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

Working Paper prepared by the WHO Regional Office for the Western Pacific
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## Country and area abbreviations (in figures and tables)

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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 Region that was adopted at the 68th Session of the Regional Committee of the Western Pacific in October 2017. The framework served as guidance to Member States and was produced from the collaboration of several units, including Health Policy and Financing; Stop Tuberculosis and Leprosy Elimination; HIV, Hepatitis, and STIs; Expanded Programme on Immunizations; and Integrated Service Delivery. This paper was developed by the Health Policy and Financing team, including Peter Cowley, Annie Chu, Maria Pena, Ronald Tamangan, and Luke Elich under the overall supervision of Vivian Lin, Director of the Division of Health Systems at the WHO Regional Office for the Western Pacific. Valuable comments were received from Xu Ke, Susan Sparkes, Joe Kutzin, and Agnes Soucat, and administrative support from Enrico Sevilla and Nuria Quiroz Chirinos.

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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 address the determinants of health and treat 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 global health initiatives.

During the 68th Session of the Regional Committee of the Western Pacific in October 2017, Member States adopted the regional framework for action and endorsed the resolution 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 of 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).

The 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 of action. The last section emphasizes the importance of political commitment and governing the transition process in a phased implementation approach.
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 other communicable diseases over the past few decades. Since 1990, TB prevalence was reduced by over 53% and deaths by over 73% (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. Non-communicable diseases account for nearly 80% of preventable deaths in the Region (8), while many countries are also undergoing accelerated aging. 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 favor increasing public spending on health.

These ongoing and new challenges, in addition to the increasing expectations from citizens and communities on access to quality health services are posing complexities with 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 GDP. The low and upper middle income Asian countries have about 3% to over 6% of their health expenditure as a % of GDP, while there is a much larger range in Pacific island countries (Figures 1 and 2) with some reaching more than 13% given significant external funding and government spending.
For the lower middle income Asian countries, the proportion of private health expenditures, mostly from out-of-pocket, are nearly half or more of current health expenditures (Figure 3). Several countries have a mixed health financing system that includes social health insurance, such as in Mongolia, Viet Nam, Philippines, and China. Some countries also have other voluntary schemes, such as private health insurance. Cambodia, Lao PDR, Mongolia, and Viet Nam receive external funds from donors, including from global health initiatives.

Figure 3. Current health expenditure in select Asian countries by financing scheme, 2015

In Pacific island countries, the composition of health expenditures show that majority is coming from government and external funds, with social health insurance in a few countries (Figure 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 includes 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 (Global Fund) and Gavi, the Vaccine Alliance, and 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 USD 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 system 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).

Gavi has disbursed USD 373.8 million in the Region since 2001. Sixty-seven per cent of the investments were 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 expected to increase co-financing commitments for vaccines to eventually fully finance them by the end of the fifth year. Funding from the United States President’s Emergency Plan for AIDS Relief (PEPFAR) has also supported a majority of treatment costs for people living with HIV (PLHIV) as well as prevention and community support systems. PEPFAR spent over USD 250 million in select Asian countries1 in the Region from 2012 to 2015. Seventy-one per cent of its spending was channelled to HIV/AIDS programme, while 29% was spent on health systems strengthening (Table 3) (11).

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1 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 Programme, covering China, the Lao People’s Democratic Republic and Thailand.
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), 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 (Figure 5).
Most upper middle income countries have over a majority of their HIV programmes funded 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 expenditures estimates in selected countries over time show this gradual transition of health financing towards more domestic resources, but yet are still heavily dependent on external funding (Figure 6).
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 countries move from lower to upper middle income (Figure 7). Some countries are increasing domestic financing of their health budgets for TB, although Global Fund can still comprise of 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 Figures 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 funding funds for several areas, such as programme management, patient support, TB care and prevention, MDR-TB, diagnosis, community systems strengthening, monitoring and evaluation, and TB/HIV (Figures 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 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 continuum of care for priority public health services, such as 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 (11).
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 (Figure 10). Essential public health functions entail surveillance, health protection and promotion, disease prevention and management, and emergency response (11) – 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, and in particular for certain countries confronting reductions in external funding, including 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 distorted and fragmented systems that support essential public health functions.
To transition from a vertically-funded to whole-of-system approach, countries are to map existing elements in disease control programmes and how they are arranged to support broader public health functions, then coordinate and integrate those functions into the general health system. 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 each donor may have its own transition plan and systems, partners and government are to coordinate and collaborate together 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.
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 the securing of essential public health functions and to improve 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 encourage staff to more closely link across the core programme elements to provide more integrated and coordinated care.
### Table 1. Core programme elements

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<th>Elements</th>
<th>Description</th>
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<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>
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| Surveillance                                                             | • Continuous process of collecting information through notification, validation and registration of cases, and assessing the burden, trends and distribution of diseases and risk factors.  
                          | • Evaluating effectiveness, accessibility, coverage and quality of individual- and population-based health services.  
                          | • Monitoring and investigating unusual occurrences of health events including disease outbreaks.                                                                                                                                 |
| Outbreaks and emergency response                                         | • Response to disease outbreaks, disasters and emergencies.  
                          | • Capacity to act on health-related issues and events that are identified by monitoring and evaluation activities including routine surveillance systems.                                                    |
| Diagnosis, treatment and care (clinical services)                        | • 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. |
| Laboratory (clinical and reference laboratories)                         | • Any public health programme requires quality-assured laboratory capacity for both diagnosis and surveillance purposes.  
                          | • 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. |
| Procurement and supply management systems                                | • Process of selecting, quantifying, purchasing and distributing quality-assured medical products that are essential for public health programmes.                                                                |
| Community-based support and social participation                        | • 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. |
| Targeted approaches for vulnerable and high-risk populations             | • Specific strategies and approaches are often needed to address the needs of vulnerable populations.  
                          | • With decreasing incidence among general populations, some diseases are highly concentrated among high-risk populations.                                                                                               |
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 (Table 2) and improve efficiency and coordination. This includes how the core programme elements are linked together to provide continuum of care. Surveillance, laboratory, procurement and supply management system, and 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 Vietnam, the flow of funds and procurement of medicines and vaccines can be complex and fragmented among the various donors (Annex 1); however, efforts are being made to move towards a more harmonized procurement and supply management system.

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<th>Programme element</th>
<th>Current organization</th>
<th>Future directions</th>
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<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>
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<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>
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Table 2. Current organization of core programme elements and future directions, cont.

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<th>Programme element</th>
<th>Current organization</th>
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| Diagnosis, treatment and care (clinical services)       | • 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.                                                                                                                                                                                      | • 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, and financial burden to patients.                                                                                                                                                                                                                           |
| Laboratory (clinical and reference laboratories)        | • Often vertically organized under each health programme. Often separated from the general public health laboratory network.                                                                                                                                                                                                                                                                                    | • 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.).                                                                                                                                                   |
| Procurement and supply management systems               | • Programme-specific supply management systems due to programmatic necessities and requirements for accountability by donors.                                                                                                                                                                                                                                                                                | • 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.                                                                                                                                                                                                                                                                               |
| Community-based support and social participation        | • Critical to many public health programmes such as treatment support for TB patients, HIV prevention and testing, and peer support programmes.                                                                                                                                                                                                                                                                     | • 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.                                                                                                                                                                                                                                                                                       |
| Targeted approaches for vulnerable and high-risk populations | • Often needed but under the purview of specific disease programmes with the engagement of community-based organizations.                                                                                                                                                                                                                                                                               | • Continue with strategies to effectively address the needs of high-risk and vulnerable populations with active engagement of civil society organizations.                                                                                                                                                                                                 |

Source: WHO Regional Framework for Action on Transitioning to Integrated Financing of Priority Public Health Services, Table 2, (under publication), 2017
Making better use of resources

Strengthening financing institutions to improve system-wide efficiency involve 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 high-risk and vulnerable 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 non-government 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 channeling their external funding through the government system to better align priorities, coordinate funding, and make use of resources (Figure 11). Transfers distributed by the government from foreign origin are channeled 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, channeling 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.
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 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 high-risk, vulnerable populations may require special arrangements and subsidies to avail of services. Other aspects of providing services paid through a health insurance system may be complicated given members register with personal information and social stigma may prevent people from accessing the care they need, in particular for TB and HIV care.
Increasing domestic financing for public health

The Region has had steady economic growth in Asian countries, while in Pacific island countries, growth has been limited. Countries that do have favorable 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 (Figure 6). 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, and the flexibility of which depends on the country’s public financial management system (16). Some countries in the Region have earmarked funds for health, such as in the Philippines (Annex 2) 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 UHC and the achievement of the SDGs. Social protection policies that have been put in place can include subsidies to enroll in social protection mechanisms and 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 support of food vouchers and monthly stipend for duration of treatment (17). 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 3).
Figure 12. Government health expenditures as % of total government expenditures, 2015

Source: Draft estimates in consultation, World Health Organization.

Notes: OECD countries are not included in this analysis.
Summary

Given the changing population needs and fiscal pressures, many countries in the Region are undergoing transitions toward 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 over 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, MDR-TB, outreach and preventive activities, to be able to provide continuum of care that is affordable.
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Annex 1. Funding funds, and drug and vaccine procurement for donor-assisted programmes in Viet Nam

Legend:
- PPM = Pooled procurement mechanism
- IDA/GLC = International Dispensary Association/Green Light Committee
- CPC-1 = Central Pharmaceutical Company 1
- OPV = Oral Polio Vaccine

External Donor Partners flow
- Direct donor support
- Global Fund HIV/AIDS
- PEPFAR HIV/AIDS
- Gavi procurement/distribution
- Global Fund TB
- Coordination lines b/n CPMU and PPMU

**Procurement Agent**
- PPM
- IDA/GLC
- UNICEF
- GAVI, WHO and UNICEF
- Global Fund
- Global Fund for TB
- PEFPAR
- USAID

**Storage**
- National Lung Hospital
- Regional Hospitals
- Provinces
- Districts

**Dispensing Points / Levels**
- Provinces
- Districts
- Communes
- Intercommunes

**Legend**
- Same dispensing point for ARVs
- Separate Central Project Management Units (CPMUs) for each disease and HSS
- Separate Provincial Project Management Units (PPMUs) for each disease and HSS
- Ministry of Health (MOH)
- Viet Nam Authority of HIV/AIDS Control (VAAC) for HIV
- National Lung Hospital for TB
- National Institute for Malaria, Parasitology and Entomology (NIMPE)
- Department of Planning & Finance (DPF) for Health Systems Strengthening (HSS)
- National Institute for Hygiene and Epidemiology
- Provincial Health Department (PHD)
- Provincial Hospital
- Provincial AIDS Committee (PAC)
- District Health Centers (DHCs)
- Outpatient Clinics (OPC)
- Methadone Treatment Centers
- Commune Health Stations (CHS)
- Intercommune polyclinic
- TB Treatment Centers
- Methadone Treatment Centers

**Annexes**
Annex 2. Health system funding flows and domestic resource mobilization in the Philippines

Legend:
- General Government Budget Flows
- LGU Budget / Flows
- PhilHealth / Social Health Insurance
- Private Voluntary Health Insurance

Flows from the gaming sector
- PCSO
- PAGCOR
- Other sectors

PCSO = Philippine Charity Sweepstakes Office
PAGCOR = Philippine Amusement and Gaming Corporation

Funding Flows:
- General government budget flows
  - Department of Budget and Management
  - Department of Health (DOH)
  - Regional Offices
  - DOH Budget
  - Government-owned and controlled corporations
  - Corporate specialty hospitals

- Social health insurance flows
  - PhilHealth
  - Subsidy
  - Some premium subsidy
  - Revenue-generating services

- Private voluntary health insurance flows
  - Premiums
  - Rural micro-health insurance

- Direct payments for fees and charges
  - Reimbursements

- External donor funding
  - All Case Rates (ACR)
  - Grants

- Loans
  - National budget

- Taxes
  - Internal Revenue Allotment (IRA)
  - Local Taxes

- Premiums

- Reimbursements

- Patients

Other Sectors:
- DOH Budget
- DOH-retained hospitals

Enclosures:
- External donor partners
- Private providers
- Non-state actors / implementing partners

Legend:
- General Government Budget Flows
- LGU Budget / Flows
- PhilHealth / Social Health Insurance
- Private Voluntary Health Insurance

Flows from other sectors
- Direct payments from fees and charges
- External donor financing
- Coordination

External donor partners
- Grants

Private providers
- Private hospitals
- Private medical clinics
- Pharmacies

Non-state actors / implementing partners
- Patients also spend for out-of-pocket payments to informal providers and overseas treatments

Private voluntary health insurance flows
- Premiums
- Rural micro-health insurance

Social health insurance flows
- Premium
- Subsidy
- Some premium subsidy
- Revenue-generating services

Private voluntary health insurance flows
- Premiums
- Rural micro-health insurance

Social health insurance flows
- Premium
- Subsidy
- Some premium subsidy
- Revenue-generating services
Annex 3. Health system funding flows and collaboration with the social sector for TB support in Fiji