poses challenges in understanding the fuller picture of progress towards UHC in the Region.

3. UNPACKING UHC PERFORMANCE: REVEALING THE BOTTLENECKS

This chapter delves into the root causes holding back progress on UHC in the Region, focusing on the following four bottlenecks:

- low public spending on health in many countries;
- suboptimal use of available resources;
- governance weaknesses; and
- slow progress on the Health for All agenda.

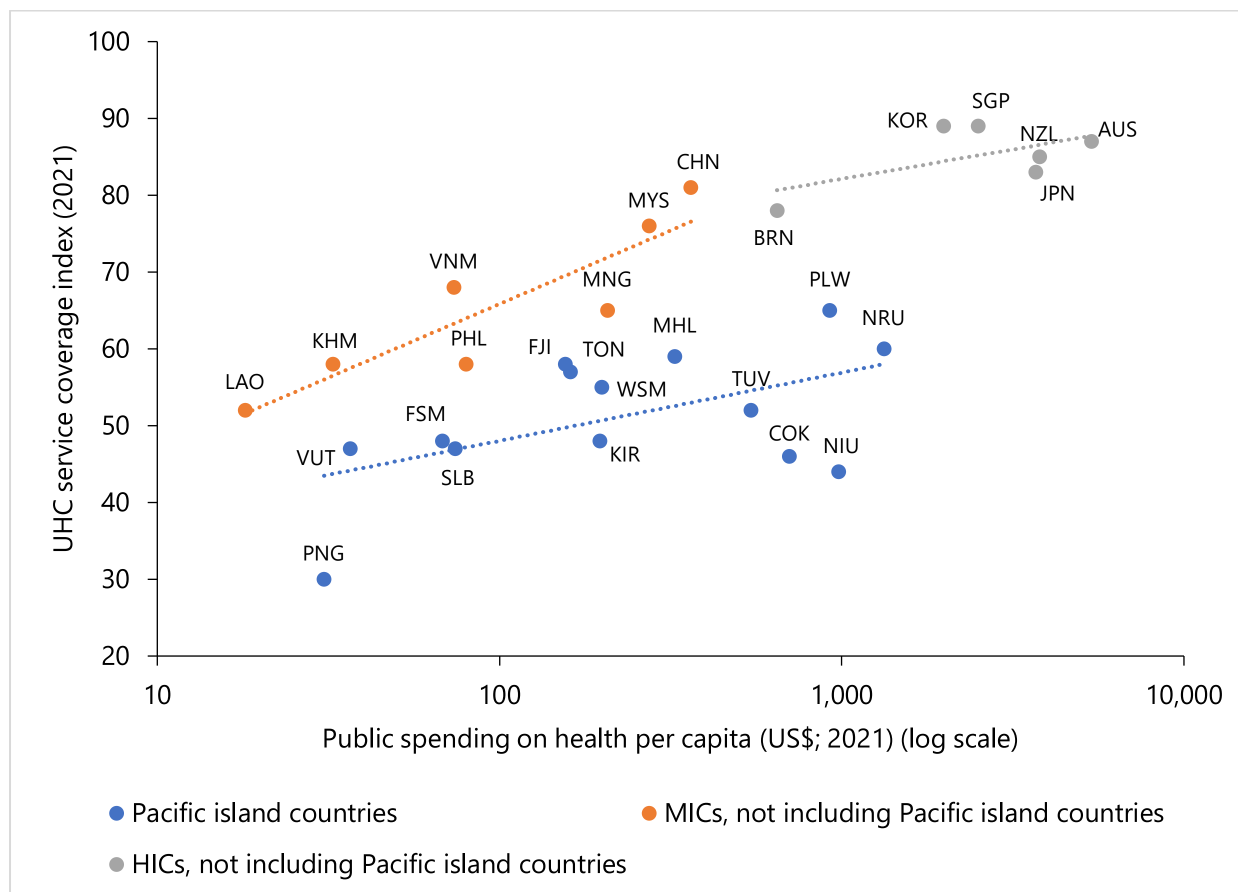
3.1 Despite increases, public spending on health remains low in many places

Public spending on health[3] plays a crucial role in advancing the UHC agenda. Global evidence suggests that the service coverage is positively correlated with the public spending on health per capita. This correlation can also be seen in each of the country groups within the Region (Fig. 11). However, the level of public health spending is not the only determinant of UHC performance. An example can be seen with Pacific island countries, which as a group have structurally lower service coverage than Asian MICs, even with comparatively similar levels of public spending on health. This likely illustrates the difficulties of providing comprehensive health services in remote and sparsely populated countries and the additional pressures on public spending (Box 2).

[3] Public spending on health throughout this Regional Action Framework refers to the combined contribution from government budgets and social health insurance contributions.

Annex

Fig. 11. Public spending on health is correlated with service coverage[4]



HICs: high-income countries; MICs: middle-income countries; UHC: universal health coverage. (A key to the country abbreviations in this figure can be found in Table 1.)

Source: Global Health Expenditure Database (*23)* and Global Health Observatory *(13)*.

Box 2. The unique service delivery challenges in Pacific island countries and areas

In most Pacific island countries and areas, governments – often supported by donors – generally play a dominant role in financing and delivering health services to the public. Via this model, progress has been made in recent years in effectively expanding basic health services to their citizens.

However, the small island developing states face unique challenges that influence health sector development. With small populations, often dispersed in large archipelagos across large tracts of ocean, they face the combined challenges of small scale and remoteness.

The challenges of distance and high costs have led to spatially uneven development in Pacific island countries and areas, with essential public services, infrastructure and employment strongly biased towards capital cities. People in more remote areas face considerable additional barriers to accessing good-quality health care because of inadequate buildings, absent staff, and a lack of necessary materials and equipment, among other

[4] Unless otherwise stated, averages for health expenditure indicators presented in this Regional Action Framework are unweighted.

challenges *(35)*. These spatial inequities drive differences in effective coverage between urban and rural areas and drive differences between health outcomes.

Moreover, the small size of Pacific island countries and areas also means a lack of specialized clinical services, limited clinical capacity and few trained medical specialists. As a result, these countries and areas depend on overseas medical referral, often funded by government schemes, with some contribution from private insurance and OOPS in some cases. Overseas medical referral is costly, averaging US$ 9000 per referral case across Pacific island countries and areas in 2017. This absorbs a substantial share of government health spending in many countries. Moreover, the price tag of overseas medical referral appears to be rising, eating into an ever-larger share of the available public resource envelope for health spending driven by increasing demand and higher costs. Notably, the cost per overseas medical referral case varies widely, ranging from around US$ 34 000 in Vanuatu to US$ 885 in Niue in 2017 *(36)*. This suggests that there may be opportunities for improved efficiencies.

Further reading:

Utz, 2021. Archipelagic economies: spatial economic development in the Pacific *(35)*.

Boudville et al., 2020. Overseas medical referral: the health system challenges for Pacific island countries *(36)*.

The rapid economic growth in the Western Pacific Region in recent decades has enabled strong growth in public spending on health. In total (from all financing sources), the Western Pacific Region spent US$ 1.96 trillion on health in 2021. This was more than triple the amount spent on health in 2000 in real terms (US$ 592 billion), representing annualized real growth in health spending of 5.9% per year. Growth in public spending on health was even faster, rising at an annualized pace of 6.1%. Key drivers of this growth have been rising incomes, coupled with governments' generally rising capacity to collect tax revenues from income, which have been instrumental in increasing the size of overall government spending in recent decades.

There are several instances, particularly among Asian MICs, of public spending on health being bolstered through SHI schemes. Notably, China, the Lao People's Democratic Republic, Mongolia, the Philippines and Viet Nam have reformed their SHI systems to expand population coverage through increased government subsidies and SHI contributions (*33)*. Importantly, there are inherent challenges to collecting individual contributions associated with SHI schemes to cover the informal sector, which often makes them dependent on government budgets (Box 3).

Box 3. The limitations of contributory-based social health insurance systems as a source of health revenues

Countries have often introduced contributory SHI in the expectation that it will add new resources to the health sector. However, global evidence suggests that the potential for SHI contributions to create additional fiscal space for health is, at best, moderate, and there is little indication that the mere initiation of contributory SHI schemes has helped developing countries achieve UHC *(37,38)*. Traditionally, SHI relies on payroll-linked premium payments from members. Challenges are particularly pronounced in low- and middle-income countries, which often have high levels of labour informality, unemployment and poverty, which make it more difficult to collect SHI contributions. Accordingly, SHI schemes are usually underpinned by subsidies allocated from government budgets to cover the premiums of certain population groups.

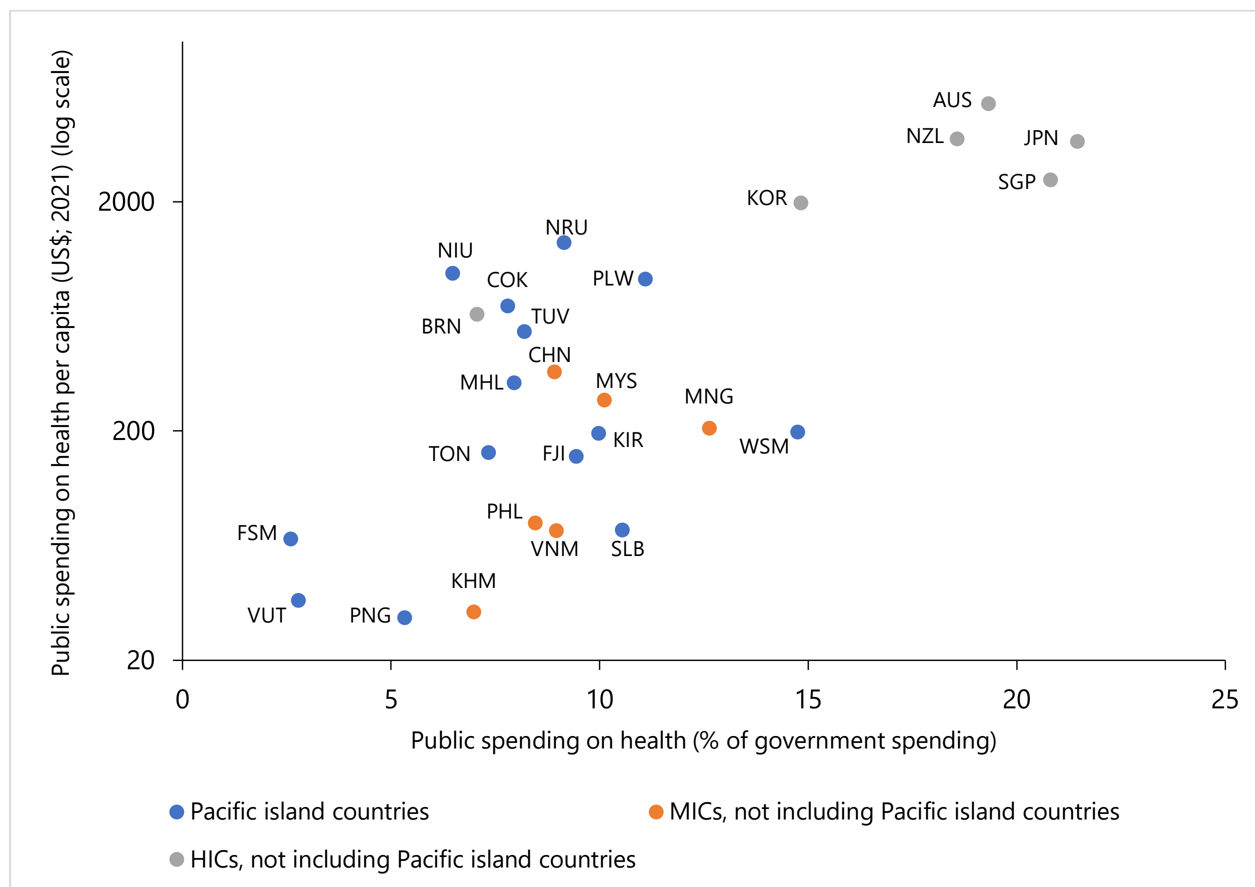
Further reading: Yazbeck AS, et al., 2023. Addiction to a bad idea, especially in low-and middle-income countries: contributory health insurance *(38)*.

Despite these increases, the level of public spending on health per capita remains low by international standards in many countries in the Region. Although there is no "magic number" in terms of the level of public spending required to achieve UHC, and increased public spending does not automatically translate into UHC progress *(39)*, the current level of public spending in many places is often inadequate to meet population health needs. This is particularly true in the MICs that are not Pacific island countries, where the average spending per capita (US$ 150 in 2021) is well below the global middle-income average (US$ 193). Indeed, eight countries in the Region (four Pacific island countries and four MICs in Asia) had government spending on health per capita of less than US$ 100 in 2021. Effectively running the health system with such low levels of public spending is likely to be a significant challenge.

Part of the reason for the low level of public spending is that prioritization of health within overall government spending often remains low. "Prioritization" refers to the share by percentage that government spending on health makes up of the total government spending across all sectors each year. Across the Region, the level of public spending on health is positively associated with the countries' level of prioritization, with the highest-spending countries also having highest prioritization (Fig. 12). Only HICs as a group meaningfully increased the prioritization of health spending within government expenditures in the past two decades, rising from 11% on average in 2000 to 17% on average in 2021.[5] In contrast, in Pacific island countries, average prioritization of health declined considerably, and in Asian MICs it remained stagnant and comparatively low (Fig. 13). However, it is important to also note that averages mask considerable country-level variation, with prioritization varying substantially between countries at similar income levels and similar levels of spending.

[5] Globally, the rise in government health spending in HICs has been faster than what might be expected from changes in demographic structure, morbidity and income. Accordingly, some of the rise in health prioritization in HICs might also reflect excessive cost growth, in particular, from advancement in medical technologies.

Fig. 12. Low public spending on health is correlated with low prioritization

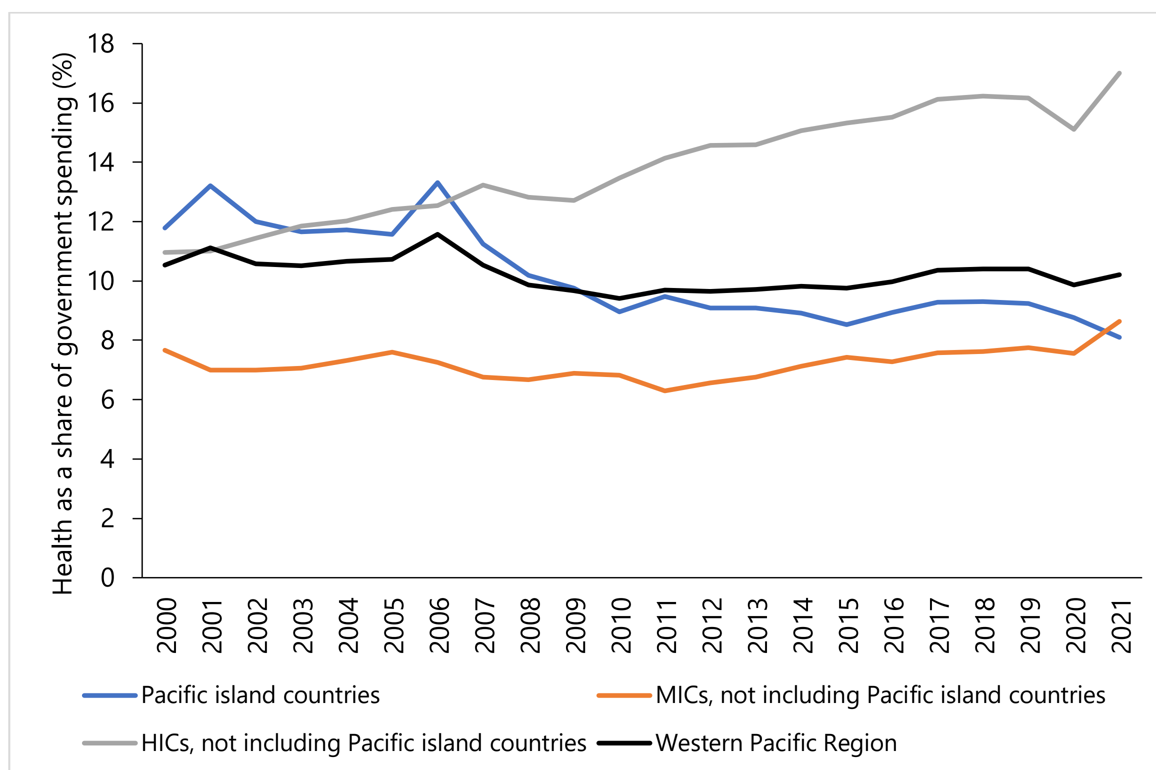


HICs: high-income countries; MICs: middle-income countries. (A key to the country abbreviations in this figure can be found in Table 1.)

Source: WHO Global Health Expenditure Database *(23).*

Annex

Fig. 13. Only HICs have increased health prioritization in the past two decades



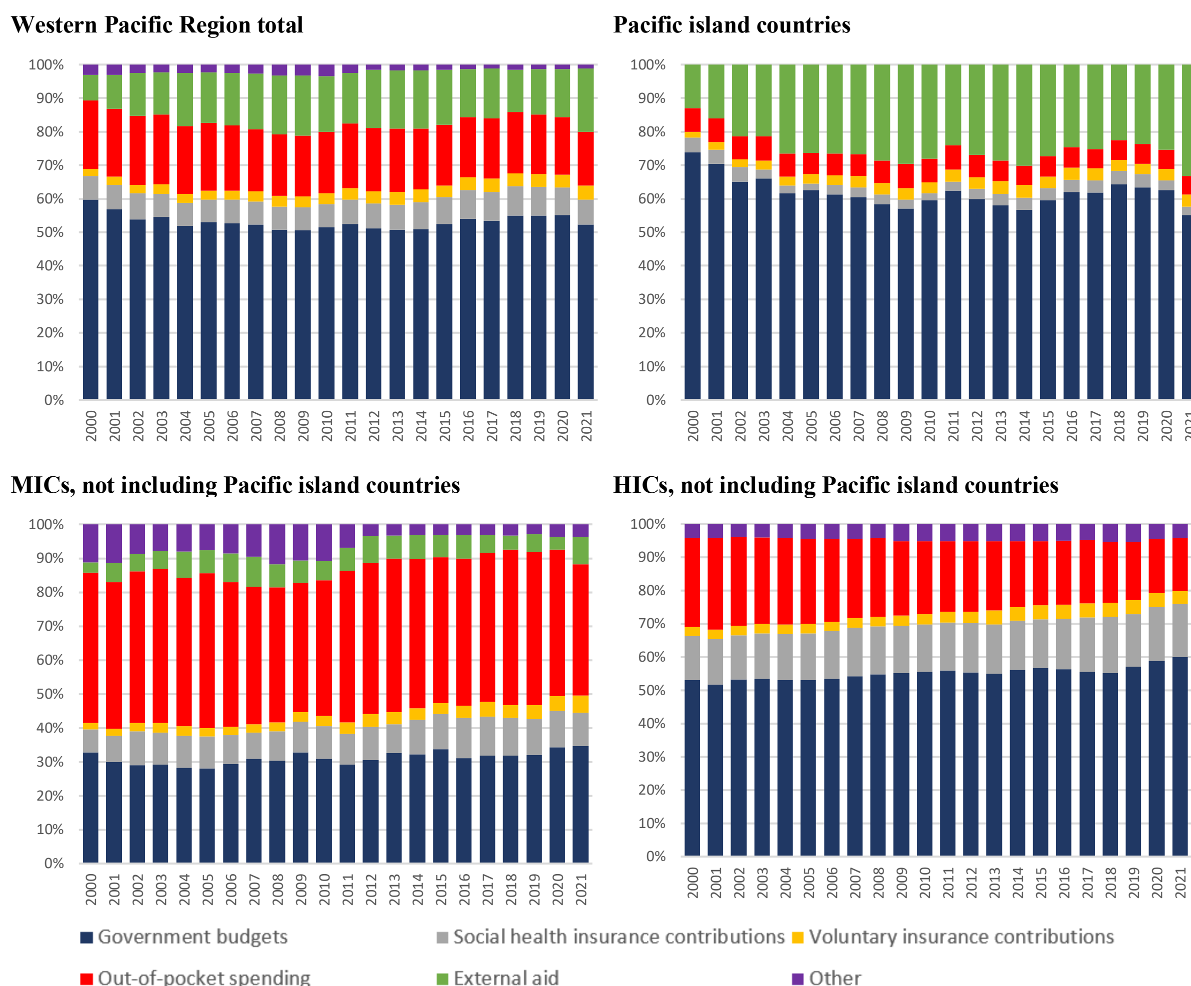
HICs: high-income countries; MICs: middle-income countries

Source: WHO Global Health Expenditure Database *(23)*.

Out-of-pocket spending (OOPS) remains a major source of health revenues in the Region despite the shift towards more public spending in some countries (Fig. 14). As of 2021, 17 of the Region's 27 countries had revenues from government budgets constituting more than half of all health revenues.[6] In countries with SHI schemes, contributions from these schemes are usually supplementary to government budgets, with the exceptions of China, Japan and the Republic of Korea, where revenues from SHI schemes were close to or exceeded government budgets. Critically though, the low level of government spending per capita in many places means that households are still required to foot a substantial bill for health care via OOPS. This is particularly the case in MICs that are not Pacific island countries, where OOPS still accounts for nearly 40% of health spending. This is considerably higher than the global average for MICs (32% in 2021). While OOPS on health per capita remains low in Pacific island countries, this may not reflect effective financial protection but instead be the result of unmet needs or foregone care, given the constraints on service coverage in the Pacific (see Box 2).

[6] Spending data for 2020 and 2021 will be influenced by the fact that in both HICs and MICs, the share of health spending funded by government budgets jumped as governments quickly reprioritized budgets towards health to respond to the needs of the COVID-19 pandemic. Nonetheless, among the HICs of the Region there has been a longer-term trend of government budgets rising as a share of total health spending.

Fig. 14. The composition of revenue sources for health has marked differences between the groups

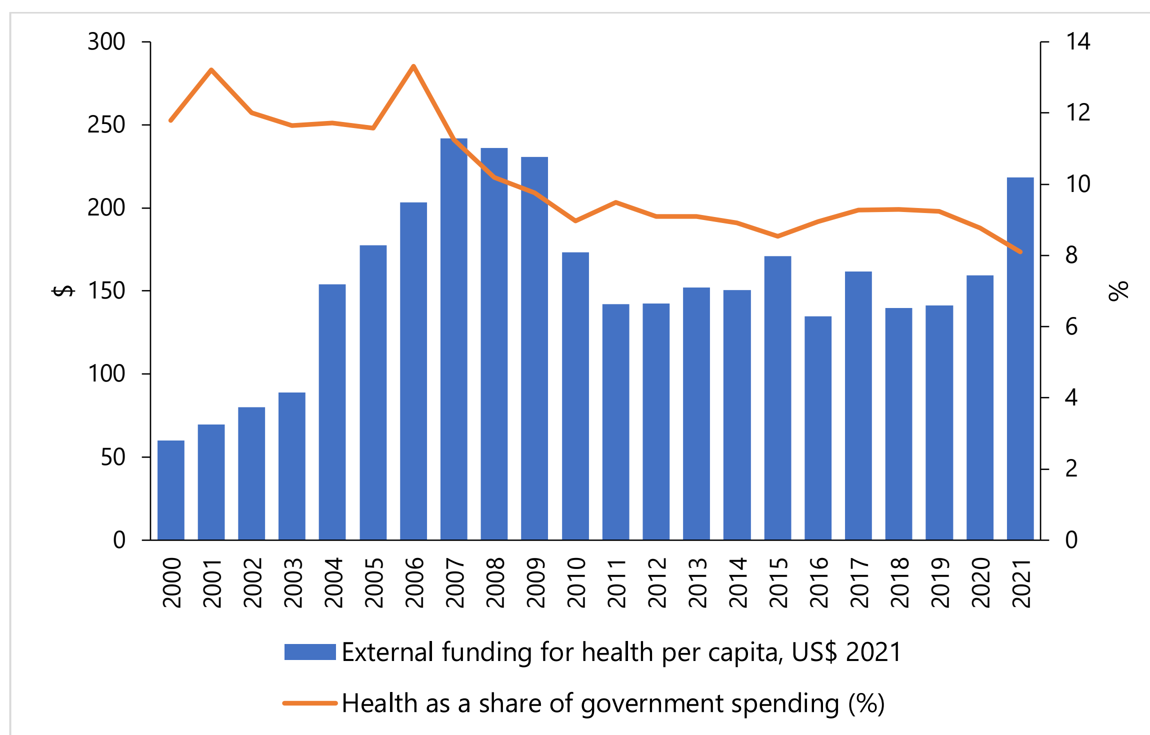


Source: WHO Global Health Expenditure Database *(23)*.

The low level of government health spending per capita has meant that countries remain dependent on external aid, especially in Pacific island countries. Moreover, there has been an inverse relationship between the amount of external aid provided and government prioritization of health (Fig. 15). As real per capita external funding has risen in Pacific island countries from US$ 60 in 2000 (constituting 13% of health spending) to US$ 141 in 2021 (24% of health spending), the average priority given to health within Pacific island countries' government budgets has declined, dropping from an average of 11.8% in 2000 to 8.1% in 2021. However, the direction of the causality is not clear and may differ from country to country. In some cases, increased donor funding may have led to lower prioritization, whereas in others, donors may have stepped in to compensate for economic downturns or declines in domestic government funding, as was the case during the COVID-19 pandemic emergency. In light of the structural challenges faced by Pacific island countries, development assistance is likely to remain an important component of health financing in the Pacific for the foreseeable future.

Annex

Fig. 15. Inverse relationship between development aid and prioritization of health in Pacific island countries



Source: WHO Global Health Expenditure Database *(23)*.

Private voluntary health insurance (VHI) is a small but growing financing source, and caution needs to be taken given its potential risks to UHC. In almost all countries in the Region where VHI exists, it has risen as a share of total health expenditure between 2000 and 2021.[7] Growth in spending from VHIs has been particularly strong among the Asian MICs, where VHI has increased at an average annualized pace average of 16% in real terms, followed by Pacific island countries (8.5%) and HICs (5.7%). Depending on the specific role of VHI in a health system, it can pose opportunities and risks for equitable progress towards UHC; however, notably, no country in the world has moved equitably towards UHC with VHI as a main pillar *(40)*.

[7] This relates to countries where data on spending from VHI are reported; while most HICs and MICs in the Region report spending from VHI schemes, only half of all Pacific island countries do. It is possible that some Pacific island countries have VHI schemes but do not report their expenditures.

3.2 The use of available resources is not optimized

Fragmentation of funding undermines equity and efficiency

Fragmentation of health financing takes many forms. Within health budgets, fragmentation occurs when parts of the health system are budgeted separately from others in an excessively complex or inconsistent manner. This can occur when there are separate and inflexible budget allocations for different inputs (for example, wages versus pharmaceuticals and other goods), different diseases (for example, vertical disease programmes), different providers (for example, hospitals versus primary care providers), different financing schemes (for example, SHI schemes, public schemes, donor schemes, etc.) and/or population groups (for example, formal sector employees, self-employed, identified poor, etc.). Central levels of government may also have separate and distinct budget allocations from subnational levels.

In countries where funding streams are poorly managed, fragmentation within budgets jeopardizes the ability to effectively plan, allocate and adjust budgets to population needs. The lack of budgetary coherence also makes it difficult to effectively track public health spending. Furthermore, smaller public funding pools weaken efficiency by limiting economies of scale to strategically influence the prices, conditions and quality of purchased services and undermine equity by limiting the capacity to redistribute risk among members. It can also create administrative duplication – within funding agencies and among spending units, such as health-care providers.

Within aid-dependent countries, these issues can be exacerbated as separate verticalized funding pools for health priorities managed by donors often stand apart from health planning and budgeting, in separate appropriations or off-budget entirely. This lack of coordination heightens the risks of misalignments in spending occurring, government and external spending can overlap and compete, or critical spending gaps can emerge.

Resources are not allocated to providers in ways that incentivize equity, quality and efficiency

Many countries in the Western Pacific Region still rely on passive provider payment mechanisms, such as historical input-based budgets and fee-for-service payment models *(33).* These payment mechanisms tend to entrench historical inequities and inefficiencies and are often blind to evolving population needs and UHC goals. For example, rigid input-based budgets tend to incentivize low productivity, while uncontrolled fee-for-service reimbursements incentivize high and often excessive output volumes. Indeed, when the perverse incentives of fee-for-service payments are combined with provider autonomy and unrestrained revenue maximization, it can lead to rapidly escalating costs and overinvestment in high-cost services, with little impact on quality (Box 4).

Box 4. Provider autonomy and UHC

Provider autonomy in hospitals and other settings has the potential to improve the responsiveness and quality of service delivery. Accordingly, there has been a trend in the Western Pacific Region towards granting hospitals more financial and administrative autonomy to improve overall efficiency *(41)*.

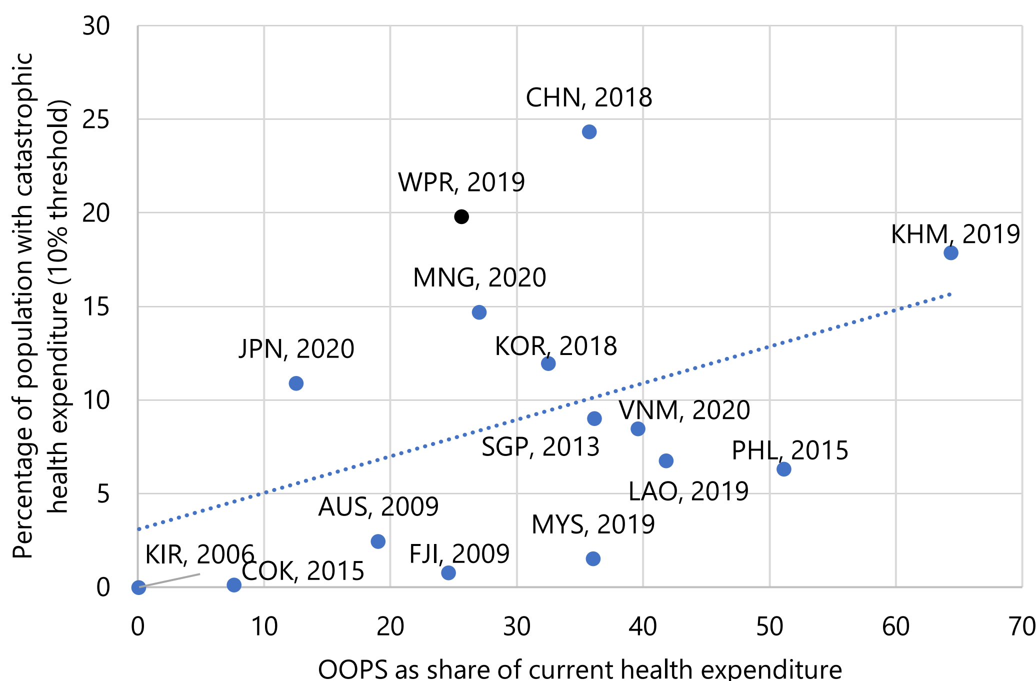
However, autonomy can have unintended adverse consequences for UHC in certain circumstances. When combined with an uncontrolled fee-for-service payment model, autonomous providers and their management teams face strong incentives to increase profits by charging higher service fees and over-providing the most profitable – but sometimes unnecessary – services, particularly expensive and high-tech procedures. If providers also face diminishing government transfers, the incentive to shift towards a profit-seeking model and away from public objectives of equity and quality people-centred care is only likely to be amplified.

Further reading: Cowley and Chu, 2019. Comparison of private sector hospital involvement for UHC in the Western Pacific Region *(41)*.

Critical benefit coverage gaps are leading to financial hardship

At the system level, the share of total health spending borne by household OOPS is an important indication of catastrophic spending in the Region (Fig. 16). Yet, the considerable country-level variation in catastrophic spending among countries at similar OOPS shares indicates that other factors also affect catastrophic health expenditure at the household level. It is therefore critical to understand the drivers of OOPS on health and who incurred the highest financial hardship when accessing health care to identify the exact policy gaps in countries.

Fig. 16. OOPS as a share of current health expenditure in relation to catastrophic health expenditure



OOPS: out-of-pocket spending. (A key to the country abbreviations in this figure can be found in Table 1.)

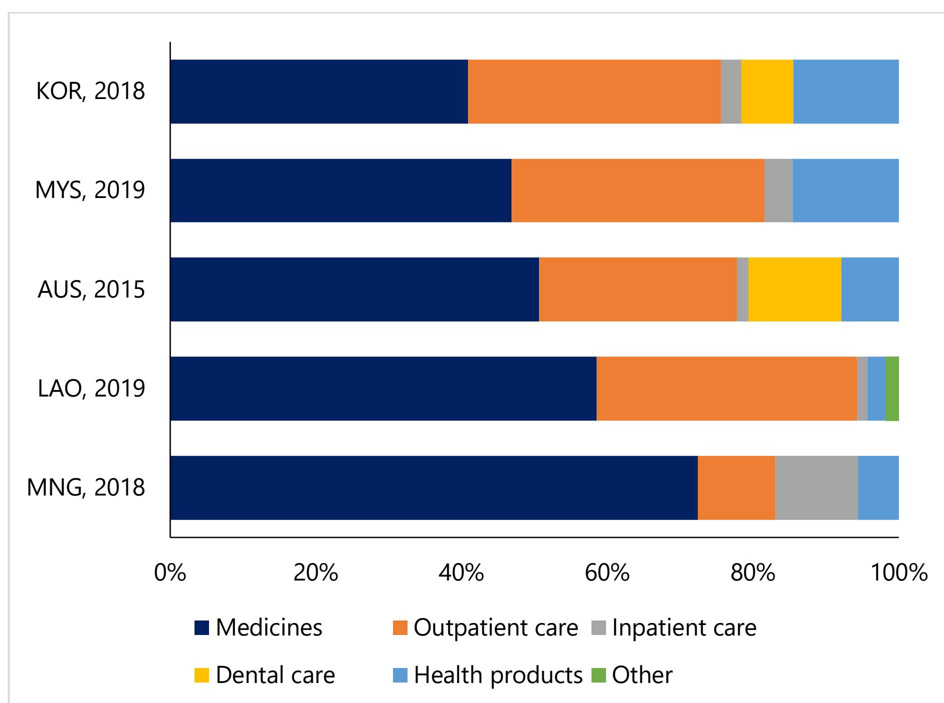
Source: Global Health Observatory *(14)* and Global Health Expenditure Database *(23).*

According to the latest regional report on financial protection, in countries in the Region for which data are available, household OOPS on health was predominantly driven by medicines, followed by outpatient care (Fig. 17). Further, literature suggests that in some of the countries in the Region, the burden of OOPS on medicines is greatest among the poorest groups *(42).* This may help to explain why populations in the poorest income quintile often had the highest incidence of financial hardship (Fig. 18).

An important factor influencing the financial burden of essential medicines and outpatient care is that, historically, they are not sufficiently covered by the national benefit packages. Instead, many countries in the Region have prioritized public resources towards covering inpatient curative care in benefit packages. Even when included, medicines and outpatient care are often subject to co-payments as a percentage of the cost of the service or when annual benefit ceilings are reached. Although some countries exempt the poor from such co-payments, this is not always the case everywhere. Indirect costs of accessing health services − for example, cost of transportation − although not included in OOPS on health estimates, can also pose significant barriers to access and lead to reduced household budgets for health.

Annex

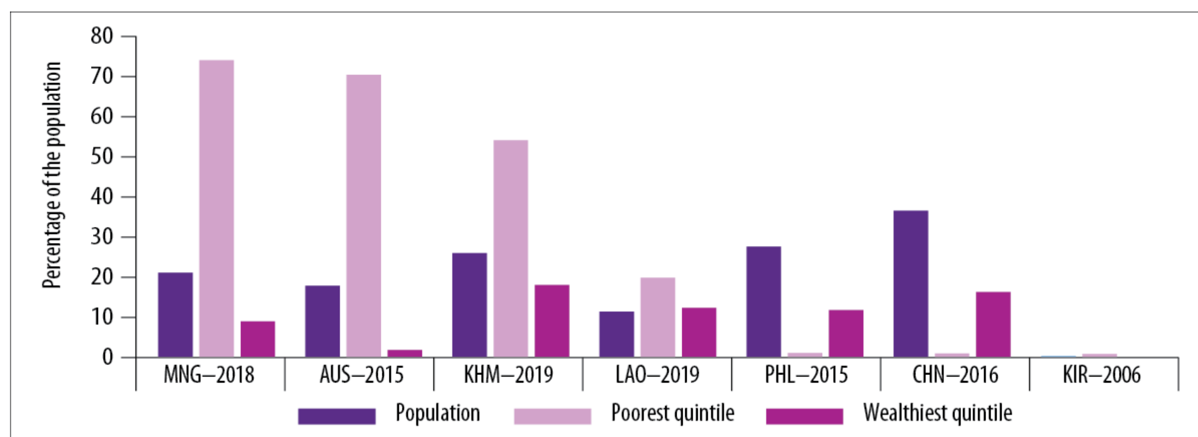
Fig. 17. Composition of OOPS in five countries in the Western Pacific Region



A key to the country abbreviations in this figure can be found in Table 1.

Source: WHO Regional Office for the Western Pacific, 2023 *(42)*.

Fig. 18. Incidence of financial hardship across per capita consumption quintiles in selected Western Pacific Region countries



A key to the country abbreviations in this figure can be found in Table 1.

Source: WHO Regional Office for the Western Pacific, 2023 *(42)*.

Inefficient procurement and asset management waste precious health resources

Wasteful spending remains pervasive in health systems, with potentially as much as 20–40% of health expenditure globally being lost through inefficiencies *(43).* Waste occurs across all input factors in the health system, though weaknesses in commodity procurement systems and supply chain management loom large and are a systemic issue across the Western Pacific Region *(44).* Procurement of goods and services is often done independently at the subnational or even facility level instead of leveraging potential economies of scale through centralized or coordinated approaches at a national level. Global evidence indicates that the accumulation of costs incurred in the end-to-end supply chain from the port of entry to the consumption by patients can represent up to 60% of the price to the patient *(45).* Accordingly, inefficiencies in procurement and distribution can magnify quickly, with impacts on resource use and access to essential medicines and vaccines. In addition, the management of health sector assets, including maintenance of infrastructure, is often inadequate, leading to capital investment needs down the line that could have been avoided.

PHC, despite being key to UHC, remains chronically underemphasized and underfunded

A model of care oriented towards PHC positions primary care and essential public health functions at the core of comprehensive, integrated service delivery. It is among the most equitable and cost-effective strategies for enhancing the health of populations and enabling UHC.

As the Lancet Global Health Commission notes, while the need to bolster PHC systems is evident and there is extensive global evidence and political commitment supporting the reorientation of health systems design and financing towards PHC, chronic underfunding has adversely affected the capacity of PHC providers to offer good-quality services *(46).* Many health systems in the Region are oriented towards specialist care at the hospital level as a result of investments and political choices spanning several decades, and funding models such as fee-for-service reimbursements (see Box 4) further entrench this orientation. This has resulted in first-contact PHC services at the primary care level receiving only limited prioritization within government health budgets.

A further challenge occurs in decentralized systems as responsibility for PHC is often allocated to subnational levels and with multiple financing streams (for example, transfers from central governments, subnational revenues and SHI schemes) and payment methods. The result is that oversight of resource allocation to PHC is especially complicated, and the lack of clear and delineated responsibilities means that PHC often remains underfunded and underprioritized. This contributes to the many operational challenges facing the primary care level, including the absence of key personnel, stock-outs of essential pharmaceuticals and equipment, and low-quality care. Patient dissatisfaction with the primary care levels is also evident in how people bypass the primary level and present directly to hospitals *(17).*

Additionally, a systematic challenge in the Region is that essential public health functions, such as public health surveillance and monitoring, public health emergency management, and disease prevention and early detection, are often underfunded. As they are public goods with broad positive spillovers for society, governments are generally responsible for funding essential public health functions through the budget (sometimes with the support of donors) rather than via SHI schemes, which tend to focus on paying for individual services consumed by members (Box 5) *(47).* Yet, hospital-centric health financing priorities and inadequate planning often mean that government health

budgets prioritize clinical treatment, leaving prevention and public health activities underfunded *(22)*. This imposes additional costs on the health system (for both purchasers and households) in the form of additional clinical treatments and weakened resilience against health threats.

Box 5. Funding essential public health functions

While various definitions of essential public health functions exist, they should fulfil the following main public health operations *(22):*

- **Surveillance**, including monitoring and analysis of the health situation; and monitoring and investigating disease epidemics, risks and threats.
- **Health protection and promotion**, including environmental, occupational and other public health hazards, and social determinants of health.
- **Disease prevention and management**, including risk factor reduction, screening and immunization, and diagnosis, treatment and care.
- **Emergency response**, including response to disease outbreaks, natural disasters and other emergencies.

In ordinary times, public health functions require stable and predictable sources of financing. Accordingly, global health financing experts increasingly advocate the use of general government budgets, especially in instances where SHI does not cover the entire population *(38,48)*.

Government budgets are the result of planning and allocation decisions made in advance and being reflected in funding commitments made for at least one year – and often more through medium-term budgeting. Moreover, in times of public health emergencies, such as pandemics, a rapid response is needed and governments, if appropriate mechanisms are in place, can quickly mobilize and reallocate budgetary resources to respond to emerging threats.

In contrast, SHI schemes usually rely on output-based payments, often limited to pre-defined benefits, and may lack the flexibility to rapidly adjust to such crises due to their more rigid structures and the need for legislative or regulatory changes.

In countries where both SHI and tax-based financing schemes exist, it is critical to clearly delineate the responsibilities between the schemes in terms of population coverage and benefit packages to ensure there are no critical gaps for people accessing essential public health services.

3.3 Governance weaknesses impede health financing reforms

Multiple governance challenges inhibit progress towards strategic purchasing

To implement strategic purchasing (Box 6), governments and insurance agencies require the institutional authority and the capacity to act strategically. However, without dedicated capacity within these agencies to drive strategic purchasing, policy inertia sets in, resulting in little practical progress *(49)*. Additionally, the strategic allocation of resources hinges on being able to access and analyse good-quality data on key features of service delivery, most notably claims. However, these data are not always available and low capacity within purchasing agencies to use data weakens the capacity to oversee and implement reform. Further, strategic purchasing requires institutional alignment. In decentralized settings, subnational governments may have limited discretion and capacity to function as strategic

purchasers of health services. Meanwhile, in countries with SHI schemes, there can be misalignments between ministries of health and SHI funds. For example, high-level policy decisions around the benefit package, payment tariffs and selection of providers made by a single department without an effective consultation and coordination process can limit the ability of SHI schemes to act as strategic purchasers (for example, by upholding quality standards and controlling costs). Fragmentation of funding pools can also dilute the capacity of purchasers to influence price and quality.

Box 6. What is strategic purchasing?

Strategic purchasing represents a shift from a passive approach to provider payment to an active one that drives change based on evidence and information about population health needs ("What services and goods to buy?"), which providers will provide these services ("From whom will it be bought"?), and how and how much providers will be paid to deliver those services ("How to buy"?). It involves searching for the right mix of provider payment mechanisms tailored to the service delivery architecture in ways that align providers' incentives with the health system's goals of equity efficiency, sustainability and quality.

Further reading: Mathauer et al., 2019. Purchasing of health services for universal health coverage: How to make it more strategic? *(50).*

Private health-care providers are not effectively leveraged for UHC objectives

Many countries in the Western Pacific Region have seen a rapid growth of private providers. This growth has been driven, in part, by economic development, rising disposable incomes, evolving consumer demands for technology, convenience and quality, and when public services are not available – or perceived not to be available – in the public sector. In many countries, supportive government policy has also facilitated the rise of the private sector based on the promise of improving the health sector's functioning and efficiency *(41)*. Over time, the private sector has grown to become an important part of the service delivery architecture in many countries, involving a heterogeneous mix of itinerant medicine sellers, independent practitioners and pharmacies – both unlicensed and licensed – and corporate hospital chains. In some countries, private providers are fully participating in the national public financing systems and comprise the majority of hospitals *(51).* However, this is often not the case in developing economies, where studies that review the impact of private hospital investment in the Western Pacific Region *(41)* and elsewhere *(52)* have found that the purported benefits of private sector engagement have failed to materialize and, in fact, when poorly managed, may have undermined UHC progress.

A key barrier to the effective integration of private providers into public health financing systems in many countries is weak regulation and enforcement. When unregulated, private providers are able to set prices and deliver services in ways that maximize profits. This can make costs prohibitive for contracting by publicly funded schemes, which further limits the scope for strategic purchasing *(41,51).* When private providers dominate the service delivery market – this is particularly the case in remote areas when public facilities are not available – but are not sufficiently covered by the public financing systems, it forces households to pay a large share of the fees, or the whole fee, charged by the private providers as OOPS *(41).*

Insufficient attention has been given to the politics of health financing

Health financing, and health policy more generally, are inherently political agendas. Strong political commitment has been fundamental in advancing the UHC agenda and increasing government funding for health in many countries in the Region *(33)*. However, the politics of health financing reforms has also held back progress in key areas. An obvious case is PHC. Although there is robust evidence and broad political support for PHC, this has not sufficiently translated into actions, partly due to the influence of powerful stakeholders such as hospital groups and specialist doctors. Another example is the lack of progress with strategic purchasing, which is often held back by an unwillingness to confront the vested interests of powerful health-care providers and prioritizing the institutional interests of the purchasers over the health needs of their beneficiaries.

Additionally, progress on implementing more strategic forms of provider payments to improve quality, efficiency and equity is likely to have stalled due to political dynamics and vested interests. Provider payments are inherently political as they shape who gets what resources and when. This likely explains why some countries with highly advanced health systems and the capacity to implement strategic purchasing still use fee-for-service and other passive payment mechanisms to reimburse providers.

Political instability has in some cases undermined the long-term viability and coherence of health financing reforms *(54,55)*. When governments change frequently, or ministers and senior bureaucrats within health ministries are haphazardly replaced, this creates key risks for policy continuity.

Citizens are also essential stakeholders in the political process. Evidence from some countries in the Region shows a lack of processes for engaging scheme members and citizens to ensure that their needs and priorities are reflected in health benefit entitlements *(56)*. This heightens the risk that purchasing choices may not reflect population health needs, preferences and values, and may not receive community buy-in.

Bottlenecks in public financial management hinder effective health financing

Regardless of a country's specific financing mix, in most places, government budgets remain the cornerstone of public spending on health. Public financial management (PFM) systems therefore play a critical role in health financing by ensuring that the government budgets are aligned with national health priorities by shaping the effectiveness of how public funds are allocated and spent within the health system. PFM also affects the feasibility of financing reforms. For instance, the strategic purchasing benefits of case-based payments can be undermined by PFM rules that require planning, disbursement and reporting of spending to follow rigid, input-based line-item budgets *(57)*.

A recent internal review of the effectiveness of budgeting for the health sector in the Western Pacific Region confirms what other datasets *(58)* and stakeholder consultations have revealed: that the Region's health systems face many PFM bottlenecks (Box 7). As a result, allocations are not always aligned with population health needs, and the health sector is limited in its ability to respond to community needs. Additionally, there is a high degree of variance between what is budgeted and what is spent, which may fuel perceptions among ministries of finance that the health sector is unable to spend its allocated budgets, thereby increasing the risk of budget reductions.

Box 7. Common PFM challenges identified in the Western Pacific Region

- Weaknesses in planning processes can lead to unrealistic initial health budget proposals and disconnects between plans and budget ceilings. The lack of an effective framework for appraising health spending plans within budget committees makes health budgets susceptible to haphazard and politicized adjustments to fit within revenue ceilings.
- There is a high degree of budgetary fragmentation (between different inputs, providers, central and subnational levels, and government and donors). This weakens the overall coherence of the budget and makes it difficult to track health spending in priority areas effectively, undermining transparency and accountability.
- There is widespread use of input-based budget structures, even in countries that had adopted a nominal programmatic classification structure. While such a focus on inputs may be effective at controlling costs and ensuring compliance, it means that health-care providers, particularly PHC providers at the front line, have limited autonomy and flexibility in the use of resources, which results in reduced accessibility by way of rationing and fees, quality and responsiveness, and ongoing improvement.
- Systematically weak budget execution is a challenge, most notably due to delays in the disbursement of budgeted funds to health-care providers and other implementers, particularly for non-wage operations. These delays occur for various reasons, including cash flow constraints and delays in approvals.[8] This further weakens the link between planning and budgets and leads to rationing, fees and arrears.
- Budgets are rarely allocated alongside expected performance measures according to which spending can be evaluated.

Source: McDonald L. Funding flows to PHC in selected Western Pacific Region countries. (Unpublished manuscript; 2022.)

In more decentralized settings, planning and budgeting issues can be compounded by misalignments between central and subnational levels (Box 8). Commonly, misalignments result from uncoordinated budget structures and planning cycles, which can weaken the overall coherence of health budgets and make it more difficult to holistically track and analyse health spending. Often there is also limited authority given to staff at the subnational level to alter resource allocations and payment methods, which undermines the capacity to implement more strategic forms of purchasing – particularly for PHC services *(59).* Misalignments between levels of government can also occur due to weaknesses in the fiscal transfer system. Typically, subnational governments and administrations rely on transfers of funds from central governments because of the limited resource-raising capacity at the local level. Transfers are also typically designed to address horizontal imbalances between locations. Accordingly, priority is given to locations where local fiscal capacity is lowest and needs are greatest. However, if a subnational government with greater fiscal capacity underfunds health, then the local population effectively misses out twice.

[8] Payment delays are not limited to government budgets; providers in the Region also experience delays due to late reimbursements from SHI and other pooled funding schemes, such as equity funds.

Box 8. The implications of decentralization for health financing in the Philippines

The Philippines has a highly decentralized governance model that assigns significant political, administrative and fiscal authority to local government units, down to the level of the *barangay*, the country's smallest political subdivision. Local government units manage essential services, including health, funded mainly by central government transfers and reimbursements from the Philippine Health Insurance Corporation, known as PhilHealth, plus local revenues. This leads to numerous autonomous local health systems and a complex and fragmented health financing system that devolves decision-making over health service purchasing, fund allocation and health service delivery quality to local levels. Key challenges include coordinating national policies with local implementation and variability in administrative capacity and political will to prioritize health in all local government units, causing disparities in spending, health outcomes and performance *(60)*.

In order to reduce fragmentation, in 2019 the Universal Health Care Act mandated the development of integrated province-wide and city-wide health systems supported by special health funds to pool and manage funds at the provincial and/or city level in order to rationalize the multiple payers, especially for PHC *(61)*.

Further reading: Nuevo et al., 2022. Three decades of devolution in the Philippines: how this has shaped health financing and public financial management reforms *(60)*.

A key consideration for PFM and health financing is that much of the authority for managing the PFM system sits with ministries of finance. Accordingly, reforms that aim for more predictable and credible health budgeting must involve dialogue with the ministry of finance and other government agencies outside of health. Also critical to the effectiveness of PFM in health – and the success of reforms – is that staff within the health system have the requisite capacity and skill to engage with the PFM system and manage and acquit funds.

Lack of timely and quality information and data to guide decision-making on resource allocations and monitor performance

Good-quality reporting on health activities and expenditures is foundational to the effective stewardship of health systems. However, countries in the Region still struggle with tracking timely and good-quality service utilization and expenditure data, especially not at the disaggregated level to allow meaningful policy analysis. Public finance, health financing and health information systems and data are often incompatible, which inhibits the ability to link spending with service delivery and performance. Data can be missing, incomplete or not presented in a way that is fit for purpose. In some places, facilities still engage in paper-based and manual reporting, which slows the transmission of information and introduces considerable scope for error. Critically, in countries where regulation is lacking, collecting useful health services and expenditure information from the private sector has been difficult. In addition to data collection and production challenges, information that is generated is not necessarily effectively used or disseminated.

These data challenges adversely impact funding and prioritization by inhibiting the ability of ministries of health to effectively make the investment case for health during budget negotiations or demonstrate the cost-effectiveness of interventions. They also adversely impact purchasing, as when the evidence base for determining spending allocations, such as claims, is missing or incomplete. Additionally, data

limitations and delays mean that key policy priorities, such as financial protection, an SDG indicator, cannot be effectively monitored.

3.4 Slow progress in moving the Health for All agenda

WHO's vision of Health for All is intended to ensure that everyone has access to the highest possible standard of health and well-being. It explicitly acknowledges that health outcomes are intimately tied to broader sustainable development, as they are affected by social, economic and environmental factors beyond just access to medical care. In fact, these broader social determinants of health – the conditions in which people are born, grow, live, work and age – are estimated to contribute to 40–60% of overall health outcomes globally *(62)*.

Accordingly, Health for All directs attention to the root causes that influence population health and health disparities. Addressing these root causes – such as better urban planning, improving health literacy in schools, and taking measures to mitigate and adapt to climate change – can effectively and efficiently enhance overall health outcomes. Additionally, it can help countries progress towards UHC and ensure more sustainable health financing.

Critically, the Health for All agenda is also about policy and financing. About a decade ago, the *Helsinki Statement on Health in All Policies* called for all governments to consider Health for All a major societal goal and the cornerstone of sustainable development. However, to date, countries in the Region and the world more generally have not given sufficient attention to mitigating the unintended risk factors of economic development on health. As the recent WHO Council on the Economics for Health for All stated in its final report, "economies are yielding poor health outcomes by design" *(15)*.

As evidence of the failure of regional and country-level efforts to sufficiently address the social, economic and environmental determinants of health, progress towards the SDGs remains uneven and inadequate within the Asia Pacific region. Pacific island countries, in particular, stand out as having the slowest progress towards almost all SDGs *(26)*. Considerable backsliding also occurred with the COVID-19 pandemic. Mobilization of sufficient financing remains a major challenge in the implementation of the SDGs *(63)*.

4. EMERGING CHALLENGES FOR HEALTH FINANCING

In addition to the bottlenecks highlighted in Chapter 2, there are a number of more recent and future challenges that are expected to increasingly pose challenges to health financing for UHC in the Region, namely:

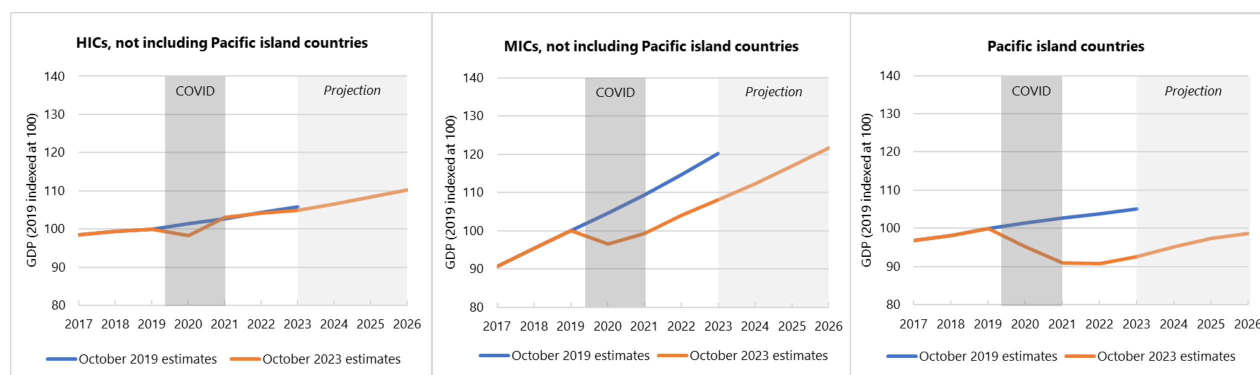
- the worsening fiscal outlook following the COVID-19 pandemic;
- the impact of ageing populations and the growing burden of NCDs; and
- vulnerability to external shocks from health security threats and climate change.

4.1 Fiscal challenges on the horizon

The economic environment has become considerably more challenging

The onset of the COVID-19 pandemic in late 2019 led to a sharp economic contraction across almost all countries in the Western Pacific Region beginning in 2020. The pandemic also brought into stark relief the interdependencies between public health and economic performance *(64)*. In the MICs and Pacific island countries of the Region, the economic scars of the pandemic remain and are considerable; the actual level of per capita income in 2023 was around 10% lower on average than what was expected pre-pandemic (Fig. 19). Moreover, for most countries in the Region, the medium-term growth outlook is expected to be weaker than the five years before the pandemic (Fig. 20). This means that most countries cannot rely on historical growth in incomes and government revenues to further increase public spending on health.

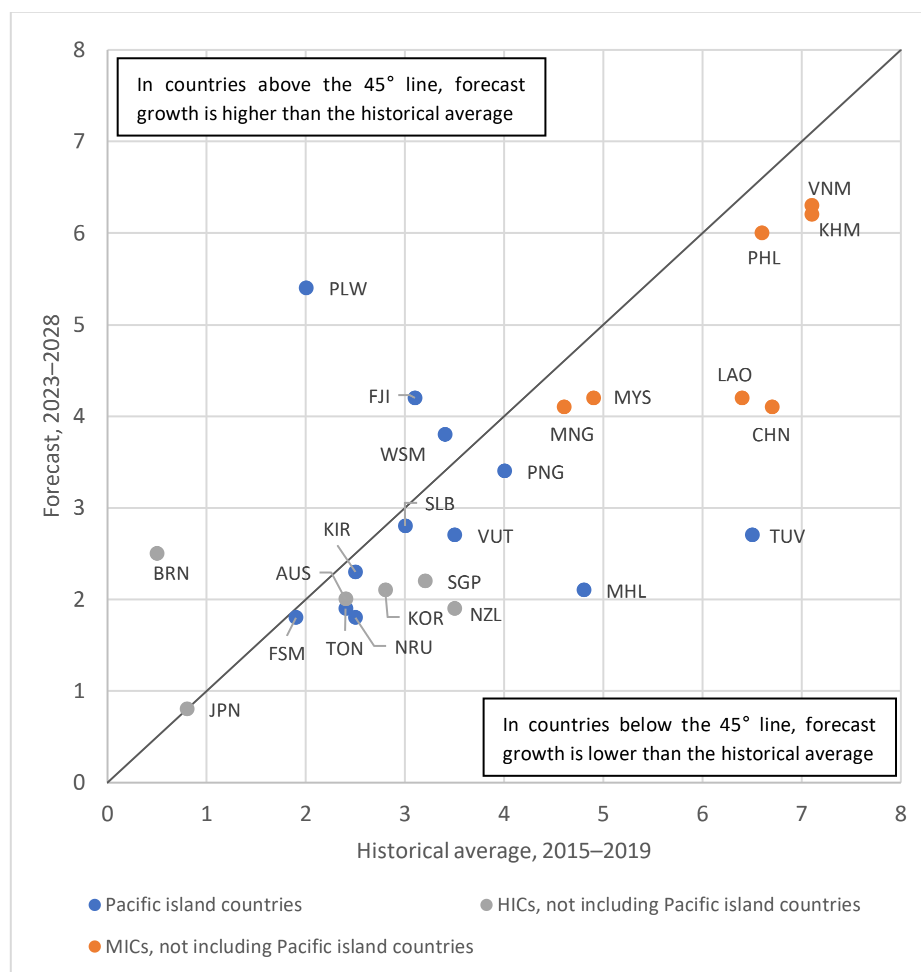
Fig. 19. Comparing economic growth trajectories before and after the pandemic



HICs: high-income countries; IMF: International Monetary Fund; MICs: middle-income countries; PICs: Pacific island countries;.

Sources: IMF World Economic Outlook, October 2019 *(65)* and October 2023 *(66).*

Fig. 20. Annualized GDP growth by country in the Western Pacific Region, before and after the COVID-19 pandemic



HICs: high-income countries; MICs: middle-income countries. (A key to the country abbreviations in this figure can be found in Table 1.)

Source: IMF World Economic Outlook, October 2023 *(66).*

There is considerable pressure on the prioritization of health within budgets

Governments all over the world responded to COVID-19 by increasing government spending on health and providing fiscal stimulus to economies, with much of this additional spending funded by debt. However, in the wake of the pandemic's emergency phase, the impetus – and fiscal capacity – for continued extraordinary government spending on health within government budgets will likely wane. Indeed, there are early indications that real per capita government health spending on health may have peaked in 2021 in many countries *(67)*. Additionally, increased debt servicing obligations, coupled with the need to reduce debt amounts, will likely narrow the budgetary space governments have to spend on health and other social sectors. Heading into the pandemic, debt servicing was already at or above government health spending (Fig. 21), and given the additional debt accumulated during the COVID-19 pandemic the situation is likely to worsen. As of June 2024, at least 12 of the countries in the Region

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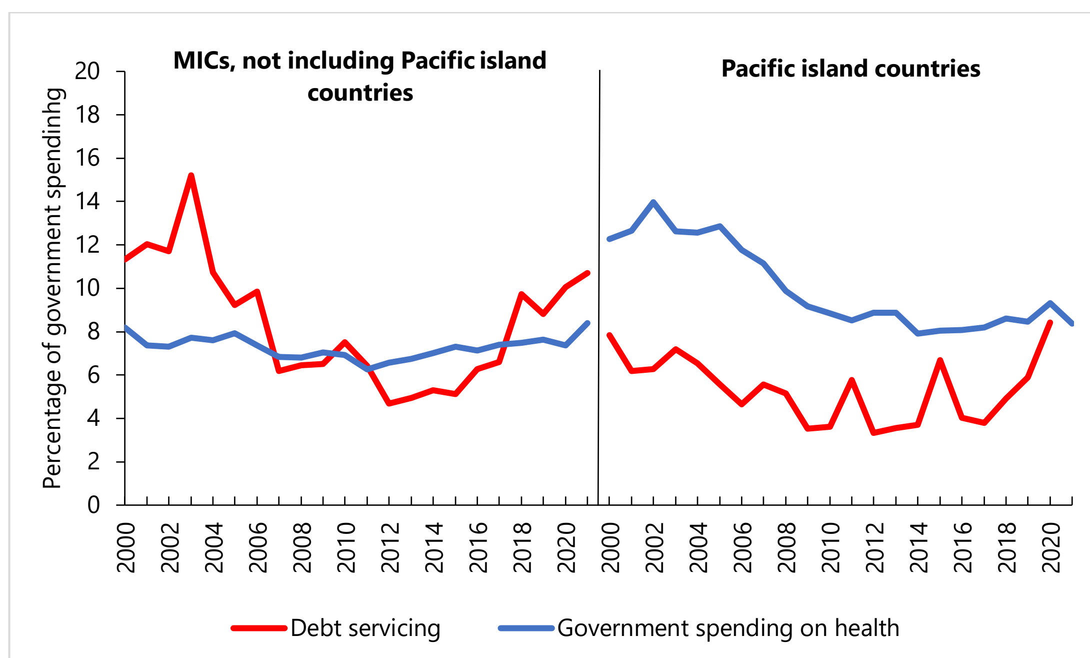
(nine Pacific island countries and one Asian MIC) were at moderate or high risk of debt distress, according to the International Monetary Fund *(68)*.

Against this backdrop, many countries in the Western Pacific Region are likely to face considerable challenges sustaining – and increasing – the priority afforded to health within government budgets. World Bank modelling indicates that some countries – those with pre-existing high levels of debt and weaker growth outlooks – are likely to be more acutely affected *(69)*.

Fig. 21. Government spending on health and debt service costs as a share of general government expenditure



MICs: middle-income countries.

Source: Global Health Expenditure Database *(23)* and World Development Indicators *(25)*.

The inherent challenges of high aid dependence in an uncertain future

High rates of aid dependence in Pacific island countries and several Asian MICs (such as Cambodia and the Lao People's Democratic Republic) heighten the risks that, if donors unwind their commitments in the wake of the pandemic, essential health functions and services may be underfunded unless absorbed by domestic public financing. Additionally, several countries in the Region have already undergone or are in the process of transitioning away from long-term donors, such as the Global Fund and Gavi, the Vaccine Alliance *(22)*. Lessons from these experiences should prove valuable for other countries in the Region (Box 9).

Box 9. Sustaining essential health services in the Lao People's Democratic Republic in the context of donor transition

As incomes in the Region have grown in recent decades, several countries have or are currently undergoing transitions from extensive donor support for their health systems. These transitions can be complex, both financially and programmatically, and it is critical to draw on lessons from country experiences.

The Lao People's Democratic Republic, while still heavily relying on development assistance to finance its health system, is anticipating graduating from its status as a least-developed country in 2026 and donor transitions in the coming years. The Government of the Lao People's Democratic Republic is therefore making efforts to take proactive steps to prepare, including increasing domestic government funding, seeking efficiencies through integrated service delivery models, and steering donors and development assistance towards health system strengthening instead of supporting vertical programmes. There is also a strong push to prioritize PHC as a foundation of the country's UHC efforts.

These experiences highlight the importance of initiating transition planning well in advance, integrating disease programmes into general service delivery and reducing fragmentation of financing arrangements through pooling and strategic allocation of funds, and prioritizing the most cost-effective interventions, particularly PHC, to be absorbed with domestic financing.

Further reading: Kim et al., 2024. Sustaining essential health services in Lao PDR in the context of donor transition and COVID-19 *(70).*

4.2 The financing impacts of ageing populations and NCDs

While it is positive that people are living longer lives, rapidly ageing populations are likely to present new challenges for health financing systems and the advancement towards UHC. Although ageing need not have an adverse impact on per capita GDP growth, this depends on people remaining active and healthy *(20)*. Accordingly, older populations are likely to generate new demands for services that promote healthy ageing, such as long-term care, the management of multi-morbidities, and the integration of health and social care, which may affect the amount and types of health and social spending.

The increased incidence of preventable NCDs, too, is recalibrating population health needs, shifting demands towards models of care that effectively coordinate health care and long-term care. This includes a steadily growing mental health burden over the past three decades, and it is estimated that more than 215 million people in the Region suffer from mental health conditions *(71).* Unless health systems and service delivery architectures adapt to these new demands – through health promotion, prevention, effective and early detection, and treatment, including through strengthening PHC − there can be substantial implications for health-care costs and, in turn, service accessibility and financial protection. Health financing systems need to be reconfigured to adequately address the changing health needs, including by ensuring that NCDs – including mental health conditions – are adequately budgeted for, and included in service packages covered by public schemes. Particular attention needs to be given to financing prevention, screening and early treatment, including incentivizing these through provider payment mechanisms, given that the long-term economic burden of NCDs often significantly outweighs the costs of prevention and early treatment *(72).* Further, containing the burden of NCDs will require interventions outside the health sector that promote healthier lifestyles.

Additionally, rising age-dependency ratios for old age can have significant implications for the sustainability of health revenues, particularly among countries dependent on revenues from contributions to SHI funds linked to the labour markets. The expansion of coverage has made SHI schemes more financially sustainable by ensuring larger and more predictable revenue streams.

However, as an increasing share of the population passes retirement age, the revenue base of insurance schemes dwindles *(73).*

4.3 Health systems are vulnerable to shocks, such as health security threats and climate change

Health risks continue to build, and the threat from future pandemics and other health emergencies never abates. A key lesson from the COVID-19 pandemic is that much of the world was unprepared to effectively manage a severe health emergency, resulting in devastating health and economic effects *(74).* In addition to the considerable rise in mortality and morbidity associated with the pandemic in the Western Pacific Region and around the world, the pandemic emergency response was highly disruptive to health systems, as the acute needs of the pandemic absorbed considerable amounts of available health resources, financial and otherwise, and caused severe disruptions in the provision of and access to routine essential services. Moreover, financial barriers, supply limitations and COVID-19-related restrictions gave rise to considerable forgone care *(2)*. The result is that there were significant reversals in public health outcomes across Asia and the Pacific, including worsening childhood and maternal health and rises in deaths from infectious diseases *(75).*

In addition, the acute vulnerability of the countries in the Region to the effects of climate change also poses significant challenges for health systems. Six of the world's top 10 countries most at risk for disasters due to natural hazards are in the Western Pacific Region, with risks only likely to amplify over time *(76).* In addition to deaths and injuries from increasingly frequent extreme weather events, climate variability threatens to disrupt human health by undermining food systems, increasing and altering the geographic distribution of zoonoses and foodborne, waterborne and vector-borne diseases, and causing mental health issues. While these risks will place additional demands on health services, extreme weather events associated with climate change also threaten to severely disrupt economies and alter the capacity of health systems to deliver good-quality services by destroying and degrading assets and disrupting supply chains.

Further, climate change is undermining many social determinants for good health, such as secure livelihoods, equality, and access to health care and social support structures. These climate-sensitive health risks are disproportionately felt by the most vulnerable and disadvantaged, including women, children, ethnic minorities, poor communities, migrants or displaced persons, older populations and those with pre-existing health conditions *(77).*

Relatedly, climate-induced displacement of populations – particularly, but not limited to, the small islands of the Pacific (Box 10) – and other humanitarian emergencies will also further threaten progress towards UHC by increasing demands for health care and posing challenges to identification and coverage of unregistered or undocumented populations.

Box 10. The vulnerability of the Pacific to climate-related threats

Pacific islands face unique vulnerabilities to climate change due to their small size, geographic isolation and exposure to climate-related risks. Rising sea levels threaten to submerge low-lying areas and contaminate fresh-water sources, while extreme weather events such as cyclones and tsunamis pose significant risks to infrastructure, disrupting essential services, including health-care facilities. Further, limited land availability restricts options for relocating or expanding health infrastructure, which compounds the challenges of

providing adequate health care to island populations. Additionally, livelihoods in the Pacific often rely on one or a few sectors, such as fisheries, agriculture and tourism, many of which are heavily dependent on natural resources that can be disrupted by climate change. Developing states are particularly vulnerable as they have limited resources and capacity to respond to health emergencies, further compromising their resilience to climate-related health threats. A WHO Special Initiative on Climate Change and Health in Small Island Developing States was launched in 2017, with the vision that all such states should be resilient to climate change by 2030. This will require significantly increased investment in climate change adaptation of health systems, through a combination of domestic efforts and international climate financing initiatives. An extensive list of international and bilateral funding opportunities has been provided by the Special Initiative on Climate Change and Health in Small Island Developing States *(78)*.

Further reading: WHO Regional Office for the Western Pacific, 2018. Climate change and health in Small Island Developing States: a WHO special initiative, Pacific island countries and areas *(78)*.

5. AN ACTION FRAMEWORK FOR FINANCING UHC AND SUSTAINABLE DEVELOPMENT

The ongoing and emerging health system challenges identified in Chapters 3 and 4 are a call to improve the performance of health financing to advance towards UHC. However, given the Western Pacific Region's considerable diversity, there is no one-size-fits-all approach. Accordingly, this Regional Action Framework aims to strike a balance by offering strategic actions that are practical to spark meaningful change while being sufficiently broad to be relevant for the whole Region. Accordingly, it is prescriptive in terms of principles and the direction in which health financing systems should move to make progress towards UHC, but recognizes that the strategies for each individual country should be homegrown and tailor-made for the country's needs and priorities.

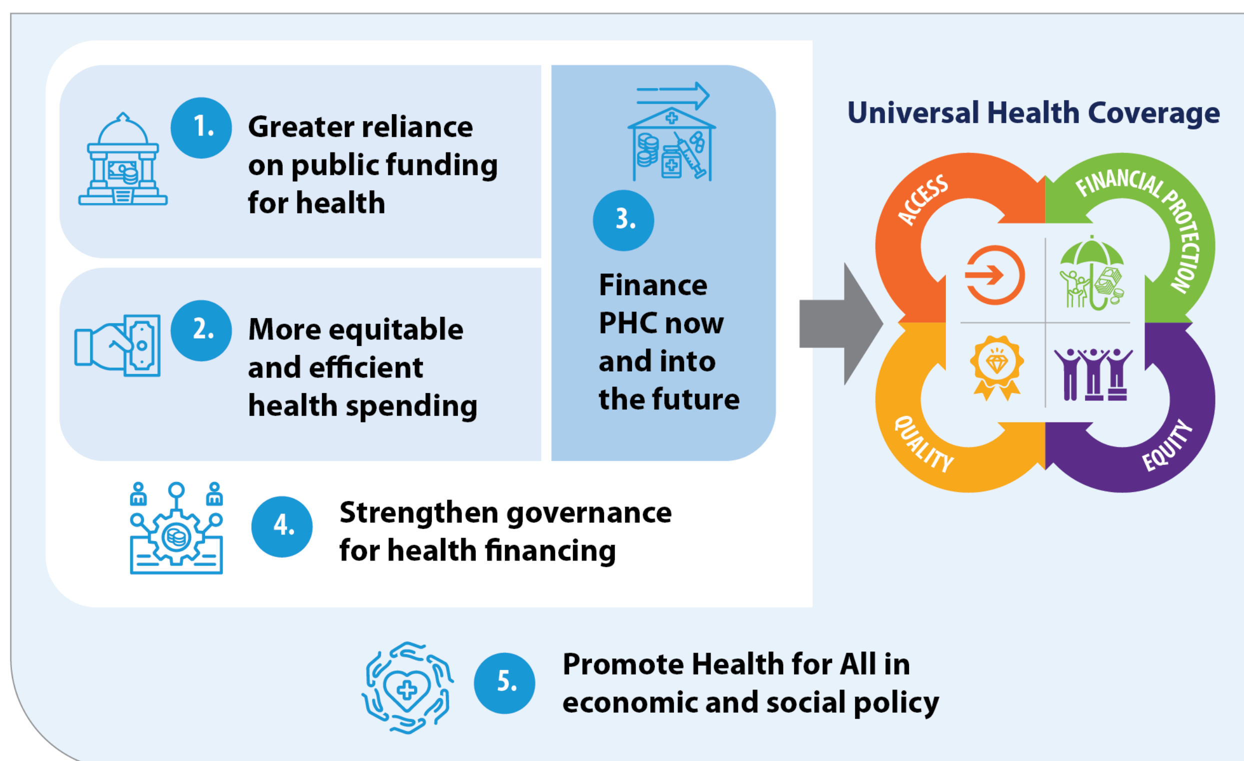
This Regional Action Framework proposes five strategic action domains:

1. **Greater reliance on public funding for health**
2. **More equitable and efficient health spending**
3. **Finance PHC now and into the future**
4. **Strengthen governance for health financing**
5. **Promote Health for All in economic and social policy**

Fig. 22 provides an illustration of these action domains and how they relate to one another and to the attainment of UHC objectives. The first and second action domains – greater reliance on public funding for health and making spending more equitable and efficient, respectively – relate mainly to the core health financing functions of WHO's conceptual health financing framework − that is, revenue raising, pooling and purchasing (see Fig. 2 in Chapter 1). Accordingly, most strategic actions proposed under these action domains are not new but rather reiterate well-established global best practices and recommendations pertinent to the Western Pacific Region based on best international evidence and practices. It is also critical that these two action domains are considered together, as advocating for more funding is predicated on existing funds being spent well.

Action Domain 3 focuses on the financing arrangements that are necessary for reorienting health systems towards PHC. Wrapped around the first three action domains is the governance of health financing (Action Domain 4), as progress in achieving UHC goals depends on having strong systems and processes in place that facilitate good decision-making and promote transparency and accountability. Action Domain 5 extends the focus of financing actions beyond the health sector and considers the broader socioeconomic influences that impact access to good-quality health services and financial protections and the opportunities for better alignment of health and the SDGs.

Fig. 22. Action domains in the Regional Action Framework for Health Financing



PHC: primary health care

The following subsections delve deeper into each of these five action domains by outlining specific strategic actions that Member States may consider.

5.1 Action Domain 1. Greater reliance on public funding for health

Strategic actions

- **Increase the level of per capita spending on health from public sources.**
- **Steer private sources of funding towards playing a supplementary and complementary role in financing health for UHC.**
- **Improve the effectiveness and predictability of development assistance.**

Public funding of the health sector, particularly from government budgets, is crucial for advancing towards UHC, and many countries in the Region need to increase their levels of public spending on health. This can be achieved through the growth of the overall economy, by increasing government revenue as a share of the economy − that is, via tax policy decisions and strengthening of collection capacity − or by increasing the prioritization of health within government budgets. Given the different starting points in terms of these three variables, each country needs to devise its own strategy for increasing public spending on health. Further, as these decisions are generally not taken within the health sector, evidence-based advocacy with key stakeholders, such as the ministry of finance, is

essential. Costed plans could, for instance, be compared to current funding allocations to assist in identifying gaps or opportunities to improve allocative efficiency or impact and ensure adequate funding for health. In decentralized settings, the resource envelope also depends on effective engagement between levels of government and measures that promote coordination and transparency. When increasing public financing, this should be done in a sustainable way that can be maintained in the context of ageing populations and that does not jeopardize long-term fiscal sustainability.

Private sources of funding should not impede progress towards UHC. OOPS on health increases the risks of financial hardship and should be limited. VHI can serve a complementary role to public financing schemes and should not undermine the objectives of these.

The unique situation of many Pacific island countries and some lower-middle-income countries means that development assistance will remain an important source of financing for the foreseeable future. Critically though, as donor financing transitions begin to take place, these transitions should not result in inadequate domestic financing levels for essential health functions and services.

Member States – and where relevant, development partners – may consider the following strategic actions:

Increase the level of per capita spending on health from public sources.

- Develop clear, costed and realistic plans with medium-term estimates of both capital and recurrent resources required to fund core services and public health functions according to regularly updated national health plans.
- Use these plans and develop evidence on the health, social and economic returns of health spending to negotiate and defend health budgets in interactions with the ministry of finance and legislators.
- In decentralized settings, use legislative and/or policy tools to ensure adequate funding for health at the subnational level.
- In countries with established contributory SHI schemes, make progressive efforts to cover poor and vulnerable groups through ongoing government budget transfers.
- Countries should investigate mechanisms that offset declines in revenue to SHI schemes from ageing, either from within the SHI system or from government budgets.

Steer private sources of funding towards playing a supplementary and complementary role in financing health for UHC.

- Minimize OOPS on health services to ensure access and financial protection, particularly for poor populations.
- Regulate VHI markets to ensure they do not undermine the expansion and effectiveness of public financing schemes.

- Align private capital investment in health, including public–private partnerships, with national health plans and public health priorities.

Improve the effectiveness and predictability of development assistance.

- Align development assistance with national priorities through close collaboration and joint medium-term planning between recipient countries and development partners.
- Avoid situations where increases in external funding are offset by lower prioritization in domestic budget allocations.
- Transitions from external assistance should be well planned, informed by robust evaluations and implemented with a phased approach that considers countries' readiness and capacity, to ensure sustained financing and operational arrangements for essential services and public health functions (Box 11).

Box 11. Preparing for a sustainable transition from external to domestic public financing

Several countries in the Western Pacific Region are facing, or will face, a reduction in external funding for their health systems. While this poses serious sustainability challenges, there are critical steps that countries can take to mitigate the negative effects of such reductions and to use the transition as entry points to processes to strengthen health system efficiency and advance UHC objectives.

The WHO *Regional Framework for Action on Transitioning to Integrated Financing of Priority Public Health Services in the Western Pacific* recommends four priority actions to secure essential public health functions during transition processes, namely: (1) confirm core programme elements and service delivery arrangements; (2) strengthen institutions to manage finances more effectively and make better use of available resources; (3) increase domestic financing where needed; and (4) govern the transition process *(22)*.

Additionally, it is critical to consider sustainability from the onset when designing development assistance programmes. This includes, where feasible, using government systems and ensuring that both domestic and external funding are aligned to the country-led unified plans, budgets, and monitoring and evaluation frameworks *(79)*.

Further reading:

WHO, 2017. Regional framework for action on transitioning to integrated financing of priority public health services in the Western Pacific *(22)*.

The Lusaka Agenda: Conclusions of the future of global health initiatives process *(79)*.

5.2 Action Domain 2. More equitable and efficient health spending

Strategic actions

- **Reduce the fragmentation of available health resources to improve equity and efficiency.**
- **Allocate resources to, or purchase services from, health-care providers in ways that incentivize greater equity, quality and efficiency.**
- **Design service packages to promote access and financial protection.**
- **Improve efficiency in procurement, logistics and asset management.**

Just as important as the level of public spending for UHC is how that money is spent, who benefits from it and the systematic constraints faced by countries. These considerations have a critical influence on the equity and efficiency of health spending.

Larger and less fragmented funding pools increase the equity and efficiency of health spending by increasing redistributive capacity across different population groups, simplifying funding flows, and increasing the bargaining power to influence the price and quality of services. This is the case for government budgets, which can be fragmented between different inputs, providers, activities, central and subnational levels, and government and donors, as well as SHI schemes that can be fragmented by beneficiary groups.

Additionally, there is potential to achieve greater value for money in service delivery. There is growing consensus that resource allocations to providers should target equity, efficiency and quality goals. This involves more strategic approaches to the way that purchasing decisions are made; it also means that supply-side budget allocations should have a focus on results or performance and not be purely based on rigid inputs, which limit provider flexibility and autonomy.

Improved managerial practices, particularly in procurement, logistics and asset management, can also improve health spending by minimizing waste and containing the cost of inputs.

Member States may consider the following strategic actions:

Reduce the fragmentation of available health resources to improve equity and efficiency.

- Consolidate fragmented public funding pools to maximize risk redistribution, strengthen the capacity to influence price and quality of services through purchasing, create economies of scale and simplify funding flows (Box 12).

- Where multiple public funding pools remain, align benefit packages, purchasing arrangements and payment methods and rates, and use common administrative and information systems.

Box 12. Merging and harmonizing pools for efficiency and equity

Several countries have merged or harmonized public health financing pools to strengthen the equity and efficiency of health financing. China centralized the management of its three major SHI systems under the National Healthcare Security Administration in 2018 *(33)*. Mongolia amended its health legislation in 2021 to unify the management of government-funded services and SHI-funded services, making the Health Insurance General Office the purchaser on behalf of both funding sources and unifying packages, flows of funds and payment methods *(80)*. Viet Nam, in its Health Insurance Law of 2008, consolidated several existing health insurance funds into a single Viet Nam Social Security scheme, which aims to cover the entire population *(81)*.

Allocate resources to, or purchase services from, health-care providers in ways that promote greater equity, quality and efficiency.

- Budget allocations to providers should be made taking into account population needs and not merely be based on previous years' budgets.
- Move towards strategic provider payment mechanisms that reward improved equity, quality and efficiency and avoid open-ended fee-for-services and rigid input-based budgets.
- In places where input-based budgets remain dominant, consider reforms that increase provider autonomy and flexibility, and begin to incorporate a performance focus into budget allocations.
- Where providers receive funding from multiple sources, ensure that incentives are coherent and aligned to UHC objectives.

Design service packages to promote access and financial protection.

- Use evidence- and value-informed processes and systems – such as health technology assessment[9] and/or other policy measures – to facilitate decision-making on what services and goods, including pharmaceuticals, should be covered by public funds and how. This may be applied to decision-making when it comes to developing the national essential service package, and promoting generic drug substitutional policies, etc. Such service packages should be reviewed and updated periodically.
- Improve the design of co-payment policies to minimize financial hardship in accessing essential health services − for example, defining low fixed user charges rather than uncapped co-payments where possible.
- Target vulnerable population groups, including women and children, through the public budget or SHI to ensure accessibility and affordability of essential health services. For example, in certain circumstances, there may be merit in exempting OOPS on essential health services and goods (Box 13) and subsidizing the indirect costs of care − for example, transport costs.

[9] A health technology assessment is a systematic and multidisciplinary evaluation of the properties, including cost-effectiveness, of health technologies and interventions, covering both their direct and indirect consequences.

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Box 13. Targeting vulnerable groups for equitable access to health care in Cambodia, Fiji and Malaysia

Cambodia has over the past two decades developed a Health Equity Fund to reduce financial hardship and remove financial barriers to accessing health care among poor populations. The Health Equity Fund covers the poorest segments of the population and finances a range of inpatient and outpatient health services, user fee exemptions and transport related to seeking care. The implementation of the Health Equity Fund has led to a reduction in catastrophic health expenditures and has improved access to health care for its poor population, narrowing the utilization gap between poor and rich households *(82)*.

Initially introduced in 2015 as a mechanism to ensure equity in terms of accessibility and availability of key medicines, Fiji's Free Medicine Scheme involves providing certain price-controlled essential medicines – including for NCDs – for free to identified poor households in participating private pharmacies. Over time, the scheme has grown from an initial list of 72 medicines in 2015 to 140 listed medicines in 2022. Reforms have also meant private pharmacies can provide medicines from their inventory and redeem monetary reimbursements from the Ministry of Health & Medical Services *(83)*.

The Health Care Scheme (*Skim Peduli Kesihatan*) for the B40 Group, which represents the 40% of households with the lowest income, is an initiative of the Malaysian Government introduced in 2019. This scheme aims to ensure individuals and their spouses aged 40 and above, in the bottom two income quintiles or the B40 Group, have access to good-quality medical services without facing financial strain. The programme particularly focuses on early detection of NCDs. Eligible beneficiaries are offered four types of benefits encompassing free health screenings at private or Ministry of Health clinics, provision of health aid assistance in the form of purchased medical equipment, incentive to complete cancer treatments, and transportation incentives to Ministry of Health hospitals when seeking treatment. By targeting early detection of NCDs, as well as strengthening prevention and health promotion, the programme moves to reduce the burden of chronic illnesses and improve overall health outcomes *(84)*.

Improve efficiency in procurement, logistics and asset management.

- Promote efficient procurement of essential medicines and medical supplies through benchmarking of prices within and between countries, bulk purchasing, open tendering and negotiations with suppliers.

- Where appropriate, centralize procurement functions or consider national pharmaceutical price negotiations based on pooled volumes that can be used at subnational levels (Box 14). Small countries may consider cross-country pooled procurement mechanisms for essential medicines and medical supplies.

- Systematically explore opportunities for efficiencies in logistics and asset management, including the use of new technologies, to reduce waste.

Box 14. Centralized procurement increasing affordability and accessibility of medicines in China

The prices of medicines achieved through government procurement processes directly impact UHC performance both in terms of access to essential medicines and the financial burden imposed on patients where co-payments are applied.

Since 2018, China has increasingly pooled the procurement of medicine at a national level through national volume-based procurement. Under this approach, the payment for medicines remains at the health facility level, but procurement is conducted at the national level, based on the estimated volumes needed for the entire country. This way, the purchasing power of the Government is maximized, whereas pharmaceutical suppliers benefit from greater predictability of orders and lower transaction costs.

The national volume-based procurement initiative resulted in a 53% average price reduction for 294 drugs between 2018 and 2022. It has also had the additional benefits of improving transparency and accountability, facilitating fair competition among suppliers and increasing the share of quality-assured drugs used from 50% to 90% of the total.

Further reading*:* Zhu et al., 2023. Improving access to medicines and beyond: the national volume-based procurement policy in China *(85)*.

5.3 Action Domain 3. Finance PHC now and into the future

Strategic actions

- **Prioritize individual and population-based PHC services within health budgets.**
- **Realign financing arrangements to incentivize the reorientation of service delivery towards integrated, people-centred PHC.**
- **Direct PHC funding towards the interventions that best address current and emerging needs.**

PHC will be essential for addressing the Region's current and emerging health challenges, such as population ageing and NCDs, and strengthening the health system's resilience in the face of climate change and health security risks. A strong PHC orientation is also crucial to an equitable and efficient health system. To that end, in the context of promoting adequate and sustainable funding for health, priority should be given to funding PHC. Once again, key stakeholder engagement and coordination are crucial, in particular coordination between levels of government, given that in many places, spending responsibility for first-contact personal PHC services has devolved to the subnational level.

Further, good-quality PHC services should be provided efficiently and equitably, by using the right mix of inputs in the correct settings and at an appropriate cost. For instance, the current hospital-centric models for treating NCDs suggest that considerable savings may be possible by the greater use of PHC. In remote and sparsely populated areas, such as the archipelagos of the Pacific, facilitating the integration of telehealth PHC consultations into payment schedules is an avenue to improve service access and reduce costs.

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Government budgets have a key role to play in funding important preventive and promotive activities and targeting vulnerable populations. These include surveillance functions, which are public goods, and activities to encourage healthier populations, which can reduce future disease burdens.

Member States may consider the following strategic actions:

Prioritize individual and population-based PHC services within health budgets.

- Clearly define the responsibilities of the central government, subnational governments and, where applicable, SHI agencies, in raising and allocating funds for PHC.
- Consider, where required, adjusting budget structures and financial systems to allow for better identification of spending on PHC.
- Redirect public funding from non-PHC services to PHC services where possible and align donor funding to national PHC priorities.
- Prioritize PHC when additional public resources or donor funding become available (Box 15).

Box 15. Mongolia's experience in increasing funding at the primary care level

Since 2020, Mongolia has intensified efforts to build a strong PHC system through increased funding, creating systems to support a single purchaser, and revised payment mechanisms to facilitate a curative cascade down to the primary level. During this period, the COVID-19 response impacted the health system significantly, including via a marked increase in financial allocations to the sector both from government and external sources. Funding was repurposed from financial allocations to secondary and tertiary levels of care, and the influx of COVID-19 funding also supported investments in the PHC system. As a result, the capitation rate was doubled twice. Age and sex adjustors for the capitation rate were reviewed, and a geographic adjustor was added to ensure that PHC centres with the most need receive greater funding. Further, performance-based financing was implemented along with the increase in funds, with a portion withheld until primary-care facilities meet quality indicators outlined in their service contracts. With the Health Insurance General Agency as the single purchaser that manages most of the financing for primary-care facilities, there is significant potential to improve PHC service provision, access and quality.

As these policy changes are still in the early stages of implementation, and their full impacts on the health, financial and equity outcomes may take time to bear fruit, continued monitoring and evaluation will be critical.

Further reading: WHO Regional Office for the Western Pacific, 2022. Monitoring financial protection and utilization of health services in Mongolia: 2009−2018 *(86).*

Realign financing arrangements to incentivize the reorientation of service delivery towards integrated, people-centred PHC

- Identify and analyse/review the existing level and mix of investments in infrastructure, health workers, medicines and medical supplies, and identify adjustments needed to optimize the use of resources in PHC provision.

- Use provider payment mechanisms to incentivize the use and delivery of PHC services at the appropriate level with the right mix of health workers and at the right cost. A blended payment model with risk-adjusted capitation at its core is generally advisable (Box 16).

Box 16. Getting incentives right in provider payment mechanisms for PHC

The Lancet Commission on Financing Primary Health Care argues that, while payment mechanisms for PHC providers are context-specific, population-based mechanisms − such as capitation − should be the cornerstone of financing people-centred PHC. Capitation is a prospective payment, where providers are allocated a lump sum payment upfront, to cover the costs of delivering a defined set of PHC services to each enrolled individual for a specified time period. This type of payment delinks funding from service utilization and incentivizes providers to attract more patients and contain costs per patient − for example, by keeping patients healthy through prevention and health promotion.

However, like any payment mechanism, capitation has some drawbacks: it can incentivize providers to contain costs by under-providing services (or unnecessarily referring patients) and by avoiding high-risk patients. These may need to be counterbalanced by complementary payment mechanisms and risk adjustments through blended payment models. For example, certain high-priority services may still be purchased using fee-for-service or performance-based payments, and unavoidable fixed costs may be paid through a fixed budget transfer.

Blended payment models should seek to maximize the desired incentives and minimize the perverse incentives of each payment method, while also ensuring other service delivery objectives, such as access and financial protection, are met.

Further reading: Hanson et al., 2022. The Lancet Global Health Commission on financing primary health care: putting people at the centre *(46)*.

- Adjust financing arrangements for funding hospitals to gradually move away from hospital-centric models of care and ensure coherent financing incentives are created across different levels of providers. For example, using financial instruments and other policy measures to promote two-way referrals between primary-care facilities and hospitals, and leverage telehealth to increase accessibility of services for integrated service delivery (Box 17).

- Where applicable, harness the private providers into national service delivery systems to deliver good-quality PHC services through appropriate payment arrangements and contracting.

Box 17. Integrated PHC provider networks

Several examples have emerged in the Western Pacific Region where countries seek to move away from PHC provision centred around individual health professionals or providers towards delivering care through integrated provider networks. For example, Cambodia improved linkage to antiretroviral therapy for HIV-positive pregnant women by introducing a linked-response approach with strong referral linkages between district hospital hubs, health centres and satellite sites *(87).* China is rolling out medical alliances as a basis for an integrated hierarchical system whereby hospitals and PHC institutions work closely to provide prevention, treatment and rehabilitation services *(88).* The Philippine Health Insurance Corporation has partnered with

local government units and private sector groups in the country to establish primary care provider networks *(89)*. In Australia, telehealth technology is leveraged so that patients can see multiple health-care providers at one virtual appointment *(90)*. In many cases, the move towards integrated multi-provider networks requires adaptation of provider payment mechanisms, such as global payment at a network level instead of individual payment arrangements with each provider *(17)*.

Further reading: WHO Regional Office for the Western Pacific, 2023. Regional framework on the future of primary health care in the Western Pacific *(17)*.

Direct PHC funding towards the interventions that best address current and emerging needs

- Provide adequate, and sustained funding for essential public health functions, including preventive and promotive activities, disease surveillance and health emergency response and preparedness mechanisms. It is recommended that such funding comes from general government budgets, especially in instances where SHI does not cover the entire population.

- Identify and fund the most cost-effective interventions to prevent, detect and treat NCDs, and promote healthy ageing based on national priorities and international best practices.

- Remove or lower co-payments, and/or provide subsidies where appropriate, for preventive and promotive activities to incentivize participation and adherence.

5.4 Action Domain 4. Strengthen governance for health financing

Strategic actions

- **Strengthen governance functions and institutional capacities to promote more transparent, accountable and inclusive health financing policy.**
- **Improve PFM of health financing.**
- **Generate better-quality and more timely data to inform health financing policy development and implementation, make the case for public spending on health, and monitor performance.**

Countries need to determine the best governance structure based on their political context, needs and priorities. However, in principle, governance systems should help align health financing with the needs of the population, taking into account the voices of communities and the private sectors, and hold the ministry of health and other managers accountable for their use of public funds. Accordingly, the political acceptability of health financing policies and decisions is a crucial enabler of reform and can be as important in shaping health financing decisions as technical considerations. Moreover, effective governance models require that stakeholders involved in health financing possess the necessary capacity to carry out their essential roles.

Robust PFM is a critical governance function as it ensures transparency, accountability and efficiency in allocating and using public funds. Government spending on health is optimized and underspending

is minimized when PFM systems work effectively to ensure that plans are realistic and credible, that funding is channelled to where it is needed in a timely way and that spending is well tracked. As the ministry of finance is primarily responsible for PFM in most countries, dialogue between health and finance ministries and auditing authorities will be vital to ensuring that bottlenecks can be overcome.

Underpinning the governance of health financing is good-quality information. Whether arguing for greater prioritization of public spending on health, developing policy, or implementing initiatives such as strategic purchasing and effective referral systems, there should be a clear link between evidence generation, monitoring and evaluation, and decision-making. To make this a reality, information systems must routinely generate relevant, reliable and timely data that are stored digitally and used by decision-makers. Monitoring activities, outputs and results is best facilitated when public finance/health financing information systems and data are compatible. Comprehensive monitoring and interpretation of both the service coverage and financial protection dimensions are critical to inform policy development for the UHC agenda.

Member States may consider the following strategic actions:

Strengthen governance functions and institutional capacities to promote more transparent, accountable and inclusive health financing policy.

- Set clear and coherent legal frameworks, regulations and institutional arrangements to enable effective implementation of health financing policies. For example, clear roles, responsibilities and mandates could be established at the national and subnational levels to effectively regulate both public and private health-care providers to ensure that they act in the best interest of the population they serve rather than their own institutional objectives. WHO has published an analytical framework for governance of strategic purchasing, which identifies governance requirements at the purchasing agency level (Box 18).

Box 18. Governance arrangements for effective strategic purchasing

Moving towards strategic purchasing is dependent on robust governance arrangements across the health system, particularly with regard to the purchasing agency. WHO has published an analytical framework to help countries review whether existing governance arrangements are conducive for strategic purchasing, identify gaps and take action to overcome those gaps. It identifies nine governance requirements for effective strategic purchasing:

1. Clear and consistent decision-making rules related to purchasing for the ministry of health, the oversight body and the purchaser.

2. Public interest mandate and clear objectives to give the purchaser strategic direction and to act strategically.

3. Sufficient autonomy and authority for the purchaser to act strategically to meet objectives, commensurate with capacity.

4. Effective oversight.

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5. Inclusive and meaningful stakeholder participation.

6. Coherent multiple accountability lines supporting transparency.

7. Firm and credible budget constraint.

8. Selection of head of purchasing agency based on appropriate skills and performance incentives to guide operations.

9. Compliance rules relating to the management and control of funds by the purchaser.

Further reading: WHO, 2019. Governance for strategic purchasing: an analytical framework to guide a country assessment *(91).*

- Where appropriate, establish governance structures for health-care providers − for example, governing boards and committees. These structures should be equipped with the necessary resources and authority to provide accountable and transparent strategic direction that aligns with health system objectives.

- Establish mechanisms for effective stakeholder and community engagement to identify and consider the positions of key stakeholders, create consensus on health financing strategies among communities and facilitate political buy-in. This could include, for instance, community engagement in participatory budgeting and representation in governance structures of purchasing agencies and providers.

- Improve effective governance of development assistance by bringing development assistance "on-system", that is, integrating into government planning, budgeting and monitoring systems development assistance in aid-dependent countries for greater country ownership, accountability and sustainability.

- Strengthen the capacity of essential actors across the spectrum of health financing − for example, parliamentarians, policy-makers, managers of SHI schemes/budget agencies, local authorities, service providers, etc., through training and other learning opportunities, to fulfil their functions in the health financing system.

Improve public financial management of health financing.

- Strengthen communication and coordination between ministries and health and finance and, where required, auditing authorities, on PFM bottleneck analysis in areas of joint responsibility in order to identify and address challenges in budget formulation (Box 19), budget execution, budget monitoring and reporting that affect health service delivery.

Box 19. Improving budget formulation and management for health

Many countries in the Western Pacific Region still rely on input-based line-item budgeting in the public sector, including for their health systems. This often causes fragmentation of funds, lack of flexibility for managers to optimize the use of available budgets, and difficulties linking budget allocations to government priorities and programmes. Increasingly, countries across the world are opting to reform their budgeting systems to create stronger links between budgets and outputs or objectives, as well as to enhance flexibility to manage budgets, while maintaining clear accountability for results. One approach to doing this is programme-based budgeting, whereby budgets are formulated and managed based on a pre-defined structure of budget programmes. At the budget formulation stage, this programme structure can help clarify and strengthen the logical framework connecting allocative budget decisions to health sector objectives. At the budget implementation stage, programme budgeting can clarify the responsibilities of budget managers and give them greater flexibility to manage and adjust allocations within their respective programmes. Finally at the budget evaluation stage, programme budgeting helps to hold budget managers accountable for results, by linking performance indicators to each programme.

Further reading:

Barroy et al., 2022. How to make budgets work for health? A practical guide to designing, implementing and monitoring programme budgets in health *(92).*

Barroy et al., 2018. Budget matters for universal health coverage: key formulation and classification issues *(93).*

- Ensure that intergovernmental fiscal frameworks in decentralized settings equip subnational levels with the requisite resources, authority and autonomy to fulfil their respective mandates.

- Within health budgets, ensure that allocations are not overly fragmented between different inputs, providers, activities, central and subnational levels, and government and donors.

- Ensure that PFM systems enable flexible and responsive spending, including during pandemics and health emergency situations, while retaining mechanisms for transparency and accountability.

Generate better-quality and more timely data to inform health financing policy development and implementation, help build the case for increasing public funding for health, and monitor performance.

- Improve the timeliness and accuracy of information flows in health systems to enable strategic purchasing, improved performance management, more responsive budgeting and effective referral systems. This may include investing in patient-based, interoperable digital health information systems that can follow the movement of patients across facilities and schemes, both public and private, to enable a patient-centred continuum of care.

- Ensure that health and financial information systems can generate data and evidence that allow policy-makers and managers to analyse the links between expenditure and service delivery results.

- Institutionalize the regular production and use of key health spending information, including national health accounts, data on financial protection (SDG 3.8.3) and foregone care.

- Provide decision-makers and the public with easy-to-understand data and develop appropriate mechanisms to support civil society and other relevant groups in participating in health financing policy and disseminating such information.

5.5 Action Domain 5. Promote Health for All in economic and social policy

Strategic actions

- **Adopt a whole-of-government approach to financing health and well-being for all.**
- **Use financial instruments to address social and commercial determinants of health.**
- **Invest in climate resilience and mitigation in the health sector.**

Health systems are not isolated entities; they are intricately woven into the fabric of our economic, environmental and social spheres, and they are closely linked to broader sustainable development paths. Strong and well-functioning health systems are an investment in economic productivity and social development, while societal and environmental factors influence the health of individuals and populations and, in turn, the demands on health systems.

Recognizing this interconnectedness, there is significant potential to produce win–win solutions that support the health sector's UHC goals and provide co-benefits for other sectors. To make this a reality, health policy-makers must think beyond the health system and look for ways to integrate the concept of financing Health for All into the broader economic and developmental agendas. The One Health approach *(94),* which dismantles sectoral silos to collectively address complex health and environmental challenges, is one such model.

Health ministries should clearly signal how the downstream demands on health systems created by broader social and environmental challenges have implications for UHC in terms of both access to services and financial protection. Measures to tackle the challenges may occur within the health sector or may occur outside the health sector but have longer-term co-benefits *(95).* Examples include the potential co-benefits between health and education and the links between sustainable, inclusive and resilient cities and population health. Given the intersectoral nature of these considerations, it is critical that ministries of health work closely with other ministries and, where relevant, international agencies.

Financial instruments, such as health taxes and subsidies, can also be important public health measures to address risk factors and have the co-benefit of generating revenue for governments. Countries considering earmarking health tax revenue for the health sector are recommended to evaluate the pros and cons of doing so. In some cases, a "soft" earmarking approach may be an option as it gives visibility to the use of the health tax revenue without the rigidities of hard earmarking *(96,97).*

Member States may consider the following strategic actions:

Adopt a whole-of-government approach to financing health and well-being for all.

- Collaborate with other ministries and with subnational levels to demonstrate the co-benefits of health, socioeconomic development and environmental sustainability to advance the UHC and Health for All agendas. Box 20 provides examples of investments and interventions that can be co-beneficial for health and other sectors.

Box 20. Examples of policies, interventions and investments that can mutually benefit the objectives of health and other sectors

- Promoting good health in schools − for example, through nutrition and health promotion − can have a positive impact on both health and educational outcomes.
- Adopting a health lens in urban planning to promote physical activity, reduce congestion and pollution, limit noise levels and reduce traffic injuries can improve health and social well-being and generate economic gains.
- Taking into account the broader societal and environmental objectives when deciding on the design, location, employment conditions and operations of new health facilities can have a positive impact on community well-being.
- Investments in ensuring that people have access to safe drinking-water and improved sanitation facilities yield considerable health benefits.
- Improving the health status of children and adults reduces absenteeism from schools and work, thereby strengthening educational outcomes and labour productivity
- Social prescribing − that is, linking primary care patients to social and community services − can improve health, well-being and social connections.
- Improving financial protection within the health system reduces the risk of poverty and thereby many poverty-related problems.
- The health sector can take climate action, both through advocacy and by limiting its own climate footprint, thereby mitigating broader climate-related risks.

Further reading: Greer et al., 2024. Health for All Policies – The co-benefits of intersectoral action *(98).*

- Consider using cross-sectoral financing approaches (Box 21) to address social and economic determinants that result in health inequities, including gender inequalities, and that disproportionately affect hard-to-reach populations or those in vulnerable and marginalized situations.

- Explore processes to ensure that the health implications of major government investments and policies are assessed before these are approved and implemented. Such processes should also consider the linkages between human health and the health of animals, plants and the environment − for example, using the One Health approach *(94)*.

Box 21. Whole-of-government budgeting for health and wellness in New Zealand, Mongolia and the Philippines

Introduced in 2019 by the New Zealand Government, the Well-being Budget represents a new approach to government budgets by putting health and well-being at the heart of the budget process. Based on the recognition that people's quality of life cannot be determined by traditional economic measures alone, a Living Standards Framework was developed to incorporate measures of mental health, poverty reduction and environmental sustainability in the budget, alongside conventional economic and fiscal indicators. This well-being approach has contributed to increased investment in mental health support, initiatives to tackle child poverty and measures to address climate change *(99).*

Meanwhile, Mongolia has, with support from United Nations agencies and other partners, embarked on a process of SDG budgeting. By integrating SDG priorities into budgetary processes, Mongolia aims to address key development challenges, such as poverty, inequality and environmental sustainability, while promoting economic growth and social inclusion. The process involves allocating funds towards programmes and initiatives that directly contribute to achieving SDG targets. The approach has been piloted at the Ministry of Finance and Ministry of Health and, based on these pilots, Mongolia aims to develop and institutionalize SDG-informed budget guidelines as part of its budget formulation process *(100).*

The Philippines has adopted a similar approach, called the Program Convergence Budgeting strategy, which seeks to improve coordination of budgets for programmes that involve multiple government departments and agencies working towards a common goal. Each instance of Program Convergence Budgeting has a designated lead agency that coordinates and allocates budgets across the other participating agencies *(101).* Examples of Program Convergence Budgeting have included programmes for early childhood development, family planning and climate change adaptation.

Use financial instruments to address social and commercial determinants of health

- Review the design, implementation and effectiveness of existing health tax measures and, if necessary, revise them to align with international best practices *(102−104)* and policy goals in consultation with relevant ministries, international agencies and other stakeholders.

- Based on international and local evidence, consider additional tax measures to deter consumption of unhealthy goods beyond alcohol and tobacco, such as sugar-sweetened beverages *(105)*; and partner with relevant ministries and international agencies to explore, and build evidence on, the use of taxes and subsidies to promote healthier behaviours, such as consumption of healthy food *(104)* and physical activity *(106)* (Box 22).

Box 22. Promoting health taxes in the Western Pacific Region

Health taxes are taxes levied on specific products, such as tobacco, alcohol and sugar-sweetened beverages, that are considered detrimental to health. The primary purpose of the taxes on these items is to improve health outcomes by reducing their consumption through higher prices to decrease affordability. They are widely used globally and have been steadily introduced in the Western Pacific Region. Presently, all 27 countries in the Region impose specific taxes, in one form or another, on alcohol *(107),* and the vast majority – 24 countries –

also impose excise taxes on tobacco. One third of the countries in the Region have also introduced taxes on unhealthy food *(108)*, and more than half have introduced taxes on sugar-sweetened beverages *(109)*.

The design and rate of health taxes are important for their effectiveness. For tobacco taxes, for instance, WHO recommends that countries use specific taxes (rates based on the volume of the targeted substance) rather than *ad valorem* taxes (based on the price), but that the excise tax should comprise at least 70% of the retail price *(102)*.

In addition to their impact on health outcomes, health taxes represent a form of revenue for governments. To that end, they can also be used to finance health. Many countries have opted to earmark revenue from health taxes for spending on health; the Philippines, for example, allocates some revenues from its so-called sin tax imposed on tobacco, alcohol products and sugar-sweetened beverages for health services *(110)*. Importantly, the strength of the case for earmarking health tax revenue is context-dependent. International evidence suggests that earmarking can be used to build acceptance for health taxes and for short-term increases in funding to launch or expand a national health programme. However, earmarking revenue does not typically result in a sustained increase in health expenditure and can result in reduced budget flexibility.

By recognizing the urgency of addressing the rising NCD burden through robust health tax measures, policy-makers can foster healthier societies and mitigate the long-term societal and economic impacts of these diseases, prevent injuries and advance health equity.

Invest in climate change resilience and mitigation in the health sector.

- Invest in the climate resilience of health systems and, where possible, reduce their environmental impact, including climate footprint, through direct government investments as well as regulation for, and incentives to, health providers and users/patients (Box 23) *(111)*.
- Generate evidence on the impact of climate change on health and health system costs, and partner with relevant ministries and agencies to promote appropriate financial instruments and regulatory measures for climate change mitigation.

Box 23. WHO operational framework for building climate-resilient and low-carbon health systems

In response to demands from Member States and partners for guidance on how the health sector can systematically address challenges presented by – and reduce its own contribution to – climate change, WHO published the *Operational framework for building climate resilient and low carbon health systems* in 2023. The operational framework aims to contribute to the design of transformative health systems that can provide safe and good-quality care in a changing climate. It outlines 10 components, covering the whole spectrum of health system building blocks, with one of the components being sustainable climate and health financing.

The financing component emphasizes the importance of identifying resource requirements, existing funding availability and resultant gaps for which additional financing must be sought. Resource requirements can be based on vulnerability and adaptation assessments and health national adaptation plans. Further, a number of outputs and indicators for sustainable climate and health financing are proposed, focusing on health-specific funding and financing mechanisms, climate change funding streams, and funding and financing for health-determining sectors.

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Further reading: WHO, 2023. Operational framework for building climate resilient and low carbon health systems *(77)*.

6. MOVING FORWARD

6.1 Considerations for Member States in implementing the strategic actions

All countries – regardless of income level, size, demographic context and health system maturity – can improve their health financing systems. Turning the tide on the deteriorating financial protection and stagnating expansion of service coverage can only be achieved through decisive action and will require a strong commitment from Member States, not only from their health ministries but across governments and societies.

Considering that health financing is highly context-dependent, countries need to tailor the implementation of the strategic actions to their local priorities and needs. Although the strategic actions outlined in this Regional Action Framework aim to provide direction for improving health financing, it is by no means a detailed blueprint for health financing reforms, as each domestic context differs. The relative importance of each strategic action needs to be determined at the country level, but users should keep in mind that many of the actions are interdependent and should, therefore, not be implemented in silos. On the contrary, problems that hinder the progress of UHC are often multifaceted and require interventions across the full range of health financing functions and beyond. For example, halting and reversing the worsening trend of financial protection in the Region, and the policy measures to deliver this goal, may include joint actions across the five action domains (Box 24).

Box 24. Improving financial protection through comprehensive health financing policy actions

Financial protection is achieved when there are no financial barriers to accessing needed health services and out-of-pocket payments required to obtain health services are not a source of financial hardship. There are different ways of organizing the health financing systems to reduce catastrophic and impoverishing household OOPS on health, and financial barriers to forgone care. Fig. 23 illustrates how actions within each of the five action domains contribute to improved financial protection.

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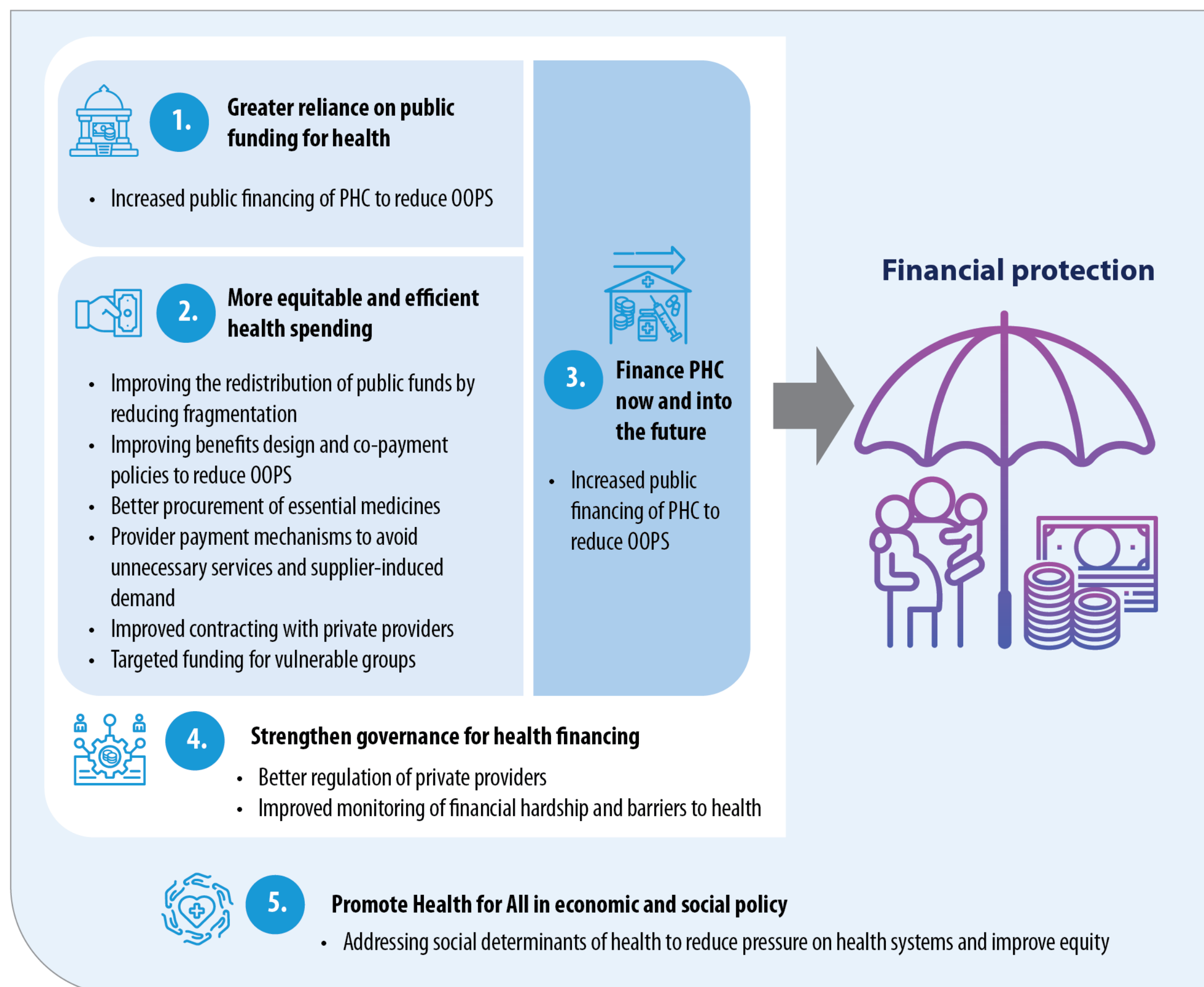
Fig. 23. Improving financial protection requires holistic action across all five action domains



OOPS: out-of-pocket spending; PHC: primary health care

Health financing reforms require careful planning and should be designed, implemented and monitored within the context of wider health sector reforms and processes. For countries in the process of developing health financing strategies and reforms, it is critical that the process is evidence-based and participatory throughout – from defining the overall health system vision and goals, conducting technical diagnostic analyses, developing specific objectives, identifying policies and actions, to establishing the necessary governance arrangements and evaluating and adjusting implementation *(1)*. Establishing domestic "think tanks" in collaboration with academia and other key health systems experts can be an important resource for routinely generating and analysing domestic evidence to inform and support health financing policy development and implementation (Box 25). Dialogues with communities and other key stakeholders throughout the process are critical to ensure that all relevant voices are heard and carefully considered, and that consensus is eventually reached. Additionally, it is important to align health financing policies with service delivery reform and ensure that the overall health sector policies are coordinated and coherent across all the key health system building blocks (health workforce, governance, medicines, etc.) to deliver the desired objectives.

Box 25. Examples of think tanks in the Western Pacific Region

Cambodia: The Health System Research Center is a programme within the National Institute of Public Health, which has a multidisciplinary team conducting research and transferring knowledge to policy-makers in areas of health financing, quality of care and antimicrobial resistance.

China: The China National Health Development Research Center, formerly known as the China Health Economics Institute, is a research institution based in Beijing. Established in 1991, it operates as a think tank providing technical consultancy to health policy-makers under the leadership of the National Health Commission.

Malaysia: The Institute for Health Systems Research is one of the six research institutes under the umbrella of one national research organization known as the National Institutes of Health at the Ministry of Health. The Institute for Health Systems Research focuses on advancing the nation's health through health policy and systems research. This institute enables evidence-based decision-making through research, training and consultancy, especially on topics related to health economics.

Mongolia: The National Center for Health Development is an organization affiliated with the Ministry of Health, supporting policy formulation and technical capacity-building in the areas of health management and information, continuing medical education, telemedicine and emergency care.

Viet Nam: The Health Strategy and Policy Institute is a policy and research institution under the Ministry of Health and primarily serves to conduct research and advise the Ministry on health strategy and policy development, and collaborate with international partners in the field of health systems policy.

Considering political dynamics when designing, planning and implementing health financing policies improves the chances of achieving the desired outcomes. Using political economy analysis to examine the interests, incentives and preferences of key stakeholders – notably political leaders, government officials, donors, health-care providers and communities – can identify potential barriers and opportunities for reform implementation *(112,113)*.[10] It can be used throughout the reform process to guide stakeholder consultations, design technical solutions to key policy goals, inform prioritization and sequencing of specific components of reforms and navigate areas of controversy. Further, it is important to think strategically about implementation sequencing and manage any resistance or obstacles through a course-correcting process. This may require an approach to validate the reform sequence with small-scale piloting, then gradually scaling up support by effective and regular monitoring and evaluation. It is essential to be technically ready when political opportunity arises.

Policy-makers who are managing health financing reforms are encouraged to engage in global and regional initiatives aimed at sharing best practices and lessons learnt. This collaborative approach facilitates the replication of successful strategies while helping to avert mistakes through robust policy discussions and peer learning opportunities. It includes fostering close collaboration with regional and global partners to address climate change and pandemic prevention, preparedness and response, and making full use of the external financial and technical resources for filling the funding gap and building institutional capacity. For example, the Pandemic Fund was recently established to

[10] For guidance on political economy analysis, refer to WHO's "how-to" guide; see reference 113.

provide financing to low- and middle-income countries and regions to strengthen their capacity. For climate and health, there is a wide range of international funding agencies, with the main ones listed in WHO's operational framework on climate change *(77)*.

6.2 WHO's role in working with Member States

The attainment of UHC through transformative PHC and ensuring that health systems are prepared for future challenges are at the heart of WHO's vision for its work in the Western Pacific Region. WHO's regional and country offices remain committed to working with and supporting countries to improve health financing, including implementing relevant actions from this Regional Action Framework. The following will be critical priorities for WHO working with Member States in this regard:

- Secure and strengthen political commitment to health financing for UHC and the Health for All agenda across the Region.
- Foster dialogues between ministries of health and finance, as well as other ministries and agencies where relevant, to build the case for investing in UHC and Health for All policies, and optimizing the effectiveness of health spending, working closely with global and regional partners.
- Set norms and standards at a technical level through the provision of global public goods, such as technical guidance on health financing and health expenditure tracking, the Global Health Expenditure Database and the annual Global Health Expenditure Report.
- Provide tailored country-level technical support to improve health financing arrangements and practices, such as for revenue raising, pooling and purchasing and PFM. This entails diagnosing gaps in health financing policies and identifying entry points and opportunities that can be leveraged.
- Facilitate peer learning and knowledge exchange on health financing policy and build and strengthen regional networks of experts, technical partners and collaborating centres to support Member States.
- Promote the alignment of development partners to domestic financing priorities and, where required, play a coordinating role in such processes.

Annex

References

1. Kutzin J, Witter S, Jowett M, Bayarsaikhan D. Developing a national health financing strategy: a reference guide. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/9789241512107, accessed 5 June 2024).

2. Tracking universal health coverage: 2023 global monitoring report. Geneva: World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2023 (https://www.who.int/publications/i/item/9789240080379, accessed 1 November 2023).

3. Climate change. In: World Health Organization [website]. Geneva: World Health Organization; 2024 (https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health, accessed 10 June 2024)

4. Heller MP. Understanding fiscal space. Washington (DC): International Monetary Fund; 2005 (https://www.imf.org/external/pubs/ft/pdp/2005/pdp04.pdf, accessed 10 June 2024).

5. Health financing for universal coverage: Pooling. In: World Health Organization [website]. Geneva: World Health Organization; 2024 (https://www.who.int/teams/health-financing-and-economics/health-financing/pooling, accessed 10 June 2024).

6. Health system governance. In: World Health Organization [website]. Geneva: World Health Organization; 2024 (https://www.who.int/health-topics/health-systems-governance, accessed 10 June 2024).

7. Reich MR. Political economy analysis for health. Bull World Health Organ. 2019;97(8):514. doi:10.2471/BLT.19.238311.

8. Primary health care. In: World Health Organization [website]. Geneva: World Health Organization; 2024 (https://www.who.int/news-room/fact-sheets/detail/primary-health-care, accessed 11 June 2024).

9. Public financial management. In: World Health Organization [website]. Geneva: World Health Organization; 2024 (https://www.who.int/teams/health-systems-governance-and-financing/health-financing/policy/public-financial-management, accessed 11 June 2024).

10. Global expenditure on health: Public spending on the rise? Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240041219, accessed 5 June 2024).

11. Promoting strategic purchasing. In: World Health Organization [website]. Geneva: World Health Organization; 2024 (https://www.who.int/activities/promoting-strategic-purchasing, accessed 10 June 2024)

12. Universal health coverage (UHC). In: World Health Organization [website]. Geneva: World Health Organization; 2024 (https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc), accessed 10 June 2024)

13. The Global Health Observatory: Coverage of essential health services (SDG 3.8.1) [online database]. Geneva: World Health Organization; 2024 (https://www.who.int/data/gho/data/themes/topics/service-coverage, accessed 4 April 2024).

14. The Global Health Observatory: SDG 3.8.2 Catastrophic health spending (and related indicators) [online database]. Geneva: World Health Organization; 2024 (https://www.who.int/data/gho/data/themes/topics/financial-protection, accessed 4 April 2024).

15. WHO Council on the Economics of Health for All. Health for All – transforming economies to deliver what matters: final report of the WHO Council on the Economics of Health for All.

Geneva: World Health Organization; 2023 (https://www.who.int/publications/i/item/9789240080973, accessed 14 November 2023).

16. Weaving health for families, communities and societies of the Western Pacific Region (2025−2029): working together to improve health and well-being and save lives. Manila: World Health Organization Regional Office for the Western Pacific; (in press).

17. Regional framework on the future of primary health care in the Western Pacific. Manila: World Health Organization Regional Office for the Western Pacific; 2023 (https://www.who.int/publications/i/item/9789290620129, accessed 5 June 2024).

18. Regional framework to shape a health workforce for the future of the Western Pacific. Manila: World Health Organization Regional Office for the Western Pacific; 2023 (https://iris.who.int/handle/10665/376704, accessed 5 June 2024).

19. Regional action framework for noncommunicable disease prevention and control in the Western Pacific. Manila: World Health Organization Regional Office for the Western Pacific; 2023 (https://www.who.int/publications/i/item/9789290620044, accessed 5 June 2024).

20. Regional action plan on healthy ageing in the Western Pacific. Manila: World Health Organization Regional Office for the Western Pacific; 2020 (https://www.who.int/publications/i/item/9789290619352, accessed 5 June 2024).

21. Asia Pacific Health Security Action Framework. Manila: World Health Organization Regional Office for the Western Pacific; 2023 (https://cdn.who.int/media/docs/default-source/wpro---documents/regional-committee/session-74/wpr-rc74-agenda-11-health-security-annex.pdf, accessed 5 June 2024).

22. Regional framework for action on transitioning to integrated financing of priority public health services in the Western Pacific. Manila: World Health Organization Regional Office for the Western Pacific; 2017 (https://iris.who.int/handle/10665/274718, accessed 5 June 2024).

23. Global Health Expenditure Database [online database]. Geneva: World Health Organization; 2023 (https://apps.who.int/nha/database, accessed 7 December 2023).

24. Health Nutrition and Population Statistics [online database] Washington (DC): The World Bank; 2024 (https://databank.worldbank.org/source/health-nutrition-and-population-statistics, accessed, 13 April 2024).

25. World Development Indicators. In: World Bank Open Data [online database]. Washington (DC): The World Bank; 2024 (https://databank.worldbank.org/source/world-development-indicators, accessed 12 February 2024).

26. The health-related Sustainable Development Goals: progress report of the Western Pacific Region, 2020. Manila: World Health Organization Regional Office for the Western Pacific; 2021 (https://www.who.int/publications/i/item/9789290619512, accessed 5 June 2024)

27. WHO Housing and health guidelines. Geneva: World Health Organization; 2018 (https://www.who.int/publications/i/item/9789241550376, accessed 5 June 2024).

28. The Global Health Observatory: Ambient air pollution attributable death rate (per 100 000 population) [online database]. Geneva: World Health Organization; 2024 (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/ambient-air-pollution-attributable-death-rate-(per-100-000-population), accessed 3 June 2024).

29. Independent evaluation of the ILO's Decent Work Country Programme Strategies and Actions in the Mekong Subregion 2012–2017. Geneva: International Labour Office; 2017

(https://www.ilo.org/wcmsp5/groups/public/---ed_mas/---eval/documents/publication/wcms_583706.pdf, accessed 5 June 2024).

30. Western Pacific regional framework for action on health and environment on a changing planet. Manila: World Health Organization Regional Office for the Western Pacific; 2017 (https://www.who.int/publications/i/item/9789290618164, accessed 5 June 2024).

31. Chand SS, Singh B, Kumar S. The economic burden of non-communicable disease mortality in the South Pacific: evidence from Fiji. PloS One. 2020;15(7):e0236068.

32. Dearie C, Linhart C, Rafai E, Nand D, Morrell S, Taylor R. Trends in mortality and life expectancy in Fiji over 20 years. BMC public health. 2021;21(1):1−4.

33. Chu A, Kwon S, Cowley P. Health financing reforms for moving towards universal health coverage in the western pacific region. Health Syst Reform. 2019;5(1):32−47.

34. Shengelia B, Tandon A, Adams OB, Murray CJ. Access, utilization, quality, and effective coverage: an integrated conceptual framework and measurement strategy. Soc Sci Med. 2005;61(1):97–109.

35. Utz, Robert J. Archipelagic economies: spatial economic development in the Pacific. Washington (DC): World Bank; 2021 (http://hdl.handle.net/10986/35997, accessed 6 June 2024).

36. Boudville A, Irava W, Motofaga S, Gilbert K, Annear P. Overseas medical referral: the health system challenges for Pacific island countries. New Delhi: World Health Organization Regional Office for South-East Asia; 2020 (https://apo.who.int/publications/i/item/9789290227700, accessed 6 June 2024).

37. Barroy H, Sparkes S, Dale E, Mathonnat J. Can low-and middle-income countries increase domestic fiscal space for health: a mixed-methods approach to assess possible sources of expansion. Health Syst Reform. 2018;4(3):214−26.

38. Yazbeck AS, Soucat AL, Tandon A, Cashin C, Kutzin J, Watson J, et al. Addiction to a bad idea, especially in low-and middle-income countries: contributory health insurance. Soc Sci Med. 2023;320:115168.

39. Jowett M, Brunal MP, Flores G, Cylus J. Spending targets for health: no magic number. Geneva: World Health Organization; 2016 (https://iris.who.int/bitstream/handle/10665/250048/WHO-HIS-HGF-HFWorkingPaper-16.1-eng.pdf, accessed 5 June 2024).

40. Mathauer I, Kutzin J. Voluntary health insurance: its potentials and limits in moving towards UHC, Policy Brief, Department of Health Systems Governance and Financing. Geneva: World Health Organization; 2018 (https://www.who.int/publications/i/item/WHO-HIS-HGF-Health-Financing-Policy-Brief-18.5, accessed 6 June 2024).

41. Cowley P, Chu A. Comparison of private sector hospital involvement for UHC in the Western Pacific Region. Health Syst Reform. 2019;5(1):59–65.

42. Progress towards universal health coverage: monitoring financial protection in the Western Pacific Region. Manila: World Health Organization Regional Office for the Western Pacific; 2023 (https://www.who.int/publications-detail-redirect/9789290620228, accessed 5 June 2024).

43. The World Health Report 2010: Health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010 (https://www.who.int/publications/i/item/9789241564021, accessed 5 June 2024).

Annex

44. Regional action framework for malaria control and elimination in the Western Pacific: 2016−2020. Manila: World Health Organization Regional Office for the Western Pacific; 2017 (https://www.who.int/publications/i/item/9789290618157, accessed 5 June 2024).

45. Silverman R, Keller L, Glassman A, Chalkidou K. Tackling the triple transition in global health procurement. Final report of CGD's Working Group on the Future of Global Health Procurement. Washington (DC): Center for Global Development; 2019 (https://www.cgdev.org/sites/default/files/better-health-procurement-tackling-triple-transition.pdf, accessed 22 July 2024).

46. Hanson K, Brikci N, Erlangga D, Alebachew A, De Allegri M, Balabanova D, et al. The Lancet Global Health Commission on financing primary health care: putting people at the centre. Lancet Glob Health. 2022;10(5):e715−72.

47. Application of the essential public health functions: an integrated and comprehensive approach to public health. Geneva: World Health Organization; 2024 (https://www.who.int/publications/i/item/9789240088306, accessed 5 June 2024).

48. Yazbeck AS, Savedoff WD, Hsiao WC, Kutzin J, Soucat A, Tandon A, et al. The case against labor-tax-financed social health insurance for low-and low-middle-income countries: a summary of recent research into labor-tax financing of social health insurance in low-and low-middle-income countries. Health Aff. 2020;39(5):892−7.

49. Barcellona C, Abdul Aziz AF, Sabtu KA, Jithitikulchai T, Nguyen TA, Nugraha RR, et al. Strengthening strategic health purchasing in southeast asia: progress, opportunities and recommendations. Singapore: Saw Swee Hock School of Public Health, National University of Singapore; 2023 (https://sph.nus.edu.sg/wp-content/uploads/2023/10/Strengthening-Strategic-Purchasing-in-Southeast-Asia.pdf, accessed 5 June 2024).

50. Mathauer I, Dale E, Jowett M, Kutzin J. Purchasing of health services for universal health coverage: How to make it more strategic? Policy Brief, Department of Health Systems Governance and Financing, Geneva: World Health Organization; 2019; (https://www.who.int/publications/i/item/WHO-UCH-HGF-PolicyBrief-19.6, accessed 5 June 2024).

51. Sakamoto H, Aya I, Tangcharoensathien V, Witthayapipopsakul W, Dayrit MM, Dayrit E at al. The role of the private sector: challenges and opportunities in Asia for achieving universal health coverage. New Delhi: World Health Organization Regional Office for South-East Asia; 2023 (https://iris.who.int/bitstream/handle/10665/366642/9789290210290-eng.pdf, accessed 5 June 2024).

52. Morgan R, Ensor T, Waters H. Performance of private sector health care: implications for universal health coverage. Lancet. 2016;388(10044):606−12.

53. Ng RJ, Choo WY, Ng CW, Hairi NN. Effect of supplementary private health insurance on out-of-pocket inpatient medical expenditure: evidence from Malaysia. Health Policy Plan. 2024;39(3):268−80.

54. Grundy J, Dakulala P, Wai K, Maalsen A, Whittaker M. Independent State of Papua New Guinea health system review. New Delhi: World Health Organization, Regional Office for South-East Asia; 2019 (https://iris.who.int/handle/10665/280088, accessed 5 June 2024).

55. International Labour Organization. Social protection in action: building social protection floors for all: country brief: Fiji. Geneva: ILO, 2021 (https://www.social-protection.org/gimi/ShowRessource.action?id=57652, accessed 5 June 2024).

56. Honda A, McIntyre D, Hanson K, Tangcharoensathien V. Strategic purchasing in China, Indonesia and the Philippines. Manila: World Health Organization Regional Office for the Western Pacific. 2016 (https://iris.who.int/handle/10665/252763, accessed 5 June 2024).

57. Cashin C, Bloom D, Sparkes S, Barroy H, Kutzin J, O'Dougherty S. Aligning public financial management and health financing: sustaining progress toward universal health coverage. Geneva: World Health Organization; 2017 (https://iris.who.int/handle/10665/254680, accessed 5 June 2024).

58. The World Bank. Government Health Budgets and Spending Database [online database]. Washington (DC): The World Bank; 2023 (https://datacatalog.worldbank.org/search/dataset/0064552/Government-Health-Budgets-and-Spending-Database, accessed 27 November 2023).

59. ThinkWell, World Health Organization. A balancing act: health financing in devolved settings. A synthesis based on seven country studies. Washington (DC): ThinkWell; 2022 (https://thinkwell.global/wp-content/uploads/2022/06/Health-financing-in-devolved-settings-1.pdf, accessed 5 June 2024).

60. Nuevo CE, Sigua JA, Samson MC, We Co PA, Yap ME. Three decades of devolution in the Philippines: how this has shaped health financing and public financial management reforms. case study series on devolution, health financing, and public financial management. Manila: ThinkWell; 2022 (https://thinkwell.global/wp-content/uploads/2022/04/Philippines-Case-Study-April-2022.pdf, accessed 5 June 2024).

61. Lam HY, Zarsuelo MA, Capeding TP, Silva ME, Mendoza MA, Padilla CD. Policy analysis on province-level integration of healthcare system in light of the Universal Health Care Act. Acta Medica Philippina. 2020;54(6).

62. Collins TE, Akselrod S, Atun R, Bennett S, Ogbuoji O, Hanson M, et al. Converging global health agendas and universal health coverage: financing whole-of-government action through UHC+. Lancet Glob Health. 2023;11(12):e1978−85.

63. United Nations Economic and Social Council. Economic and Social Council forum on financing for development follow-up, 25–28 April 2022 (https://www.undrr.org/media/79849/, accessed 5 June 2024).

64. Kurowski C, Evans DB, Tandon A, Eozenou PH, Schmidt M, Irwin A, et al. From double shock to double recovery: implications and options for health financing in the time of COVID-19. Health, Nutrition and Population Discussion Paper. Washington (DC): World Bank; 2021 (http://hdl.handle.net/10986/35298, accessed 5 June 2024).

65. World Economic Outlook – October 2019 [online database]. Washington (DC): International Monetary Fund; 2019 (https://www.imf.org/en/Publications/WEO/Issues/2019/10/01/world-economic-outlook-october-2019, accessed 5 June 2024).

66. World Economic Outlook – October 2023 [online database]. Washington (DC): International Monetary Fund; 2023 (https://www.imf.org/en/Publications/WEO/Issues/2023/10/10/world-economic-outlook-october-2023, accessed 5 June 2024).

67. Global spending on health: coping with the pandemic. Geneva: World Health Organization; 2023 (https://www.who.int/publications/i/item/9789240086746, accessed 5 June 2024).

68. List of LIC DSAs for PRGT-Eligible Countries as of April 30, 2024 [online database]. Washington (DC): International Monetary Fund; 2024 (https://www.imf.org/external/Pubs/ft/dsa/DSAlist.pdf, accessed 5 June 2024).

69. Old scars, new wounds? Public financing for health in times of COVID-19 in the Asia-Pacific Region. Washington (DC): World Bank Group Publications; 2023 (https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099331405112322325/idu0fd1e7cbb0a88e042e108b8e0c7da7a5fbbdb, accessed 5 June 2024).

70. Kim E, Park YL, Lo YR, Keoprasith B, Panyakeo S. Sustaining essential health services in Lao PDR in the context of donor transition and COVID-19. Health Pol Plan. 2024;39(Supplement 1):i131−6.

71. Regional framework for the future of mental health in the Western Pacific 2023–2030. Manila: World Health Organization Regional Office for the Western Pacific; 2023 (https://www.who.int/publications/i/item/9789290620075, accessed 5 June 2024).

72. Dutta A, Ly C. Financing the health systems of the future: a proposed framework for including non-communicable diseases [website]. Washington (DC): World Bank; 2018 (https://blogs.worldbank.org/en/health/financing-health-systems-future-proposed-framework-including-non-communicable-diseases, accessed 4 June 2024).

73. Cylus J, Roubal T, Ong P, Barber S. Sustainable health financing with an ageing population: implications of different revenue raising mechanisms and policy options. In: Sagan A, Normand C, Figueras J, North J, White C, editors. The economics of healthy and active ageing series. Copenhagen: European Observatory on Health Systems and Policies; 2019 (https://www.ncbi.nlm.nih.gov/books/NBK550584/, accessed 5 June 2024).

74. Lessons learned from COVID-19 pandemic: virtual regional consultation with informal expert group. New Delhi: World Health Organization Regional Office for South-East Asia; 2021 (https://www.who.int/publications/i/item/sea-whe-6, accessed 5 June 2024).

75. The Sustainable Development Goals Report 2023 Special edition. New York: United Nations; 2023 (https://unstats.un.org/sdgs/report/2023/, accessed 5 June 2024).

76. Regional framework for reaching the unreached in the Western Pacific (2022−2030). Manila. World Health Organization Regional Office for the Western Pacific; 2023 (https://iris.who.int/handle/10665/372270, accessed 5 June 2024).

77. Operational framework for building climate resilient and low carbon health systems. Geneva: World Health Organization; 2023 (https://www.who.int/publications/i/item/9789240081888, accessed 5 June 2024).

78. Climate change and health in Small Island Developing States: a WHO special initiative, Pacific island countries and areas. Manila: World Health Organization Regional Office for the Western Pacific; 2018 (https://iris.who.int/bitstream/handle/10665/276506/9789290618669-eng.pdf, accessed 4 June 2024).

79. The Lusaka Agenda: Conclusions of the Future of Global Health Initiatives Process. 2023 (https://d2nhv1us8wflpq.cloudfront.net/prod/uploads/2023/12/Lusaka-Agenda.pdf, accessed 5 June 2024).

80. Jigjidsuren A, Oyun B. Supporting health-care financing reform in Mongolia: experiences, lessons learned, and future directions. Manila: Asian Development Bank; 2022 (https://www.adb.org/sites/default/files/publication/850416/eawp-055-health-care-financing-reform-mongolia.pdf, accessed 4 June 2024).

81. Le QN, Blizzard L, Si L, Giang LT, Neil AL. The evolution of social health insurance in Vietnam and its role towards achieving universal health coverage. Health Policy OPEN. 2020;1:100011.

82. Jithitikulchai T, Feldhaus I, Bauhoff S, Nagpal S. Health equity funds as the pathway to universal coverage in Cambodia: care seeking and financial risk protection. Health Pol and Plan. 2021;36(1):26−34.

83. Free Medicine Scheme. In: Fiji Ministry of Health & Medical Services [website]. Suva: Ministry of Health & Medical Services; 2024 (https://www.health.gov.fj/free-medicine-scheme/, accessed 6 June 2024).

84. Mat Zuki AH, Isa MR, Suddin LS. A review on the cost-utility analysis for the FELDA residents in Malaysia with "Health Care Scheme (Skim Peduli Kesihatan) for the B40 Group" (PeKa B40) Coverage. J Pub Health Issue Pract. 2022;6(1):202.

85. Zhu Z, Wang Q, Sun Q, Lexchin J, Yang L. Improving access to medicines and beyond: the national volume-based procurement policy in China. BMJ Glob Health 2023;8:e011535.

86. Monitoring financial protection and utilization of health services in Mongolia: 2009-2018; Manila. World Health Organization Regional Office for the Western Pacific. 2022; (https://www.who.int/publications/i/item/9789290619895, accessed 18 June 2024).

87. Delvaux T, Samreth S, Barr-DiChiara M, Seguy N, Guerra K et al. Linked response for prevention, care, and treatment of HIV/AIDS, STIs, and reproductive health issues: results after 18 months of implementation in five operational districts in Cambodia. J Acquir Immune Defic Syndr. 2011;57(3):e47−55.

88. Wu Y, Zhang Z, Zhao N, Yan Y, Zhao L, Song Q, et al. Primary health care in China: a decade of development after the 2009 health care reform. Health Care Science. 2022;1(3):146−59.

89. Ombay G. PhilHealth forms PH's first 7 primary care networks. GMA Integrated News. 19 June 2023 (https://www.gmanetwork.com/news/topstories/nation/873372/philhealth-forms-ph-s-first-7-primary-care-networks/story/, accessed 5 June 2024).

90. Virtual Outpatient Integration for Chronic Disease (VOICeD). In: Queensland: Queensland Health [website]. Brisbane: Government of Australia; 2020 (https://clinicalexcellence.qld.gov.au/improvement-exchange/virtual-outpatient-integration-chronic-disease-voiced, accessed 29 March 2024).

91. Governance for strategic purchasing: an analytical framework to guide a country assessment. Health Financing Guidance, No. 6. Geneva: World Health Organization; 2019 (https://www.who.int/publications/i/item/9789240000025, accessed 20 June 2024).

92. Barroy H, Blecher M, Lakin J, editors. How to make budgets work for health? A practical guide to designing, implementing and monitoring programme budgets in health. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240049666, accessed 28 June 2024).

93. Barroy H, Dale E, Sparkes S, Kutzin J. Budget matters for universal health coverage: key formulation and classification issues. Geneva: World Health Organization; 2018 (https://iris.who.int/handle/10665/273000, accessed 28 June 2024).

94. One Health. In: World Health Organization [website]. Geneva: World Health Organization; 2024 (https://www.who.int/health-topics/one-health, accessed 2 April 2024).

95. Greer SL, Falkenbach M, Vissapragada P, Wismar M. From Health in All Policies to Health for All Policies: the logic of co-benefits. In: Greer SL, Falkenbach M, Figueras J, Wismar M, editors. Health for All Policies: the co-benefits of intersectoral action. Cambridge: Cambridge University Press; 2024 (https://eurohealthobservatory.who.int/publications/m/health-for-all-policies-the-co-benefits-of-intersectoral-action, accessed 5 June 2024).

Annex

96. Ozer C, Bloom D, Martinez Valle A, Banzon E, Mandeville K, Paul J, et al. Health earmarks and health taxes: what do we know? Washington (DC): The World Bank; 2020 (https://documents1.worldbank.org/curated/en/415911607500858658/pdf/Health-Earmarks-and-Health-Taxes-What-Do-We-Know.pdf, accessed 5 June 2024).

97. Cashin C, Sparkes S, Bloom D. Earmarking for health: from theory to practice. Geneva: World Health Organization; 2017 (https://iris.who.int/handle/10665/255004, accessed 5 June 2024).

98. Greer SL, Falkenbach M, Figueras J, Wismar M. Health for All Policies – the co-benefits of intersectoral action. Cambridge: Cambridge University Press; 2024 (https://eurohealthobservatory.who.int/publications/m/health-for-all-policies-the-co-benefits-of-intersectoral-action, accessed 5 June 2024).

99. New Zealand – Implementing the Well-being Budget. In: Well-being Economy Alliance [website]. 2022 (https://weall.org/resource/new-zealand-implementing-the-well-being-budget, accessed 5 June 2024).

100. Davaakhuu O. Mongolia: budget credibility and the Sustainable Development Goals. Ulaanbaatar: Open Society Forum; 2023 (https://internationalbudget.org/publications/mongolia-budget-credibility-and-the-sustainable-development-goals/mongolia-budget-credibility-and-the-sdgs-26-07/, accessed 5 June 2024).

101. Budget preparation activities and documentary requirements for priority programs under the program convergence budgeting (PCB) approach. National Budget Memorandum No. 150. Manila: Republic of the Philippines; 2024 (https://www.dbm.gov.ph/wp-content/uploads/Issuances/2024/National-Budget-Memorandum/NATIONAL-BUDGET-MEMORANDUM-NO-150.pdf, accessed 6 June 2024).

102. WHO technical manual on tobacco tax policy and administration. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240019188, accessed 18 June 2024).

103. WHO technical manual on alcohol tax policy and administration. Geneva: World Health Organization; 2023 (https://www.who.int/publications/i/item/9789240082793, accessed 18 June 2024).

104. Fiscal policies to promote healthy diets: WHO guideline. Geneva: World Health Organization; 2024 (https://www.who.int/publications/i/item/9789240091016, accessed 18 June 2024).

105. WHO manual on sugar-sweetened beverage taxation policies to promote healthy diets. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240056299, accessed 11 July 2024).

106. Global action plan on physical activity 2018–2030: more active people for a healthier world. Geneva: World Health Organization; 2018 (https://www.who.int/publications/i/item/9789241514187, accessed 11 July 2024).

107. Global Health Observatory data repository [online database]. Geneva: World Health Organization; 2024 (https://apps.who.int/gho/data/view.main.55680, accessed 21 February 2024).

108. Global Health Observatory data repository [online database]. Existence of tax on foods high in fat, sugars or salt. Geneva: World Health Organization; 2024 (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/existence-of-tax-on-foods-high-in-fat--sugars-or-salt, accessed 11 July 2024).

109. Global Health Observatory data repository [online database]. Existence of tax on sugar-sweetened beverages. Geneva: World Health Organization; 2024

(https://www.who.int/data/gho/data/indicators/indicator-details/GHO/existence-of-tax-on-sugar-sweetened-beverages, accessed 11 July 2024).

110. Sin Tax Annual Report 2023. Manila: Department of Health; 2023 (https://www.officialgazette.gov.ph/downloads/2023/10oct/2023-DOH-Annual-Sin-Tax-Report-FRM.pdf, accessed 11 July 2024).

111. Oranje M, Mathauer I. A health financing policy agenda for climate mitigation and adaptation. Bull World Health Organ. 2024;102(5):363−5 (https://iris.who.int/handle/10665/376679, accessed 5 June 2024).

112. Sparkes SP, Kutzin J, Soucat A, Bump JB, Reich MR. Introduction to special issue on political economy of health financing reform. Health Syst Reform. 2019;5(3):179−82.

113. Political economy analysis for health financing: a ‘how to’ guide. Geneva: World Health Organization; 2024 (https://www.who.int/publications/i/item/9789240092099, accessed 16 July 2024).