

WHY THIS MATTERS?

Universal health coverage (UHC) means everyone can access essential, quality health services without financial hardship.

Financial hardship due to health arises when health-related out-of-pocket (OOP) payments push households into poverty or further into poverty, or force them to cut back on basic needs such as food and housing. Financial protection, aimed at reducing financial hardship due to health, is central to UHC.

In March 2025, the Inter-Agency and Expert Group on SDG Indicators endorsed a revised definition of the Sustainable Development Goals (SDG) 3.8.2 to a more sensitive methodology for measuring financial hardship due to OOP health spending, particularly in capturing challenges among poor and vulnerable households.

WHAT CHANGED?

Financial hardship indicator is now defined as the proportion of the population with positive OOP health spending exceeding 40% of a household's discretionary budget, which is total consumption net of the cost of basic needs, measured by the societal poverty line (SPL).

The SPL is used as a proxy of the cost of basic needs, corresponding to whichever is greater of the following: (1) the international poverty line (US\$2.15/day), or (2) a relative threshold set at US\$1.15 plus 50% of median household consumption (net of OOP), using 2017 PPPs. It is a standardized calculation, allowing for cross-country comparisons.

This approach counts any OOP spending among households below the poverty line as hardship and combines impoverishing and large OOP payments into a single measure. It better reflects the challenges at lower socio-economic levels and has a clearer alignment with SDG 1 (poverty) and SDG 10 (inequality).

WHAT ARE THE KEY FINDINGS IN THE WPR?

Financial hardship in the Western Pacific declined from 40% in 2000 to 27% in 2022. Despite overall progress, 596 million (27%) people still face financial hardship and 840 million (38%) lack essential service coverage as of 2022 (Fig.1).

The reductions are largely due to impoverishing out-of-pocket (OOP) health spending, with a decrease from 35% in 2000 to 20% in 2022. However, large OOP payments due to health are rising among non-poor households (from 4% to 7%), and hardship remains concentrated among the poorest and rural households, with more than 50% of the poorest households incurring financial hardship. Multigenerational households also have less capacity to absorb unexpected health costs, with 30-45% struggling with hardship.

Country progress varies (Fig.2): In the latest year of data available, the incidence of impoverishing OOP health spending across non-Pacific Island Countries (non-PICs) ranges from 4.5% in Republic of Korea to 30% in the Philippines. In PICs, impoverishing OOP health spending ranges from less than 1% (e.g., Nauru and Tuvalu) to over 10% in Samoa, the Marshall Islands, and Vanuatu. Large OOP health spending is generally lower (or less than 0.5% in PICs) but remains a considerable burden in several non-PIC middle-income settings.

Fig.1: Impoverishing health spending shows more rapid improvements relative to the rest of the world. Meanwhile, large OOP spending exhibits consistent increase

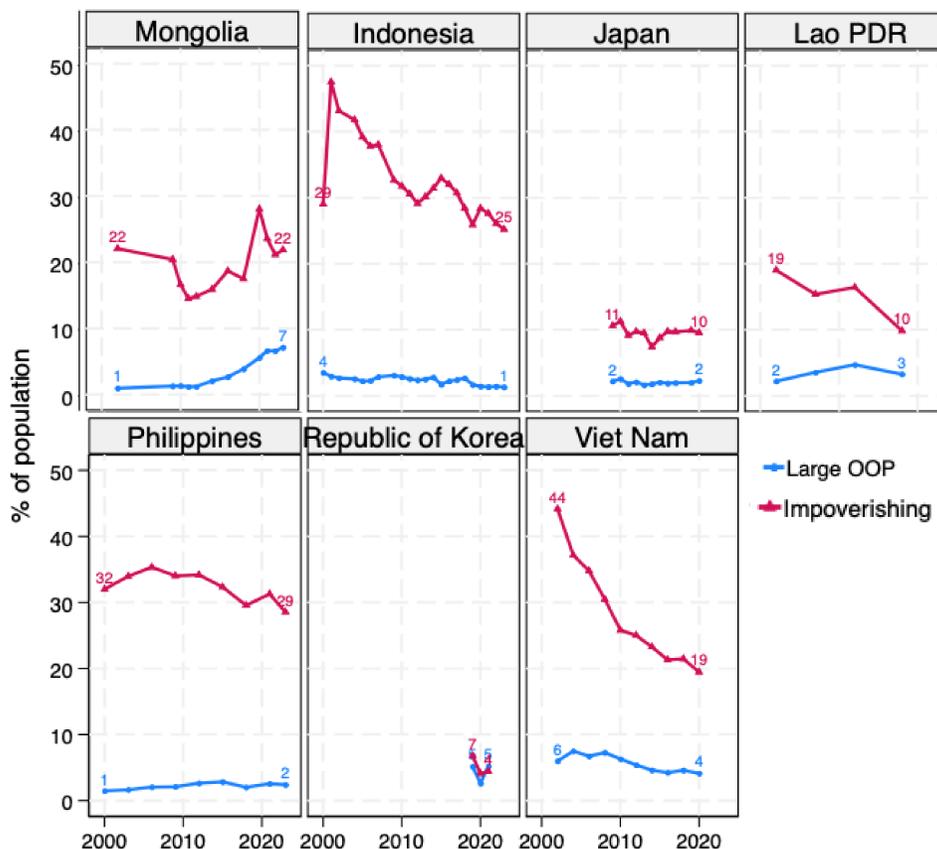
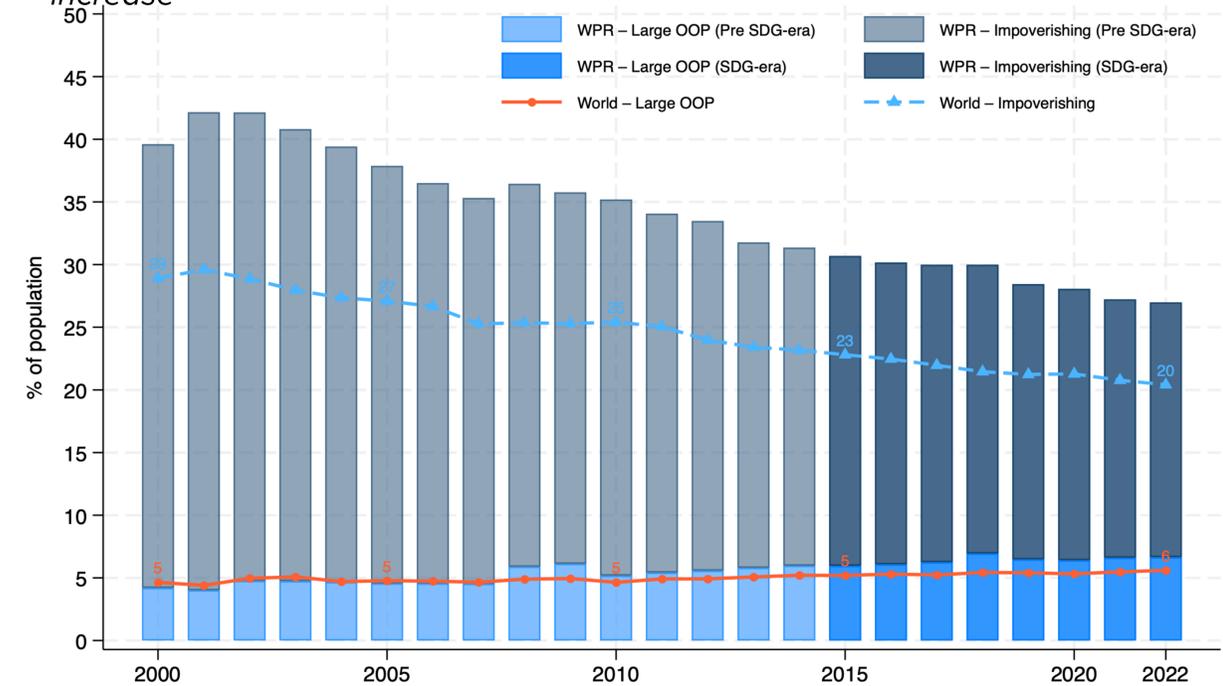
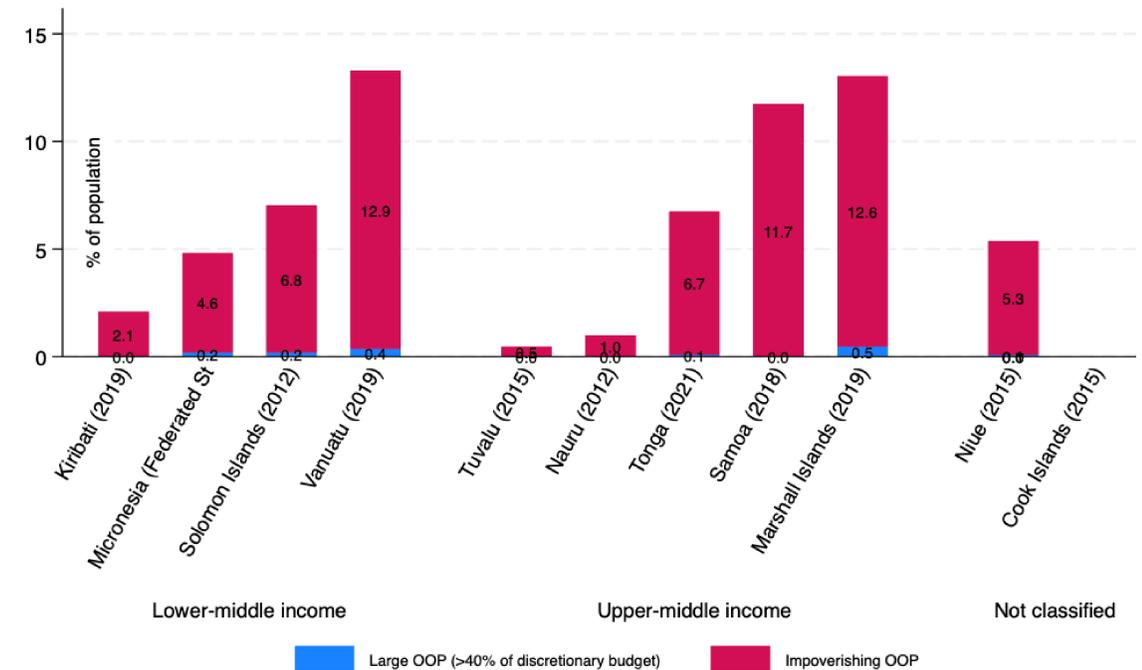


Fig.2: Financial protection has improved over the years in the WPR, however, differences persist in financial protection values and corresponding trajectory across non-PICs and PICs



WHAT ARE THE KEY DRIVERS OF THE TRENDS?

Large reductions in impoverishing health spending before the SDG era were linked to broader economic growth and poverty reduction across the region, driving the declines in overall financial hardship. Since the SDGs (2015), many countries have made efforts to progress towards UHC by starting to consolidate health financing schemes and to invest more in primary health care (PHC).

Increase in utilization corresponding with improvement in service coverage and availability has been observed in countries; however, limitations in financial protection persist, demonstrated by the upward trends in large OOP health spending. Further, health systems remain oriented towards hospital-centric healthcare and service delivery, driving costs up despite increase in government health spending. Medicines are still a significant component of OOP health expenses, particularly for poorer households, highlighting gaps in benefit packages and coverage.

As a result, household OOP payments for health continues to finance a significant proportion of WPR countries' total health spending, placing pressure on households' ability to afford care and/or basic needs. Uneven progress in financial protection, especially for poorer (Fig.3), rural, and multigenerational households (Fig.4) reflect inequalities in service provision and gaps in financing mechanisms to incentivize provision of care for these vulnerable populations.

Fig.4: Multigenerational households are associated with greater financial hardship, though households with only older people drive large OOP spending

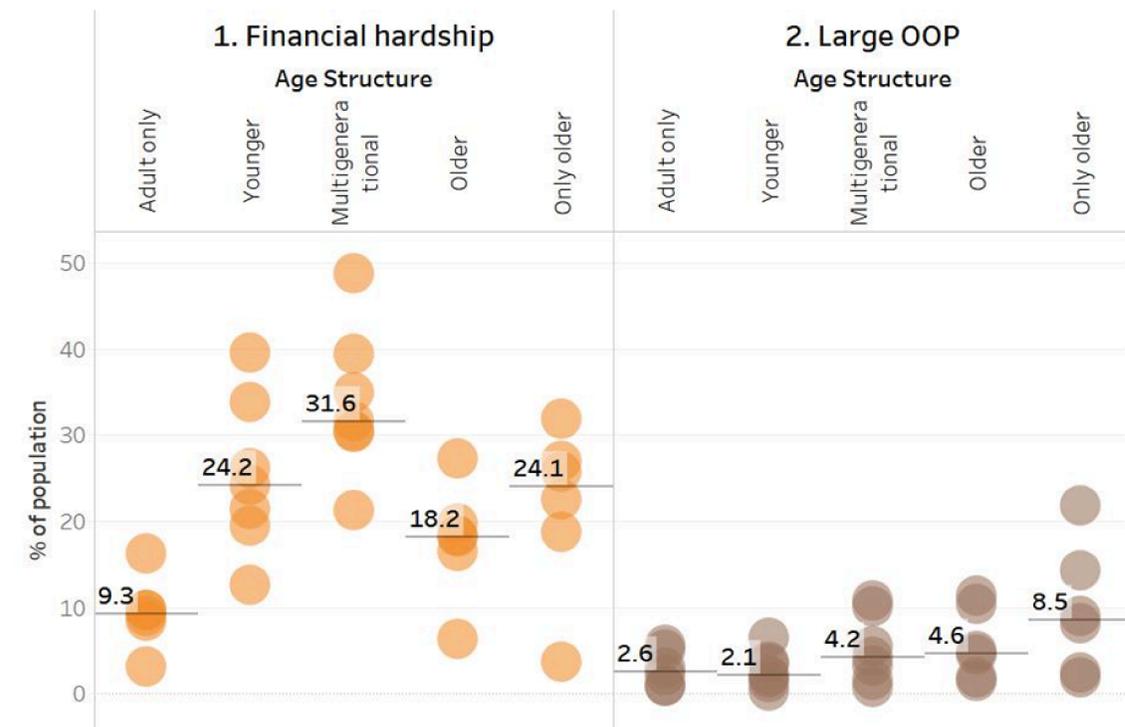
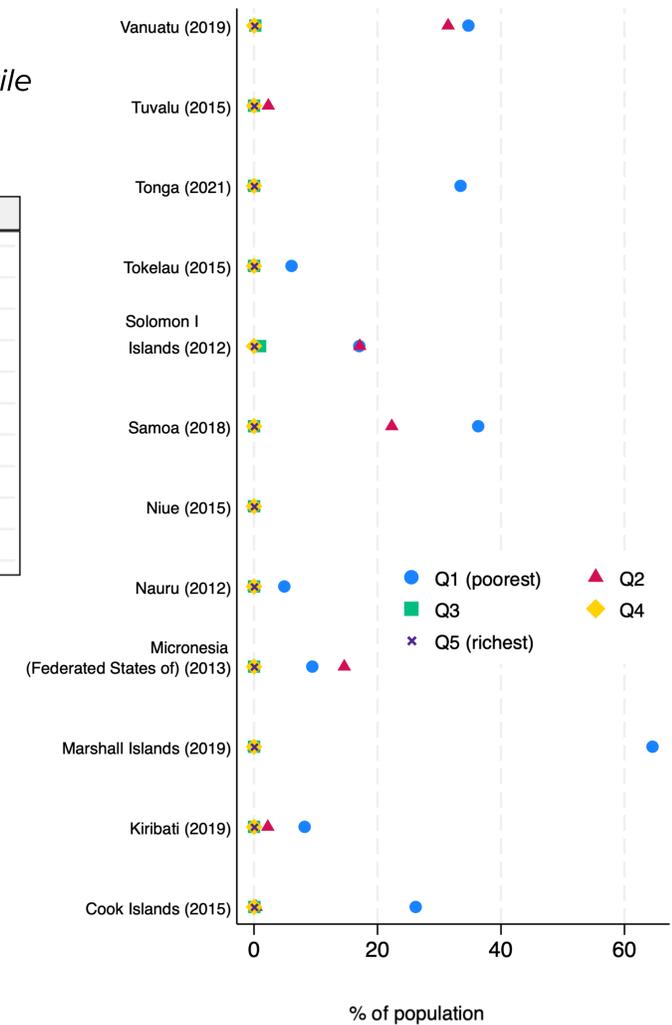
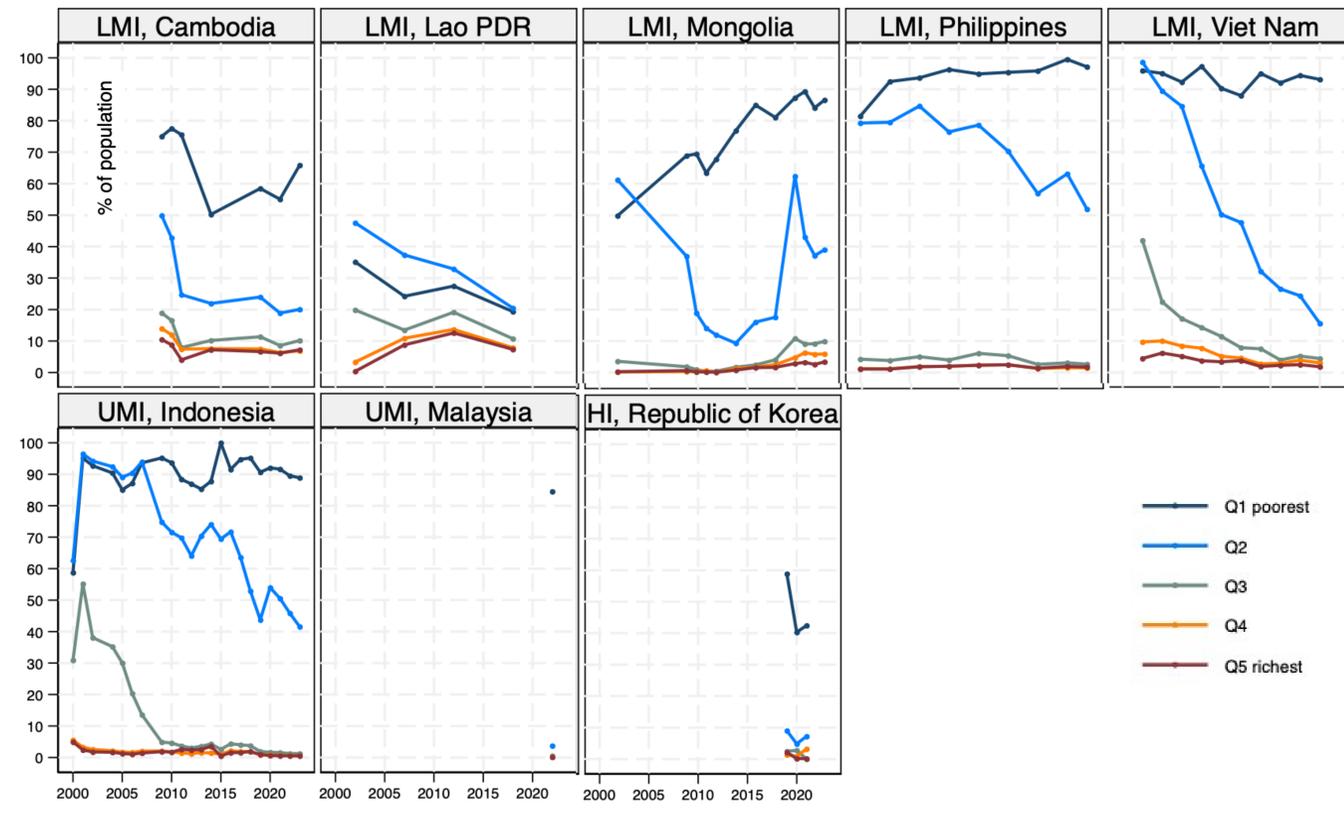


Fig.3: Financial hardship remains concentrated among the poorest consumption quintile across the Region and inequalities worsen across the quintiles in non-PICs and PICs



HOW SHOULD COUNTRIES ACCELERATE REDUCTION OF HEALTH-RELATED FINANCIAL HARDSHIP AND PROGRESS TOWARDS UHC?

Profound challenges remain. Despite past economic growth, mounting macro-fiscal risks (high public debt, economic uncertainty, stagnant revenue) constrain the capacity for sustained and increased public spending on health. Cuts in external aid will further strain the health financing landscape, especially for low income countries. Rapid urbanization and population aging are driving an emerging health crisis dominated by NCDs, which cause nearly 87% of regional deaths. The dramatic rise in NCDs and the sharp increase in the population over 64 years old struggling with such chronic illnesses will pose a major risk to financial protection.

Bold, multi-sectoral action is needed:

- 1. Further strengthen financing for primary health care (PHC)** to reorient health systems from hospital-centric service delivery and address growing challenges of NCDs and population aging.
- 2. Utilize financing levers for pooling, purchasing, and benefits package design and entitlements** to improve publicly-funded healthcare and facilitate access and financial protection especially for poor and vulnerable households.
- 3. Address the high OOP spending on medicines** through both demand and supply side adjustments such as evidence-informed expansion of benefits packages and cost-sharing designs, shift towards public provision and reimbursement of generics and biosimilars, and improvement in procurement and pricing.
- 4. Catalyze "health financing reforms 3.0"**, a new wave of strategies and policies that can address the changing health needs of increasing NCD burden and ageing populations while leveraging digital tools.