厚生労働省科学研究費補助金

地球規模保健課題解決推進のための行政施策に関する研究事業

ユニバーサル・ヘルス・カバレッジ（UHC）推進における新たな要素の同定と世界のUHC 達成に向けた我が国の施策検討のための研究

令和 6 年度　総括研究報告書

研究代表者　本田　文子

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I.　総括：2024 年度の研究体制と研究内容の概括

A.　背景と目的

ユニバーサルヘルスカバレッジ（UHC）は、持続可能な開発目標のゴール３でも掲げられ、国際社会の重要政策課題である。UHC は「全ての人が適切な予防、治療、リハビリ等の保健医療サービスを必要な時に支払い可能な費用で受けられる状態」と定義され、その進捗を促す制度の策定、改革に、各国政府が取り組んでいる。

UHC は、公的医療保険または税方式のように、保健医療財源への事前払い方式（Prepayment System）を導入し、高額な医療費の自己負担から保護（Financial Protection）する一方、支払い機関からサービス提供者への支払い機能を活用し、保健医療サービスの効率性と質を図る制度を推奨している。具体的には、UHC を可能にする制度要件として、次の点が挙げられている：（１）財源への事前払い方式を用い資源プールと所得とリスクの再配分を促す；（２）制度への加入を義務化；（３）公的資金の投入による脆弱層の保護；（４）医療機関への支払い制度に 「Strategic Purchasing」の概念を適用し、効率的で良質な保健・医療サービスの提供を図る。

本研究は、国際社会での UHC の概念の変遷と新しい要素を同定し、グローバルヘルスにおいて我が国が UHC の領域で行うべき施策を纏めることを目的とする。具体的には、国際政策レビューにより、新しいテーマを、探索的手法を用いて特定する一方、近年、すでに重要なテーマとして周知されている「健康危機」と「サービスの質」をサブテーマとして取り上げ、UHC との相互関連性について理解と知見を深める。特に、コロナ禍を経て健康危機の政策対応に関する国際議論が高まる中、UHC の視点から概念を整理し、低中所得国で平時から健康危機に備えておくべき保健システムの要件を、文献レビューとステークホルダーの経験を基に纏める。また、近年、UHC の礎石として効果的で安全なサービスの重要性が指摘されており、UHC 改革におけるサービスの質の向上に関し、概念とエビデンスを整理し、低中所得国に有用な政策提言を纏める。

B.　研究の構成と手順

上述の通り、本研究は、（１）国際政策レビュー、（２）健康危機、（３）サービスの質の三つのテーマから構成される。各テーマは、次の成果の創出を目的とする。

（１） 国際政策レビュー：①国際政策文書における UHC の新たな要素に関する年次推移の纏め、②UHC と周辺分野の関連性に関する学術的、技術的な動向の分析と概念整理、③UHC の新たな要素の推進に関し、今後我が国が取り得る施策オプション

（２） 健康危機：①UHC と健康危機における保健システム強化及びその他要素の概念整理、②低中所得国での健康危機時の保健システム上の課題の同定、③UHC の要素である「平時における健康危機への備え」に向けた保健システム強化に関し、我が国の国際協力の指針や施策への提言

（３） サービスの質：①サービスの質の向上を図る政策ツールの整理、②UHC におけるサービスの質の向上に資する施策オプション

研究の実施・運営において、本研究を構成する３つのテーマを次の５つのワーキングループ（WG）に分け、活動を行った。

WG 1：UHC に関する政策トラッキング（Prospective review）

WG 2：UHC 国際政策レビュー（Retrospective review）

WG 3：健康危機（パンデミック）と UHC に関する概念の整理

WG 4：健康危機（パンデミック）と保健医療財政

WG 5：UHC と保健医療サービスの質

また、本研究班の最終的な目的は、我が国の UHC における国際貢献の指針をまとめることにあり、日本の国民皆保険の経験に基づく教訓を分析するため、日本の公的保健医療制度の公平性の分析も併せて実施する。

C. 2024 年度の進捗の概要

国際政策レビュー

WG 1：政策トラッキング（Prospective review）

政策トラッキング用のプロトコール（情報源、抽出情報のストレージ、テーマ（コード）分類、サマリーテンプレート）を作成し、継続的に情報収集とレビューを実施、２ヶ月毎に、

サマリーレポートを作成した。６つの要素（国と地域、UHC の概念、アプローチ、評価・測定、ヘルスシステムとの関連、疾患別課題、グローバル・イシュー）を含む枠組みを用い、対象期間中の頻出テーマの同定と内容の整理を行った。

WG 2：政策レビュー（Retrospective review）

政策レビューの対象組織･団体の検討および政策文書の種類を決定し､第１段階としてWHOの世界保健総会の決議および決定とその関連文書のうち、UHC に関連するものを同定、収集し、テーマ分析を行った。

健康危機（パンデミック）

WG 3：パンデミックと UHC に関する概念の整理

効率的に作業を進めるため WG 2 と連携し、政策レビューで収集した UHC に関する政策文書及びその関連文献から健康危機に関するものを選別し、情報の抽出と整理を開始した。

WG 4：パンデミックと保健医療財政

低中所得国のパンデミック時の保健医療財政上の対応について、簡易レビューを実施した。コロナ禍、低中所得国では、政府の資金調達と管理の機能が重要であることが分かったため、次年度の活動に向けて、パンデミックと公共財政管理に関するスコーピングレビューのプロトコールを作成し、文献検索とレビューを開始した。

サービスの質

WG 5：保健医療サービスの質に資する政策介入

２段階の文献レビュー（迅速レビューと本格レビュー）を採用した。サービスの質の向上に関する迅速レビューを行い、３つのレベル（制度、組織、コミュニティー）の介入から一つずつ、本格文献レビュー用のテーマを選定した：（１）支払い制度上の政策ツールと医療の質、（２）医療従事者の内的動機付けと政策ツール、（３）ソーシャルメディアと医療サービスの質。各テーマの文献レビュープロトコールを作成し、文献検索、レビューを開始した。

日本の公的保険医療制度の公平性の分析では、保健・医療アクセスの水平的公平性の分析及び社会経済的要因による健康格差の分析を行った。

II. 研究テーマ別報告

1. UHC に関するグローバル政策トラッキング

A. 目的

グローバル・ヘルス・コミュニティが、UHC に関して発表・発信する文書を継続して収集し（前向きモニタリング）、系統的な分析を通して、UHC に関する最新の情報を確認し、UHC の新たな側面を特定する。本報告書は、2024 年 4 月 1 日から 2025 年 3 月 31 日までの情報を対象としている。

B. 手法

対象期間中、毎週月曜日。以下のウェブサイトを確認し、政策文書、ニュースリリース、イベントなどの関連情報を抽出した。

- Alliance for Health Policy and Systems Research
- EuroHealth
- Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP)
- OECD Health
- P4H Social Health Protection Network
- UHC Partnership
- UHC Watch
- UHC2030
- WB Health
- WHO UHC

さらに、International Health Policy（IHP）ニュースレターやその他のニュースソースを定期的に確認し、UHC 関連情報を入手した。

上述の追跡作業で収集した情報の保存と管理には、NVivo14 を使用した。 次の 6 つの項目で構成される枠組みを用いてテーマ分析を行った。

- **国と地域：**WHO の地域分類を用いた各国の分類

- **UHC の概念：**UHC の定義を構成する要素
- **UHC へのアプローチ：**UHC の進捗に資する戦略、アプローチ
- **UHC の測定：**UHC の進捗を評価する指標、分析手法
- **ヘルスシステムと UHC：** UHC とヘルスシステムの 6 つの構成要素(ガバナンス、サービス提供、財政、人材、薬剤・ワクチン・技術、情報システム）との関連性
- **疾患別課題と UHC：**非感染性疾患（NCDs)、抗菌薬耐性（AMR）など、UHC と特定の疾病・健康状態との関連性
- **地球規模課題と UHC：**プラネタリー・ヘルス、グローバル・ヘルス・ガバナンス、健康危機など、UHC と地球規模課題との関連性

テーマ分析では、枠組みに含まれる項目毎に頻出コードを特定し、コードの分解、内容の整理、概念化を行なった。政策トラッキングで収集された情報は、2 ヶ月ごとに要約をまとめ、研究班チームに共有した。

C. 分析結果の概要

分析結果の概要（頻出テーマと内容の要約）を下記にまとめた。(詳細は、資料 5 の報告書を参照。)

a. 国と地域

世界各地で UHC 改革が行われているが、アフリカ地域における UHC 関連の情報が最も多く、東南アジア地域、南北アメリカ地域がそれに続く。地域に関わらず UHC 改革に共通する要素として、UHC 政策の対象人口の拡大 (ケニア、南アフリカ、インド等)、プライマリ・ケアへの投資（ガーナ、エジプト、チリ等)、デジタル・ヘルスの導入（ケニア、カメルーン、チリ等)、制度の分断化への取り組み（インド等)、地方分権とガバナンス（コンゴ等）が挙げられる。

b. UHC の概念

UHC の概念として、「全国民を対象とした公的制度の確立（ユニバーサリティ)」、「社会的弱者の包摂性」、「包括的サービスカバレッジ」、「質の高い医療サービスへのアクセス確保」

が頻出テーマとして挙げられた。

- **ユニバーサリティ**：公的制度の受給資格を全ての国民に保証する（対象者を特定の人口グループに限定しない）ことは、資源とリスクの再配分の機能を高め、アクセスの公平性の確保に資する。
- **社会的弱者の包摂性**：真に公平な制度を確保するため、UHC 改革は、障害者、女性、難民、移民等、社会的弱者や社会から疎外された人々を包摂する仕組みが肝要である。
- **包括的サービスパッケージ**：UHC 改革は、予防、治療、リハビリテーションだけでなく、緩和ケア、メンタルヘルス、医療・ケアの連携と継続も含め、ライフコース全体を視野に、必要なサービスへのアクセスを確保する必要がある。
- **質の高い医療サービスへのアクセス**：健康アウトカムを改善し、UHC を達成するために効果的で安全なサービス提供は必須である。質の高いケアへの時宜に適った公平なアクセスが、疾病負担を軽減する。

c. UHC へのアプローチ

UHC の進捗を促すアプローチとして、「プライマリヘルケア（PHC）強化」「民間セクターとの協力とガバナンス」「社会参加」が、頻出テーマとして挙げられた。

- **PHC 強化**は、PHC は、地域コミュニティで、社会的弱者や遠隔地の人々の保健・医療へのアクセスを促し、住み慣れた場所でのケアを支援する等、UHC の進捗を加速させる効果的で効率的な（費用対効果の高い）アプローチである。
- サービス提供における**民間セクターとの協力**は不可避である。多くの国で、民間の医療機関がサービスを提供しているが、特に低・中所得国では規制が不十分で、公平性と質の観点から課題が生じている。官民の協力が UHC の推進に資するために、ガバナンスの整備が求められる。
- 近年、プライベート・エクイティ企業の医療分野への投資の影響が増大している。営利を目的とした医療と開発金融機関と連携は、人権侵害や健康格差の拡大を助長するとして、国際社会に懸念が生じている。
- 第 77 回世界保健総会決議「UHC、健康、幸福のための**社会参加**」は、政策プロセスとサービス提供への、市民社会、患者団体、若者等、多様なステークホルダーの参加の重要性を謳っている。制度設計、政策実施、モニタリング・評価への社会参加は、個人や

コミュニティのニーズに迅速に対応できるヘルスシステムを構築し、行政の説明責任を確保し、人々の「信頼」が醸成される。

d. UHC の測定

従来の「高額な医療費の自己負担（catastrophic expenditure)」「自己負担による貧困化（impoverishment effect)」「基礎的なサービスカバレッジ指数」に加え、近年、「Effective coverage index」「Unmet needs」を用いた分析も行われている。また、サービスの質の測定や、UHC 改革の政策プロセスにおける政治経済分析も頻出テーマとして挙げられた。

- 「UHC effective coverage index（効果的カバレッジ指数)」は、人々の「ニーズ」と健康アウトカムの改善におけるサービスの有効性を加味し、必須の保健・医療サービスを提供する国（制度）の能力を評価する複合指標である。GBD 2019 UHC Collaborators が開発し、試行している。
- EU は、EU 所得・生活状況統計調査（EU-SILC）と欧州保健インタビュー調査（EHIS）のデータを用い、UHC モニタリングを実施。特に、EU 各国における保健・医療へのアクセスと「アンメットニーズ（充足されていないニーズ)」のモニタリングを行なっている。
- 「患者の経験」は、サービスの質を測る重要な側面である。ケアに関するネガティブな経験は、サービス利用の意欲や治療のアドヒランスを低下させ、健康アウトカムとサービスへの信頼を損なうことになる。
- UHC 改革におけるステークホルダーの利害関係や政治力学を系統的に分析し、政策実施のプロセスを明らかにするため、政治経済分析を応用した研究が行われている。WHO の PHC Implementation Solutions Initiative は、政治経済分析を用い、各国がどのように PHC 指向の保健システムの拡大に成功したかを検証した。

e. ヘルスシステムと UHC

ヘルスシステムの 6 つの構成要素に関連し、公共財政管理（財政)、国内の財源確保（財政)、デジタルヘルス（サービス提供、情報）が頻出テーマであった。

- **公共財政管理（PFM)**：多くの LMICs では、非効率な予算執行（硬直的な予算構造、吸収能力の低さ、予算執行の遅れ）が依然として大きなボトルネックとなっており、

UHC に向けた進展を妨げている。プログラムに基づく予算編成は、従来の項目別予算編成に代わる選択肢の一つである。PFM においては、保健・財務両省の効果的な連携が不可欠である。

- **国内の財源確保**：パンデミックは、国内の財源確保を促進するきっかけとなったが、持続的な政治的・財政的コミットメントが依然として必要である。米国の援助停止は、アフリカ諸国全体で、保健・医療財政を見直す端緒となっている。AU サミット等のハイレベル会議では、国内の財源確保、保健分野における官民パートナーシップ、外部資金の多様性の確保が議論された。タバコ、アルコール、砂糖入り飲料への課税は、国内の財源確保の手段の一つである。
- **デジタル・ヘルス**：デジタル・ツールを活用したサービス提供は、サービスの拡充と効率性を促す手段として潜在性が高い。電子カルテや予防接種登録などの情報システムへの応用は、データ管理を強化し、情報に基づいた意思決定を支援する。また、医療財政システムへの導入は、資金フローの透明性を高め、不正防止に役立つ。一方、デジタル・ヘルスの運用には、倫理、規制、説明責任の枠組みなど、ガバナンスの整備が求められる。

f. 疾患別課題と UHC

非感染性疾患（NCDs）が頻出テーマであったが、薬剤耐性と UHC の関連性についての議論も目立った。

- **薬剤耐性（AMR）**：予防、診断、薬剤・治療への公平なアクセスは、抗菌薬の誤用や過剰使用を低減するために不可欠であり、近年、UHC 関連の政策に、AMR に関する介入を組み込むこと（例：公的制度の給付パッケージに、AMR 対策に資するサービスを導入する）の重要性が指摘されている。
- **非感染性疾患（NCDs）**：LMIC における疾病負担の増大にも拘らず、NCDs への開発援助は微増に留まっている。PHC 強化は、効率的かつ効果的な NCDs への取り組みを可能とする。がん患者の半数以上が壊滅的な医療費の自己負担に直面しており、公的制度の拡充、財政支援、新しい治療や薬剤の価格の透明性の確保が急務である。

g. 地球規模課題と UHC

多数の地球規模課題の中でも「グローバル・ヘルス・ガバナンス」「健康危機」「プラネタリーヘルス」が、UHC との関連で、頻出テーマであった。

- **グローバル・ヘルス・ガバナンス**は、国際機関、地域機関（アフリカ連合など)、市民社会組織、非保健セクター等、複数のステークホルダーのパートナーシップに拠り形成される。イニシアティブの調整、取り組みの断片化、政治的圧力等、課題が山積している。
- **健康危機**：パンデミックを契機に、世界健康安全保障（GHS）と UHC の概念の整理が進んでいる。加えて、ヘルスシステムの強靭性、パンデミックへの備え（pandemic preparedness）に係る概念と制度要件の整理も肝要である。
- **人道危機と紛争**：武力紛争はヘルスシステムを混乱させ、サービスへのアクセスを制限し、人々の健康リスクを増大させる。国際法の枠組みは、人道危機における人々の健康の権利の保護を強調しているが、その履行は依然として弱い。
- **プラネタリーヘルス**：気候変動は、感染症と NCDs の双方に影響する。気候変動による健康リスクへの備えを、制度や政策に反映する必要がある。PHC は、早期警報システムやコミュニティでの対応等、取り組みの中心的役割を果たす。

D. 今後の分析軸

2024 年度は、国と地域、UHC の概念、UHC のアプローチ、UHC の測定、ヘルスシステムと UHC、疾患別課題、地球規模課題と、 6 つの項目を軸に、頻出テーマと内容の整理を行なった。2025 年度は、同様の情報収集、整理を継続して実施すると共に、政策文書を発行する組織、プラットフォームの属性による傾向分析を行う。また、WG 2 で実施している、過去の UHC に関する政策文書の分析結果とのシナジーを図るため、WG1、WG2 の両分析結果の統合に資する枠組みの同定を行う。

2. ユニバーサル・ヘルス・カバレッジに関する国際政策レビュー

研究分担者　野田信一郎　国立健康危機管理研究機構国際医療協力局研修課長

研究要旨　ユニバーサル・ヘルス・カバレッジ（UHC）の進捗が停滞する中、新たな保健課題も登場してきている。本研究では、グローバルヘルスの主要な組織がそれぞれの組織内での合意として、どのような UHC の新しい要素を認識しているのか、公式文書をデータとしてテーマ分析と傾向分析を行う。1 年目は、2016 年から 2023 年までの 8 年間に WHO の世界保健総会で出された決議・決定文のテーマ分析を行い、91 の UHC 関連テーマを同定した。

A.　研究目的

国際社会におけるユニバーサル・ヘルス・カバレッジ（UHC）の概念の変遷と新しい要素を同定し、我が国が行うべき施策を纏める。

B.　研究方法

国際機関、開発銀行、地域機構、主要国首脳会議において各組織の意思決定メカニズムの中で合意形成されたものとして発表された公式文書の中で、Universal Health Coverage という文言が含まれるものを収集し、テーマ分析により UHC と関連付けられたテーマを同定する。その後、文書の発表年と発表組織毎に傾向分析を行う。人を対象とした研究ではないので、特記すべき倫理面への配慮はない。

対象組織は、地域的な偏りが生じないよう配慮し、下記を対象とした。カッコ内は対象とした意思決定メカニズムである。

- **国際機関**：国際連合（国連総会）、WHO（世界保健総会）
- **開発銀行**：世界銀行（WB-IMF 年次会議）、アジア開発銀行（年次総会、財務・保健大臣会合）、米州開発銀行（理事会年次総会）
- **地域機構**：ASEAN（首脳会議、保健大臣会議）、アフリカ連合（首脳会議、保健大臣会議、アフリカ CDC 会議）、欧州連合、カリビアンコミュニティ

- **主要国首脳会議：**G7（首脳会議、保健大臣会議）、G20（首脳会議、保健大臣会合、財務・保健大臣会合）
- **その他：**東京アフリカ開発会議（TICAD）

文書に関しては、2016 年から 2023 年までに発表された宣言文、議長要約、決議・決定など会議体として合意されたものを対象として、報告書は除外した。収集した文書は MAXQDA24 に保存し、一つの文書に対して 2 名が独立して同ソフトウエアを使ってコーディングを行い、意見が異なる場合は他のメンバーも交えてコンセンサスを形成した上で最終コードとする。

C. 研究結果

12 組織、112 文書が収集された。今年度は、第 1 段階のテーマ分析として、WHO の世界保健総会の決議・決定文を対象にコーディングを行った。MAXQDA の検索機能を使い“universal health coverage”をハイライトし、それが含まれる決議または決定のタイトルからテーマをコーディングした。次に、“universal health coverage”が含まれるパラグラフを同定し、その中でコーディングしたテーマと UHC との関係に関し分析しコーディングを行った。同定されたテーマとＵＨＣとの関係は大きく 4 つのカテゴリー（for UHC, by UHC, and UHC, link to UHC）に分類できた。for UHC は同定されたテーマが UHC 達成に必要なものとして扱われており、by ＵＨＣに分類されたテーマはそのテーマを推進していく手段として UHC を位置づけている。and UHC に分類されるものは同定されたテーマと UHC が同列に扱われているもので、link to UHC にはテーマとＵＨＣの関係が明確ではないものである。

UHC に関連つけられたものとして 91 のテーマが同定された。for UHC, by UHC, and UHC, link to UHC に分類されテーマは重複も含み、それぞれ 63、22、14、60 あった。また、個々のテーマと UHC の関係性を説明している文章がある場合は、それをサブコードとしてコーディングした。

また、同定された 91 テーマは、49 が高齢化、非感染性疾患、マラリア対策、口腔保健などの保健課題で、残りの 42 は保健システム系のテーマであった。42 の保健システム系のテー

マのうち、医薬品・ワクチン・テクノロジーが 13 テーマで最も多く、10 はリーダーシップ・ガバナンス、保健財政 6、サービス提供 5、保健人材 3、保健情報システム 1 であった。

これらのコードとそのサブコードを基本コード群として、これから行う WHO 以外の組織のデータのコーディングを行い、その後 for UHC に分類されたコード・サブコードの傾向分析を行う予定である。

D. 考察

WHO の世界保健総会では、一回の総会で 40 題前後の決議・決定がなされており、十数題程が UHC と関連付けられている。同定された 91 テーマとそれぞれの UHC との関係性としては、UHC 達成に資するものとして取り扱われているものが 63 と最も多かった。次いで多かったのは、曖昧な関係性（link to UHC）のもので、多くは決議文の前文の中で、1 箇所程で言及されているようなもので、口腔保健や道路安全などこれまであまり取り上げられてこなかったテーマが多く、枕詞的に UHC に便宜的に言及しているようである。

一つのテーマでも、UHC との関係性が for UHC、by UHC、and UHC、link to UHC の 2 つ以上に分類されるものも少なくなく、これは決議文が書かれた時期の違いを反映しているのかもしれない。今後の傾向分析で確認していく。

テーマによっては、UHC との関係性をより具体的に言及しているものもあり、このようなテーマの中に、国際社会と国々が新たに力を入れて取り組んでいく価値のあるものが含まれていると推察される。

E. 結論

WHO の世界保健総会で合意された決議文や決定においては、UHC と関係付けられているテーマは非常に多岐に及んでいるが、UHC との関係性の程度は様々で、今後の分析で国際社会と国々が新たに力を入れて取り組むテーマが同定されると思われる。

3. UHC と保健医療サービスの質

A. 目的

サービスの質の向上を図る政策ツールを整理し、具体的な研究課題を設定するため、次の二つの活動を行なった。

- UHC と保健･医療サービスの質に関する優先課題とナレッジギャップを特定するため、主要文献の迅速レビュー
- 迅速レビューの結果、UHC と保健・医療サービスの質に関する具体的な研究課題の設定とプロトコールの作成

B. 迅速文献レビュー

UHC と保健・医療の質に関し、優先課題とナレッジギャップを特定するため迅速文献レビューを行った。文献検索には、学術書誌データベース（Medline、Knowledge of Science）、国際機関のウェブサイトで（European Observatory of Health Systems Research、WHO、OECD）を用い、学術論文と「グレー・リテラチャー」双方を検索した。次の基準で迅速レビューの対象となる文献を選定した。

- 保健・医療制度改革とサービスの質との関連を検証した実証的研究及び文献レビュー
- UHC とサービスの質に関する国際機関の報告書など「グレー・リテラチャー」
- 過去 5 年間に発表された文献

文献検索とスクリーニングの結果、学術論文 56 本と、グレー・リテラチャー10 本を迅速レビューの対象とした。

迅速文献レビューの結果、保健･医療サービスの質の向上に資する介入を、（１）制度、（２）組織、（３）患者・地域社会の３つのレベルに分けて検証した。それぞれのレベルで、これまで次のような介入に関し、研究が行われてきた：

- 制度：(有資格者、保健・医療施設、医薬品提供組織の）規制と認可、外部評価（認定、認証、指導)、パブリック・リポーティング（施設名を明らかにした上で臨床指標の結果を一般に公開)、ベンチマーキング（病院同士が臨床指標を比較)、サービスの質に基

づいた契約、サービスの質を成果指標に導入した診療報酬、電子カルテ管理システム

- 組織：診療ガイドライン、クリニカル・パス、臨床監査とフィードバック、医療施設内の安全性確保の取り組み、人材への介入（インセンティブ、動機づけ等）
- 患者・地域社会：社会参加、ヘルスリテラシーの向上、患者の経験のモニタリング、ピアサポートと患者グループの設立

また、次の点にナレッジギャップが存在することがわかった。

- 診療報酬上の改革と、保健医療サービスの質向上のメカニズムの理解
- 保健・医療の質に関する介入・プログラムの実施プロセスの解明
- 保健･医療の質に関する政策決定プロセスにおけるステークホルダーの関与（価格設定に関する政策、質の測定法の開発等）
- 利用者の経験の共有と患者中心のサービス提供
- 保健・医療の質と医療従事者のモチベーションとインセンティブ

C. スコーピングレビューの研究課題の特定と進捗

迅速文献レビューの結果をもとに、次の二つの研究課題を特定し、スコーピングレビューに拠る研究のプロトコールを作成した（資料1、資料2）。

- ソーシャルメディアに拠る患者の経験の共有と保健・医療サービスの質
- 保健・医療従事者の内的動機づけを高めるための介入

各スコーピングレビューの背景と目的は次の通り。

a. ソーシャルメディアに拠る患者の経験の共有と保健・医療サービスの質

ソーシャルメディアを通して、患者が医療サービスや医療提供者の経験を共有する事例が増加している。国際社会は、患者の声、価値、選好を医療サービス提供に反映し、サービスの質を向上させる「患者中心のアプローチ」を重視している。ソーシャルメディアの利用は増え続けているが、オンラインプラットフォームを通じて共有される患者の声がどのようにサービスの質の向上に影響するかについて、未だほとんど知られていない。このため、患者が自分の経験を共有することを可能にするソーシャルメディアの役割と、患者の声が受

療行動と医療提供者のサービス提供にどのような影響を与えるかを理解することは極めて重要である。具体的には、本スコーピング・レビューでは以下の点を検証する。

- 患者が共有する情報が、人々の受療行動や医療施設の選択に与える影響
- ソーシャルメディア上で患者が共有する情報が、医療サービスの提供、特に医療提供者の行動の変化に与える影響
- 患者の声を伝えるツールとしてのソーシャルメディアの利点と課題
- ソーシャルメディアを通じて患者が共有する情報が、医療サービスの質の向上に効果的に活用されるために必要なガバナンスの仕組み

これまで、文献検索を実施し、検索結果（968 本）から重複文献を削除し（524 本)、タイトルと概要による第１スクリーニング（120 本）を経て、今後、フルテキストスクリーニングと文献レビューによる情報の抽出を行う。

b. 保健・医療従事者の内的動機づけを高めるための介入

既存研究の多くは、経済的インセンティブが医療従事者のパフォーマンスに果たす役割について検証してきた。一方、近年、医療従事者の内的動機づけの医療の質への影響も指摘されている。「内的動機づけ」の定義は学問領域に拠り異なる。本研究では、心理学と経済学を含む内的動機づけの広範な定義を適用する。これまでの研究では、医療従事者の内的動機づけが、サービスの質の向上に資することが示されているが、医療従事者の内的動機づけを促進する具体的な介入策や政策手段については体系的な検証は行われていない。本研究ではスコピング・レビューを用いて次の点を明らかにする。

- 内的動機づけの概念化と測定
- 医療従事者の内的動機づけを強化するための介入と効果
- 内的動機づけの強化を目的とした介入や政策に関するナレッジギャップ

これまで、プロトコールに基づいて文献検索を実施し、検索結果（7258 本）から重複文献を削除 (4950 本)、タイトルと概要による第１スクリーニング (154 本) を実施した。今後、フルテキストスクリーニングと文献レビューによる情報の抽出を行う。

4. 日本の公的保険医療制度の公平性の分析

A. 背景・目的

我が国は、1961 年、国民皆保険を達成したが、近年、少子高齢化が進む中、社会の変化に応じて制度の持続性を確保し、国民が必要な時に効果的な保健医療サービスにアクセスできるよう、政府は、さまざまな改革を行っている。特に、近年、国の経済が停滞する中、所得格差が拡大傾向にあり、我が国の公的医療保険制度における公平性を検証することが求められている。

医療制度における公平性とは、個人が支払い能力に応じて医療財源（直接税、間接税、保険料、自己負担等）を支払い、必要に応じて医療サービスの恩恵を受けることを意味する。これまで、日本の医療制度に関する公平性の分析は、主として医療施設や人的資源の分布など、医療資源の地理的偏在の課題に焦点が当てられてきたが、医療財源への支払いや、医療サービスのアクセスの公平性に関する研究は、未だ限定的である。

本研究では、我が国の公的医療保険制度のもとで、財源への支払いにおける公平性（直接税、間接税、社会保険料、自己負担への支払いが、それぞれ世帯の支払い能力に応じているかどうか）と、医療サービス利用の公平性（医療サービス利用による便益が利用者のニーズに基づいているか）を分析する。

B. 手法

手法として、Financing Incidence Analysis と、Benefit Incidence Analysis を用いる。FIA は、誰が、どのような手段で（直接税、間接税、保険料、自己負担、等）医療費を支払い、費用負担が、所得グループ間でどのように分布し、世帯の支払い能力に応じているかを検証する手法として、これまで様々な研究で用いられてきた。本研究では、FIA を用いて、国民健康保健の保険料の支払いの累進性（高所得世帯の保険料負担割合（所得に対する）が低所得層より高い）を分析する。具体的には、ジニ係数と保険料支払いの集中度指数を用いて、保険料負担の累進性を表すカクワニ係数を推計する。

BIA は、所得グループ（またはそれ以外の属性）の中で、誰が、保健・医療サービスの利用からどのような便益を受けているかを明らかにする手法である。便益は、種々の保健・医療サービスの利用率に、サービスの単価を乗じて算出され、金銭の単位に換算して示される。本研究では、国民健康保険加入者のサービス利用の公平性（必要に応じて保健医療サービスが利用されているか）を検証するため本分析手法を用いる。

C. これまでの分析と概要

2024 年度は、研究の一環として、日本における（1）健康格差の分析と、（2）保健・医療アクセスの「水平的公平性」の分析を行なった。以下に結果の概要を報告する。それぞれの研究の要約は、資料 3、資料 4 を参照。

a. 日本における健康格差の分析

本研究では、2001 年から 2022 年の国民健康基礎調査のデータを用い、主要健康アウトカム（自己評価による健康状態、自覚症状、日常生活動作の制限、ストレス・不安、非感染性疾患）の集中指数と相対格差指数を推計し、健康の社会経済的格差の推移を検証した。全ての指標は年齢と性別で標準化した。分析の結果、低所得層における健康不良の分布の偏りが増大し、所得による健康格差が拡大していることが観察された。加えて、高血圧症や糖尿病等の非感染性疾患の健康格差も増加した。所得による健康格差が拡大しており、公平な医療利用を確保するための政策的取り組みの重要性が示唆された。

b. 保健・医療アクセスの「水平的公平性」の分析

近年、高齢化、雇用形態の変化、所得格差の拡大により、医療アクセスの公平性が懸念されている。本研究では、日本における医療利用における「水平的公平性（ニーズに基づいた医療サービスの利用)」を検証する。1986 年から 2022 年までの国民生活基礎調査のデータを用いて、医療利用の集中指数と医療ニーズで調整した水平的不公平指数（horizontal inequity index）推計した。医療利用の公平性に寄与する要因を特定するため、集中指数の分解分析を行った。分析の結果、医療ニーズは低所得層に集中しており、その傾向は近年顕著であるが、医療利用の分布も医療ニーズにほぼ一致する傾向が見られ、僅かに「水平的不公平性」が確認されたが、調査期間を通して限定的であった。所得は、高所得層の医療利用の分布に

寄与しているが、国民健康保険と高齢者を対象とした施策が、低所得層の医療利用の分布に寄与し、所得による医療利用の不公平性を相殺することがわかった。分析の結果、非雇用労働者を対象とした国民健康保険と、後期高齢者医療制度が、人口動態と社会経済状況の変化による医療ニーズの増大に対し、医療利用の経済的保護を提供していることが示唆された。

D. 今後の分析

2024 年度は、日本における健康格差と医療サービス利用の公平性について分析した。2025 年度は、保健・医療財源への支払い（特に保険料と自己負担）の「垂直的公平性」を分析し、累進・逆進の背景となっている制度的要点について考察する。

資料 1

A scoping review on the use of social media as a tool for expressing patient voice and impact on healthcare service delivery

1. Aim and objectives

Social media – websites and applications that allow users to create and share content or participate in social networking - has been used by patients to express their experiences of healthcare services and providers (World Health Organization, 2023). The World Health Organization (WHO) and the international community have increasingly recognized the importance of a 'people-centered approach' to improving quality in healthcare service delivery by considering people's opinions (World Health Assembly, 2019). While the use of social media, in general, continues to grow, the impact of patient voice shared through online platforms remains largely unknown. Consequently, it is crucial to understand the role of social media in allowing patients to share their experiences, and how their voices influence health-seeking behaviour and healthcare provider service delivery. Specifically, this scoping review will examine:

- The social media platforms that patients use to share their experiences of healthcare services and providers
- The social media platforms patients use to seek information on experiences of healthcare service providers
- The types and forms of information shared by patients through social media
- The impact of information shared by patients on other people's healthcare-seeking behaviour or choice of healthcare provider
- The impact that information shared by patients on social media has on the provision of healthcare services, particularly on the improvement of healthcare service quality through changes in healthcare provider behaviour
- Benefits and challenges of social media as a tool for patient voice, and
- The types of regulatory frameworks that need to be developed so that the quality, safety, reliability of the information on healthcare experiences that is shared by patients through social media is assured and used to improve healthcare service quality.

2. Literature search strategies

The following keywords will be used in the literature search:

Category	Search terms
Social media	"social media"; "social network*"; Facebook; X; Twitter; YouTube; WhatsApp; Instagram; TikTok
User experience	"patient* experience*"; "user experience*"; "public reporting"; "user generated content*"; "patient* satisfaction"; "patient* feedback"; "patient* interaction*"; "patient* engagement*"; "crowdsourced feedback*"; "patient* voice*"
Patient behaviour	"health* seeking*"; "health care seeking"; "health* seeking behavio*"; "health care seeking behavio*"; "health* utilization"; "health care utilization"; "health* service utilization"; "health care service utilization";

	"patient* behavio*"; ("patient* choice*" AND "health* provider*"); ("patient* choice*" AND "health care provider*")
Service quality	"provider* behavio*"; "health* provider* behavio*"; "health care provider* behavio*"; "people-cent* care"; "patient-cent* care"; "patient-focused care"; "person-cent* care"; "quality of care"; "quality of healthcare"; "quality of health care"; "health* quality"; "health care quality"; "health* service quality"; "health care service quality"

The literature search will use the following databases: Medline, Web of Science, and Embase. In addition to the formal citation databases, the search will include gray literature from the websites of international organizations, such as WHO and European Observatory of Health Systems and Policies.

3. Criteria for the selection of literature

The literature for review will be selected using the following criteria:

- Articles on empirical studies
- Literature review articles that synthesize the results from empirical studies
- Gray literature that reports on (1) patient voice/experience and healthcare quality and (2) social media related to digital health
- Literature published in English

4. Information to be gathered from the literature review

The following information will be gathered from the literature:

- Literature metadata including author/s, title, publication year, publisher or name of journal, publication type
- Data about the study setting including country, regions, socio-economic status, health system background related to the organization of healthcare service delivery and health financing mechanisms
- Types of social media that patients use to express their experiences on healthcare services and/or healthcare providers
- Types and forms of information shared by patients about their experience of healthcare services and/or healthcare providers through social media
- Impact of social media posts about patient experience on people's healthcare-seeking behaviour or their choice of healthcare providers
- Impact of social media posts about patient experience on healthcare provider behaviour and healthcare service quality
- Advantages and challenges of using social media to gather information on patient experiences to improve healthcare service quality
- Any healthcare system responses (such as regulatory frameworks) required to mitigate challenges in using social media as a tool to gather information on the patient experience

5. Synthesis of information

Information gathered through the literature review will be coded and analyzed using NVivo software. Thematic analysis of the data will be used to answer the study questions. The analysis

will also address patterns of social media use in different study settings, including socio-economic status of countries, population access to digital devices and the internet (e.g., mobile phones, PCs).

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World Health Organization. (2023). *Classification of digital interventions, services and applications in health: a shared language to describe the uses of digital technology for health* (2nd ed.). Geneva: World Health Organization.

資料 2

Fostering intrinsic motivation in health professionals: a scoping review

1. Introduction

A large number of existing studies have looked at the role of extrinsic incentives, including monetary and other material incentives, on the performance of healthcare professionals [1-3]. However, health professionals are not only motivated by external and material incentives, and the intrinsic motivation of health professionals can play an important role in the quality of health care. [4-6].

The definition and use of the term "intrinsic motivation" varies according to academic discipline. The field of psychology refers to intrinsic motivation as "an individual's enjoyment or inherent satisfaction in undertaking a particular action without external prods, pressures or rewards" [7]. In psychology, the self-determination continuum includes: (1) externally derived motivation, (2) introjected motivation, (3) identified motivation, (4) integrated motivation, and (5) intrinsic motivation [8]. The first four categories in the continuum are considered to be extrinsic as the performance of an activity achieves separable outcomes [8].

In the field of behavioural economics, intrinsic motivation is defined as "the drive to undertake an activity without receiving any tangible rewards" [9] which contrasts with economic incentives that are an inducement to take a particular action in accordance with expected material rewards [10]. In economics research, intrinsic motivation can be categorized as: (1) enjoyment-derived motivation; (2) self-norms or internalized values; (3) personal goal-derived motivation; and (4) motivation driven by social interaction.

Table 1 organizes the concepts of intrinsic motivation in the fields of psychology and economics. As indicated in the table, some of the economic sub-categories of intrinsic motivation (i.e., self-norms, personal goals, social interaction) are considered to be extrinsic motivation in psychology, although some economic sub-categories refer to common motivational factors (e.g., social interaction in economics and introjected motivation in psychology share common factors). This study applies a broad definition of intrinsic motivation, examining intrinsic motivation from the perspectives of both the psychology and economics academic disciplines and identifies policy tools that use forms of motivation other than economic incentives to encourage health professionals to improve the quality of service delivery.

Table 1: Conceptual map of intrinsic motivation in psychology and economics, and inherent motivational factors

Psychology	Intrinsic motivation	Extrinsic motivation			
	Intrinsic motivation	Integrated motivation	Identified motivation	Introjected motivation	External motivation
Economics	Intrinsic motivation				Extrinsic

					incentives
	Enjoyment-derived motivation	Self-norm or internalised value	Personal goal-derived motivation	Motivation driven by social interaction	Motivation driven by economic incentives
Motivational factors	Enjoyment, interests, satisfaction, etc.	Altruism, pro-social behaviour, professionalism, etc.	Personal importance, conscious valuing, etc.	Reputation, social affirmation. social recognition, etc.	Financial incentives, material rewards, etc.

2. Aim and objectives

Research exploring the association between pro-social attitudes and health worker behaviour indicates that higher pro-social attitudes result in better quality of care [11-14], and health professionals with higher pro-social values require fewer extrinsic incentives than health professionals with a lower level of pro-social values [15-17]. In addition, pro-social preferences are stronger in those who choose to work in the public sector, non-profit organisations and other sectors that offer low material rewards [4 14 18-21].

Existing studies indicate that the intrinsic motivation of health professionals can play an important role in health system strengthening [4-6]. To date, there has not been a systematic examination to determine the interventions and policy tools that can foster intrinsic motivation in health professionals, so this study uses scoping review to investigate the following research questions:

(1) What interventions have been implemented in routine practices to strengthen the intrinsic motivation of health professionals?
(2) What impact do the interventions have on the quality of care?
(3) What are the knowledge gaps in the existing literature on interventions and policy tools aimed at strengthening intrinsic motivation, and what are potential areas for future research?
(4) How is intrinsic motivation conceptualised and measured in the identified interventions? [secondary question]
(5) How effective are the interventions in improving intrinsic motivation? [secondary question]

3. Literature search strategies

Various combinations of the keywords are summarised in the table below will be used in the literature search. The term “health professionals” includes medical doctors, nursing and midwifery professionals, paramedical practitioners, community health workers, and other health professionals. The term “intrinsic motivation” includes intrinsic motivation, internal motivation, internal work motivation, internal motivator, enjoyment, positive self-norms

(including professionalism and altruism), personal goals, and social interactions. The term "health care quality" includes concepts such as people-centred care, patient-centred care, and quality of care.

The literature search will use the following databases: PubMed, Web of Science, and PsyInfo. In addition to the aforementioned databases, the search will include grey literature from the websites of international organisations, such as WHO and the European Observatory of Health Systems and Policies.

Table 2: Literature search terms by category

Structure	Definition	Search terms
Population	Health professionals	"health* professional*"; "health care professional*"; "health* worker*"; "health care worker*"; "health* personnel*"; "health* practitioner*"; "medical doctor*"; doctor*; physician*; specialist*; clinician*; "general practitioner*"; nurse*; "nursing* professional*"; midwife; midwives; paramedic*; "community health worker*"; "village health worker*"
Intervention	Intrinsic motivation	"intrinsic motivation", "internal motivation", "internal work motivation", "internal motivator*", "integrated motivation"; "identified motivation"; "introjected motivation"; "self-determined motivation"; "self-determination"; enjoyment, "self* norm*"; professionalism; altruism; "personal goal*"; "social interaction*"; "pro-social behavio*"; reputation*; "social affirmation"; "social recognition"
Outcome	Health care quality	"people-cent* care"; "patient-cent* care"; "patient-focused care"; "person-cent* care"; "quality of care"; "quality of healthcare"; "quality of health care"; "health* quality"; "health care quality"; "health* service quality"; "health care service quality"

4. Criteria for the selection of literature

The literature for review will be selected using the following criteria:

- Empirical studies published in peer-reviewed journals
- Review studies and grey literature that examine interventions and policy tools that aim to strengthen intrinsic motivation
- Studies where participants are health professionals who provide services to people
- Studies with the primary aim of enhancing the intrinsic motivation of health professionals
- Studies looking at interventions and/or policy tools that allow individuals to behave in accordance with expected financial and material rewards (i.e., economic incentives) are to be excluded
- Literature written in English.

5. Information to be gathered from the literature review

The authors will develop a data charting form to systematically collect information from the articles identified in the literature search. The form is expected to capture the following key details:

(1) Type of literature: empirical study, review study, or grey literature
(2) Study objectives
(3) Interventions implemented to strengthen intrinsic motivation
(4) Determinant categories of intrinsic motivation: competency, autonomy, and/or relatedness
(5) Definitions, theoretical or conceptual frameworks for intrinsic motivation, and how indicators of intrinsic motivation have been measured (if undertaken)
(6) Effectiveness of the interventions in improving intrinsic motivation (if measured)
(7) Impact of the intervention/s on quality of care (if any)
(8) Challenges faced when implementing the intervention (if any)
(9) Identified limitations and policy recommendations related to the topic.

6. Synthesis of information

A PRISMA flow diagram will be used to illustrate the workflow for the scoping review. A table summarising the basic information for all papers included in the review will be compiled. Microsoft Excel will be used for data analysis. To bring an analytical lens to the data synthesis and conceptualize the links between policy tools and intrinsic motivation, the three mediating factors for intrinsic motivation used in self-determination theory, i.e., competency, autonomy, and relatedness [7], will be applied to the data.

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資料 3

Does widening income disparity increase health inequality? Evidence from Japan between 2001–2022

Takashi Oshio, Ruru Ping, and Ayako Honda

ABSTRACT

Background: Japan has experienced widening income disparity in recent years, which has raised concerns about increasing health inequality in the country. This study aims to investigate trends in income-related concentration and inequality in key health outcomes between 2001 and 2022.

Methods: This study utilized repeated cross-sectional data from 500,580 individuals (238,746 men and 261,834 women) aged ≥ 6 years, obtained from eight waves of population-based national surveys conducted between 2001 and 2022. The study examined trends in the concentration index and the relative index of inequality for key health outcomes, including self-rated health, subjective symptoms, limitations in undertaking activities of daily living, and experience of stress/anxiety, as well as the number of physician visits and incidence of selected non-communicable diseases (NCDs). All measures were standardized by age and sex.

Results: Increasing concentrations of poor health status among low-income individuals and rising income-related health inequality were observed over the study period, although a greater pro-poor concentration was noted for physician visits. Additionally, income-related inequality increased for some NCDs, such as hypertension and diabetes.

Conclusions: Japan has experienced widening health inequality in recent years, highlighting the need for strengthened policy efforts to ensure equitable healthcare utilization.

Keywords: concentration index; Gini coefficient; income-related health inequality; relative index of inequality

資料 4

Impact of population aging and labor market changes on income-related inequality and horizontal inequity in healthcare utilization in Japan

Takashi Oshio, Ruru Ping, and Ayako Honda

ABSTRACT

Background: Population aging, changes in employment patterns, and widening income disparity raise concerns about equity in healthcare access in Japan's universal health insurance system. This study examines income-related inequality and horizontal inequity in healthcare utilization in Japan.

Methods: Using repeated cross-sectional data from 827,168 individuals aged ≥ 20 years, collected from 13 waves of a nationwide population-based survey (1986–2022), trends in the concentration index and horizontal inequity in healthcare utilization were analyzed. A decomposition analysis of the concentration index was undertaken to identify key factors contributing to inequality in healthcare utilization.

Results: Horizontal inequity remained low over the study period after adjusting for healthcare needs; that is, actual healthcare use closely aligned with healthcare needs. Although pretax income consistently contributed to an unequal distribution of healthcare utilization in favor of the rich, the impact was modest and mitigated by the growing pro-poor contribution of residence-based health insurance plans and health insurance programs for older adults.

Conclusions: The study results suggest that covering the increasing number of precarious workers with residence-based health insurance plans and providing financial support to the aged population through lower co-payment rates have provided protection against the increasing need for healthcare services caused by the rapid change in the demographic composition and labor markets in Japan.

Key words: concentration index; healthcare utilization; horizontal inequity; universal health coverage

資料 5

Global Policy Tracking on Universal Health Coverage: Annual report for FY 2024

1. Introduction

As a theme of the study entitled "*identifying novel components and effective measures to progress towards universal health coverage (UHC), with a focus on health crisis and quality of care*", we have been conducted an international policy review since 1st April 2024 to examine the evolution of the UHC concept and explore novel elements in global UHC debates. This effort aims to identify potential areas where Japan can contribute to global progress towards UHC through international cooperation.

Specifically, this policy tracking exercise systematically monitors and collects international policy documents related to UHC to ensure up-to-date awareness of global UHC policies, strategies, and initiatives. It also serves to identify emerging dimensions of UHC. This report covers global UHC policies from 1st April 2024 to 31st March 2025.

2. Methods

2.1. Strategies for policy tracking

The following websites are reviewed every Monday throughout the research period. Relevant information, including new publications/policy documentation, news releases, and events, is extracted from their respective 'News and Events' sections of the following websites:

- UHC2030
- UHC Partnership
- Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP)
- Alliance for Health Policy and Systems Research
- P4H Social Health Protection Network
- WHO UHC
- World Bank Health

- EuroHealth
- OECD Health

In addition, the International Health Policies (IHP) newsletter and other news sources are regularly monitored for key updates from international bodies (such as G7, G20, etc.) and relevant global health events.

2.2. Storage of information and analysis

NVivo 14 is used to store and manage the information collected from the above-mentioned policy tracking.

Thematic analysis is conducted using the following broad areas:

- Countries and regions
- Dimensions of UHC (including equity in healthcare access; financial protection; quality of healthcare services)
- Approaches to UHC (human rights; life course approach; primary health strengthening, promoting equity, social participation, etc.)
- Measurements of UHC (data; indicators; measures)
- Health system factors and UHC (health information systems; health system financing; health workforce; leadership and governance; medical products, vaccines and technologies; service delivery)
- Disease specific issues and UHC (antimicrobial resistance; communicable diseases; NDCs; etc.)
- Global health issues and UHC (economic and political stability; global health governance; health crisis; health system resilience, etc.)

An inductive approach is used to identify key themes arising from the review of collected information.

2.3. Synthesis of information

The information gathered from policy tracking is summarized every two months, according to

the themes identified through the analysis. These summaries are shared with the MHLW UHC study team.

This annual report for FY2024 is primarily based on the policy and academic documents listed in Appendix C, as well as the international global health events summarised in Appendix A. A visualisation of the thematic analysis coding conducted in NVivo is illustrated in Appendix B.

3. Findings

3.1. Countries and regions

UHC reform is a global movement, with all regions receiving international attention. The African Region has gathered the most focus, followed by the South-East Asia Region and Region of the Americas.

Common elements across UHC reforms include the expansion of health insurance (e.g., Kenya, South Africa, India), investment in primary care (e.g., Ghana, Egypt, Chile), adoption of digital health systems (e.g., Kenya, Cameroon, Chile), efforts to address system fragmentation (e.g., India), and moves towards decentralized governance (e.g., Congo). For instance, Kenya launched a major reform in November 2023 through the Social Health Insurance Fund (SHIF), supported by four new UHC-related laws: the Social Health Insurance Act, the Primary Health Care Act, the Digital Health Act, and the Facility Improvement Financing Act. This initiative aims to extend public health coverage to all Kenyans, and its impact has been widely discussed by global Health scholars and international organisations (e.g., WHO's Health Financing Progress Matrix Kenya Assessment).

Egypt is undertaking an ambitious rollout of the Universal Health Insurance Law, with progress in reducing out-of-pocket expenses and strengthening primary health care. Chile is advancing UHC by expanding Universal Primary Health Care coverage to 21 communes, with the adoption of telehealth, especially in remote areas. India's efforts to integrate health financing

through integrated Information and Communication Technology systems, as seen in the Pradhan Mantri Jan Arogya Yojana (PMJAY) reform, illustrate how addressing fragmentation is critical to achieving UHC and enabling objective-oriented health system reform. In contrast, the Congolese government is pursuing decentralisation of the health sector and revitalization of health districts.

Variations in approaches to achieving UHC have been observed across geographical regions. The African Region prioritizes domestic financing and community-based schemes to advance UHC, as seen in efforts like Côte d'Ivoire's increasing domestic health budget, Senegal's departmental reform of community-based health insurance, Chad's state-funded medical assistance scheme, and Rwanda's integration of community health workers into national primary health care. These examples reflect a growing emphasis on sustainable, locally owned solutions tailored to informal sector and vulnerable populations.

The South-East Asia region emphasizes large-scale health insurance expansion to advance UHC, as seen in India's Ayushman Bharat scheme with an ambitious objective to cover over 500 million people and Nepal's National Health Insurance Programme, although both face challenges related to fragmentation, enrolment, and equity.

The Region of the Americas prioritizes integration and equity in health system reforms, as seen in unified, tax-financed models (e.g., Brazil, Cuba), Argentina's integrated and decentralized Programa Sumar, and equity-driven initiatives in countries like Chile and Mexico that target underserved and remote populations through primary health care expansion and social protection schemes.

The Eastern Mediterranean region focuses on comprehensive health system reform through state-led universal health insurance and institutional restructuring, as seen in Egypt, Morocco, Tunisia, and Djibouti. These reforms typically involve phased national rollouts, pooled financing mechanisms, adoption of family health models, and the establishment of specialized agencies to

manage purchasing, provision, and regulation. The overarching goals are to reduce out-of-pocket spending and promote equity in access to care.

The European region emphasizes health system resilience and solidarity through strategic health financing reforms, equitable access, and strong public service delivery. Even amidst crises, such as Ukraine's wartime UHC reforms, countries have maintained a focus on UHC. Germany and Belgium demonstrate leadership in global health; countries like Moldova, Georgia, and Tajikistan continue to invest in primary health care and financial protection.

The Western Pacific region emphasizes financial protection, pro-poor reforms, and health system equity, as seen in Cambodia's UHC Roadmap (2024–2035), the Philippines' implementation of the UHC Law with expanded benefits, and Vietnam's community-based preparedness. However, persistent out-of-pocket spending, especially in rural areas like Cambodia, highlight the need for integrated social protection and primary care reforms to advance UHC.

3.2. Dimensions of UHC

Universality

Universal entitlement to a publicly funded system targeting the entire population is critical to ensuring equity in healthcare access. This approach avoids fragmentation and ensures that no one is excluded based on income or employment status. Evidence from Kenya and global policy recommendations emphasize that non-contributory, universal entitlement promotes equitable access, enhances efficiency through pooled resources, and reduces financial hardship.

Inclusiveness of the vulnerable population

To ensure truly equitable health systems, inclusive UHC reforms must prioritize vulnerable and marginalized populations, such as persons with disabilities, women and girls, refugees and migrants, and those with low socioeconomic status. Despite increased global attention, disability and migration remain under-prioritized in UHC reforms. People with disabilities face systemic barriers and a 14-year life expectancy gap, while refugees and migrants often experience poor health due to exclusion and substandard living conditions. Gender disparities persist, particularly in access to sexual and reproductive health. Although these groups are increasingly mentioned in global frameworks, consistent prioritization, particularly beyond gender, is still lacking. Achieving equity requires targeted action and strong institutional commitment to reach those most at risk.

Comprehensiveness of service coverage

UHC reforms must ensure equal access to a full continuum of quality health services across the life course. Global commitments (e.g., by WHO, UNGA, G20) increasingly emphasize integrated, people-centred systems that provides preventive, curative, rehabilitative, and palliative care, making them available when and where people need them, without financial hardship.

Comprehensiveness of service coverage

Equal entitlement to comprehensive coverage for the entire population is essential for achieving equity. Policy frameworks in global declarations (e.g., United Nations General Assembly-endorsed Political Declaration of the High-Level Meeting on Universal Health Coverage) call for universally available essential service packages, free at point of care,

regardless of financial contribution level, with particular attention to underserved groups and closing coverage gaps across regions and socioeconomic groups.

Access to quality healthcare services

Access to quality healthcare services is essential to improving health outcomes and achieving UHC. Evidence across policy and academic sources consistently highlights that timely, equitable access to comprehensive, quality care can prevent avoidable mortality and reduce disease burden.

3.3. Approaches to UHC

Primary health care (PHC) strengthening

PHC strengthening is consistently recognised as an inclusive, equitable, cost-effective, and efficient approach to accelerating progress toward UHC by countries and international organizations (e.g., WHO, G20 and PAHO). Reorienting health systems toward PHC builds health system resilience, enhances people's health and well-being, and improves preparedness and response to health emergencies.

Strengthening PHC is key to advancing equity and access. A PHC approach ensures essential services reach marginalized or remote populations, supports community-led and gender-responsive care, and thus drives progress achieving UHC. As noted at the 156th WHO Executive Board, this approach could deliver 90% of essential health services, potentially saving 60 million lives, and increase global life expectancy by 3.7 years by 2030 and generate an estimated 75% of the projected health gains under the SDGs.

Moreover, investing in disease prevention and public health functions through PHC strengthens health system resilience. G7 and EU policy frameworks highlight the importance of

lifelong prevention, early intervention, and integrated community care as cost-effective means to address demographic shifts and reduce long-term healthcare costs.

Sustainable and coherent PHC financing is essential to strengthen UHC systems. Chronic underfunding, fragmented funding flows, and over-reliance on external aid undermine the efficiency and equity of PHC services. Countries such as Argentina, Burkina Faso, Indonesia, and Tanzania have taken practical steps such as consolidating coverage schemes and harmonizing health purchasing to reduce fragmentation and improve service delivery outcomes.

Developing a skilled PHC workforce and robust information systems is essential for effective service delivery and health system resilience. Global initiatives – the WHO Academy, the G20 Public Health Workforce Laboratorium, the UHC Knowledge Hub, the WHO Hub for Pandemic and Epidemic Intelligence for collaborative surveillance, and the WHO SCORE (Survey, Count, Optimize, Review, Enable) for Health Data Technical Package – support national efforts to build capacity through workforce training and data systems, enabling countries to advance PHC and UHC, especially in preparing for and responding to future health emergencies.

Governance mechanisms that align PHC financing with national systems and climate agendas are critical. The Lusaka Agenda calls for domestically financed PHC systems, inclusive governance, and strategic coherence among global health initiatives. WHO's Fourteenth General Programme of Work also emphasizes PHC as the foundation for climate-resilient health systems, highlighting its role in disaster preparedness and response (e.g., early warning systems for extreme heat and infectious disease outbreak).

Innovative and integrated PHC service delivery models are critical to achieving UHC. Community health programmes, such as those implemented in Ethiopia, Mozambique, and

Chile, have improved access to essential services, reduced hospitalisation rates, and addressed social determinants of health. Integration of care across levels and engagement with private health providers, as emphasized by WHO, can help create people-centred, equitable, and efficient PHC systems.

A compassionate culture is an often overlooked yet vital enabler of high-quality PHC and sustainable UHC. Compassion, as recognized by WHO, cultivates awareness, empathy, and action among health workers, fostering respectful, people-centred care. Compassionate leadership shapes supportive organizational cultures, reduces burnout, and motivates the PHC workforce to deliver high-quality services. This makes cultivating a compassionate culture a vital engine for health system transformation toward UHC.

Working with the private sector

As countries strive to achieve UHC, the role of the private sector in healthcare financing, governance, and service delivery is expanding. While private actors can bring innovation and investment, their growing influence also presents significant challenges that must be addressed through robust governance and aligned policy frameworks to ensure equity, quality, and system coherence.

The growing influence of private equity firms and the use of development funds for for-profit healthcare have raised serious concerns. Investigations reveal that private equity ownership in health services can lead to worse outcomes, including increased patient mortality and reduced access to affordable care. Criticism is mounting against development finance institutions, such as the World Bank's IFC, for funding private hospitals that have been linked to human rights violations, widening health inequities, and undermining UHC goals.

Effective governance of the private health sector is essential to align private provision with national UHC goals. In many LMICs, the private sector plays a dominant role in healthcare delivery yet remains underregulated, posing risks to equity, quality, and system coherence. Countries in the Eastern Mediterranean Region have initiated large-scale, state-funded purchases of private health services, emphasizing the need for stronger stewardship and national strategies. WHO's new *Progression Pathway for the Governance of Mixed Health Systems* offers a practical tool to support governments in managing mixed health systems through inclusive policy processes, conflict-of-interest safeguards, and capacity development.

Public-private partnerships (PPPs) are increasingly used to expand healthcare service delivery by combining resources of both public and private sectors. To ensure these partnerships advance UHC, WHO and partners emphasize the need for coherent national strategies, strong stewardship, and effective governance frameworks.

Social participation

Social participation is increasingly recognized as a foundational element of health system strengthening and a critical enabler of UHC. The *2024 77th World Health Assembly resolution on Social Participation for UHC, Health and Well-being* affirms the critical role of engaging communities, civil society, health workers, and youth in shaping health policies and services. By embedding inclusive, participatory mechanisms into the design, implementation, and evaluation of health systems, countries can build trust, strengthen accountability, and ensure that health policies are more responsive to the real needs of individuals and communities.

The rationale for social participation is well-established in international policy frameworks. It is regarded as a neutral way of assessing public values and gathering insights to inform policy. Furthermore, social participation can build trust, help to create informed policies, make

health systems more responsive, and thus being key to creating an inclusive health system. It gives people a voice in decisions that affect their health and well-being. A whole of society approach –encompassing all sectors and stakeholders – is considered essential for achieving UHC, making social participation a key driver of equity and responsiveness.

Engaging a diverse range of actor group is vital to achieving meaningful participation. This includes civil society, faith-based organisations, informal health actors, patient organisations, and youth leaders, as noted in international policy documents.

Several mechanisms for social participation have been identified and prompted in global health discourse. These include civil society involvement in budgeting and priority-setting; public engagement in health benefit design and financing, viewed as a neutral way to surface societal preferences on coverage and trade-offs; storytelling and testimony from people with lived experiences of NCDs and mental health to shape policy and advocate for change; youth and intergenerational engagement in global UHC discussions; institutionalizing social participation, as called for by the WHA Resolution, which urges embedding it in national legislation and systems; empowering people and communities; and maintaining ongoing dialogue with civil society.

3.4. Measurement of UHC

Effective coverage

Unlike previous service coverage indicators (e.g., contact with the health system), effective coverage captures the fraction of total potential health gains actually delivered relative to what a health system could have theoretically delivered. The GBD 2019 UHC Collaborators developed a UHC effective coverage index that accounts for the quality and appropriateness of care, not just contact with the health system, ensuring that services actually improve health outcomes.

Specifically, the UHC effective coverage index is assessed using 23 health service indicators covering five service types (promotion, prevention, treatment, rehabilitation, palliation) and five population-age groups spanning from newborn to older adults. The index is weighted by disability-adjusted life-years to capture potential health gains.

In addition to the UHC effective coverage index, WHO has been monitoring the population lacking access to essential health services and tracking the UHC service coverage index. According to the 77th World Health Assembly, at least 4.5 billion people – more than half of the world's population – are not fully covered by essential health services. The global UHC service coverage index increased from 45 to 68 (out of 100) from 2000 to 2021, slowed from 2015 to 2019 (65–68) and stalled from 2019 to 2021, as reported in the 156th WHO Executive Board report.

The indicator of unmet needs has gained increasing attention. The EU contributes to UHC monitoring by collecting data through the European Union Statistics on Income and Living Conditions Survey (EU-SILC) and the European Health Interview Survey (EHIS). These data sources help monitor access to health care and unmet medical needs across EU countries. In a recent study of 16 LMICs, at least three quarters of people reported no unmet need for health care in most countries between 2022 and 2023.

Quality of care

Quality of care is a fundamental dimension of UHC, reflecting not just whether people can access services, but whether those services are effective, safe, timely, and respectful. Care effectiveness is a key indicator of the functioning of the health system, highlighting its ability to deliver appropriate and timely services. A recent WHO Bulletin study across 16 countries found that fewer than half of adults aged 40 and above had received basic checks like blood pressure

and glucose screening in the past year, underscoring gaps in routine preventive care and the need for stronger system responsiveness.

Efforts to improve quality at scale are exemplified by the work of the Quality of Care Network (QCN), which operates in 11 network countries and has been evaluated for its effectiveness, legitimacy and sustainability. The QCN Evaluation Series (2017–2022) highlights that national leadership, multi-stakeholder partnerships, and an enabling health system environment are key to advancing and sustaining quality improvements, particularly in maternal, newborn, and child health.

For UHC reforms to succeed, quality must be prioritised alongside expanding coverage and financial protection. Evidence from literature and case studies shows that well-designed UHC reforms can reduce inequalities and enhance health outcomes by ensuring care is not only accessible but also effective and safe.

User experience is a critical dimension of health system performance. Poor experiences with care, particularly related to respect, communication, and customer service, can discourage care seeking and adherence, ultimately undermining health outcomes and public trust.

Political economy analysis

Political economy analysis has been increasingly applied in assessing UHC, as it helps uncover systemic power dynamics, stakeholder interests, and institutional practices that shape UHC reforms. For example, in Nigeria, entrenched beliefs in private healthcare and strong private sector influence led to a National Health Act that reinforced private provision, despite its stated UHC goals. In contrast, Zambia's 26-year policy process for enacting national health

insurance succeeded due to strong political will, public support, and alignment with global UHC narratives.

Political economy tools help reformers to identify and leverage windows of opportunity, particularly during crises. In Southeast Asia, countries such as Nepal, Thailand, and Indonesia used moments of disruption to introduce health financing reforms.

The P4H Network has developed a political economy framework to support country focal persons (P4H-CFPs) in advancing social health protection and health financing reforms. Piloted in Cambodia and Cameroon in 2023, the tool helps users understand national political economies to improve collaboration and reform implementation.

WHO's PHC Implementation Solutions Initiative applies a political economy lens to understand how countries have successfully scaled up PHC-oriented health systems. Its first series of country case studies – *The Political Economy Analysis of Primary Health Care–oriented Reforms Country Case Study Series* – aims to unpack implementation pathways, examining how political challenges were addressed and why reforms unfolded the way they did in different national contexts.

3.5. Health system factors and UHC

Public financial management (PFM)

Strong PFM systems are foundational to achieving UHC, as they determine how health budgets are formed, executed, and prioritized. Yet in many LMICs, inefficient budget execution remains a major bottleneck impeding progress toward UHC. Common challenges include rigid budget structures, low absorptive capacity, and delays in fund disbursement.

To overcome these bottlenecks, programme-based budgeting offers a promising alternative to traditional line-item budgeting. It aligns expenditures with health system goals

and improves flexibility and accountability, especially for primary health care. WHO recently issued a technical guidance on *Programme-Based Budgeting for Primary Care Financing: Insights for Practitioners,* offering actionable strategies to support practitioners in implementing this reform.

Effective governance, coordination, and system integration are critical to successful PFM reform. Close collaboration between ministries of health and finance is critical. Inter-ministerial dialogue and joint policy-making help advance PFM reforms, strengthen primary care financing, and support strategic purchasing. Recent global initiatives – including the Lusaka Agenda and renewed Montreux Collaborative – have revitalised global interest around PFM as a key enabler for UHC. These platforms aim to channel external resources more effectively into health systems, and foster inclusive, multistakeholder engagement across governments, non-health partners (e.g., OECD, IMF), academia, and civil society.

Enhancing transparency, accountability, and anti-corruption mechanisms is also vital to ensure equitable resource use and trust in public systems. Without such safeguards, efforts to increase spending may fail to produce meaningful health outcomes or reach the populations most in need.

In terms of strategic resource allocation and prioritization, health remains under-prioritized in national budgets, as shown in WHO's 2024 Global Health Expenditure report on *Global Spending on Health: Emerging from the Pandemic*. WHO calls for countries to raise the share of health spending and invest more strategically in health promotion and disease prevention.

Amid ongoing fiscal constraints, public financial systems should consider disinvesting in low-priority, low-impact health services as a potential solution to redirect resources towards higher-impact areas, particularly those advancing UHC. Tools such as well-designed earmarking

and strategic revenue use can enhance PFM for health. Earmarking allocates revenue for specific health priorities (e.g., smoking cessation), improving targeting but potentially reducing flexibility. Alternatively, broader revenue use mechanisms can direct funds toward priority expenditures. Ministries of Health and Finance play a crucial role in shaping and implementing health taxes and financing reforms to maximize health and fiscal outcomes, making these tools powerful levers within PFM systems for advancing UHC.

Mobilizing domestic resources

The COVID-19 pandemic served as a catalyst to promote domestic investment in health systems, but sustained political and financial commitment is still needed. Despite some progress, many countries remain far from meeting the Abuja target of allocating 15% of national budgets to health. For example, only South Africa met this goal in the African Region between 2014 and 2020.

The suspension of US aid has sparked renewed momentum to rethink health financing across Africa. High-level forums such as the AU Summit and the 2024 Africa Health Agenda International Conference have highlighted the urgency of mobilizing domestic resources, exploring public-private partnerships (PPP) in the health sector, and diversifying donor sources. A clear message has emerged: African health systems can no longer rely solely on foreign aid and must build partnerships with domestic businesses and philanthropies to close financing gaps.

Taxation and innovative revenue generation could be powerful tools for financing health and advancing UHC. Health taxes on tobacco, alcohol, and sugary drinks are among the most effective tools to generate revenue and improve public health. Meanwhile, civil society and global platforms (e.g., G20) are calling for progressive taxation, including minimum taxes on

billionaires and a coordinated international standard to ensure effective taxation of ultra-high-net-worth individuals. These resources can be used to tackle health inequalities and advance UHC.

Leadership and governance

Effective leadership and governance are foundational to achieving UHC. Many countries have developed legal frameworks as an imperative step towards advancing UHC. Countries such as the Philippines (UHC law), South Africa (National Health Insurance Act), Tanzania (Universal Health Insurance Bill), and Kenya (Social Health Insurance Act) have enacted legislation to formalise health as a legal right and to institutionalise reforms. These legal frameworks often align with global commitments such as the International Health Regulations (IHR), UHC, and SDGs.

Multisectoral collaboration is another critical element of governance. Strengthening health systems and achieving UHC require coordinated action across diverse stakeholders. The Lusaka Agenda emphasizes the importance of coordinated efforts among funders, governments, global health organizations, civil society, and the research and learning community to enhance primary health care, align health financing with equity goals, and coordinate R&D and regional manufacturing. This requires inclusive governance and close alignment with national systems.

Within governments, cross-sectoral partnerships – especially between ministries of health, finance, labour, and social protection – are vital for policy coherence and effective service delivery. Notable examples include Botswana's inter-ministerial dialogues on primary health care financing between the ministries of health and finance, and the Democratic Republic

Congo's call for collaboration between Ministry of Health and the Ministry of Employment, Labour, and Social Security to avoid institutional conflicts.

Political will and leadership play an indispensable role in driving UHC reforms. For instance, in Zambia, the 27-year journey to establish the National Health Insurance Scheme was made possible by sustained political will and leadership from the Ministry of Health, supported by stakeholder engagement and alignment with global UHC narratives. However, political will alone is not sufficient. It must be paired with clear and objective-oriented reform strategies. An objective-oriented approach to health system reform – grounded in problem-solving, consistency with evidence, and continuous evaluation – helps reformers align political momentum with technical goals, avoid superficial policy gestures, and strategically adapt reforms to improve system performance.

Digital health and AI

Digital health and AI are transforming the delivery of healthcare and offer significant potential to accelerate progress toward UHC. When designed and governed effectively, digital tools and AI can enhance access, improve system efficiency, and support more equitable and inclusive health outcomes.

Digital health tools are expanding access for remote and marginalized populations. For examples, Ghana's interactive platforms support community health access and India's digital campaigns for malaria prevention have effectively targeted high-risk households. Similarly, telemedicine and self-help digital tools are improving mental health coverage in underserved areas by providing accessible, affordable services, especially when developed with strong data protection and ethical safeguards.

Digital solutions can also improve health system efficiency and integration. Digital tools such as electronic medical records and immunization registries enhance data management, support informed decision-making, and streamline service delivery at the primary care level. Integration of digital technologies into health financing systems also enhances transparency, prevents fraud, and enables more informed resource allocation, supporting progress toward UHC.

Global and regional policy frameworks are shaping the digital health landscape, offering guidance to countries on how to adopt and implement digital innovations responsibly. The UN's High-level Panel on Digital Cooperation and WHO Global Strategy on Digital Health, alongside with regional action frameworks (e.g., Pan American Health Organization, WHO South-East Asia Regional Office), highlight the importance of digital health. These frameworks guide member countries in developing national digital health blueprints. With WHO support, countries such as India, Sri Lanka, and Bangladesh are advancing efforts to integrate digital innovations into their UHC strategies.

AI presents both promise and peril for health equity. While technologies such as large multimodal models can help address workforce shortages, optimize resource allocation, and advance scientific progress toward UHC, they must be governed with strong ethical, regulatory, and accountability frameworks to prevent misuse, bias, and deepening inequalities.

Global platforms are calling for multi-stakeholder collaboration to ensure appropriate AI governance. International initiatives such as the Prince Mahidol Award Conference 2025 and the UN Global Digital Compact highlight the importance of developing AI tools that are inclusive, transparent, and aligned with human rights, especially in LMICs, to support equitable digital health ecosystems.

Integrated care

Integrated care is a cornerstone of UHC, ensuring that health services are coordinated across the continuum of care and centred on individuals' needs. Integrated, people-centred health services, endorsed by the UN Political Declaration on UHC and the WHO Global Competency Framework for UHC, are being scaled across regions to ensure that health services are designed and delivered around people's needs and preferences. Egypt's reforms exemplify integrated care by creating seamless service pathways that link family health units with hospitals and specialty centres, ensuring continuity of holistic, community-based care.

Primary health care remains the backbone of integrated service delivery. Mozambique's community health strategy underscores this by delivering an essential package of integrated primary health care services through strong community leadership and well-supported community health workers.

Integrated emergency, critical and operative care is gaining strategic attention, with WHO calling for a global strategy (2026–2035) to embed these services into UHC and health emergency preparedness, as discussed at the 77th World Health Assembly.

Countries like Brazil, Costa Rica and Cuba have advanced UHC by pooling funding from various sources to create integrated healthcare service networks and unified health systems that offer equal benefits.

Innovative health workforce models are also central to integrated care. These new care models combining multidisciplinary teams and task-sharing are vital to address the rising burdens of NCDs and mental health conditions by enabling more flexible, coordinated, and cost-effective service delivery.

In high-income settings, integration between health and long-term care systems is increasingly recognised as vital, particularly in the context of ageing populations. EU has

recognised the importance of integrating long-term care with health systems to address the needs of an ageing population, reinforcing the vision of continuity of care throughout the life course.

3.6. Disease-specific issues and UHC

Antimicrobial resistance (AMR)

AMR poses a growing threat to global health security and the achievement of UHC. AMR goals are fundamentally linked to UHC, as equitable access to affordable, quality services for infection prevention, diagnosis, and treatment is essential for reducing antimicrobial misuse and overuse. However, the integration of AMR objectives within UHC-related initiatives is often overlooked. To address this gap, WHO calls on Member States to integrate its people-centred core package of AMR interventions into UHC benefit packages.

Several key enablers support effective national responses to AMR. Innovative diagnostics, coupled with context-specific awareness, are crucial for ensuring antimicrobial stewardship and effective integration with UHC initiatives. Furthermore, strategic financing mechanisms – such as outcome-based budgeting, earmarked funding, and joint financing – can strengthen the implementation of national action plans on AMR; however, only about a quarter of countries follow through the plans with a monitoring framework and domestic financing.

Multisectoral collaboration is a vital enabler for effective AMR containment. Efforts in multisectoral communication, prevention, surveillance, and health system resilience, as seen in Namibia, demonstrate how countries can mount effective AMR responses with cross-cutting enablers.

At the global level, AMR is increasingly recognized as a practical application of the One Health approach. High-level platforms such as G20 and G7 consistently emphasize the

interconnectedness of human, animal, plant, and environmental health in AMR control. The One Health perspective reinforces the need for integrated, cross-sectoral action to reduce the emergence and spread of resistant pathogens across domains.

Noncommunicable diseases (NCDs)

NCDs represent one of the greatest public health challenges of the 21st century, yet they remain underfunded and underprioritized in global health financing. Despite the growing burden of disease, development assistance for NCDs remains low, rising only from 1% in 1990 to 2% in 2022 of the total multilateral and bilateral development assistance for health, while HIV/AIDS and maternal and child health continue to dominate funding. A strategic realignment is needed to ensure development assistance for health reflects the needs of recipient countries and prioritises NCDs and health system strengthening.

Strengthening PHC is consistently recognised as the most efficient pathway for delivering NCD services under UHC. Investing in PHC improves access to cost-effective, context-specific interventions, especially for chronic conditions.

Sustainable financing is critical to advance NCD prevention and care. Introducing excise taxes on tobacco, alcohol, and sugary beverages, along with the removal of harmful subsidies (e.g., fossil fuels), offer a valuable strategy to boost domestic financing for NCD services.

Financial protection for NCD-related care remains inadequate, particularly in the case of cancer. Over half of cancer patients face catastrophic health expenditures, underscoring the need to expand health insurance, provide financial support, and ensure affordable cancer care. Calls are growing in international events to protect cancer care from harmful commercial influences and ensure financial protection under UHC, particularly ahead of the 2025 UN High-Level Meeting on NCDs.

Regional efforts are driving targeted action on NCDs. In Europe, the *Beating Cancer Plan* emphasizes access to cancer prevention, screening, treatment, and care, as part of building a resilient European Health Union. In Africa, cervical cancer was highlighted at a recent health ministers' forum, with a strong call to prioritize HPV vaccination and screening.

Mental health, a historically neglected area, is now gaining global recognition as an essential component of UHC. Despite this growing awareness, mental health remains widely excluded from national UHC benefit packages. G7, G20, and WHO recognise mental health as an integral part of UHC, and emphasize the need for equitable access, long-term support, and parity with physical health. Civil society plays a critical role in advocating for people-centred services, particularly in underserved communities.

Diabetes prevention and management are being strategically integrated into ongoing UHC efforts in Africa. The World Health Organization (WHO) Regional Committee for Africa adopted the *Framework for the Implementation of the Global Diabetes Compact in the WHO African Region*. This framework outlines a strategic plan for Member States to enhance diabetes prevention, early diagnosis, and comprehensive management, particularly at the primary health care level.

Oral health is also being increasingly acknowledged within the broader NCD agenda. Global frameworks now emphasize the inclusion of oral diseases in UHC policies, recognizing their contribution to overall health and well-being and their importance in achieving the goal of "Health for All by 2030."

Communicable diseases

Global political momentum remains strong for ending AIDS, TB, malaria, and polio. The G7, G20, and UN continue to reaffirm commitments to eradicate these diseases by 2030. Despite

progress, global targets for reductions in the TB burden are currently off-track. WHO warns that global targets are unlikely to be met without accelerated efforts.

Immunization is crucial to ending communicable disease threats. Initiatives such as Nigeria's campaign to reach over 2.2 million "zero-dose" children and WHO's "Big Catch-Up" campaign are parts of the broader Immunization Agenda 2030.

Maternal, newborn and child health

Global progress on maternal mortality is slow and uneven. While the global maternal mortality rate declined marginally from 227 per 100,000 live births in 2015 to 223 in 2020, achieving the SDG target of 70 by 2030 requires an annual reduction of 11.6% between 2021 and 2030, according to the 2024 SDG Progress Report. Sub-Saharan Africa and Southern Asia account for 87% of maternal deaths, underscoring regional disparities.

Quality of care networks are improving maternal, newborn, and child health outcomes. Since 2017, countries including Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India, Malawi, Nigeria, Sierra Leone, Uganda, and the United Republic of Tanzania have partnered with WHO in the Network for Improving Quality of Care for Maternal, Newborn and Child Health. This initiative focuses on strong national leadership and multi-stakeholder collaboration to embed quality in health services.

3.7. Global health issues and UHC

Global health governance

Global health governance is increasingly shaped by multi-stakeholder partnerships, involving civil society, regional bodies (e.g., the African Union), and non-health sector. The public–private partnerships (PPPs) model faces criticisms regarding its sustainability and equity.

Despite growing commitments, challenges remain regarding alignment of initiatives, fragmentation of efforts, and pressures on multilateral institutions.

Alignment of initiatives remains a persistent challenge. Although the WHO's SDG3 Global Action Plan process has emphasized the need for better coordination among multilateral partners to support alignment with and across other health-related initiatives, partnerships, and strategies (e.g., health security, UHC, and other interconnected SDG targets), fragmentation continues to impede process.

WHO faces political and financial pressures, especially following the US's funding fluctuations, and calls for downsizing. There are growing expectations for efficiency, transparency, and results-based management, particularly with respects with funding reforms and the WHO Investment Round. The WHO Investment Round, an initiative designed to secure predictable and flexible funding for WHO's 2025–2028 core work, represents a pivotal shift towards sustainable financing models involving both traditional and non-traditional donors, including LMICs.

While WHO remains a central actor, multilateral coordination now involves institutions such as the World Bank, IMF, and Gavi, particularly for pandemic preparedness financing (e.g., Pandemic Fund). The Africa CDC's role has been expanded through initiatives like the Lusaka Agenda and African Epidemic Fund, reflecting stronger regional ownership in global health governance. Recent coordination between IMF, World Bank, and WHO highlights synergies across finance and health sectors.

Multilateral initiatives, such as the Montreux Collaborative, the Pandemic Fund, and the Coalition for Local and Regional Production demonstrate the broadening of participation and mandates in global health governance.

Countries like Germany, Belgium, and Japan continue to support UHC via bilateral cooperation, often through WHO's UHC Partnership. While bilateral donors often act as catalysts for multilateral cooperation, they may also inadvertently duplicate efforts if their actions are not well aligned with broader governance frameworks.

Health crisis

COVID-19 created a policy window to align Global Health Security (GHS) and UHC norms. A growing normative convergence is observed between the two notions: GHS is increasingly framed using equity and rights-based language, while UHC documents emphasizes resilience and outbreak preparedness. Although integration is more implicit than explicit, it is gaining momentum through overlapping discourse and shared functions. This convergence is reflected in recent policy and framework synergies, such as the WHO Pandemic Agreement, the 2023 UHC Political Declaration, and WHO's new global health strategy (GPW14).

COVID-19 also served as a turning point, catalysing reforms for UHC and GHS integration. It exposed the inadequacy of pandemic prevention architecture and revealed funding gaps. Sustainable financing is essential for both GHS and UHC. However, many African countries fall short of meeting the Abuja Declaration commitments (15% of budget to health) and continue to rely heavily on out-of-pocket payments to fund health services, according to WHO's *Global Spending on Health: Emerging from the Pandemic* report.

Pandemic prevention, preparedness, and response have since risen to a top global health agenda. G20, G7, and WHO are actively promoting resilient health systems, pandemic financing, and equitable access. For example, the G20 Joint Finance & Health Task Forces encouraged diverse contributions to the Pandemic Fund and supported negotiations on a WHO-led convention or agreement on pandemic prevention, preparedness, and response to complement

the International Health Regulations. Trilateral cooperation among the IMF-WBG-WHO aims to enhance financing and technical support for pandemic preparedness, including through initiatives such as the IMF's Resilience and Sustainability Trust.

However, intellectual property protections and geopolitics, such as resistance to the TRIPS waiver, continue to complicate equitable responses. In particular, big pharma's lobbying in the U.S. opposed the TRIPS waiver and now advocates for strong intellectual property protections in the WHO Pandemic Agreement, prioritizing commercial interests over global access to medicines.

Beyond pandemics, armed conflicts severely disrupt health systems, limit access to essential services, and increase risks for vulnerable populations, especially women and children. While international legal frameworks emphasize the protection of the right to health during crises, enforcement remains weak. In 2024, WHO provided aid to millions of people facing health emergencies in 87 countries and territories – including Gaza, Haiti, Sudan, and Ukraine – and coordinated health emergency responses with over 900 partners globally.

The emerging concept of "polycrisis" refers to overlapping challenges: armed conflict, food insecurity, economic instability, climate change, and pandemics. Responding to polycrisis requires reappraisal of health, economic, and social policies to support systemic resilience. These shocks may also act as catalysts for UHC reform.

Health system resilience

Resilient health systems are essential for addressing a range of health challenges, including pandemics, NCDs, and climate change. Building resilience is closely linked to the achievement of UHC and Global Health Security. Several international organisations (e.g., WHO, IMF, World Bank) have committed to strengthening health system resilience through coordinated policy,

funding, and technical support. Collaboration among these institutions promotes pandemic preparedness and strengthens country-level health security.

Financing resilience remains a major challenge. Underfunding remains a major barrier to building resilient health systems, particularly in African countries where the Abuja Declaration commitment to allocate 15% of national budgets to health remains largely unmet. Public Financial Management and resilient financing strategies (e.g., risk pooling, diversified funding sources) are being promoted to enhance sustainability. Institutions like the IMF and World Bank are providing long-term, low-interest financing to support structural health resilience.

Integrated governance and coordination are equally vital for building resilience. Cross-sectoral collaboration, donor-NGO coordination, and integrated governance are vital for resilience planning and implementation. Strong political commitment and accountability mechanisms are necessary to institutionalize resilience-building efforts. WHO's resilience roadmap suggests integrating resilience into existing strategies through coordinated planning, implementation, and monitoring.

A resilient health system also depends on a capable and protected health workforce. A skilled and adequately supported health workforce is fundamental to system resilience. Initiatives such as WHO Academy and UHC Knowledge Hub aim to strengthen global health workforce capacity. Efforts to enhance local leadership and management (e.g., PERFORM2Scale initiative in Africa) are crucial for UHC and resilience. Special attention is needed for conflict-affected settings (e.g., Ukraine), where innovative financing and workforce strategies have been key to maintaining health service delivery during crises.

Planetary health

Planetary health—the recognition that human health is intricately linked to the health of the Earth's natural systems—has become an increasingly urgent concern in global health discourse. Planetary health threats exacerbate social inequalities, disproportionately affecting rural areas and disadvantaged populations.

Climate change stands out as the most significant planetary health threat, with far-reaching impacts on both communicable and non-communicable diseases, health equity, and the functioning of health systems. There is growing global momentum for integrating climate resilience into health systems, especially through primary health care (PHC) and UHC. PHC is central to climate adaptation, such as early warning systems and community-based response.

WHO, the G20 Health Ministers' Meeting, and other key partners advocate for climate-resilient health systems grounded in the core building blocks of health systems, such as financing, governance, and health workforce. Intersectoral initiatives such as One Health and climate-health financing mechanisms are at the forefront of global policy dialogues (e.g., G20, COP, SDG summits).

While momentum is growing, financing remains a major barrier, particularly in low-income settings. According to a recent report by the Rockefeller Foundation, financing for climate-health interventions increased tenfold from 2018 to 2022. However, significant funding gaps persist, particularly in low-income countries.

Beyond climate, environmental pollutants continue to pose serious health risks. Air pollution remains a major health risk, contributing to increased risks of both communicable and non-communicable diseases. WHO highlights that billions are exposed to harmful air pollutants annually. The Executive Board will discuss strategies to enhance the global response to the adverse health impacts of air pollution.

In addition, chemical exposure, waste, and broader pollution-related risks contribute significantly to global mortality. WHO estimates that 13.7 million deaths in 2016 were due to environmental factors including chemical exposure and pollution. WHO's Global Chemicals and Health Network, which includes over 80 countries, facilitates data exchange on chemical pollution, thereby protecting more communities from its dangerous effects.

Universal social protection

Universal Social Protection (USP) is essential for eradicating poverty, promoting gender equality, and reducing inequalities, particularly in vulnerable settings. It complements UHC by addressing both financial barriers to healthcare access and social determinants of health. Synergizing USP and UHC enhances both health equity and financial protection. A national social protection strategy (e.g., in Libya) can strengthen resilience against future crises and disruptions.

Appendix A: Key UHC-related events in FY 2024

Title of the event	Hosting organization	Date	Place
7th Annual Health Financing Forum (AHFF)	World Bank, USAID, and the Global Financing Facility	15 – 17 April, 2024	Washington D.C., USA
Spring Meetings	World Bank Group	15 – 20 April, 2024	Washington D.C., USA
G7 Ministerial Meeting on Finance	G7	23 – 25 May, 2024	Stresa, Italy
Seventy-seventh World Health Assembly (WHA77)	World Health Organization	27 May – 1 June, 2024	Geneva, Switzerland
African regional meeting for developing a roadmap to reshape global health financing on the continent	WHO Regional Office for Africa	13 June, 2024	Addis Ababa, Ethiopia
International dialogue on sustainable financing for NCDs and mental health	WHO and World Bank	20 – 21 June, 2024	Washington D.C., USA
Video conference meeting on debt swap for health investments	G20 Joint Finance and Health Task Force	24 June, 2024	Video conference
High-level Political Forum on Sustainable Development (HLPF)	Economic and Social Council, UN	8 – 17 July, 2024	New York, USA
Member State Information session on Monitoring UHC	WHO	21 August, 2024	Online
Tokyo International Conference on African Development (TICAD) Ministerial Meeting	Japanese government	24-25 August, 2024	Tokyo, Japan
74th session of the WHO Regional Committee for	African Region, WHO	26-30 August, 2024	Brazzaville, Republic of Congo

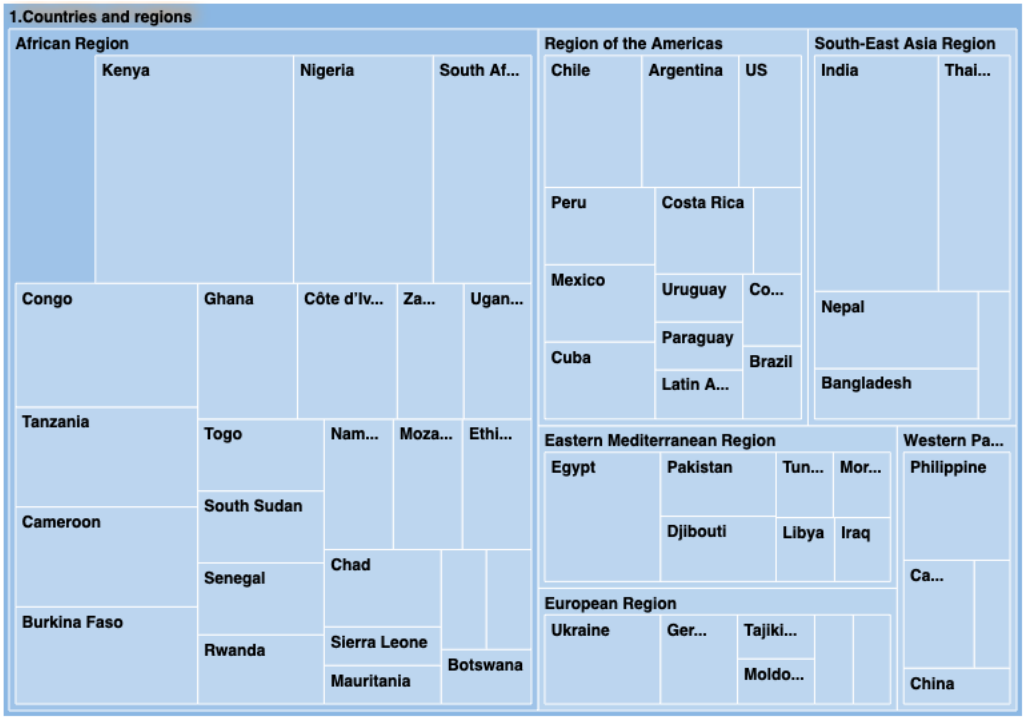
Africa			
Final meeting of the G20 Joint Finance and Health Task Force under Brazil's presidency	G20	9 September, 2024	Videoconference
11th meeting of the Intergovernmental Negotiating Body (INB)	INB (established by the World Health Assembly in 2021)	9-20 September 2024	Hybrid (Geneva, Switzerland)
World Cancer Congress	Union for International Cancer Control	17-19 September, 2024	Geneva, Switzerland
79th session of the United Nations General Assembly (UNGA79)	United Nations	20-30 September, 2024	New York, USA
G7 Health Ministers' Meeting	G7	10-11 October, 2024	Ancona, Italy
15th World Health Summit 2024	WHS Foundation GmbH	13-15 October, 2024	Berlin, Germany
UNITE Global Summit	UNITE Parliamentarians Network for Global Health	16 October, 2024	Berlin, Germany
2024 Annual Meetings of the International Monetary Fund and the World Bank Group	IMF and World Bank	21-26 October, 2024	Washington DC, USA
G20 Health-related meeting	G20	29-31 October, 2024	Rio de Janeiro, Brazil
2024 United Nations Climate Change Conference (COP29)	United Nations	11-22 November, 2024	Baku, Azerbaijan
G20 Leaders' Summit	G20	18-19 November, 2024	Rio de Janeiro, Brazil
8th Global Symposium on Health Systems Research (HSR 2024)	Health Systems Global	18-22 November, 2024	Nagasaki, Japan

Fifth WHO Global School on Refugee and Migrant Health	WHO	2-6 December, 2024	Online
Webinar on UHC Compass launch	International Alliance of Patients' Organizations (IAPO)	11 December, 2024	Online
UHC Partnership Global Meeting 2024	UHC Partnership	11-13 December, 2024	Lyon, France
UHC Day 2024	WHO	12 December, 2024	N.A
2024 UHC Day Annual Parliamentarian Town Hall	UHC2030	12 December, 2024	Online
World Economic Forum 55th Annual Meeting 2025 (Davos 2025)	World Economic Forum	20-24 January, 2025	Davos-Klosters, Switzerland
Geneva Global Health Hub (G2H2) preparatory webinars	G2H2	20-24 January, 2025	Online
G20 Health Working Group meeting	G20	24 January, 2025	Online
Prince Mahidol Award Conference (PMAC) 2025	PMAC	28 January – 2 February, 2025	Bangkok, Thailand
WHO's 156th Executive Board Meeting	WHO	3-11 February, 2025	Geneva, Switzerland
Johns Hopkins International Conference on Drug Affordability and Pricing	Johns Hopkins University	5 February, 2025	Online
High Level Consultations on Health Financing during Emergencies	AU, Africa CDC, AUDA-NEPAD & Partners	14 February, 2025	Addis Ababa, Ethiopia
38th African Union (AU) Summit	AU	15-16 February, 2025	Addis Ababa, Ethiopia
6th Africa Health Agenda International	Amref Health Africa	2-5 March, 2025	Kigali, Rwanda

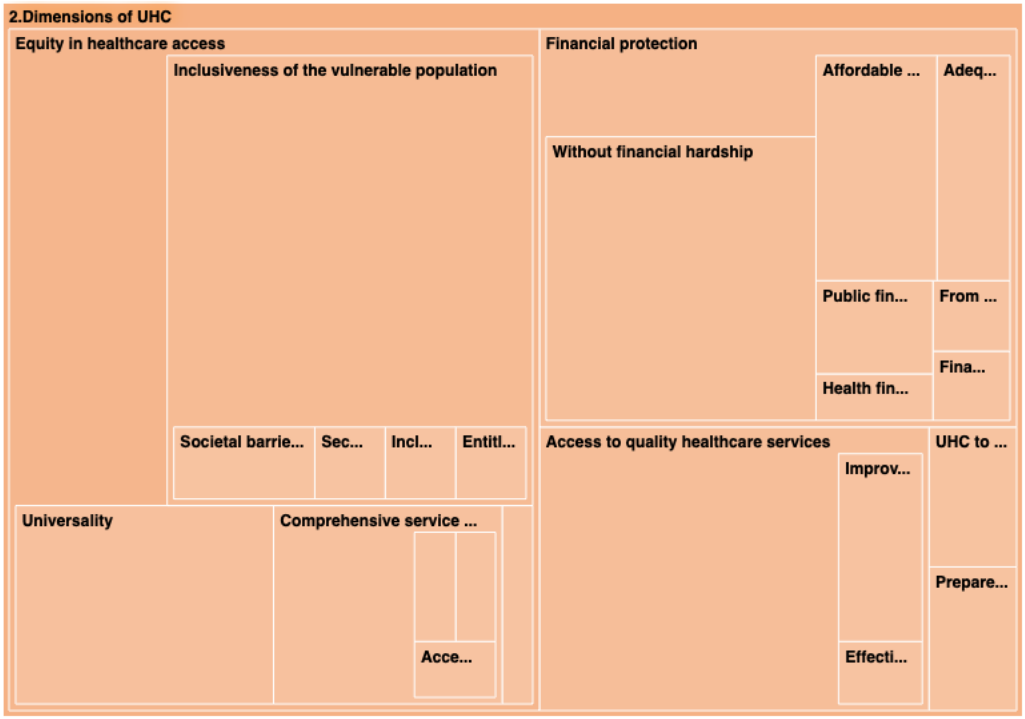
Conference (AHAIC)			
WHO Health Financing and Economic webinar	WHO	6 March, 2025	Online
The awarding of the 2024 Virchow Prize to Professor Lucy Gilson	Alliance (for Health Policy and Systems Research)	10–11 March 2025	Geneva, Switzerland
Webinar on 'How Does Population Ageing Affect Health System Financial Sustainability and Affordable Access to Health Care?'	WHO and EU4Health Programme	19 March, 2025	Online

Appendix B: Frequently discussed themes

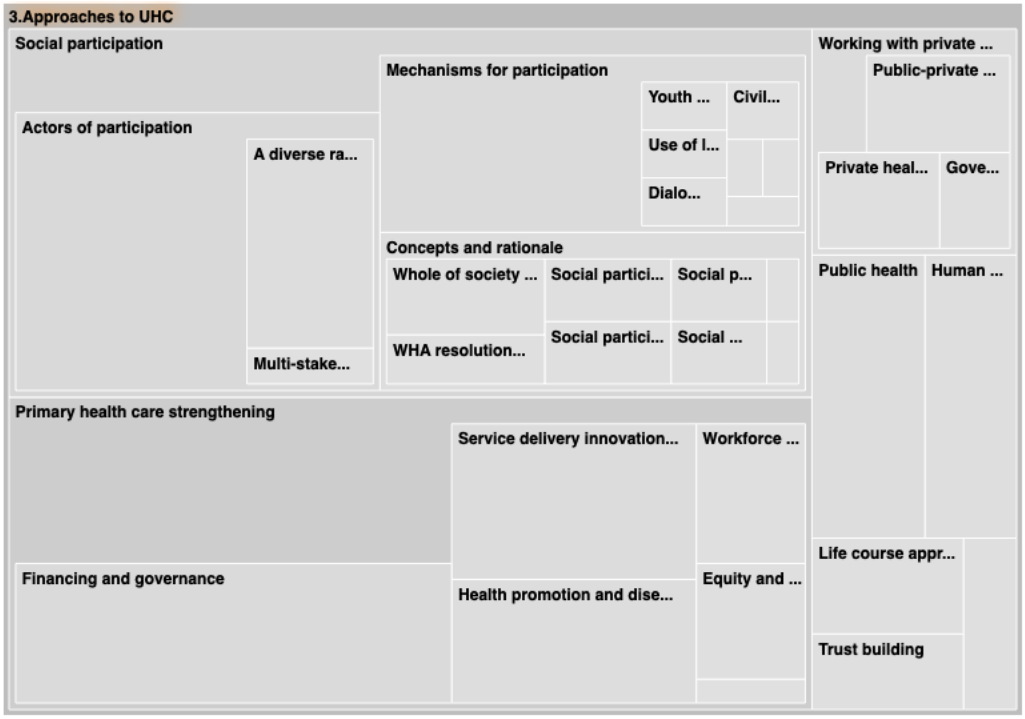
a. Countries and regions



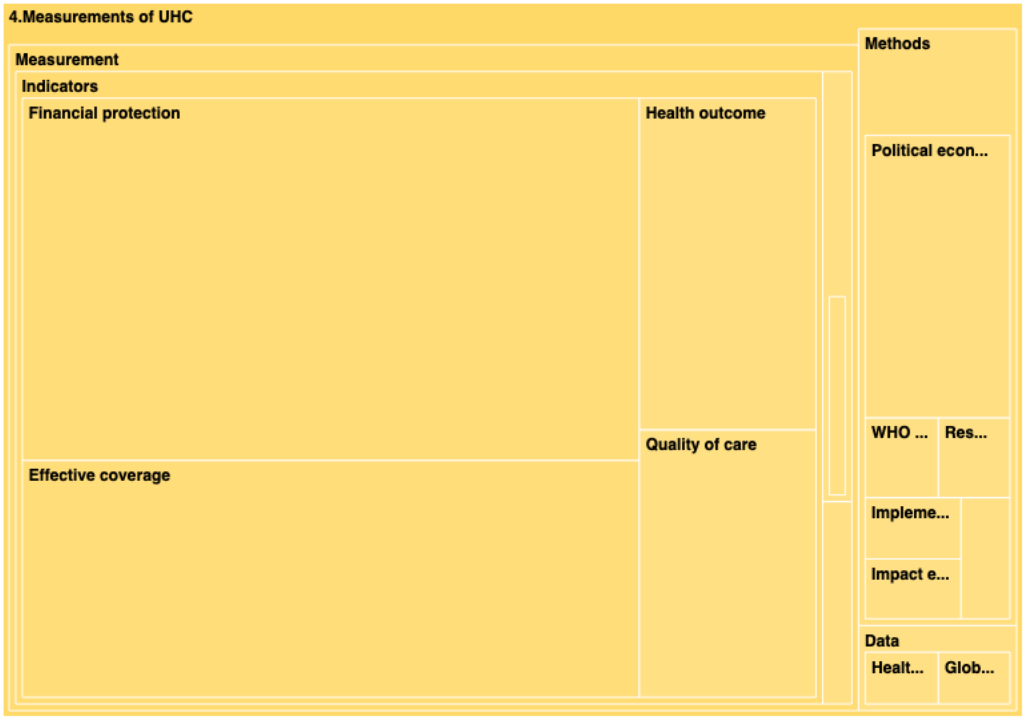
b. Dimensions of UHC



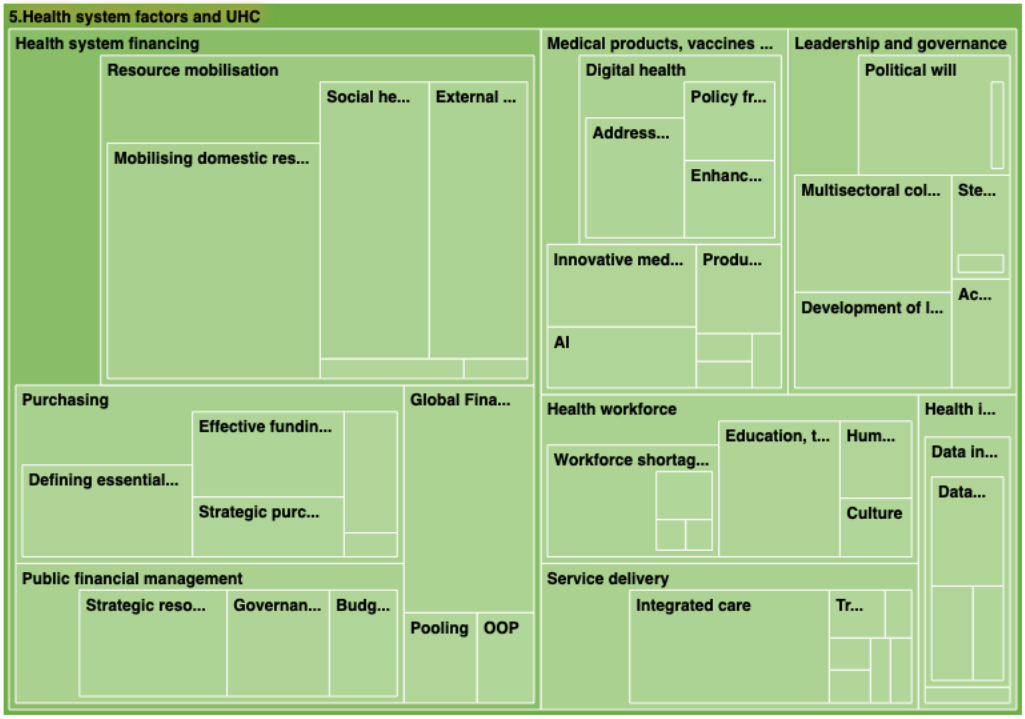
c. Approaches to UHC



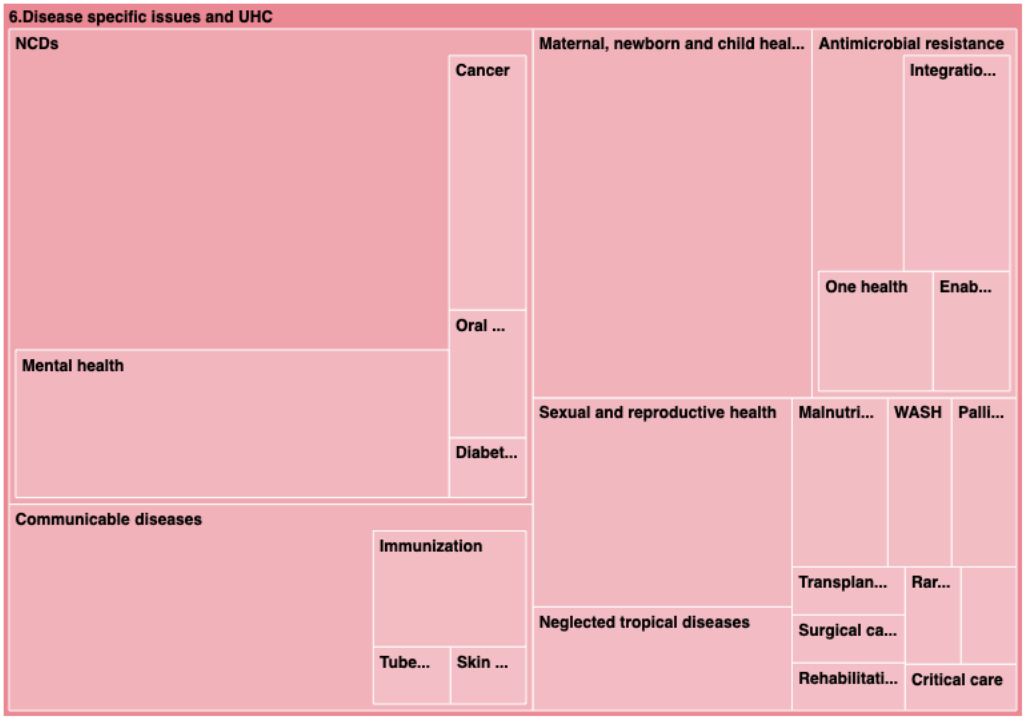
d. Measurements of UHC



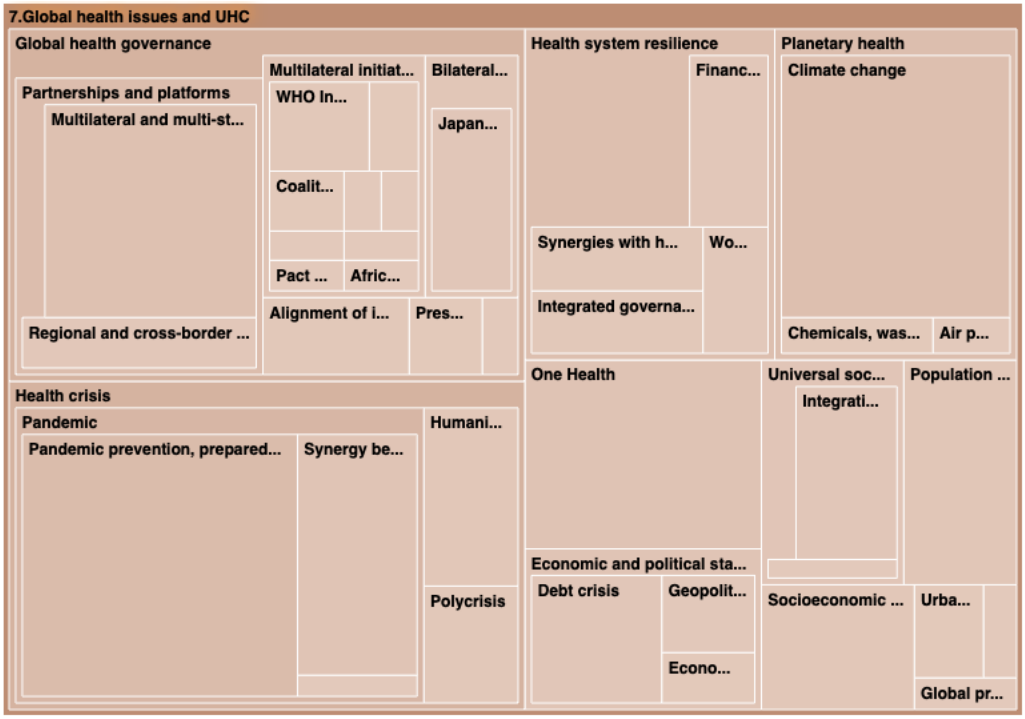
e. Health system factors and UHC



f. Disease specific issues and UHC



g. Global Health issues and UHC



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別添５

研究成果の刊行に関する一覧表

書籍

著者氏名	論文タイトル名	書籍全体の編集者名	書　籍　名	出版社名	出版地	出版年	ページ
該当無し							

雑誌

発表者氏名	論文タイトル名	発表誌名	巻号	ページ	出版年
該当無し					

2025年　5月　18日

厚生労働大臣
~~（国立医薬品食品衛生研究所長）~~ 殿
~~（国立保健医療科学院長）~~

機関名　国立大学法人一橋大学

所属研究機関長　職　名　学長

氏　名　　中野　聡

次の職員の(令和)　7年度厚生労働科学研究費の調査研究における、倫理審査状況及び利益相反等の管理については以下のとおりです。

１．研究事業名　地球規模保健課題解決推進のための行政施策に関する研究事業

２．研究課題名　ユニバーサル・ヘルス・カバレッジ（UHC）推進における新たな要素の同定と世界の UHC 達成に向けた我が国の施策検討のための研究

３．研究者名　（所属部署・職名）　一橋大学大学院経済学研究科　社会科学高等研究院・教授

（氏名・フリガナ）　本田　文子（ホンダ　アヤコ）

４．倫理審査の状況

	該当性の有無 有　無	左記で該当がある場合のみ記入（※1）		
		審査済み	審査した機関	未審査（※2）
人を対象とする生命科学・医学系研究に関する倫理指針（※3）	□　☑	□		□
遺伝子治療等臨床研究に関する指針	□　☑	□		□
厚生労働省の所管する実施機関における動物実験等の実施に関する基本指針	□　☑	□		□
その他、該当する倫理指針があれば記入すること（指針の名称：　　）	□　☑	□		□

（※1）当該研究者が当該研究を実施するに当たり遵守すべき倫理指針に関する倫理委員会の審査が済んでいる場合は、「審査済み」にチェックし一部若しくは全部の審査が完了していない場合は、「未審査」にチェックすること。

その他（特記事項）

（※2）未審査の場合は、その理由を記載すること。
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研究倫理教育の受講状況	受講 ☑　未受講 □

６．利益相反の管理

当研究機関におけるＣＯＩの管理に関する規定の策定	有 ☑　無 □（無の場合はその理由：
当研究機関におけるＣＯＩ委員会設置の有無	有 ☑　無 □（無の場合は委託先機関：
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（留意事項）　・該当する□にチェックを入れること。
・分担研究者の所属する機関の長も作成すること。

令和７年４月９日

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（~~国立医薬品食品衛生研究所長~~） 殿
（~~国立保健医療科学院長~~）

機関名　国立健康危機管理研究機構

所属研究機関長　職　名　理事長

氏　名　國土 典宏

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３．研究者名　（所属部署・職名）国立国際医療センター国際感染症センター・センター長

（氏名・フリガナ）大曲 貴夫・オオマガリ ノリオ

４．倫理審査の状況

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厚生労働省の所管する実施機関における動物実験等の実施に関する基本指針	□　■	□		□
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