Maldives 2025

Health Financing Progress Matrix

Assessment Report

Ministry of Health
Republic of Maldives

World Health Organization
South-East Asia Region

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Abbreviations and acronyms

ADB	Asian Development Bank
CEA	Cost-Effectiveness Analysis
CEO	Chief Executive Officer
DNR	Department of National Registration
DTP	Diphtheria, Tetanus Toxoid and Pertussis
FMIS	Financial Management Information System
GDP	Gross Domestic Product
HFPM	Health Financing Progress Matrix
HPA	Health Protection Agency
HTA	Health Technology Assessment
IHR (2005)	International Health Regulations (2005)
IMF	International Monetary Fund
INFF	Integrated National Financing Framework
MFDA	Maldives Food and Drug Authority
MMA	Maldives Monetary Authority
MoF	Ministry of Finance
MoH	Ministry of Health
MTEF	Medium-Term Expenditure Framework
NCD	Noncommunicable Disease
NHA	National Health Accounts
NIC	National Identification Card
NSHI	National Social Health Insurance
NSPA	National Social Protection Agency
OOP	Out-Of-Pocket (Spending On Health)
PBB	Programme-Based Budgeting
PEFA	Public Expenditure and Financial Accountability
PER	Public Expenditure Review
PNC	Postnatal Care
PSIP	Public Sector Investment Programme
RMNCH	Reproductive, Maternal, Newborn And Child Health
SCI	Service Coverage Index
SDG	Sustainable Development Goal
STO	State Trading Organization
UHC	Universal Health Coverage
UMIC	Upper-Middle-Income Country

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FOREWORD

The Maldives is currently going through a pivotal moment in the journey towards Universal Health Coverage (UHC). A successful wave of reforms saw a significant increase in public resources to the health sector. This included the establishment of Aasandha, a national health insurance programme aimed at purchasing health services from all hospitals and health centers, including those from the booming private healthcare sector. Since the mid-2010s, the Maldives has significantly reduced the share of health financing funded directly by patients at the point of care, mostly through prepaid arrangements funded by government.

Today, after a decade of positive returns on investment for the sector, the Maldives' health financing performance is demonstrating a shift in its trajectory. The country is at a turning point and needs to make policy adjustments to establish a conducive health financing system for UHC. The World Health Organization (WHO) is supporting the government throughout this policy cycle, from formulation to the implementation of these reforms. Among them is the application of the Health Financing Progress Matrix (HFPM). The matrix assesses a country's health financing system against a set of evidence-based benchmarks that are key in making progress towards UHC.

This comprehensive HPFM report explores the Maldives' health financing landscape, provides an in-depth analysis of the current situation, and sheds light on required strategic changes in health financing. The report points out the need to address the issue of fragmentation in the allocation of public financing in the sector. It also illustrates the necessity to move towards more strategic purchasing for increasing overall efficiency and quality in spending of pooled funds, including through enhanced complementarity between public schemes and the Private Health Insurance sector. Also highlighted is the need to improve public financial management within the health sector, ensuring greater adequacy between allocations and benefits. Additionally, the report stresses the critical role of leveraging data and information systems for more evidence-informed decision-making. These recommendations are crucial for advancing Maldives's health financing system and moving closer to the goal of UHC.

We value the collaboration between the government of Maldives and WHO in the health financing landscape. We will continue to stand by the government to further define operational approaches to implement these recommendations, and support monitoring of their effectiveness in contributing to the goal of accessible, affordable and quality health care for all.

Dr Catharina Boehme
Officer-in-Charge
WHO South-East Asia

FOREWORD

Health financing is a crucial component of a strong health system and plays a critical role in achieving universal health coverage (UHC), aligning closely with the national goal of enhancing the health and well-being of the population. Effective financing mechanisms determine not only the sustainability of health services but also their accessibility, equity, and quality. Importantly, robust health financing ensures financial protection, allowing individuals to access necessary health services without the risk of financial hardship or impoverishment. While the Maldives has achieved remarkable progress in health financing over the years, continued reform is needed to address challenges posed by an ageing population and the rising prevalence of non-communicable diseases. The Ministry of Health remains committed to strengthening the health system in the face of such emerging challenges.

The Health Financing Progress Matrix (HFPM) Report provides a detailed assessment of the health financing system in the Maldives and represents a key step in the efforts to strengthen the health sector and accelerate progress towards UHC. The report identifies systemic strengths and weaknesses and highlights the necessary reforms required in health financing. Its findings are intended to support policymakers and stakeholders in formulating evidence-based policies and strategic plans to enhance the health financing landscape in the Maldives. I am confident that these efforts will ultimately contribute to building a more resilient, equitable, and efficient health system.

I would like to express my gratitude to the World Health Organization (WHO) for their invaluable assistance in developing the HFPM Report and for their unwavering support in improving the health sector in the Maldives. I also extend my sincere appreciation to the stakeholders who participated in the HFPM assessment for providing their valuable insights. Finally, I commend the team from the Health Information Management and Research Division for coordinating and supporting this important work. Together, we can achieve a healthier and more equitable Maldives for all.

Abdulla Nazim Ibrahim
Minister of Health

About the Health Financing Progress Matrix

1. About the Health Financing Progress Matrix

The WHO Health Financing Progress Matrix (HFPM) is the standardized qualitative assessment of the health financing system of a country. The assessment builds on an extensive body of conceptual and empirical work, and summarizes "what matters in health financing for universal health coverage (UHC)" into a set of desirable attributes, which form the basis of the assessment (Annexure 1). By identifying areas of strength and weakness in the current health financing system, along with priority policy directions, HFPM assessments complement monitoring of key quantitative indicators on service coverage and financial protection, now enshrined in the Sustainable Development Goals (SDGs) agenda.

HFPM assessments can be implemented within a short period and provide close-to-real-time information for policy-makers. Findings support the development of health financing strategies and technical alignment across government and external technical assistance agencies, while also providing the basis for monitoring progress over time. This allows for systematic tracking of the development and implementation of health financing policies that matter for UHC. HFPM assessments have been conducted in several countries, including in the South-East (SE) Asia Region; some have been published (Bangladesh and the state of Jammu and Kashmir in India) while others have remained unpublished (Nepal, Myanmar, Sri Lanka).

HFPM country assessments consist of two stages:

- Stage 1: This involves a mapping of the health financing landscape consisting of a description of the key health coverage schemes and programmes in a country. For each scheme or programme, the key design elements are mapped, such as the basis for entitlement, benefits and provider payment mechanisms, offering an initial picture of the extent of fragmentation in the health system.
- Stage 2: This involves a detailed assessment of the health financing policy based on a series of questions (Annexure 2). Each question builds on one or more desirable attributes of health financing, and is linked to relevant intermediate objectives and the final goals of UHC. Each attribute receives a maturity score from 1–4, as follows: 1 = Emerging, 2 = Progressing, 3 = Established, 4 = Advanced. The score is complemented by qualitative analysis to provide a granular assessment of health financing arrangements.

Further details about the HFPM are available here: **https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix**.

2. Methodology and Timeline

In collaboration with the Ministry of Health (MoH), the WHO Country Office for Maldives initiated the country assessment using the WHO Health Financing Progress Matrix (HFPM) in 2022. WHO commissioned this assignment to an independent health financing consultant. The assessment was conducted through desk reviews of relevant studies, reports and documents, and key informant interviews with representatives from the Ministry of Health, the Ministry of Finance (MoF), the National Social Protection Agency (NSPA), Aasandha (government health insurance scheme administrator) and private insurance companies. The interviews were guided by a list of questions tailored to each institution that participated. A total of 14 interviews from six institutions were conducted (Annexure 3).

The HFPM assessment was carried out during the second half of 2022. The first draft was shared with the MoH in December 2022. A revised draft with preliminary findings and proposed policy actions was presented to the MoH, the MoF and the NSPA in the first quarter of 2023 to provide an opportunity for stakeholders to validate the HFPM report and jointly prioritize proposed policy actions. Feedback from stakeholder validation meetings, along with inputs from WHO across the three levels – the WHO Regional Office for South-East Asia (WHO-SEARO), the WHO Country Office for Maldives and the WHO headquarters (WHO HQ) – was incorporated into the final version of the report, which was submitted to the MoH in September 2023.

Following the presidential election in September 2023, the new MoH administration was expected to take office in November 2023. Anticipating policy shifts and financial reforms with this administrative change and a new leadership, the report was put on hold to reflect changes and ensure its presentation to the incoming team of policy-makers.

In the second quarter of 2024, the revised version underwent an external review by three independent experts, resulting in further revisions to the scoring and recommendations based on the changes that came into effect with Maldives health financing reform.

Table 1

Timeline for HFPM assessment in Maldives

Dates	Component
Sep. 2022	Team preparation and development of data collection tools
Oct. 2022	Desk review
Nov. 2022–Jan. 2023	Key informant interviews
Dec. 2022	First draft shared with MoH and WHO
Feb. 2023	First draft revised and presented to MoH, MoF and NSPA
Sep.–Oct. 2023	Final draft shared with MoH and WHO
2024	WHO internal review
May–July 2024	HFPM scoring validation by external reviewers
July–October 2024	Revisions based on external review feedback
Dec. 2024 to Sept 2025	Final report completed
Jan - June 2025	Production of final report

Source: UHC service coverage index (SDG 3.8.1) [online database]. Global Health Observatory. Geneva: World Health Organization; 2023 (**https://www.who.int/data/gho/data/themes/topics/servicecoverage**, consulté le 24 mars 2023)

3. Maldives UHC performance

This section reviews the UHC performance in Maldives. It is measured by the indicators of SDGs 3.8.1. and 3.8.3 (Figs. 1–4).

The figures have been produced using data from the latest WHO and World Bank UHC global monitoring reports.[1,2 3]

Fig. 1

UHC Service Coverage Index, 2000–2023

Source: Tracking universal health coverage: 2025 Global Monitoring Report. Geneva: World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2023. Licence: CC BY-NC-SA 3.0 IGO

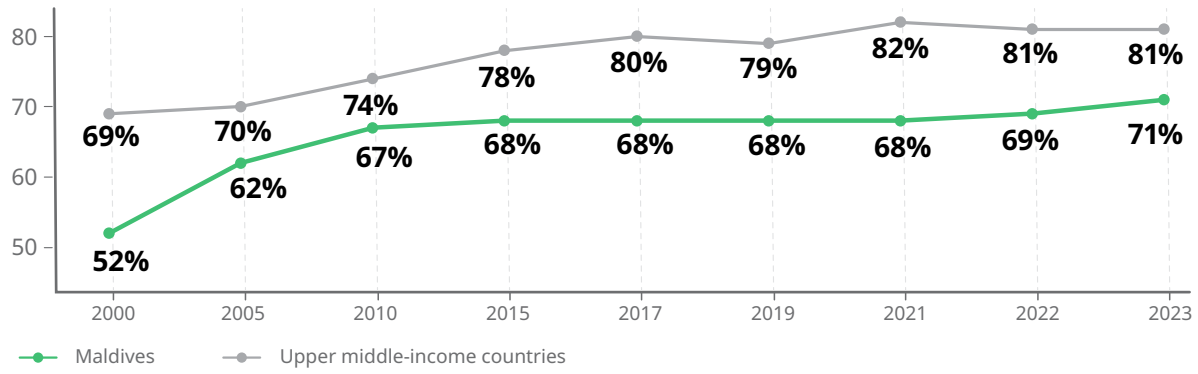


Fig. 1 presents the progress on the UHC Service Coverage Index (SCI), which is a key measure of advancements in UHC and Sustainable Development Goals (SDGs) (SDG indicator 3.8.1). The Index assigns a score between 0 and 100 based on the average coverage of essential services tracer indicators that include reproductive, maternal, newborn and child health (RMNCH), infectious diseases, noncommunicable diseases (NCDs), and service capacity and access. The score of Maldives on the UHC SCI increased by 50% (20 points) between 2000 (41) and 2021 (61), a significant and sizeable achievement in the two-decade period. Although Maldives was making gradual and steady progress until 2017, there was a significant decline in the UHC SCI – from 71 in 2017 to 61 in 2021. Data show that the indicators under the infectious diseases' domain are the key contributors to this decline.

The UHC SCI of Maldives is below the average of upper-middle-income countries (UMICs), which stood at 79 in 2021. A possible reason for this gap is the country's disadvantage of having a small and geographically dispersed population, which makes it harder to sustain high levels of health service delivery.

Fig. 2

Antenatal care coverage (at least four visits), 2004–2017

Source: WHO Global Health Observatory (2024), accessed on 10 April 2025[4]

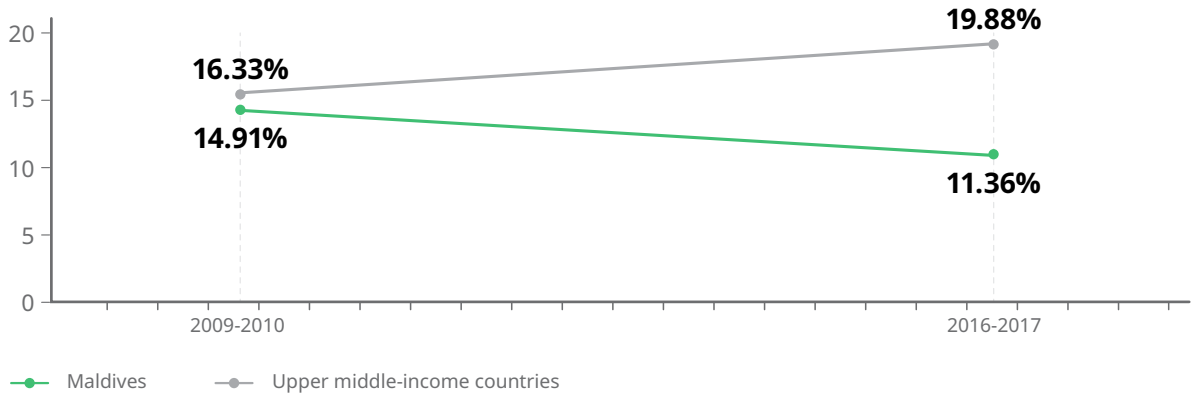


Fig. 2 shows globally reported data on the coverage of at least four visits of antenatal care (ANC) in Maldives in 2004–2017. While the rate was reasonably high in 2017 (81.6%), it had declined since 2004 (91.0%).[5] One reason for this may be the shift from public PHC facilities providing ANC to more specialized care in the private sector, which may offer fewer ANC services. The MoH and WHO released new national guidelines for ANC and postnatal care (PNC) in 2023, which outline a comprehensive vision and technical approach to improving ANC and PNC outcomes.[6]

Fig. 3

Vaccination against diphtheria, tetanus toxoid and pertussis (DTP3) among one-year-olds

Source: WHO Global Health Observatory (2024), accessed on 10 April 2025

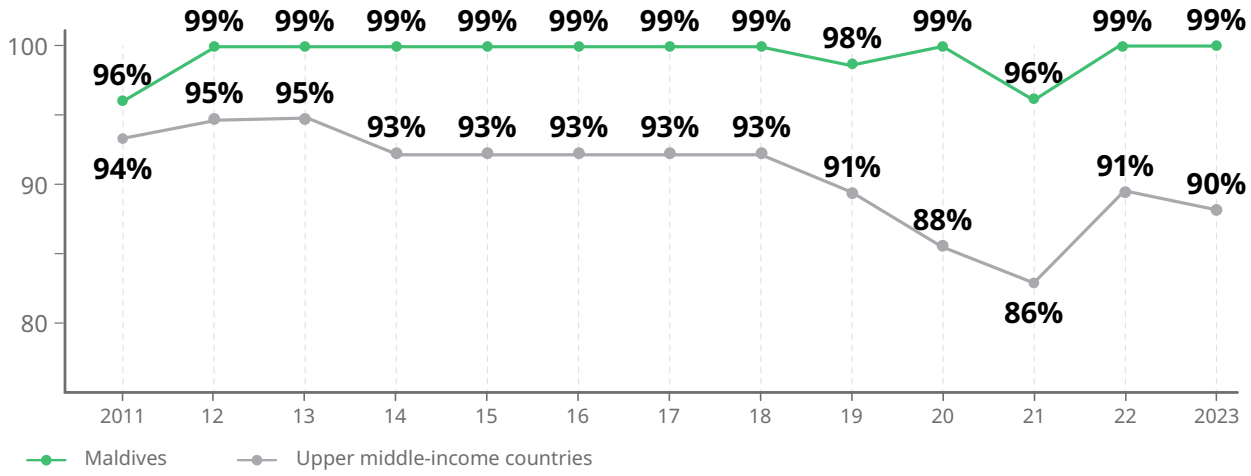
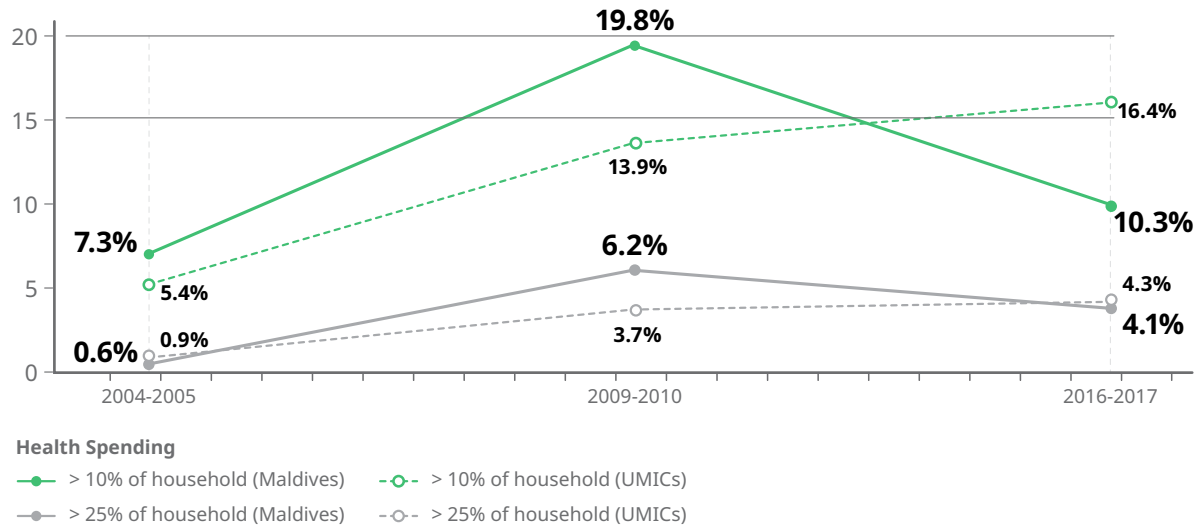


Fig. 3 demonstrates Maldives has developed a strong immunization programme. Coverage of vaccination against diphtheria, tetanus toxoid and pertussis (DTP3) has been above 95% in the last 10 years. There was a small decrease from 99% in 2020 to 96% in 2021, which may be due to the impact of COVID-19 on routine immunization. However, coverage rebounded to 99% in 2022[7]. Several countries have experienced decline in routine immunization rates because of the impact of COVID-19 on health systems. Maldives compares well with UMICs, which had an average DTP3 coverage of 91% in 2022.

Fig. 4

Percentage of population suffering catastrophic out-of-pocket health spending

Source: SDG 3.8.2 – catastrophic health spending (and related indicators) [online database]. Global Health Observatory. Geneva: World Health Organization; 2023 (**https://www.who.int/data/gho/data/themes/topics/financial-protection**, accessed 10 April 2025).

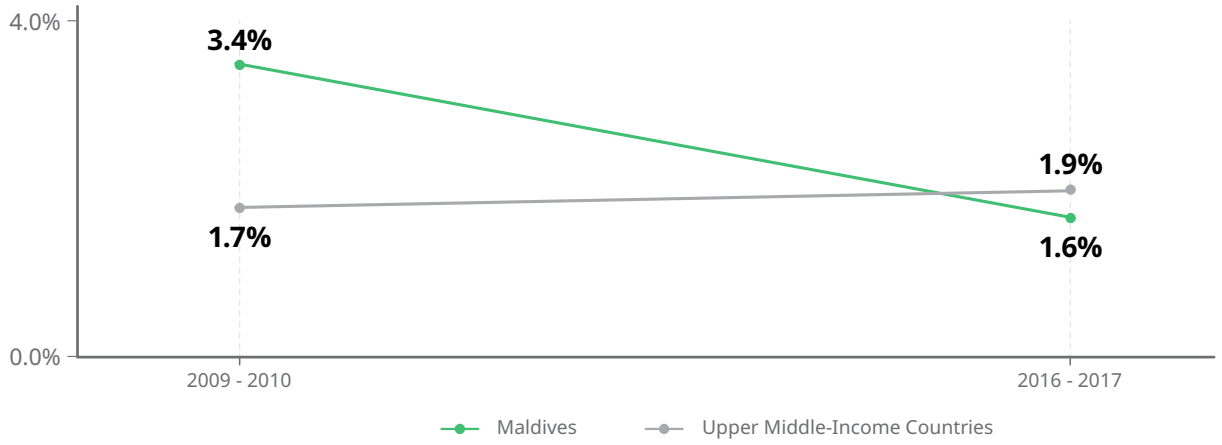


Figs. 4 and 5 present data on the SDG indicators used to measure financial protection (3.8.2 = population with household expenditure on health greater than 10% or 25% of total household expenditure or income). Fig. 4 shows that catastrophic health spending decreased over 2009–2016 at both thresholds (10% and 25% of household expenditure), marking an important achievement. In contrast, catastrophic health spending increased, on average, in upper-middle-income countries during the same period, rising from 13.9% to 16.4% at the 10% threshold and from 3.7% to 4.3% at the 25% threshold.[8]

Fig. 5

Percentage of population pushed below a relative poverty line by household out-of-pocket health expenditures - 60% of median daily per capita consumption or income (%, national)

Source: SDG 3.8.2 Catastrophic health spending (and related indicators) [online database]. Global Health Observatory. Geneva: World Health Organization; 2023 (**https://www.who.int/data/gho/data/themes/topics/financial-protection**, accessed 10 April 2025).

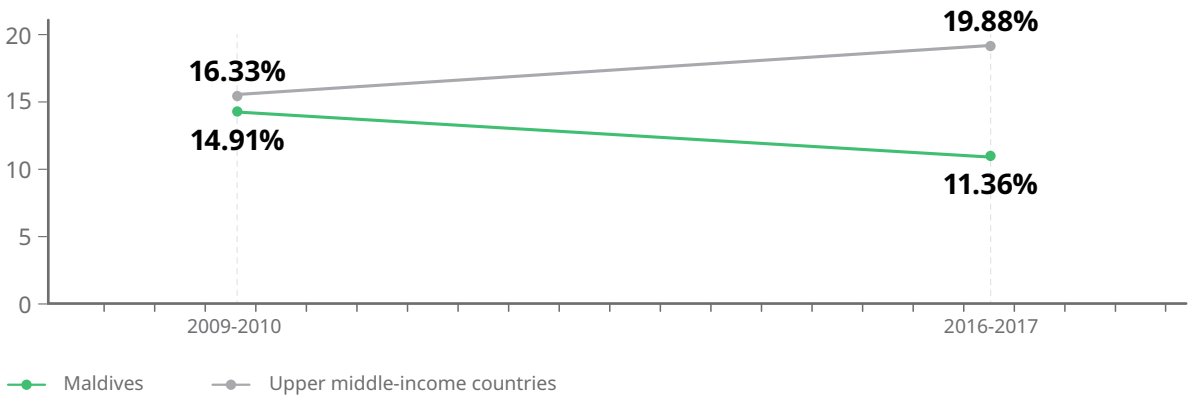


Health spending is closely related to the impoverishing effect on the population that occurs when households are pushed – or pushed further – into poverty due to out-of-pocket health payments. In 2009, 3.4% of the population were pushed below the relative poverty line (60% of the median daily per capita consumption) because of spending on health care (Fig. 5). The proportion was halved, down to 1.7 % in 2016.

Fig. 6

Population pushed further below a relative poverty line by household health expenditures - 60% of median daily per capita consumption or income (%, national)

Source: SDG 3.8.2 – catastrophic health spending (and related indicators) [online database]. Global Health Observatory. Geneva: World Health Organization; 2023 (**https://www.who.int/data/gho/data/themes/topics/financial-protection**, accessed 10 April 2025).



In addition, over the same period, the proportion of the population pushed further below the same relative poverty line reduced from 14.9% (2009) to 11.4% (2016). (Fig 6). However, data from the latest Household Income Expenditure Survey (HIES) 2019 suggest that household spending on health care as a proportion of total household expenditure declined from 9.4% in 2010 to 3.5% in 2019.[9] An analysis is underway to assess whether catastrophic and impoverishing expenditure on health also decreased in 2019, based on the newly published HIES data.

Annexure 4 provides additional graphical representation of data for key health financing indicators (Figs. 8–13).

It is important to recall that indicators of financial protection in health do not reflect foregone care and these are also not very sensitive to non-resident populations. In Maldives, where the resident foreign population is estimated around 26% (Census 2022), the unmet needs and financial hardship may, therefore, be underestimated, warranting the need to strengthen information systems and development of financial schemes targeted at migrants.

4. Top three areas for priority action

This section presents the top three areas for priority action based on the key findings of the HFPM assessment:

1. under the MoH stewardship, strengthening health financing policy development and coordination efforts by strategically engaging key government institutions and international partners;
2. efficiency as the key priority for health financing policy agenda in Maldives, with a focus on improved resource allocation and spending policies; and
3. implementation and strengthening of strategic purchasing capacity of Aasandha, with the initial policy geared towards clear governance and accountability mechanism, improving systems for provider selection and payment, and establishing rigorous mechanisms to control costs.

1. Strengthen health financing policy development and coordination by strategically engaging key government institutions and international partners.

Maldives has incorporated health financing objectives aligned with SDG 3.8 UHC into key policy documents, such as the Maldives Health Master Plan 2016–2025 and the 2011 National Social Health Insurance Act, which provides a framework for affordable and quality health care. Recent initiatives, including the Maldives Integrated National Financing Framework (INFF), aim to enhance sustainable financing for health and development priorities.

The absence of a comprehensive national health financing strategy constrains the effective and sustainable implementation, evaluation and adaptation of health policies. Rising health-care costs, the country's substantial debt burden and the potential for resource shifts associated with political transitions pose significant challenges to long-term financial sustainability.

There is a need to develop a national health financing strategy to guide efforts towards establishing sustainable and equitable financing of the health system. The health system in Maldives operates in a multi-actor space with diverse objectives and interests, with no functioning, high-level national platform bringing together key stakeholders to coordinate efforts related to health financing for UHC. These limitations constrain the implementation of a coherent and comprehensive approach to how the health system should be financed.

The following priority actions are recommended:

- Develop a national health financing strategy to guide efforts towards an equitable, efficient and sustainable health system in the medium term.
- Establish an intergovernmental task force, chaired by the President's Office or the Ministry of Finance, to coordinate and align policy efforts in health financing and social health insurance across government agencies.
- Establish a health financing partner group, co-chaired by MoH and WHO, to coordinate and align efforts of the government and development partners.

2. Efficiency is the key priority for health financing policy agenda in Maldives, with a focus on improved resource allocation and spending policies in line with global practices and country challenges.

Maldives has made significant progress in health financing by transitioning from out-of-pocket payments to public resources, with the government bearing 78.1% of health expenditure in 2022, supported by stable revenue streams

primarily from international tourism. Flexible funding mechanisms, such as the "open budget" for drugs and consumables and the introduction of program-based budgeting (PBB), enhance adaptability and alignment with strategic priorities. However, challenges persist – these include the absence of a Medium-Term Expenditure Framework (MTEF) for long-term fiscal planning and frequent overspending under the Aasandha scheme. Furthermore, significant progress has been made in consolidating its health financing system under the National Social Health Insurance (NSHI) scheme, enhancing efficiency by replacing out-of-pocket payments with public funding and improving redistributive capacity to expand access to publicly financed health services.

Efforts to refocus public resources towards poorer households, such as encouraging wealthier individuals to pay higher copays, aim to enhance equity. However, inefficiencies persist due to fragmentation in resource allocation and the coexistence of different private insurance schemes, which limit the redistributive potential of the system. While proposed policies to address overlapping benefit coverage between Aasandha and private insurers may improve cost control, they risk exacerbating fragmentation and creating a two-tiered system that favours wealthier individuals, undermining overall system efficiency.

Health purchasing in Maldives faces significant inefficiencies due to weak and poorly coordinated purchasing arrangements across the Ministry of Health (MoH), Aasandha and voluntary health insurance schemes. Payments to providers are primarily driven by historical trends, line-item budgeting for public providers and ill-regulated fee-for-service payments for private providers, with little alignment with population health needs or provider performance. This fragmented approach heavily prioritizes curative services (83.8% of health expenditure) at the expense of prevention (<1%) and primary health care (11.8%), exacerbating inefficiencies. The government's recent policy intentions, such as revitalizing primary care and regulating medicine prices to reduce costs while maintaining accessibility, mark a step towards addressing inefficiencies. However, stronger purchasing arrangements are required to deliver meaningful improvements.

On the other hand, health financing policy-making lacks systematic use of data and evidence, with no explicit processes such as cost-effectiveness analysis or health technology assessments to guide resource allocation. Limited health service costing data, along with gaps in capacity and incentives to generate, analyse and effectively use data for policy and planning, hinder informed decision-making.

The following priority actions are recommended:

- Strengthen stakeholder collaboration by engaging policy-makers and health planners to identify data needs, clarify roles in generating, interpreting and sharing evidence, and develop a validated plan with appropriate incentives to enhance data use in health policy and financing.
- Build capacity for health technology assessment (HTA) and cost-effectiveness analysis (CEA) to improve the resource allocation and design of the health benefit package.
- Develop a plan and roadmap to reduce fragmentation in health financing by reviewing and harmonizing population coverage and benefit packages across all health financing schemes to improve the efficiency of public spending.
- Introduce a Medium-Term Expenditure Framework (MTEF) to improve long-term fiscal planning, ensuring better predictability of revenues and expenditures.
- Increase investment in prevention and primary health care, re-allocating resources to address the current imbalance favouring curative services and align expenditures with long-term population health outcomes.
- Strengthen policy and political support for Aasandha to enhance its strategic purchasing capacity to channel and manage various health funds and schemes.

3. Implementation of strategic purchasing in the health system

Strengthen the capacity of Aasandha through a three-tier intervention aimed at:

- establishing clearer governance and accountability mechanisms;
- improving systems for provider selection and payment; and
- implementing rigorous mechanisms to monitor provider performance and control costs.

Health purchasing arrangements in Maldives fail to incentivize providers to achieve service delivery objectives, such as better quality or coordination of care, nor do they encourage the efficient use of resources for health. The current provider payment mechanism is not designed and implemented to link financing to outcomes, performance and appropriate use of health resources. For instance, the measures to discourage overprescription of medicines and diagnostic services by providers are inadequate as the dominant provider payment mechanism – fee-for-service – tends to increase costs in a health system. Similarly, mechanisms to discourage patients from accessing multiple providers and pharmacies for the same health event do not exist. The benefit package remains broad and comprehensive. As the implementor of the national health insurance scheme, Aasandha Company Ltd. fails to keep up with existing and evolving health financing challenges.

The following priority actions are recommended:

- Develop a roadmap for implementing a strategic health purchasing system, supported by agreed milestones and a monitoring framework.
- Invest in strengthening the organizational capability of Aasandha Company Ltd., focusing on such areas as clarification of roles and responsibilities with a clear governance and accountability mechanism, enhancing human resources capacity in data analytics, improving provider contracting and monitoring, and leveraging digital technologies for efficient operations.
- Consider measures to control costs (reducing overutilization, overprescription through development of standard treatment guidelines and medicine formulary for insurance scheme): copayments, raising patient awareness, gatekeeping role of primary health care providers.
- Routinely monitor data on pricing of medicines to facilitate future implementation of a maximum retail price (MRP) and promote use of generic medicines by demonstrating cost savings and ensuring quality.
- Consider alternatives to fee-for-service as provider payment methods, with implementation of more bundled payment approaches, such as capitation for PHC and case-based provider payment for hospital-based services.

5. Summary of key findings by assessment area

This section presents a summary of the responses to each of the 33 questions in Stage 2 of the assessment, including the ratings for each against the four progress levels. These results reflect the key informant interviews and discussions at the workshop held in February 2023, which brought together various stakeholders to assess the country's progress with regard to each of the questions. The final findings will be presented to key stakeholders for validation in the course of 2025.

Table 2

Summary of findings

Scores are assigned as follows: 1 = Emerging, 2 = Progressing, 3 = Established, 4 = Advanced. For the aggregation score, one decimal point is used for numerical calculations, and the following approach is used to convert each scores into one of the four levels or categories: $1.00 \leq X \leq 1.75 \rightarrow$ 'Emerging'; $1.75 < X \leq 2.50 \rightarrow$ 'Progressing'; $2.50 < X \leq 3.25 \rightarrow$ 'Established'; and $3.25 < X \leq 4 \rightarrow$ 'Advanced'.

ASSESSMENT AREA	SCORE: 2 OF 4
Policy process and governance	PROGRESSING

Summary of findings

The country's health financing policy relies on the 2011 National Social Health Insurance (NSHI) Act, which aligns with UHC to reduce out-of-pocket expenses, ensure affordability, and promote sustainable health financing. The Maldives Health Master Plan (2016–2025) emphasizes sustainability while the Medium-Term Fiscal Strategy (2022–2024) addresses rising health costs, exacerbated by the COVID-19 pandemic. The Integrated National Financing Framework (INFF), endorsed in 2023, supports national development plans. However, frequent political and leadership changes have disrupted the health policy-making process and implementation. In 2024, the newly elected President proposed reforms to the Aasandha system, aiming to improve health sector efficiency.

There are several key stakeholders with decision-making roles for health financing. While the Ministry of Health (MoH) oversees the national health system, some regional health facilities are managed by governing boards appointed by the President's Office. The Ministry of Finance plays a critical role in the health resource allocation and spending decisions. The National Social Protection Agency (NSPA) acts as a purchaser and payer for health schemes such as Aasandha, Meranaa and Medical Welfare. The Aasandha scheme is under a tripartite agreement between Aasandha, the NSPA and the MoF. In summary, Maldives faces governance challenges to health financing, including inefficiencies due to overlapping responsibilities, frequent administrative changes disrupting policy continuity and limited oversight as private insurance schemes lack reporting obligations to the Ministry of Health, reducing policy integration and technical supervision.

While Aasandha is the main organization with an established operational system, health financing data and information are fragmented across institutions, which constrains the systematic use of data to inform, monitor, and refine health policy and implementation. Maldives produces National Health Accounts (NHA), but there is usually a two-year lag before publication of the NHA report. There are limited data on the costs of health services in Maldives, including that on hospital-based health service costing; this constrains Aasandha during negotiations with private health providers on the pricing of service packages. There is a missed opportunity to strengthen strategic and operational planning because of the lack of analysis of data on service provision collected by Aasandha. The company,

as an organization charged with the scheme administration, lacks capacity in data analysis and usage for policy information.

ASSESSMENT AREA

Revenue raising

SCORE: 2.8 OF 4

ESTABLISHED

Summary of findings

Maldives has made notable progress in raising revenue for health, with public resources now being the primary source of health financing, reflecting a shift from out-of-pocket payments at the point of care in the early 2000s. Tax revenues, particularly from international tourism, account for a significant portion of government budget revenue, with health expenditure rising steadily from 4.5% of GDP in 2010 to 7.5% in 2022, demonstrating resilience even during the COVID-19 pandemic. The government prioritizes health spending above the average for upper-middle-income countries, with 78.1% of the current health expenditure funded by the government in 2022.

However, exogenous and domestic factors bring challenges, including a relatively low tax-to-GDP ratio (17.7% in 2021), limited direct tax collection from local entities and households, and high reliance on international tourism. At the implementation level, key financial management challenges persist. The advance fund finances only project-related costs (both donor and domestically funded), primarily for capital expenses, while all current expenses are managed through the consolidated revenue fund, with details of government accounts published weekly on the MoFP's website, alongside investment project financial progress.

Programme-based budgeting (PBB) has been partially implemented by the Ministry of Finance and Planning (MoFP), with key performance indicators (KPIs) under development by budgetary organizations, aiming to better align financing with strategic priorities and outcomes. Full implementation of PBB will depend on compliance with MoFPS's budgetary instructions in developing KPIs. The MoH exhibited low budget execution rates (70%–80% in recent years), signaling inefficiencies in budget utilization. Additionally, the National Social Protection Agency (NSPA) routinely overspends its approved budgets, driven by the National Health Insurance SchemeScheme (Aasandha). However, at the provider level, the flow of public funds to health service providers in Maldives is relatively stable, with financing through Aasandha reimbursements and direct supply provisions from the Ministry of Health (MoH) and the State Trading Organization (STO).

While Maldives is one of the countries with the highest level of publicly raised revenue for health, and its financing system is broadly considered to be progressive, the out-of-pocket (OOP) health spending still remains significant, indicating room for further improvement in equitable health financing. The introduction of the Aasandha insurance scheme has reduced OOP spending, although it is still high.

ASSESSMENT AREA

Pooling

SCORE: 2.6 OF 4

ESTABLISHED

Summary of findings

Maldives has made significant strides in consolidating its health financing system by establishing a single institutional structure for the National Social Health Insurance (NSHI) scheme. Over the past 15 years, the government has expanded and progressed across all three dimensions of the UHC cube through public funding, effectively reducing out-of-pocket (OOP) spending with public funds and enhancing substantively the redistributive capacity of prepaid funds. These efforts demonstrate a

successful translation of international evidence into national policy measures, resulting in reduced OOP spending and improved access to publicly financed health care. The government is also exploring reforms to target public money towards poorer households by encouraging wealthier individuals to pay higher copays or prepayments for Aasandha, reallocating resources to poorer populations.

Despite progress, fragmentation in the allocation of public resources and the existence of multiple private health insurance schemes continue to limit the government's redistributive capacity. There are efforts to ensure coherency and complementarity of benefit packages across smaller-scale schemes through Aasandha institutional arrangements. However, the way health financing is organized creates barriers. Public funds are channeled through different mechanisms with varying incentives, such as financing public providers via the Ministry of Health or the Ministry of Finance and Planning and paying private providers through Aasandha/ National Social Protection Agency.

The proposed policy aims to address the long-standing issue of overlapping benefit coverage between Aasandha and private health insurers by limiting Aasandha's outpatient coverage for privately insured patients to services that exceed their private insurance limits, effective November 2024. This will improve resource allocation towards those reliant on public funding.

ASSESSMENT AREA

Purchasing

SCORE: 1.7 OF 4

EMERGING

Summary of findings

Health purchasing is the most important challenge in Maldives as the resource may not have been used efficiently and the use of strategic purchasing is limited. There has been limited coordination across payment methods used by the MoH, Aasandha and voluntary health insurance schemes to date. By and large, provider selection and payments in Maldives are not based on systematic assessments of population health needs but are driven by historical trends, line-item budgeting for public providers, and ill-regulated fee-for-service payments for private providers under Aasandha and voluntary health insurance schemes. This approach neglects adjustments for health needs or performance, with resource allocation heavily skewed towards curative services (83.8% of current health expenditure) and minimal spending on prevention (<1%) and primary health care (11.8%).

Private provider payments also lack alignment with health needs, as decisions are not informed by comprehensive cost or health data. While recent efforts, such as the introduction of programme-based budgeting (PBB) and digital health tools, show potential to enhance resource allocation and performance tracking, these initiatives are not yet fully integrated with or focused on aligning payments with population health priorities. Moreover, purchasing arrangements in place do not provide clear mechanisms to ensure service quality. This is because current purchasing arrangements, including those by Aasandha, fail to incentivize better care or coordination, with limited use of standard treatment guidelines and insufficient leveraging of purchasing power to control overutilization and unnecessary services.

The Aasandha claims information system (VINAVI) holds significant potential to enhance health system planning and resource allocation in Maldives by enabling analysis of service use patterns, quality of care and access equity. However, its capabilities remain underutilize due to its primary function as a claims

[10] World Bank (2021). Public Expenditure and Financial Accountability (PEFA) Performance Assessment Report 2020. Washington, DC: World Bank; 2021.

processing system rather than a comprehensive data management and analysis tool. In the absence of shared electronic health record (EHR), VINAVI serves as a de-facto EHR, but its limitations in data management and analysis hinder effectiveness for broader health system planning. On the other hand, health providers have limited autonomy and are not held adequately accountable for their performance, as public providers operate under strict budgetary rules while private providers face minimal accountability measures.

There are policy intentions; as of end 2024, the government has been taking measures to regulate the price of medicines and lower the budgetary impact of medicines on Aasandha's finance while ensuring accessibility for patients.

One specific challenge that Maldives faces lies in expanding the scope of its strategic purchasing arrangements to health services provided abroad. Overseas treatments are highly expensive and the current arrangements to purchase such services using Aasandha's funds are suboptimal. When it comes to ensuring transparency in the treatment process and accountability for curative outcomes, contractualization of individual private providers has proven to be both costly and challenging. It is, therefore, recommended that innovative arrangements be explored to cover overseas treatment.

ASSESSMENT AREA

Benefits and entitlements

SCORE: 2.6 OF 4

ESTABLISHED

Summary of findings

Benefits appear to be reasonably well understood by the population since most of the health-care costs are covered by the Aasandha scheme and the MoH, with some exclusions in place. Benefits are explicitly defined for Maldivian citizens, but expatriates are required to purchase health insurance from private insurance companies. There is currently no established process in place that uses explicit criteria or priority-setting mechanisms to make resource allocation decisions, such as the results of cost-effectiveness analysis (CEA) or health technology assessments (HTAs) to inform the design of an appropriate benefit package.

There are no user charges in the national health system and the Aasandha scheme.

Defined benefits under the Aasandha scheme have so far aligned with revenues only through frequent budget amendments to cover financing gaps, leading to overspending and arrears. The purchasing mechanisms, including an empanelment process for providers and pharmacies, face challenges from weak regulatory enforcement, fragmented coordination, and unregulated proliferation of pharmacies that complicate the provision of medicines and services.

Box 1: Spending on the national response to COVID-19 in Maldives

The most recent report on spending on the national COVID-19 pandemic response was released by the Ministry of Finance in September 2022. As of August 2022, Maldives had spent a total of MVR 4181 million (US$ 270 million) since the onset of the pandemic in 2020, funded through a specific COVID-19 budget from the MoF.[74] External resources from the Asian Development Bank (ADB), the International Monetary Fund (IMF) and the World Bank financed US$ 116 million (42.8%) of the response.[75] Social and health spending accounted for MVR 2391 million (USD 155'158'988[1]) (57.2%) and the Economic Relief Programme (ERP) (various types of income support and public utility discounts) for MVR 1789 million (USD 116'093'446[2])(42.8%).[76]

The total spending on COVID-19 decreased significantly over time. For example, 56.5% of the total social and health spending occurred in 2020, 34.9% in 2021 and 8.6% in 2022 (January–August), and 84.2% of the ERP spending occurred in 2020. The MoH accounted for 39.5% of the total health and social spending, the National Disaster Management Authority for 36.3%, Indira Gandhi Memorial Hospital for 9.7%, the National Social Protection Agency for 5.1% and other institutions for 9.4%. The primary spending items included medical supplies and capital investment to establish a national operation centre, a 300-bed COVID-19 health facility, isolation beds at health facilities (400 beds) and five regional health facilities.[77, 78] The Aasandha benefit package was expanded to cover the costs of vaccine delivery and COVID-19-related services.[79]

[1] Official monthly exchange rate for December 2024 on: **https://www.mma.gov.mv/#/statistics/exchangerates**
[2] Idem

ASSESSMENT AREA

Public financial management

SCORE: 2 OF 4

PROGRESSING

Summary of findings

The Public Expenditure and Financial Accountability (PEFA) Performance Assessment Report 2020 showed that macroeconomic and fiscal forecasting and the budget preparation process perform well in Maldives. Furthermore, the PEFA reported that medium-term strategic plans are prepared for line ministries, including health, but none are fully costed and linked to outputs and programmes. As described above, the MoFP is in the process of implementing PBB, though KPIs are still in development. PBB has the potential to improve approaches and processes for planning and resource allocation and better link the sector performance to financing.

The public procurement domain does not perform adequately overall.[10] Public health providers have the financial autonomy to operate and manage the approved budget.. Measures to address under- and over-budget spending in health are limited and lack coordination, as reimbursement practices encourage inefficiencies, such as overprescription and unnecessary procedures; however, the government aims to strengthen the Aasandha scheme and reduce wastage by introducing bulk procurement systems and setting reimbursement rates to control expenditures.

The challenges in expenditure reporting in health include untrained health professionals handling financial management, fragmented data systems, delays in publishing National Health Accounts (with a two-year lag) and limited real-time access to consolidated data for decision-making.

ASSESSMENT AREA

Public health functions

SCORE: 2.8 OF 4

ESTABLISHED

Summary of findings

Public health emergency programmes in Maldives, such as the response to COVID-19, are partially aligned with the overall health financing strategies and policies, as evidenced by the amendment to the Public Health Protection Act to establish expenditure protocols and supplemental funding mechanisms, integration of the Health Protection Agency's activities into broader public health initiatives, and allocation of resources for disease surveillance, control and health promotion. Gaps in comprehensive alignment may still exist though.

Pooling arrangements do not demonstrate coordination and integration across health programmes and the broader health system, as 44% of CHE is allocated to hospitals while preventive care receives less than 0.5% of the health budget.

Financing arrangements in Maldives have supported the implementation of International Health Regulations (2005) [IHR (2005)] capacities for emergency preparedness, with substantial investment in COVID-19 response, totaling MVR 4181 million (US$ 270 million) by August 2022, including a dedicated budget for medical supplies, health facility upgrades and economic relief measures.

Furthermore, the public financial management system enables a timely response to public health emergencies, as evidenced by the requirement for the Minister of Finance to report to Parliament for approval of any supplemental spending, ensuring effective funding for rapid COVID-19 response and preventing community transmission. However, to avoid inappropriate use of public funds, there is a need to have mitigation measures to ensure accountability while maintaining timely responses to public health emergencies. Implementing an emergency financial response plan specifically for health emergencies may be useful in ensuring adequate emergency response while maintaining safeguards.

Fig. 7

Average rating by assessment area

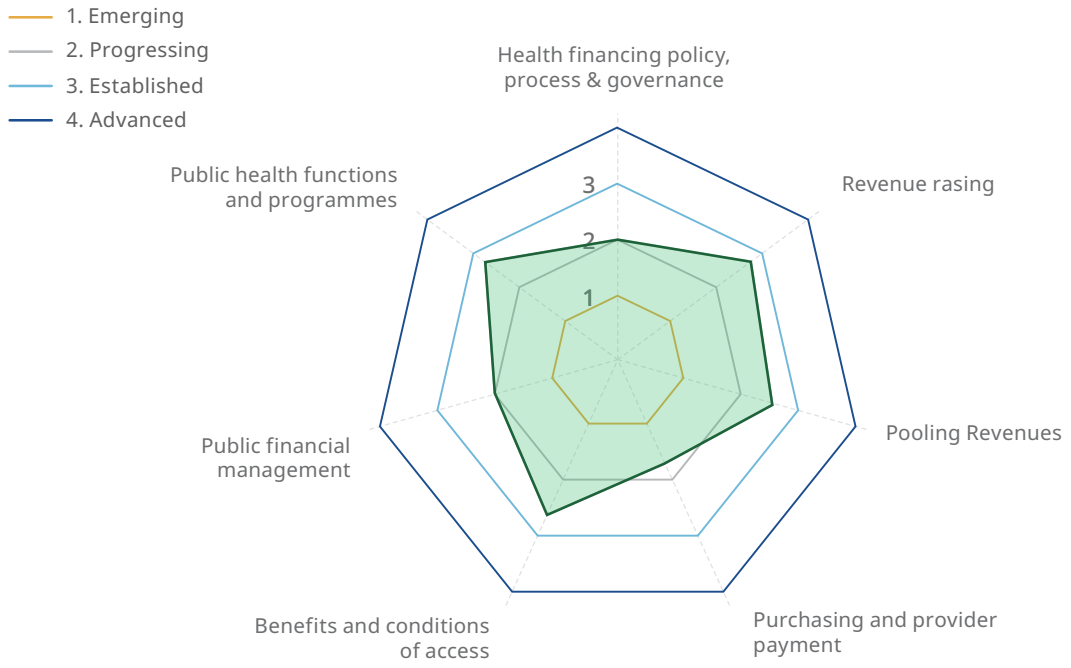


Fig. 7 presents the average rating of the health financing system of Maldives across seven categories of assessment areas. Revenue raising and Public health functions received the highest scores (Established; 2.8 out of 4), followed by Pooling and Benefits entitlement (both Established; 2.6 out of 4). Policy progress and governance and Public financial management were rated as Progressing (2 out of 4), while purchasing received the lowest score (Emerging' 1.7 out of 4). No assessment area received an Advanced rating (4).

Fig. 8

Average rating by UHC goals and intermediate health financing objectives

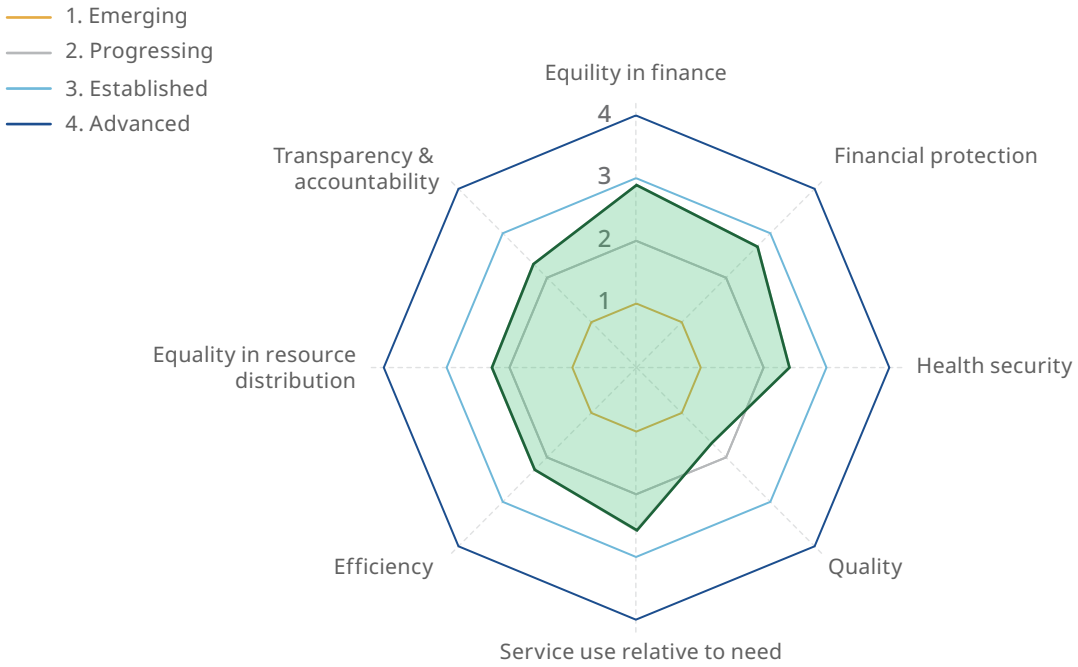


Fig. 8 presents the country's average rating in terms of progress towards UHC goals and intermediate health financing objectives. These include financial protection (preventing catastrophic and impoverishing expenditure on health), equity in finance (mobilizing resources for the health sector through progressive mechanisms), quality of care (promoting quality of care through strategic purchasing and provider payment arrangements), health security (facilitating robust responses to public health emergencies), equity in resource distribution (implementing effective and equitable pooling arrangements) and efficiency (promoting value for money in health spending). Equity in finance, financial protection, and service use relative to need received the highest scores (Progressing: 2.9, 2.7, and 2.6 out of 4, respectively), followed by health security (Emerging: 2.4 out of 4) and efficiency, equity in resource distribution, and transparency & accountability (Emerging: 2.3 out of 4). Quality received the lowest score (Emerging: 1.7 out of 4). No assessment area received the highest rating (4 = Advanced)

6. Summary of findings and recommended policy actions by desirable attributes of health financing

Table 3. Findings by desirable attributes of health financing assessment areas

1. Public health functions

DESIRABLE ATTRIBUTE GV1

Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies for both individual- and population-based services.

Key strengths and weaknesses

Maldives has incorporated health financing objectives aligned with UHC goals into key policy documents, such as the Maldives Health Master Plan 2016–2025 and the 2011 National Social Health Insurance Act, which provides a framework for affordable and quality health care. Recent initiatives, including the Maldives Integrated National Financing Framework (INFF), aim to enhance sustainable financing for health and development priorities.

The absence of an explicit national health financing strategy, and the shifts in government policy and priority after each administration and health leadership change have hindered the consistent implementation, evaluation and adjustment of health policies and reforms. Additionally, the rising health-care costs and political instability pose challenges to long-term planning and sustainability.

Recommended policy actions

Develop a national health financing strategy to guide efforts towards an equitable, efficient and sustainable health system in the medium term.

Establish an intergovernmental task force chaired by the President's Office or the Ministry of Finance to coordinate and align policy efforts in health financing and social health insurance across government agencies.

Establish a health financing partner group co-chaired by the MoH and WHO to coordinate and align efforts of the government and development partners.

DESIRABLE ATTRIBUTE GV2

There is transparent, financial and non-financial accountability, in relation to public spending on health.

Key strengths and weaknesses

The Ministry of Health (MoH) oversees a significant portion of the health budget and is represented on the National Social Health Insurance Board, indicating a degree of institutional involvement in governance. The Ministry of Finance (MoF) provides some accountability for health spending by overseeing budget implementation.

There is no split between purchaser and provider for a large proportion of health services. The MoH acts as policy-maker, provider and payer. Services financed by the Aasandha scheme are separated by the purchaser and provider function, but it does not act as a strategic purchaser in practice. It plays a passive role as an administrator that reimburses claims from health providers.

Regulation of private providers is ineffective, resulting in duplication and inefficiencies in service provision and pharmacy sales.

The extent to which Parliament, media and civil society play a role in the governance and accountability process is unclear.

Recommended policy actions

Empower the National Social Health Insurance Board (NSHIB) to play a more strategic role in oversight and accountability of the Aasandha scheme.

The NSHIB needs to clarify the roles of government agencies involved in health financing decision-making and implementation, and set clear responsibilities with accountability mechanisms.

DESIRABLE ATTRIBUTE GV3

International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments.

Key strengths and weaknesses

Maldives utilizes the National Health Accounts (NHA) as a key tool for measuring health expenditure and collects considerable service provision data through the Aasandha scheme, providing a foundation for health financing analysis and planning.

However, health financing data and information are fragmented across institutions; this constrains the systematic use of data to inform, monitor, and refine health policy and implementation. A recent Public Expenditure Review (PER) by the World Bank noted that "while reasonably granular data on public expenditure is available at the national level, information on outputs, outcomes and activities of ministries and agencies are not published on a regular basis in Maldives".[11] Reporting requirements (e.g. from private providers to the MoH) are

inadequate and not enforced. Maldives produces National Health Accounts (NHA), but there is usually a two-year lag before the publication of the NHA report. The main tool to measure and report on health expenditure in Maldives is the NHA. The most recent NHA report includes expenditure data for 2018–2020.[12]

There are limited data on the financial implications and costs of health services in Maldives. The Maldives Health Master Plan 2016–2025 acknowledged that it should have been costed to support planning and budgeting but noted that there were not enough data to do so.[13] During interviews with MoH officials, it was suggested that costing analysis (including utilization projections) is an urgent priority (especially for services that are costly) to inform budgeting and purchasing decisions. There is a missed opportunity to strengthen strategic and operational planning because of the lack of analysis of data on service provision collected by the Aasandha scheme.

Aasandha collects a considerable amount of information on service provision both in the public sector and the private sector, although it does not pay public providers as they are mainly paid through budget allocations (which may affect data quality as this is a blank billing exercise with little incentive for public health service providers to report accurate information). However, because there is no financial transfer from Aasandha to public facilities, the scheme does not use the data submitted by public providers, who in turn have limited incentive to submit quality data.

Recommended policy actions

Develop in-house capacity for design, implementation and monitoring of health financing policies through the strengthening and dedication of MoH staff to inform design and implementation of health economics and financing policies (through the establishment of a specific unit or dedicated staff within an existing division of MoH).

Institutionalize the production of NHA for monitoring resource allocation and long-term trends in health expenditure by source, scheme, services, providers and burden of disease.

Strengthen the capacity in the MoH to collect, consolidate and analyse health financing data to steer the health sector and monitor the effects of changes in purchasing arrangements on provider behaviour.

Conduct a review to identify needs and gaps to strengthen data analysis and interpretation capacity in the MoH and the Aasandha scheme.

Instill a process for regular and systematic use of Aasandha data on service provision for planning and resource allocation.

Ensure reporting from private providers by establishing and enforcing a requirement to report data on utilization to qualify for reimbursement from the Aasandha scheme.

2. Revenue raising

DESIRABLE ATTRIBUTE RR1

Health expenditure is predominantly based on public/compulsory funding sources.

Key strengths and weaknesses

Government health expenditure accounted for 78.1% of current health expenditure (CHE) in 2022, which is a considerable increase compared with 2010 (53%) and in line with international good practices. Out-of-pocket (OOP) spending (17.5%) and external resources (2.8%) accounted for relatively small shares of health spending in 2021.[14] Other small island developing states (SIDS) rely on external grants to a much larger degree. Health expenditure is financed primarily by government tax revenues, as taxes (2022) are projected to account for 63.4% of the total government revenue collection, compared with 26.3% in non-tax revenues and 11.9% in grants.[15] The total tax revenue accounted for 20.4% of GDP in 2022, which is slightly higher than the average for Asia and Pacific countries (19.3%) and the average for MICs (18.4%).[16, 17]

Compared with other SIDS, Maldives collects relatively little direct tax on income, profits and capital gains from local firms and households. The Maldives tax system primarily relies on indirect taxes, particularly the goods and services tax (GST), which is levied at varying rates across different sectors. The highest share of tax revenues in Maldives in 2022 was derived from value-added taxes/goods and services tax (50.4%). The second highest share of tax revenues in 2022 was derived from other taxes on goods and services (27.3%), followed by corporate income tax (21%).[18] A personal income tax was introduced in 2019, broadening the business profit tax introduced in 2011. The income tax rates are progressive, but very low (the maximum rate is 15%).[19]

This structure, while generating significant revenue, has raised concerns about its impact on low-income households and the potential for regressive effects (International Monetary Fund, 2023). To address these concerns, the Maldives Inland Revenue Authority (MIRA) administers a variety of taxes besides the GST, including but not limited to business profit tax (BPT), tourism goods and services tax (TGST), airport development charge (ADC), and various import and export duties (Maldives Inland Revenue Authority, 2023). Efforts are still underway to diversify the tax base and explore alternative revenue sources, such as income tax and environmental levies, to enhance tax equity and sustainability.

Importantly too, a third of government revenue is accounted for by taxes on international tourism, a source of revenue that was revealed to be not only vulnerable to external/exogenous shocks during the COVID-19 pandemic, but also potentially costly as international tourism industry is an important contributor to climate change. Money raised from that source may partly be the driver of costly mitigation measures the government is forced to take to reduce the impact of climate deregulation and environmental degradation. Reliance on tourism to fund the key public service provisions such as health may need to be regularly reconsidered, given the rapidly evolving context, as this source of revenue may become more fluctuant and therefore, less predictable in the near future.

Recommended policy actions

Implement a strategic plan to ensure long-term sustainability of health system financing. Advocate for continued efforts to collect income tax as a more sustainable source to finance public spending on health, compared with tourism revenues, while tightening the efficiency of allocated resource.

DESIRABLE ATTRIBUTE RR2

The level of public (and external) funding is predictable over a period of years.

Key strengths and weaknesses

The level of public funding for health has increased steadily, from 4.5% of GDP in 2010 to 7.5% of GDP by 2022. However, there is a significant fluctuation, affecting the predictability of sustainable health financing system in Maldives. In 2020, the health sector represented 9.1% of GDP. However, this figure should be interpreted with caution, as it reflects both the impact of the COVID-19 response (which bolstered the sector's resilience compared with others) and a drastic contraction of GDP.[20] In real terms, the health spending per capita actually dropped from US$ 670 to US$ 660 between 2019 and 2020. In the meantime, the GDP plummeted by more than a third of its 2019 level. By 2022, the per capita government spending had risen to US$ 878 in real terms.

Tax revenue was hit hard during the pandemic by the losses in tourism and the total revenue declined by 32% from 2019 to 2020. However, since 2019, Maldives had implemented multiple tax policy reforms and tax revenues were expected to rebound to pre-pandemic levels by 2023.[21], [22] The stability and predictability of health sector funding would be enhanced through the implementation of a Medium-Term Expenditure Framework (MTEF) or a similar policy instrument.

Recommended policy actions

Ensure that the MoH is closely involved in the design, implementation and monitoring of the MTEF process to ensure predictable and sustainable public spending on health.

Strengthen the MoH capacity to track and monitor health financing revenue streams.

DESIRABLE ATTRIBUTE RR3

The flow of public (and external) funds is stable and budget execution is high.

Key strengths and weaknesses

Public funding for health providers in Maldives remains stable. Approximately one-third of the health budget is allocated to expenditures on drugs and consumables, which are managed as an "open budget" item. Another third is dedicated to public sector wages, while the remaining third is allocated for capital spending. Efforts to enhance transparency and accountability for public spending include rolling out a financial accounting system (SAP) and introducing programme-based budgeting (PBB), linking finances to strategic priorities and outcomes.

The process is overseen by the Fiscal Affairs Department of the MoF. In the first phase (for the 2022 budget), a framework for allocating resources in accordance with strategic priorities and for allocating resources to programmes and activities that address the achievement of these goals was developed.of health sector funding would be enhanced through the implementation of a Medium-Term Expenditure Framework (MTEF) or a similar policy instrument.

To support budget execution, the Chart of Accounts was modified to enable a programme classification architecture through the MoF's Financial Management Information System (FMIS).[23]

Recommended policy actions

Strengthen the implementation of programme-based budgeting and the MoF's Financial Management Information System (FMIS) in the health sector to bolster links between financing, outputs and performance.

DESIRABLE ATTRIBUTE RR4

Fiscal measures are in place, creating incentives for healthier behaviour among individuals and firms.

Key strengths and weaknesses

In 2020, the government introduced taxes and duties on tobacco products, and announced that 3% of duty revenues would be allocated to a public health fund to finance health promotion and prevention activities. Specifically, the funds will be used to carry out anti-tobacco public awareness campaigns and other health promotion and prevention activities under the Public Health Protection Act (Law 7/2012).[24] The fund is managed by the MoH and overseen by a committee including the Minister of Health and the Director-General of Public Health. There are taxes on sugary-sweetened beverages (SSBs): MVR 33.64 (US$ 2.24) per litre import tariff on all energy drinks and an MVR 4.60 (US$ 0.31) per litre tariff on soft drinks (including sweetened and unsweetened carbonated sodas and sports drinks).[25]

Climate deregulation is, however, a major concern for Maldives. It is likely to affect the country's health outcomes in multiple ways in the near future, be it through, among other things, degradation of living environments or air pollution. Paradoxically, the Maldivian government revenues rely heavily on international tourism – a sector that massively contributes to the CO2 world emissions and is contributing to what will drive health spending higher in the near future, with air pollution set to become a major cause of morbidity and mortality globally.

Recommended policy actions

Ensure that the stipulated share of revenues from tobacco tax and duties is allocated to the public health fund to finance health promotion and prevention activities.

Explore the potential of allocating a share of taxes on sugary-sweetened beverages to the public health fund.

3. Pooling

DESIRABLE ATTRIBUTE PR1

Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds.

Key strengths and weaknesses

Over the past 10 years, as the National Health Insurance Programme gets scaled up (accounting for about 55% of government spending on health in 2020, as reported in the latest National Health Accounts report), the government has made significant efforts to consolidate health financing arrangements. By 2022, 78.1% of the current health spending came from public revenues, substantively enhancing the government's ability to redistribute prepaid funds.

However, various health financing schemes continue to pay for different – sometimes overlapping –benefits. The main health coverage schemes are the national health system, the Aasandha scheme, the Medical Welfare scheme operated by the National Social Protection Agency (NSPA) and private insurance companies. There are also schemes operated by the military and police, but obtaining information on the coverage and benefits of those schemes has not been possible. There is also a Zakat Fund operated by the Ministry of Islamic Affairs, which spent a total of US$ 3 million on medical treatment in 2019–2022.[26] However, undocumented migrants, many of whom work in the tourism sector, do not benefit from any pooling arrangements.

The lack of coordination across these schemes and overlaps in benefit coverage are problematic as these issues lead to duplication and inefficiencies. This is exacerbated by the lack of economies of scale in the health sector overall, given the small and dispersed population.

However, evidence suggests that Aasandha has increased access to health services and financial protection. The 2022 PER prepared by the World Bank suggested that

the introduction of the Aasandha scheme had helped shield households against unpredictable health shocks.[27] The largest reduction in the OOP share has been for lower-income households, resulting in a more equal distribution of public health spending across income groups in 2019. However, higher income groups have also seen reductions in OOP spending.[28] Catastrophic expenditure declined by at least half across all quintiles between 2016 and 2019.[29] One factor explaining this decline is the decrease in overseas treatment: the share of households with at least one overseas visit in 30 days almost halved from 6.2% in 2016 to 3.3% in 2019. The share of households with at least one domestic outpatient visit increased from 48% in 2016 to 55% in 2019.[30], [31]

Recommended policy actions

Develop a plan and roadmap to reduce fragmentation of schemes by reviewing and aligning population coverage and benefit packages across all schemes to improve efficiency of public spending.

Strengthen policy and political support to Aasandha to enhance its strategic purchasing capacity to channel and manage different health funds and schemes.

Progressively expand population coverage to cover the whole residing population (including migrants) and explore the best approach to harmonize coverage across the different selected coverage modalities (to mitigate the undesired consequences of fragmentation).

To inform a more policy-oriented approach to improving financial protection, conduct in-depth analysis of out-of-pocket spending on health (including by expatriate workers and undocumented migrants) to determine why catastrophic and impoverishing spending continues even with such comprehensive coverage by Aasandha (and complementary private insurance) and what drives such spending (for example, spending on medicines).

Establish MoH as the line ministry responsible for the National Health Insurance Board.

DESIRABLE ATTRIBUTE PR2

Health system and financing functions are integrated or coordinated across schemes and programmes.

Key strengths and weaknesses

As of 2023, the management of both the National Health Insurance (NHI) Scheme and the Medical Welfare scheme had been consolidated under Aasandha, promoting greater coherence between the two benefit packages. This integration addresses previously conflicting signals sent to the population and supports efforts to streamline health-care financing. Additionally, the government is exploring bulk procurement of medicines to achieve cost savings and enhance oversight of funds allocated for medical supplies.

There are opportunities for the MoH to strengthen its stewardship role by providing guidance and engaging with the Aasandha scheme more strategically. For example, there are no standard treatment guidelines to support the verification of claims submitted by providers.

Private health insurance accounts for a small share of the population coverage and health expenditure (1.5% in 2022). There is no specific private health insurance law in Maldives except

for expatriate health insurance, revised in 2022 to include outpatient services. Private insurers appear to be seeking a stronger regulation and improved coordination to minimize overlapping coverage and unnecessary expenditure. There are four health insurance companies in Maldives, three private companies and one company that is majority-owned (80%) by the government, under the State Trade Organization (STO), which may create incentives in favour of voluntary health insurance promotion. Private insurance coverage for expatriate workers (not covered by the national health system or by the Aasandha scheme) as well as for some influential groups (such as Members of Parliament) remains a policy decision for going forward.

Recommended policy actions

Support continued data analytics for efficiency of functions and spending across schemes and programmes.

Expand the use of streamlined digital health solutions to facilitate exchange of patient data across schemes and health facilities, including pharmacy outlets.

Revisit the legal and regulatory framework for private voluntary health insurance to ensure coherence of health system policy goals and objectives.

4. Purchasing

DESIRABLE ATTRIBUTE PS1

Resource allocation to providers reflects population health needs, provider performance or a combination.

Key strengths and weaknesses

Positive developments in health resource allocation include the introduction of programme-based budgeting (PBB) to align health budgeting with population health needs and performance; integration efforts, such as incorporating the VIRA portal into the Aasandha mobile app, aim to streamline patient access to medical welfare information.

However, the government health budget is developed based on historical budget data.

There is a disproportionate focus on curative services (83.8% of health expenditure) at the expense of prevention and primary health care (less than 1% and 11.8% respectively).[32] The focus on investment in curative care is also shown by spending on PHC, which accounts for only 11.8% of current health expenditure. The recent introduction of PBB would need to be accompanied by clear definitions of performance from standard treatment guidelines.

Resource allocation to private providers is also not optimal. Aasandha's purchasing of services and medicines from private providers and pharmacies is not driven by a systematic analysis of population health needs. There is no comprehensive dataset on costs of health services that can be used to inform resource allocation. In addition, private providers are paid through an ill-regulated fee-for-service schedule that does not generate appropriate incentives for rational provision and use of services.

Recommended policy actions

Develop a roadmap with strategic actions, a monitoring framework and a timeline to transform the Aasandha scheme into a strategic purchasing agency.

Assess the feasibility of adopting capitation- and case-based provider payment mechanisms to set incentives for providers to improve quality and ensure efficiency in service delivery.

Strengthen the use of data to make purchasing decisions by creating an integrated data management system across public and private providers.

DESIRABLE ATTRIBUTE PS2

Purchasing arrangements are tailored in support of service delivery objectives.

Key strengths and weaknesses

Purchasing arrangements do not provide incentives that promote service delivery objectives such as better quality or coordination of care. Aasandha is not yet a strategic purchaser. In the absence of clear models of care that reflect current and future population health needs, along with treatment guidelines including well-defined patient pathways (norms to be set by the MoH), it is not easy to promote coordination and quality of care. The scheme administers retroactive reimbursement of claims submitted by health providers. Public sector health facilities and health workers are paid through the government budget and salary payments, which are currently not linked to performance and quality of care. Fee-for-service is the dominant form of paying providers, and capitation- and case-based provider payment mechanisms are not yet used. However, interviews with government officials revealed a willingness to explore such provider payment methods.

There are currently no performance-based provider payment mechanisms in the Maldives health system, but the introduction of PBB described above has the potential to improve the effectiveness and efficiency of public expenditure. In Maldives, the term used is "programme performance-based budgeting" to emphasize the link between the funding of public sector organizations and the results they deliver.[33] Aasandha would benefit from building on the same approach when they pay private providers.

Recommended policy actions

Develop standard treatment guidelines to improve quality of care and empower the Aasandha scheme to review provider reimbursement claims more rigorously.

Explore purchasing instruments to promote quality of care and/or coordinated care, such as bundled payments and provider networks.

Accelerate efforts to use digital health solutions as a means of generating data for analysis and feedback to providers.

DESIRABLE ATTRIBUTE PS3

Purchasing arrangements incorporate mechanisms to ensure budgetary control.

Key strengths and weaknesses

Maldives implements traditional economic line item-based policy approach to exercise control over government budgeting. However, the public finance system is undergoing reforms across all key areas and sectors, including the recent implementation of programme-based budgeting in the public sector to link budgets to sector priorities while maintaining the broader budgetary control.

There is scope for improving the efficiency of spending by the Aasandha scheme. The rapid increase in Aasandha expenditure is not due to the moderate increase in beneficiaries, but mainly because of the combination of increased NCD burden and rising costs of outpatient care and medicines. For instance, there are limited systematic policy processes or tools to address potential over- or under-provision of health services, especially for prescriptions for medicines. Given the comprehensive scope and ceilings of the Aasandha benefit package, an open-budget system for items such as medicines makes it vulnerable to overspending. A 2018 study by the World Bank found that average drug prices were 15–75 times higher than international benchmarks, reflecting the absence of robust procurement and purchasing approaches.

Fragmented and inadequate standard treatment guidelines make it challenging for the Aasandha scheme to verify claims submitted by providers for adequacy of clinical care. With no local production capacity in the country, reimbursement prices for drugs are largely determined by importers and wholesalers; there is little control over markups. In 2018, Aasandha introduced a common rate list so that pharmacies were paid the same rates for the drugs. There are discussions on establishing a maximum retail price. A significant weakness is that doctors are free to prescribe any brand drug, limiting the leverage of generic drugs to reduce costs.

As the administrator of the national health insurance scheme, Aasandha has limited autonomy to modify key purchasing arrangements, such as benefit design, provider empanelment process or payment methods.

WHO provided support to Aasandha in 2023 to develop medical product pricing control mechanisms – it introduces two main price control mechanisms, external referencing pricing (ERP) and international reference pricing (IRP), as possible options for Aasandha to explore and adopt in conjunction with other price control mechanisms and policies.

Aasandha is currently responsible for reimbursing medicines, health products and health services in Maldives in both public and private sectors. However, Aasandha has limited authority in setting pricing and reimbursement guidance, overseeing medicine utilization and informing what gets procured nationally.

As a result, medicine expenditures in Maldives have increased at a five-year CAGR of 4.5% to reach US$ 63.6 million in 2022. Private hospitals, clinics and pharmacies witnessed the fastest rate of growth in medicine expenditures, with a five-year CAGR of 16.2%, 11.6% and 8.1% respectively. These entities had the least oversight from the MoH and the MFDA.

On the other hand, public providers have limited autonomy as they are required to operate within the strict budget lines specified by the MoH while private providers have autonomy to operate within the general health legal and regulatory framework.

In addition, there are external reasons beyond Aasandha as to why health resources may not be used in the most efficient manner. For example, Maldives relies heavily on more expensive expatriate staff because of an inadequate local supply of trained health workers (64% of medical doctors and 42% of nurses were expatriates in 2019).

However, it is worth mentioning that the current government has taken important measures to improve Aasandha's financial situation. These include the following:

- As a measure to reduce resource wastage, Aasandha has started to cut prices of 250 medicines, expects to save MVR 220 million (US$ 14 million) The price reductions will be carried out in phases; the prices of 87 medicines was reduced starting 1 November 2024 and the prices of the remaining 126 medicines reduced effective 24 November. Bulk procurement will continue as previously announced (**link**).
- Effective November 2024, patients who hold private insurance only receive Aasandha coverage for outpatient services once they reach the limit of their private insurance coverage (for both medicines and services) (**link**).
- In 2025 government plans to introduce for patients belonging to the high-income group to either be charged a specific amount for medicine and outpatient services or will need to bear the whole cost on their own. Patients who pay income tax is also planned to be charged a pre-payment for Aasandha, so that they can contribute to financing the scheme (**link**).
- **Additional reforms** planned for 2025 include setting and harmonizing package rates for services from private hospitals and medical facilities.

Recommended policy actions

- Identify the key cost drivers and implement measures to control the escalating costs of health services; implement service delivery models and interventions, including an intensified focus on strengthening PHC services to reduce the number of referrals from atolls.
- Establish monitoring mechanisms within the MoH to ensure that required essential medicines are made available in the country at a reasonable cost.
- Review effectiveness and impact of policies for regulating health-care costs financed by the Aasandha scheme (transportation of referrals, price cuts for 250 medicines).
- Further explore and develop options to reduce such costs in a fair and effective way.
- Develop methods and ensure data availability to inform the potential establishment of a maximum retail price to reduce spending on medicines and other consumables, and accelerate the use of generic medicines.
- Further expand initiatives aimed to reduce procurement prices, such as international bulk procurement (as initiated since June 2023) through an agreement between the Government of Maldives and the United Nations Development Programme (UNDP) Maldives, utilizing the UNDP's global health procurement services. Other options can be explored, including joint ventures with other countries, especially for high-volume medicines.
- Consider implementing payment mechanisms such as global budget and risk-adjusted capitation payment to control costs.
- Strengthen Aasandha Company Ltd. as the strategic purchaser in Maldives.
- For Aasandha to establish its role as a national agency for pricing and reimbursement and to effectively operate going forward, reforms in five areas are recommended, requiring improved governance, coordination and accountability among the MoH, MFDA, STO, MoF and the Customs Office in Maldives.

5. Benefits and entitlements

DESIRABLE ATTRIBUTE BR1-2

Resource allocation to providers reflects population health needs, provider performance or a combination.

Key strengths and weaknesses

The benefits appear to be reasonably well understood by the population. The National Social Health Insurance Act (2011) defines the benefits under the National Health Insurance Scheme in Maldives and provides the policy foundation for the national health insurance system, which ensures access to affordable and quality health services for all Maldivian citizens. Benefits are explicitly defined for Maldives citizens, but expatriates are required to purchase health insurance from insurance companies that set their coverage policies independently from the government scheme. However, there is no common understanding among providers as well as on the part of the purchaser (Aasandha) regarding what a certain medical procedure should entail, owing to challenges such as lack of standard treatment guidelines.

Recommended policy actions

A review and integration of benefit coverages across health schemes (including the expatriate insurance scheme) should be conducted to identify overlap, eliminate duplication, and ensure care continuity. Policy efforts for better harmonization and alignment must be initiated to address and support the government's agenda on health system efficiency. Address coverage issues of groups of residents, such as undocumented migrants who are not covered by any pooling arrangements, investigate how they access health services and how they pay for these, and explore options for effective coverage.

DESIRABLE ATTRIBUTE BR3-4

Resource allocation to providers reflects population health needs, provider performance or a combination.

Key strengths and weaknesses

No policy process that uses explicit criteria to make resource allocation decisions is currently in place. There is no platform for using cost-effectiveness analysis (CEA) or health technology assessments (HTAs) to improve resource allocation decisions and appropriateness of the health benefit package. A functioning CEA or an HTA or a similar process could identify ways of financing more cost-effective interventions, for example, prevention of NCDs. As in many other countries, one of the key health challenges in Maldives is the increase in NCDs, which account for 73% of the disease burden and 80% of all deaths.[34]

Defined benefits under the Aasandha scheme have aligned with revenues only through frequent budget amendments to cover financing gaps, leading to overspending and arrears. Furthermore, the purchasing mechanisms, including an empanelment process for providers and pharmacies, face challenges from weak regulatory enforcement, fragmented coordination, and unregulated proliferation of pharmacies that complicate the provision of medicines and services.

Recommended policy actions

As part of effective health financing policy measures, establish a formal process for priority-setting and benefit package design, including prioritization criteria and budget implication assessments.

Investigate the potential for the establishment of an HTA process and tools to enable better resource prioritization.

Build country capacity to conduct CEA and budget impact analyses to promote optimal use of public resources.

Develop and implement a process for regular costing of health services to inform design of benefit package and support purchasing decisions.

Review the treatment abroad programme to identify opportunities for efficiency gains and cost reductions without jeopardizing access to health and quality of care.

DESIRABLE ATTRIBUTE BR5

Benefit design includes explicit limits on user charges and protects access for vulnerable groups.

Key strengths and weaknesses

The national health system and the Aasandha scheme do not impose user charges; however, patients have to cover any costs at private providers that are above the approved benefit package. Members of the schemes managed by private insurance companies pay 10%–15% (depending on the insurance package) in copayment fees.

Recommended policy actions

To inform policies on improving financial protection, conduct an in-depth analysis of the out-of-pocket spending on health (including by expatriate workers and undocumented migrants) to determine why catastrophic and impoverishing spending continues even with such comprehensive coverage by Aasandha (and complementary private insurance) and what drives such spending, including the spending on medicines.

6. Public financial management (PFM)

DESIRABLE ATTRIBUTE PF1

Health budget formulation and structure support flexible spending, and are aligned with sector priorities.

Key strengths and weaknesses

Health budget formulation and implementation lack alignment with sector priorities and flexible resource use due to weak linkage between budgeting and strategic goals, inefficient resource allocation and uncoordinated procurement systems. However, the introduction of programme-based budgeting (PBB) under the Ministry of Finance shows promise in improving accountability, transparency and alignment with strategic objectives through a restructured programme classification framework.

Broadly, the recent assessment of the PFM system in Maldives by the government and the World Bank highlighted some positive points; areas for improvement were identified as well. The Public Expenditure and Financial Accountability (PEFA) Report found that the aggregate expenditure for the three years under review was above the budgeted expenditure while both functional and economic resource allocations were weak. However, it found that macroeconomic and fiscal forecasting and the budget preparation process performed well. It also noted that the medium-term perspective in expenditure budgeting performed poorly. Medium-term strategic plans were prepared for some ministries, but none were costed. It also confirmed that public procurement did not perform adequately.[35]

Recommended policy actions

Continue the implementation of programme-based budgeting to strengthen links between financing, sector outputs and performance.

Improve the capacity for coordination across the agencies involved in medium-term annual health budgeting, including the NSPA, Aasandha, the MoF, the MoH and the STO.

DESIRABLE ATTRIBUTE PF2

Providers can directly receive revenues, flexibly manage them, and report on spending and outputs.

Key strengths and weaknesses

While most health-care providers can directly receive funds through line item-based disbursements, there is limited financial (and operational) autonomy at the spending level. For instance, private providers can, and do, receive revenues directly, but they have limited flexibility in managing them. Consolidated reporting by providers for both outputs and finances and use of their data for analysis and monitoring is underdeveloped.

There are limited measures to address under- or over-budget spending in the health sector. This is reflected in health spending, which is on par with that of high-income countries as a share of GDP, as well as in government health spending as a share of total government spending. As mentioned above, the Government of Maldives is in the process of introducing PBB, which has the potential to better link financing to outcomes and performance.

Recommended policy actions

Explore options to increase provider autonomy by enabling more flexible use of funds; at the same time, continue strengthening the capacity of Aasandha to monitor and adjust policy instruments, such as the provider payment mechanism.

Create incentives for providers to improve their reporting of expenditure data and implement measures such as strengthening the contract management capacity of Aasandha company Ltd.

7. Health coverage schemes in Maldives

Table 4

Findings of Stage 1 of HFPM Maldives

Key design feature	National health system	Health Insurance Programme Aasandha	Medical Welfare	Private health insurance
Year established	1965	The targeted Madhana health insurance scheme (initiated in 2008) was transformed into a universal scheme and launched on 1 January 2012 as the Aasandha health insurance scheme.[36, 37] The full name of Aasandha is Husnuvaa Aasandha, loosely translated as "unlimited Aasandha". The 2011 National Social Health Insurance (NSHI) Act mandated the National Social Protection Agency (NSPA) to manage the national social health insurance scheme and the establishment of Aasandha Company Ltd. (referred to as Aasandha) as the administrator of the scheme. Aasandha operates the scheme under a tripartite agreement between Aasandha, the NSPA and the MoF. The NSPA is responsible for regulatory and policy oversight, Aasandha is the executor and the MoF is responsible for financing and payments. Aasandha also manages the Meraana scheme that was established in 2019. The scheme is an extension of Aasandha coverage but for Maldivian residents living in Sri Lanka, India and Malaysia. Under the Meraana scheme, health service providers empanelled under the Aasandha scheme in India and Sri Lanka will provide cashless services. In Malaysia, the scheme uses a reimbursement model, wherein patients are requested to submit a reimbursement form for services availed from facilities recognized under the scheme.	The Medical Welfare scheme was established by the Social Protection Act 2/2014. Up to 2022, it was directly managed by the NSPA. Since November 2022, all state-funded medical treatment aid is provided under one roof as VIRA service, through Aasandha Company Ltd., in collaboration with the National Social Protection Agency (NSPA).	There are five private insurance companies in Maldives,[38] four of which offer health insurance: • Allied Insurance Company: 1985[39] • Amana Takaful: 2003 (Takaful represents the Islamic approach to insurance) • Dhivehi Insurance Company: 2016 • Solarelle Insurance Company: 2016[40]

Key design feature	National health system	Health Insurance Programme Aasandha	Medical Welfare	Private health insurance
Managed by	Ministry of Health	Aasandha Company Ltd. is a state-owned company (100% government-owned), established in 2011, tasked with managing the government's health-care financing services for all Maldivians, as per the Aasandha Scheme Regulation. The NSHI Act states that "the Social Health Insurance Scheme established under this Act shall have a minimum of 40% government shares". Aasandha Company Ltd. is a state-owned company (100% government-owned), established in 2011, tasked with managing the government's health-care financing services for all Maldivians, as per the Aasandha Scheme Regulation. The NSHI Act states that "the Social Health Insurance Scheme established under this Act shall have a minimum of 40% government shares".Aasandha Company Ltd. is a state-owned company (100% government-owned), established in 2011, tasked with managing the government's health-care financing services for all Maldivians, as per the Aasandha Scheme Regulation. The NSHI Act states that "the Social Health Insurance Schem	The National Social Protection Agency (established by the NSHI Act) manages six financial assistance programmes: • Medical Welfare Programme • Disability Allowance Programme • Single Parent Allowance Programme • Foster Parent Allowance Programme • Food Assistance Programme • Social Health Insurance Scheme[41]	• Allied: subsidiary of the State Trading Organization (STO) (government owns 81.4%) [42] • Amana: privately owned • Dhivehi: privately owned • Solarelle: privately owned
A) Focus of the scheme	The national health system is a tax-funded one, supported through budget allocation from the government. The government-run health facilities' operational cost is covered by the Ministry of Finance and there is no reimbursement from the Aasandha scheme. However, the cost of services availed by Maldivians is recorded in the Aasandha information system to capture and monitor usage of services[43]	Aasandha and Meraana are public tax-funded health insurance schemes to ensure financial protection for citizens.	Medical Welfare is a financial assistance programme designed to complement Aasandha by covering health care-related costs not covered by Aasandha for citizens with medical conditions; it is in need of f inancial assistance.	Offers health insurance products to companies and individuals based on premium payments.

Key design feature	National health system	Health Insurance Programme Aasandha	Medical Welfare	Private health insurance
B) Target population	Emergency care is provided to the whole population officially residing in Maldives (including undocumented migrants), irrespective of their legal status and their financial means. However, for undocumented migrants, relevant embassies are notified and billed for the provided services.	Maldivian citizens, including those residing in India, Sri Lanka and Malaysia	The Medical Welfare scheme is available for all Maldivian citizens.	Open to all citizens who pay private health insurance premiums. Often, state-owned enterprises and private companies subscribe to private health insurance on behalf of their employees. Some population groups, such as Parliamentarians and Cabinet ministers, are also automatically enrolled to private health insurance (supplementary), paid by the government. One group is mandated to enroll with a Private Health Insurance (PHI). Expatriates are indeed required to sign up for private health insurance (from a Maldives insurance company) to apply for work visas (they also need to submit a medical report issued from a hospital or clinic approved by the MoH).44 The expatriate insurance requirements are overseen by the Ministry of Economic Development.[45] According to guidelines from the Ministry of Economic Development, pre-existing conditions should be covered.[46]
C) Population covered	The whole residing population	100% of Maldivian citizens **Aasandha Annual Report (2023):** 377 180 individuals used benefits in 2023.[47] About 7000 patients receive services abroad (mainly India and Sri Lanka) per year. Some patients receive follow-up treatment (e.g. cancer treatment) in Maldives after treatment received abroad. Sometimes, specialists come from India and Sri Lanka, but this collaboration has been limited by the adequate availability of equipment at Maldives health facilities. In 2023, through the Meraana scheme, a total of 257 beneficiaries were covered out of 5847 people registered in the scheme from the eligible three countries.[48]	Any Maldivian citizen with a documented medical need that the NSPA has approved, and service is not covered through the Aasandha scheme. **Statistical Yearbook of the Maldives 2024:** 29 880 individuals used benefits in 2023[49]	Allied: 19 000 citizens and 20 000 expatriates (2021) Amana: 80 000 individuals (November 2022)[50] Solarelle: 45 000–50 000 beneficiaries

[3] Official monthly exchange rate for December 2024 on: **https://www.mma.gov.mv/#/statistics/exchangerates**
[4] Idem

Key design feature	National health system	Health Insurance Programme Aasandha	Medical Welfare	Private health insurance
D) Basis for entitlement/ coverage	Automatic for Maldives legal residents (universal entitlement with no defined contribution required from the users)	NSHI Act states that it is "obligatory for all Maldivian citizens to participate in the Scheme established under this Act". Every Maldivian with a valid National Identification Card (NIC), which is managed by the Department of National Registration (DNR), has access to the scheme[51]. There is also coverage between birth and registration for an NIC through a birth form completed by the midwife.[52] As of November 2024, if a citizen has private insurance, it must be utilized first for outpatient care until the coverage limit is reached. If the private insurance does not cover specific health-care services that are covered by Aasandha, the individual will receive coverage under Aasandha. For Meraana, the basis for entitlement is to be a Maldivian national officially registered as a resident in Sri Lanka, India and Malaysia, either as a labour migrant or as a student.	Any Maldivian citizen can apply for the Medical Welfare programme by submitting a form and a medical certificate or prescription from a doctor specifying the medical need. The NSPA will review the application form to see if the benefit is justified and to verify if any benefits have been provided to the person in the past. While the NSPA considers income when determining eligibility for Medical Welfare benefits, medical need remains the main criterion.[53]	Individuals (and corporations if they enroll their staff) pay premiums to access benefits.

Key design feature	National health system	Health Insurance Programme Aasandha	Medical Welfare	Private health insurance
E) Benefit entitlements	Preventive, promotive, curative (outpatient and inpatient) and rehabilitative care	For Aasandha: 1. Inpatient and outpatient treatments 2. Medicines and consumables 3. Diagnostics and surgical interventions 4. All transportation fees of emergency cases, emergency evacuations 5. Annual medical check-up under packages specific to age group (below 18 years, 19–39 years and above 40 years) 6. Medical cover for terminally ill patients and those with special needs 7. Infertility treatment (IVF/IUI) covered with a pre-approval process, if selected criteria are met 8. Medical cover during pregnancy54 9. Costs of care abroad at empanelled facilities for services unavailable in Malé55 10. Oversea treatments for services not available in Maldives For Meranaa: The scheme guarantees each registered individual a total coverage of up to MVR 150 000 (USD 9'734) per year at empanelled hospitals and covers outpatient care up to MVR 10 000 per year (USD 649) from total coverage.	Benefits are intended to complement Aasandha by shouldering costs not covered by Aasandha. 1. Assistance in travelling abroad for medical care (including members of Aasandha, e.g. additional travel costs for caretakers not covered by Aasandha) 2. Medicines and injections not covered by Aasandha 3. Oxygen/BiPAP/ CPAP/VPAP machines for those in need 4. Bone marrow programme for people with thalassaemia 5. Medical care from private hospitals is not offered by government hospitals. 6. HLA typing/MRI T2 7. Medical equipment not provided by Aasandha; [56] prosthetics and assistive devices are procured by the NSPA. The supplier will provide the equipment to the beneficiary.[57]	Inpatient and outpatient services Treatment abroad depends on the insurance policy. • Allied: Basic and Select Excel and Gold health insurance plans • Amana: Corporate health insurance (considering launching individual products) • Dhivehi: Executive health insurance (inpatient, outpatient, wellness, dental, vision, maternity benefits) • Solarelle: corporate health insurance, expatriate health insurance
Exclusions	At government health facilities, as per the health-care facility, the services available will be as per MoH facility grading criteria.	See Annexure 5 for Aasandha and Meraana scheme exclusions.	Everything not listed in nos. 1–7 above	Depending on each individual private health insurance schem.

[5] Official monthly exchange rate for December 2024 on: **https://www.mma.gov.mv/#/statistics/exchangerates**

Key design feature	National health system	Health Insurance Programme Aasandha	Medical Welfare	Private health insurance
Providers	Public health facilities from primary to tertiary level, pharmacies at public hospitals	Members can access from registered public and private health-care providers. A doctor's prescription and diagnostics requisition are required to avail these services through the scheme. The list of facilities empanelled in Maldives is available here: https://aasandha.mv/en/scheme/aasandha-scheme/empanelled-facilities-local. The list of hospitals empanelled for medical evacuation is available here: https://aasandha.mv/en/overseas-treatment/empanelled-facility. Under the Meraana scheme, health service providers empanelled under the Aasandha scheme in India and Sri Lanka will provide cashless services. Maldivian citizens living in Malaysia registered under the Meraana scheme submit the reimbursement form within 60 days after receiving services from recognized hospitals under the Meraana scheme. Bills will be reimbursed within 20 days of receipt submission. The list of Malaysian hospitals/clinics recognized under the Meraana scheme: Aasandha Company Ltd.	Same providers as Aasandha, suppliers of prosthetics and assistive devices	Network of empanelled providers (differs by insurance company)

[6] Official monthly exchange rate for December 2024 on: **https://www.mma.gov.mv/#/statistics/exchangerates**
[7, 8] Idem

Key design feature	National health system	Health Insurance Programme Aasandha	Medical Welfare	Private health insurance

F) Copayments/ user fees	Full service fee exemptions for Maldivians, but user fees apply for foreign residents.	No co-payments.
		
		The NSHI Act states that "in no circumstance shall the Scheme be one where services provided under this Scheme are paid for by the participants and those amounts recovered")
		
		Coverage ceilings were removed in 2014 and there is no reimbursement cap anymore, neither in the private nor in the public sector.
		
		The copayment model is applied in the case of private hospitals and clinics. Pharmacies are, however, excluded from this copayment model. The copayment applied varies across various service providers and medical services. Medical service providers must register as a network partner and be approved by the Aasandha Company Limited to finance health care from the Aasandha scheme.
		
		Attempts to introduce copayment for medicines is an ongoing discussion under government initiative for financing reform.
			No co-payments	• Allied: 15%
				
				• Amana: 10%–15% (depends on insurance product)
				
				• Solarelle: copayment: excess, single and/or combined variations are deployed depending on policyholder's preference and requirement:
				
				  • Deductible: a fixed amount member had to bear before starting claiming (varies between US$ 100 and US$ 500 or above)
				
				  • Copay: a fixed flat and minimum amount deducted from each claim (claim being expenses for a sickness/illness) – usually used in reimbursements (usually minimum MVR 100 –USD 6[5])
				
				  • Co-insurance: fixed percentage from total amount claimed (5%–20%).

G) Other conditions for access	There is an official referral system within service delivery, but it has not yet been enforced. Patients can bypass the referral system and make direct appointments for specialists without consultations with general physicians.	To seek care abroad for services not available in Maldives, the treating physician/clinician must provide a letter of recommendation for the patient to submit for Aasandha approval. For the Meraana scheme, Maldivian citizens living/working abroad must first go through a registration and verification process	None in addition to information in Section D	Members need to access services at health providers registered by MoH and empanelled by insurance companies.

Key design feature	National health system	Health Insurance Programme Aasandha	Medical Welfare	Private health insurance
H) Revenue sources	Tax and non-tax revenues of the government	The NSHI Act states, "Scheme shall be financed from the State, contributions from the participants and through other means as stipulated in this Act and Regulations made under this Act." In reality, there are no contributions from participants; the scheme is entirely financed by the government. The NSHI Act also states that "funds required for the administration of the Agency shall in each year be included in the State budget". Funds for the Aasandha scheme are provided by the Ministry of Finance through the NSPA. With the implementation of the tripartite agreement between the Aasandha Company Ltd., the National Social Protection Agency and the Ministry of Finance, starting from 2021, Aasandha earns its revenue based on the claims being processed (local pharmacy and clinic service providers). With the commencement of the VIRA function, the company also receives a percentage as the fee (Aasandha, 2024)	Tax and non-tax revenues of the government	Premium payments from companies, organizations and individuals

Key design feature	National health system	Health Insurance Programme Aasandha	Medical Welfare	Private health insurance
Expenditure	MoH budget: 2022: MVR 1.9 billion 2023: MVR 1.8 billion[58] The MoF provides budget envelope for each sector based on historical budget data. Addu Equatorial Hospital: MVR 192.5 million Male Group of Hospitals: 1.271.8 million Total government budget: MVR 34 923 million[59]	**Statistical Yearbook of Maldives 2021:** Expenditure in 2020: MVR 2014 million (85.3% of total government spending on social protection programmes) [60] Hospitals accounted for 53.8%, pharmacies 37.4%, other categories <10%. Outpatient care accounted for 40.1%, outpatient medicines 34.8%, inpatient care 15.2%, inpatient medicines 1.5%, other categories <10%. **MoF 2021 Budget in Statistics:** Budget for social protection (pensions, Aasandha scheme, assistance programmes) for 2021: MVR 3702 million (USD 240'233'615[61]) (10.6% of total budget) The largest component of Aasandha expenditure (MVR 500 million per year on average (USD 32'446'463[62]) involves reimbursements of medicines (one of the fastest growing segments of Aasandha expenditure over the past few years). The second largest expenditure component is medical treatments abroad.[63] Outpatient pharmaceutical expenditures (through prescriptions filled at local public and private pharmacies) account for 50%–60% of the total expenditure of the scheme. The government has started efforts to improve monitoring of drugs and drugs sales, including price controls for commonly used medications and central procurement to bring down costs. International bulk procurement is being discussed by the MoH, the MoF and the Ministry of Foreign Affairs (MoFA).[64] National Health Accounts 2020 Expenditure 2020: MVR 1680 million[65] (USD 109'020'117) Private inpatient 33.3 Private outpatient 191.1 Private medicines inpatient 42.1 Private medicines outpatient 355.9 Public inpatient 37.3 Public outpatient 392.2 Public medicines inpatient 24.1 Public medicines outpatient 238.1 Overseas inpatient 86.3 Overseas outpatient 30.5 Public (IGMH) 248.9	**Statistical Yearbook of Maldives 2021:** Expenditure in 2020: MVR 79.9 million (3.4% of total government spending on social protection programmes)[66] As of November, the NSPA spent MVR 175 million (USD 11,356,262[67]) on the Medical Welfare scheme in 2022. The budget for 2023 is MVR 200 million (USD 12'978'585).[68]	Private health insurance accounted for 1.9% of health spending in 2020.[69] However, Maldives Monetary authoritiy's statistics show that the total revenues generated by private health insurance schemes through premiums have doubled over the past five years, despite the drop experienced due to COVID-19 in 2020. Claims have also followed an upward trend over the same period. The claim ratio jumped from 43% in 2019 to 66.5% in 2023
I) Pooling	Pooling of tax revenues for all residents	Pooling tax revenues for all Maldivian citizens	Targeted financing using government tax revenues	Pooling of revenues from health insurance premiums

Key design feature	National health system	Health Insurance Programme Aasandha	Medical Welfare	Private health insurance
J) Governance of health financing	The national health system is managed by the MoH. Some regional-level health facilities (around five tertiary care hospitals) are overseen by a hospital governance board appointed by the President's Office.	The Aasandha scheme is overseen and regulated by the National Social Protection Agency (NSPA). The NSPA was established by the NSHI Act, which states, "The Agency shall be administered by the CEO of the Agency. CEO of the Agency shall be appointed by the President with the advice of the Minister [of Health]. CEO of the Agency shall be accountable to the Board and Minister [of Health]." The NSHI Act stipulates that the board should consist of seven members (serving for a period of three years) appointed by the President of Maldives: MoH,[70] MoF, insurance sector, government agency responsible for social security, finance and investment sector, civil society and the CEO of the NSPA. This board is for the Aasandha scheme. There is also a board for the Aasandha Company Ltd., which comprises representatives from the MoF, MoH, government bodies (insurance, social sector), and private sector representatives appointed by the Privatization and Corporatization Board (PCB) - Privatization and Corporatization Board.[71]	The Medical Welfare scheme is managed by the NSPA.	Schemes are managed by private health insurance companies. The Maldives Monetary Authority (MMA) is the government authority responsible for the supervision and regulation of the Maldivian insurance and re-insurance industry based on the Insurance Industry Regulation (IIR), which was enacted in 2004. Insurance companies are required to report to the MMA through quarterly and annual reports with information on the number of members, number and type of claims, re-insurance information, etc.[72]
K) Provider payment	The MoH Accounts Division distributes earmarked funds to all government health facilities (165+) through separate budget lines per facility. The health facilities (regional and tertiary hospitals) managed under the President-appointed hospital governance boards have autonomy for making payments and financial decisions, unlike the health facilities under the MoH.	Fee-for-service There is no direct payment/reimbursement to public health facilities through the Aasandha insurance scheme (only private sector hospitals, polyclinics and pharmacies are reimbursed). The NSPA pays when Aasandha Company Ltd. has verified the invoices (submitted through electronic SAP system to the Ministry of Finance). Claims processing usually takes less than 90 days, payment by the NSPA usually takes 15–30 days. Aasandha Company Ltd. is paid an administrative fee (7%) to cover claims processing.[73]	Fee-for-service or fee-for-medical product	Fee-for-service based on itemized invoices from providers reviewed and approved by insurance companies Providers are generally paid within 30 days.

Note: Employee health benefits for police and military were excluded in this analysis due to low population coverage.

8. Priorities to strengthen health financing system in Maldives

Several policy options were put forward for consideration in Section 6(summary of findings by desirable attributes of health financing). This section presents a selection of those policy options that authors believe should be prioritized to strengthen financing of the health system in Maldives. The policy options presented are related to policy and coordination, and to implementation and monitoring. The section also discusses considerations related to the implementation of those policy options, such as prioritization of policy options, timeframe (short-term 1–2 years and medium-term 3–5 years), roles and responsibilities of key stakeholders, political leadership, risks and mitigating actions, and monitoring and evaluation.

8.1 Prioritized policy options

Table 5

Prioritized policy options

Policy option	Key government stakeholders	Milestones
1. Establish an intergovernmental task force chaired by the President's Office or the MoF to coordinate health financing policy and implementation.	President's Office MoF MoH	• Task force ToRs (short) • Meeting minutes (short)
2. Develop a national health financing strategy to guide efforts towards a sustainable health system.	Intergovernmental task force MoH	• Draft National Health Financing Strategy (short) • Stakeholder validation and adoption of strategy (medium)
3. Raise awareness of policy-makers about implications of policy decisions on health system sustainability.	MoH	• Awareness-raising strategy (short) • Awareness-raising activities (policy dialogue, webinars, policy briefs) (short–medium)
4. Develop a plan to reduce fragmentation of schemes by reviewing and aligning population coverage and benefit packages.	MoH NSPA	• Draft plan (short)
5. Develop strategic purchasing roadmap with milestones and monitoring framework.	MoH NSPA Aasandha STO	• Draft roadmap (short) • Stakeholder validation and adoption of roadmap (medium term)
6. Streamline procurement and leverage bargaining power (bulk procurement) to reduce prices.	MoH NSPA Aasandha	• Review of current practices (short) • Plan for strengthening procurement practices (short)

Policy option	Key government stakeholders	Milestones
7. Consider measures to control costs (reducing overutilization, overprescription): copayments, patient awareness-raising, gatekeeping role of providers.	MoH Aasandha	• Review of measures to control costs with recommendations (short)
8. Generate/update data on pricing of medicines to facilitate maximum retail price (MRP).	MoH	• Map medical product supply chain and determine price control points. • Map various market players/stakeholder, analysing potential consequences of different pricing mechanisms. • Develop medical product pricing control mechanisms with key recommendations and strategies, with the objective to improve purchase efficiency and value for money, and mitigate stakeholder resistance.
9. Promote use of generic medicines by demonstrating cost savings and ensuring quality.	MoH	• Policy brief (short) • Capacity-building informed by international best practice and country examples (medium)
10. Consider alternatives to fee-for-service as provider payment methods.	MoH Aasandha	• Review of provider payment methods (short) • Summary of international best practice and country examples (medium)
11. Develop standard treatment guidelines to improve quality of care and facilitate monitoring of service provision and provider reimbursement claims.	MoH	• Draft standard treatment guidelines (medium)
12. Build capacity on health technology assessment (HTA) and cost-effectiveness analysis (CEA) to optimize resource allocation and benefit package (focus on PHC and prevention).	MoH MoF	• Review of current status of resource allocation process (short) • Capacity-building informed by international best practice and country examples (medium)
13. Develop a more comprehensive and interoperable information system across different health coverage schemes and payment systems.	MoH MoF NSPA Aasandha PHI (including STO)	• Review of current status and identification or required policy actions (short)
14. Strengthen capacity to analyse and use health financing and service provision data to guide planning, resource allocation and monitoring of health spending.	MoH	• Review of capacity gaps (short) • Capacity-building plan and implementation (medium)

8.2 Prioritization of policy options

To ensure that policy options are relevant and appropriate, and owned by key stakeholders among government agencies, non-state actors and development partners, it is recommended that a consultative workshop be organized to review and validate the policy options proposed in Section 8.1. The dialogue should not be limited to those policy options, and participants should be encouraged to put forward additional ideas and suggestions. The validation workshop should also include facilitated discussions on the feasibility of implementing the recommendations, timeframe, sequencing of implementation, required resources to build capacity in policy and technical areas, roles and responsibilities, and potential risks and mitigating actions.

8.3 Timeframe, and roles and responsibilities

The implementation of the selected policy options in Section 8.1 would benefit from the development of a roadmap or a similar tool outlining specific actions to implement and monitor the policy options. The roadmap should consider sequencing of prioritized policy options and can be separated into short-term (1–2 years) and mid-term (3–5 years) actions. Table 5 defines key government stakeholders (to be supported by WHO and other development partners) and the suggested timeframe for the implementation of the policy options, which can serve as a starting point for discussion. The roadmap should also define the roles and responsibilities of relevant stakeholders, including the government, non-state actors and development partners.

8.4 Political leadership

High-level political leadership is critical to establish an enabling environment, aligning all stakeholders around common goals, and designing and implementing coherent and sustainable health financing policies and arrangements that contribute to the progress on UHC. Establishing an intergovernmental task force on UHC and health financing would provide a platform to ensure broad buy-in and support at the highest level and coordinate the efforts of state and non-state actors. It would also facilitate raising awareness of policy-makers about the implications of policy decisions on health system sustainability.

The task force should be chaired by the President's Office and the Ministry of Finance. A mechanism to coordinate health financing policy with the health sector is also needed. Several countries have established such platforms in the form of a Technical Working Group, bringing together representatives from government agencies and development partners. The scope and agenda of such mechanisms include policy dialogue, supporting resource mobilization through the development of investment cases and other tools, monitoring of progress on policy options, and reporting to policy-makers on the progress and challenges to inform future policy, budgeting and planning.

8.5 Risks and mitigating actions

There are certain risks associated with the implementation of policy options. First, lack of political leadership and commitment would jeopardize successful implementation of policy options. Mitigating actions include sustained advocacy efforts to raise awareness of the importance of sound policies to enable progress on UHC, supported by high-quality evidence and advocacy messages tailored to key actors. For example, investment case messages that emphasize the economic benefits of investing in health may resonate well with the MoF. Parliamentarians may be especially receptive to advocacy around the social benefits of making progress on UHC for their constituents.

Second, the resources needed to implement certain policy options may not materialize. Mitigating actions include efforts to secure enough resources through the development of an investment case for health and engagement with key decision-makers involved in the prioritization and allocation of resources. Third, the technical capacity to implement certain policy options may be limited; take, for example, strategic purchasing. Mitigation actions include identifying gaps and needs, and designing and implementing a set of capacity-building activities to address them, led by the MoH and its development partners.

8.6 Monitoring and evaluation

A monitoring and evaluation plan should be developed to track progress and assess the results of the implementation of selected policy options, highlighting any areas in need of mid-course adjustments. The plan should specify which actors are responsible for monitoring specific policy options, describe the frequency of monitoring, define monitoring indicators, explain how data will be collected and analysed, and how data collection results will be disseminated to key stakeholders and utilized to improve implementation.

Annexures

Annexure 1
Desirable attributes of health financing

Policy process and governance	
GV1	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies for both individual and population-based services.
GV2	There is transparent, financial and non-financial accountability in relation to public spending on health.
GV3	International evidence and systemwide data and evaluations are actively used to inform implementation and policy adjustments.

Revenue raising	
RR1	Health expenditure is based predominantly on public/compulsory funding sources.
RR2	The level of public (and external) funding is predictable over a period of years.
RR3	The flow of public (and external) funds is stable and budget execution is high.
RR4	Fiscal measures are in place that create incentives for healthier behaviour among individuals and firms.

Pooling	
PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds.
PR2	Health system and financing functions are integrated or coordinated across schemes and programmes.

Purchasing	
PS1	Resource allocation to providers reflects population health needs, provider performance or a combination.
PS2	Purchasing arrangements are tailored in support of service delivery objectives.
PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control.

Benefits and entitlements	
BR1	Entitlements and obligations are clearly understood by the population.
BR2	A set of priority health service benefits within a unified framework is implemented for the entire population.
BR3	Prior to adoption, service benefit changes are subject to cost-effectiveness and budgetary impact assessments.
BR4	Defined benefits are aligned with available revenues, health services and mechanisms to allocate funds to providers.
BR5	Benefit design includes explicit limits on user charges and protects access for vulnerable groups.

Public financial management	
PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities.
PF2	Providers can directly receive revenues, flexibly manage them, and report on spending and outputs.

Annexure 2
HFPM assessment questions

Policy process and governance	
Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?
Q1.2	Is health financing information systemically used to monitor, evaluate, and improve policy development and implementation?

Revenue raising	
Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
Q2.2	How predictable is public funding for health in your country over a number of years?
Q2.3	How stable is the flow of public funds to health providers?
Q2.4	To what extent are the different revenue sources raised in a progressive way?
Q2.5	To what extent does the government use taxes and subsidies as instruments to affect health behaviours?

Revenue raising	
RR1	Health expenditure is based predominantly on public/compulsory funding sources.
RR2	The level of public (and external) funding is predictable over a period of years.
RR3	The flow of public (and external) funds is stable and budget execution is high.
RR4	Fiscal measures are in place that create incentives for healthier behaviour among individuals and firms.
RR4	Fiscal measures are in place that create incentives for healthier behaviour among individuals and firms.

Pooling	
Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
Q3.2	To what extent is the capacity of the health system to redistribute prepaid funds limited?
Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
Q3.5	What is the role and scale of voluntary health insurance in financing health care?

Purchasing	
Q4.1	Health expenditure is based predominantly on public/compulsory funding sources.
Q4.2	The level of public (and external) funding is predictable over a period of years.
Q4.3	The flow of public (and external) funds is stable and budget execution is high.
Q4.4	Fiscal measures are in place that create incentives for healthier behaviour among individuals and firms.
Q4.5	Fiscal measures are in place that create incentives for healthier behaviour among individuals and firms.
Q4.6	To what extent do providers have financial autonomy and are held accountable?

Benefits and entitlements	
Q5.1	Is there a set of explicitly defined benefits for the entire population?
Q5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
Q5.4	Are user charges designed to ensure financial obligations are clear? Do they have functioning protection mechanisms for patients?
Q5.5	Are defined benefits aligned with available revenues, available health services and purchasing mechanisms?

Public financial management	
Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
Q6.3	Are processes in place for health authorities to engage in overall budget planning and multiyear budgeting?
Q6.4	Are there measures to address problems arising from both under- and over-budget spending in health?
Q6.5	Is health expenditure reporting comprehensive, timely and publicly available?

Annexure 3
List of interview participants

Name	Title	Institution	Date interviewed
Ms Aishath Samiya	Permanent Secretary	MoH	6 November 2022
Dr Shah Abdullah Mahir	Minister of State for Health	MoH	10 January 2023
Mr Ahmed Eman	Chief Accounts Executive	MoH	8 November 2022
Ms Aminath Shaina Abdulla	Deputy Director-General, Policy Implementation and International Relations	MoH	30 November 2022
Ms Moomina Abdullah	Deputy Director-General, Health Information Management and Research	MoH	3 November 2022
Mr Ahmed Mirza Shakeeb	Deputy Director-General, Procurement	MoH	7 November 2022
Mr Nayaz Ahmed	Deputy Director-General, Regional and Atoll Health Services Division	MoH	8 November 2022
Uza Thasleema Usman	Commissioner of Quality Assurance	MoH	4 November 2022
Ms Aminath Afnan Haneef Mr Ibrahim Shareef Mr Ahmed Eman	Fiscal Analyst, Ministry of Finance Budget Expert (seconded by USAID) Chief Accounts Executive	MoF MoF MoH	10 November 2022
Ms Mariyam Shafeeq	Chief Executive Officer	National Social Protection Agency	9 November 2022
Mr Ismail Azzam Wajeeh	Managing Director	Aasandha	9 November 2022
Mr Shakir Mohamed Mr Hisham Nimal	Head of Operations Head of Medical Operations	Amana Takaful	22 November 2022
Mr Ahmed Shabig	General Manager	Allied Health Insurance Company	29 November 2022
Mr Ahmed Munawwar	Senior Manager Claims	Solarelle Insurance Company	14 December 2022
Ms Yasmin Rasheed Mr Mohamed Shahudh	Assistant Resident Representative Senior Economist	UNDP	8 February 2023

Annexure 4
Selected contextual indicators

Fig. 9

Current health expenditure per capita (US$)

Source: WHO (2024)[77]

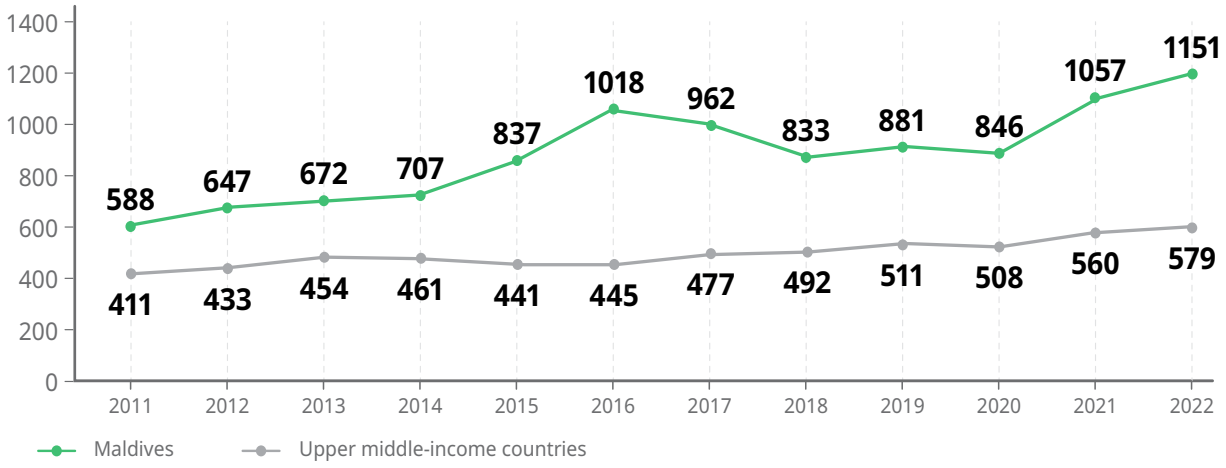


Fig. 10

Current health expenditure as % of GDP

Source: WHO (2024)

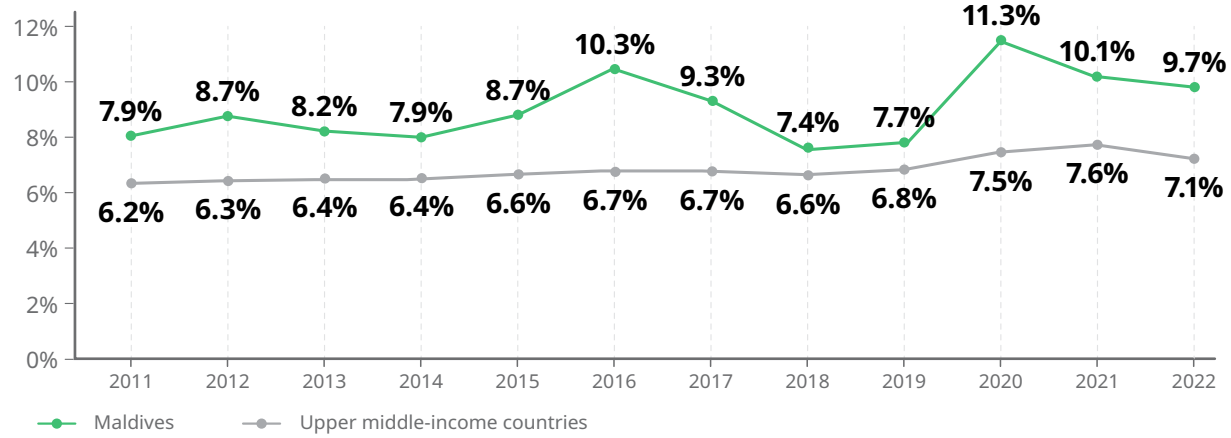


Fig. 11

Government health expenditure as % of current health expenditure

Source: WHO (2024)

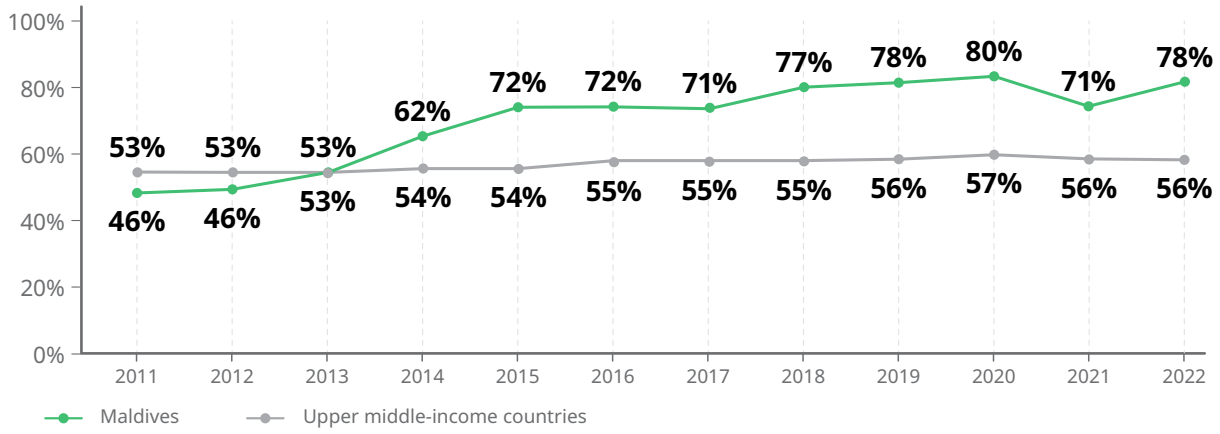


Fig. 12

Out-of-pocket expenditure as % of current health expenditure

Source: WHO (2024)

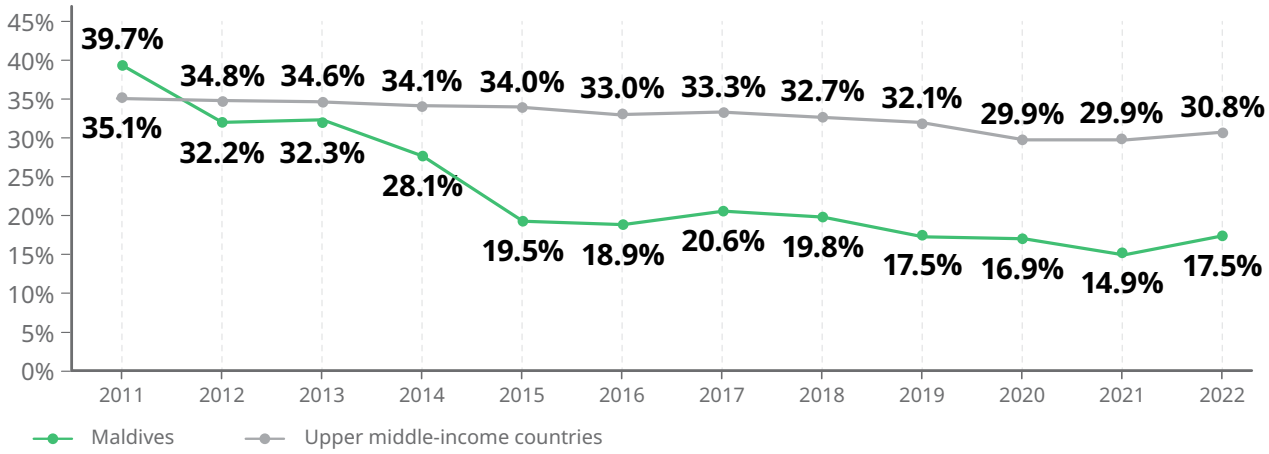


Fig. 13

Government health expenditure as % of total government expenditure

Source: WHO (2022)

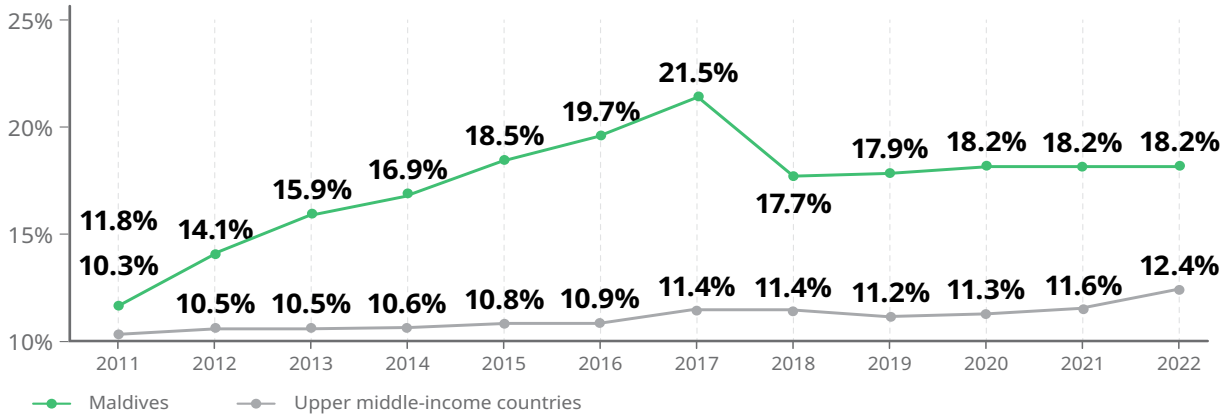
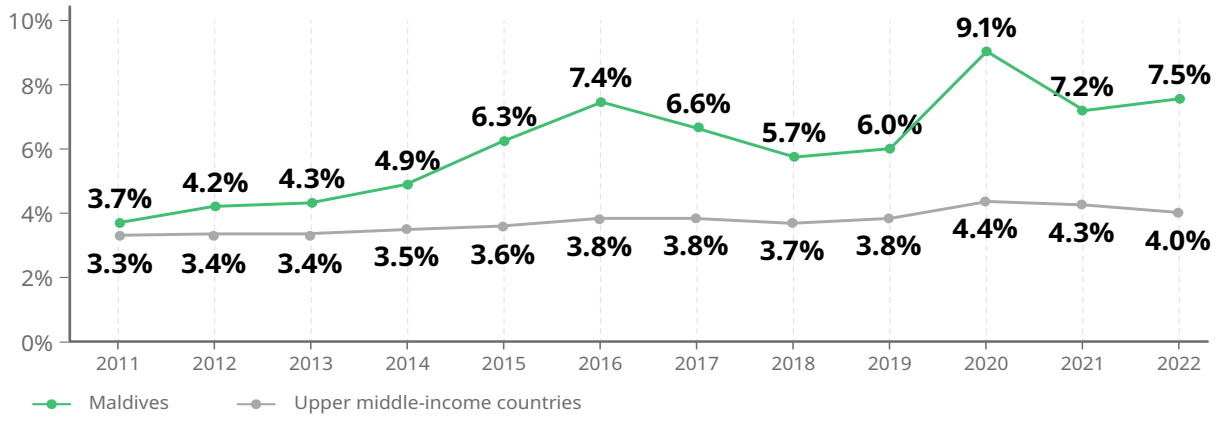


Fig. 14

Government health expenditure as % of GDP

Source: WHO (2022)



Annexure 5
Excluded benefits in the Aasandha scheme

1. Private room fees for admitted patients
2. Services obtained from health facilities not empanelled with the scheme
3. Rehabilitation and detoxification treatments (provided by a specific government agency with a dedicated programme budget)
4. Cosmetic treatment and cosmetic surgery; the term "cosmetic" refers to preparations externally applied or a treatment used to change, improve or enhance the structures of the body, especially skin, hair, nails, lips, eyes and teeth, in order to improve the appearance (this includes orthodontic treatments and teeth whitening), and contact lenses and sunglasses.
5. Assistive devices for persons with disability (already covered under the Disability Programme by the NSPA)
6. Care and treatment for hair loss, hair transplants or any drug that promises hair growth, whether or not prescribed by a specialist
7. Treatments for snoring disorders
8. Charges for physical fitness, exercise
9. equipment or exercise programmes, whether or not prescribed or recommended by a medical practitioner
10. Medications bought without a doctor's prescription and diagnostic services obtained without a doctor's requisition
11. Admission charges incurred, with regard to diagnostic tests, X-rays and medical checkups performed, without a doctor's admission slip
12. Charges or expenses incurred for food extracts, nutritional supplements or for items classified as personal hygiene, such as toothpaste, shampoo, soap, etc., whether or not prescribed or recommended by a medical practitioner
13. Charges for or in connection with counselling services (clinical psychology counselling covered under the scheme)
14. Charges for massage therapy
15. Treatment specifically for weight reduction
16. Charges for meals, telephone, television, internet, radio, newspaper and other ineligible non-medical items whilst an inpatient or day-patient
17. Experimental or unproven treatment
18. Treatment of impotence or any consequence thereof
19. Treatment directly associated with a sex change
20. Vaccine (covered under the national immunization schedule)
21. Alternative or complementary medicine and treatments (Ayurvedic, acupuncture, Chinese medicine, Dhivehi beys, etc.)
22. Business class airfare
23. Abortions (unless allowed under medical and religious rulings)
24. Infertility treatments

Source: **https://aasandha.mv/en/scheme/scheme-exclusion**

References

References

- 1 WHO, World Bank (2021). Tracking universal health coverage: 2021 Global Monitoring Report. Geneva: World Health Organization; 2021 (**https://www.who.int/data/monitoring-universal-health-coverage**, accessed 27 May 2025).
- 2 WHO, World Bank (2021). Global monitoring report on financial protection in health 2021. Geneva: World Health Organization; 2021 (**https://www.who.int/data/monitoring-universal-health-coverage**, accessed 27 May 2025).
- 3 WHO, World Bank (2023). Tracking universal health coverage: 2023 global monitoring report. Geneva: World Health Organization; 2023 (**https://www.who.int/data/monitoring-universal-health-coverage**, accessed 27 May 2025).
- 4 WHO (2022). Global Health Observatory database. WHO. 2022 (**https://www.who.int/data/gho**, accessed 27 May 2025).
- 5 WHO (2022). Global Health Observatory database. WHO. 2022 (**https://www.who.int/data/gho**, accessed 27 May 2025).
- 6 MoH, WHO (2023). National Guide for Antenatal and Postnatal Care. Malé: Ministry of Health, World Health Organization; 2023 (**https://health.gov.mv/en/downloads/national-guide-for-anc-and-pnc-in-the-maldives**, accessed 27 May 2025).
- 7 WHO, UNICEF (2022). Maldives: WHO and UNICEF estimates of immunization coverage: 2021 revision. Geneva: World Health Organization; 2022 (**https://cdn.who.int/media/docs/default-source/countryprofiles/immunization/2022-country-profiles/immunization_mdv_2022.pdf?sfvrsn=803cf90f_3&download=true**, accessed 27 May 2025).
- 8 WHO (2023). Global Health Observatory database. WHO. 2023 (**https://www.who.int/data/gho/data/themes/topics/financial-protection**, accessed 27 May 2025).
- 9 Maldives Bureau of Statistics (2023). HIES 2019. MBS. 2023 (**https://statisticsmaldives.gov.mv/hies-2019/**, accessed 27 May 2025).
- 10 World Bank (2021). Public Expenditure and Financial Accountability (PEFA) Performance Assessment Report 2020. Washington, DC: World Bank; 2021.
- 11 World Bank (2022). Maldives Public Expenditure Review: restoring fiscal health. Washington, DC: World Bank; 2022 (**https://documents.worldbank.org/en/publication/documentsreports/ documentdetail/099205108062235369/p174394036aa910c309ecf0fbecff0d7654**, accessed 27 May 2025).
- 12 MoH (2022). National Health Accounts 2018–2020: Report of key findings. Unpublished report.
- 13 Republic of Maldives (2016). Maldives Health Master Plan 2016–2025. Malé: Ministry of Health; 2016 (**https://health.gov.mv/en/publications/health-master-plan**, accessed 27 May 2025).
- 14 MoH (2022). National Health Accounts 2018–2020: report of key findings. Unpublished report.
- 15 Republic of Maldives (2022). Government Budget 2022. Malé: Ministry of Finance; 2022 (**https://www.finance.gov.mv/public/attachments/AnfMT9C9mYDCP8Vu5SdJsyP-3GUieL17fSNQQGSG.pdf**, accessed 27 May 2025).
- 16 OECD (2022). Revenue statistics in Asia and the Pacific 2022 – Maldives. Paris: Organisation for Economic Cooperation and Development; 2022 (**https://www.oecd.org/tax/tax-policy/revenue-statistics-asia-and-pacificmaldives.pdf**, accessed 27 May 2025).
- 17 World Bank Open Data. Available at: **https://data.worldbank.org/**.
- 18 OECD (2022). Revenue statistics in Asia and the Pacific 2022 – Maldives. Paris: Organisation for Economic Cooperation and Development; 2022 (https://www.oecd.org/tax/tax-policy/revenue-statistics-asia-and-pacificmaldives.pdf, accessed 27 May 2025).
- 19 **https://www.mira.gov.mv/Pages/View/ictindividuals**
- 20 MoH (2022). National Health Accounts 2018–2020: report of key findings. Unpublished report.
- 21 Coelho M, Burns L, Mullins P (2022). Maldives technical assistance report: modernizing the goods and services tax. Washington, DC: International Monetary Fund; 2022 (**https://www.**

imf.org/en/Publications/CR/Issues/2022/06/16/Maldives-Technical-Assistance-Report-Modernizingthe-Goods-and-Services-Tax-519746, accessed 27 May 2025).

- 22 Hebous S, Seguin M, Vernon N (2022). Maldives technical assistance report: estimating tax expenditures. Washington, DC: International Monetary Fund; 2022 (**https://www.imf.org/en/Publications/CR/Issues/2021/10/20/Maldives-Technical-Assistance-Report-Estimating-Tax-Expenditures-494780**, accessed 27 May 2025).
- 23 Republic of Maldives (2022). Government Budget 2022. Malé: Ministry of Finance; 2022 (**https://www.finance.gov.mv/public/attachments/AnfMT9C9mYDCP8Vu5SdJsyP-3GUieL17fSNQQGSG.pdf**, accessed 27 May 2025).
- 24 Corporate Maldives (2020). Tax charged on cigarettes – is it the most effective way to stop usage? Corporate Maldives. 5 August 2020 (**https://corporatemaldives.com/tax-charged-on-cigarettes-is-it-the-most-effective-wayto-stop-usage/**, accessed 27 May 2025).
- 25 UNC (2020). Sugary drink taxes around the world. Chapel Hill, NC: University of North Carolina; 2020 (https://globalfoodresearchprogram.org/wpcontent/uploads/2020/08/SugaryDrink_tax_maps_2020_August_REV.pdf, accessed 27 May 2025).
- 26 PSM News (2022). USD3 million from Zakat Fund spent on treatment. PSM News. 20 November 2022 (**https://psmnews.mv/en/112457**, accessed 27 May 2025).
- 27 World Bank (2022). Maldives Public Expenditure Review: restoring fiscal health. Washington, DC: World Bank; 2022 (**https://documents.worldbank.org/en/publication/documentsreports/documentdetail/099205108062235369/p174394036aa910c309ecf0fbecff0d7654**, accessed 27 May 2025).
- 28 World Bank (2022). Maldives Public Expenditure Review: restoring fiscal health. Washington, DC: World Bank; 2022 (**https://documents.worldbank.org/en/publication/documentsreports/documentdetail/099205108062235369/p174394036aa910c309ecf0fbecff0d7654**, accessed 27 May 2025).
- 29 World Bank (2022). Maldives Public Expenditure Review: restoring fiscal health. Washington, DC: World Bank; 2022 (**https://documents.worldbank.org/en/publication/documentsreports/documentdetail/099205108062235369/p174394036aa910c309ecf0fbecff0d7654**, accessed 27 May 2025).
- 30 World Bank (2022). Maldives Public Expenditure Review: restoring fiscal health. Washington, DC: World Bank; 2022 (**https://documents.worldbank.org/en/publication/documentsreports/documentdetail/099205108062235369/p174394036aa910c309ecf0fbecff0d7654**, accessed 27 May 2025).
- 31 Household Income Expenditure Survey (2019) (**https://statisticsmaldives.gov.mv/nbs/wpcontent/uploads/2021/05/HIES2019-Expenditure.pdf**)
- 32 MoH (2022). National Health Accounts 2018–2020: report of key findings. Unpublished report
- 33 Republic of Maldives (2022). Program performance-based budgeting (PBB) in the Maldives: guidelines for developing performance information. Malé: Ministry of Finance; 2022 (**https://www.finance.gov.mv/public/attachments/bWN4Nj1MSbzvYXyB2teXXQY-CAWwZ8PxDpTuAXL.pdf**, accessed 27 May 2025).
- 34 World Bank (2022). Maldives Public Expenditure Review: restoring fiscal health. Washington, DC: World Bank; 2022 (**https://documents.worldbank.org/en/publication/documentsreports/documentdetail/099205108062235369/p174394036aa910c309ecf0fbecff0d7654**, accessed 27 May 2025).
- 35 Government of Maldives (2021). Public Expenditure and Financial Accountability (PEFA) performance assessment report 2020. Malé: Ministry of Finance; 2021 (**https://www.pefa.org/node/4341**, accessed 27 May 2025).
- 36 Selvaraj S (2019). Maldives health financing system: an analysis of public spending on health (including Aasandha and spending on medicines). Report submitted to WHO Country Office, Maldives.
- 37 Maldivian Healthcare Financing Scheme 'Aasandha'- Evolution and Future. 4th WHO Bi-regional Health Financing Policy Workshop 10–13 June 2019, New Delhi, Session 1.3.
- 38 Maldives Monetary Authority. **https://www.mma.gov.mv/#/financialstability/insurancesector/insurance**.

- 39 Allied Insurance Company. **https://allied.mv/**.
- 40 Solarelle Insurance. **http://www.solarellein-surance.com/**.
- 41 National Social Protection Agency, Maldives. **https://www.nspa.gov.mv/v2/index.php/about-us/**.
- 42 **https://www.sto.mv/investors**
- 43 MoH (2022). National Health Accounts 2018–2020: report of key findings. 2022.
- 44 Maldives Immigration. **https://immigration.gov.mv/regarding-expatriate-health-insurance-policy-and-medicalreport-submission/**.
- 45 Interview with Managing Director, Aasandha Scheme. 9 November 2022.
- 46 Ministry of Finance (2022). COVID-19 Spending Report. Ministry of Finance, Malé. 4 September 2022 (**https://www.finance.gov.mv/publications/statistical-releases/cov-id-19-spending-report**, accessed 27 May 2025).
- 47 Aasandha Company Limited (2023). Annual Report 2023. Malé: Aasandha Company Ltd.; 2023 (**https://www.aasandha.mv/en/scheme/governance/annual-reports**, accessed 27 May 2025).
- 48 Interview with Managing Director, Aasandha Scheme. 9 November 2022.
- 49 Maldives Bureau of Statistics (2024). Statistical Yearbook of Maldives 2024. Malé: Ministry of National Planning, Housing & Infrastructure; 2024 (**https://statisticsmaldives.gov.mv/yearbook/2024/#**, accessed 27 May 2025).
- 50 Interview with Head of Operations and Head of Medical Operations. 22 November 2022.
- 51 Aasandha, Maldives. **https://www.aasandha.mv/en/scheme/aasandha-scheme/overview**
- 52 Interview with Managing Director, Aasandha Scheme. 9 November 2022.
- 53 Interview with Chief Executive Officer, National Social Protection Agency. 9 November 2022.
- 54 Aasandha, Maldives. **https://www.aasandha.mv/en/scheme/aasandha-scheme/overview**
- 55 WHO Country Office for Maldives (2020). Health system response to COVID-19. 2020.
- 56 NSPA, Maldives. **https://www.nspa.gov.mv/v2/index.php/medical-welfare/**.
- 57 Interview with Chief Executive Officer, National Social Protection Agency. 9 November 2022.
- 58 Interview with Chief Accounts Executive, MoH. 8 November 2022.
- 59 Ministry of Finance. 2021 Budget in Statistics.
- 60 Official monthly exchange rate for December 2024 on: https://www.mma.gov.mv/#/statistics/exchangerates
- 61 Idem
- 62 Ministry of Finance. 2021 Budget in Statistics. MoF. 2021 (**https://www.finance.gov.mv/public/attachments/Em0mwtqxQ9hYFJUq6lhfuqvFjs-4Bpp5wIAE4FxUF.pdf**, accessed 27 May 2025).
- 63 Interview with Managing Director, Aasandha Scheme. 9 November 2022.
- 64 MoH (2022). National Health Accounts 2018–2020: report of key findings. 2022.
- 65 Maldives Bureau of Statistics (2021). Statistical Yearbook of Maldives 2021. Malé: Ministry of National Planning, Housing & Infrastructure; 2021 (**http://statisticsmaldives.gov.mv/yearbook/2021/#**, accessed 27 May 2025).
- 66 Idem
- 67 Interview with Chief Executive Officer, National Social Protection Agency. 9 November 2022.
- 68 MoH (2022). National Health Accounts 2018–2020: report of key findings. Unpublished report.
- 69 **https://www.nspa.gov.mv/v2/index.php/social-health-protection-act/**
- 70 Interview with Managing Director, Aasandha Scheme. 9 November 2022.
- 71 Interview with Head of Operations and Head of Medical Operations. 22 November 2022.
- 72 Interview with Managing Director, Aasandha Scheme. 9 November 2022.
- 73 Maldives Bureau of Statistics (2021). Statistical Yearbook of Maldives 2021. Malé: Ministry of National Planning, Housing & Infrastructure; 2021 (**http://statisticsmaldives.**

gov.mv/yearbook/2021/#, accessed 27 May 2025).

- 74 Ministry of Homeland Security & Technology. Expatriate Health Insurance Requirements. **https://xpat.egov.mv/Home/ViewAnnouncement/65**.
- 75 Gadsden T, Ford B, Angell B, Sumarac B, de Oliveira Cruz V, Wang H, Tsilaajav T, Jan S (2022). Health financing policy responses to the COVID-19 pandemic: a review of the first stages in the WHO South-East Asia Region. Health Policy and Planning, 37(10): 1317-27. Available at: **https://academic.oup.com/heapol/article/37/10/1317/6692678**.
- 76 World Bank (2021). Maldives development update, April 2021: a digital dawn. Washington, DC: World Bank; 2021 (**https://openknowledge.worldbank.org/handle/10986/35832**, accessed 27 May 2025).
- 77 Gadsden T, Ford B, Angell B, Sumarac B, de Oliveira Cruz V, Wang H, Tsilaajav T, Jan S (2022). Health financing policy responses to the COVID-19 pandemic: a review of the first stages in the WHO South-East Asia Region. Health Policy and Planning, 37(10): 1317-27. Available at: **https://academic.oup.com/heapol/article/37/10/1317/6692678**.
- 78 Asian Development Bank (2020). Government schemes covered in the (Maldives) COVID-19 health response, social protection and economic assistance package. Manila: Asian Development Bank (ADB); 2020 (**https://www.adb.org/sites/default/files/linked-documents/54189-001-sd-03.pdf**, accessed 27 May 2025).
- 79 Aun YW (2021). COVID-19 vaccination financing contextualization in the South-East Asia Region. October 2021.

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South-East Asia Region