## CONTENTS

Health Financing Regional Profile: Transitioning to Integrated Financing and Service Delivery of Priority Public Health Services

<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>iv</td>
<td>Country and area abbreviations</td>
</tr>
<tr>
<td>v</td>
<td>Acknowledgements</td>
</tr>
<tr>
<td>1</td>
<td>Introduction</td>
</tr>
<tr>
<td>3</td>
<td>Overview of regional context</td>
</tr>
<tr>
<td>17</td>
<td>Transitioning to integrated financing and service delivery</td>
</tr>
<tr>
<td></td>
<td>• Strengthening service delivery across core programme elements</td>
</tr>
<tr>
<td></td>
<td>• Making better use of resources</td>
</tr>
<tr>
<td></td>
<td>• Increasing domestic financing for public health</td>
</tr>
<tr>
<td>25</td>
<td>Summary</td>
</tr>
<tr>
<td>27</td>
<td>References</td>
</tr>
<tr>
<td>28</td>
<td>Annexes</td>
</tr>
<tr>
<td>Code</td>
<td>Country/Region</td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>AUS</td>
<td>Australia</td>
</tr>
<tr>
<td>BRN</td>
<td>Brunei Darussalam</td>
</tr>
<tr>
<td>KHM</td>
<td>Cambodia</td>
</tr>
<tr>
<td>CHN</td>
<td>China</td>
</tr>
<tr>
<td>COK</td>
<td>Cook Islands</td>
</tr>
<tr>
<td>FJI</td>
<td>Fiji</td>
</tr>
<tr>
<td>JPN</td>
<td>Japan</td>
</tr>
<tr>
<td>KIR</td>
<td>Kiribati</td>
</tr>
<tr>
<td>LAO</td>
<td>Lao People’s Democratic Republic</td>
</tr>
<tr>
<td>MYS</td>
<td>Malaysia</td>
</tr>
<tr>
<td>MHL</td>
<td>Marshall Islands</td>
</tr>
<tr>
<td>FSM</td>
<td>Micronesia (Federated States of)</td>
</tr>
<tr>
<td>MNG</td>
<td>Mongolia</td>
</tr>
<tr>
<td>NRU</td>
<td>Nauru</td>
</tr>
<tr>
<td>NZL</td>
<td>New Zealand</td>
</tr>
<tr>
<td>NIU</td>
<td>Niue</td>
</tr>
<tr>
<td>PLW</td>
<td>Palau</td>
</tr>
<tr>
<td>PNG</td>
<td>Papua New Guinea</td>
</tr>
<tr>
<td>PHL</td>
<td>Philippines</td>
</tr>
<tr>
<td>KOR</td>
<td>Republic of Korea</td>
</tr>
<tr>
<td>WSM</td>
<td>Samoa</td>
</tr>
<tr>
<td>SGP</td>
<td>Singapore</td>
</tr>
<tr>
<td>SLB</td>
<td>Solomon Islands</td>
</tr>
<tr>
<td>TON</td>
<td>Tonga</td>
</tr>
<tr>
<td>TUV</td>
<td>Tuvalu</td>
</tr>
<tr>
<td>VUT</td>
<td>Vanuatu</td>
</tr>
<tr>
<td>VNM</td>
<td>Viet Nam</td>
</tr>
</tbody>
</table>
Acknowledgements

This paper was based on the WHO Regional Framework of Action on Transitioning to Integrated Financing of Priority Public Health Services in the Western Pacific that was adopted at the sixty-eighth session of the Regional Committee for the Western Pacific in October 2017. The framework served as guidance to Member States and was produced through collaboration of several units: Health Policy and Financing; End Tuberculosis and Leprosy; HIV, Hepatitis, and Sexually Transmitted Infections; Expanded Programme on Immunization; and Integrated Service Delivery. This paper was developed by the Health Policy and Financing team including Peter Cowley, Annie Chu, Maria Peña, Ronald Tamangan and Luke Elich and with Ke Xu, Rochelle Eng and Marlon Sison. Management support was received from Vivian Lin, Director of the Division of Health Systems at the WHO Regional Office for the Western Pacific. Valuable comments were received from Susan Sparkes, Joe Kutzin and Agnes Soucat, and administrative support from Enrico Sevilla and Nuria Quiroz Chirinos.

Financial support for the work was provided by the Ministry of Health, Labour and Welfare, Japan; the Ministry of Health and Welfare, Republic of Korea; and the Department for International Development, United Kingdom of Great Britain and Northern Ireland.

The views expressed in this publication are those of the authors and do not necessarily reflect those of WHO.
Introduction

Strengthening essential public health functions is relevant for all health systems as they underpin priority public health services in all countries. A resilient health system requires the capacity to adapt to change, including in the areas of public health preparedness, community engagement in disease prevention and emergency preparedness and response, and an ability to withstand economic shocks. Essential public health functions refer to a set of functions fundamental to the protection of population health that addresses the determinants of health and treats disease. The need to secure essential public health functions is relevant for countries undergoing service delivery and budgeting reforms, and particularly critical to countries facing reduced external funding, such as funding from global health initiatives.

During the sixty-eighth session of the Regional Committee for the Western Pacific in October 2017, Member States endorsed the Regional Framework for Action on Transitioning to Integrated Financing of Priority Public Health Services in the Western Pacific (1). In consultation with Member States, independent experts and development partners, WHO developed the Regional Framework for Action, which provides guidance to countries on using a whole-of-system approach to secure essential public health functions and respond to changing population needs for more sustainable and resilient systems that deliver the best health outcomes. It builds on the regional action framework Universal Health Coverage: Moving Towards Better Health and the Regional Action Agenda on Achieving the Sustainable Development Goals in the Western Pacific, both adopted by the Regional Committee (2,3).

This paper contains three major sections. The first section outlines the regional health financing context and key challenges in the Western Pacific. The second section highlights the need to take a whole-of-system approach to move towards more integrated financing and care through improving health system efficiencies and increasing domestic financing for health, drawing from the Regional Framework for Action and the regional analytical approach for policy development on improving the efficiency and sustainability of priority public health programmes (Annex 1). The last section emphasizes the importance of political commitment and governing the transition process in a phased implementation approach.
“Sustaining progress requires continued and targeted efforts”
Overview of regional context

In the Western Pacific Region, great progress has been made in reducing the burden of communicable diseases, such as tuberculosis (TB), HIV/AIDS, malaria and others, over the past few decades. Since 2000, TB prevalence has been reduced by over 25% and TB mortality has declined by over 53% (4). There have also been impressive gains in lowering the burden of HIV/AIDS and increasing antiretroviral therapy (ART) coverage in the Region (5). Nine out of 10 malaria-endemic countries achieved their malaria-related targets in the Millennium Development Goals (6), and millions of deaths and disabilities have been prevented due to the work of the Expanded Programme on Immunization (EPI) (7). However, sustaining the progress requires continued and targeted efforts to ensure equitable coverage and access to treatment for vulnerable and hard-to-reach populations.

In addition, the health needs of the populations in the Region are changing. Environmental, workplace and lifestyle diseases have accompanied economic progress. Noncommunicable diseases (NCDs) account for nearly 80% of preventable deaths in the Region (8), while many countries are also undergoing accelerated ageing. Over 200 health security threats are detected each year. Epidemics and disasters continue to threaten millions of people each year, and health inequalities in some rapidly developing countries are growing rather than shrinking. The fiscal context with rapid economic development in many countries may favour increasing public spending on health.

These ongoing and new challenges, in addition to the increasing expectations from citizens and communities for access to quality health services, are posing complexities in terms of how to address public health priorities from a whole-of-system perspective.

Over the past decade, several countries in the Western Pacific Region have increased their current health expenditure as a share of gross domestic product (GDP). The lower-middle- and upper-middle-income Asian countries spend between roughly 3% and over 6% of their GDP on health, while there is a much larger range in the Pacific island countries (Figs 1 and 2), with some reaching more than 13% given significant external funding and government spending.

1 This considers only HIV-negative individuals.
Fig. 1
Current health expenditure as a share of GDP for Asian countries, 2015

LMI: lower-middle-income; UMI: upper-middle-income; HI: high-income; GGHE-D: domestic general government health expenditure; PVT-D: domestic private health expenditure.

Note: From the OECD countries: Australia, New Zealand and Japan have been incorporated using their latest estimates. 2014 estimates for Australia and Japan and 2013 estimates for New Zealand.


Fig. 2
Current health expenditure as a share of GDP for Pacific island countries, 2015

LMI: lower-middle-income; UMI: upper-middle-income; HI: high-income; GGHE-D: domestic general government health expenditure; PVT-D: domestic private health expenditure.

Note: Cook Islands and Kiribati estimates are based on 2014.

For the lower-middle-income Asian countries, the proportion of private health expenditures, mostly from out-of-pocket payments, is nearly half or more of current health expenditures (Fig. 3). Several countries have a mixed health financing system that includes social health insurance, such as China, Mongolia, the Philippines and Viet Nam. Some countries also have other voluntary schemes, such as private health insurance. Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam receive external funds from donors, including from global health initiatives.

In Pacific island countries, the composition of health expenditures shows that the majority derive from government and external funds, with social health insurance in a few countries (Fig. 4). While the out-of-pocket health expenditures are lower than compared to Asian countries, there are still geographical and financial barriers to accessing health services, which include spending on transport costs. Also, estimates over time show that there is significant volatility in external health expenditures in several Pacific island countries.

Several countries in the Region are facing a decline of external funding from bilateral partners and global health initiatives, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria; Gavi, the Vaccine Alliance; and the United States President’s Emergency Plan for AIDS Relief (PEPFAR). The global health initiatives, in particular, triggered a rapid, large-scale response to disease through direct cash and in-kind funding to develop disease control programmes. Since 2003, the Global Fund has disbursed US$ 2.5 billion in treating and preventing AIDS, TB and malaria, and in building more resilient and sustainable systems for health in the Western Pacific Region. Of the total Global Fund grants disbursed, 35.3% was allocated for HIV/AIDS programmes, 32.6% for TB, 28.3% for malaria and 4.2% for others/health systems strengthening. In the Global Fund Round 8 grants, health systems strengthening funding allocated to countries accounted for 37% of the total Global Fund funding (9).

2 From 2002 to 2013, the Global Fund operated through a rounds-based funding model and Round 8 was launched in March 2008. The Global Fund launched a new funding model in 2013.
Fig. 3
Current health expenditure in select Asian countries by health expenditure source, 2015

LMI: lower-middle-income; UMI: upper-middle-income; HI: high-income; “Public” refers to domestic public revenues; “External” refers to transfers from foreign origin; “Other private” refers to other domestic revenues from corporations or non-profits; OOP: out-of-pocket payment.

Note: From the OECD countries: Australia, New Zealand and Japan have been incorporated using their latest estimates, 2014 estimates for Australia and Japan and, 2013 estimates for New Zealand.


Fig. 4
Current health expenditure in Pacific island countries by health expenditure source, 2015

LMI: lower-middle-income; UMI: upper-middle-income; HI: high-income; “Public” refers to domestic public revenues; “External” refers to transfers from foreign origin; “Other private” refers to other domestic revenues from corporations or non-profits; OOP: out-of-pocket payment.

Note: From the OECD countries: Australia, New Zealand and Japan have been incorporated using their latest estimates, 2014 estimates for Australia and Japan and, 2013 estimates for New Zealand.

Gavi has disbursed US$ 373.8 million in the Region since 2001. A total of 67% of the investments was for vaccine support, while 33% was for non-vaccine support, which included health systems strengthening (10). Four countries in the Region have entered the five-year accelerated transition phase – the Lao People’s Democratic Republic, Papua New Guinea, Solomon Islands and Viet Nam – and are expected to increase co-financing commitments for vaccines to eventually fully finance them by the end of the fifth year. Funding from PEPFAR has also supported a majority of treatment costs for people living with HIV, as well as prevention and community support systems. PEPFAR spent over US$ 250 million in select Asian countries3 in the Region from 2012 to 2015; 71% of its spending was channelled to HIV/AIDS programmes, while 29% was spent on health systems strengthening (11).

Several countries in the Region that receive funding from global health initiatives are in the process of transition or have already transitioned. While the meaning of transition and how it is implemented may vary across global health initiatives, early planning and graduated co-financing commitments that are embedded in the programme design are at the core of transition and sustainability policies. Both the Global Fund and Gavi have clear eligibility and transition policies that outline predictable timelines and triggers for a transition. Gavi’s trigger for a transition is economic development classified by gross national income (GNI) per capita, while the Global Fund’s support is reduced in accordance with both country income classification and the reduction of disease burden indicators for HIV, TB and malaria. During the transition, global health initiatives will require countries to co-finance and at an increasing share as countries are further along the transition stage. For example, the portion of domestic financing of HIV programmes ranges widely across countries in Asia, which are at different stages in the transition (Fig. 5).

Most upper-middle-income countries fund the bulk of their HIV programmes domestically, with some countries such as China and Malaysia fully or nearly fully self-financed, while lower-middle-income countries are gradually mobilizing more funds from domestic sources. HIV expenditure estimates in selected countries over time show this gradual transition of health financing towards more domestic resources, while still heavily dependent on external funding (Fig. 6).

3 PEPFAR has investments in Cambodia, Papua New Guinea and Viet Nam, and also channelled funding for HIV/AIDS and health systems strengthening through its Asia Regional Program, covering China, the Lao People’s Democratic Republic and Thailand.
Proportion of domestic financing of HIV programmes in selected Asian countries, latest available year

HI: high-income; LMI: lower-middle-income; UMI: upper-middle-income.

Source: Investing for results: how Asia Pacific countries can invest for ending AIDS, 2015 (AIDS Data Hub)
Fig. 6
HIV expenditure by financing source over time in selected countries in the Western Pacific Region (in million US$), 2006–2015 (or latest available data)

Source: UNAIDS data (accessed December 2017)
Fig. 7
TB health budget by funding source in selected countries in the Western Pacific Region (in million US$), 2006–2014

Fig. 8
Proportion of TB expenditure by funding source and programme area in Fiji, 2016/2017

HSS: health systems strengthening, M&E: monitoring and evaluation, MDR-TB: multidrug-resistant tuberculosis, TB: tuberculosis, TB/HIV: tuberculosis and HIV collaborative activities

Sources: National TB Programme of Fiji, 2017; WHO Fiji case study on the Tuberculosis and Immunization Programme Transition to integrated financing, 2017.
Similar trends are also seen with TB funding in selected countries in the Region where the different stages of transition are reflected and there is increasing co-financing from domestic sources as in countries moving from lower-middle- to upper-middle-income status (Fig. 7). Some countries are increasing domestic financing of their health budgets for TB, although the Global Fund still comprises a significant part of the health budget and the budget itself can vary over time. Other grants, including bilateral support, have been supporting several countries in the Region. In several countries, local governments also help finance costs of priority public health services.

While Figs 6 and 7 show how some countries have gradually increased their domestic financing for HIV and TB programmes over time at different rates depending on their stage of transition, further details on countries’ expenditures reveal how the external and domestic funds and their distributions have contributed across programme areas. As an example, the proportion of TB expenditure by funding sources and programme areas in Fiji and Mongolia show external funds for several areas, such as programme management, patient support, TB care and prevention, multidrug-resistant TB (MDR-TB), diagnosis, community systems strengthening, monitoring and evaluation, and TB/HIV (Figs 8 and 9). Domestic funding typically first covers staff and other human resource costs, including programme management and supervision, and first-line drugs. Financing for MDR-TB is still heavily financed through external funding for countries that are transitioning.

Certain programme areas may be more vulnerable than others to the withdrawal of external funding during the transition phase. External funding can contribute towards several areas of support, including prevention and HIV testing, care and treatment, and systems strengthening and programme coordination.

The challenges lie in how to gradually integrate and finance the programme areas that are all interlinked and rely on each other to provide a continuum of care for priority public health services, such as treating HIV and TB.
Similar to the TB programme, for HIV, countries have a distribution of external and domestic funding across different programme areas. For example, in Malaysia, the majority of external funds were spent on care and treatment, while, in Mongolia, prevention and HIV testing was the main area of external support. In Viet Nam, the majority of external funds are spent on prevention and HIV testing, and care and treatment.

**Fig. 9**
Proportion of TB expenditure by funding source and programme area in Mongolia, 2013-2014

ACSM: advocacy, communication and social mobilization; FLD: first-line drug; HRD: human resource development; IPC: infection prevention and control; M&E: monitoring and evaluation; MDR-TB: multidrug-resistant tuberculosis; OR: operational research; PPM: public–private mixed approach; TB: tuberculosis; TB/HIV: tuberculosis and HIV collaborative activities.

Health systems need to respond to the increasing pressures on health expenditures for priority public health services and changing health needs.
Fig. 10
Whole-of-system approach to essential public health functions

Source: WHO Regional Office for the Western Pacific
Transitioning to integrated financing and service delivery

Health systems need to respond to the increasing pressures on health expenditures for priority public health services and changing health needs. While strengthening health financing is fundamental, taking a whole-of-system approach for sustainable and resilient systems is needed to deliver the best health outcomes (Fig. 10). Essential public health functions entail surveillance, health protection and promotion, disease prevention and management, and emergency response (13) – the interlinkages between financing, governance and role of institutions in discharging essential public health functions enable the protection of health. Securing essential public health functions is pressing for countries undergoing service delivery and budgeting reforms, in particular for certain countries confronting reductions in external funding – including from global health initiatives – for disease control programmes.

While global health initiatives have brought about massive immediate cash and in-kind support to countries, they have also enlarged core programme elements and fragmented systems that support essential public health functions. To transition from a vertically funded to a whole-of-system approach, countries can develop a phased transition plan, which includes a four-part analytical approach (Annex 1). This requires changing the way of work and enables countries to do more with available resources and achieve efficiencies at the health system level in addition to mobilizing domestic resources. Given that each donor may have its own transition plan and systems, partners and governments are to coordinate and collaborate to smooth the overall transition in countries. Government leadership is critical to establishing the vision for health sector development, ensuring active participation of stakeholders, sustaining health gains and driving the entire transition process.
<table>
<thead>
<tr>
<th>ELEMENTS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy, guidelines, stewardship and regulations</td>
<td>Government has fundamental stewardship and regulatory functions, including setting national policies and strategies, developing guidelines, preparing annual work plans and budgets, and overseeing programme implementation, including monitoring, evaluation and supervision.</td>
</tr>
<tr>
<td>Prevention</td>
<td>Includes individual-based interventions (e.g. counselling; risk mitigation) and population-based interventions (e.g. immunization; promotion of prevention commodities; environmental control, including vector control; and health promotion and communication).</td>
</tr>
<tr>
<td>Surveillance</td>
<td>Continuous process of collecting information through notification, validation and registration of cases, and assessing the burden, trends and distribution of diseases and risk factors.</td>
</tr>
<tr>
<td></td>
<td>Evaluating effectiveness, accessibility, coverage and quality of individual- and population-based health services.</td>
</tr>
<tr>
<td></td>
<td>Monitoring and investigating unusual occurrences of health events, including disease outbreaks.</td>
</tr>
<tr>
<td>Outbreaks and emergency response</td>
<td>Response to disease outbreaks, disasters and emergencies.</td>
</tr>
<tr>
<td></td>
<td>Capacity to act on health-related issues and events that are identified by monitoring and evaluation activities, including routine surveillance systems.</td>
</tr>
<tr>
<td>Diagnosis, treatment and care (clinical services)</td>
<td>Quality clinical services such as diagnosis, treatment and care are a fundamental element of many public health programmes such as TB, malaria, sexually transmitted infections, HIV and NCD programmes.</td>
</tr>
<tr>
<td>Laboratory (clinical and reference laboratories)</td>
<td>Any public health programme requires quality-assured laboratory capacity for both diagnosis and surveillance purposes.</td>
</tr>
<tr>
<td></td>
<td>Requires a tiered laboratory network at various levels such as reference laboratory, secondary (referral) laboratory, district laboratory and point-of-care facilities. Small-country contexts may have regional reference or referral laboratories.</td>
</tr>
<tr>
<td>Procurement and supply management systems</td>
<td>Process of selecting, quantifying, purchasing and distributing quality-assured medical products that are essential for public health programmes.</td>
</tr>
<tr>
<td>Community-based support and social participation</td>
<td>Community-based support is critical to many public health programmes such as community patient support for TB, peer education programmes, self-help groups and social mobilization for outreach activities.</td>
</tr>
<tr>
<td>Targeted approaches for vulnerable and high-risk populations</td>
<td>Specific strategies and approaches are often needed to address the needs of vulnerable populations.</td>
</tr>
<tr>
<td></td>
<td>With decreasing incidence among general populations, some diseases are highly concentrated among high-risk populations.</td>
</tr>
</tbody>
</table>
Strengthening service delivery across core programme elements

Critical to the process of transition are the mapping and analysis of core programme elements that are included in national public health programmes and part of essential public health functions and other health system functions (Table 1). While global health initiatives have supported the development of the core programme elements and disease-specific systems, further strengthening of these elements and their linkages should contribute towards securing essential public health functions and improving the sustainability and resilience of the health system. Some of the main challenges are how to move towards more sustainable and integrated systems, given the large fractures brought about by vertically funded disease control programmes, and to encourage staff to more closely link across the core programme elements to provide more integrated and coordinated care.

For each of the core programme elements, it is important to understand how they are organized, financed and implemented or delivered to explore options on how to reduce fragmentation, integrate into the general health system or better harmonize across the system, and improve efficiency and coordination (Table 2). This includes how the core programme elements are linked together to provide a continuum of care. Surveillance, laboratory, procurement and supply management systems, and a community-based approach are some of the elements that may gain efficiencies in integration. However, not all core programme elements are necessarily expected to be integrated as some may still need to fulfill specialized technical requirements. For example, in Viet Nam, the flow of funds and procurement of medicines and vaccines can be complex and fragmented among the various donors (Annex Fig. A1); however, efforts are being made to move towards a more harmonized procurement and supply management system.
Table 2
Current organization of core programme elements and future directions

Source: Regional framework for action on transitioning to integrated financing of priority public health services in the Western Pacific. Table 2 (2018).

<table>
<thead>
<tr>
<th>PROGRAMME ELEMENT</th>
<th>CURRENT ORGANIZATION</th>
<th>FUTURE DIRECTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy, guidelines, stewardship and regulations</td>
<td>National public health programmes in collaboration with specialized institutions.</td>
<td>Retain policy and stewardship functions under ministries of health.</td>
</tr>
<tr>
<td>Prevention</td>
<td>Largely through primary health care network, often with significant input from specific programmes and funding. Civil society organizations may play a significant role in health promotion, service delivery and communications.</td>
<td>Mostly retained under public responsibility with ongoing collaboration with civil society organizations. Some can be shifted to health insurance or other funding sources.</td>
</tr>
<tr>
<td>Surveillance</td>
<td>Parallel reporting procedures created substantial burden, especially at the peripheral levels.</td>
<td>Integrated systems, including disease notification systems, and national health management information systems.</td>
</tr>
<tr>
<td>Outbreaks and emergency response</td>
<td>Often organized by specific programmes, and not linked with general surveillance and response capacity of the country.</td>
<td>Strengthened linkages between general surveillance and response systems and disease control programmes. Build response capacity along with declining disease incidence.</td>
</tr>
<tr>
<td>Diagnosis, treatment and care (clinical services)</td>
<td>Largely through the primary health care network. Task-shifting in some settings that may be associated with integration of clinical care under health insurance schemes.</td>
<td>Ensure quality of care especially where the role of general clinical facilities, including private sector, is expanded. During the transition, it is critical to monitor service uptake and coverage, as well as financial burden to patients.</td>
</tr>
<tr>
<td>Laboratory (clinical and reference laboratories)</td>
<td>Often vertically organized under each health programme. Often separated from the general public health laboratory network.</td>
<td>Integrated public health laboratory networks using existing infrastructure and human resources. Investment made by specific programmes to be fully utilized (bio safety, molecular diagnostic platforms, etc.).</td>
</tr>
<tr>
<td>Procurement and supply management systems</td>
<td>Programme-specific supply management systems due to programmatic necessities and requirements for accountability by donors.</td>
<td>Programme-specific parallel systems gradually merged. Programmatic expertise critical for product selection, sound quantification and harmonization with national protocols. Central procurement may be continued for efficient procurement practices.</td>
</tr>
<tr>
<td>Community-based support and social participation</td>
<td>Critical to many public health programmes such as treatment support for TB patients, HIV prevention and testing, and peer support programmes.</td>
<td>Explore options to maintain services provided by civil society organizations that are currently funded by external donors. May require different contractual modalities or merging into the government sector function.</td>
</tr>
<tr>
<td>Targeted approaches for vulnerable and high-risk populations</td>
<td>Often needed but under the purview of specific disease programmes with the engagement of community-based organizations.</td>
<td>Continue with strategies to effectively address the needs of vulnerable and high-risk populations with active engagement of civil society organizations.</td>
</tr>
</tbody>
</table>
Making better use of resources

Strengthening financing institutions to improve system-wide efficiency involves both allocative and technical efficiency efforts and changing the way of work. Key considerations include prioritizing and ensuring sufficient public funding for core programme elements, aligning different funding sources and funding flows, and determining the role of health insurance in mixed health financing systems.

Having a transparent, evidence-informed and participatory process for decision-making is important in prioritization of interventions and how this is translated into the health budget. This is also critical in holding decision-makers and health managers accountable for how funds are spent. Ensuring that vulnerable and high risk populations have access to health services needs to be considered in the prioritization process. Further, the funding gap should not be equated to exactly replacing the external funding amount that will be reduced.

Some of the more difficult actions countries consider are with managing and absorbing the programme staff within the general health system, how to strengthen and utilize the public financial management system, and how to align incentives for providers to improve equitable access to quality services. In particular, one of the major challenges countries face is having flexibility in the public financial management system to contract nongovernmental organizations, which play a vital role in core programme elements, such as prevention and community outreach. In addition, several countries channel or are in the process of channelling their external funding through the government system to better align priorities, coordinate funding and make use of resources (Fig. 11). Transfers distributed by the government from foreign origin are channelled through the government, while direct foreign transfers are those funds that are directly received by the health financing schemes. As countries transition towards integrated financing or increased domestic financing, channelling external funding through the government system can reduce fragmentation across various sources, improve monitoring of how external funds are used and encourage strengthening of accountability mechanisms within the system.
**Fig. 11**
External funding as a share of current health expenditure, 2015

LMI: lower-middle-income; UMI: upper-middle-income; HI: high-income.
Note: Only those countries with external funding are included.

World Bank income classifications (accessed 13 June 2018)

---

**Fig. 12**
Government health expenditure as a share of total government expenditure, 2015

During the transition, several countries with mixed health financing systems are also determining the role of health insurance and potential ways in which the health financing mechanism can be used to cover the cost of some core programme elements. Health insurance may be another way to raise funds for health, but it may not necessarily result in more total funding than through other mechanisms. Government subsidies may also be needed to sustain the health insurance system. Individual-based clinical services can be covered by health insurance, while this would not be suitable for population-based services or functions. Individual-based prevention may depend on the existing insurance function. Some of the key concerns of the transition with health insurance entail ensuring a continuum of care and no disruptions in the treatment course given what may or may not be covered in the benefit package. In middle-income countries with growing health insurance systems, not all of the population is covered and vulnerable and high risk populations may require special arrangements and subsidies to avail of services. Other aspects of providing services paid through a health insurance system may be themselves complicated given that members register with personal information and social stigma may prevent people from accessing the care they need, in particular for TB and HIV.

Increasing domestic financing for public health.

In the Region, Asian countries have experienced steady economic growth, while in the Pacific island countries, growth has been limited. Countries that do have favourable fiscal contexts may not necessarily have increasing budgets for health. There is a wide range in the government expenditure on health as a share of overall government spending in Asian and Pacific island countries (Fig. 12). Over the past decade, countries have made efforts to increase domestic spending for health in their health sector reforms and are strengthening the engagement and trust between ministries of health and finance. Ministries of health are often faced with questions regarding how effectively they spend their funds, what evidence they have and what they are doing to improve efficiency. Also, having a clear and realistic health sector plan with performance indicators and costing and budgetary implications is important to evaluating how public funds are used to achieve health policy goals.

Regarding earmarking funds, this is often a political decision rather than purely a financial one. There are advantages and disadvantages to earmarking, the flexibility of which depends on the country’s public financial management system (14). Some countries in the Region have earmarked funds for health, such as the Philippines (Annex Fig. A2), where a percentage of tobacco and alcohol taxes and gambling revenues are used to subsidize health insurance coverage for poor populations and assist needy patients for inpatient care.

Furthermore, collaboration with various partners, such as other government sectors and non-state actors has supported health promotion and objectives in several countries in the Region. Improving cooperation and coherence across government sectors for public health and health promotion will be instrumental in meeting public health standards and supporting a country’s efforts towards universal health coverage (UHC) and achievement of the Sustainable Development Goals (SDGs). Social protection policies that have been put in place can include subsidies to patients to enrol in social protection mechanisms and to provide patient support. For example, the Fiji National Tuberculosis Programme negotiated with the Ministry of Women, Children and Poverty Alleviation for preferential inclusion of needy or vulnerable TB patients in a social protection scheme with the provision of food vouchers and a monthly stipend for the duration of treatment (15). While funding channels directly from the Ministry of Women, Children and Poverty Alleviation to patients, the Ministry of iTaukei Affairs also supports non-state actors that contribute to health (Annex Fig. A3).
Taking a whole-of-system approach for sustainable and resilient systems is needed to deliver the best health outcomes.
Summary

Given the changing population needs and fiscal pressures, many countries in the Region are undergoing transitions towards more integrated service delivery and financing for priority public health services. Health financing serves as a trigger to broader service delivery and health sector reform. The transition process itself may last a long period of time and may be country-specific with various opportunities and risks. Political commitment and long-term vision are needed from the government to smooth the transition.

Governing the transition process is important towards ensuring a well-planned and implemented phase-wise approach. This also entails having a transparent and participatory process throughout to build consensus and coordinate among the several partners. Having an oversight mechanism and being able to routinely monitor and evaluate progress of the transition to be able to adjust where needed in a timely manner are essential.

One of the major challenges in the transition will be managing the change in the way of work and workforce involved. Having the support and commitment of the workforce – particularly those from disease control programmes – early on in the transition is fundamental to mitigating potential staff demotivation and attrition. Another major challenge in the transition will be reconstructing the public health system from a fractured, distorted system using a whole-of-system approach. Doing so will also translate to investing not just in human resources, but in the core programme elements and their linkages across one another, such as laboratories, treating MDR-TB, outreach and preventive activities, to be able to provide a continuum of care that is affordable.
References

1. Regional framework for action on transitioning to integrated financing of priority public health services in the Western Pacific. Manila: WHO Regional Office for the Western Pacific; 2018.


5. HIV data and statistics [website]. Manila: WHO Regional Office for the Western Pacific; 2016 www.wpro.who.int/hiv/data/en/


The purpose of this annex is to support countries in sustaining the progress made by priority public health programmes within the health system context through the development of a phased transition plan. This includes a four-part analytical approach which consist of: (1) identifying options for integration and coordination by understanding the health system and its context; (2) setting up of up-to-date, clearly defined essential public health functions and the mapping of core programme elements within programmes and their prioritization; (3) mapping of core programme elements and commonalities across programmes and the rest of the health system including options for integration and coordination; (4) development of a phased and systematic transition plan that is situation-specific and responsive to a number of factors during the process to ensure long-term sustainability. The analytical approach will guide the examination of priority public health programmes from a health systems perspective, applying the principles of improving quality of services, equity and efficiency.

### 1. Health system architecture and context
- Brief overview of the health system architecture (governance, financing mechanisms, institutions involved, essential public health functions and core programme elements) and the overall governance and stewardship (legislation, regulations, national health strategy, organizational structures, coordination, monitoring and evaluation), which significantly influence the functioning of the health system.

### 2. Within-programme mapping and prioritization
- Mapping of core programme elements by financing mechanisms and service providers within a specific programme
- Funding and other gap analyses
- Prioritization of interventions within each programme

### 3. Across-programme mapping and options for coordination and integration
- Mapping of core programme elements and commonalities across programmes and the rest of the health system
- Options for coordination and integration

### 4. Phased and systematic transition plan
- Assessment of the options for coordination and integration, including feasibility, enabling factors, and associated benefits and risks
- Identification of entry points and sequence of actions
- Development of road map, including division of labour and key milestones within a time frame
- Monitoring and evaluation of progress
Guiding questions

1. Health system architecture and context

HEALTH STATUS AND HEALTH SYSTEM CONTEXT

• What are the major health issues that the country is facing, including major causes of mortality and morbidity?

• What are the characteristics of the current political and economic environment?

• Which ongoing public sector reforms are relevant to the health system?

GOVERNANCE

• What important legislations and regulations are in place that shape the whole health system? How does the national health strategy align with the overall country development plan(s)?

• Which government agencies are important to the health system (health sector agencies as well as central agencies and other bodies)? What are their functions and their authority?

• How can the country’s health system be described – including the roles of the public and private sectors and available information on current performance?

• What is the level and distribution of resources, including infrastructure, human resources, equipment, essential medicines and technologies?

• What is the process for national health planning (annual planning and budgeting and long-term planning) and which stakeholders are involved?

• What is the current capacity – including managerial – of the government to strengthen the health system? What are the roles of the private sector and civil society?

• What donor activity is present and planned within the health system and how is it coordinated?

• How is information on health system performance generated and used?
FINANCING

• What are the past, current and forecast levels of expenditure on health by the government? How much is the general health budget and what is it allocated towards?

• Is there earmarked funding for programmes (and what are the sources)? Are there any plans for more earmarked revenues for health?

• Is there any leveraging of resources from and for non-state actors for health?

• What is the level of external funding provided and what is it used for (e.g. budget support)?

CORE PROGRAMME ELEMENTS AND ESSENTIAL PUBLIC HEALTH FUNCTIONS

• What are the core programme elements in different priority public health programmes and how are they aligned with the essential public health functions?

• How are the core programme elements delivered in the health system? Which providers are involved in delivering them?

• How are services regulated? How is quality managed at the population and individual levels and within health facilities and by whom?

• What are the arrangements and logistics for procurement of supplies? How is procurement regulated? How is compliance ensured?

• Is there any community-based support and social participation within priority public health programmes?

• What strategies and approaches are taken to target vulnerable and high-risk populations?

2. Within-programme mapping and prioritization

HEALTH STATUS

• What is the prevalence of the disease and its incidence rate? What is the target population? What is the burden of disease (including geographical, epidemiological risk and evolution, most at-risk population groups, etc.)?

• What is the programme strategy and relevant evidence base?
ESSENTIAL FUNCTIONS AND SERVICES

• What are the core programme elements for the particular programme?

• Which providers are involved in delivering the various functions and services and how are they funded?

GOVERNANCE

• What are the legal and regulatory frameworks relevant for the programme?

• What are the institutional arrangements for the programme? How are decisions made and who is involved in the decision-making process?

• What are the responsibilities at the different levels of government and institutions for implementing the programme?

• What is the prioritization process for interventions in the programme? Which interventions are prioritized and which populations are affected?

• What are the management structure and mechanisms for the programme?

• How are donors currently involved in the programme? What is the forecast in relation to future donor involvement?

• Who is responsible for creating and enforcing the technical guidelines and standards for the programme? What are these and who will manage the training in these guidelines?

• What monitoring and evaluation mechanisms are used for the programme?

FINANCING

• How much funding goes towards which functions and from which sources? (Sources include government – excluding social protection schemes; external – bilateral, multilateral, global health initiatives, etc.; social protection schemes; private insurance; and out-of-pocket payments.)

• How do funds flow across the levels of the health system, between central government and local governments, including for donor funding? How is donor funding used?

• What financing mechanisms are in place for providers and patients?

• What are the requirements for reporting on financial management and performance of the programme? Who determines these requirements and how well are they currently being met?

• How much funding is forecast for the programme?
3. Across-programme mapping and options for coordination and integration

MAPPING ACROSS PROGRAMMES

• Are there common core programme elements that can be better coordinated or integrated to improve efficiencies? Are there functions that need to remain vertical? How can these functions be distributed or merged among the different levels of service delivery networks within the continuum of health care (primary, secondary and tertiary care) and among stakeholders, including private and civil society groups?

• Are there governance arrangements or financing mechanisms across programmes that can be better coordinated or integrated to improve efficiencies?

• What are the potential options and their associated benefits and risks? What conditions are needed for implementation? How do they align with other reforms?

• What implications would changes have for the mainstream health system and the vertical programme(s)?

OPTIONS FOR COORDINATION AND INTEGRATION – CORE PROGRAMME ELEMENTS

• What interventions are high-impact, evidence-based and aligned with the country’s burden of disease? What aspects should be prioritized in accordance with the country’s principles and national health priorities?

• How will the system continue to provide affordable, quality health services to target populations?

OPTIONS FOR COORDINATION AND INTEGRATION – GOVERNANCE ARRANGEMENTS AND FINANCING MECHANISMS

• Given the funding gap, how can domestic funding be increased and efficiency improved? What is the capacity of the government to increase domestic funding? What types of domestic funding options can be used to mobilize more funding?

• How can the different funding sources and funding flows be aligned? How will programme staff be absorbed into the general health system?

• How can public financial management (PFM) systems and payment mechanisms be strengthened? How can flexibility be built into the PFM systems for contracting nongovernmental organizations? Can external funding be channelled through the PFM system?
HOW CAN THE COVERAGE OF TARGET POPULATION GROUPS BY THE DIFFERENT FUNDING MECHANISMS BE COORDINATED OR STREAMLINED?

• How are incentives aligned for the appropriate provision and use of health services? Specifically, how are the provider-payment mechanisms aligned with the incentives and services to be delivered?

• What services and functions can be potentially covered by health insurance (if applicable)? How will the different funding mechanisms be coordinated and integrated with health insurance? How can effective coverage of appropriate benefit packages for priority populations be ensured? Can government funding subsidize health insurance for programme-related services?

• What governance arrangements can enable the transition and which stakeholders are involved?

4. Phased transition plan

ENTRY POINTS

• What entry points can be helpful in achieving coordination and integration? Which of the different authorities is responsible for doing what? How can the entry points be aligned with current reforms?

• What are some of the benefits and risks associated with the merging of certain functions? What can be done to minimize those risks?

• Who are the different stakeholders and what are they responsible for in the implementation phase?

• What are the different scenarios that can be envisaged based on funding conditions and/or enabling environment?
ENABLING FACTORS

• How willing are donors to make long-term plans to slowly reduce funding? What can be done by the government to negotiate a predictable and gradual shift (or withdrawal) of funding?

• What types of institutional change(s) are needed for integration to happen – including social rules and norms on how the health system functions and is governed?

• What are the implications of the proposed changes for planning, monitoring and evaluation, and how can these be coordinated? How might the different national programme plans be aligned with each other and with the national plan?

• What processes are in place to build a consensus on a plan to move forward? Who needs to be involved?

• What are the enabling factors that may affect the change?

ROAD MAP AND MILESTONES

• What are the key milestones that measure progress and what is their timeline within the road map?

• What monitoring and evaluation framework will be used to track performance of implementation?
Viet Nam Flow of Fund and Procured Drugs/Vaccines for Donor-Assisted Programmes

Fig. A1

**Procurement Agent**
- First line ARV, methadone
- First, second, pediatric ARVs, and methadone
- 2nd line Drugs, Isoniazid Preventive Therapy
- Pentavalent and Measles-Rubella Combination Vaccine and OPV

**CPC-1**
- National Lung Hospital
- 3 Regional Hospitals
- Same dispensing points for ARVs

**PPM**
- National Institute of Malariology, Parasitology and Entomology (NIMPE)

**UNICEF Supply Division**
- Province Health Department (PHD)
- Provincial AIDS Committee (PAC)
- Outpatient Clinics (OPC)
- Methadone Treatment Centres
- Commune Health Stations (CHS): Intercommune Polyclinic, TB Treatment Centres, Methadone Treatment Centres

**Vaccines**
- OPV = Oral Polio Vaccine
- ARV = Antiretroviral therapy
- PPM = Pooled procurement mechanism
- IDA/GLC = International Dispensary Association/Green Light Committee
- CPC-1 = Central Pharmaceutical Company 1
- Gavi, WHO and UNICEF Global Fund PEFPAR USAID

**Northern, Central Highland, Southern regions**
Fig A2
The Philippines’s Health System Funding Flows

Legend:
- General Government Budget Flows
- LGU Budget / Flows
- Private Voluntary Health Insurance / Micro-health insurance
- Flows from other sectors
- Direct payments from fees and charges
- Reimbursements
- Lottery Revenues
- PCSO
- PAGCOR
- Other sectors
Suppliers / vendors / contractors → National budget → Ministry of Economy

Capital spending plus other procurement flows exceeding 50,000 FJD

Procurement of goods and services

Taxes → Premiums

Private voluntary health insurance

People / Patients

User charges to service delivery facilities

User charges paid to consolidated fund account

Payments

Social assistance to poor patients

Remuneration / allowances of volunteer partners

Direct support to NGOs or implementing partners

External Donor Partners

Ministry of iTaukei Affairs

Ministry of Women, Social Welfare and Poverty Alleviation

Ministry of Health and Medical Services

Third-party procurement agent

State budget flows

External Donor funding

Flows from other sectors

State budget flows

Direct payments for fees and charges

Programme funding transfers / aid-in-kind

Agency budget

Grant Mgt Unit

Public health facilities

Private health facilities and pharmacies

Non-state actors (NGOs, CHWs)

Legend:
CHW = Community health worker
NGO = Non governmental organization

Fig A3
Fiji's Health System Funding Flows