

OLD SCARS, NEW WOUNDS? PUBLIC FINANCING FOR HEALTH IN TIMES OF COVID-19 IN THE ASIA-PACIFIC REGION

DISCUSSION PAPER

MAY 2023

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Health, Nutrition, and Population (HNP) Discussion Paper

OLD SCARS, NEW WOUNDS? *Public Financing for Health in Times of COVID-19 in the Asia-Pacific Region*

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This document was prepared as a background for informing activities related to the Advance Universal Health Coverage Multi-Donor Trust Fund and the Domestic Resource Mobilization Collaborative of the Joint Learning Network for Universal Health Coverage.

Abstract: Despite a rebound in economic growth following the pandemic, new geopolitical developments and macroeconomic shocks—inflation and monetary responses to inflation, Russia’s invasion of Ukraine, and the COVID-19 debt overhang—as well as the lingering uncertainty of the COVID-19 pandemic pose further challenges to sustainable public financing for health. These recent challenges are superimposed on longer-term issues—aging, noncommunicable diseases (NCDs), climate change, and future pandemic preparedness—which are shared across the Asia-Pacific, a dynamic region ranging from small Pacific Island states to the two most populous countries in the world. Three specific health reform opportunities, with country spotlights highlighting relevant successes and remaining challenges, have been identified to improve the efficiency and equity of public health spending (“more health for money”) while justifying “more money for health” by demonstrating its effectiveness: (i) strengthen primary health care as an efficient and equitable solution to improving health outcomes, especially in the Asia-Pacific where the burden from uncontrolled NCDs is high; (ii) leverage health taxes to reduce costly unhealthy environments and lifestyles while supporting health financing, given the feasibility of such taxes to supplement low government revenues prevalent in the Asia-Pacific; and (iii) increase pro-poor public spending on health by improving targeting of poor and vulnerable populations with critical health services to improve health outcomes and financial protection.

Keywords: COVID-19, economic outlook, public financing for health, primary health care, health taxes, pro-poor targeting

Disclaimer: The findings, interpretations, and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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KEY MESSAGES

- Despite a rebound in economic growth following the pandemic, new geopolitical developments and macroeconomic shocks—inflation and monetary responses to inflation, Russia's invasion of Ukraine, and the COVID-19 debt overhang—as well as the lingering uncertainty of the COVID-19 pandemic pose further challenges to sustainable public financing of health.
- These recent challenges are superimposed on longer-term issues—aging, noncommunicable diseases (NCDs), climate change, and future pandemic preparedness—which are shared across the Asia-Pacific, a dynamic region ranging from small Pacific Island states to the two most populous countries in the world.
- Three specific health reform opportunities, with country spotlights highlighting relevant successes and remaining challenges, have been identified to improve the efficiency and equity of public health spending (“more health for money”) while justifying “more money for health” by demonstrating its effectiveness: (i) strengthen primary health care, as an efficient and equitable solution to improving health outcomes, especially in the Asia-Pacific, where the burden from uncontrolled NCDs is high; (ii) leverage health taxes to reduce costly unhealthy environments and lifestyles while supporting health financing, given the feasibility of such taxes to supplement low government revenues prevalent in the Asia-Pacific; and (iii) increase pro-poor public spending on health by improving targeting of poor and vulnerable populations with critical health services to improve health outcomes and financial protection.

INTRODUCTION

Although COVID-19 appears to be headed for endemicity, considerable uncertainty remains. By the end of 2022, over 600 million reported cases and almost 7 million reported deaths were directly attributed to COVID-19 globally. COVID-19 has also indirectly halted or reversed progress in health outcomes beyond the direct impact of COVID-19 itself (United Nations 2021). Mortality and hospitalizations from COVID-19 have declined sharply due to the unprecedentedly rapid development and deployment of vaccines and immunity from natural infection. However, the impact of long COVID-19 and the trajectory of the pandemic where vaccination coverage rates are low (e.g., in Papua New Guinea [PNG], the Solomon Islands, and sub-Saharan Africa) and the potential emergence of new variants of concern remain important uncertainties.

COVID-19 was an economic shock, not just a health shock. Pandemic-related restrictions in social and economic activities resulted in a global economic contraction in 2020, among the deepest the world has experienced in almost a century. As a result, poverty rates and socioeconomic inequalities have risen, interrupting decades of progress. An estimated 90 million additional people were pushed into extreme poverty by the end of 2020, raising the global total to over 700 million (World Bank 2022a). Human capital accumulation stalled, especially among those aged 24 years and younger (Schady et al. 2023). Public debt levels rose as governments expanded health and social protection spending in the face of declining revenues, leading to a higher burden from interest rate repayments. Several low- and middle-income countries—Argentina, Belize, Belarus, Ecuador, Lebanon, Suriname, Sri Lanka, and Zambia—have defaulted on their debt (Rogoff 2022). Several others, including many in the Asia-Pacific, remain at moderate to high risk of debt distress.

Subsequent shocks have interrupted global economic recovery. The global economy rebounded in 2021 as the vaccine rollout enabled the lifting of some of the most stringent restrictions. However, a combination of new shocks—inflation, geopolitical events, and monetary policy tightening—have dampened economic prospects (World Bank 2023b; IMF 2023b). Several countries have now seen the emergence of “stagflation,” a combination of sluggish economic growth combined with inflation, on top of a pandemic-induced debt overhang. Not all countries have been impacted in the same way. There is considerable diversity in how these events are constraining the ability of governments to undertake additional public investments, including for health (Kurowski et al. 2021).

This paper analyzes key macrofiscal indicators and discusses their implications for public financing of health in the Asia-Pacific. We discuss what a challenging macrofiscal environment—combined with longer-term trends related to aging, the rising noncommunicable disease (NCD) burden, climate change, and the urgent need for bolstering pandemic preparedness—may imply for public financing for health in the region. Adverse macrofiscal developments are inflicting fresh wounds on vulnerable economies and health systems, widening global disparities, and placing goals such as universal health coverage (UHC)—the attainment of which is contingent on having adequate public financing and financial protection—at high risk. The paper also highlights possible options—especially those related to enhancing the efficiency and equity of public expenditures—that will be necessary to ensure that the hard-won gains made toward UHC attainment over the last several decades are not lost.

Latest Macrofiscal Landscape

Economic contraction and muted recovery

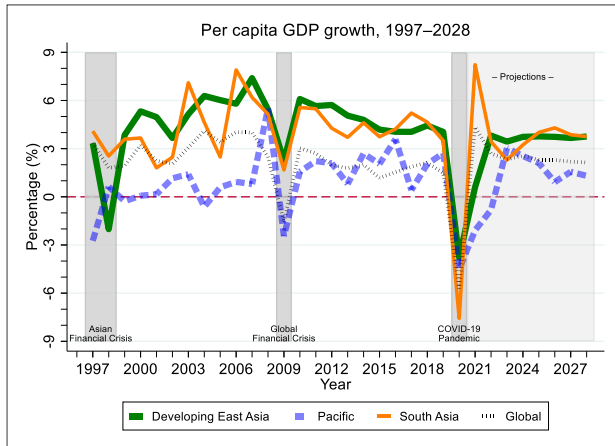
In 2020, COVID-19 resulted in the most widespread and deep global economic contraction in living memory. Global gross domestic product (GDP) per capita shrank by 5.7 percent in 2020 (Source: Authors' calculations using IMF WEO April 2023; unweighted average). Within the Asia-Pacific, South Asia (SA) was hit hardest (GDP per capita declined by 7.6 percent), followed by Pacific countries (PA) (declined by 4.5 percent) and developing East Asia (EA) (declined by 3.8 percent).¹ On the demand side, falls in consumption and trade were followed by falls in investment. On the supply side, the services sector was most negatively impacted, followed by manufacturing. Within the Asia-Pacific region, the economies of Fiji, Maldives, Palau, the Philippines, and Timor-Leste contracted the most in 2020. Meanwhile, Bangladesh, China, Myanmar, Nauru, Tonga, and Vietnam experienced slowdowns in economic growth but did not contract (Figure 2). More generally, economic growth was more adversely impacted in countries where exposure to COVID-19 was greater, lockdowns were more stringent, or where economic diversification was low. Conversely, countries that implemented larger fiscal stimuli, had lower preexisting debt, and better governance faced less negative economic consequences (Niermann and Pitterle 2021).²

By contrast, the economic fallout from earlier crises was shallower and less widespread. Average economic growth rates per capita dropped to -1.6 percent in 2009 during the 2007–2008 Global Financial Crisis (GFC), with the United States, Europe, and PA countries being the most negatively impacted. However, EA and SA experienced only a slowdown rather than negative growth (IMF 2023a). Subsequently, over 2010–2019, global economic growth averaged 2.0 percent, while both EA and SA posted growth rates almost double this global average. PA grew at rates comparable to the global average. For Asia-Pacific, even the 1997–1998 Asian Financial Crisis (AFC) had a shallower economic fallout than the economic shock from COVID-19.

¹ Within the context of this paper, the **Asia-Pacific region** refers to three distinct groups of low- and middle-income countries. **EA** countries are Cambodia, China, Indonesia, Lao PDR, Malaysia, Mongolia, Myanmar, the Philippines, Thailand, Timor-Leste, Vietnam. **SA** countries are Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka. **PA** countries are Federated States of Micronesia (FSM), Fiji, Kiribati, Marshall Islands, Nauru, Palau, Papua New Guinea (PNG), Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu.

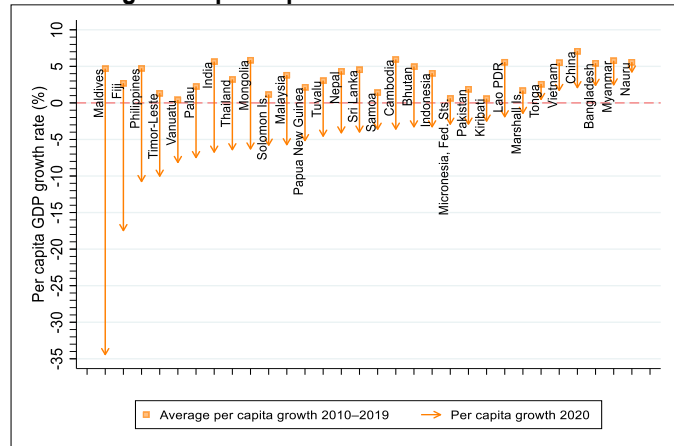
² See <https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19> for further information on country policy responses (including fiscal responses) to limit the human and economic impact of the COVID-19 pandemic.

Figure 1: Impact of AFC, GFC, and the COVID-19 Pandemic on Economic Growth



Source: (IMF 2023a)

Figure 2: GDP per capita Growth in 2020 Compared with Average GDP per capita Growth from 2010–2019

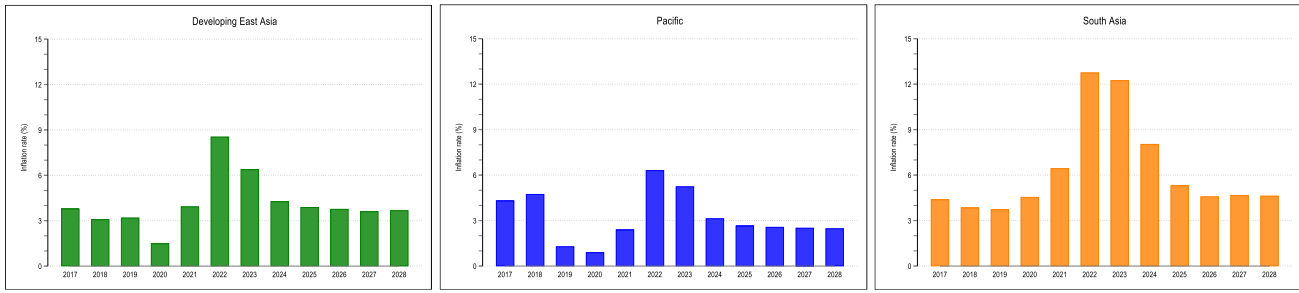


Economic growth in 2021 improved dramatically, but inequalities in the recovery emerged. Global GDP per capita growth jumped from -5.7 percent in 2020 to 4.3 percent in 2021, driven by reductions in lockdown restrictions and rising vaccine coverage rates. China grew by 8.4 percent in 2021, up from 2.1 percent in 2020, driven by consumption and exports. India's economy rebounded to 8.0 percent growth in 2021 from -6.7 percent in 2020, driven by large increases in investment and consumption and supply-side increases in manufacturing and services (World Bank 2022b). However, the 2021 economic rebound was more muted in many other Asia-Pacific countries: GDP per capita growth was only 2.8 percent in Nepal, 2.9 percent in Indonesia, 2.0 percent in Cambodia, and 1.6 percent in Vietnam. PA countries, on the other hand, continued to contract in 2021 as COVID-19 reached PA much later, and international borders for these countries were only reopened in late 2021 (e.g., Fiji) or, in some cases, in 2022.

Subsequent economic recovery in 2022 and 2023 has been stymied by new geopolitical and macroeconomic developments. Disruptions in commodity markets (particularly food and fuel) due to Russia's invasion of Ukraine, pent-up demand from the pandemic coupled with supply-chain challenges, and a rise in the strength of the US dollar resulted in unexpectedly high inflation rates. There have been differential impacts of these developments across countries within the Asia-Pacific. SA was the worst affected—inflation rates more than doubled from 6 percent in 2021 to 13 percent in 2022 and is expected to be 12 percent in 2023 (Figure 3). SA countries most affected by high inflation are Pakistan and Sri Lanka.³ EA and PA have been relatively less impacted by inflation, but specific countries—the Lao People's Democratic Republic (Lao PDR), Mongolia, Myanmar, and Papua New Guinea—have experienced high inflation rates ranging from 14 to 18 percent in 2022. Central banks have tightened monetary policy in response to high inflation, thus cooling short-term economic growth, including in the global “engines” of economic growth—the United States, the European Union (EU), Japan, and China (Figure 4). As a result, global economic growth is projected to slow to 2.3 percent in 2023. The economic outlook for SA continues to be muted with growth slowing further in 2023 to 2.3 percent before a slight expected uptick in 2024. Growth in EA is projected at 3.4 percent in 2023, an increase due to rebounds from easing restrictions in China, but downside risks remain, however, as declining goods export growth, extreme weather, China's real estate sector, and global monetary tightening remain as looming risks (World Bank 2023b; IMF 2023b).

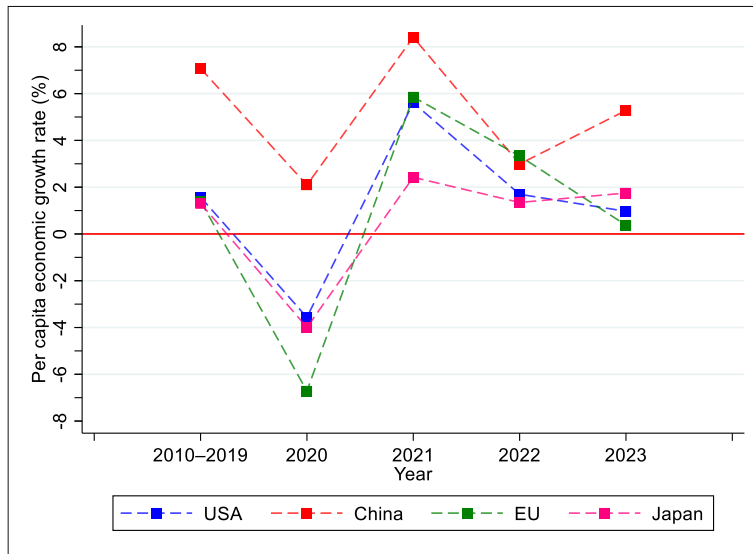
³ Sri Lanka's economic challenges started even before COVID-19; the pandemic dramatically exacerbated the situation in the country.

Figure 3: High Inflation Rates in EA, SA, and PA



Source: (IMF 2023a)

Figure 4: Several Global Engines of Economic Growth—USA, China, Japan, and the EU—Will Experience a Slowdown in 2023



Source: (IMF 2023a)

As a result, it will take several years for economic activity just to recover back to prepandemic levels. Indonesia and Samoa—both recently classified as upper-middle-income countries (UMICs)—have now been reclassified as lower-middle-income countries (LMICs) (Hamadeh 2021). Palau has similarly been downgraded from high income country (HIC) to UMIC (Hamadeh 2022). The Philippines and Thailand are expected to recover to 2019 levels of per capita GDP in 2023 (Table 1). Fiji is expected to regain its economic losses only by 2025 and Papua New Guinea by 2026. Moreover, Myanmar, Samoa, Solomon Islands, Sri Lanka, and Vanuatu are projected not to recover to 2019 prepandemic levels of economic activity in per capita terms even by 2028. Although Pakistan rebounded in 2021 and 2022, it is projected to contract by 1.5 percent in 2023 due to persistent structural problems aggravated by rising commodity prices and depleting foreign reserves.

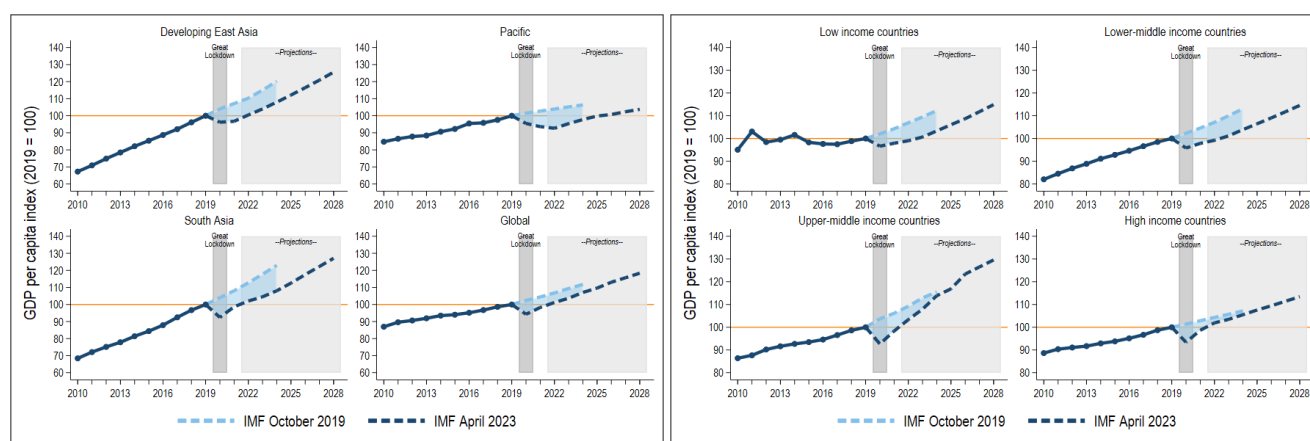
Table 1: Lingering Economic Impact from COVID-19 as well as Additional Recent Global Developments

Did not contract in 2020	Prepandemic 2019 per capita levels of economic activity projected to recover by								Expected not to recover by 2028
	2021	2022	2023	2024	2025	2026	2027	2028	
Bangladesh		Cambodia							Myanmar
China	India	Indonesia		Marshall Is.	Bhutan		Micronesia, Fed. Sts.		Samoa
Nauru	Kiribati	Lao PDR		Philippines	Mongolia	Fiji	Palau		Solomon Is.
Timor-Leste	Pakistan	Malaysia		Thailand	Tonga		Papua New Guinea		Sri Lanka
Vietnam		Maldives		Tuvalu					Vanuatu
		Nepal							

Source: Authors' calculations based on (IMF 2023a)

There is evidence that most countries in Asia-Pacific have faced some degree of permanent scarring due to the multiple shocks. In EA, PA, and SA countries, the gap between pre-COVID projections and post-COVID projections has risen over time (Figure 5, left side). At a global level, economic growth prospects in 2023 are now clearly split across UMICs and HICs whose growth prospects are converging back to the prepandemic trend, versus LICs and LMICs facing permanent scarring as projected growth trajectories are not converging with prepandemic trends (Figure 5, right side). The implication is clear: from the point of view of lost income and economic growth, the wounds inflicted by COVID-19 have become permanent scars with direct consequences for regional development and for many LICs and LMICs.

Figure 5: Comparison of Pre- and Post-COVID-19 Economic Growth Trajectories



Source:(IMF 2023a)

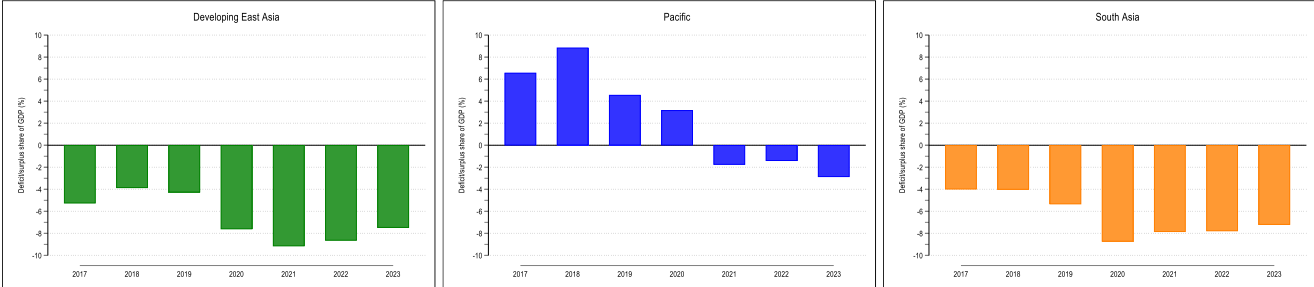
Declining incomes and sluggish economic recoveries have increased global poverty and socioeconomic inequalities. Extreme poverty (at US\$2.15-a-day at 2017 purchasing power parity [PPP] exchange rates) rose for the first time in more than two decades: in 2020, an estimated 90 million additional people globally were pushed into extreme poverty, mainly in SA, followed to a much lesser extent in EA. The estimates increase to 167 million additional poor if a higher poverty threshold of US\$3.65-a-day is used instead. In proportional terms, the poor have been hit much harder than the rich globally in terms of the adverse impact of COVID-19. Such households, with fewer economic reserves, would subsequently be even more dependent on public resources to access social services.

Rising public debt

Fiscal deficits increased due to declines in government revenues and increased government spending. Overall government revenues, especially tax revenues, declined with declining economic activity in 2020. However, financing the emergency COVID-19 response and social protection support programs to mitigate the economic impact on households and businesses warranted increased government spending in 2020 and 2021. This increase was largely funded through fiscal deficits (Figure 6). These deficits increased, in 2020, to over 8 percent of GDP in Fiji and PNG; over 9 percent of GDP in China and

Mongolia; and over 12 percent of GDP in India, Maldives, and Sri Lanka. For comparison, the average fiscal deficit for developing countries in EA and PA countries in 2019, prepandemic, was just above 1 percent of GDP, and about 5 percent in SA. While such deficits are justifiable in the short term for emergencies and to protect investments in human capital, there are long-term implications on the trajectory of economic growth and future government spending. Deficits can also affect the credit rating of countries, thus making it more expensive to borrow and service debt, which can reduce investments and create a burden of indebtedness that is difficult for governments and taxpayers to bear over time, and can compromise the living standards of current and future generations (IMF 1996).

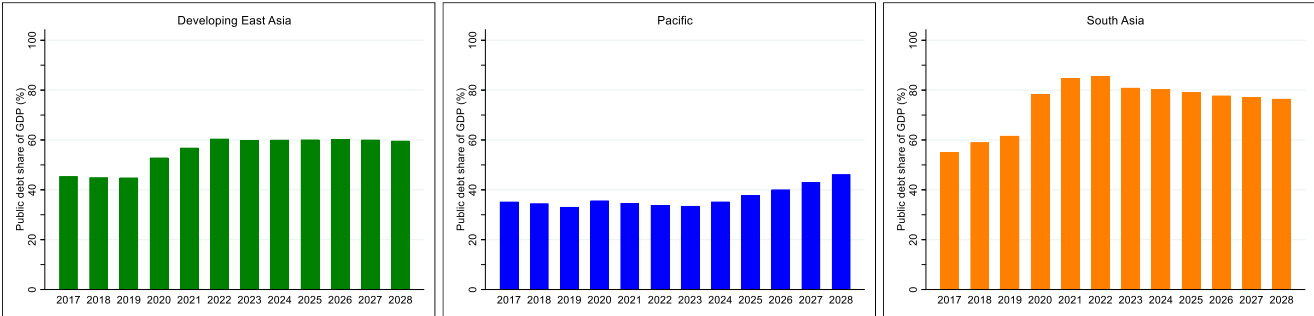
Figure 6: Deficits Rose Across Most Countries in the Region



Source: (IMF 2023a)

Public debt has risen globally as fiscal deficits increased. Public debt in SA, which was already high (more than 60 percent) before the crisis, is estimated to have reached 86 percent of GDP in 2022. Public debt levels are exceptionally high in Bhutan, India, Maldives, and Pakistan. Sri Lanka defaulted on its external debt in April 2022. Public debt in EA has increased but to a lesser extent than in SA. Nevertheless, China, Lao PDR, and Malaysia had public debt levels in excess of 60 percent of GDP. PA, by contrast, has relatively low levels of debt (Figure 7). Importantly, debt distress is a function not only of debt as a share of GDP but of other factors such as exposure to external debt, projected economic growth, and repayment schedules and maturities. For this reason, Afghanistan, Maldives, Kiribati, Lao PDR, Marshall Islands, the Federated States of Micronesia, PNG, Samoa, Tonga, and Tuvalu, are at a high risk of debt distress in the Asia-Pacific region. Bhutan, the Solomon Islands, Timor-Leste, and Vanuatu are at moderate risk of debt distress (IMF 2023c).

Figure 7: Public Debt's Share of GDP has Risen

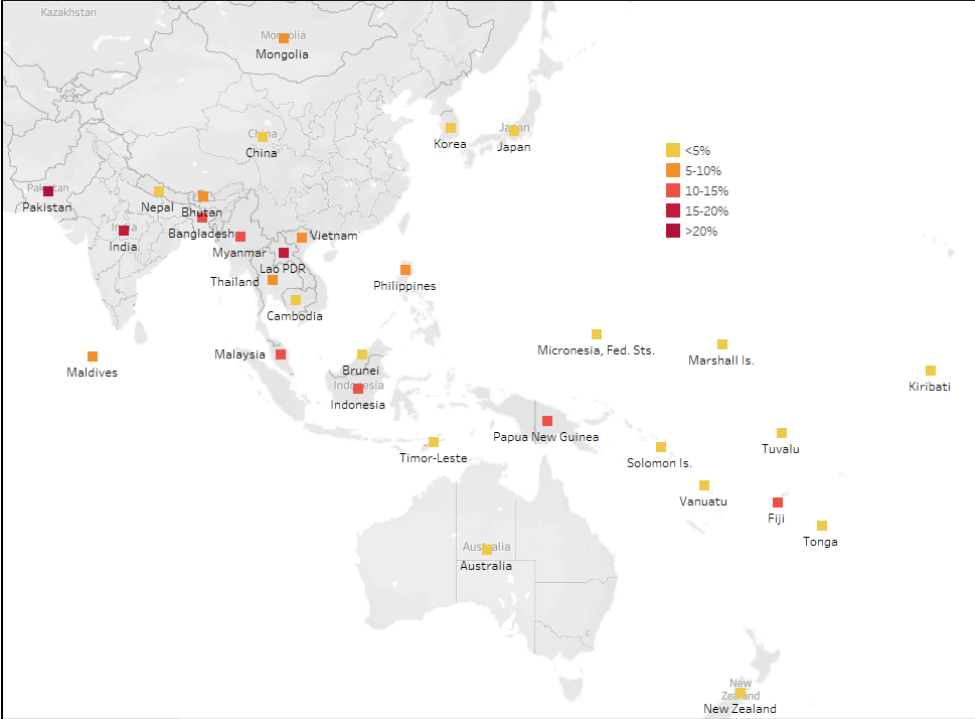


Source: (IMF 2023a)

Interest payments, already a substantial component of government expenditures in some countries, increased with higher public debt. The rise in interest payments will further constrain the ability of governments to finance public investments across all sectors. Interest payments as a share of government spending are projected to increase from less than 11 percent in 2019 to greater than 14 percent in 2028 within SA, from less than 6 percent in 2019 to greater than 8 percent in 2028 within EA, and from less than 3 percent to greater than 4 percent within PA. Pakistan is projected to have interest payments greater than 20 percent of total government expenditure over 2023–2028 and India and Lao PDR are in the range of 15–20 percent and

Bangladesh, Fiji, Indonesia, Malaysia, and Myanmar are in the range of 10-15 percent of total government expenditure (Figure 8). The competing necessity of higher expenditures to pay interest is a risk factor for many countries in the Asia-Pacific region and, indeed, across the globe, which can potentially impact the future trajectory of public investments in health and other sectors (Kurowski et al. 2022; Fan and Gupta 2023; Stubbs et al. 2023). Finally, historical interest rate hikes by the Federal Reserve in the United States in 2022 have created strong global demand for the US dollar, which drove currency devaluations across the SA and EA regions: exchange rates against the US dollar have hit historical lows in countries extending from Pakistan and Sri Lanka to Malaysia (Daisuke Wakabayashi and Ben Dooley 2022). The consequence is that US dollar-denominated debts accrued by regional governments in 2020 and 2021 have become more expensive to service as the price of the US dollar rises. Lastly, rising interest rates—in the United States and globally—have triggered greater financial instability, including a banking crisis in early 2023, thus suppressing global growth prospects and development further (Adrian 2022).

Figure 8: Average Interest Payments as a Share of Government Spending, 2022–2028

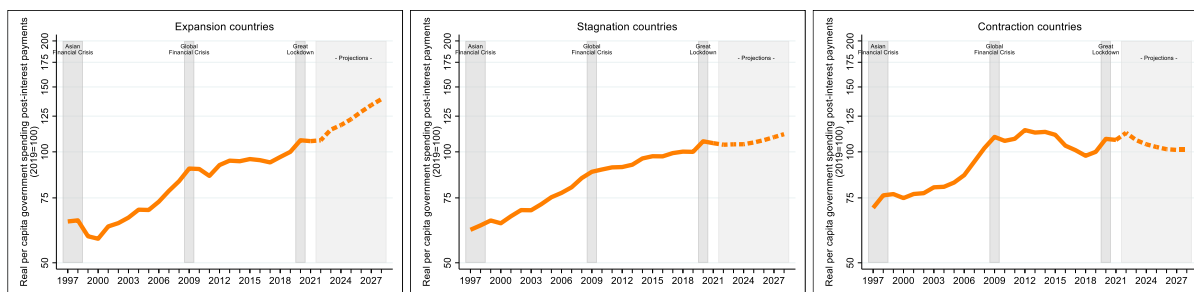


Source: (IMF 2023a)

Given this context, projections of real per capita government spending postinterest payments reveal the diversity of trajectories and challenges faced within the Asia-Pacific. This indicator captures the net fiscal impact of the COVID-19 economic contraction, uneven global recovery hampered by new macroeconomic and geopolitical developments, and rising debt. Although every country in the world was exposed to these developments, preexisting country fundamentals and contexts, the course of COVID-19 within the country, and subsequent responses have impacted each country’s macrofiscal conditions along different trajectories. Based on current projections, three country groupings are becoming evident (Figure 9 and Table 2): (i) expansion countries, that is, those countries for which constant—that is, inflation-adjusted, real per capita government spending postinterest payments is projected to increase by 2.6 percent per year or higher from 2022 to 2028 (e.g., China, India, and Indonesia); (ii) stagnant countries, that is, those for which real per capita government spending postinterest payments is projected to stay at largely the same level as it was in 2019 or grow by less than 2.6 percent per year from 2022 to 2028 (e.g., Fiji, Lao PDR, and Pakistan); and (iii) contraction countries, that is, countries for which real per capita government spending postinterest payments is projected to contract, on average, between 2022 to 2028 (e.g., Myanmar, Papua New Guinea).⁴

⁴ 2.6 percent was the average annual growth rate in real per capita government spending postinterest payments across low- and middle-income countries from 2010 to 2019.

Figure 9: Trends and Projections in Constant per capita Postinterest Government Spending across Expansion, Stagnation, and Contraction Countries



Source: (IMF 2023a)

Table 2: Expansion, Stagnation, Contraction Countries in Asia-Pacific (2022–2028)

Expansion	Stagnation	Contraction
Bangladesh	Bhutan	Micronesia, Fed. Sts.
Cambodia	Fiji	Marshall Islands
China	Kiribati	Myanmar
India	Lao PDR	Papua New Ginnuea
Indonesia	Malaysia	Solomon Islands
Mongolia	Maldives	Timor-Leste
Nepal	Pakistan	Tonga
Philippines	Thailand	Vanuatu
Vietnam	Tuvalu	

Source: (IMF 2023a)

Implications for Public Financing of Health

Weaknesses in economic growth can jeopardize public financing of health, but government revenue collection and health prioritization are also critical factors. Historically and especially for the Asia-Pacific region in recent decades, real per capita economic growth—more accurately, increases in government revenue that typically accompanies economic growth—has been a major driver of public spending on health. Improving general government revenue collection, independent of economic growth, also enables public spending including for health, even if the health share of overall government spending remains unchanged. Finally, the share of health in government spending—that is, the prioritization given to health—is another factor driving changes in public spending on health. Globally, economic growth has been the largest determinant of increases in public spending on health, followed by increases in the size of overall government spending and, to a lesser extent, increased prioritization of health in overall government spending (Tandon, Cain, et al. 2020). All three determinants do not necessarily move in the same direction. For example, the economy can contract, but if overall government spending as a share of the economy and the priority given to health rises, public spending on health would increase if the magnitude of the latter two is greater than the economic contraction.

Despite the massive global economic contraction, public spending on health increased during the pandemic in 2020. Although public spending on health has historically been procyclical—increasing during economic growth and declining during economic contractions—the opposite occurred during COVID-19 (WHO 2022; Tandon, Roubal, et al. 2020). Public spending on health rose in 2020 due to pandemic-related health care expenditures such as personal protective equipment, expansion in surveillance and bed capacity, and other forms of emergency response, despite the global economic contraction. Globally, country-weighted current health expenditure (CHE), which includes public and private sources of financing, rose from US\$1,143

per capita (average from 2017 to 2019) to US\$1,218 in 2020, or as a share of GDP, from 6.5 to 7.1 percent (WHO 2023). The increase was driven mainly by public financing. Out-of-pocket (OOP) health expenditure declined both in levels and as a share of CHE in 2020 relative to the average from 2017 to 2019, likely due to declining income and utilization (WHO 2023). This global trend of higher public spending for health and a decline in OOP health spending in 2020 occurred across the Asia-Pacific, including in EA, PA, and SA (Table 3) (WHO 2022).⁵ However, the observed declines in OOP health spending in the region were relatively small, approximately 1–3 percentage points, and mirrored declines in social health insurance (SHI) contributions as well.

Table 3: Health Financing Profiles, 2017 to 2019, compared with 2020

Classification	Year	Current health spending per capita	Share of GDP (%)	Public share of current (%)	Public per capita	Share of public (%)			OOP share of current (%)
						General taxation	SHI	External	
EA	2017–2019	187	4.4	51	102	74	18	8	40
	2020	212	5.2	54	120	75	16	9	37
PA	2017–2019	528	8.7	83	432	73	5	22	6
	2020	591	9.5	83	488	78	3	19	5
SA	2017–2019	173	5.3	41	109	88	1	11	50
	2020	174	6.1	43	115	91	1	8	48
Global	2017–2019	1,143	6.5	56	777	71	20	9	31
	2020	1,218	7.1	59	865	72	19	9	29

Source: Authors' estimates based on WHO (2023); all expenditures are reported in constant 2020 US\$.

Notes: SHI = Social health insurance; OOP = Out-of-pocket.

Increases in public spending for health in 2020 were driven by increases in overall government spending financed through deficits, although in some countries, health was further prioritized as a share of overall government spending.

These two factors offset the impact of declining economic activity leading to an increase in overall levels of public financing for health in 2020 (WHO 2022). A small decline in SHI contributions was evident, likely a result of pandemic-induced unemployment. External financing appears not to have changed substantially, but anecdotal evidence suggests a large increase in in-kind support unrecorded by the recipient (typically, PA) countries. Finally, the decline in OOP health spending was likely due to decreasing household income and lower health care utilization (Shapira et al. 2021; Kiarie et al. 2022; Xiao et al. 2021) due to lockdowns and foregone care (Kakietek et al. 2022).

The increase in public spending on health seen in 2020 is unlikely to continue at the same pace. This is primarily due to renewed weaknesses in the macrofiscal environment, including projections of sluggish economic growth, the higher burden from interest payments, and inflation, compounded by the legitimate demands for scarce public resources from other sectors following the dissipation of immediate threat from COVID-19. Even in countries that have rebounded, such as India, government expenditures shifted toward physical capital investments and fiscal consolidation—that is, reducing public deficits and debt—rather than sustained prioritization of health. Given this macrofiscal outlook, the trend growth rate of real per capita public spending on health is projected to decline over 2022 to 2028 compared with 2010 to 2019 if the prioritization of health (as a share of government spending) remains the same as in 2019. To preserve the trend growth rate of real per capita public spending on health (same average annual growth rate from 2022 to 2028 as the growth rate from 2010 to 2019), prioritization of health will have to increase significantly, not only across contraction and stagnation countries but even (albeit to a lesser extent) among expansion countries. However, as the case of India suggests, the demands of fiscal consolidation may actually imply deprioritization of health to varying degrees in the short term. Deprioritization will have important impacts on health systems already struggling to improve health service delivery, access, and equity after suffering from COVID-19's catastrophic impacts. Widening disparities in health spending across countries can be expected in this context, and policy makers should remain mindful of new macrolevel risk factors affecting the capacity of countries to invest in pandemic preparedness and future health threats while also exacerbating inequalities before the next health emergency strikes (Glassman, Keller, and Smitham 2023). Note that expenditures on COVID-19 vaccinations in 2021 (expenditures not only to reduce the health impact of COVID-19 but

⁵ Some of these estimates are modeled and hence inferences need to be caveated pending availability of more robust data estimates.

to allow for an economic reopening of all sectors) were exceptional, likely to represent a one-off expense rather than a change in the trend of public spending on health.

Implications for Universal Health Coverage (UHC)

Public financing for health is critical for sustaining progress toward UHC by assuring high levels of service coverage and financial protection. Health financing systems that most support the advancement of UHC are financed predominantly from public sources (general taxation, or, in some cases, SHI or a combination of general taxation and SHI).⁶ Such financing allows for broad pooling of resources, which can then be allocated toward effective service coverage. Furthermore, where OOP financing accounts are kept under 15 to 20 percent of CHE, financial protection from the risk of impoverishment from OOP health spending at the time and place of care becomes negligible. In some countries where a large part of OOP health spending is done by the wealthy—such as Malaysia—financial protection can still be maintained even if OOP health spending levels are higher than this benchmark. Thailand is an example of a high-performing health financing system in the Asia-Pacific region: CHE was US\$305 per capita in 2020, of which 70 percent was public financing and only 11 percent was OOP health spending. Financial protection was strong: only 1.9 percent of Thai households experienced catastrophic health spending and only 1 percent were either pushed into or further into poverty due to OOP health spending (WHO and World Bank 2021).^{7,8} The Asia-Pacific region, specifically SA and EA (but not PA), generally has the greatest concentration of households exposed to catastrophic health spending (WHO and World Bank 2021).

The UHC agenda in the Asia-Pacific region is far from finished, especially in the dimensions of service coverage and financial protection. Over the last several decades, much progress has been made to improve service coverage (Figure 10), but the Asia-Pacific region still has a long way to go, even if pandemic-related regressions are disregarded. The UHC service coverage UHC index, an index of proxy indicators of average attainment across infectious diseases, maternal and child health, NCDs, and service delivery capacity, reveals the disparities and remaining progress needed. The index is lowest in PA (but higher than in sub-Saharan Africa), followed by SA (WHO and World Bank 2021). EA is ahead of both SA and PA but lags behind the low- and middle-income countries of Europe and Central Asia (ECA) and Latin America and the Caribbean (LAC).⁹ Service coverage for NCDs, noting that NCDs account for the largest share of the disease burden across Asia-Pacific, remains weak across much of the region. Furthermore, there is a large, unfinished agenda related to undernutrition, maternal and child health, and communicable diseases (such as tuberculosis), even among larger members of the region—for example, India, Indonesia, and PNG. Lastly, while UHC service coverage indicators have shown improvement in the region, relatively modest progress with financial protection has been made in comparison. With the exception of PA and countries like Thailand, where OOP spending is negligible,¹⁰ OOP share has continued to remain stubbornly high in developing EA and SA countries since 2000 (Figure 11). Financial protection improvements that were visible in SA and EA prior to the pandemic due to declining poverty rates were then reversed in 2020 due to the stark increase in the number of poor and near-poor households (Mahler, Yonzan, and Lakner 2022).

⁶ As noted subsequently, PA countries are the exception in that despite having largely public financed health systems, progress toward UHC is relatively poor.

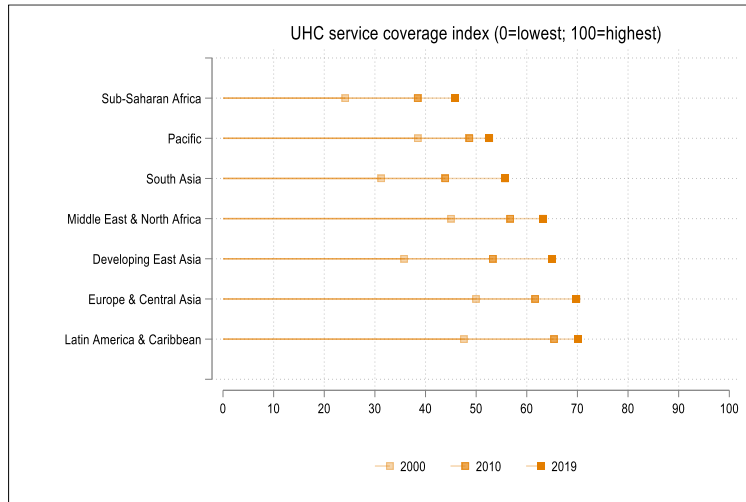
⁷ At the relative poverty line of 60 percent of median consumption or income.

⁸ Catastrophic health spending: OOP spending in excess of 10 percent of the household budget.

⁹ Most high-income countries, by way of contrast, have UHC service coverage index scores of >80.

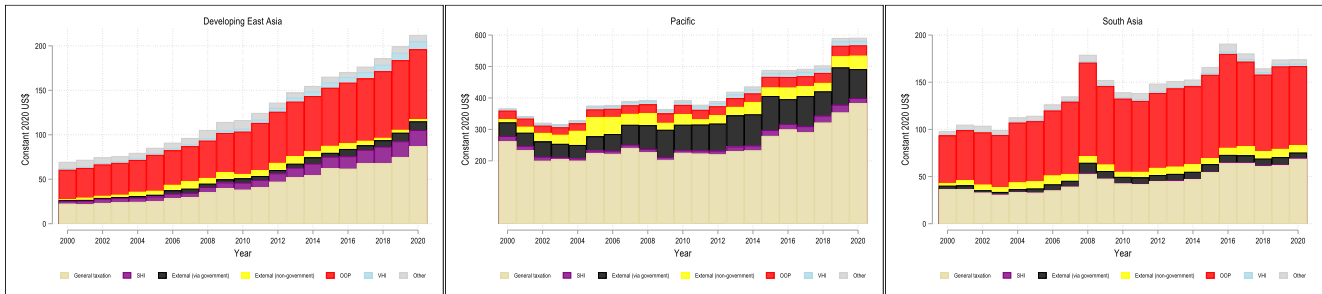
¹⁰ Nevertheless, travel-related access costs and opportunity costs (such as childcare and foregone wages) are a challenge and are not adequately captured in statistics related to the financial hardship of accessing care.

Figure 10: Trends in UHC Service Coverage



Source: (WHO & World Bank 2021)

Figure 11: Trends in the Level and Composition of Health Spending



Source: (WHO 2023)

Note: SHI = Social health insurance; OOP = Out-of-pocket; VHI = Voluntary health insurance.

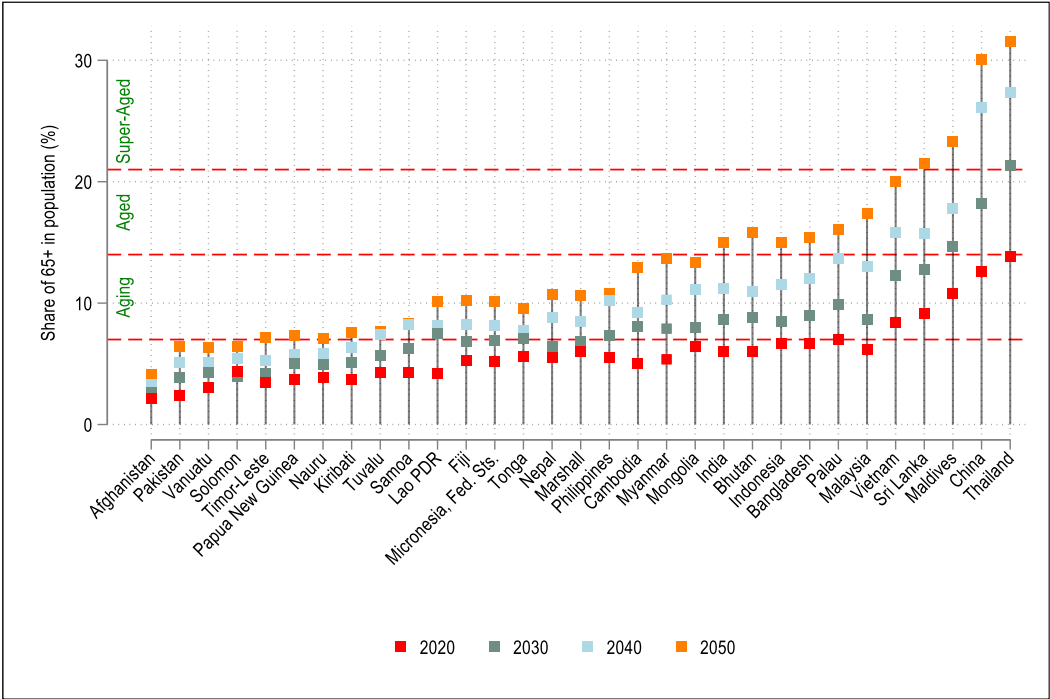
Long-term risks such as demographics further threaten UHC: Health care costs are rising due to aging. Although reflective of a health success story, the Asia-Pacific is aging rapidly due to rising life expectancy and declining fertility. The pace of demographic change is astounding. For example, in China, both the overall population and working-age population (aged 15 to 64) have begun to decline. India is projected to overtake China as the most populous country in the world in 2023.¹¹ Thailand has the highest share of the population aged 65+ years, followed by China, Sri Lanka, Maldives, and Vietnam, all of which had a share of the population aged 65+ of greater than 7 percent in 2020, the threshold at which the population can be described as “aging.” By 2030, among low- and middle-income countries in the region: Thailand is projected to be “super-aged” (with a share of the population aged 65+ share greater than 21 percent); China and the Maldives would be “aged” (with a share of the population aged 65+ greater than 14 percent); and Bangladesh, Bhutan, Cambodia, India, Indonesia, Malaysia, Mongolia, Myanmar, Palau, the Philippines, and Sri Lanka, and would have joined the ranks of “aging” countries (Figure 12). Demand for health care services rises with age, while the complexity (and costs) of care also increases with age due to a multiplicity of chronic conditions and slower recovery.

Health financing is also strained by aging. Countries that raise public financing for health from the working-age population will find it harder to support a large aging population from a shrinking share of the working age. In particular, health systems dependent on SHI contributions, wherein entitlements are linked to employment, will also face challenges supporting nonworking

¹¹ 2022 Revision of World Population Prospects. Data available from <https://population.un.org/wpp/>.

older persons. At the household level, aging has also been shown to be significantly correlated with weakened financial protection (Eozenou, Neelsen, and Smits 2021).

Figure 12: Aging across the Asia-Pacific



Source: (UN Population Prospects 2022)

Climate change also poses challenges to UHC, food security and nutrition, and health financing. Health systems across Asia-Pacific face growing challenges related to climate change—including higher temperatures, pollution, and extreme weather. Higher temperatures can expand the range of infectious diseases, as warmer temperatures permit the transmission of water-, food-, and vector-borne diseases. Higher temperatures can also kill the elderly and vulnerable through dehydration, heat exhaustion, and heat stroke (Romanello et al. 2022). Climate change can also affect food security and, by implication, nutrition. Extreme weather due to climate change is particularly relevant to the Asia-Pacific. SA, EA, and PA are all frequently affected by extreme weather—cyclones, floods, droughts, and heat waves. Floods in Nepal, Bangladesh, Pakistan, and India annually claim hundreds of lives and lead to substantial economic losses and damages—for example, the recent floods in Pakistan in 2022 inundated one-third of the country and caused damages amounting to almost 5 percent of GDP and untold financial ruin to millions of households (Government of Pakistan 2022). Large populations live along the coast and shallow delta regions (e.g., in Bangladesh) and low-lying islands and atolls in PA. SA and EA countries are also significant producers and subsidizers of greenhouse gases, a key determinant of climate change pollution, which can damage population health, and, as described later, are an opportunity for reforms in the form of health taxes.

High-impact Reform Areas

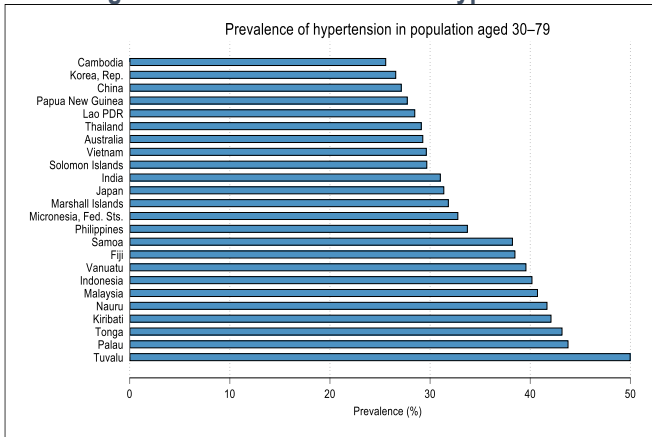
Given the realities of the macrofiscal risks to public financing for health, a renewed focus on improving the efficiency and equity of public spending on health is imperative. The Asia-Pacific region cannot merely rely on rapid economic growth to finance health in the near term. We highlight three high-impact reform areas where efficiency and equity gains can be realized: strengthening primary health care (PHC), expanding health taxes to reduce unhealthy environments and lifestyles (not to mention its additional fiscal benefits), and increasing pro-poor benefit incidence of public spending for health. Successes and experiences from across the Asia-Pacific region are also used to exemplify and qualify the potential but so are risks and implementation challenges.

A. Strengthen Primary Health Care: Improving health outcomes equitably and efficiently

Strong PHC is the essential foundation of UHC, which has the profound potential to improve health outcomes while saving overall health care costs and improving system equity.¹² Strengthened PHC, with its emphasis on the delivery of preventive and promotive interventions in a coordinated manner, is estimated to save 60 million lives and increase average life expectancy by 3.7 years by 2030 across low- and middle-income countries (WHO 2019), while reducing total health expenditure (Hou, Liu, and Cain 2022).

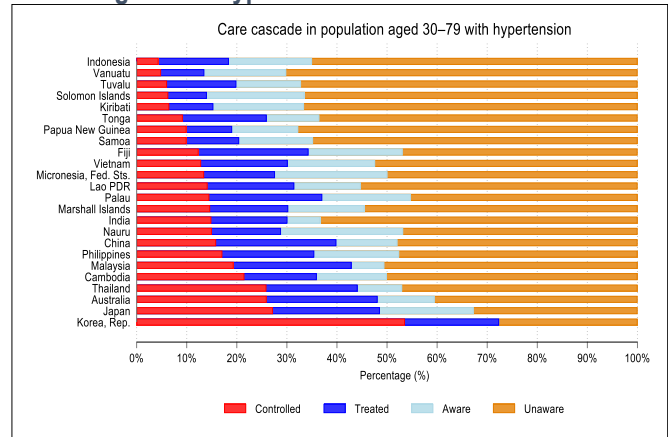
Strong PHC is particularly relevant for the Asia-Pacific region due to the high prevalence of NCDs, including complex multimorbidities, which reflect a high burden of health risks. NCDs are exceptionally high in PA (Figure 13) due to the high prevalence of modifiable health risks such as excessive salt consumption, high saturated fat diets, physical inactivity, low intake of fruits and vegetables, and overweight or obesity. Furthermore, many NCDs and health risks remain undiagnosed. And, even among the diagnosed, management of these diseases and risks is suboptimal. In Indonesia, for example, fewer than 5 percent of adults aged 30 to 79 with hypertension have their blood pressure levels controlled within the appropriate range (Figure 14). Opportunities to strengthen PHC include (i) expanding effective access by reducing formal (user fees) and informal barriers to access (inconvenient opening hours, long waiting times, and lack of female health workers); (ii) using technology (where appropriate and available) and community outreach to expand the coverage of care; (iii) inviting participation by the patient-person and the family members in their care; (iv) increasing the availability of diagnostics and evidence-based, rational therapeutics; (v) leveraging multidisciplinary team-based provision of a range of health services; and (vi) transforming PHC as the center for coordinated and integrated care across the continuum of health care levels. The content of PHC can also be further tailored to the disease burden in the Asia-Pacific—beginning with health promotion and disease prevention, and followed by the proactive screening of health risks and NCDs¹³ (which often go undiagnosed because early symptoms are nonspecific and easy to miss), and comprehensive management of these health risks and NCDs over the life course given their chronicity and complexity (e.g., multimorbidities, where multiple diseases/morbidities coexist).

Figure 13: Prevalence of Adult Hypertension



Source: (Zhou et al. 2021)

Figure 14: Hypertension Care Cascade



PHC is efficient. Health promotion and disease prevention at the PHC level reduce the ultimate burden of disease and the need for health care. Strong PHC, through well-managed health risks and NCDs, can decrease the need for unnecessary hospital admissions, prevent avoidable readmissions, and limit inappropriate use of emergency departments. These not only

¹² “PHC is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people’s needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people’s everyday environment” (WHO and UNICEF, A Vision for Primary Health Care in the 21st Century: Toward UHC and the SDGs).

¹³ Sri Lanka’s PHC reorganization empowers primary medical care institutions to adopt a population health management approach by screening the population for NCDs and follow-up with those diagnosed with NCDs such as diabetes and hypertension with free treatment and lifestyle interventions.

reduce the discomfort, morbidity, and mortality associated with hospitalization but, importantly, reduce total health care costs and free scarce public hospital beds in resource-constrained settings (WHO 2018). While empirical evidence for greater efficiency through improved PHC is extensive for high-income countries, data on hospitalizations for Ambulatory Care–Sensitive Conditions¹⁴ (ACSCs) from across the region, as an indicator of PHC strength, bolster the efficiency argument for investing in strong PHC in the Asia-Pacific. The magnitude of the efficiency gains by reducing ACSCs, in fact, is very large in the Asia-Pacific. For example, a recent study in Vietnam found that 30 percent of hospital admissions in 2019 under its single-payer national health insurance scheme were for ACSCs. Provincial variations were notable across the country due to varying disease patterns and disparities in the provision and effectiveness of PHC services (Bales 2022). Recent claims analysis from PhilHealth in the Philippines, the public health insurance scheme, shows that 34 percent of all PhilHealth-covered hospital admissions from 2018 to 2021 were for ACSCs (Flaminiano et al. 2022). Admissions for hypertension alone account for 6 percent of tertiary care hospital expenditures.¹⁵ Many of such admissions could have been avoided through careful clinical management and the provision of antihypertensive pharmacologic therapy or similar treatments in far less costly PHC settings, provided that these settings are able to provide an adequately comprehensive package of services.

PHC is equitable. The role of PHC in equity is particularly relevant for resource-constrained countries during low economic growth periods. Evidence from both the United States and other high-income countries has consistently shown that financially accessible PHC helps lessen existing disparities in health outcomes between socioeconomic groups (WHO 2018). Similarly, primary care providers are more accessible to lower socioeconomic status subpopulations compared with specialist providers. Further strengthening PHC systems in Asia-Pacific is a critical means to improve health equity and financial protection, of particular relevance in SA, where a high proportion of the global financially vulnerable live (Mahler, Yonzan, and Lakner 2022).

PHC is a critical element of health security and health care resilience. The COVID-19 crisis revealed and exacerbated weaknesses in PHC capacity. Countries with stronger PHC responded faster and more effectively during the COVID-19 pandemic, while countries with weak PHC systems, following decades of neglect and chronic underinvestment, were less able to respond effectively (Barış et al. 2022). Moving forward, PHC remains relevant beyond the COVID -19 pandemic, and arguably for future pandemics, for targeted vaccinations and therapeutics, especially among high-risk groups, and for disease surveillance, including sentinel surveillance.

Modest investments will be needed to reap the PHC dividend, including investments in strengthening human resources for health and access to essential medicines. Although strong PHC will result in cost savings through efficiency gains, investments are needed initially to realize these gains. As countries seek to increase public investments in PHC, they must overcome common public financial management (PFM) challenges that limit how effectively existing and new resources are actually used by providers and facilities on the front lines. The [Indonesia country spotlight](#) highlights how Indonesia leveraged provider payment mechanisms to channel more resources to PHC while incentivizing outcomes. Beyond provider payment mechanisms through health insurance reforms, another policy instrument available to extend greater and more flexible resources to PHC providers is performance-based financing. Diagnostic tools are available (Piatti-Fünfkirchen, Hadley, and Mathivet 2021), which can support country policy makers in reorienting the fiscal autonomy and absorptive capacity of frontline health care providers and PHC. Furthermore, the [Pacific countries and Timor-Leste country spotlight](#) highlights how countries are beginning to reconceptualize PHC, expanding the definition of which services are and are not traditionally included under PHC. Weaknesses in human resources for health are also a critical challenge, but innovations and thinking outside the box to identify community resources that can be mobilized, as highlighted in the [India country spotlight](#), are a good start. Improving supply-side readiness at the PHC level is critical to meet the increasing demand for PHC, generated, for example, by screening programs or other initiatives to reorient demand toward PHC. Supply chain management is also critical to ensure that health commodities are readily available with minimal stockouts.¹⁶ Household-level surveys from across eight countries in the Southeast Asia region (Wang, Torres, and Travis 2018) show that spending on medicines accounts for 62 to 82 percent of OOP spending,¹⁷ suggesting that investments to expand access to essential medicines will also help to improve the efficiency and equity of PHC systems in the region.

¹⁴ ACSCs are “are those conditions for which hospital admission could be prevented by interventions in primary care” (Purdy et al. 2009).

¹⁵ World Bank 2023c.

¹⁶ World Bank 2023d

¹⁷ National averages for all countries included in financial protection analysis, excluding Sri Lanka.

Country spotlight | Indonesia's Jaminan Kesehatan Nasional: Leveraging provider payment mechanisms to revitalize PHC

Indonesia is attempting to strengthen PHC to address pending and new health challenges facing its population by piloting a lifecycle approach and including home visits as part of its PHC package. Antenatal care has been expanded to a minimum of six visits during pregnancy (including twice with a physician and two ultrasound scans) to better address obstetric risks. Screening has been expanded to include 14 priority conditions (including congenital hypothyroidism, thalassemia, anemia, stroke, coronary heart disease, hypertension, chronic obstructive pulmonary disease [COPD], lung cancer, hepatitis, diabetes, breast cancer, cervical cancer, and colon cancer) and the basic immunization schedule now includes 14 antigens, including human papillomavirus, porcine circovirus, and rotavirus. Growth monitoring for children is integrated within the PHC package to detect and reduce stunting.

To channel more resources to PHC and incentivize the delivery of this extended benefits package, provider payment mechanisms used by Indonesia's single-payer national health insurance scheme, *Jaminan Kesehatan Nasional (JKN)*, are being adjusted so that certain screenings are reimbursed on a fee-for-service rather than part of a basic capitation. Capitation payments to PHCs are also being revised to compensate for demographics and performance.

Country spotlight | India: Innovations in PHC human resources for health to transform access in the community

India is implementing PHC-focused reforms that have the potential to be transformational. One foundational element of India's reforms is the role of its newly minted public delivery health and wellness centers (HWCs), which are used to provide comprehensive PHC, with the objective of taking less than 30 minutes to provide care and a stronger focus on NCD screening and management. In rural areas, catchment populations of 3,000 to 5,000 will now have access to at least one HWC. In urban areas, where the focus is explicitly on providing services for those living in slums, the corresponding catchment population is 15,000 to 20,000.

To staff these frontline HWCs, a "primary health care team" headed by a Community Health Officer (CHO) and supported by a team of two Multipurpose Health Workers (at least one of whom is female) and three to five Accredited Social Health Activists (ASHAs), are leveraged to provide preventive, promotive, curative, and rehabilitative care via community outreach, at the HWCs themselves, and via upward referrals. One of the primary tasks of HWCs is to create population-based household lists and undertake registration of all individuals and families residing within a catchment area of an HWC. ASHAs undertake home visits to ensure screening, risk factor modification, counseling, and treatment adherence. Although honorary volunteers on paper, ASHAs receive activity-based compensation and incentives. From the communicable diseases surveillance perspective, ASHAs and other frontline workers report on syndromic surveillance. Screening and early detection of NCDs are core objectives of India's HWC reforms, as is the provision of additional services beyond reproductive, maternal, child, and adolescent health, including care for the elderly and dental and eye care services.

Country spotlight | Pacific countries and Timor-Leste: Rethinking the norms of PHC

PHC is not basic care. In recognition of this reality, many PA countries (such as Kiribati, Solomon Islands, and Tonga) have developed role-delineation policies or packages of essential health services to clarify the PHCs, even though initial rollout has been slow and further impacted by the pandemic.

Timor-Leste formalized the "Essential Service Package for Primary Health Care" in 2022 (Timor-Leste, Ministry of Health, 2022). The updated essential service package aims to improve population health and strengthen the country's progress toward UHC. The update responds to the changing disease burden in the country and the new policy environment and strategies (decentralization, health financing, and human resources for health). The service package, which has been costed and increasingly mainstreamed into health sector planning and resource allocation decisions, focuses on integrated health systems strengthening, distributional equity of health services, community empowerment, and accountability of state institutions.

B. Leverage Health Taxes: Reduce costly unhealthy environments and lifestyles while supporting health financing

Health taxes, which are taxes on goods and services that have harmful health effects, support health systems by reducing the societal and health care costs of unhealthy behaviors and increasing fiscal space. Such goods and services can include tobacco, alcohol, sugar-sweetened beverages (SSBs), other unhealthy products, and carbon emissions. The removal of subsidies on fossil fuels¹⁸ and harmful agricultural subsidies perform analogously. Although the impact of health taxes on lifestyles is vital, this paper focuses on the secondary revenue-raising aspects of health taxes, which is relevant whether or not such taxes are “soft” or “hard” earmarked to health. “Soft” earmarking is preferred to “hard” earmarking¹⁹ as the latter can lead to fiscal rigidities and is procyclical (Cashin, Sparkes, and Bloom 2017; Ozer et al. 2020).

Health taxes are progressive, feasible to collect, and can supplement the low general government revenues prevalent in the Asia-Pacific region. Although concerns have been raised about the potential regressivity of health taxes, recent analysis confirms that if the externalities of increased health costs and reduced productivity are considered, the net effect of health taxes is progressive, and even more so when linked to pro-poor health policies such as UHC expansion (Fuchs et al. 2019). Tax revenue collection rates among many low- and middle-income Asia-Pacific countries are often far below the 15 percent of GDP benchmark recommended for sustainable growth and development across countries (Jaramillo, Wingender, and Gaspar 2016), and challenges in revenue collection are notable. Collecting direct taxes (taxes on income and profits) is more challenging than indirect consumption taxes (e.g., sales taxes, value-added taxes [VATs], and excise taxes). Health taxes are usually excise taxes, which are administratively easier to collect than broader consumption taxes such as value-added taxes. Improving tax revenue collection will require longer-term actions such as the efficient design and implementation of value-added taxes, improving property taxation, and increasing the base for taxing income from firms and individuals (de Mooij et al. 2020). Health taxes can hence be an opportunity to increase general government revenues in the short and medium terms while strengthening the overall government revenue collection system. In the long term, health taxes should not be solely relied upon to anchor health financing. However, decreased health care expenditures due to improved health and health taxes would provide long-term tailwinds to the health system (unless offset by increased costs from improved life expectancy).

The Asia-Pacific is home to health taxes success stories. Examples include the Philippines, which has achieved the twin goals of increased health and increased financing for health (see the [Philippines country spotlight](#)), and various other countries are at the early stages of implementing health taxes (such as Bangladesh²⁰ and Nepal²¹), but implementation details are essential for success (see [India, Lao PDR, and Tonga country spotlight](#)). As are specific design considerations such as earmarking and the specific range of products to include or exclude (see [SSB spotlight](#)).

¹⁸ Further information is available on <https://www.imf.org/en/Topics/climate-change/energy-subsidies>.

¹⁹ “Hard” earmarking mandates use of revenue for a particular program through legislation. “Soft” earmarking involves designating revenue toward a particular program, service, or population but in a nonlegally binding manner. Earmarking benefits toward pro-poor health programs or to vulnerable or poor households is a feature that can be leveraged in the design of health tax initiatives.

²⁰ Bangladesh recently introduced a *Health Development Surcharge* to finance tobacco control activities. This is a 1 percent price-based surcharge on all imported and domestically produced tobacco products. Potential revenue generated from this surcharge was estimated as Bangladeshi Taka 0.3 billion or about 1.5 percent of the 2014 Ministry of Health and Family Welfare’s (MOHFW) budget (World Bank 2016). Revenue from this surcharge is fully earmarked for tobacco control activities, by the National Tobacco Control Cell under MOHFW, and prevention of NCDs (particularly tobacco-related diseases). Bangladesh also applies an additional “Supplementary Duty” to SSBs (25 percent on carbonated SSBs, 35 percent on energy drinks) on top of standard 15 percent VAT.

²¹ Nepal made a significant political commitment to use health taxes as a fiscal policy tool to improve health outcomes. Nepal’s recent National Health Financing Strategy, formulated jointly by the Finance and Health Ministries, has a major health taxes component. The strategy argues for increasing taxation of unhealthy products including tobacco, alcohol, and SSBs not only as an option to expand fiscal space but also to improve population health outcomes.

Country spotlight | The Philippines: Expanding UHC while reducing unhealthy lifestyles

The Philippines demonstrated astounding success in population health outcomes through earmarked health taxes. The Republic Act 10351, popularly known as the *Sin Tax Reform Law (2012)*, changed the excise tax structure for tobacco products and increased excise taxes on alcohol and tobacco (Kaiser, Bredenkamp, and Iglesias 2016). The primary objectives of this reform were to (i) generate revenue for public spending on health, particularly for universal health care, and (ii) reduce alcohol and tobacco consumption.

The *Sin Tax Reform Law* (Republic Act 10351) was a significant departure from historical tobacco and alcohol tax policies as it was the first time that health taxes were earmarked for health in the Philippines: approximately 85 percent of the incremental revenue (i.e., revenue from the increased tax structure but not revenue from the preexisting tax) from the tobacco tax and the alcohol tax were earmarked for health. Of this earmarked amount, 80 percent was allocated for universal health care through the National Health Insurance Program, preventive health programs toward attainment of Millennium Development Goals and health awareness programs to achieve population health improvements. The remaining 20 percent was dedicated to medical assistance and a health enhancement facilities program. On average, slightly less than half of the total Department of Health budget in 2014–2019 was sourced from the incremental excise tax revenues on sin products.

The Philippines is pushing ahead the health tax reforms. The Republic Act 10351 was amended and repealed by Republic Act 11346 and Republic Act 11467 in 2019 and 2020, respectively. Among other amendments, the Republic Act 11346 expanded the sin products to heated tobacco products and vapor products, and sweetened beverages; it also increased excise rates for tobacco products. Further, Republic Act 11467 amended the allocation of the incremental revenues from each sin product but still supports universal health care through the National Health Insurance Program, medical assistance and health facilities enhancement program, and programs toward attainment of Sustainable Development Goals (Tiu 2020).

Besides its health financing impact, there have been remarkable improvements in population health behaviors. The prevalence of smoking (current smokers) dropped from 28.2 to 18.5 percent of the population from 2009 to 2021, implying that an estimated 2.2 million Filipino lives were saved from the harmful health hazards of smoking in the last six years (Rodrigo 2023).

Country spotlight | India, Lao PDR, and Tonga: Implementation is critical

India has made progress with health taxes, but rates are suboptimal. Under the Goods and Service Tax (GST) in 2017, all tobacco products in India were levied a tax rate of 28 percent. The tax revenue from cigarettes across India in the fiscal year 2016/2017 was INR 217 billion. However, the total tax burden (taxes as a percentage of final tax-inclusive retail price) is only about 53 percent for cigarettes, 22 percent for bidis, and 64 percent for smokeless tobacco. This is significantly lower than the WHO recommended tax burden of at least 75 percent of the retail price for all tobacco products (WHO 2015). A cigarette tax increase to 78 percent of retail price can avert 3.4 million premature tobacco-related deaths, while raising about INR 146 billion as health tax, which could easily finance the expansion of coverage, even if it is not directly earmarked for health.

Nevertheless, there are positive health and fiscal implications for India's health taxes. An increase in country liquor taxation and foreign liquor prices by 20 percent is estimated to result in 9.2 million years of life gained (YLGs) and 32,000 YLGs, respectively, over 15 years and buoy tax revenues by INR 2.7 trillion. Furthermore, since 2017 an additional 28 percent GST on aerated beverages and lemonades was implemented in India, plus an additional 12 percent surcharge. A 20 percent price increase could result in 23.5 million YLGs over 15 years and increase tax revenues by INR 6.5 trillion (Laxminarayan 2023).

Implementation of Lao PDR's health taxes is hampered by weak enforcement capacity and health tax design. The government of Lao PDR established the Tobacco Control Fund (TCF) in 2014 as a health promotion fund to implement and promulgate the law on tobacco control. The objective of the TCF is to mobilize funds for tobacco control efforts from the earmarked taxes on tobacco products. These funds were supposed to be generated by the extra 2 percent profit tax on tobacco product business owners, and a surcharge-specific tax of LAK 200 per pack on imported and domestic manufactured tobacco products. The government projected that the TCF would have received income of about US\$6 million per year, of which 37 percent would have been for tobacco control activities, 32 percent for the national health insurance scheme, 25 percent for improving health care service quality, and 6 percent for TCF administrative management. Unfortunately, in practice, the TCF is not fully active. The tobacco industry is referring to an Investment License Agreement (ILA) as the basis for not complying with the excise tax law. This hampers overall tobacco tax revenue collection as well as revenue flow to the TCF, and this 25 years agreement is set to expire in 2026. In 2023, the government formed a task force to make progress on the health tax agenda, the including ILA, TCF, earmarking, and excise tax reform.

In Tonga, consumption switching toward harmful substitutes and other unintended market responses have impacted the effectiveness of health taxes. Tonga has also used fiscal policy instruments to stimulate healthier consumption with lessons for other countries (World Bank 2019). Excise taxes were raised on imported manufactured cigarettes in July 2016; unlike small incremental increases in previous years, excise taxes were increased by nearly 50 percent. At the same time, the government removed a 15 percent consumption tax on imported fruits to stimulate their consumption (World Bank 2019). As expected, the higher excise tax reduced consumption of manufactured cigarettes among the poor to a far greater degree than among the well-off. However, some of this impact was diluted due to the shift toward locally manufactured cigarettes and toward untaxed loose-leaf hand-rolled tobacco (*Tapaka Tonga*), also in part due to the misperception that this was a healthier "organic" alternative. The tax exemption for imported fruits did not result in a lowering of prices for consumers but rather benefited traders. The increase in excise taxes on alcohol reduced consumption but, at the same time, stimulated demand for unhealthy alternatives. SSB taxes were found to be largely inelastic to changes in price.

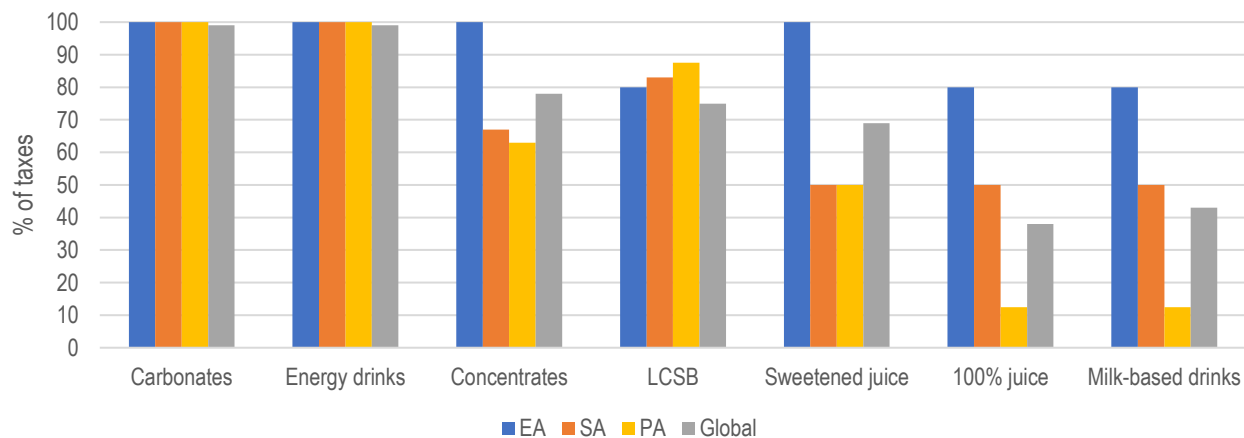
Spotlight | Sugar-sweetened beverage taxes

Strengthening existing health taxes with SSB taxes is an opportunity for the Asia-Pacific region. SSB taxes are a cost-effective, evidence-based (World Bank 2020), and increasingly popular tool for reducing SSB consumption and improving population health. In the Asia-Pacific region, national SSB taxes are in effect in 19 of 31 countries. Coverage ranges from 75 percent in SA (6 of 8 countries) and 67 percent in PA (8 of 12), to 45 percent in developing EA (5 of 11). Some of the largest populations in developing EA (China, Indonesia, and Vietnam) and the Pacific (Papua New Guinea and the Solomon Islands) are not yet covered by national SSB taxes.

Most SSB taxes in the region have been introduced with health objectives; however, most governments do not earmark revenue for health programs. The revenue-raising potential (World Bank 2023a) of SSB taxes may be lower than that for tobacco and alcohol taxes. However, they can make a not insignificant contribution to government revenues in low- and middle-income countries, in addition to their capacity to reduce future health costs. The potential to raise revenue for priorities like UHC can be used alongside the public health argument to boost public and political support for a tax. Among 19 countries in the region with national SSB taxes, 14 countries introduced the measures with explicit health objectives. However, only two countries—the Marshall Islands and Sri Lanka—explicitly earmark at least a portion of the revenue for health programs. Taxes in Cambodia, Bangladesh, Lao PDR, Nepal, and Pakistan do not include explicit health objectives, nor are they earmarked for health programs. There is scope for greater allocation of revenue from health taxes toward health programs.

Expanding the products covered by SSB taxes holds the potential to increase revenue and improve health gains, but healthy substitutes must be excluded from the tax. All SSB taxes in the region apply to carbonated soft drinks and energy drinks, and most taxes in EA apply to all key SSB categories (15). However, there is clear potential in SA and PA for many countries to extend the range of taxed products to include all SSBs. Half of SA countries and most PA countries do not currently tax juices (whether sweetened or not) or milk-based drinks. Globally, more than a third of SSB taxes include healthy alternatives such as unsweetened bottled water. While increasing revenue potential, this discourages the substitution of healthier products. In the Asia-Pacific, most SSB taxes already exclude unsweetened bottled water or tax unsweetened water at a lower rate, but Cambodia and Lao PDR do not.

Figure 15: Proportion of SSB Taxes Applying to Key SSB Categories



Source: Hattersly and Mandeville 2023.

Note: LCSB = Low-calorie sweetened beverages.

While excise taxes are the optimal instrument for health taxes, Asia-Pacific countries are unusual in having used a range of instruments to tax SSBs. Excise taxes make up 88 percent of all existing SSB taxes worldwide but only 70 percent of SSB taxes within the Asia-Pacific region. In SA, India and Bangladesh have made use of differentiated VAT/GST structures

and surcharges, while Maldives applies an import tax on energy drinks and other SSBs. Several PA countries—Marshall Islands, Nauru, and Vanuatu—also apply import taxes on SSBs as explicit health measures aimed at reducing consumption. Import taxes are not generally considered a best practice as a health tax instrument. However, they may have specific advantages for heavily food import-dependent Small Island Developing States without domestic SSB manufacturing industries and with limited tax administration capacities. In contrast, all EA countries with SSB taxes have opted for excise taxes.

Tax structures vary across the region. Sri Lanka is the only country in the region that has introduced a sugar-based tax on SSBs. This is regarded as the optimal structure to target the harmful ingredient (sugar) but is dependent on the administrative capacity to monitor sugar content. Thailand and Tonga have introduced volume-based taxes with tiered (differential) rates defined by sugar content thresholds, which approximate sugar-based taxes. The most common SSB excise tax structures in the region are volume-based (seven taxes) and ad valorem (five taxes). All SA countries apply tiered SSB taxes, but with rates tiered by beverage type rather than sugar content. All PA countries except Tonga apply uniform (flat) volume-based or ad valorem taxes.

C. Increase Pro-Poor Public Spending on Health

Target public financing for health to the poor and vulnerable subpopulations to expand effective service coverage and financial protection when fiscal space is limited. From an economic perspective, such interventions increase the net benefit incidence of public spending on health—that is, spending becomes more pro-poor. This can be achieved by levying additional prepayments on the well-off (or, less preferably, charging them for accessing public services), explicitly targeting publicly financed coverage toward the poor, or lowering informal barriers of access to publicly funded health services, such as transportation and childcare costs or lost wages for the poor or vulnerable.

Many pro-poor health programs are already in existence in the Asia-Pacific, using a variety of targeting mechanisms and providing varying benefits. Targeting (Table 4) can be done at the individual, household, and geographic levels based on means testing, proxy means testing, or other criteria. Benefits can include very specific services (such as childbirth), categories of services (such as inpatient care), or be in the form of conditional cash transfers for pro-poor utilization of preventive care or other underutilized but critical health services (such as childbirth at a health facility or attended by a skilled birth attendant). Some programs even allocate specific health care resources, such as inpatient beds, to the poor.²² Interventions targeted at individuals or households can be implemented using “health cards” or vouchers, which act as proof of entitlement and can involve nongovernmental organizations (NGOs) and the private sector as administrators and providers. Unified population registries, targeting databases, and strengthened civil registration and vital statistics (CRVS) systems would be desirable prerequisites for a broad and well-targeted pro-poor program. Challenges remain, particularly with quality (Cambodia), supply-side availability in the relevant geographic context, awareness of eligibility,²³ and errors in targeting—consisting of both incorrect inclusion and incorrect exclusion.

Pro-poor health programs, given their initial more limited scope, are an important on-ramp toward universal coverage. The ultimate goal remains universal coverage, but where implementation capacity and fiscal space are limited, these pro-poor programs allow the piloting of interventions, subsequent scale-up, and eventual universalization (see [India country spotlight](#)).

²² Bangladesh requires government hospitals to reserve hospital beds for poor patients: 60 percent of beds at the primary level, 50 percent at the secondary level, and 40 percent at tertiary-level hospitals. Patients eligible for these free beds are only required to pay for outdoor ticket and admission fees (MOHFW, Unpublished circular in Bangla, no. 403, issued June 25, 1990).

²³ For example, the Patients Welfare Fund (Bangladesh) is available for poor patients but funds are not easily accessible, and the poor patients are often not fully aware of the funds and the procedures involved in accessing them.

Country spotlight | India: Beginning with the bottom 40 percent, leveraging the private sector, and going universal

India is implementing one of the world's largest tax-financed noncontributory health insurance schemes—the *Pradhan Mantri Jan Arogya Yojana (PM-JAY)*—which provides coverage for inpatient care at public and empaneled private hospitals to an estimated 500 million poor and vulnerable individuals in the country. PM-JAY entitlements are targeted toward the bottom 40 percent of India's population as identified by the *2011 Socioeconomic Caste Census* based on deprivation criteria in rural areas, occupational categories in urban areas, and household factors. PM-JAY is cofinanced by the central and state governments and provides coverage up to a maximum annual limit of INR 500,000 (~US\$7,000) per eligible family. In 2018, accompanying the launch of PM-JAY, the central government also expanded its education cess²⁴ (at a rate of 3 percent of income) to a health and education cess (with an increased rate of 4 percent of income).²⁵ Additional revenues from the cess are not “hard” earmarked to the health sector, but the labels were used to politically justify income tax increases. Notably, those that pay these taxes are not typically the beneficiaries of PM-JAY; hence the incremental increase in the cess is entirely redistributive by intention, representing an attempt by the government to increase the net pro-poor benefit-incidence of public spending.

Going universal. Although PM-JAY is not universal, unlike the HWC PHC reform (see earlier [India country spotlight](#)), which is universal (though arguably geographically targeted toward rural areas and the urban poor), PM-JAY can be a stepping stone toward going universal, beginning with some states. For example, in October 2022, Nagaland, a small northeastern state of 2.2 million in the eastern Himalayan region of India, expanded the PM-JAY hospitalization insurance program to its entire population (including formal public and private sector employees, students, and pensioners). Over the long term, as the fiscal space improves, Nagaland is also considering expanding the hospitalization package. Pro-poor targeting can be a helpful step toward UHC, especially in resource-constrained contexts, but is not the ultimate destination.

Table 4: Selected Pro-Poor Health Programs in the Asia-Pacific

Country program	Targeting	Benefits	Outcomes and remaining challenges
Bangladesh Shasthya Surokhsha Karmasuchi	<ul style="list-style-type: none"> Below poverty line Eight subdistricts of Tangail district 	<ul style="list-style-type: none"> Health card Entitlement for inpatient care at designated facilities of up to BDT 50,000 annually 78 diseases covered 	Going universal by expanding this to a contributory scheme for higher income groups by 2032.
Bangladesh Maternal Health Voucher Scheme (2006)	<ul style="list-style-type: none"> Poverty, no more than two children Began with one but expanded to 55 subdistricts in Bangladesh 	<ul style="list-style-type: none"> Vouchers for antenatal care, childbirth including cesarean section, and postnatal care. Transport costs BDT 500 Delivery benefit BDT 2,000 	1.8 million pregnant women have received benefits from this program since 2006.

²⁴ A cess refers to taxes on income.

²⁵ Cesses have the disadvantage that these proceeds are not shared with states and are subtracted from the divisible pool so this still leaves open sources of financing at the state level.

Country program	Targeting	Benefits	Outcomes and remaining challenges
Cambodia Health Equity Funds (2000)	<ul style="list-style-type: none"> Bottom 20 percent, as identified via periodic household means testing and at the point of care when health care staff find patients without prior health equity fund (HEF) enrollment unable to pay 	<ul style="list-style-type: none"> Equity card Care without user fees for essential benefit package from public health posts, health centers, and referral hospitals Transport costs for referrals 	<p>Providers are reimbursed according to the service provided, the facility-level, and performance adjustments (based on periodic quality of care checks). Penalties imposed for false claims and incomplete documentation. HEF operation was transferred from an NGO-supported implementer to an autonomous unit under the Ministry of Health in 2017. Financing is planned for a full transition to domestic government (currently shared with external partners). Remaining challenges are quality care, insufficient financial protection, and targeting errors—both inclusion of the nonpoor and exclusion of the eligible (Nagpal, Bauhoff, and Kayla 2019; Jithitikulchai et al. 2021), but HEFs have already improved health care access (Annear et al. 2019), reduced OOP health spending, and contributed toward pro-poor public health spending (Annear et al. 2019; Asante et al. 2019; Ensor et al. 2017; Flores et al. 2013).</p>
Nepal Free Health Services (2006)	<ul style="list-style-type: none"> Poor and vulnerable citizens in peripheral public health facilities and district hospitals 	<ul style="list-style-type: none"> Free health services for motherhood and family planning, child health, and communicable diseases, including medicines Outpatient care 	
Nepal SHI scheme (2016)	<ul style="list-style-type: none"> Ultrapoor families Families of individuals with select conditions (Multidrug-Resistant-Tuberculosis, human immunodeficiency virus, Leprosy, severe disability) Elderly (>70 years old) population 	<ul style="list-style-type: none"> Full subsidy of SHI premiums as prescribed by the Health Insurance Act (2017) Secondary outpatient and some inpatient health care services 	<p>The SHI scheme currently covers one-fourth of Nepal's population across all 77 districts.</p>
Pakistan Waseela-e-Sehat (2012) & Sehat Sahulat Program (2015)	<ul style="list-style-type: none"> Waseela-e-Sehat targets poor families Sehat Sahulat Program offers universal health insurance 	<ul style="list-style-type: none"> Inpatient care 	<p>Various federal and provincial programs aimed at providing free inpatient care (up to certain annual caps).</p>

Country / program	Targeting	Benefits	Outcomes and remaining challenges
The Philippines Pantawid Pamilya (2007)	<ul style="list-style-type: none"> • Bottom 20 percent 	Conditional cash transfer: <ul style="list-style-type: none"> • ~8 percent of average beneficiary household incomes • Health-related conditionalities are regular health checkups, growth monitoring, and vaccinations 	The program has substantively increased the uptake of health services among the poor and led to significant reductions in severe stunting among children aged 6 to 36 months (Kandpal et al. 2016).

Conclusion: Old scars and new wounds necessitate a renewed focus

Old scars from the health, health care, and economic trauma of the COVID-19 pandemic have not fully healed in the three years since the start of the pandemic. The global economy and health systems struggled with the immediate impact of the COVID-19 pandemic and related restrictions on social and economic activities. The economic downturn in 2020 was one of the largest global economic contractions the world has seen in a century. Some countries are projected *not* to return to the same economic growth trajectory. Progress in UHC, already faced with prepandemic challenges, regressed in many countries.

New wounds on vulnerable health systems and UHC have been inflicted by the recent downturn in the macrofiscal environment and by the challenges of underlying long-term trends—demographic (aging), epidemiological (rising NCDs), and climate change, and the gap in pandemic preparedness revealed by COVID-19. The economic recovery from the vaccine rollout and the lifting of restrictions on social and economic activities was stymied by a combination of new shocks—inflation and perhaps even stagflation, debt, geopolitical developments, and monetary policy tightening—which has dampened prospects again for economies, the macrofiscal position of countries, and sustainable public financing for health.

A renewed focus on efficiency and equity is urgent and necessary, as additional public financing from budgetary authorities will not be readily available: “More health for the money” and, through a demonstration of the effectiveness of investments in health and by explicitly tracing the contribution of public investments in health to economic growth and poverty reduction, “more money for health.” Three high-impact reform areas, drawing from successes and lessons learned from across the Asia-Pacific, inform feasible pathways to finance UHC: (i) **Strengthen primary health care**, as an efficient solution to improving health outcomes, especially in the Asia-Pacific, where the burden of NCDs is high; (ii) **Leverage health taxes** to reduce costly unhealthy environments and lifestyles while supporting health financing, given the feasibility of such taxes to supplement the low general government revenues prevalent in the Asia-Pacific; and (iii) **Increase pro-poor public spending on health** by selectively targeting poor and vulnerable populations with critical health services to improve health outcomes and financial protection.

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Despite a rebound in economic growth following the pandemic, new geopolitical developments and macroeconomic shocks—inflation and monetary responses to inflation, Russia's invasion of Ukraine, and the COVID-19 debt overhang—as well as the lingering uncertainty of the COVID-19 pandemic pose further challenges to sustainable public financing for health. These recent challenges are superimposed on longer-term issues—aging, noncommunicable diseases (NCDs), climate change, and future pandemic preparedness—which are shared across the Asia-Pacific, a dynamic region ranging from small Pacific Island states to the two most populous countries in the world. Three specific health reform opportunities, with country spotlights highlighting relevant successes and remaining challenges, have been identified to improve the efficiency and equity of public health spending (“more health for money”) while justifying “more money for health” by demonstrating its effectiveness: (i) strengthen primary health care as an efficient and equitable solution to improving health outcomes, especially in the Asia-Pacific where the burden from uncontrolled NCDs is high; (ii) leverage health taxes to reduce costly unhealthy environments and lifestyles while supporting health financing, given the feasibility of such taxes to supplement low government revenues prevalent in the Asia-Pacific; and (iii) increase pro-poor public spending on health by improving targeting of poor and vulnerable populations with critical health services to improve health outcomes and financial protection.

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