JICA Global Agenda for

No. 06 Health

Cluster Strategy on Financial Protection in Health

toward a society where healthcare costs are financed equitably so that the poor and vulnerable can use quality health services without financial hardship

Executive Summary

Japan International Cooperation Agency (JICA) works toward the achievement of the Sustainable Development Goals (SDGs).

2026.1

1. Purpose and Overview of the Cluster

1.1 Purpose of the cluster

This cluster aims to contribute to the achievement of Universal Health Coverage (UHC), which ensures that all people receive health services they need without suffering financial hardship, even in times of public health emergencies – the goal of the JICA Global Agenda (JGA) for Health. Both health service delivery and financial protection in health need to be optimized to achieve UHC and this cluster targets the latter, aiming to ensure that all people, including the poor and vulnerable, do not suffer financial hardship from the use of health services, that is, they can have access to health services without excessive out-of-pocket spending. Contributing to UHC through this cluster is directly linked to human security, aiming for a society where everyone can live in dignity, free from fear and want.

1.2 Overview of the cluster

Health financing systems in low and middle- income countries often have weak capacity of raising revenue from public funds, such as tax and compulsory health insurance premiums. As a result, they depend too much on out-of-pocket payment, which especially makes the poor and vulnerable impoverished and reluctant to access health services. Pools of health funds are excessively fragmented as many health financing systems have been developed without strong coordination among national and local governments as well as development partners, which leads to inefficiency. Health benefit packages are sometimes not determined in consideration of cost-effectiveness and population needs on health technologies. Payment mechanisms for health service providers are not often designed to provide incentives to contain costs and improve quality of health services.

In order to address these issues, the cluster sets up a scenario for achieving the immediate and intermediate outcomes, based on the three key functions of health financing: (1) “revenue raising” to collect funds necessary for health service provision, (2) “pooling revenues” to consolidate those funds at an appropriate scale, and (3) “purchasing services”, along with strengthening governance as the foundation for those three functions.

2. Current Development Issues and Development Cooperation Approaches

2.1 Current status of development issues

The 2025 UHC Global Monitoring Report[1] reported that while Universal Health Coverage (UHC) has advanced in both service coverage and financial protection since 2000, progress has slowed during the SDG era. As of 2023, an estimated 4.6 billion people still lack access to essential health services, and in 2022, 2.1 billion people experienced financial hardship due to out-of-pocket health spending, highlighting the urgent need for renewed action toward achieving UHC. Globally, the proportion of people experiencing financial hardship decreased from 34% in 2000 to 26% in 2022. However, among the poorest population, the share facing financial hardship increased from 64% in 2000 to 74% in 2022, indicating a worsening situation.

In addition, the global aging and the rapid increase in non-communicable diseases are creating more financial burden on many countries. Health financing systems are needed to control cost of health care services, and to strengthen service delivery system that includes disease prevention and health promotion.

2.2 Development cooperation approaches

In 2005, the concept of Universal Coverage (UC) was proposed at the World Health Assembly, which emphasizes the importance of protection against financial risks. The World Health Report 2010[2] published by WHO featured health financing and used the term UHC in addition to UC, emphasizing the importance of health financing and the need to remove financial barriers, which led directly to the current global efforts toward UHC. Subsequently, in the Sustainable Development Goals (SDGs), the achievement of UHC was set as Target 3.8 under Goal 3 (Good Health and Well-being). The Government of Japan has included mainstreaming UHC as one of the actions in “Japan’s Strategy on Global Health Diplomacy” formulated in 2013. More recently, Japan set achieving more resilient, equitable, and sustainable UHC, which is needed in the post-COVID-19 era, as one of the policy goals of “Global Health Strategy” formulated in 2022. JICA co-hosted the UHC Forum 2017 in Tokyo with the Japanese government and international organizations, and has continued to organize side events to promote discussion on concrete measures to achieve UHC by 2030

[1] WHO・World Bank. (2025). Tracking Universal Health Coverage: 2025 Global monitoring report. https://www.who.int/publications/i/item/9789240117815

[2] WHO.(2010). The World Health Report 2010: Health Systems Financing - The Path to Universal Coverage. https://www.who.int/publications/i/item/9789241564021

since TICAD V in 2013.

3. Cluster Scenario and Rationale

3.1 Scenario

The cluster aims to ensure that all people, including the poor and vulnerable, do not suffer financial hardship from the use of health services, and sets out a scenario as a theory of change to be achieved through improvements in each of the three phases of revenue raising, pooling revenues, and purchasing services along with strengthening governance as the foundation for these three functions (see attached figure).

Revenue raising: Develop a feasible plan to raise financial resources for health care, by estimating the health services to be provided and the budget needed, forecasting economic growth and tax collection capacity, and allocate the resources for the implementation of the plan. Under the plan, the government will collect taxes and health insurance premiums according to the people's ability to pay, and will work on internal and external advocacy to increase the health budget and to secure health financial resources.

Pooling revenues: Extend the effective size of the funding pools by integrating fragmented small-sized pools into larger pools, so that funds of the pools are collected from diverse sources such as urban areas and rural areas, employers and employees of governments, private companies as well as self-employed. Such integration promotes cross-subsidy between rich and poor as well as healthy and sick, and increases financial stability of the pools.

Purchasing services: Allocate the pooled funds to health service providers strategically based on needs of population and performance of the service providers, considering: (1) *what to buy?* – which health services and medicines are purchased to respond to needs of population, (2) *from whom to buy?* – from which providers health services are purchased to ensure quality of services, and (3) *how to buy?* – how will providers be paid to incentivize to provide quality services in an efficient and sustainable manner.

3.2 Rationale and evidence for the scenario

The three main functions of health financing and actions under each function have been widely used to achieve UHC, especially since they were shown and recommended in the

WHO's 2010 World Health Report mentioned above, and Kutzin's 2013 article in the Bulletin of the World Health Organization.

4. Basic Policy for Cluster Development

4.1 Basic policy for scenario development

While the main focus of this cluster is to improve health financing systems, provision of health services necessary to achieve UHC should also be considered to some extent when selecting countries to be supported. While few countries have none of the three main functions of health financing mentioned above as a system, “revenue raising” is fundamentally necessary as a prerequisite for the other two among the three main functions. It is important to formulate and implement appropriate health financing plans (including improvement of the operation of existing systems) and also important to mobilize domestic resources. Therefore, JICA will consider the possibility of combining technical cooperation for both: 1) the formulation and implementation of health financing plans; and 2) improvement of institutional operation with financial cooperation for promoting domestic resource mobilization. In doing so, JICA will consider the use of financial cooperation as a leverage to support the reform and implementation of related policies and measures, and will seek collaboration with other development partners to better leverage domestic resource mobilization. As a prerequisite, it is important to build capacity in the necessary aspects through JICA’s technical cooperation and technical assistance from other development partners. Such necessary aspects for capacity building include, for example, promotion of domestic resource mobilization; integration of fragmented pools; and establishment of a mechanism for determining health services under a benefit package based on cost-effectiveness and prioritization.

JICA has a history of cooperation in health financing with only about 10 years of experience, and has so far cooperated with Thailand, Cambodia, Vietnam, the Philippines, Kenya, Senegal, Sudan, South Africa, Côte d'Ivoire, Egypt, and Morocco, building relationships of trust. In addition to low-income and lower- middle-income countries, there is a need in upper-middle-income countries for Japan's experience and expertise in maintaining national health insurance of more than 60 years. In the future, when developing cooperation in countries other than those where JICA has implemented cooperation, JICA will assess political commitments; and while confirming that there are certain assets of JICA's past cooperation in the health sector (service provision), JICA will start with policy dialogue-type technical cooperation to build trust with a particular country related to the issue of health financing systems, and then consider developing specific cooperation based on the progress of that

country's health financing systems. In assessing the progress of the health financing system of a particular country, it is necessary to overview both the health service provision and health financing systems in that country. The level of progress in health financing systems does not necessarily correspond to the level of economic development, and the economic level is not a factor to determine the target countries, but an overview of the countries by income level is shown below as a rough guide.

Country income groups **(World Bank Classification[3])**	Issues in health service provision	Health financing systems	Cooperation menu
Low income countries (GNI per capita: less than USD1,135) *Sudan, etc.	Basic service provision systems are not in place. The impact of non-communicable diseases and access to services are also major challenges.	Most of the population is not covered. Although health spending accounts for a small percentage of household expenditures, the impact of impoverishment caused by health spending is significant.	**Revenue raising:** Health financing planning and advocacy, piloting health financing systems (Technical Cooperation). Securing tax revenue sources, financial support to health financing for the poor and vulnerable (Finance and Investment Cooperation) **Pooling revenues:** Establishment and operational improvement of pools of financial resources for health financing systems (for the poor and vulnerable) (Technical Cooperation, Finance and Investment Cooperation) **Purchasing services:** Priority provision of basic health services. Development of ICT system for health financing systems (Technical Cooperation, Finance and Investment Cooperation)
Lower-middle income countries (GNI per capita: USD1,336 - USD4,495) *Cambodia, Vietnam, Philippines, Kenya, Senegal, Côte d'Ivoire, Egypt, Morocco, etc.	Inequality within the country in basic service provision systems exists in the country. A wider range of service provision including non-communicable disease control is needed.	Less coverage for the non-poor informal sector. Health spending as a percentage of household expenditure is high, but the impact of impoverishment due to health spending is reduced.	**Revenue raising:** Health financing planning and advocacy (Technical Cooperation), identification and expansion of health financing systems coverage (Technical Cooperation, Finance and Investment Cooperation), expansion of financial resources and financial support (Finance and Investment Cooperation) **Pooling revenues:** Promoting the integration of financial resource pooling (Technical Cooperation, Finance and Investment Cooperation) **Purchasing services:** Introduction of health technology assessment

[3] The World Bank income level classification is based on the 2026 classification based on 2024 per capita GNI.

			(Technical Cooperation), provider payment methods improvement (Technical Cooperation, Finance and Investment Cooperation), accreditation system for health facilities (Technical Cooperation, Finance and Investment Cooperation), development of ICT system for health financing systems (Technical Cooperation, Finance and Investment Cooperation)
Upper-middle income countries (GNI per capita: USD4,496 – UDS13,935) *Thailand, South Africa, etc.	Basic services are provided almost nationwide, more advanced services are needed.	Much of the population is covered but protection from financial risks and sustainability is insufficient.	**Revenue raising, Pooling revenues, Purchasing services:** Expansion and improvement of health financing systems (long-term care, cost control, etc.) (Technical Cooperation, Finance and Investment Cooperation). Promotion of South-South cooperation (Technical Cooperation)

JICA actively promotes digital transformation (DX) initiatives to improve the quality and efficiency of health financing. Specifically, the cluster aims to improve the transparency and timeliness of health financing systems by building and operating a database which will promote the identification of the target population for health financing systems based on a national ID system, the adjustment of taxes and health insurance premiums according to income and assets, and electronically filing insurance claims. Through data analysis, JICA will also aim to gain insights that can be used to improve health financing systems and support policymaking. In addition, to improve the efficiency of health financing and ensure its sustainability, linkages with the “Strengthening the national fiscal foundation” cluster of the JICA Global Agenda for Public Finance and Financial Systems is encouraged.

4.2 Efforts to maximize cooperation impact and achieve final outcome

Section 4.1 described JICA's policy, institutional, operational and technical support. However, since the scope achievement by JICA's efforts alone is limited, JICA aims to maximize development impact by cooperating with relevant ministries and agencies in the partner country, including the Ministry of Health, Ministry of Finance, National Tax Agency, and Ministry of Internal Affairs; development finance institutions such as the WB, ADB, IDB, AfDB; specialized agencies such as the WHO; and various external actors, including domestic and foreign research institutions.

5. Cluster Objectives and Monitoring Framework

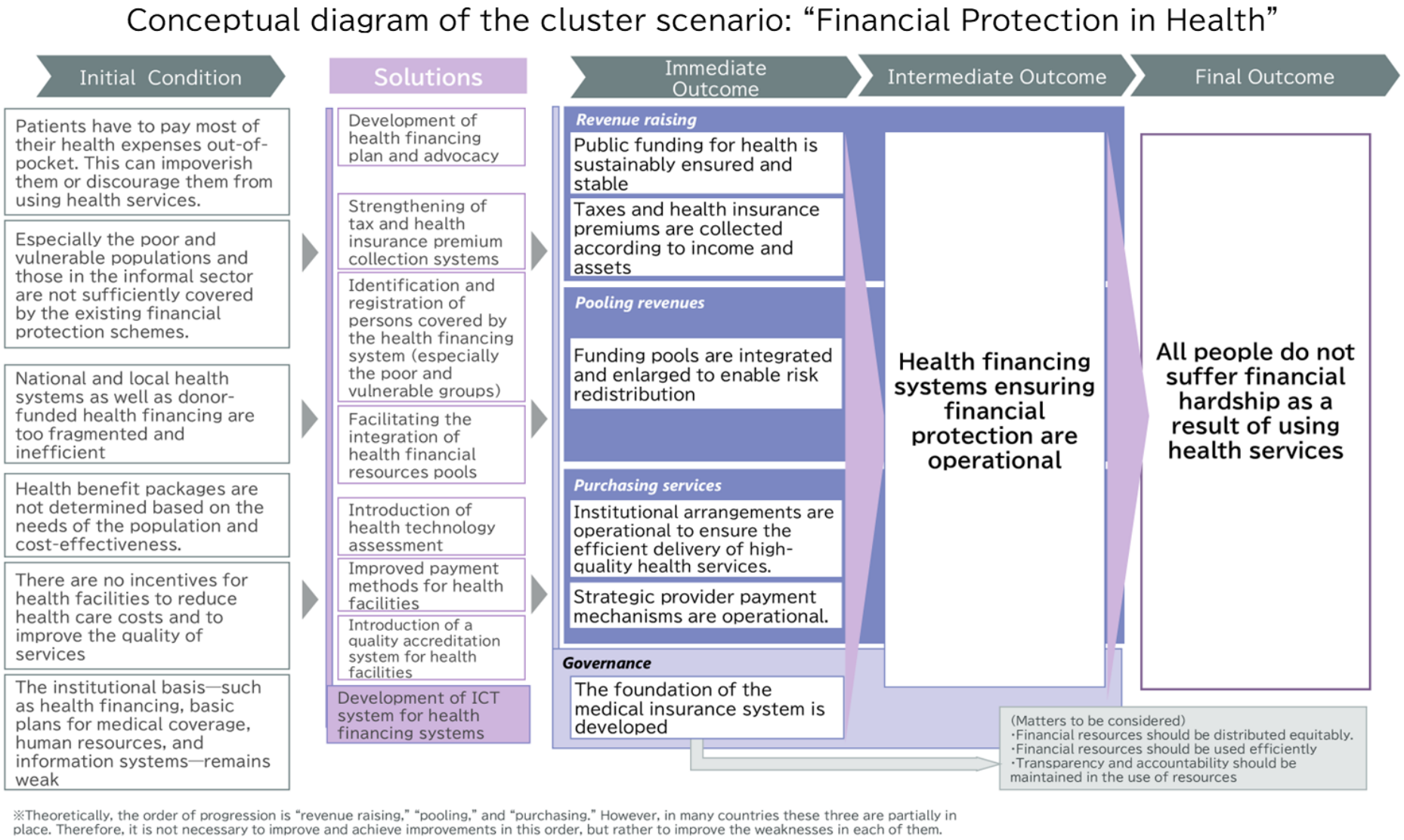
5.1 Cluster outcome targets and indicators

The cluster evaluates countries where technical cooperation and finance and investment cooperation (DPL and RBL) have been implemented to strengthen health financing systems that ensure financial protection. Outcomes and indicators are organized hierarchically: the ultimate and intermediate outcomes are targets to be achieved through collaboration with partner countries and other development partners, while overall improvements in health financing systems are assessed using common indicators. Immediate and supplementary indicators measure JICA's intervention results based on relevant indicators for each project. Although quantitative assessment using indicators is the primary approach, qualitative evaluation through narratives on initiatives and achievements is also conducted.

Final outcome (2030)	"All people do not suffer financial hardship as a result of using health services" **Indicator** 1. Proportion of the population with financial hardship in health [SDG Target Indicator 3.8.2].
Intermediate outcomes (2030)	"Health financing systems ensuring financial protection are operational" 1. Reduce the share of out-of-pocket payments in total health expenditure. 2. Increase population coverage under health financing schemes. 3. Expand the range of services covered by health financing schemes. **Indicators** 1-1. Government health expenditure per capita 1-2. Share of out-of-pocket payments in current health expenditure 2-1. Percentage and number of populations covered by health financing schemes 2-2. Number of poor and vulnerable people covered by health financing schemes 3. UHC Service Coverage Index [SDG Target Indicator 3.8.1]
Immediate outcomes	■ Revenue raising 1. Public health budgets are secured in a stable manner. 2. Health insurance premiums are collected according to income and assets. **Indicators** 1-1. Number of countries with medium- to long-term health financing plans (e.g., health financing strategy, fiscal space analysis) in place. 1-2. Number of countries that improved execution and allocation of health financing budgets. 2. Number of countries with operational health insurance contribution collection systems. **Supplementary Indicators** • Government health spending as a share of GDP. • Government health spending as a share of total government expenditure. • Amount of health insurance premiums collected (including government

	subsidies). ■ Pooling revenues 1. Expand and integrate health financing pools to strengthen risk-sharing functions. **Indicators** 1-1. Number of countries that expanded or integrated health financing pools. 1-2. Number of countries that strengthened enrollment and identification of beneficiaries of health financing systems. **Supplementary Indicator** • Number of individuals enrolled in health financing schemes with direct support from JICA. ■ Purchasing services 1. Institutional arrangements are operational to ensure the efficient delivery of high-quality health services. 2. Strategic provider payment mechanisms are implemented. **Indicators** 1-1. Number of countries with operational quality accreditation systems for health facilities covered by health financing schemes. 1-2. Number of countries that designed benefit packages based on health technology assessment (HTA). 2-1. Number of countries that strengthened claims and payment systems for provider reimbursement. 2-2. Number of countries that institutionalized strategic purchasing in provider payment mechanisms. **Supplementary Indicators** • Number of health facilities accredited under quality assurance systems. • Total amount of claims and payments processed under provider payment systems. ■ Governance 1. The foundation of the health financing system is developed. **Indicators** 1-1. Number of countries with health financing policy frameworks (e.g., UHC roadmap, health financing policy) in place 1-2. Number of countries with implementation capacity (organizations and human resources) for health financing systems

Attachment: Conceptual diagram of the cluster scenario



※Theoretically, the order of progression is “revenue raising,” “pooling,” and “purchasing.” However, in many countries these three are partially in place. Therefore, it is not necessary to improve and achieve improvements in this order, but rather to improve the weaknesses in each of them.