Regional Framework for Action on Transitioning to Integrated Financing of Priority Public Health Services
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#### Abbreviations

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<th>Description</th>
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<tbody>
<tr>
<td>ART</td>
<td>antiretroviral therapy</td>
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<tr>
<td>CSO</td>
<td>civil society organization</td>
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<td>DHIS</td>
<td>District Health Information Software</td>
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<td>DOTS</td>
<td>directly observed treatment, short-course</td>
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<td>DR-TB</td>
<td>drug-resistant tuberculosis</td>
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<td>GDP</td>
<td>gross domestic product</td>
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<td>Global Fund</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>M&amp;E</td>
<td>monitoring and evaluation</td>
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<td>NCD</td>
<td>noncommunicable disease</td>
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<td>NCHS</td>
<td>National Catholic Health Services (Papua New Guinea)</td>
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<td>OOP</td>
<td>out-of-pocket (payment)</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief (United States of America)</td>
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<td>PhilHealth</td>
<td>Philippine Health Insurance Corporation</td>
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<td>PFM</td>
<td>public financial management</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
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<td>TB</td>
<td>tuberculosis</td>
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<td>UHC</td>
<td>universal health coverage</td>
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<td>WHO</td>
<td>World Health Organization</td>
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## Country and area abbreviations (in figures and tables)

<table>
<thead>
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<th>Country/Region</th>
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<td>ASM</td>
<td>American Samoa (United States of America)</td>
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<td>AUS</td>
<td>Australia</td>
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<td>BRN</td>
<td>Brunei Darussalam</td>
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<td>Fiji</td>
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<td>PYF</td>
<td>French Polynesia (France)</td>
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<td>GUM</td>
<td>Guam (United States of America)</td>
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<td>HKG</td>
<td>Hong Kong SAR (China)</td>
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<td>KIR</td>
<td>Kiribati</td>
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<td>LAO</td>
<td>Lao People’s Democratic Republic</td>
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<td>MAC</td>
<td>Macao SAR (China)</td>
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<td>MYS</td>
<td>Malaysia</td>
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<td>MHL</td>
<td>Marshall Islands</td>
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<td>FSM</td>
<td>Micronesia, Federated States of</td>
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<td>Mongolia</td>
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<td>NRU</td>
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<td>New Zealand</td>
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<td>Niue</td>
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<td>Northern Mariana Islands, Commonwealth of the (United States of America)</td>
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<td>PLW</td>
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<td>Papua New Guinea</td>
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<td>PHL</td>
<td>Philippines</td>
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<td>PCN</td>
<td>Pitcairn Islands (United Kingdom of Great Britain and Northern Ireland)</td>
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<td>KOR</td>
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<td>WSM</td>
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<td>Singapore</td>
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<td>Solomon Islands</td>
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<td>Vanuatu</td>
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<td>VNM</td>
<td>Viet Nam</td>
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<td>SLK</td>
<td>Wallis and Futuna (France)</td>
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Annex
Executive summary

This document *Transitioning to Integrated Financing of Priority Public Health Services* provides guidance to Members States on actions to help secure essential public health functions that can ensure the sustainability and resilience of their health systems. In particular, it considers the implications of reductions in available external funding from global health initiatives, the need for certain countries to transition from external to domestic financing, and the importance of using this transition as an entry point to improve health system efficiency, advance universal health coverage (UHC) and achieve the Sustainable Development Goals (SDGs). The need to secure essential public health functions is relevant not only for countries facing reductions in funding from global health initiatives, but also for countries undergoing service delivery and budgeting reforms.

Four recommended actions are identified: (i) confirm core programme elements and service delivery arrangements; (ii) strengthen financing institutions to make better use of available resources; (iii) increase domestic financing; and (iv) govern the transition process.

**Action 1. Confirm core programme elements and service delivery arrangements**
The first action entails mapping existing core programme elements in disease control programmes that are externally financed, followed by in-depth analysis of their current organization and options for future arrangements in order to strengthen the performance of the public health system, including possible efficiency gains. National disease control programmes consist of a set of core programme elements that are closely linked with essential public health functions.

**Action 2. Strengthen financing institutions to make better use of available resources**
The second action identifies key considerations for improving efficiency through health financing systems. This requires coordination and integration of various funding streams for priority programmes to reduce fragmentation and duplication across the health system at various levels, alignment of public financial management and provider incentives, and coordination of external funding.

**Action 3. Increase domestic financing**
The third action presents avenues for domestic resource mobilization and cross-sectoral spending that could impact favourably on health. These include earmarking of sources of funding or expenditure, leveraging private resources for health and collaborating across government sectors. Key enablers include active engagement between health and finance authorities and the development of a comprehensive health sector plan with clear objectives, which include integrated vertical programme strategies and realistic performance indicators, as well as effective implementation of the allocated budget.

**Action 4. Govern the transition process**
The fourth action provides guidance on how the process of transition from external funding should be governed. It recognizes that the transition process in countries will be situation specific. What is essential is that countries understand and respond appropriately to the risks and opportunities of the transition that are relevant to their particular contexts. Further, for all countries going through a transition, it should be well planned, inclusive, and overseen by an appropriate constituted and informed oversight mechanism.
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The way forward

It is recommended that Member States clearly define a set of essential public health functions for population health gains that are secured through adequate public funding from domestic sources. In transitioning to increased reliance on domestic sources and/or integrated financing, Member States are encouraged to take action to ensure a phased approach for a smooth transition. These actions include ensuring the transition is well incorporated into the national health strategy and annual operational plan with clear budget indications, taking a whole-of-system approach to improve efficiency through integration and better coordination among programmes. Building consensus, mapping core programme elements with essential public health functions, assessing health system capacity to deliver these functions, monitoring progress and adjusting policy accordingly are also considered key actions.

The World Health Organization (WHO) will continue to support countries in managing the transition from external funding to domestic and integrated financing and in securing essential public health functions as part of this process. Priority actions will focus on engagement with global health initiatives and development partners to facilitate actions for countries in the process of transition, including: designing a midterm funding plan and co-financing approaches to encourage countries to increase domestic funding; reviewing vertical programme delivery mechanisms and supporting operational changes for greater efficiency; aligning and channelling external funding through domestic financing systems to the extent possible; and encouraging greater collaboration among disease control and other public health programmes, between ministries of health and finance, and health insurance agencies where applicable.

WHO will facilitate country-level policy dialogue on priority setting and planning based on a clear framework and robust evidence, and synthesize experiences and provide guidance for a smooth transition according to each country’s specific context.
1. Introduction

Developing a health system that is sustainable and resilient is a challenge shared by all countries. A high-performing health system provides optimal health services to meet population and individual needs and achieve optimal health outcomes. But it must do so in a sustainable manner that ensures future generations will continue to benefit from the health system. A high-performing health system is able to cope with and recover quickly from internal and external shocks, and to prepare for and adapt to changing circumstances (1).

Governments need to secure the delivery of essential public health functions as part of a resilient and high-performing health system. While there is no universally agreed definition of “essential public health functions”, these broadly refer to the services and operations included under the broad scope of public health. They reflect a set of functions fundamental to the protection of population health that address the determinants of health and treat disease. These functions underpin targeted programmes, regardless of whether financed through domestic or external sources. The government does not need to implement all of these functions, but does need to ensure they are financed sustainably and delivered in a manner that responds to the health needs of the population.

The challenge of securing a set of essential public health functions in the face of a changing environment is shared by all countries. The need to secure essential public health functions is not only a concern for countries facing reductions in funding from global health initiatives; it also is relevant to countries undergoing service delivery and budgeting reforms. However, the challenge is particularly acute for countries facing reductions in available external funding from global health initiatives. It requires these countries to not only consider increases in domestic funding for public health, but also transition from vertically funded programmes to more sustainably financed integrated delivery of public health programmes, as a means to achieving universal health coverage (UHC).

Document outline

This document, Transitioning to Integrated Financing of Priority Public Health Services, provides guidance to Member States on actions to help secure essential public health functions that can ensure the sustainability and resilience of their health system. In particular, it considers the implications of reductions in available external funding from global health initiatives and the need for certain countries to transition priority public health programmes to domestic financing.

This document has four chapters. Chapter 1 provides an introduction. Chapter 2 focuses on the importance of sustainable and resilient health systems, first elaborating on the various challenges facing health systems in the Western Pacific Region and then highlighting the importance of essential public health functions in meeting these challenges. Chapter 3 provides specific guidance to countries on the transition away from disease-specific vertical funding mechanisms, in particular those funded by global health initiatives, to a whole-of-system approach. Chapter 4 summarizes the key directions for the World Health Organization (WHO) and Member States in the Region to move forward.

Regional context

Over the past few decades, the WHO Western Pacific Region has made great progress lowering the burden of disease, such as for tuberculosis (TB), HIV/AIDS, malaria and other communicable diseases. Since 1990, concerted efforts have reduced TB prevalence by over 53% and deaths by over
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73% (2). There have also been impressive gains in lowering the burden of HIV/AIDS and increasing antiretroviral therapy (ART) coverage in the Region (3). Nine out of 10 malaria-endemic countries achieved their malaria-related targets in the Millennium Development Goals (4), and millions of deaths and disabilities have been prevented due to the work of the Expanded Programme on Immunization (EPI) in the Region (5).

Sustaining and building upon this progress, however, is not automatic. Equitable coverage and access to treatment remain struggles for the major disease control programmes, particularly for vulnerable and hard-to-reach populations. Emerging issues, such as recent outbreaks of poliomyelitis (polio) and measles, and increasing drug resistance (Box 1) are also posing new challenges to the need to address public health priorities from a whole-of-system perspective.

**Box 1: Drug-resistant tuberculosis**

Resistance to tuberculosis (TB) drugs is a formidable obstacle globally to effective TB care and prevention. Drug-resistant TB (DR-TB) is driven by many factors and fuelled by improper treatment of patients, poor management of the supply and quality of drugs, and airborne transmission of bacteria (6). In 2015, there were approximately 580,000 cases globally of DR-TB and nearly half of those people died (2).

Treating DR-TB is costlier – at least 30 times more expensive than treating drug-sensitive TB – and takes longer. Standard drug-sensitive TB treatment lasts six months, while DR-TB treatment can take 2–4 times as long.

Clinical management of DR-TB patients is also difficult, and second-line anti-TB medicines used for treatment of DR-TB often have devastating side-effects. This challenge is compounded by catastrophic economic and social costs that patients face when seeking DR-TB diagnosis and treatment. These costs can put families in poverty and undermine economic gains and stability.

To achieve the global goal of ending TB as an epidemic by 2030 and to prevent a potential health disaster, all efforts should be taken to stop the spread of DR-TB. To defeat DR-TB, countries and partners need to invest more, ensure universal access to diagnosis and treatment, and adopt and expand the uptake of new diagnostic tools, drugs and treatment regimens as well as innovative approaches to tackle the problem.

*Sources: WHO (6), (2).*

Further, health systems are being required to meet new systemic challenges – emerging pandemics, health emergencies and natural disasters that require diverse health system capacities to respond to rapidly changing circumstances. Reductions in external funding in some countries, due to rapid economic development, are placing greater responsibility on domestic health financing institutions.

To address these challenges, a renewed emphasis on, and investment in, essential public health functions and in ensuring the continuity of core programmatic elements will be required. This will enable countries to more effectively and efficiently develop sustainable and resilient health systems to achieve UHC. *Universal Health Coverage: Moving Towards Better Health*, the action framework for the Western Pacific Region, has identified a range of actions to strengthen health system attributes to achieve quality, efficiency, equity, accountability, sustainability and resilience (1). Furthermore, the *Regional Action Agenda on Achieving the Sustainable Development Goals in the Western Pacific* provides guidance on implementation of the Sustainable Development Goals (SDGs) based on
country context and entry points (7). The rest of this section provides additional details on the various trends and challenges impacting health systems in the Region.

**The health needs of the populations in the Region are changing.** All countries in the Region are undergoing changes in their epidemiological and demographic profiles. Successes in addressing communicable diseases in the past few decades, plus a combination of urbanization, ageing and changing lifestyles, mean that people are dying less from communicable diseases, but are more likely to be living with chronic noncommunicable diseases (NCDs), such as cardiovascular disease, diabetes and dementia. NCDs are now responsible for nearly 80% of preventable deaths in the Region (8). The Region also faces continuous health security threats with an average of 200 events detected and managed each year. Furthermore, citizens and communities are more informed and active in participating in their health. This places greater expectations on already burdened systems to deliver higher-quality care and a broader package of services at an affordable cost.

**Rapid economic development in many countries in the Region over recent years has provided a favourable context for increasing public spending on health.** However, total health expenditure as a percentage of gross domestic product (GDP) in countries in the Region range from less than 3% to over 16%. Private health expenditure, a majority of which is from out-of-pocket (OOP) payments for many countries, can be a large share of total health expenditure (Fig. 1). The differences in the components of total health expenditure between Asian countries and Pacific island countries and areas reflect different mixed health financing systems. High OOP payments can be problematic for accessing preventive services and achieving public health gains, which require population-level coverage.
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Fig. 1. Total health expenditure as a % of GDP in Asian and Pacific island countries, 2014

HI = high-income, L&LMI = lower and lower-middle-income, UMI = upper-middle-income.

Sources: Cambodia from National Health Accounts Report (9); Viet Nam provisional 2013 health accounts data; Lao People’s Democratic Republic from 2011–2012 National Health Accounts Report (10); all other countries from WHO Global Health Expenditure Database (11).

Financing for essential public health functions, such as for prevention and public health services, represents a wide range as a share of total health expenditure but tends to be low in many countries in the Region (Appendix 1). Typically, clinical treatment absorbs most available resources, while prevention and public health activities, for example maternal and child health, family planning, immunizations, prevention of communicable diseases and NCDs, screening and surveillance, have been under-resourced.

External funding can comprise a sizeable portion of a country’s total health expenditure and of priority public health programmes. Several countries in the Region are highly dependent on external funding (Appendix 2), which has played a key role in helping contain the spread of communicable diseases in the Region. Significant support has been received from global health initiatives, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and Gavi, the Vaccine Alliance, and through support from bilateral partners. 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 (Appendix 3). Of the total Global Fund grants disbursed, 35.33% was allocated for HIV/AIDS programmes, 32.6% for TB, 28.26% for malaria and 4.24% 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 (12).

Gavi has disbursed US$ 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 (Appendix 4) (13). 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 (Box 2). PEPFAR spent over
US$ 250 million in select Asian countries in the Region from 2012 to 2015. Seventy-one per cent of its spending was channelled to HIV/AIDS programme expenditures, while 29% was spent on health systems strengthening (Appendix 5) (14).

Several countries in the Western Pacific Region are either in the process of transition, or beginning the process of transition away from long-term donors such as the Global Fund and Gavi. For each of the global health initiatives, transition is interpreted slightly differently; however, their transition and sustainability policies are underpinned by the central tenet that in order for countries to successfully transition from external donor assistance, planning for and co-financing commitments need to be part of the programme design from the outset – no matter where a country lies on the development continuum. 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) as measured by the World Bank, 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.

<table>
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<th>Box 2: United States President’s Emergency Plan for AIDS Relief (PEPFAR) strategy</th>
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PEPFAR has helped introduce and scale up life-saving treatment for millions of people living with HIV worldwide. PEPFAR evolved from an initial emergency response to the epidemic (PEPFAR 1, 2003–2007) to a more focused and sustainable approach (PEPFAR 2, 2008–2012), and now to an accelerated approach to epidemic control that targets populations and geographic areas with the highest rate of new HIV infections, while sustaining gains made to date (PEPFAR 3.0, 2013–2019).

PEPFAR has included support for several countries in Asia, including Cambodia, China, the Lao People’s Democratic Republic, Papua New Guinea, Thailand and Viet Nam, where the focus has been on collaborating with national programmes to provide technical assistance to accelerate the national response, including supporting catalytic models and innovations designed for national impact, filling gaps in underserved populations and strengthening key systems needed to sustain epidemic control, such as sustainable financing. To guide these sustainability activities, PEPFAR has developed a tool, the HIV/AIDS Sustainability Index and Dashboard, to sharpen the understanding of each country’s sustainability landscape and to assist in making informed HIV/AIDS investment decisions. PEPFAR’s financial support has gradually decreased in Asia over the past decade as the initiative has begun to prioritize high-burden geographical regions, such as eastern and southern Africa.

*Source:* Vogus & Graff (15).

Reductions in donor funding for disease programmes have obvious and significant implications for public health priorities in transitioning countries, particularly in terms of financing and health system governance. Lessons learnt from countries that have transitioned from all or some disease components funded by global health initiatives, such as China, Malaysia and Mongolia, highlight the need for a systematic and phased transition process in order to sustain relevant and critical functions (see Gavi example in Box 3). The transition process can act as a catalytic entry point to review and improve

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1 PEPFAR has investments in Cambodia, Papua New Guinea and Viet Nam. It has also channelled funding for HIV/AIDS and health systems strengthening through its Asia Regional Programme, which covers China, the Lao People’s Democratic Republic and Thailand.
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health system efficiency and performance, through, for example, rationalization and integration of disease-specific activities, or investing in broader health system functions such as procurement and supply chains, integrated health information systems and national UHC efforts. While this may not be possible in all scenarios, donors and technical assistance partners have a responsibility to support countries to achieve financial and programmatic sustainability of public health priorities, and promote efficiency gains and the integration people-centred services where possible.

Box 3: Gavi’s approach to increase domestic financing and strengthen the health system in support of a sustainable immunization programme

Gavi, the Vaccine Alliance, is an international organization supporting lower-income countries to protect the health of children through increasing equitable access and use of vaccines. Gavi’s transition and sustainability vision foresees countries to successfully expand their national immunization programmes, with vaccines of public health importance and sustain these vaccines post-transition, with high and equitable coverage of target populations. In addition, countries should have robust systems and decision-making processes to support the introduction of future vaccines. In essence, the vision is to build the necessary conditions for a successful transition to achieve programmatic and financial sustainability of the immunization programme.

To achieve this, Gavi and its partners expect to engage early on with the countries, taking a differentiated approach and sequencing investments to ensure that the appropriate interventions are implemented at the right time. Sustainability, therefore, needs to be fully embedded in the design and implementation of all Gavi investments, including new vaccine and health systems strengthening support.

In the Western Pacific Region, five countries are currently receiving Gavi support: Cambodia, the Lao People’s Democratic Republic, Papua New Guinea, Solomon Islands and Viet Nam. Kiribati and Mongolia, having passed the eligibility threshold in 2011, have transitioned and are no longer eligible for Gavi support.

As part of supporting systematic planning for financially sustainable immunization programmes, Gavi-eligible countries are expected to gradually increase their co-financing contributions to Gavi-supported vaccines as a commitment to domestic financing responsibility. The Lao People’s Democratic Republic, Papua New Guinea, Solomon Islands and Viet Nam have all entered the five-year accelerated transition phase after passing the eligibility threshold. Although each country is in a different stage of accelerated transition, they all are required to progressively increase their co-financing commitment for vaccines to achieve full self-financing status by the end of their fifth year.
As part of the transition process, countries are supported to conduct joint transition assessments and develop transition plans with the assistance of Gavi and its Alliance partners – the World Health Organization, the United Nations Children’s Fund and the World Bank. The focus of the transition plans vary from country to country, but include interventions to support strengthening domestic financing systems, improving efficiency and increasing domestic resources for immunization services, as well as interventions to strengthen the programmatic and governance components of national immunization programmes.

Source: Gavi (16).

Other challenges include increasing stakeholder complexity, the need for flexible financing, further integration of service delivery, and contradictory policies that undermine the potential to reach better results. There is an increasingly complex array of stakeholders – within and outside government – that need to be effectively engaged in light of the general trends towards decentralization, increasing role of private sector and focus on social determinants of health, among other factors. Regulatory, financing and other governance strategies and capabilities are required to protect and promote the public interest.

In many countries, the fragmentation of funding flows affects service delivery, including how services are delivered, by whom, and the corresponding quality and cost. Financing and service delivery should be integrated in a way that places people at the centre (17) and promotes continuity of care for the patient rather health services that revolve around providers.

Health system challenges can also be reflective of the contradictory policies and limit the ability of different levels, institutions and other stakeholders to work together. For example, updated care and treatment guidelines for HIV and TB may be at odds with outdated public health acts that may necessitate alternative service delivery arrangements to overcome outdated institutional processes.

2. Transition to integrated delivery and financing

The way public health is financed is a critical determinant in whether the health needs of the population are addressed in a sustainable and resilient manner. Countries are undergoing their health financing transitions, moving from external funding and OOP payments to more sustainable domestic financing as they continue to experience economic growth. As health systems reorient around integrated people-centred care and seek to secure public health functions, health financing systems also need to transition to facilitate and support relevant policy objectives.

There is no single way in which this should be done, and countries will need to carefully design how funds are collected, pooled and used to purchase health services and fulfil relevant public health functions. Countries are currently considering or implementing various health financing mechanisms, such as increased use of performance-based payment mechanisms and financing of integrated networks of providers, and improving the flexibility and responsiveness of public financial management systems. Particularly important for countries facing reductions in external funding – and for this document – is the transition towards a greater reliance on domestic financing. This requires an overall increase in domestic financing for health but also highlights the importance of improving health system efficiency and performance.
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2.1 Whole-of-system approach to securing essential public health functions

Strengthening essential public health functions is relevant for all health systems as they underpin public health programmes in all countries. While there are various approaches to organizing a health system, a resilient 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. A functioning health system is crucial for UHC and achieving SDG health goals. *Universal Health Coverage: Moving Towards Better Health*, the UHC action framework for the Western Pacific Region, makes this explicit in its identification of sustainability and resilience as health system attributes to UHC (1).

All health systems must have the capacity to discharge a set of public health functions that are essential to promote and protect public health. While various definitions of essential public health functions exist (Appendix 6), they should fulfil the following main public health operations:

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

Health system components, such as governance, financing, human resources for health, health information systems and research, social participation, and public health communications, are also important (Fig. 2).
Fig. 2. Whole-of-system approach to essential public health functions

The whole-of-system approach entails the following key principles that are critical in the transition to integrated delivery and financing for priority public health programmes.

- **A set of up-to-date, clearly defined essential public health functions based on changing health needs.** While there are different ways to define essential public health functions, each country needs to have clearly defined public health functions to be able to effectively ensure population health, including infectious disease control, NCD risk-factor control and health emergencies. How countries achieve this is context specific. However, all countries should be well informed on how their own health system delivers and finances the relevant functions, as a precondition to sustaining and improving performance.

- **Health system architecture needs to be developed to efficiently discharge public health functions and meet population health needs.** This includes clear articulation of the roles of various health institutions at different levels of the health system coupled with appropriate coordination and accountability measures. It also requires rational allocation of resources to ensure primary care and prevention, and harnessing of non-state service providers for the public benefit.

- **Adequate public funding from domestic sources for public health functions (prioritize public health functions).** Funding for public health institutions, including capital investment, staff salary and activities, should mainly come from the regular government budget. The
importance of domestic financing for public health is increasingly important in the context of reduced external funding for health, particularly for countries transitioning out of support under global health initiatives.

- **Governments need to effectively use regulatory, financing and other governance strategies to achieve public health objectives.** Public health challenges and potential solutions are increasingly characterized by a complex array of stakeholders – within and outside government – that need to be effectively engaged to protect and promote the public interest. As the stewards of their nation’s health, governments cannot only rely on administrative measures and must use information, regulation, contracting and financing to shape and influence the whole of society.

- **Effective discharge of essential public health functions requires a fit-for-purpose workforce.** Health systems need to have appropriately skilled public health practitioners, as well as particular public health competencies across the entire health workforce. This includes the ability to monitor health risks and changing needs, prevent and control health problems, respond to outbreaks and emergencies, and engage and empower communities.

- **Equity of outcomes and leaving no one behind.** Addressing marginalized populations is one of the core elements in many disease control programmes (5). Shifting to prepayment of health expenditures, through government general revenue and social health insurance, should help address some of the entrenched economic barriers to accessing health services that result from the high reliance on OOP health financing. The budget can also be used to prioritize improving the access to services for vulnerable and hard-to-reach populations.

Essential public health functions are supported by the core programme elements in priority public health programmes, such as HIV, malaria and TB, which underpin time-bound targets and goals to reduce mortality and morbidity. Each disease control strategy has a unique set of core programmatic elements depending on the nature of the disease and available cost-effective interventions. National capacities have been developed ensuring the implementation of such core programme elements with substantial donor investment during past decades.

In principle, these core programme elements are closely linked with, or are an integral part of, essential public health functions and other health system functions. However, the level of such integration and harmonization varies depending on countries and individual programmes, which determines overall system efficiency.

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2 For example, core elements of the TB control strategies can be summarized as early diagnosis through quality-assured diagnostic services and standardized treatment with patient support mechanisms. Malaria control strategies have been emphasizing prevention through various vector-control methods in addition to early diagnosis and prompt treatment, similar to TB strategies. HIV control strategies emphasize both prevention and treatment underpinned by new evolving interventions.
### 2.2 Actions for smooth transition from a vertically funded programmatic approach to a whole-of-system approach

Within the context of reduced funding for disease control programmes, this document outlines measures that countries can take to plan for a smooth and phased transition from a vertically funded approach to disease control to a whole-of-system approach. Four recommended actions are identified: (i) confirm core programme elements and service delivery arrangements; (ii) strengthen financing institutions to make better use of available resources; (iii) increase domestic financing; and (iv) govern the transition process.

**Action 1. Confirm core programme elements and service delivery arrangements**

Core programme elements should be interlinked with national systems in order to strengthen system-wide efficiency, sustainability and resilience. The first action entails two steps: (i) identify the core programme elements in disease control programmes; and (ii) examine the current implementation arrangements for each element and the potential options for future integration and harmonization.

**a. Identify core programme elements**

Although the specific composition of core programme elements tends to vary across health system settings, there are a number of elements that are universal. Table 1 provides a list of core programme elements that are typically included across national public health programmes.

#### Table 1. Core programme elements

<table>
<thead>
<tr>
<th>Elements</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy, guidelines,</td>
<td>Government has fundamental stewardship and regulatory functions including setting national policies and strategies, developing guidelines, and overseeing programme implementation including monitoring, evaluation and supervision.</td>
</tr>
<tr>
<td>stewardship and regulations</td>
<td></td>
</tr>
<tr>
<td><strong>Prevention</strong></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><strong>Surveillance</strong></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><strong>Outbreaks and emergency response</strong></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><strong>Diagnosis, treatment and care</strong></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 and HIV programmes.</td>
</tr>
</tbody>
</table>
## Annex

| 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. |
| 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. |

*Source: Authors.*

Ideally, individual programme elements should be integral parts of system-wide essential public health functions. For example, individual programme surveillance systems should fit hand-in-glove as part of a broader national disease surveillance system (Case A, Fig. 3). This would allow for a mutually reinforcing relationship between an essential public health function and core programme elements. However, in reality, many disease-specific surveillance systems are designed as stand-alone systems that may not be consistent or compatible with the overall national surveillance system, or each other (Case B, Fig. 3). In general, investments in strengthening a disease-specific core programme element should contribute to strengthening the essential public health functions of the health system. Further, whenever the integration and harmonization of core elements are pursued, maximum efforts should be made to utilize general essential public health functions instead of building disease-specific systems. Similar arguments are valid for many core programme elements such as procurement and supply management systems, laboratory services/networks and community-based services.
Fig. 3. Core programme elements and the essential public health functions

b. Analyse current organization of core programme elements and explore options to address fragmentation and improve coordination

Many contextual factors will influence the current organization of core programme elements. These include the overall health system architecture, the division of responsibilities between public health and clinical services and between the public and private sectors, the levels of delegation and decentralization, the availability and maturity of quality health services, and health financing systems including payment mechanisms.

An example of the role of health system architecture influencing the organization of programmes is in service delivery, in which vertical programme design has often led to fragmentation. In some settings, clinical services, such as diagnosis and treatment of priority diseases, are provided by dedicated public facilities, for example designated TB facilities, HIV treatment clinics, etc., while in other settings general health-care facilities can provide clinical services supported by disease notification, coordination and payment mechanisms.

The division of responsibilities influences service delivery for immunizations. Traditionally, immunization programmes utilize the primary health care network. However, many countries with relatively advanced health system capacity have introduced a system in which general practitioners and paediatricians, both in the public and private sectors, become the primary providers for immunizations, often with a specific provider payment mechanism.
Annex

For each of the identified core programme elements, options should be explored for future arrangements to pursue efficiency, system coherence and sustainability. Although it is highly context specific, there are some areas in which relatively large efficiency gains can be expected.

Surveillance and disease-specific information systems represent a good example where efficiency gains could be made through combining multiple separate surveillance systems into one. Historically, parallel reporting procedures have been established by disease programmes. This can create a substantial administrative burden for general health workers, especially at the peripheral levels. Having recognized continued needs for disease-specific information, there has been increasing consensus that the future direction is to move towards integrated health information systems. It streamlines data and reporting needs across programmes to reduce the burden of reporting, promote effective use and facilitate timely response. Some countries are spearheading such efforts (Box 4).

Box 4: Implementation of Lao health sector reform: applying District Health Information Software (DHIS2) as an integrated health information platform

In 2013, the Ministry of Health of the Lao People’s Democratic Republic developed the National Health Sector Reform Strategy to 2025 that highlights the twin goals of achieving the Millennium Development Goals by 2015 and universal health coverage (UHC) by 2025.

Under the Reform Strategy, the Ministry of Health decided to switch its health management information system from paper-based Excel spreadsheets to DHIS2 – an open source, web-based software that can serve as a data collection and reporting tool as well as a data warehouse and information exchange platform. Between 2014 and 2016, DHIS2 application was rolled out nationwide, capturing data from every public health facility for the health management information system, with an average 95% of all facilities reporting monthly. As of the end of 2016, DHIS2 is the reporting tool and reporting system for eight programmes, which can be seen in the diagram below.

The Department of Planning and International Cooperation, which is in charge of the Health Information System, believes that the best way to sustain the current DHIS2-based system is to institutionalize integration of multiple subsystems using the DHIS2 platform, with a vision to interoperate with other potential systems, such
as for logistic management, electronic medical records and surveillance, for which several programmes are seeking information technology solutions.

The first act of the Department of Planning and International Cooperation towards institutionalizing the DHIS2-based Health Information System was to launch the concept of “One Plan/Multiple Partners”. The goal was to get all interested development partners to align their funding and support with an overall Health Information System reform framework and joint annual workplans. The Department of Planning and International Cooperation plays a key role in coordination, setting up expected objectives and defining interventions. For sustainability, legal documents (official directives, ministerial decrees) were issued, ensuring compliance by subnational health authorities and programmes. The funding for the roll-out of DHIS2 as the reporting software for programmes came from contributions by each of the programmes through various sources, including the Government and development partners. The core Health Information System is managed by the Department of Planning and International Cooperation, with funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank, WHO and the Government budget.

The integrated Health Information System on DHIS2 has enabled health system managers to see across all programmes and monitor the implementation of the annual workplan, while inputs for reports are entered by health facilities according to programmes to avoid duplication and overlap. In addition, DHIS2 allows access to more detailed information down to the level of service delivery facilities.

Source: WHO country office in the Lao People’s Democratic Republic.

Another important priority area is the supply management system. In many settings, public health programmes created parallel supply management systems largely driven by programmatic necessity to scale up quickly access to quality-assured essential medicines and diagnostic testing to meet performance-based funding criteria and/or accountability requirements of donors. Along with the strengthening of central procurement and supply management systems, disease-specific parallel systems should be gradually merged into the general supply procurement and management systems (Box 5).

Box 5: Central procurement of HIV and TB commodities

The Government of Viet Nam procures first-line anti-TB drugs by way of national competitive bidding with local manufacturers or importers through its Targeted Programme. It also procures first-line antiretroviral (ARV) drugs manufactured domestically, with only two formulations available due to cost considerations under its Targeted Programme. Eventually, the Government plans to procure pharmaceutical products, including anti-TB drugs and ARVs, offered in the public health system through a dedicated Central Procurement Unit within the Ministry of Health. Having a dedicated procurement unit will help improve competition among suppliers for contracts, establish lower pharmaceutical prices and more accurate quantities, select the right vendors, and improve the quality and types of procured drugs.

The structure, governance and implementation of the new procurement unit are being worked out. The Government could consider several arrangements, such as: (i) centralized procurement of drugs conducted by the Ministry of Health; (ii) price and quantity agreements negotiated by the Ministry of Health at the central level and implemented through a dedicated/authorized purchasing agent; or (iii) framework prices and quantity agreements that are negotiated by the Ministry of Health centrally. However centralized procurement is arranged, the Government needs financing strategies to mobilize resources and improve efficiencies through payment and reimbursement mechanisms. As a case in point, the Prime Minister’s Decision No. 1899 calls for national-level centralized procurement using the social health insurance fund for ARV procurement, but current
policy prohibits Viet Nam Social Security from making direct payments for drugs at the central level or from the social health insurance fund to any supplier.

Setting up an effective procurement unit will also require improvements in the procurement processes and systems. The Government’s current procurement processes for anti-TB drugs and ARVs are characterized by a strict bureaucratic and lengthy process with lead times of about 12 months. Local tenders can take as long as 3–4 months. This lengthy process could lead to major delays, possible outdated orders and misalignment in current drug needs. Ways to streamline or simplify the process without prejudice to quality and control could be considered.

Sources: Case study on Strengthening Domestic Financing Institutions for Universal Health Coverage in Viet Nam. WHO Regional Office for the Western Pacific (forthcoming); Prime Minister’s Decision No. 1899 – Prescribing payment for anti-HIV drugs (ARVs) upon national-level centralized procurement using the health insurance fund and the ARV support fund – Viet Nam.

Table 2 provides a brief summary of the current organization of typical core programme functions and some important principles to guide future harmonization and integration during transitions. More detailed explanations are provided in Appendix 7.

Table 2. Current organization of core programme elements and future directions

<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.</td>
<td>• Mostly retained under public responsibility with ongoing collaboration with civil society organizations.</td>
</tr>
<tr>
<td></td>
<td>• Civil society organizations may play a significant role in health promotion, service delivery and communications.</td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td>• Build response capacity along with declining disease incidence.</td>
<td></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.</td>
</tr>
<tr>
<td></td>
<td>• During the transition, it is critical to monitor service uptake and coverage, and financial burden to patients.</td>
<td></td>
</tr>
</tbody>
</table>
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: Authors.

Integration of core programmatic elements supports national programmes to become more efficient and to focus efforts towards providing improved technical leadership (Boxes 6 and 7). It is also critical to note that moving towards a more integrated and harmonized approach does not imply that specialized technical capacities of programmes should always be integrated. Rather, specific stewardship and programmatic expertise should be retained. Policy and stewardship functions that are required for specific disease control efforts remain a core mandate of ministries of health. Specialized clinical and laboratory services are critical and need to be maintained, as do specialist skills in areas such as entomology and polio as countries advance towards elimination goals.

Box 6: Triple elimination: Collaboration among different programmes

Interventions to prevent mother-to-child transmission of HIV, hepatitis B and syphilis are the essential components of quality care for maternal, newborn and child health. The similarity of the interventions for these three infections means they can be nested in a common platform for maternal, newborn and child health, thus providing a unique opportunity for coordination and integration to maximize the accessibility, efficiency and sustainability of these interventions. Studies have also shown that these nested interventions are cost-effective. However, the interventions are not always implemented in a coordinated manner, resulting in inefficiencies and suboptimal outcomes.
Encouraged by a country-led initiative on the triple elimination of mother-to-child transmission, WHO, in collaboration with Member States and partners, is developing a regional framework for the triple elimination of mother-to-child transmission of HIV, hepatitis B and syphilis in Asia and the Pacific 2018–2030. It is intended as a coordinated and sustainable approach that emphasizes the principle of mother-newborn-and-child-centred care for every child and mother, as well as partners and the entire family.

Sources: Ishikawa et al. (18); Nguyen et al. (19).

Box 7: Integrated service delivery through M-health in Fiji and Mongolia

Mobile health clinics in Fiji

Under the general umbrella of outreach health-care activities, mobile health clinics can serve to improve the health of the population especially by reaching out to disadvantaged population groups.

In Fiji, one of the key aspects in strengthening the diagnostic capacity and TB case detection is through mobile healthclinics. Fiji has two mobile trucks equipped with GeneXpert and portable x-ray machines that can go to hard-to-reach areas and even the outer islands of Fiji. The trucks and equipment were procured through a Global Fund grant. TB cases from hard-to-reach populations have already been detected through this mobile caravan. Furthermore, the GeneXpert system could be used to diagnose NCDs, providing a means to deliver more integrated diagnostic services.

HIV/AIDS testing in Fiji is almost entirely voluntary and accompanied by pre- and post-test counselling. Although some testing of general outpatients is conducted by hospitals, it is largely conducted in antenatal clinics, hub centres, and other youth-friendly centres. These clinics often set up mobile booths at community events for voluntary counselling and testing associated with community awareness campaigns. Additionally, a mobile health clinic has also been introduced in collaboration with the tourism sector to provide counselling and testing for HIV/AIDS, sexually-transmitted infections and hepatitis B.

Note: excerpt pending government review
Source: Fiji case study on the tuberculosis and immunization programmes’ transition to domestic financing, WHO (forthcoming)

Mobile health technology in Mongolia

The Parliament approved Mongolia’s Sustainable Development Vision 2030 in February 2016. The Vision calls for, among others, improving the living environment of the Mongolian people towards leading a healthy and long life, and thus increasing life expectancy at birth to 78 years. It is also underpinned by the principle of “leaving no one behind”, the core concept of the SDGs.

In subscribing to that principle, the national and local governments have strengthened the capacity of primary health care services. The project “Introduction of Mobile Health Technology at the Primary Health Care and Community Level in Mongolia” has been implemented in peri-urban and rural areas. It aims to maximize the added value of mobile health technology innovations through integrated annual screening for NCDs and communicable diseases, such as hypertension, diabetes, TB, HIV/STIs and viral hepatitis B and C, in addition to medical check-ups and treatment and care of people with illnesses. Based on the results of the pilot implementation phase, and the demands from the rest of the local governments, the continued support on the use of cost-effective mobile health technology is expected to improve both access and quality of primary health care for hard-to-reach segments of the population, such as those in rural areas.

Source: WHO country office in Mongolia.
Action 2. Strengthen financing institutions to make better use of available resources

Improving efficiency entails doing more with available funds. Inefficiency has many forms, many of which result from the health financing system, either in resource allocation or in the way the system operates. Cutting ineffective spending and waste will produce savings and facilitates a more value-based health-care system (20). While there will be best practices of vertically funded programmes that need to be retained, efficiency at the programme level does not necessarily translate to efficiency at the health systems level.

Action 2 outlines the key considerations for improving system-wide efficiency, including the prioritization of core programme elements and ensuring they have access to sufficient public funding, identification of the overall transition landscape and key features of the public financial management system, and understanding of the role of health insurance in mixed health financing systems.

a. Prioritize and fund core programme elements

It is critical for countries to ensure core programme elements and the continuation of interventions during the transitional phase, as well as meeting the changing health-care needs of the population.

- **Establish a transparent process in priority setting.** While each country has its own prioritization process, such a decision-making process should be based on evidence and be transparent. Prioritization depends on many factors, such as burden of disease, cost-effectiveness, equity, ethical and societal values, and budget impact.

- **Prioritize based on country context.** Prioritization can be considered within disease priorities and across priorities and the system as a whole. Particular consideration should be given to those interventions that have a high impact and target high-risk or the most marginalized population groups. Prioritization across priorities should consider areas of duplication and misalignment and ways to gain efficiencies across the health system. The transition process is complex and while particular priorities will be readily identified, it will also be important to foster conditions that allow for emergence.

- **Target high-risk and disadvantaged populations.** Ensuring access to services by high-risk and vulnerable populations is critical for the protection of the whole population, as well as for human rights principles. People with infectious diseases, such as HIV or TB, often face stigma and discrimination in the community, at the workplace or schools, and at the health facility.

- **Address funding gaps and overlaps in the transition.** It is important to address potential funding gaps and overlaps in financing key programme elements. This is not just to simply replace donor funding with domestic sources, but to map the funding needed with the new direction, as indicated in Action 1. The flow of funds is affected by how public finances are managed within the health system at different levels. Population-based services should be mainly funded by the government budget from domestic sources (Box 8), while individual-based services can be covered by either general budget allocation or health insurance.
Box 8: Mongolia’s Government budget

Mongolia’s state budget funds individual- and population-based health services covering four priority health areas: maternal health, child health, communicable diseases and NCDs. It finances population-based services that include communicable disease monitoring, safe water supply and sanitation, health promotion and education, disease prevention, and environmental health. The national Health Insurance Fund, as a component of the Social Insurance Fund, is part of the state budget. Inpatient and outpatient services at the secondary and tertiary levels, including emergency services and long-term care, are subsidized by the Health Insurance Fund with co-payments by patients for inpatient care. To avoid overlaps, duplications or gaps in services, Mongolia’s medical service and health insurance laws clearly delineate the entitlements funded through the state budget and the national Health Insurance Fund.

The Ministry of Health continues to finance most public health facilities using historical line-item budgets. Private family group practices receive Government funds by capitation to deliver primary care. As the health system is decentralized to the level of the aimag (provinces), aimag and capital city governors are responsible for primary health services and receive earmarked transfers (special purpose transfers) from the central Government. They can also provide additional financing to health facilities within their provinces and make adjustments to the health sector budgets under their control. To ensure consistency of health policies, the Ministry of Health arranges output-based contracting with directors of tertiary-level health-care facilities and aimag and city governors. This contracting is good for purposes of accountability, but it can also undermine and reduce the role of the national Health Insurance Fund in financing and management.


b. Align different funding sources and funding flows

Coordination and integration of different funding streams for priority programmes are needed to reduce fragmentation and duplication across the health system at various levels. Moving towards strengthened domestic financing requires consideration of coherent policy between central and local government, alignment of public financial management and provider incentives, and coordination of external funding.

- **Absorb programme staff into the general health system.** Various payment methods to facilities and health workers have been used in vertically funded programmes to focus attention on the implementation of priority public health programmes. In most countries, health workers, such as doctors and nurses, are civil servants, often paid a low salary for what is a specialized and vital field of work. This salary is usually set centrally. An issue to address during the transition is how to absorb these programme-specific staff into the public health system and ensure that they continue to be adequately remunerated, despite their reclassification as civil servants.

- **Strengthen public financial management systems and payment mechanisms.** The public financial management (PFM) system that outlines the budgeting process – planning, allocation, execution and monitoring – is essential to understanding how public funding flows through the health system and how they are used. Countries face several challenges, including delay of or underutilized funds, non-transparent processes, and inflexibilities in being able to use funds across line items or over time, that need to be addressed to make the most out of
limited resources. In addition to PFM, there are various mixed payment mechanisms that can provide incentives to improve equitable access to quality services.

- **Create flexibility in PFM systems for contracting nongovernmental organizations.** As countries move toward general budget allocations, payments to private providers, such as nongovernmental organizations and volunteers, need to be addressed as they may play a large role in the delivery of essential public health functions. In many countries, flexibility in the PFM system on the use of public funds to contract nongovernmental organizations and volunteers is limited, which can be critical given nongovernmental organizations and volunteers may be one of the major providers of preventive services and serve the most-at-risk and vulnerable groups. Engagement with nongovernmental organizations can also be strengthened through the setting of incentives, in-country mechanisms or systems to support core programme elements.

- **Channel external funding through the PFM system.** At the country level, donor funding has to be better coordinated – both with the government and among other development partners. Using the PFM system will increase the visibility of programme spending to budget decision-makers and help to strengthen government systems. In particular, it should strengthen the coherence of annual operational plans and budgets and help to improve oversight and monitoring systems.

- **Set donor co-financing requirements to encourage more domestic resources.** Global health initiatives and other external donor partners may require co-financing from governments (Box 9). This unlocks more resources for health in countries, promotes ownership of and accountability by government, and facilitates a graduated approach towards longer-term sustainability of vertically funded programmes. For donors, it is important that required government co-financing be aligned with the national context and priorities and to ensure the increase in total funding to health from the government.
Box 9: The Global Fund’s Sustainability, Transition and Co-financing Policy

The Sustainability, Transition and Co-financing Policy was approved during the 35th Global Fund Board Meeting in April 2016. It is based upon the principles of differentiation (country context), alignment (with existing systems and processes), predictability (to give sufficient time for the transition), and flexibility (in adaptation of the policy).

**Sustainability and transition – increasing alignment and predictability**

<table>
<thead>
<tr>
<th>LIC/LMIC</th>
<th>L-LMIC/U-LMIC</th>
<th>U-LMIC/UMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Support National Strategic Plans to ensure the sustainability of HIV, TB, and malaria programs</td>
<td>• Transition Readiness Assessment</td>
<td>• Once country-component becomes ineligible, may receive 3 years of Transition Funding</td>
</tr>
<tr>
<td>• Support development of Health Financing Strategies in countries with high burden of disease and/or low revenue capture</td>
<td>• Transition Work Plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Transition Work Plan basis for funding request (funding comes from country allocation)</td>
<td></td>
</tr>
</tbody>
</table>

LIC = low income countries, L-LMIC= low-lower middle income country, LMIC= lower middle income countries, U-LMIC= upper-lower middle income country, UMI = upper middle income.

The Global Fund’s approach to supporting countries for sustainability of programmes and to successfully transition includes:

- investing in and providing support for the development of robust, inclusive (including key and vulnerable populations), quality and evidenced-based national health strategies, disease-specific strategic plans, and health financing strategies;
- aligning requirements to ensure that Global Fund-financed programmes can be implemented through country systems;
- supporting countries to assess their readiness to transition both programmatically and financially, to ensure robust planning, and to allow transition workplans to serve as the basis for funding requests;
- providing transition funding for up to one allocation period upon becoming ineligible; and
- applying graduated co-financing requirements and associated application focus requirements (for key and vulnerable population and/or highest-impact interventions) depending upon the income status of the country.

The approach aims to stimulate increased domestic financing for health and for the three disease programmes (AIDS, TB and malaria). The Global Fund will also explore the use of innovative financing mechanisms in an effort to encourage increased co-financing and programme sustainability.

*Source: Global Fund (21).*
c. Determine the role of health insurance in mixed health financing systems

Where health insurance exists, it may be one of the potential mechanisms to cover the cost of the selected functions and services that were previously funded vertically. However, the role of health insurance depends on the features of the insurance schemes – whether they are centrally managed or employ decentralized segmented management, involve a single pool or multiple pools, the levels of risk adjustment, their ability to collect contributions from the formal sector and the presence of special schemes for certain population groups. Health insurance is another way to raise funds for health, but may not result in more total funding than through other means. It may also require substantial government subsidies to be sustainable. Examples of the role of health insurance in mixed health financing systems are featured in Box 10.

- **Identify services and functions that can be potentially covered through health insurance.** Individual-based clinical services can be covered easily by existing health insurance while population-based services or functions are not well suited to be covered by insurance. However, individual-based prevention, as well as case registry and reporting, very much depends on the specific situation of the existing insurance function. Where existing insurance covers the individual-based prevention services, similar functions under vertically funded disease programmes can be covered by insurance; otherwise, they should be covered through general budget allocation. Case registry and reporting are often funded by separate funding streams even though the treatment can be covered by health insurance.

- **Ensure effective coverage of appropriate benefit packages for priority populations.** During the transition, countries are likely to encounter the following challenges:
  - Very often health insurance decides the benefit package according to certain rules and a specific process. Not all services fully covered by the programme will be free for patients under the insurance coverage. To minimize the disturbance of the treatment course, programmes need to prioritize the interventions, as well as to make full use of the exemption rules for co-payment. As some priority populations may be exempt from co-payment, the potential for overutilization of services or over-medication for certain diseases should be monitored.
  - Insurance beneficiaries are membership based. Premium contribution is often compulsory either by the members themselves, employers or government for those do not have capacity to pay. Not everyone in programme-targeted populations may be eligible to be fully subsidized members. To ensure the continuum of treatment, special arrangements need to be considered, including subsidizing the targeted members to be covered by insurance or making the intervention free at the point of receiving services. The choice will have implications on the government budget and the effort of expansion of population coverage under health insurance.
  - Health insurance coverage does not necessarily guarantee the utilization of services. High co-payments and low quality of service are often cited as main reasons that services are not utilized. Members of the population may also be ineligible or may not meet registration criteria, such as fixed residency. In addition, social stigma can also be a reason for people not using the services. This is particularly true for key populations, such as people living with HIV; people who inject drugs; sex workers; and lesbian, gay, bisexual, transgender and intersex people. While insurance registration that requires personal information is a desirable management measure for health insurance, appropriate
measures and efforts must be made to ensure that disclosure or non-disclosure of one’s personal identity does not adversely impact the use of services by key populations or discriminate against their use. For example, discrimination in health-care settings remains highly prevalent and the stigma attached to revealing HIV status to a health-care worker has been recognized as a major barrier to uptake and provision of HIV services by people living with HIV.

- **Subsidize health insurance for programme-related services with government funding.**
  Health insurance has multiple stakeholders within and outside the health sector. Sustainability of the insurance fund has a broader social impact beyond health. In order to keep the balance between revenue and expenditure, extra revenues are needed when population coverage is expanded to high-risk groups. There are different ways to fill the funding gap, such as increasing government subsidies, increasing premium contributions for those who have the capacity to pay, exhausting surpluses, cutting benefits to reduce expenditures and delaying payment to providers. Each of the options has short- and long-term implications. However, without filling the funding gap, sustainability of the insurance funds will be threatened and service quality compromised, and ultimately access to essential health-care services and the overall health outcomes of priority populations will be unduly jeopardized.

**Box 10: Role of health insurance in mixed health financing systems in the Region**

**Efforts to progressively minimize the patient financial burden in the Republic of Korea**

The Republic of Korea in 1989 established a National Health Insurance System to cover every citizen. TB services were included in its coverage. In the early years, patient OOP expenses averaged around 50% of the total cost. In 2007, in order to protect drug-resistant TB patients from catastrophic financial burdens, insurance coverage was raised to 90% – leaving 10% to be borne by patients. The policy was later extended to all TB patients in 2010.

To further minimize the financial burden to patients, an additional 5% subsidy from the Government was put in place in 2011, leaving patient OOP payments at 5%. Patients were supported by this policy for up to two years for an episode of drug-susceptible TB and up to five years for drug-resistant TB. In 2016, coverage was increased to 100% of medical expenses as part of the enhanced UHC policy of the Ministry of Health and Welfare.

This expansion of coverage illustrates the continuous effort of the Government to progressively minimize patient financial burden in order to achieve universal access to quality TB care for all people affected by TB.

*Source: WHO (22).*

**The role of social health insurance in transition: the case of PhilHealth**

The Philippine Health Insurance Corporation (PhilHealth) has demonstrated how social health insurance targeted for both formal and informal sectors can mobilize additional funds for health, support the Philippine Government in its health goals, and help create a condition for equity both in revenue mobilization and service delivery. It also has demonstrated how state funds and social health insurance can be complementary.
The Philippine Government increased its allocation to PhilHealth in the 2017 budget by 3 billion Philippine pesos (around US$ 61 million). Ninety-two per cent of the population has PhilHealth coverage as of 2016. With this increase in the Government subsidy, about 20 million Filipinos (or 8% of the population) will receive free health-care coverage – from basic primary care to catastrophic packages. Included in PhilHealth’s treatment packages are: (i) an outpatient malaria package; (ii) an outpatient HIV/AIDS package; and (iii) outpatient TB treatment, among others. These treatment packages were introduced to help the Government reach the health-related targets in the Millennium Development Goals.

PhilHealth does not cover services provided by private sector health-care professionals and facilities for most primary outpatient care. Exceptions to this rule are for maternal and newborn care and TB treatment. PhilHealth covers services provided by accredited midwives in accredited private maternity facilities and covers accredited centres offering directly observed treatment, short course, for TB (TB-DOTS). PhilHealth has also operationalized a primary care benefit package, which largely offers diagnostic services. In time, immunizations, maternal health and early childcare packages, as well as TB-DOTS, could be incorporated into this package, and some obligated services could be incentivized through pay-for-performance.

Some indigent families already receive free hospitalization in public hospitals through PhilHealth. However, guidelines are still being finalized to include private hospitals starting in 2018. Furthermore, under PhilHealth’s “No Balance Billing” policy, the Government will pay for the medical expenses of PhilHealth-sponsored members. While treatment packages are focused on inpatient care, sponsored members are eligible for an outpatient diagnostic and consultation package. Sponsored members include orphans, abandoned children, abused minors, out-of-school youths, street children, people with disability, senior citizens, battered women under the care of the Department of Social Welfare and Development, barangay workers and volunteers. PhilHealth, however, does not cover outpatient services, and this is one reason some Filipinos struggle to buy medicines. At their discretion health facilities may purchase drugs for sponsored patients, but PhilHealth does not explicitly cover medicines required by families for outpatient care.


Strengthening the role of health insurance and other health financing mechanisms in Viet Nam

As a part of national health systems reform and in anticipation of transitioning away from funding from global health initiatives, Viet Nam has taken great strides to strengthen domestic financing mechanisms and increase Government spending on public health priorities, such as HIV and TB.

With an estimated HIV prevalence of 0.25%, approximately 240 000 people are living with HIV, 48% of whom were receiving treatment in 2016. The epidemic is concentrated in key populations, with the highest prevalence observed among people who inject drugs. Treatment coverage in 2016 was 48% with over 116 000 people receiving ARV therapy.

In November 2016, the Prime Minister called for using health insurance funds for central procurement of ARVs and for provincial governments to support the health insurance premiums and co-payments for people living with HIV. The Government commitment to establish more sustainable domestic financing mechanisms is a major step in the transition away from external funding. However, challenges still remain in the transfer of responsibility to the provincial governments, which may not have sufficient means to mobilize resources. Coverage of health insurance was also limited to 40% of people living with HIV in 2016.
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While Viet Nam is undergoing structural reform with the integration of the district health system and the strengthening of primary care, HIV outpatient clinics are moving from the preventive medicine system to hospitals in order for HIV treatment to be covered by health insurance. This effort requires retraining of a large number of health-care workers in HIV treatment. Moreover, health insurance will cover only treatment and care, and the programme still needs to explore ways to finance other essential public health activities, for example prevention services such as harm reduction and testing for pregnant women, surveillance and other programme functions.

In addition to the HIV response, the Government is in the early stages of seeking alternative sources of funding for TB control with the creation of a foundation to fund patient support and other expenses.

Source: Viet Nam Ministry of Health, Circular No. 15/2015/TT-BYT dated June 26, 2015

Action 3. Increase domestic financing

While external assistance has been instrumental in augmenting health financing and achieving health outcomes, it has been declining because of the steady economic growth in most low- and middle-income countries in the Western Pacific Region. Economic growth, however, does not translate automatically into more domestic resources for health. While increases in domestic financing are expected to address the financing gap due to the phase-out of donor support, it is considered the primary mechanism to meet resource needs for achieving the SDGs (22).

Options to increase domestic financing could vary depending on the country context. Action 3 presents considerations for domestic resource mobilization and cross-sectoral government spending that could impact favourably on health. This includes an increase in public financing, harnessing the investment capacity of the private sectors (and ensuring the regulation of private providers), and better alignment of government investments in other sectors (24). Along with strengthening domestic financing institutions and improving efficiencies, it is critical for countries to increase domestic funding to sustain and further advance progress in infectious disease control.

a. Increase the government’s budget share to health

Public financing is important for the sustainability and resilience of any health system. It is important to mobilize resources through progressive taxation and prioritize health, within a sustainable macroeconomic framework (24). There is no threshold for the optimal share of any health budget to total government budget or to a country’s GDP due to varying country characteristics. But in low-and middle-income countries, the government health budget could be allocated on a priority basis to primary health care, to expand the supply of quality services and quickly address unmet health needs. Political commitment is vital in prioritizing a Health in All Policies approach. Such commitment is manifested in having clear government plans with priorities, institutional arrangements, and, more importantly, continuing budgetary commitments and allocation of resources to health programmes (26).

3 Some studies have provided benchmarks. Cross-country analysis by Xu et al. (25) suggests that 15–20% of OOP as a share of total health expenditure and 5–6% of government expenditure on health as a share of GDP could considerably reduce the incidence of financial catastrophe in a country. McIntyre et al. (26) suggests a target of government spending on health of at least 5% of GDP for progressing towards UHC.

4 Government health budgets should be sufficient enough to support operational and ample social health protection spending, maintenance and depreciation of existing stock of health infrastructure and assets, provide for current health needs and have contingency for health emergencies.
Ministries of health compete with other sectors for limited resources. There are several reasons why governments may not prioritize health in their budgets. Some are related to fiscal issues, some are political, and some are linked to the perception of ministries of finance on inefficiency, waste and poor public financial management practices in ministries of health. Considerations for improving the prioritization of health in government budgets include:

- **Ensure active engagement between health and finance authorities.** At the central level, active engagement and a stronger dialogue between the ministries of finance and health in sectoral planning, budgeting, expenditure and implementation reviews are essential to make a better case for higher budget allocations for health. The formation of inter-ministerial committees and other policy-oriented bodies to foster dialogue and information sharing can enhance coordination and interaction between ministries of health and finance (Box 11). Similar mechanisms and processes apply at the subnational level where there is fiscal decentralization.

**Box 11: Engagement with ministries of finance**

Ministries of finance need to balance the financing demands from various sectors, such as education, health and infrastructure, among others. Ministries of health need to be prepared to answer questions such as: Did you spend all the resources allocated to health? How did you spend those resources? What results did you generate? How can resources be spent more efficiently? Ministries of health and ministries of finance may lack common language, systems, priorities and incentives, and few opportunities exist for dialogue on priorities and funding.

The participation of ministries of finance in the health financing process – from agenda setting to implementation and monitoring of interventions – could help in meeting the challenges of health financing. Further, in many countries in the Region, budget allocations by ministries of finance tend to be based on historical spending rather than on needs and possible results across sectors. Ministries of health can benefit from supporting reform agendas driven by ministries of finance including, for example, linking expenditures to outcomes, which would help strengthen the efficient allocation and use of resources, inform governments’ strategic planning and long-term investment decisions, and improve the accountability of governments and donors.

Stronger coordination between ministries of health and finance will help further facilitate understanding of the importance of a Health in All Policies approach and the alignment of government investments in other sectors in order to optimize government investments in health. With this understanding, ministries of finance could prioritize a mix of social spending on pro-health subsidies targeted to the poor. This could cover a range of social services, including: housing; nutritional assistance; education; care coordination and community outreach; public safety; managing environmental risks; and income support. Equally important are investments in social health protection that includes arrangements and mechanisms that go to the heart of UHC, specifically enhancing access to health services and strengthening financial protection. These could include: interventions that impact various sectors at different levels, such as transport allowances for the poor going to health facilities; food allowance subsidies; subsidies for income loss due to illness; occupational injury insurance and unemployment insurance; and conditional cash transfers with health included as a precondition for income support, to name a few. Likewise, the optimization of the health-enhancing impact of other sectors, such as water and sanitation, education, energy, agriculture, telecommunications, urban planning and transport, makes for good health and fiscal policies.

**Source:** Various country case studies in the Western Pacific Region on strengthening domestic financing institutions for universal health coverage.
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- **Develop a clear and realistic health sector plan and performance indicators.** Having a comprehensive health sector plan with a multi-year framework, with clear costing and budgetary implications, is important. As the operation and management of the health sector is complex, health outcomes can be attributed to multiple factors, within and beyond the health sector. It is therefore critical to set clear and realistic performance indicators for the health sector to provide feedback on how public funds are used to achieve health policy goals. Further, as long-term improvements in health outcomes often take years before they can be clearly recognized, it is important to have a set of public health indicators that help focus understanding of how public health priority areas are doing year by year, both nationally and locally.

- **Ensure effective implementation of the allocated budget.** Effective implementation and adherence to sound PFM principles signal sectoral performance and are critical for central budget negotiations between ministries of health and finance. Good public sector management and strong institutional capacity are important for effective budget implementation. This implies that ministries of health make full use of the flexibilities in expenditure management to improve the efficiency of the health sector’s operations and service delivery.

b. Earmark additional revenues for health

Earmarking the source or expenditure is often considered a means to increase or secure the total amount of public funding on health without decreasing the regular budget allocation to health. The payroll tax for health insurance is a typical earmarked funding source for health. In the past decade, more and more countries have used health-related taxes, such as taxes on tobacco, alcohol and unhealthy products (Box 12). Earmarking taxation on unhealthy products may itself also create public health benefits, such as reduced smoking or alcohol consumption. Other innovations in the form of solidarity taxes can be mobilized and dedicated to health, such as taxes on airline tickets, tourism fees, currency transactions and capital transfers, to name a few.

Earmarking is often a political decision to protect a priority, and it could also be subject to a country’s PFM system. Countries with weak policy–budget linkage could benefit well from earmarking. Earmarking is also a way to potentially increase the flexibility of health expenditures. However, the purpose of creating additional funds for health due to earmarking could be undermined by the general government’s funding cut on the health budget. Furthermore, depending on the country’s PFM system, earmarked revenue can be carried over from year to year – particularly if managed through an extra-budgetary fund – or any unspent funds will revert to the national treasury (28).

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5 Revenue earmarking for health dictates what proportion of a specific revenue source should be allocated to the health sector in general or to a specific health programme, population or service, while expenditure earmarking for health can specify the proportion of expenditure that should be allocated to the health sector in general or to a specific health programme, population or service (28).
Box 12: Health Promotion Fund in the Republic of Korea

The National Health Plan 2020 of the Republic of Korea is the third national health promotion plan launched since the enactment of National Health Promotion Law in 1995. The National Health Plan 2020 aims to enhance population health and to reduce inequalities in health. Not only did it establish targets to reduce health inequities in individual projects such as alcohol and tobacco control, as well as efforts to increase physical activity, it also aims to enhance the health of vulnerable groups such as people with disabilities and ethnic minorities.

A National Health Promotion Fund was established under the National Health Promotion Act. The Fund is financed by a tobacco tax that combines ad valorem and specific tax regimes. In recent years, a huge increase in the tobacco tax increased the flow of funding into the Health Promotion Fund. From 2014 to 2015, there was a 40% increase in tobacco tax revenue for the Fund from 2.3 trillion Korean won to 3.3 trillion Korean won (around US$ 2 billion to US$ 2.9 billion). The price increase due to the tax brought about a 10% decrease in cigarette sales from 2014 to 2015. The fund helps finance projects on prevention, diagnosis and management of diseases, as well as the treatment of cancer.


c. Leverage resources from and for non-state actors for health

The nature of non-state actors (for example, for profit or not-for-profit, secular or non-secular) varies, as do their respective roles (for example, disease specific, comprehensive, health promotion, primary or tertiary care). Civil society organizations (CSOs) and other private entities play important roles in bringing in more resources to make health services available (Box 13). The challenge for governments is how to coordinate and engage non-state actors to work towards maximizing their contributions for public benefit.

Strengthening the capacity of governments to secure better performance and investments from these organizations and entities is crucial. Governments should ensure the policy environment exists and that resources can be channelled to finance CSOs, including their ongoing development, for example start-ups, innovations, service development and similar endeavours. These could be done through tax policies that could introduce incentives (30).

- **Harness providers of clinical and non-clinical health services.** Given that these services may be provided through CSOs and other private entities, governments should have clear priorities, entry points and pathways for engagement with non-state actors. They should also have strong mechanisms for coordination, monitoring and reporting. Further, ministries of health should have clear mandates for regulation and oversight over health services, and these should be strictly enforced to ensure the quality of private health services.

- **Encourage mobilization of other sources of funding for core functions and services.** Many CSOs involved in the provision of services for key populations, disease control programmes or community health services are equally reliant on external donor funding. There should be a clear policy approach and financing mechanism for CSOs. Depending on the country’s PFM system, CSOs could receive direct budget subsidies from the government, including from the social security system.
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Box 13: Role of CSOs

In Western Pacific Region, CSOs play various roles, including the provision of public health services, such as immunizations. While the majority of CSOs provide ad hoc or event-based support, some provide more systematic and defined support for programmes. Also, the involvement of CSOs varies by country. Two scenarios are presented here: Papua New Guinea where National Catholic Health Services plays a partner role, which is not typical for a CSO; and the Lao People’s Democratic Republic where the role of Lao Front for National Construction is a classic CSO, with limited event-based involvement.

Church health services in Papua New Guinea

In Papua New Guinea, the delivery of health services through church health services is an integral part of the health system. Over 50% of rural primary health-care services are delivered by the churches. The primary health-care services delivered align with the key national priority public health programmes: child survival; maternal health; and communicable disease control (malaria, HIV and TB) and NCD control. National Catholic Health Services of Papua New Guinea (NCHS) is one of the largest nongovernmental health service providers. NCHS provides a range of clinical and preventative public health services through outpatient, inpatient, and mobile and outreach clinics across a wide network of facilities to their targeted populations by trained qualified medical and nursing staff and community health workers.

NCHS in Papua New Guinea is a unique CSO partnership model for the delivery of primary health care in the Western Pacific Region. NCHS and the other church-run health services in Papua New Guinea function as “quasi-CSOs”, receiving significant recurrent funding from the Government to deliver primary health-care services and are considered integral to the overall health system. They deliver the same services and fund the same programmes as the Government-sector facilities, and have supervisory responsibilities over other NCHS facilities in line with the National Health Service Standards. The main funding for salary and operational costs comes via the National Church Health Services grants from the Government through the Church Medical Council. Funds from the Catholic dioceses or from charging small user fees at health facilities provide supplementary internal revenue. NCHS facilities are also eligible to receive funding from various local government supplementary budgets. In Papua New Guinea, where the health system performance is constrained by substantial financial and human resource shortages, the church health services and NCHS provide a cost-effective model for primary health-care service delivery and fulfil an important role in filling the gaps in rural and remote areas, or where Government facilities are not functioning.

Source: NCHS. https://sites.google.com/a/nchspng.org/www/Home/health_facilities/vunapope-rural-hospital/catholic-health-services

Lao Front for National Construction

Between October 2015 and January 2016, the Lao People’s Democratic Republic experienced an outbreak of circulating vaccine-derived poliovirus. From the beginning of the outbreak response, the Lao Front for National Construction, a CSO, extensively contributed to social mobilization and communications activities. Mobilization of communities included building the social mobilization skills of village chiefs, health providers, teachers, community health volunteers, local media and members of the mass organizations. Since these actors interface directly with caregivers, they were provided with both knowledge about immunization and vaccine-preventable diseases and their communication skills were enhanced. Successful implementation of these activities resulted in significantly increased uptake of polio vaccination and other health interventions by communities, leading to an interruption of transmission of the poliovirus.

• **Make use of public–private partnerships.** Public–private partnerships in mobilizing resources for disease control are commonly used in many countries. Good health financing, even when mobilized through public–private partnerships, should go beyond raising adequate funds for health and should provide incentives for providers and users to be efficient (31). As an example, the creation of foundations and dedicated societies under public–private partnerships that earmark funds for a specific purpose could serve as a means of complementary health financing. To achieve intended results requires strong regulation and stewardship to mitigate potential risks.

d. Collaborate across government sectors

The health sector and social sectors have related and/or overlapping objectives and targets. Working together across government sectors can make better use of existing resources and align government investments in other sectors. 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. In view of the critical roles that other sectors play in achieving better health outcomes, ministries of health could strengthen cooperation across government sectors in the areas of water and sanitation, reproductive health, gender, HIV/AIDS, nutrition, school health, road safety and tobacco control. More importantly, some of the critical policies and programmes under social health protection mechanisms involve other social ministries, for example labour, social welfare and veteran affairs, among others (Box 14).

Ministries of health could pursue policies and approaches that would facilitate a programmatic approach by all government partners to cooperate more effectively and reduce inefficiencies related to independent programmes. These could include jointly agreed sectoral plans, a jointly agreed and supported monitoring and evaluation framework, mechanisms for sector reviews including public expenditure reviews, and a jointly agreed and supported medium-term expenditure framework.

**Box 14: Social sector policies to advance health objectives – TB**

TB control offers a wide range of examples of diversified, enhanced resources through multisectoral engagement. Historically, in many low-incidence countries, TB control activities were often embedded in the policies of various sectors such as labour, education, immigration and prisons. Such policies determine the roles and responsibilities of relevant entities and institutions for screening of employees, students and inmates; for clinical services such as diagnosis, treatment and patient support; for awareness raising; and in some cases for job protection.

Enhancing social protection is particularly important as the disease disproportionately affects poor and marginalized communities. There are many examples of service coordination between TB programmes and welfare programmes in developed countries, but collaborative efforts have been recently extended in many developing countries as well.

In an effort to increase social protection for TB patients, the Fiji National Tuberculosis Programme successfully negotiated with the Ministry of Women, Children and Poverty Alleviation for preferential inclusion of needy or vulnerable TB patients in a generic social protection scheme. Support for TB patients consists of food vouchers and a monthly stipend for the duration of treatment.

*Source: WHO (22).*
Annex

Action 4. Govern the transition process

The transition process in countries will be situation specific and will need to respond to a number of factors including relevant triggers for the transition, the scope and scale of change, and coordination with related reforms. It is essential that countries understand and respond appropriately to the risks and opportunities of the transition that are relevant to their particular contexts. This requires a process that is well planned and managed, and is inclusive of all stakeholders.

a. Plan and implement in a phased and systematic manner

Governments need to set priorities on an ongoing basis. In the context of a transition triggered by significant reductions in available funding, the extent and time pressures on prioritization may be particularly acute. While specific priorities will depend on particular country circumstances, it is important for all countries to translate these priorities into a whole-of-system approach. This requires systematic planning that is guided by a long-term vision for the health system.

- **Set direction and long-term strategy.** The transition should be guided by a long-term view of the health system that extends beyond the immediate pressures of the transition. It should be future oriented and able to respond to broader social, economic and political reforms as well as health system reforms, such as those in service delivery, financing and human resources. The vision should be ambitious but realistic, including in relation to forecasting fiscal space for health and the broader sociopolitical context.

- **Plan systematically.** Specific transition plans should be systematically included in the national health strategy, midterm plan and annual operation plan with a clear budget framework. The transition should be planned as early as possible and ideally from the outset of a particular initiative or programme of support. Many of the challenges in relation to the transition need to be considered far in advance of the actual withdrawal of donor funding. Donors and governments need to promote sustainable investments from the outset.

- **Implement in phased manner.** The transition will be a long and continuous process. Each individual step needs to be carefully considered, while short-term gains need to align with the long-term vision. As the transition involves many changes, it is important to be mindful of minimizing the disruption to service delivery and the continuity of care. This is particularly the case when functions are merged and roles and responsibilities are shifted.

b. Build consensus through transparent and participatory process

The transition process is likely to face many obstacles throughout its planning and implementation. It is essential to have broad and high-level commitment and support for the changes proposed. Generating this commitment and support, including through a participatory process and effective communications, should help ensure the process is as smooth as possible.

- **Maintain and improve transparency of financial information from both donors and national government.** Having financial information systems that are accessible and can provide routine and timely information is fundamental to improving transparency and accountability mechanisms among donors, programmes and governments. This includes streamlined financial reporting to various stakeholders and health system performance monitoring and evaluation. Clear targets and indicators on how to measure progress should be defined with roles and responsibilities of stakeholders clearly assigned. In many cases, financial information and reporting systems may be well established in the vertically financed
programmes, but need to be strengthened across the general health system as the financial information and reporting systems become integrated. This transition requires building new capacity within the general health system and carefully planning steps on how to integrate financial information and reporting systems to prevent any gaps and/or overlapping functions.

- **Ensure donor engagement and coordination.** The importance of donor coordination and aid effectiveness is heightened in the context of the transition (Box 15). As far as possible donor support needs to be included in plans and on the budget to enable government ownership and leadership and to inform reliable medium-term planning. Specific to the transition, donors should be encouraged to undertake joint planning and reviews and to harmonize their own functions, where possible. Specific transition plans, where developed, and funding should specifically address transitional issues and financing requirements, and progressively foster alignment with health system functions and funding flows.

**Box 15: Donor coordination efforts in Cambodia and Solomon Islands**

**Donor funding in Cambodia**

Spending by the Government of Cambodia on health has continued to grow over the past 10 years, with total health expenditures reaching over US$ 1 billion in 2014. Donors finance around 20% of Cambodia’s health budget and more than 70% of disease-specific programme budgets. As Cambodia’s economic status improves, eligibility to receive support from global health initiatives will shrink; however, a greater amount of domestic resources can and are being made available for health. Co-financing by the Government is gradually filling the financing gap as global health initiatives retreat. For example, in 2018 over US$ 1 million in funds will be allocated to cover contract staff positions previously funded under a grant from the Global Fund, and similar funding amounts are expected for 2019–2020. The Government also has committed to funding a greater proportion of the cost of antiretroviral drugs (US$ 3.9 million over three years, ending in 2017), and first-line TB drugs are to be 100% financed by the Government by 2020. In addition, the Government has agreed to an increase in funding for contraceptive commodities from US$ 100 000 in 2014 to US$ 2 million in 2016.

Despite these advances, several sustainability challenges persist. Domestic resource constraints are expected to lead to a funding gap for public health, which requires prioritization and strategic decision-making – at times in the absence of adequate information. The country is taking steps to address this concern and further explore options to re-engineer the implementation of health programmes to improve health system efficiency. Donor financing also remains unpredictable. The multitude of donor health projects needs an overarching strategy to ensure a smooth transition under the stewardship of the Government.

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*a Global Fund Health Sector concept note.

*b Draft National Reproductive and Sexual Health Strategy 2017–2020 (almost finalized.)

Source: WHO country office in Cambodia.
Annex

**Development partner support in Solomon Islands**

The economic growth of Solomon Islands has been fairly stagnant over the past decade and the Government has been investing nearly 13% of its total budget on health. The likelihood of this investment increasing significantly over the next couple of years is remote. Meanwhile, approximately 45% of the total health expenditure comes from development partners working in health. Eighteen of them are signatories to the Sector-Wide Approach (SWAp) mechanism through which they collaborate their support to the Ministry of Health and Medical Services. Many more support the health sector, though their support is not streamlined and coordinated. Many faith-based organizations that play a pivotal role in supporting the health sector fall into this category. Against this backdrop, the Ministry of Health and Medical Services is making a concerted effort to improve aid coordination by bringing all partners together on plan, on budget and on system. This means all partners are expected to pledge their support (budgetary and non-budgetary) on one Annual Operational Plan of the Ministry of Health and Medical Services towards achieving the objectives spelt out in its National Health Strategic Plan. The Ministry has recently established a Partnership Coordination Unit, which is expected to play this pivotal role, in order to achieve optimum throughput from development partner support.

Note: excerpt pending government review

*Source:* WHO country office in Solomon Islands.

- **Involve the workforce.** Ultimately, the effectiveness of any transition rests with the people involved. Consequently, garnering the support and commitment of the workforce during the transition is important, particularly at middle and lower levels in organizations where the effects will be most personal. In many cases, reforms involving disease control responses are likely to represent cultural change in relation to disease-specific mindsets, particularly where they are aiming to integrate or coordinate particular functions or resources. The transition will also inevitably impact people’s role descriptions, terms and conditions of employment, working relationships and teams, and status and authority. Specifically addressing and supporting the workforce through these changes can help mitigate the risks of staff demotivation and loss, and are critical enablers to effective transition in this particular context.

- **Ensure participation of affected populations.** Processes such as bottom–up planning and budgeting, service mapping, and formal consultation processes that encourage and include the participation of the community and key affected populations, service delivery providers, implementers and programme administrators will strengthen accountability for the transition and the post-transition processes and outcomes. Clear communication of results, successes, challenges and performance expectations will foster a responsive, inclusive and transparent transition environment.

- **Manage different interests of stakeholders towards the transition.** The varied interests of a wide range of stakeholders and associated politics will shape the transition at every step. Planning and implementation of the transition should always be sensitive to the perception and impact of the transition on related issues and agendas. It will be important to have evidence to support priorities identified as part of the transition and be able to clearly articulate benefits of the transition more broadly, including for example the economic impacts of the transition and relationship with other priorities of government.
c. Establish and maintain oversight and monitoring
A transition requires monitoring and oversight. Depending on the country-specific situation, this may involve established oversight bodies with a broader mandate or body specific to a particular reform or initiative. It is essential that oversight bodies be well informed and empowered to fulfil their function. They can fulfil a number of important functions including coordination of effort, management of risk, identification of improvement opportunities and consensus building.

- **Use existing mechanisms:** Established oversight bodies, such as sector working groups, country coordinating mechanisms, immunization interagency coordinating committees or disease-specific technical working groups are well placed to oversee and monitor a transition. Through the use of tools such as transition plans, workplan tracking measures, budgets, and monitoring and evaluation plans, oversight mechanisms can effectively support in-country transition processes. Investments in strengthening secretariat functions for oversight bodies will support systematic processes, improving overall effectiveness of the mechanism for the follow-up and monitoring of transition-related action items and recommendations. Oversight mechanisms also have a role in monitoring co-financing obligations and can advocate increased domestic contributions by providing critical information and recommendations to other sectoral mechanisms, such as planning and budget committees.

- **Take whole-of-system approach:** The transition of processes of donor-specific oversight mechanisms into other sector mechanisms may also be considered for improving transparency and accountability (Box 16), for example ensuring formal representation of key affected populations or stakeholders in health sector committees or working groups. Effective oversight requires an appropriate mix of stakeholder representation and involves procedures that foster fairness and participation in decision-making and prioritization. A whole-of-system approach will mean that oversight bodies are inclusive of and/or include processes for inclusion of intragovernmental stakeholders, as well as internal ministry of health committees and technical working groups.

### Box 16: Aligning fund flows – Transition of the principal recipient implementation arrangements in the Lao People’s Democratic Republic

The Lao People’s Democratic Republic has been receiving support from the Global Fund since 2003. The Ministry of Health has been the sole principal recipient. A Principal Recipient Office was established in the Department of Communicable Disease Control, which is directly involved in directing, managing and supervising communicable disease prevention and control programmes at the national, provincial, district and community levels.

As a result of a decree issues by the Ministry of Finance, the Ministry of Health has begun a process of transferring the budget, procurement and administrative functions of the Principal Recipient Office under the Department of Communicable Disease Control to the Department of Finance and the Department of Planning and Cooperation within the Ministry of Health. This transition follows a decree issued by the Ministry of Finance and is designed to address the issues of official development assistance flowing outside of the PFM system, which has made it difficult for the Ministry of Finance and the Ministry of Planning and Investment to determine the real cost of AIDS, TB and malaria.

The Department of Communicable Disease Control is still critical, especially in relation to technical oversight, monitoring and prioritization of interventions being funded by the Global Fund. Therefore, the realignment of functions requires not only strong leadership during the transition process, but also investment in building governance and coordinating mechanisms for all three departments to jointly manage and monitor the performance of Global Fund grants.

*Source:* WHO country office in the Lao People’s Democratic Republic.
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- **Ensure information for decision-making.** To be effective, oversight bodies require access to and the use of clear and precise information. This is likely to include evidence and analysis on inputs, service access and coverage, health outcomes, financial protection, and cost of services, as well as broader policy and political contextual information, such as packages of policy options and reform opportunities and effects. Effectiveness necessitates clear processes for decision-making, recording of outcomes and communication of decisions to all stakeholders.

- **Develop monitoring and review processes.** Better conceptual clarity of the entire transition process can be attained through developing a monitoring and evaluation (M&E) process prior to the transition. A robust M&E process can support oversight bodies to measure readiness, amend transition plans, establish accountability for key stakeholders and for the post-transition period, and provide a tool for documenting lessons learnt for an effective transition. Ideally, transition and sustainability processes should be integrated into routine monitoring and review processes and should be reported against regularly to the oversight body. Oversight management tools such as risk management frameworks, transition plans and performance monitoring frameworks are ideal. Sufficient budget needs to be allocated for transition M&E activities.
3. The way forward

All Member States face challenges in their efforts to develop sustainable and resilient health systems. Sustaining essential public health functions is increasingly important in the context of demographic changes, evolving population health needs, reduced external funding for health and other challenges. These challenges require Member States to reorient their health systems to better meet population health needs, employing a whole-of-system approach. These challenges also increase the demands on Member States to prioritize and advance health system reforms intended to improve health system efficiency as part of their road maps to achieve UHC.

The transition away from externally funded disease control programmes needs to be well planned to sustain and improve performance of the health system and to ensure equitable access to quality health services. For countries facing reductions of donor-funded disease programmes, it is essential that relevant functions be sustained through systematic planning and phased implementation. This does not necessarily require the continuation of all activities. The transition from external funding should be viewed as an entry point to review and improve health system efficiency and performance, as well as equitable access to quality health services without compromising coverage. For countries instituting changes to coordinate and integrate financing and service delivery systems, these principles are equally relevant. This document, *Transiting to Integrated Financing of Priority Public Health Services*, is not prescriptive. Countries may need to select an appropriate mix of actions based on their country context, recognizing that the transition is a long-term process.

3.1 Member States

Member States are urged to commit to the following actions:

1. Clearly define a set of essential public health functions based on population health needs.
2. Ensure adequate public funding from domestic sources for essential public health functions.
3. Take a well-planned and phased approach to the transition, including:
   - mapping service delivery outlines and financial flows;
   - identifying opportunities for integrated service delivery;
   - reviewing funding gaps and inefficiencies at points of service delivery;
   - creating an oversight mechanism to ensure the transition is well incorporated into the national health strategy and annual operational plan with clear budget indication;
   - establishing one coherent health information system; and
   - monitoring progress, reporting to stakeholders and adjusting policy accordingly.

3.2 WHO in the Western Pacific Region

To support Member States, WHO in the Western Pacific Region commits to the following:

1. Collaborate with global health initiatives and development partners to facilitate the process for countries going through a transition and ensure sustainable support, including by:
   - designing medium-term funding plans and co-financing approaches to encourage countries to increase domestic funding and to change the operational mechanisms of programmes to ensure greater efficiency;
   - working towards external funding that is channelled through existing domestic systems as much as possible; and
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- encouraging collaboration among disease and health programmes and between ministries of health and finance and health insurance agencies, where applicable.

2. Facilitate country-level policy dialogue on priority settings in order to identify entry points, critical implementation issues and transition steps as part of country UHC road maps.

3. Monitor the process of transition of each country.

4. Synthesize experiences and provide guidance for smooth transition support to each country’s specific context.

5. Support country institutional capacity to manage funding, develop information systems and implement integrated service delivery models.
References


(3) HIV/AIDS data and statistics [webpage]. Manila: WHO Regional Office for the Western Pacific; 2016 (www.wpro.who.int/hiv/data/en/).


(7) Regional action agenda on achieving the Sustainable Development Goals in the Western Pacific. Manila: WHO Regional Office for the Western Pacific; 2017.

(8) Health topics: noncommunicable diseases [webpage]. Manila: WHO Regional Office for the Western Pacific (www.wpro.who.int/topics/noncommunicable_diseases/en/).


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Appendices

Appendix 1. Prevention and Public Health Services as % of total health expenditure, 2014 or latest year

Source: WHO Global Health Expenditure Database and health accounts reports from the Lao People’s Democratic Republic (Lao PDR), Malaysia, Papua New Guinea and Viet Nam.

Appendix 2. External funding as % of total health expenditure (THE) by GDP per capita in the Region, 2014*

* Excludes countries not receiving external funding
Note: L&LMI = lower- and lower-middle-income, UMI = upper-middle-income, HI = high-income

<table>
<thead>
<tr>
<th>COUNTRIES</th>
<th>Investments in Western Pacific Region countries</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIV/AIDS</td>
<td>TB</td>
</tr>
<tr>
<td>Cambodia</td>
<td>233.2</td>
<td>45.8</td>
</tr>
<tr>
<td>China*</td>
<td>323.2</td>
<td>365.4</td>
</tr>
<tr>
<td>Fiji</td>
<td>-</td>
<td>11.0</td>
</tr>
<tr>
<td>Lao People’s Democratic Republic</td>
<td>50.5</td>
<td>28.7</td>
</tr>
<tr>
<td>Malaysia</td>
<td>9.7</td>
<td>-</td>
</tr>
<tr>
<td>Mongolia</td>
<td>20.0</td>
<td>26.7</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>38.3</td>
<td>38.0</td>
</tr>
<tr>
<td>Philippines</td>
<td>36.4</td>
<td>191.2</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>-</td>
<td>6.1</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>151.1</td>
<td>82.1</td>
</tr>
<tr>
<td><strong>REGIONAL INITIATIVES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCM Asia (Regional Steering Committee)*</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>RCM Western Pacific**</td>
<td>27.2</td>
<td>14.9</td>
</tr>
<tr>
<td><strong>Total (country and regional initiatives)</strong></td>
<td><strong>889.6</strong></td>
<td><strong>809.7</strong></td>
</tr>
</tbody>
</table>

| % share to total disbursement**    | 35.33%  | 32.16%| 28.26%  | 4.24% |

*This grant agreement is designed to help prevent the spread of artemisinin-resistant malaria by working with mobile and migrant populations in Cambodia, the Lao People’s Democratic Republic, Myanmar, Thailand and Viet Nam.

**HIV, malaria and tuberculosis in Cook Islands, Kiribati, the Federated States of Micronesia, Nauru, Niue, Palau, Samoa, Tonga, Tuvalu and Vanuatu.

Total (%) does not add up to 100 due to rounding.

*Transitioned out in 2014

Appendix 4. Gavi, the Vaccine Alliance, disbursements in the Western Pacific Region (US$ million)

<table>
<thead>
<tr>
<th>COUNTRIES</th>
<th>Non-vaccine support</th>
<th>Vaccine support</th>
<th>Value</th>
<th>Transition status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>24.6</td>
<td>50.3</td>
<td>74.9</td>
<td>Preparatory transition</td>
</tr>
<tr>
<td>China*</td>
<td>16.7</td>
<td>22.0</td>
<td>38.7</td>
<td>Graduated</td>
</tr>
<tr>
<td>Kiribati</td>
<td>0.3</td>
<td>0.3</td>
<td>0.6</td>
<td>Fully self-financing</td>
</tr>
<tr>
<td>Lao People’s Democratic Republic</td>
<td>9.9</td>
<td>22.3</td>
<td>32.2</td>
<td>Accelerated transition</td>
</tr>
<tr>
<td>Mongolia</td>
<td>1.3</td>
<td>5.2</td>
<td>6.5</td>
<td>Accelerated transition</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>4.2</td>
<td>26.6</td>
<td>30.8</td>
<td>Accelerated transition</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>1.5</td>
<td>2.4</td>
<td>3.9</td>
<td>Accelerated transition</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>64.1</td>
<td>122.1</td>
<td>186.2</td>
<td>Accelerated transition</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>122.7</strong></td>
<td><strong>251.1</strong></td>
<td><strong>373.8</strong></td>
<td></td>
</tr>
</tbody>
</table>

% to disbursements to date: 33% 67% 100%

*Graduated in 2007


Appendix 5. PEFPAR Expenditures in thousands US$, 2012–2015

<table>
<thead>
<tr>
<th>Areas/ Countries</th>
<th>Components</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asia Regional Programme</td>
<td>Health systems strengthening related expenditures</td>
<td>-</td>
<td>-</td>
<td>1636</td>
<td>3815</td>
<td>5452</td>
</tr>
<tr>
<td></td>
<td>HIV/AIDS programme expenditures</td>
<td>-</td>
<td>-</td>
<td>5727</td>
<td>5817</td>
<td>11 544</td>
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<tr>
<td>Cambodia</td>
<td>Health systems strengthening related expenditures</td>
<td>-</td>
<td>-</td>
<td>2401</td>
<td>2871</td>
<td>5271</td>
</tr>
<tr>
<td></td>
<td>HIV/AIDS programme expenditures</td>
<td>-</td>
<td>-</td>
<td>7789</td>
<td>7057</td>
<td>14 846</td>
</tr>
<tr>
<td>Cambodia total</td>
<td></td>
<td>-</td>
<td>-</td>
<td><strong>10 189</strong></td>
<td><strong>9927</strong></td>
<td><strong>20 117</strong></td>
</tr>
<tr>
<td>Papua New Guinea (PNG)</td>
<td>Health systems strengthening related expenditures</td>
<td>-</td>
<td>-</td>
<td>1050</td>
<td>1024</td>
<td>2075</td>
</tr>
<tr>
<td></td>
<td>HIV/AIDS programme expenditures</td>
<td>-</td>
<td>-</td>
<td>2357</td>
<td>2485</td>
<td>4842</td>
</tr>
<tr>
<td>PNG total</td>
<td></td>
<td>-</td>
<td>-</td>
<td><strong>3,407</strong></td>
<td><strong>3,510</strong></td>
<td><strong>6,917</strong></td>
</tr>
<tr>
<td>Viet Nam</td>
<td>Health systems strengthening related expenditures</td>
<td>11 710</td>
<td>15 928</td>
<td>18 088</td>
<td>14 886</td>
<td>60 613</td>
</tr>
<tr>
<td></td>
<td>HIV/AIDS programme expenditures</td>
<td>41 008</td>
<td>41 887</td>
<td>29 833</td>
<td>34 457</td>
<td>147 186</td>
</tr>
<tr>
<td>Viet Nam total</td>
<td></td>
<td><strong>52 719</strong></td>
<td><strong>57 816</strong></td>
<td><strong>47 921</strong></td>
<td><strong>49 343</strong></td>
<td><strong>207 798</strong></td>
</tr>
<tr>
<td>Sub-totals</td>
<td>Health systems strengthening related expenditures</td>
<td>11 710</td>
<td>15 928</td>
<td>23 175</td>
<td>22 596</td>
<td>73 410</td>
</tr>
<tr>
<td></td>
<td>HIV/AIDS programme expenditures</td>
<td>41 008</td>
<td>41 887</td>
<td>45 706</td>
<td>49 816</td>
<td>178 418</td>
</tr>
</tbody>
</table>
Annex

<table>
<thead>
<tr>
<th>% share to total spending</th>
<th>Health systems strengthening related expenditures</th>
<th>HIV/AIDS programme expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>22%</td>
<td></td>
<td>78%</td>
</tr>
<tr>
<td>28%</td>
<td></td>
<td>72%</td>
</tr>
<tr>
<td>34%</td>
<td></td>
<td>66%</td>
</tr>
<tr>
<td>31%</td>
<td></td>
<td>69%</td>
</tr>
<tr>
<td>29%</td>
<td></td>
<td>71%</td>
</tr>
</tbody>
</table>

Grand Total

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Informing, educating and empowering people about health issues</td>
<td>3. Development of policies and planning in public health</td>
<td>3. Health protection, including management of environmental, food, toxicological and occupational safety</td>
<td>3. Health protection, including environmental, occupational, food safety and others</td>
</tr>
<tr>
<td>4. Mobilizing community partnerships to identify and solve health problems</td>
<td>4. Strategic management of health systems and services for population health gain</td>
<td>4. Health promotion and disease prevention through population-based interventions, including action to address social determinants and health inequity</td>
<td>4. Health promotion, including action to address social determinants and health inequity</td>
</tr>
<tr>
<td>5. Developing policies and plans that support individual and community health efforts</td>
<td>5. Regulation and enforcement to protect public health</td>
<td>5. Effective health governance, public health legislation, financing and institutional support</td>
<td>5. Disease prevention, including early detection of illness</td>
</tr>
<tr>
<td>7. Linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable</td>
<td>7. Health promotion, social participation and empowerment</td>
<td>7. Communications and social mobilization for health</td>
<td>7. Sufficient and competent public health workforce</td>
</tr>
<tr>
<td>8. Ensuring a competent public and personal health-care workforce</td>
<td>8. Quality assurance in personal and population-based health services</td>
<td>8. Public health research to inform and influence policy and practice</td>
<td>8. Sustainable organizational structures and financing</td>
</tr>
<tr>
<td>10. Searching for new insights and innovative solutions to health problems</td>
<td></td>
<td></td>
<td>9. Public health research to inform policy and practice</td>
</tr>
</tbody>
</table>

Appendix 7. Current organization of core programme elements and future directions

Core programme element: **Policy, guidelines and stewardship**

**Current organization**
- In many high-burden settings, specific disease programmes under ministries of health discharge these functions by collaborating with specialized institutions and experts.
- Dedicated cadres of staff in each programme are charged with designing and conducting training, supervision of services, and monitoring quality of services and programme performance.
- Division of roles and responsibilities between central and subnational levels, depending on the national systems.
- Both central and local government are the primary funding sources for these functions.

**Future directions**
- While the scale of programmes will change over time in response to changing epidemiology and programmatic needs, it is important to retain essential stewardship functions and expertise for specific programmes.
- Mechanisms to engage national experts and relevant professional associations can ensure that policy and guidance are always updated and based on the best available evidence.
- While ensuring the implementation of national policies and strategies, a greater engagement and responsibility of local health authorities may be favourable in designing and implementing effective interventions, especially for the diseases with uneven distributions.

Core programme element: **Prevention**

**Current organization**
- Implementation of prevention interventions are carried out through facility- and community-based outreach services, largely through the primary health care network, but often by specific programmes such as the Expanded Programme on Immunization (EPI), TB, HIV and malaria. Often under each programme resources are allocated and utilized.
- Primarily, most prevention interventions (e.g. immunizations, screening and testing, contact investigations) are designed and organized by public health authorities with domestic and external funds.
- Civil society organizations may also play significant roles in delivering prevention interventions, especially at the grass-roots level. This is particularly prominent in HIV programmes and also for communications, public awareness and social mobilization across the programme areas.

**Future directions**
- Most prevention interventions, in principle, will stay under the public responsibility, though some individual-based preventive services can be shifted to health insurance or other funding sources (see Action 2).
- HIV prevention interventions, in particular, those targeting key populations, are better delivered by community-based or civil society organizations. Accordingly, ways to support their role should be identified. These services can be delivered at lower cost and more effectively than engaging health workers.
- Considering the limited resources at the field level, pooling resources and integrated and decentralized service delivery on a priority basis (depending on disease epidemiology, specific programme objective and sustaining achievements) are more rational and cost-effective, when funds are limited.
- Prevention interventions can be sourced from other social sector schemes. For example, in many developed countries, screening programmes can be organized by non-health sector policies and resources (e.g. TB screening in the labour, education and immigration sectors).
- There are diverse options in terms of implementation arrangements. Central and local governments may contract out some of the prevention services to different service providers.
including the private and business sectors (e.g. communication campaigns, immunization services, disease screening, etc.).

### Core programme element: Surveillance

#### Current organization
- Public health authorities (both at the national and subnational levels) are primarily responsible for surveillance systems, although the level of delegation and the mandate of clinical service providers differ according to the local settings.
- Conventionally, parallel reporting procedures are used for disease programmes and projects funded by different donors. This can create substantial administrative burden for general health workers, especially at the peripheral levels.

#### Future directions
- There has been general move towards integrating health information systems in order to streamline data and reporting needs across programmes. Electronic information platforms such as District Health Information System 2 (DHIS2) have a great potential to facilitate effective and efficient integration.
- For infectious diseases and other acute health events, integrated disease notification systems may also be needed for timely notification and response.
- Some countries have established a web-based disease notification system that often contributes to the improvement in overall quality and completeness of information.

### Core programme element: Outbreak and emergency response

#### Current organization
- Together with surveillance, the response capacity constitutes an integral part of the core capacities to respond to public health events under the International Health Regulations (2005).
- The surveillance and response systems for specific disease control programmes tend to be organized separately from the general infectious disease response systems.
- Nevertheless, programme-specific response capacities are generally very weak in high-burden settings, which can be illustrated by a low level of implementation in TB contact investigation, prophylactic treatment for children in close contact with TB, and inability to detect and contain clustered occurrence of key infectious diseases such as drug-resistant TB and HIV.
- As for surveillance, the response capacity is generally under the responsibility of the public health authorities (both at the national and subnational levels) and it is critical to ensure sufficient human resources with right skill sets are in place to implement this element.

#### Future directions
- Along with the national core capacity development under the International Health Regulations (2005), there should be a general shift towards integration and harmonization of all surveillance and response systems. The specific timing and modality of integration will depend on the epidemiological situation and national systems.
- Maximum effort should be made to harmonize surveillance and response systems when these systems operate in parallel. General surveillance and response capacity can be expanded to specific disease control programmes (e.g. the Field Epidemiological Training Programme to train TB-dedicated health workers, and epidemiological investigation services to establish a branch in TB control programmes).
- In the context of declining disease burden, outbreak investigations may play an increasing role, such as the clustered occurrence of HIV infection, the outbreak of TB among specific populations (high-risk groups, schools, workplaces) and malaria occurrence through post-elimination surveillance.
Core programme element: **Diagnosis, treatment and care (clinical services)**

**Current organization**
- Clinical services for diagnosis, treatment and care are most commonly delivered through the primary health care network in the public sector. Some programmes primarily use peripheral health facilities as the main service delivery points (e.g. TB and malaria) while others may have a higher-level service structure (e.g. core HIV services provided at district-level health facilities).
- In some cases, certain clinical services (e.g. HIV clinics) are provided independently under a separate management system from other services, often supported by disease-specific funding.
- Major task shifting is happening in some countries where clinical services are shifted from public health facilities to general clinical facilities both in the public and private sectors.
- This shift may be associated with integration of clinical care under health insurance schemes.

**Future directions**
- Enhanced people-centred services should be a core principle across the service delivery structure, as should ensuring a continuum of care.
- Maximum efforts should be made to avoid any service interruption in the transitional period. Any increase in financial burden to patients may cause serious deterioration of service uptake and coverage.
- Service coordination among various programmes (e.g. TB, HIV, maternal and child health) should be improved, supported by effective referral mechanisms between different tiers of health facilities.
- Where general clinical facilities are increasingly engaged and playing critical roles, ensuring quality standards will be a major challenge. In such settings, public health facilities may need to play more regular stewardship roles rather than direct service delivery.
- Ensuring timely referral to specialized services continues to be needed for specific diseases. This becomes even more important when disease burden decreases and expertise needs to be centralized.

Core programme element: **Laboratory (clinical and reference laboratories)**

**Current organization**
- Programme-specific investments often contribute to strengthening of disease-specific requirements for laboratory services (e.g. laboratory networks for polio, TB and other diseases).
- Especially in many high-burden settings, laboratory networks are often vertically organized under the purview of each disease-specific programme. They are often separated from the general public health laboratory network with little interaction.

**Future directions**
- It is increasingly important to strengthen and integrate public health laboratory networks by effectively using existing infrastructure. Increasing infrastructure demands for laboratories (e.g. biosafety level) will not justify continued building of separate structures by disease.
- Some of the infrastructure developed through disease-specific investments represent many opportunities for strengthening an integrated laboratory network. For example, the Xpert MTB/RIF, a WHO-recommended automated molecular diagnostic test for TB, can also be utilized for other testing such as HIV, hepatitis and antimicrobial resistance.
- Laboratory services are also part of the International Health Regulations (2005) core capacity in which a range of pathogens of public health importance has to be managed. Effective links among laboratory, clinical and surveillance systems are also critical for effective use of data and a timely response.
- Clinical and reference laboratories will need to sustain disease-specific expertise for disease surveillance and monitoring programme outcomes.
### Core programme element: **Procurement and supply management systems for public health commodities**

**Current organization**
- There are many occasions in which public health programmes have created parallel supply management systems due to programmatic necessities and, in some cases, requirements for donor accountability.
- Reasons behind the parallel supply management systems include:
  - general supply management systems cannot manage the disease-specific needs for product selection, quantification, distribution and rationale use;
  - the general supply management system is still underdeveloped; and
  - the procurement and supply monitoring system is not matured sufficiently to fulfil donor accountability requirements.

**Future directions**
- Along with the development of national supply procurement and management systems, disease-specific parallel systems should be gradually merged into the general system.
- Centralized procurement is often advantageous for quality assurance, standardization and price control.
- It is critical to maintain centralized procurement for certain commodities such as medicines (e.g. antiviral drugs for hepatitis treatment, anti-TB drugs), vaccines and prevention commodities.
- Need to explore the ways to maximally utilize international mechanisms to improve access to quality medical products even if the countries are no longer eligible for grant arrangements (e.g. pooled procurement mechanism, concessional pricing).

### Core programme element: **Community-based support and social participation**

**Current organization**
- Community-based care and services are critical to many public health programmes. Since they are often delivered by diverse implementers, there should be a mechanism for harmonization and coordination both at the national and local levels. This includes the joint mapping and planning of services offered by nongovernmental and civil society organizations across disease programmes, coordination with the formal public health sector and active engagement of communities.

**Future directions**
- It is important to explore options to maintain the services provided by nongovernmental and civil society organizations that are funded by external donors. Some activities many need to be continued with different contractual modalities and funding, while others can be merged into the formal government sector function. Typical priority activities that should be continued are treatment support for TB patients, HIV prevention and combined testing for HIV and other sexually transmitted infections.

### Core programme element: **Identifying and implementing approaches for vulnerable populations**

**Current organization**
- Specific strategies and approaches are often needed to address needs of vulnerable populations.
- Vulnerable and key populations defined by disease-specific programmes for targeted interventions such as outreach services, prevention interventions and the provision of testing opportunities are typically under the purview of specific disease programmes, often with project-based funds.

**Future directions**
- Vulnerable and key populations may continue to be defined based on surveillance reports, yet the periodic assessment may shift to expert groups convened by disease surveillance and response teams or policy/ guideline working groups.
- Engaging civil society organizations to develop innovative approaches for reaching vulnerable and key populations, such as use of social media, online services and self-administered tests for screening with self-referral or online consultation may be explored.
- School health services and care for older people may include integrated disease-specific prevention, screening and chronic disease management.

*These are illustrative examples for future directions. Certain countries will have already implemented some of these strategies. Timing of changes will depend on the specific country’s stage of transition.*