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Items 2 and 3 of the provisional agenda*

Review of progress made towards the implementation of the Asian and Pacific Ministerial Declaration on Population and Development, as well as of the Programme of Action of the International Conference on Population and Development and the key actions for its further implementation in Asia and the Pacific

Thematic discussion on achievements, challenges, gaps and emerging issues in the implementation of the Asian and Pacific Ministerial Declaration on Population and Development, as well as of the Programme of Action of the International Conference on Population and Development and the key actions for its further implementation in Asia and the Pacific

Universal health care in Asia and the Pacific**

Summary

The present paper considers trends and characteristics of universal health coverage in Asia and the Pacific, with special reference to the indicators and targets of Sustainable Development Goal 3 on ensuring healthy lives and promoting well-being for all at all ages. As with the 2030 Agenda for Sustainable Development, the Programme of Action of the International Conference on Population and the Asian and Pacific Ministerial Declaration on Population and Development note the significance of health in making progress in other spheres of development.

Given the 2030 Agenda call to leave no one behind, as well as the people centred approaches of both the Programme of Action and the Asian and Pacific Ministerial Declaration on Population and Development, issues of equity and increasing access to health care are highlighted. This includes reference to out-of-pocket health expenditures, health-care financing and access to quality health care, as well as human resources for health, while demographic factors, including population ageing, are also considered.

The paper is intended to inform deliberations during the Seventh Asian and Pacific Population Conference to be held in Bangkok and online from 15 to 17 November 2023.

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I. Introduction

1. Health is an important element of the Programme of Action of the International Conference on Population and Development. Moreover, the Asian and Pacific Ministerial Declaration on Population and Development cites health as one of its eleven priority areas, though health has a significant bearing on several other priority areas. In order to assess progress made in implementing the Ministerial Declaration, as well as the Programme of Action in Asia and the Pacific, a voluntary survey was developed and subsequently sent to ESCAP member States. Responses used in the analysis of this paper are cited as “ESCAP 2022/23 Survey responses”,¹ while most data are taken from the Sustainable Development Goal database provided by United Nations custodian agencies and other international sources.²

2. Universal health coverage refers to people having the full range of quality health services available, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, diagnosis, treatment, rehabilitation, and palliative care across the life course.³

3. In Asia and the Pacific, notable progress has been achieved with regard to several of the Sustainable Development Goals of the 2030 Agenda for Sustainable Development. However, taken in aggregate terms, the region should have made 50 per cent of the progress needed to achieve the Goals by the midpoint towards the 2030 target year, yet the overall progress has reached only 14.4 per cent. Progress concerning Sustainable Development Goal 3, on ensuring healthy lives and promoting well-being for all at all ages has been modest. Good progress has been achieved in reducing child and maternal mortality. Yet, target 3.8, on universal health coverage, stands out as one of the handful of the 169 Sustainable Development Goals targets where there is a need to reverse trends to achieve targets. Essentially, there has been regression.

4. This puts the Asia-Pacific region in a challenging position, especially since access to health services and information is a basic universal human right. Clearly more needs to be done. The COVID-19 pandemic may well have hampered efforts to achieve universal health coverage, which, in essence, covers the full continuum of essential health services. It means that access is available to all people, when and where needed. It also implies that financial hardship should not result from accessing the aforementioned health services. This is a critical point, since protection from the potential financial burden caused by out-of-pocket payments for health services – including selling assets, spending life savings and borrowing at high interest rates – mitigates risks of people and other family members incurring catastrophic expenditures and being pushed into poverty.

¹ Additional information on the survey is available at www.unescap.org/events/2023/seventh-asian-and-pacific-population-conference. For an analysis of the responses to the survey, see ESCAP/APPC(7)/INF/2 (English only).

² ESCAP SDG Gateway. Available at <https://data.unescap.org/data> (accessed on 20 September 2023) and United Nations, Department of Economic and Social Affairs, Population Division (2022). World Population Prospects 2022, Online Edition.

³ World Health Organization (WHO), “Universal health coverage (UHC)”. Available at [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)) (accessed on 15 September 2023).

5. Now that the heaviest impacts of the COVID-19 pandemic are largely past, it is time for governments to work with other stakeholders and redouble efforts, especially in light of General Assembly Resolution A/RES/74/2, of 2019. This contains the Political Declaration of the high-level meeting on universal health coverage. Therein, Heads of State and Government and representatives of States and Governments noted that this declaration had, for the first time, a dedicated focus on universal health coverage. They reaffirmed that “health is a precondition for and an outcome and indicator of the social, economic and environmental dimensions of sustainable development and the implementation of the 2030 Agenda for Sustainable Development”. They further stated that they would “strongly recommit to achieve universal health coverage by 2030, with a view to scaling up the global effort to build a healthier world.

6. Most recently, the 2023 United Nations High-level Meeting on Universal Health Coverage took place on 21 September 2023. The related Political Declaration: “Universal Health Coverage: expanding our ambition for health and well-being in a post-COVID world” calls upon countries and stakeholders to reinvigorate progress towards delivering health for all. Among others, it also stresses the need for strong global partnerships with all relevant stakeholders to collaboratively support the efforts of Member States.

7. In moving forward to achieve universal health coverage, the COVID-19 pandemic underscored the urgent need to focus more on equity issues, for in an age of globalization characterized by increasing connectivity, it is essential that medical advances reach all populations in the timeliest way. In this context, while climate change and geopolitical instability pose additional challenges, harnessing technology and enhancing collaboration present significant opportunities.

II. An overview of progress in attaining Sustainable Development Goal 3 in Asia and the Pacific

8. Asia and the Pacific, as a region, has made mixed progress in achieving the targets of Sustainable Development Goal 3. This Goal, with target 3.8 specific to universal health coverage, is very relevant to understanding how effective health systems are and the significance of strengthening them. Goal 3, on health and well-being, has a significant impact on and is closely related to many other Sustainable Development Goals, especially Goal 1 on poverty reduction, Goal 2 on zero hunger, Goal 4 on quality education, Goal 5 on gender equality, Goal 6 on clean water and sanitation, Goal 8 on decent work and economic growth, and Goal 10 on reduced inequality. In this regard, good health is fundamental in promoting progress in attaining other Sustainable Development Goals.

9. Health is also a central priority area of the 2013 Asian and Pacific Ministerial Declaration on Population and Development, as well as the Programme of Action of the International Conference on Population and Development. Notably, with regard to the voluntary survey developed to inform the Seventh Asian and Pacific Population Conference, when asked to rank the priority areas needing further attention and action in the future from least important (1) to most important (10), 23 of the 33 countries submitting survey responses ranked health as the top priority area.⁴

⁴ ESCAP 2022/23 Survey responses.

10. The various targets under Sustainable Development Goal 3 relate to two indicators: indicator 3.8.1 captures population coverage with essential health services; indicator 3.8.2 captures financial protection and the concept that the use of health services should not lead to financial hardship. Indicator 3.8.1 is based on four broad categories of tracer interventions. The first is reproductive, maternal, newborn and child health, with indicators on family planning, pregnancy care, child immunization and child treatment. The second is infectious diseases, consisting of indicators on tuberculosis, HIV/AIDS, malaria, and water, sanitation and hygiene. The third is non-communicable diseases, where the indicators are on hypertension, diabetes and tobacco. The fourth is service capacity and access, comprising indicators on hospital access, health workforce and health security.

11. The Asia-Pacific region has made significant progress under two of the four tracer categories mentioned earlier. Specifically, the region has achieved notable improvements in targets related to maternal, newborn and child health as well as malaria; yet concerning other targets, such as on family planning, as well as tuberculosis and HIV/AIDS, progress has been very slow. In the remaining two categories (non-communicable diseases and service capacity and access), overall progress has been very far from fast enough to reach the 2030 target. This stated, certain countries have made considerable progress with regard to specific targets. For instance, in 2019, Bangladesh, Thailand and Turkmenistan had, respectively, achieved 77.4, 88.2 and 79.4 per cent of family planning demand satisfied.

12. Regarding HIV antiretroviral therapy coverage, Cambodia stands out with a figure of 83 per cent in 2020, while in four countries the rate is below 30 per cent. Considering prevalence of current tobacco use among the population aged 15 and above, in 2020, only nine countries had rates of less than 20 per cent,⁵ indicating the need for greater progress, given that tobacco is a major risk factor contributing to cardiovascular and respiratory diseases. Moreover, each year, over 8 million people die globally from tobacco use, with the majority of tobacco-related deaths occurring in low- and middle-income countries. These are frequently targets of intensive interference and marketing by the tobacco industry,⁶ posing significant challenges to improving health outcomes.

III. Current status of universal health coverage and demographic change in Asia and the Pacific

13. More than one third of the population in Asia and the Pacific is not effectively protected by a health-care scheme. This means that around 1.6 billion people are being left behind and approximately 60 per cent of workers need to cover their own health-care costs in times of illness.⁷

14. To understand the situation better, the universal health coverage service coverage index provides insight in terms of measuring progress towards Sustainable Development Goal indicator 3.8.1. In Asia and the Pacific, a broad range of experiences have been observed in this area. At the same time,

⁵ ESCAP SDG Gateway. Available at <https://data.unescap.org/data> (accessed on 20 September 2023).

⁶ WHO, "Tobacco". Available at https://www.who.int/health-topics/tobacco#tab=tab_1 (accessed on 20 September 2023).

⁷ International Labour Organization (ILO), *Extending social health protection: Accelerating progress toward universal social health protection in Asia and the Pacific* (ILO, Geneva, 2021).

attainment and progress made do not uniformly correlate to level of socioeconomic development. For instance, in addition to high-income countries, countries as diverse as Cambodia, Islamic Republic of Iran, Kazakhstan, Kyrgyzstan, Malaysia, Maldives, Mongolia, the Russian Federation, Tajikistan, Thailand, Türkiye and Viet Nam have all managed to achieve a universal health coverage service coverage index score of well over 60, while having less than 20 per cent of households spending over 10 per cent of their total expenditures or income on health.

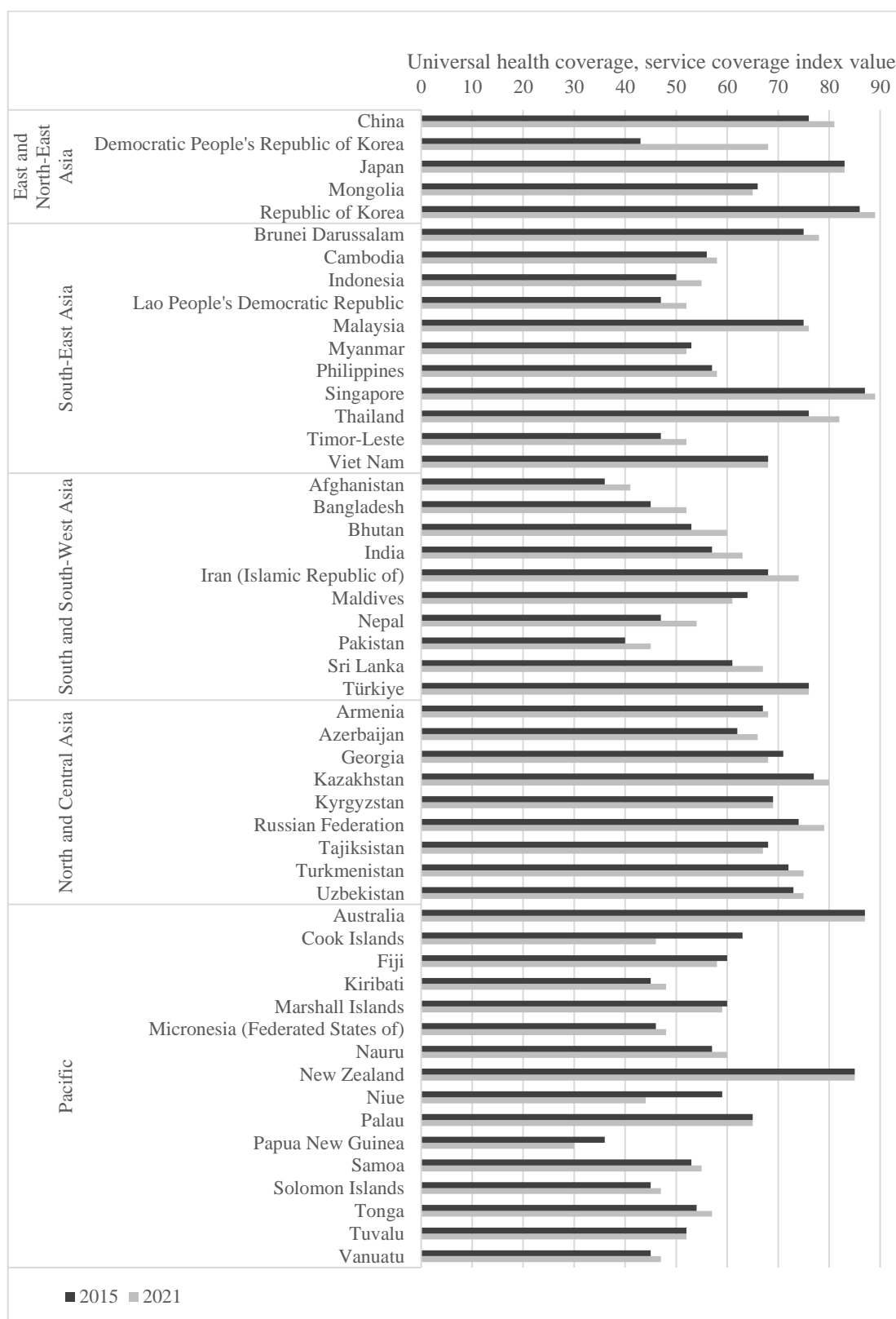
15. The Republic of Korea has made significant progress in expanding access to health care. There are currently 45 tertiary hospitals spread across the country equipped with world-class facilities and staff. Moreover, there are 40 regional emergency medical centres, 15 regional trauma centres and 14 regional cardio-cerebrovascular centres, which rapidly provide emergency care. The Republic of Korea operates its health care through the National Health Insurance system, which provides all of the country's population with appropriate levels of medical security, including mitigation of the burden of medical expenditures.⁸

16. With few exceptions, and these mainly being countries in the Pacific, the majority of countries have made progress in terms of achieving universal health coverage between 2015 and 2021, measured by the universal health coverage service coverage index (figure I).⁹

⁸ ESCAP 2022/23 Survey responses.

⁹ The indicator is measured as an index reported on a unitless scale of 0 to 100; this is computed as the geometric mean of 14 tracer health service coverage indicators. These are to be indicative of service coverage and not be interpreted as an exhaustive list of the health services or interventions required to attain universal health coverage.

Figure I
Universal health coverage service coverage index, Asia-Pacific countries, 2015 and 2021¹⁰



Source: ESCAP SDG Gateway, <https://data.unescap.org/data> (accessed on 20 September 2023).

¹⁰ Percentage of tracer indicators in the universal health coverage service coverage index with primary country data sources between 2013-2017.

17. Generally, values are highest among countries in East and North-East Asia, and North and Central Asia, while values tend to be lowest among countries in South and South-West Asia. Encouragingly, some of the most notable progress between 2015 and 2021 has been in countries in South and South-West Asia which had values below 50 or even 40 at the start of the period in question. Specifically, Afghanistan, Bangladesh, Bhutan, India, Nepal and Pakistan all had increases in coverage of over 10 per cent. Of every country in the region, the Democratic People's Republic of Korea saw the largest change, with an increase in its value for the service coverage index of almost 60 per cent between 2015 and 2021.

18. While the service coverage index sheds light on what health services are available, Sustainable Development Goal indicator 3.8.2 covers financial protection as measured by catastrophic health expenditure. This specifically considers impoverishing out-of-pocket health spending, namely when people are pushed below a poverty line as a result of household expenditures on health. When looking at the percentage of a country's adult population (aged 20–59 years old) that have household expenditures on health greater than 10 per cent of total household expenditure or income, nine countries in the region for which data are available have rates of over 10 per cent.¹¹

19. When only older adults (those aged 60 years or older) are considered, rates are over 15 per cent in 13 countries, and between 32 and 57 per cent in the 4 countries with the highest rates.¹² This latter point indicates a significant challenge, especially given that Asia and the Pacific, as a region, is experiencing population ageing at a pace faster than any other region of the world. While the number of older persons, defined as those aged 60 years or over, is estimated at 697 million people in 2023, accounting for 15 per cent of the total population of the Asia-Pacific region, by 2050, the figure is projected to be 1.3 billion people, accounting for 26 per cent of the total population.¹³

20. A significant implication of population ageing in this context is that future health-care expenditures are very likely to increase. Economic modelling yields projections of total overall health-care expenditure as a percentage of aggregate gross domestic product in the Asia-Pacific rising from 5.3 per cent in 2020 to 9.7 per cent in 2060, under the assumption of healthy ageing.¹⁴ If assumptions regarding future healthy ageing do not hold, the figure for 2060 is projected to be 13.2 per cent. The importance of following a trajectory of healthy, as opposed to standard ageing, can be highlighted by looking at country examples. The difference in projected health-care expenditure under these two scenarios is as high as 55 per cent in the Islamic

¹¹ WHO, “The Global Health Observatory”. Available at <https://www.who.int/data/gho/data/indicators> (accessed on 20 September 2023).

¹² Ibid.

¹³ United Nations, Department of Economic and Social Affairs, Population Division (2022), *World Population Prospects 2022*. Available at <https://population.un.org/wpp/> (accessed on 20 September 2023).

¹⁴ Here, a healthy ageing adjustment allows for the age profile of health-care expenditures for age groups over 50 to shift downwards by at least one five-year age group. For instance, health-care expenditures for individuals aged 50 to 55 falls to the level of that for individuals aged 45 to 50. This follows linear interpolation on the basis of remaining life expectancy.

Republic of Iran and Maldives, while it is over 40 per cent in Cambodia, China, Indonesia, Mongolia, Nepal and Tajikistan.¹⁵

21. Another consideration is the epidemiological transition from communicable diseases to non-communicable diseases (or chronic diseases), and how these tend to affect older persons more than those of other age groups. Developing countries face the largest challenges of this rising burden of disease, especially given the resource constraints they experience. This affects the quality of care being provided as well as leading to the rationing of health-care services. The regressive budget allocation in several Asia-Pacific developing countries (as discussed below) has detrimental effects on health; these include underfunded, inefficient and expensive health-care systems lead to a vicious cycle of heightened morbidity and mortality.¹⁶

22. Examples of addressing such shortcomings and promoting more inclusive access to health care exist in developing countries from the region. For instance, Samoa has two initiatives with the specific objective of providing everyone with quality people-centred health-care services and high standards of patient care in order to promote the health and well-being of the whole population. The first initiative is the Pathway for the Development of Samoa, which provides the overarching guidance for Samoa's development over the period 2021–2025. The second is the Health Sector Plan (2020–2030); this focuses more specifically on providing health care for all. Among the strategies of the Health Sector Plan are interventions to: promote better nutrition to reduce obesity rates; and improve prevention, control and management of communicable and neglected tropical diseases, including reducing the incidence of HIV infection and prevalence of progression to AIDS. Results thus far have been institutional reforms, improved immunization rates, a refocus on primary health care and improved health infrastructure. Also in the Pacific, Vanuatu has seen successes with its National Strategic Plan for Malaria Elimination 2021–2026. Through coordinated national and provincial programmes, with community support, and a phased approach starting with high incidents communities first, many of the country's islands have seen malaria eradicated. Moreover, through this strategic plan, neglected tropical diseases, such as yaws, elephantiasis, helminths, are being addressed.¹⁷

23. The scenarios noted earlier on projections of total overall health-care expenditure as a percentage of aggregate gross domestic product call for accelerating progress toward universal health coverage, along with strategies to promote a healthy ageing. Through universal health coverage, governments and other stakeholders can develop strategies and interventions to improve health outcomes from early ages and hence contribute to healthy ageing and prevent or even reverse the trends that see growth in future health spending.

24. Promoting health and well-being, along with skills development and decent jobs, means that the Asia-Pacific workforce is better prepared to contribute to socioeconomic development, while being more comprehensively covered by social protection. Alternatives include the risk of impoverishing out-of-pocket health expenditures being magnified. This is especially the case

¹⁵ Howdon, D. and S. S. Pasali “The impact of ageing on accessibility, affordability and availability of healthcare services in Asia and the Pacific”, ESCAP Working Paper (Bangkok, 2022).

¹⁶ Fazal, F. and others “The rising cost of healthcare and its contribution to the worsening disease burden in developing countries”, *Annals of Medicine and Surgery*, vol. 82 (October 2022).

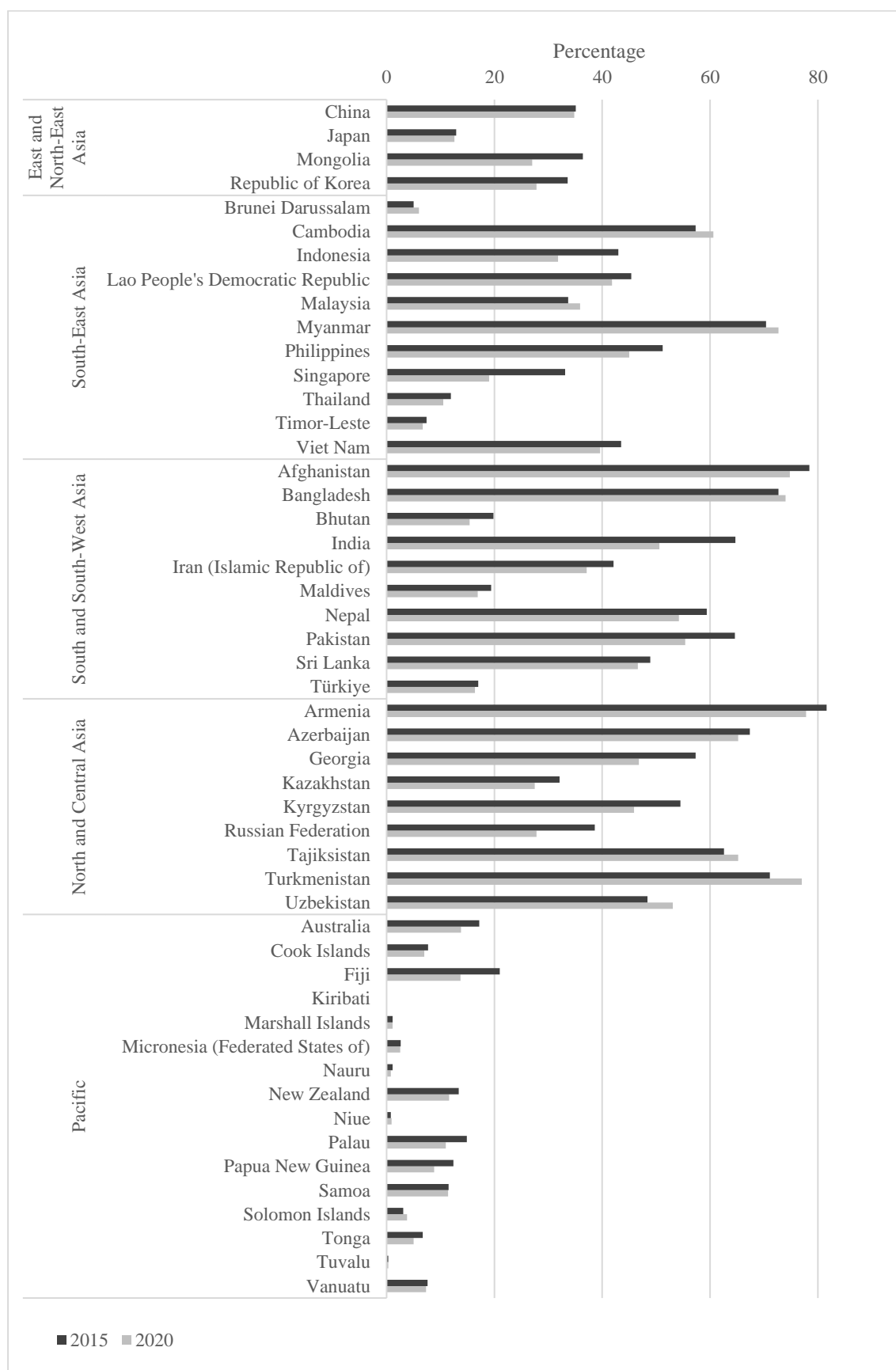
¹⁷ ESCAP 2022/23 Survey responses.

in lower-income countries, where older persons and workers in general are engaged in informal jobs and largely unprotected in the event of life contingencies and health risks.

25. A broader perspective of data at the regional, subregional and national level that considers health expenditure and the proportion of that comprising out-of-pocket expenditure sheds light on the situation across the Asia-Pacific region. In 2020, in aggregate terms, household out-of-pocket expenditure accounted for 31 per cent of total health expenditure for the Asia-Pacific region. The figure for South and South-West Asia, at 45 per cent, was considerably higher than the figures for other subregions, though in least developed countries, as a group, the figure was 70 per cent.¹⁸ Country level figures for 2015 and 2020 are shown in figure II.

¹⁸ ESCAP SDG Gateway. Available at <https://data.unescap.org/data> (accessed on 20 September 2023).

Figure II
Out-of-pocket health expenditure as a percentage of current health expenditure, Asia- Pacific countries, 2015 and 2020



Source: ESCAP SDG Gateway, <https://data.unescap.org/data> (accessed on 20 September 2023).

26. Of the 50 countries in figure II, 35 experienced relative increases in out-of-pocket health expenditure from 2015 to 2020, while in 3 there was no change. This leaves 12 countries, none of which experienced an increase similar in magnitude to the decreases of the majority of the aforementioned 35 countries. In sum, it indicates that the significant majority of countries are not making progress in reducing out-of-pocket health expenditure. The matter becomes more relevant when considering that only Bangladesh (albeit with relatively high levels of out-of-pocket expenditure), among the eight countries of the region with population of over 100 million, experienced a reduction in out-of-pocket health expenditure. The remaining seven countries (China, India, Indonesia, Japan, Pakistan, the Philippines and the Russian Federation), all with increases in out-of-pocket health expenditure, alone account for just over 75 per cent of the region's total population, highlighting the need to reverse trends and reduce out-of-pocket health expenditure, especially given their disproportionate impact on poorer households.

IV. Issues of financing, service capacity, access and equity

27. Financial protection of all people is at the core of universal health coverage as a notion. It is acknowledged by the World Health Organization (WHO) as one of the final coverage goals, while health financing policy is noted as directly affecting financial protection. The barometer in knowing when financial protection is achieved is when people are not exposed to financial hardship or compromised living standards due to making direct payments to obtain health services.

28. Health care can be financed through a variety of mechanisms. In some countries, such as Thailand, health care is predominantly financed through government schemes, through which individuals are automatically entitled to health care based on their residency. Sri Lanka also has a predominantly tax-funded public system, which has provided universal, free public health-care services, through a network of government hospitals, clinics, and health centres, for the whole population since 1951, when user fees were abolished. The country has achieved a high level of health coverage, with a well-developed public health-care system, and levels of immunisation coverage and skilled attendance at labour at almost 100 per cent. Furthermore, Sri Lanka implements health promotion initiatives through an empowerment model with active participation of communities, including with regard to tobacco, alcohol and other risk factors associated with chronic non-communicable diseases.¹⁹ Despite the aforementioned progress, the severe effects of the current economic crisis on Sri Lanka's health-care sector should be noted. This has affected the financing of the public health systems and contributed to shortages of essential medical supplies in public hospitals.²⁰

29. In other cases, the bulk of health spending is financed through compulsory health insurance schemes (either through public or private entities) linked to payment of social contributions or health insurance premiums. In addition to these modalities, a varying proportion of health-care spending consists of households' out-of-pocket payments – either as standalone payments or as part of co-payment arrangements – as well as various forms of voluntary payment schemes, such as voluntary health insurance.

¹⁹ ESCAP 2022/23 Survey responses.

²⁰ Talha Burki "Uncertainty over the future of Sri Lankan health care", *The Lancet*, vol. 400, No. 10357 (24 September 2022).

30. In general, although there are significant exceptions, the higher a country's income level is, the greater is the proportion of health-care expenditure financed through government schemes or compulsory health insurance schemes. These forms of financing tend to be more effective at promoting equitable access to health-care services, especially since they help reduce dependence on out-of-pocket health spending and the impoverishing effects this has. However, these schemes may face fiscal sustainability constraints and limit the quality of their service benefits package. In Asia and the Pacific, Brunei Darussalam, Japan and New Zealand had over 75 per cent of health expenditure covered by government and compulsory health insurance schemes in 2019. In Thailand, as well as two low-income countries (Papua New Guinea and Solomon Islands), similar patterns were found. Other notable achievements are increases of over 10 percentage points in proportions of health spending financed by government and compulsory health insurance schemes in Indonesia, Lao People's Democratic Republic, Pakistan and Singapore between 2010 and 2019.²¹

31. The transition in health financing towards enhanced financial protection entails moving from an initial stage of low public health-care spending with high out-of-pocket payments, to a later stage where government spending is higher and funds are collectively pooled across the population. To achieve broader health-care coverage, equitable access and financial protection, health systems should mainly rely on mandatory, pre-paid public funding instead of voluntary contributory methods of funding. Mandatory pooling ensures even disadvantaged individuals have access to health-care services. This accords to the principles of universal health coverage and equitable national health insurance schemes.

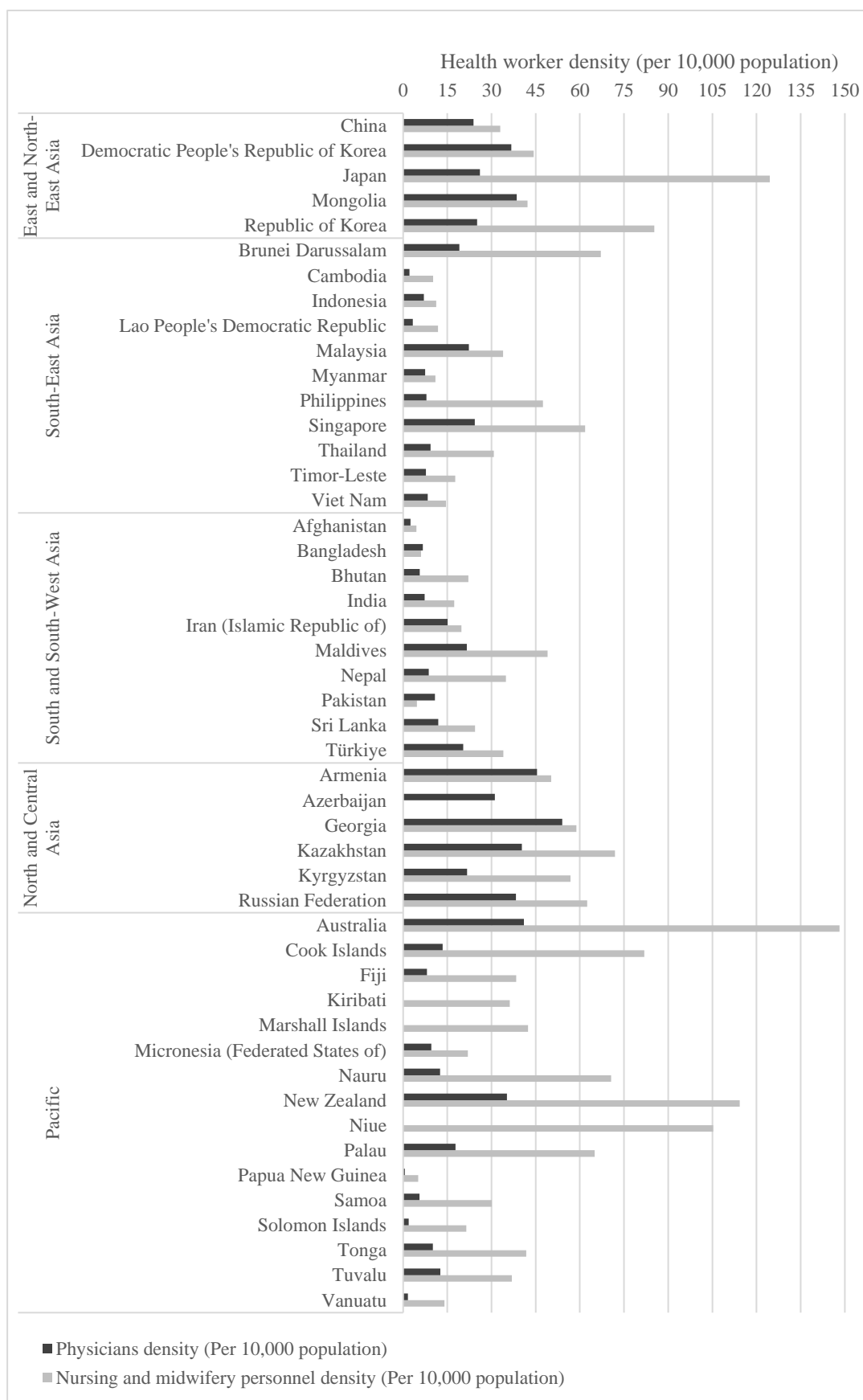
32. In addition, it should be noted that financial protection is not assured by entitlement and membership to a health coverage scheme. For this, broader changes in the health system, supported by inclusive and efficient organizations and institutional arrangements, are needed. Some common elements of successful reforms are: coordinated or pooled use of different revenue sources; progressively expanding the size of compulsory prepaid funds; and redistribution of finances from prepaid funds.²² Other critical issues are working to secure sustainable financing, whether through tax funding or contributory payments. As with pensions, this is largely contingent on a social contract in society and an understanding of the public good nature of health. To this effect, intergenerational solidarity is fundamental in the long-term success of any health system.

33. While health systems need to be well financed, they also need to have effective service capacity. Under the fourth broad category of service coverage noted earlier, indicators concerning the health workforce are important in understanding what goes on at the country level, though the aggregate figures do not provide insight into subnational issues as well as access contingent on socioeconomic and other factors, as discussed later. Figure III shows health worker density for countries across Asia and the Pacific for which data are available, with specific reference to nursing and midwifery personnel, as well as physicians.

²¹ OECD/WHO, "Health at a Glance: Asia/Pacific 2022: Measuring Progress Towards Universal Health Coverage" (OECD Publishing, Paris, 2022).

²² WHO, "Financial protection". Available at https://www.who.int/health-topics/financial-protection#tab=tab_1 (accessed on 25 September 2023).

Figure III
Health worker density: Nursing and midwifery personnel; physicians (per 10,000 population), selected Asia-Pacific countries, latest available year



Source: ESCAP SDG Gateway, <https://data.unescap.org/data> (accessed on 29 September 2023).

34. With regard to nursing and midwifery personnel, in aggregate terms, countries in the Pacific and North and Central Asia have the highest rates, with around 100 nursing and midwifery personnel per 10,000 population. The subregion with by far the lowest aggregate rate per 10,000 population is South and South-West Asia, with a figure of 17. Then for South-East Asia and East and North-East Asia, the figures are, respectively, 36 and 42. A look at specific countries shows that some perform disproportionately well relative to their income levels; these include Armenia, Democratic People's Republic of Korea, Georgia and Kyrgyzstan.²³

35. Turning to physicians, as expected, there are fewer of these than nursing and midwifery personnel. However, the differentials between subregions are far less pronounced when considering numbers of physicians. In the Pacific and North and Central Asia, the rates per 10,000 population are similar, at, respectively, 40 and 39. In East and North-East Asia, the rate is 24, while in South-East Asia and South and South-West Asia, the rates are both at 8 physicians per 10,000 population. Countries which have proportionally high rates of physicians per 10,000 population relative to income level, similar to figures for nursing and midwifery personnel, include Armenia, Azerbaijan, Democratic People's Republic of Korea, Georgia and Mongolia.²⁴

36. Some of the differences in the number of nurses and doctors working in countries in Asia and the Pacific can be explained by emigration of health personnel. Poor working conditions, low wages and lack of career development opportunities have contributed to health personnel leaving countries in Asia and the Pacific. In the voluntary national surveys, for example, Fiji and the Philippines reported on the negative effects of a "brain drain" of health workers on national health systems leading to health inequalities. Moreover, within countries, rural and remote areas are often underserved by health personnel who prefer to work in urban areas.

37. The aforementioned figures help understand differences between countries; however, subnational variations and, in particular disadvantages faced by certain groups are at the core of considering equity issues and how to put more effective health systems in place. This is crucial for the successful attainment of universal health coverage, especially in the context of "leaving no one behind" and bearing in mind the call for a people-centred approach in both the Programme of Action of the International Conference on Population and Development and the Asian and Pacific Ministerial Declaration on Population and Development. With such concepts in mind, progress can only really be made by addressing the social determinants of health. These determinants refer to the non-medical factors that influence health outcomes, in particular, the conditions in which people are born, grow, live, work and age. They, in turn, are mostly responsible for health inequities, played out as the unfair and avoidable differences in health status prevalent within and between countries.²⁵

38. Governments across the region need to face this reality and act; some are doing so and developing policies, plans and strategies to address the social determinants of health. For example, in the Philippines, the Philippine

²³ Countries with GDP per capita of under \$5,000 and over 40 nursing and midwifery personnel per 10,000 population.

²⁴ Countries with GDP per capita of under \$5,000 and over 30 physicians per 10,000 population.

²⁵ WHO, "Social determinants of health". Available at https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 (accessed on 28 September 2023).

Development Plan for 2023–2028 envisions that by 2028 all Filipinos throughout the country will enjoy longer and healthier lives, including due to assured access, with financial protection, to quality health services when needed. Specifically, the plan seeks to achieve the following health outcomes: (a) social determinants of health are improved; (b) healthy choices and behaviour are enabled; (c) access, quality, and efficiency of health care are improved; and (d) health systems are strengthened.²⁶

39. It should be noted that economic and environmental factors are also relevant determinants of health and can exacerbate inequities further. While environmental policymaking should be aligned to health objectives at all levels, from local to global, in effect, policy inconsistencies and episodic approaches inhibit efficient, cost-effective and expedient anticipatory action on environment-health risks.²⁷ In rural and other underserved areas, drivers of poverty also drive ill health. Health systems are often insufficiently equipped to respond to the needs of populations in underserved areas, contributing to health inequities. This also applies to specific groups of people that may be at a disadvantage.

40. Inequities are often hard to note given existing data collection mechanisms that tend to focus more on aggregate levels. In this context, only by looking beyond aggregate data that may mask inequalities within countries can disparities be better understood and addressed. For instance, coverage of sexual, reproductive, maternal, child and adolescent health services is generally greater among those who are richer, more educated, and living in urban areas, particularly in low-income countries.²⁸ Furthermore, people living with HIV and people from key populations,²⁹ often face many barriers in accessing health insurance schemes, in addition to there being limited coverage of prevention services.

41. Legislation may exist to allow people from key populations to access insurance, yet in practice there may face stigma and discrimination, as well as barriers such as complicated administrative processes, requirements for documentation that people particularly from mobile populations may not have; co-payments or facility fees; and weak data privacy systems.³⁰ Migrants are also commonly at a disadvantage in terms of access to health-care services, especially in the case of irregular migration and circumstances such as statelessness. This includes children who accompany parents that migrate.³¹ In all these cases, barrier in access to health-care services are similar to those faced by people living with HIV and people from key populations.

²⁶ ESCAP 2022/23 Survey responses.

²⁷ ESCAP and IISD, “Operationalizing the Environment-Health Nexus in Asia and the Pacific: A Policy Guide on Opportunities for Enhancing Health, Biodiversity, Food System and Climate Action”, ESCAP Policy Brief (Bangkok, 2022).

²⁸ WHO, “Universal health coverage (UHC)”. Available at [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)) (accessed on 20 September 2023).

²⁹ Sex workers, gay men and other men who have sex with men, transgender people, people who inject drugs and people in prison.

³⁰ UNAIDS, “Key populations are being left behind in universal health coverage: landscape review of health insurance schemes”. Available at <https://www.unaids.org/en/resources/documents/2022/key-populations-universal-health-coverage-asia-pacific> (accessed on 20 September 2023).

³¹ *Asia-Pacific Migration Report 2020: Assessing Implementation of the Global Compact for Migration* (United Nations publication, 2020).

42. In moving forward, and in many ways building on good practices developed during the height of the COVID-19 pandemic, information and communication technology hold much promise to increase equitable access to health care. In the Russian Federation, initiatives have recently been developed to improve the efficiency of the health system through the provision of digital services, including telemedicine technologies, electronic doctor appointments and electronic prescriptions. This works to enhance a variety of processes such as vaccination, medical examinations, preventive medical examinations, planned hospitalization and telemedicine consultations.³²

43. While technology has great potential, it is important to consider the needs of persons with disabilities and older persons in terms of accessibility. Issues of privacy, along with getting feedback from diverse groups on what technology is appropriate, also need to be considered. Such considerations adhere to the rights-based and whole-of-society approaches of the Programme of Action of the International Conference on Population, as well as the Asian and Pacific Ministerial Declaration on Population and Development.

V. Conclusions and recommendations

44. In aggregate terms, Asia and the Pacific, despite progress in certain areas, such as with regard to maternal, newborn and child health, is off track to achieve many of the targets under Sustainable Development Goal 3. Among those targets in which progress is most lacking is target 3.8 on universal health coverage, a cornerstone to ensuring that all people have equitable access to the full continuum of essential health services, without facing financial hardship such as that brought about by catastrophic out-of-pocket expenditure on health.

45. At the same time, there are several success stories at the country level, including with regard to expanding health-care coverage and attaining good levels of human resources for health, such as relative numbers of nurses, midwives and physicians. Yet, more needs to be done to achieve universal coverage across the Asian and Pacific region. In particular, countries should take into consideration the urgent need to strengthen national health systems so that they are better resourced, more efficient and more equitable. It is also vital that such systems are responsive to the needs of all population groups, especially those at greatest disadvantage, while being versatile to cope with both demographic and epidemiological changes, along with having the capacity to adapt to the impacts of climate change and disasters.

46. In order for universal health coverage to reach all people, there should be a move from health systems being designed around diseases and institutions to such systems designed with people at the fore. This is essentially which primary health care entails by considering a whole-of-society approach to health that aims to ensure the highest possible level of health and well-being along with equitable distribution. It is achieved by focusing on people's needs at the earliest possible along the continuum going from health promotion and disease prevention to treatment, rehabilitation and palliative care. It also aims to be as close as feasible to people's everyday environment.³³

47. From a perspective of leaving no one behind, much needs to be done to increase access to health care in rural, remote and underserved areas, including urban slums. This is largely contingent on investments in infrastructure and

³² ESCAP 2022/23 Survey responses.

³³ WHO, "Primary health care". Available at <https://www.who.int/news-room/fact-sheets/detail/primary-health-care> (accessed on 10 October 2023).

human resources in such places, along with making health care accessible to all. A similar approach is necessary with diverse population groups who may face barriers in access, with attention to awareness raising, including by means of the media, capacity development and innovative ways to improve equitable accessibility of services, such as through use of information and communications technology. As noted, people living with HIV and people from key populations, as well as migrants, are often excluded from health care. Other groups of people facing barriers are older persons and persons with disabilities, while women, youth and minority groups may also face barriers, including stigma and discrimination. Areas of particular concern (as discussed in information paper ESCAP/APPC(7)/INF/3) on sexual and reproductive health and reproductive rights.

48. As indicated, technological innovations can help attain greater equity and enhance progress in achieving universal health care. In particular, patients, health-care personnel and the community can benefit from digital health modalities, such as telemedicine. These can facilitate the exchange of information on diagnosis, treatment and prevention. They can also enhance research and continuing education of providers of health care. Technology can also enhance information systems and the way in which data are collected and analysed, allowing for more effective monitoring of the health-related Sustainable Development Goals, including target 3.8 on universal health coverage. More robust health information systems allow for more effective policymaking. In this regard comprehensive household expenditure surveys and effective civil registration and vital statistics are needed to produce timely and high-quality data.

49. Given population ageing across the region and likely inflationary pressure on the cost of health care, it is essential that policies and initiatives both use a life course approach and promote healthy ageing.³⁴ This includes enhancing lifelong learning on health, along with raising awareness of the four main risk factors of non-communicable diseases, namely unhealthy diets, physical inactivity, tobacco use and harmful use of alcohol. It also calls for multisectoral approaches which address the social determinants of health so that all segments of society have the opportunities to be empowered in the process of healthy ageing.

50. In order to create enabling environments to promote health and more efficaciously support implementation of the Asian and Pacific Ministerial Declaration in settings from the community to the national and regional levels, greater collaboration is needed in sharing good practices and lessons learnt, as well as capacity development. This involves political will and governments partnering with civil society, the private sector and others to both adequately fund health systems and deliver health services effectively to all members of society. With such commitments, along with cohesion brought about by social contracts and intergenerational solidarity, the reality of universal health coverage and equitable access to health care, will make the Asia-Pacific region one in which widespread well-being prevails.

51. The present document is intended to inform deliberations during the Seventh Asian and Pacific Population Conference to be held in Bangkok and online from 15 to 17 November 2023.

³⁴ On the United Nations Decade of Healthy Ageing (2021–2030), see General Assembly resolution 75/131.