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).

Reference:

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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

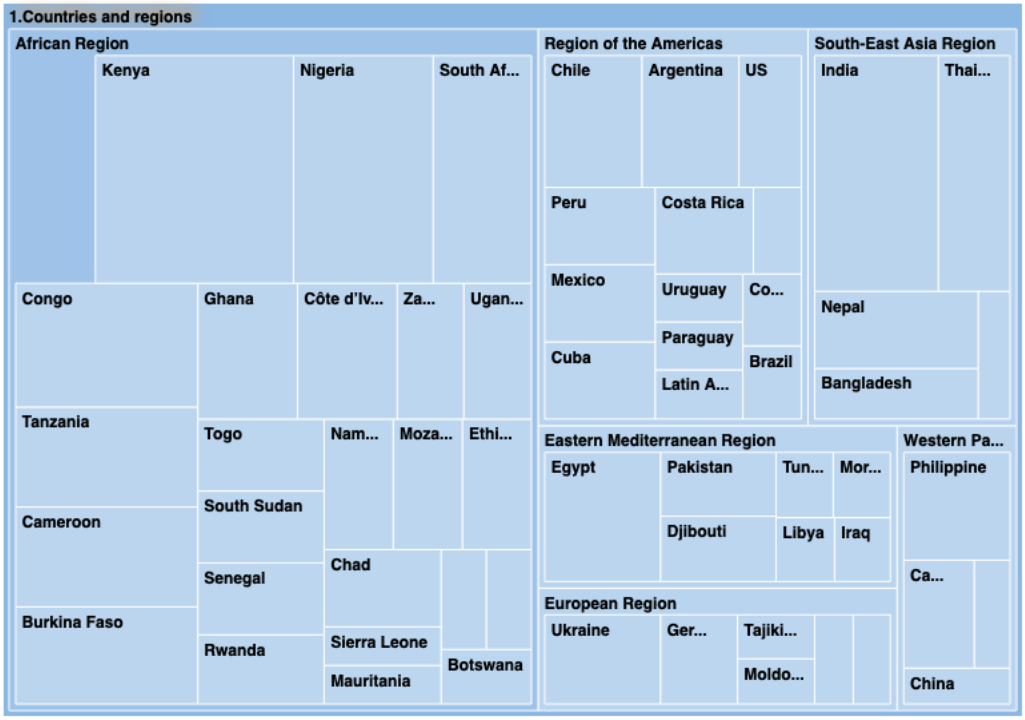
Africa			
Final meeting of the G20 Joint Finance and Health Task Force under Brazil's presidency	G20	9 September, 2024	Videoconference
11th meeting of the Intergovernmental Negotiating Body (INB)	INB (established by the World Health Assembly in 2021)	9-20 September 2024	Hybrid (Geneva, Switzerland)
World 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

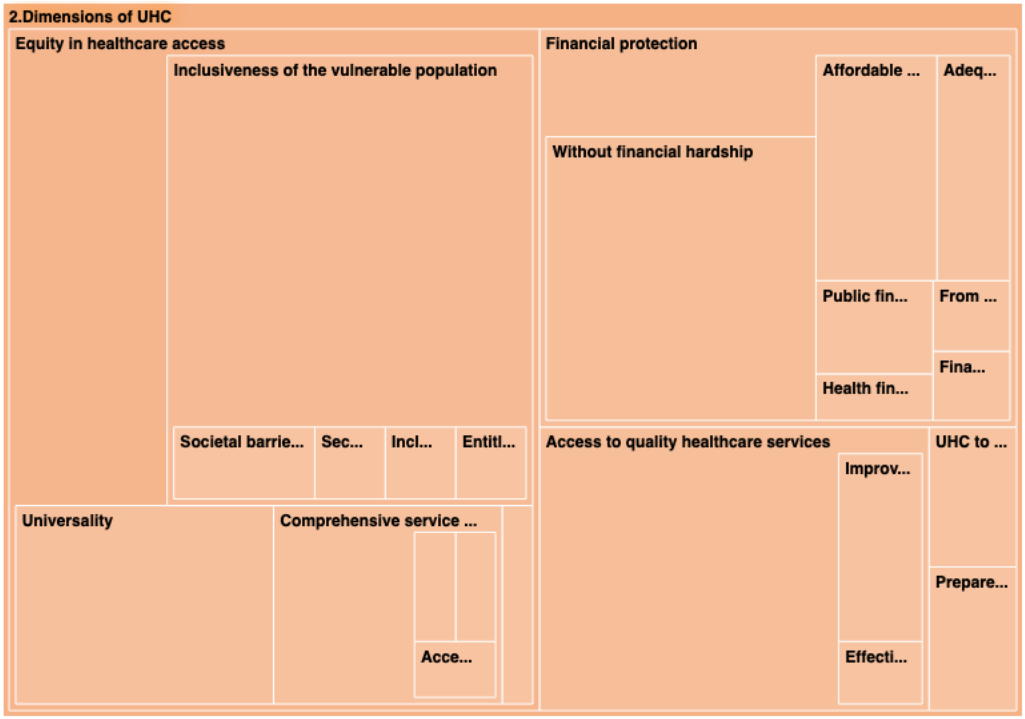
Conference (AHAIC)			
WHO Health Financing and Economic webinar	WHO	6 March, 2025	Online
The awarding of the 2024 Virchow Prize to Professor Lucy Gilson	Alliance (for Health Policy and Systems Research)	10–11 March 2025	Geneva, Switzerland
Webinar on 'How Does Population Ageing Affect Health System Financial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

Appendix B: Frequently discussed themes

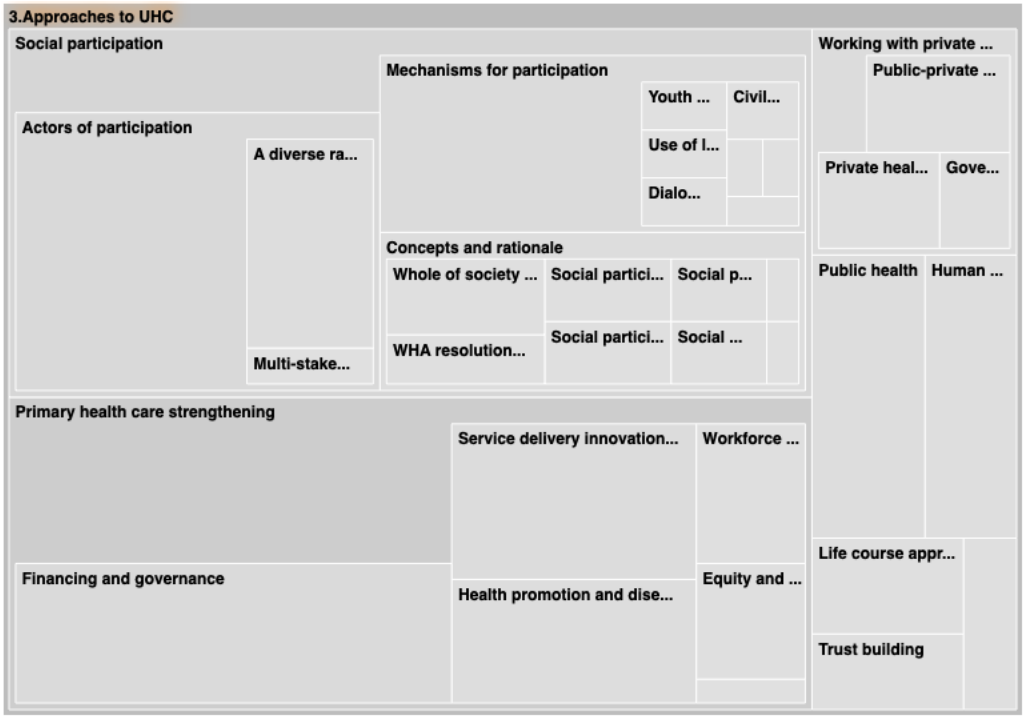
a. Countries and regions



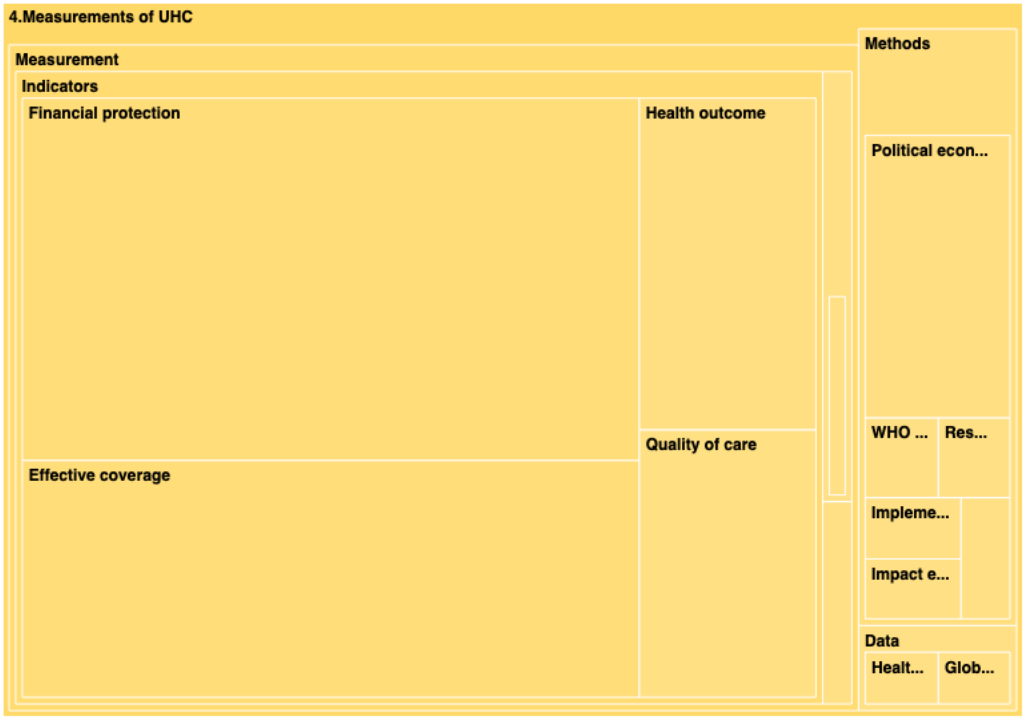
b. Dimensions of UHC



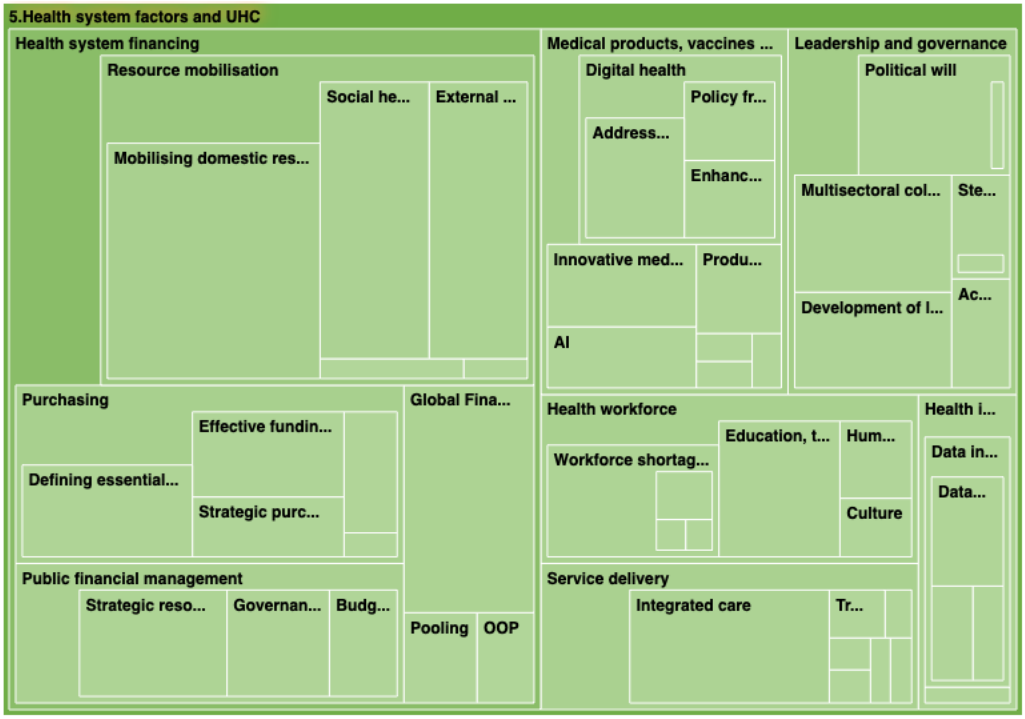
c. Approaches to UHC



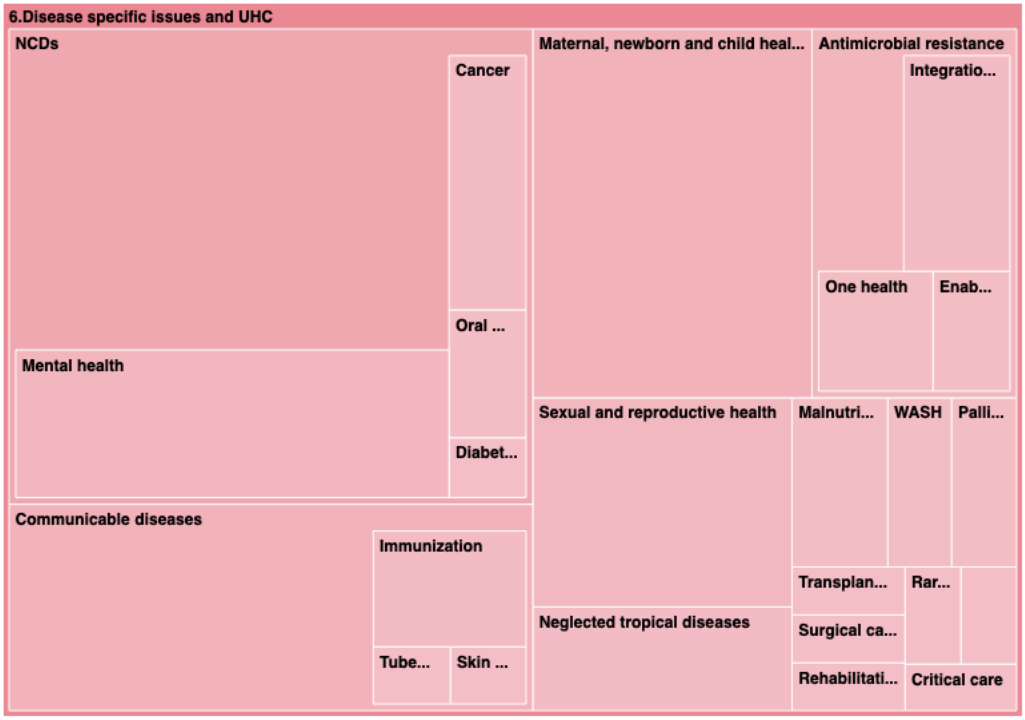
d. Measurements of UHC



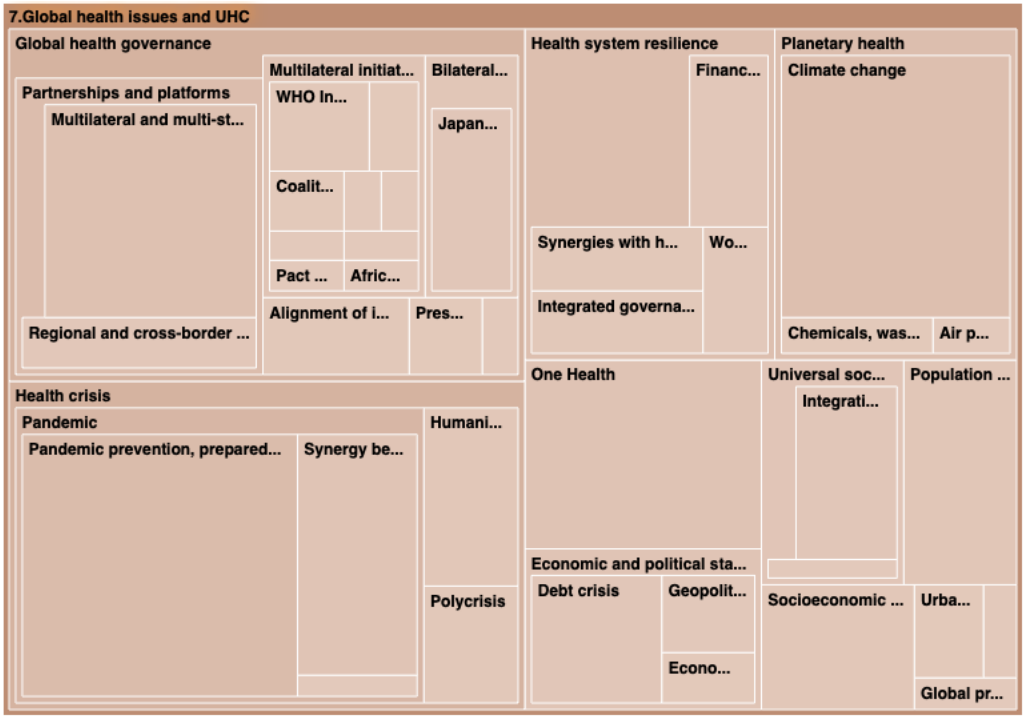
e. Health system factors and UHC



f. Disease specific issues and UHC



g. Global Health issues and UHC



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