Consideration of the recommendations arising out of the Technical Discussions on "Universal Health Coverage"

(Report of the Technical Discussions)

The Regional Director convened a regional meeting to hold Technical Discussions on "Universal Health Coverage" from 10 to 12 July 2013 in New Delhi, India, as per the decision of the Sixty-fifth Session of the WHO Regional Committee for South-East Asia.

The report of the Technical Discussions is submitted to the Sixty-sixth Session of the Regional Committee for its information and consideration.
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Introduction

1. As per the decision of the Sixty-fifth Session of the WHO Regional Committee for South-East Asia, a regional meeting was organized in New Delhi, India from 10 to 12 July 2013 to hold Technical Discussions on the subject of “Universal Health Coverage”. The recommendations arising out of the Technical Discussions will be submitted to the Sixty-sixth Session of the Regional Committee, to be held in New Delhi, India from 11 to 13 September 2013, for its consideration.

2. In his opening remarks, Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia set the overarching context for the Technical Discussions. The Regional Director emphasized that equity was at the heart of UHC and the principles of primary health care remained valid in strengthening health systems for UHC to focus on the health needs of the poor through the appropriate use of technology, particularly in balancing prevention/promotion and curative care and through sustainable financing based on domestic resources.

3. Discussions were organized around the four strategic directions endorsed by Member States in the Regional Strategy for Universal Health Coverage (SEA/RC65/R6) and based on studies commissioned to inform policy and strategy development at the country level.

4. The Technical Discussions were attended by 29 participants from 10 Member States of the South-East Asia Region, from ministries of health as well as planning commissions. In addition, resource persons from academia and WHO collaborating centres, as well as WHO staff, contributed to the meeting.

The Regional Strategy for Universal Health Coverage

5. In 2012, Member States of the WHO South-East Asia Region endorsed the Regional Strategy for Universal Health Coverage in resolution SEA/RC65/R6. Applying technical concepts and, in particular, international experience to the health and development context of the South-East Asia Region, the regional strategy identified four strategic directions for accelerating progress on UHC, as follows.

6. A conceptual strategic direction

- **Placing primary health care oriented health systems strengthening at the centre of UHC.** Member States of the Region have defined UHC in different ways and are at different levels of achievement. However, it is useful to have a common framework for Member States and WHO, as the basis for taking the UHC agenda forward. UHC may be defined as having three dimensions:
  - universal, or a population dimension (who is to be covered);
  - health, or a service delivery dimension (covered with which services);
  - affordability, or a financing dimension (covered at what cost).
The definition and principles of primary health care are especially relevant to informing strategic choices along the three dimensions of UHC. Primary health care can be defined as: a benefit package that gives priority to the health needs of the poor and to public health, delivered using appropriate technology and at a sustainable cost. Using this definition of primary health care, significant progress on UHC can be made at low cost and in resource-constrained settings. A pragmatic way forward would be to phase-in UHC, starting with primary health care priorities to eliminate avoidable systems inequities and inefficiencies, and extending to more comprehensive coverage as the requisite systems and institutional capacities are developed.

7. Two technical strategic directions

- **Improving equity through social protection.** Out-of-pocket payments for health in the South-East Asia Region are the highest among all WHO regions (over 60% of total health expenditure) and are a key driver of health-related inequities in the Region. Countries that have progressed well on UHC have reduced out-of-pocket payments to less than a third of total health expenditure, with government spending at about 5% of gross domestic product. Therefore, countries are reviewing health financing as a lead area of health systems strengthening for UHC.
  - Experience suggests that the way forward on reducing inequities is through social protection, by shifting to mandatory prepayment and consolidated pooling through tax-based funding and/or social insurance contributions at the national level.
  - There is potential to raise additional financing through a higher share of government revenue or ear-marked contributions to social insurance. There is also some scope to raise marginal, supplementary resources from community-based initiatives and innovative financing; these mechanisms are best used during an “intermediary/transitory stage” for specific activities and for targeted populations.
  - These options for social protection have been successfully implemented in contexts similar to those found in the South-East Asia Region.

- **Improving efficiency in service delivery.** In addition to improving equity through better health financing, technical and allocative efficiencies in service delivery are equally relevant for UHC. They determine which services are provided and at what cost and, therefore, who can have access to them. In the South-East Asia Region, there is a push away from low-cost alternatives (including prevention/public health care) to higher-cost curative care driven by the dominance of private providers, the increasing burden of noncommunicable diseases and the availability of high-end technology. There are four main areas of broad systems inefficiencies; it is noteworthy that these are not independent of systems financing, nor are they independent of each other – thus implying the importance of a comprehensive approach in strategy development. The main areas of broad systems inefficiencies are as follows.
  - Expenditure on medicines is the largest component of out-of-pocket expenditure in the Region, and experience highlights the significance of increased public investment in medicines, better price control, and use of generics.
Experience also shows that provider payments can be used to “correct” the health systems incentive structure to influence the type of service, cost of provision and overall performance in both the public and private sectors, including supporting public–private partnerships.

In decentralized service delivery structures, inequities between decentralized units must be minimized through, for example, needs-based allocation criteria of central funds. Furthermore, it is important to review administrative decentralization from the perspective of health systems needs – some health functions may not be appropriate for decentralization, such as procurement or financing of public health.

An effective response to address these issues requires the strengthening of regulations to overcome political, administrative and information constraints.

8. An operational strategic direction

- **Strengthening capacities for UHC.** Member States of the South-East Asia Region have a long history of detailed national, subnational and programme planning, and processes are well institutionalized. However, an assessment of national plans revealed some content gaps that needed to be addressed.
- Evidence-based decision-making, including capacities to monitor and evaluate, need to be strengthened in countries.
- Resource planning: linkages with ministry of finance processes has been found to be particularly weak (e.g. costed health plans that are linked to annual budgets and medium-term expenditure plans); human resource planning within the health sector also requires attention.
- Linkages between all health-related plans within the health sector (at government/administration and programmes level) are relatively well aligned. However, linkages with health activities of other sectors are increasingly important for the requisite multisectoral UHC effort, especially ministry of health leadership.

Global agreements and debates

9. Significant efforts have been made at global level and by Member States of the South-East Asia Region to profile UHC in the health and development agenda – including in the ongoing debate on the post-2015 development agenda.

10. Listed below are some important agreements. It is worth noting that the regional strategy has already captured key recommendations from these as a practical, systematic reference for national strategic development on UHC.

- World Health Assembly resolution WHA58.33 in 2005 on “Sustainable health financing, universal coverage and social health insurance” focuses on improving health financing as a leading area of reform to improve equity in health systems. It recommends prepayment mechanisms that allow creation of large pools for effective
cross-subsidization: from the rich, healthy and young to the ill, poor and old, including tax-based financing.

- The Sixty-seventh General Assembly of the United Nations in 2012: “recognizing the intrinsic role of health in achieving international development goals, the General Assembly ... – through the unanimous adoption of a resolution on global health and foreign policy – encouraged Governments to plan or pursue the transition towards universal access to affordable and quality health-care services.”

11. During 2013, WHO convened meetings with Member States, civil society and development partners to build consensus on UHC in the post-2015 development agenda.

- In February in Geneva, WHO/World Bank brought together high-level representation from 27 Member States to discuss best practices for moving forward on UHC. Delegations from India, Indonesia, Nepal and Thailand attended from the South-East Asia Region.

- In February/March, nongovernmental and civil society organizations came together in the Regional Office for South-East Asia, to provide a collective input to the High-Level Dialogue on Health in the Post-2015 Development Agenda held in Gaborone, Botswana from 4 to 6 March.

- In March, Member States of the South-East Asia Region met in Bangkok to agree on a regional perspective for the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda held in Bali, Indonesia from 24 to 27 March.

12. Recommendations from these meetings flagged UHC as both a leading means and outcome for health, within an overarching development vision of human well-being:

- UHC is the “means” for improving better health throughout the life-course as a key dimension of human well-being and development;

- UHC, in as much it places equity at the centre of the health effort, is an important “end”, at least for health systems.

Technical discussions

13. As a follow-up to the Regional Strategy for Universal Health Coverage, the Regional Office for South-East Asia commissioned a set of studies to better inform the UHC effort. These studies comprehensively examined health systems through linkages between financing and all other systems areas. This was considered an appropriate approach to emphasize that UHC is not about health financing alone, even as countries are considering financing as the lead area of reform for their UHC effort. The studies address issues arising from policy/strategy discussions at country level through in-depth analysis in the country and/or from international experience. While some work is still in progress, initial findings were presented and discussed in preparation for the Sixty-sixth Session of the Regional Committee, as follows.
Defining UHC

14. WHO has proposed the following definition for UHC: “The goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them.” Accordingly, a pragmatic approach would be to set targets for each of the three dimensions of UHC: the universal, or population dimension (who is to be covered); the health, or service delivery dimension (covered with which services), and; the affordability, or financing dimension (covered at what cost). This gives UHC an operational side, and would support countries to move systematically towards bridging the gap between need and demand for health care in their specific contexts.

Measuring UHC

15. Measuring UHC is a challenge not just because of definitional issues, but also due to data availability especially for cross-country comparisons. Two useful parallel approaches could be considered. First, as developed by Bhutan, a composite index with multiple indicators relevant to the country's specific social, economic, political, geographic and other relevant contexts and policy requirements. However, even though the indicators may be identified along the three agreed dimensions of UHC, their complexity and contextualization will not allow international comparisons. This of course should not be the primary objective, but is an important issue that will require further deliberation. Accordingly, a second approach could be more akin to the Millennium Development Goals type of measurement using a limited number of indicators (such as reduction in catastrophic/impoverishing/out-of-pocket health spending) of improved equity, as has been suggested in the post-2015 development agenda discussions.

Understanding health inequities

16. An analysis of inequity in Nepal indicates that both access and outcome inequities are influenced by geographical and social determinants, and income factors. Understanding their relative impact could help policy by identifying priority benefit packages for target populations. It would also be useful to assess how health may be broadening inequities, so these influences could be addressed simultaneously. The complex relationship between health and inequities requires multisectoral action. As a health sector response, it may be more effective to take aggregate decisions regarding population coverage or benefit packages, rather than attempting to be very specific when selecting services and populations.

Increased government financing

17. International experience suggests that to make good progress towards UHC, countries must reduce out-of-pocket expenditure to 15–30% of total health expenditure and aspire to increasing government health expenditure to at least 10% of total government budget. Government spending has, in fact, been central in all successful UHC efforts, through the budget or through social insurance. Contributions to social insurance by formal public- and private-sector employees can be used to supplement government financing and
(as prepayment methods) both may be pooled together. This has been done in countries that have chosen mixed systems of health financing – the formal sector paying through payroll contributions and the government subsidizing the poor.

18. International experience suggests that a single risk pool at the national level is most effective, and has the potential to support the most effective cross-subsidization for equity and the most comprehensive benefit package. These may be implemented with subnational management and/or collection, which is particularly relevant in the context of a large informal sector such as is found in South-East Asia Region countries. Experience indicates that smaller pools fragment the health system, and merging these at a later stage may be challenging (for both schemes of national scope and community-based initiatives). There are successful examples of consolidating community-based initiatives through social health insurance that may be useful to inform South-East Asia Region countries as they develop health-financing strategies for UHC.

**Improving provider performance and containing costs in service delivery**

19. Countries need to choose strategically between government financing and social health insurance, the key distinction being that autonomously-managed funds separate the purchaser-provider function, allowing potential gains in efficiency including engagement of the private sector. It is important to note that the source of funding – general government revenues and/or household contribution – does not limit the way in which they may be pooled. In an integrated model, for which the ministry of health serves the two functions of financier and provider, it becomes difficult to make health-care providers accountable for availability and quality of care. The purchasing function – through provider payment mechanisms – may be used strategically to change the incentive structure and send proper signals to guide provider behaviour towards efficiency, rational use of medicines, diagnostics and treatment; and therefore, as Thailand has demonstrated, contain costs for sustainable UHC.

20. In Member States of the Region, the main provider payment mechanisms are salaries (public sector), fee-for-service plans (private sector), and per diem (in-patient care). Salaries, while being predictable with low administrative costs, provide little incentive for improvements in performance and could result in underprovision and poor quality of service (unless they are specifically linked, as in pay-for-performance instruments). Fee-for-service plans, where schedules are fixed, often result in overprovision and cost escalation, as does per diem for in-patient care that encourages extended stays or increases the number of hospital admissions. Both could potentially be corrected through global caps and alternative payments mechanisms.

21. Capitation has been used successfully by some countries, including Thailand, to improve technical efficiency and re-emphasize preventative care with low administrative costs. This is particularly important in a region that needs to restore the balance between prevention and curative services; otherwise, the increasing cost from the rising burden of noncommunicable diseases and aging issues will be unsustainable.
22. Thailand has also used diagnosis-related groups to improve efficiency and contain costs in its health system, although evidence suggests that effective implementation requires relatively complex management and quality assurance to be in place which may be currently lacking in some Member States. After introduction of diagnosis-related groups, hospital discharge summary in Thailand with the application of ICD-10 has much improved in both completeness and accuracy of diagnosis, as this forms a key part for reimbursement of admission services.

Innovations for UHC

23. Social impact bonds (SIBs) could provide an innovative way to improve efficiency and expand coverage through private partnerships. In a SIB, governments sign a pay-for-performance contract with one or several providers, often non-state actors, while the providers borrow up-front capital from private or public investors. Governments outside the South-East Asia Region have started to experiment with SIBs in criminal justice, homelessness and health care. In the Region, India is using SIBs to improve the education of girls. While it is acknowledged that SIBs may not be applicable in all Member States of the Region and that adjustments would need to be made for specific contexts, this could be a useful means to capture corporate social responsibility in an economically-dynamic region or align multiple donor contributions/multisectoral activities.

Improving equity and efficiency through better access to medicines

24. A major share of out-of-pocket spending goes towards the purchase of medicines. Furthermore, these are often purchased at considerable mark-up to ex-factory prices. Another area of inefficiency is the irrational use of medicines, which is estimated at 50% for the Region.

25. To tackle India’s “70-70 dilemma” (70% out-of-pocket spending, with 70% of this being spent on medicines) as a first effort to improve equity and efficiency for UHC, the state of Rajasthan is providing free access to essential medicines. While keeping the financing mechanism the same (i.e. government financing), Rajasthan has used reform in the procurement, pricing and distribution of essential medicines and other diagnostics, together with enforcing changes to provider behaviour, in order to reduce out-of-pocket spending and improve access and utilization of services.

26. Systems readiness has been critical for success, including adequate and appropriate human resources and, crucially, monitoring and evaluation of both supply and demand. Efficiency gains, in particular a dramatic lowering of the cost of medicines, could imply significant savings. Although detailed analysis is needed on systems costs and financial sustainability, this is clearly an extremely valuable option for “more health for the money” in countries where the more direct route of regulation of pharmaceuticals may be difficult to enforce.
Improving the balance and performance of human resources for health

27. The way health systems are financed impacts human resource distribution – an area that is understudied for policy. A key component of health workforce performance, as defined by the World Health Report 2006, is the availability of health workers where they are most needed. In terms of policy-making, financial incentives are important as poor remuneration has often been cited as a major underlying reason for leaving the health profession or contributing to health workforce out-migration.

28. In the same vein, literature reviews on nursing supply found a positive relationship between wage and labour supply. Several studies point to salaries and allowances as two key factors influencing whether health workers stay in, or leave, a rural workplace. Rural–urban maldistribution and geographical imbalances are major health workforce challenges.

29. While there is clear potential for financial incentives, the literature has generally shown that the magnitude of their effect is dependent on the context, and that financial incentives alone are not enough to improve health workforce performance. Based on a systematic assessment of these factors and of current good practices, WHO has developed 16 evidence-based policy recommendations that policy-makers can use to improve recruitment and retention of health workers in underserved areas. The recommendations are grouped into four categories:

   (i) appropriate financial incentives;
   (ii) education interventions, such as clinical rotations in remote and rural/targeted areas, and continuous professional development programmes;
   (iii) regulatory interventions, such as compulsory service or bonding schemes, and enhanced scope of practice;
   (iv) professional and personal development, such as improved living and working conditions, professional networks and public recognition measures.

30. None of these interventions works alone, nor is one better than the other. In order to correct unintended negative impacts of health-financing policy and improve deployment, retention and performance of health workers in rural areas per se, these interventions need to be selected based on country-specific contexts and implemented in a mutually reinforcing manner.

The central role of governance

31. Governance of the UHC effort will be critical for progress. The following two aspects are of particular relevance in the South-East Asia Region.

   • Regulation for credible enforcement of UHC reform, especially within the context of a dominant private sector: In systematic assessments of country capacity in regulating the health-care sector in low- and middle-income countries, the three key constraints for improving public–private partnerships were found to be political constraints, administrative constraints, and information constraints.

   • Strengthening evidence-based decision-making for UHC, including monitoring and evaluation: Thailand’s Health Intervention and Technology Assessment Programme
provides a useful illustration of how economic evaluations, and budget and ethical impact assessments have been institutionlized for policy support and decision-making on coverage of benefit packages. There is a need to build capacity for providing evidence on the cost-effectiveness of health technologies, and health technology assessment is recommended for urgent adoption in all countries.

Conclusions

32. It is important to consider the full potential of the financing function, particularly its links with other systems areas, when assigning it a leading role in UHC reforms. Health financing could significantly impact both equity and efficiency across health systems for “quick wins” on UHC as well as sustainable long-term achievements.

(1) The dimensions of who to cover, with which services and at what level of protection, provides a working definition of UHC and is a pragmatic way to operationalize the concept in countries. Countries can then plan systematic phasing-in of measurable outcomes towards a broader, longer-term aspirational vision.

(2) Detailed indicators based on country context and grouped under the three dimensions of UHC are a useful way to inform national policy formulation and revision. For an international comparison of progress on UHC, measurements would need to be simpler and require further discussion and agreement. At the least, indicators should be measured against the two objectives of UHC, namely equitable access to health service and financial risk protection. Country level measurements can be designed for specific policy use and political concerns.

(3) Health-related inequities – both as a cause and result of ill-health – need to be better understood to develop policy and strategy responses, including multisectoral action on social determinants of health. Although there are tools and techniques available for measuring inequity, there is a need to strengthen institutional capacities to apply these tools to country-specific contexts and to inform policy.

(4) To attain UHC, countries must strengthen their health systems to meet health needs through people-centred integrated care (with respect to continuum of care and vertical programmes) that is available, accessible, acceptable and affordable.

(5) Government financing is central to the UHC effort in the South-East Asia Region. However, there are ways to manage and supplement this source of funding based on the principles of prepayment and pooling which could improve both equity and efficiency, notably social health insurance.

(6) Member States of the Region must examine the effective use of purchasing to improve performance, contain costs and restore the balance between preventative and curative care.

(7) Addressing access to essential medicines has been demonstrated as a very effective “quick win” that can be sustained for both improved equity and efficiency. This approach lends itself to easy replication in other countries.
(8) Human resources for health will be a crucial input for UHC and countries need to assess the use of financial and non-financial incentives within their specific contexts for strengthening deployment, retention and performance, especially in underserved areas. The limited international evidence on this indicates that a combination of financial and non-financial incentives is most effective.

(9) Governance and ministry of health leadership will be critical for the UHC effort in the South-East Asia Region, within which two important areas are particularly highlighted:

- credible regulation of stakeholders in order to align all contributions to the national health agenda;
- evidence-based policy, strategy, planning and decision-making at all levels including monitoring and evaluation.

**Draft resolution**

33. A draft resolution on health intervention and technology assessment in support of universal health coverage was discussed and drafted. The draft resolution is annexed.
Annex

Draft resolution on health intervention and technology assessment in support of universal health coverage

The Regional Committee,

Recalling World Health Assembly resolutions WHA52.19 (Revised drug strategy, 1999), WHA60.16 (Progress in the rational use of medicines, 2007), WHA60.29 (Health technologies, 2007) and WHA63.21 (WHO's roles and responsibilities in health research, 2010), and its own resolutions SEA/RC55/R4 (Accessibility to essential medicines, 2002), SEA/RC62/R6 (Measures to ensure access to safe, efficacious, quality and affordable medicinal products, 2009), and SEA/RC63/R5 (Regional Strategy on Universal Health Coverage, 2010);

Noting that efficient use of resources is among crucial factors of sustainable health systems, especially when significant increase in access to essential medicines, medical devices, procedures and other healthcare interventions is pursued by Member States in the South-East Asia Region, as they are moving towards universal health coverage;

Noting that the World Health Report 2010 indicates that the waste in spending on health is as high as 20 to 40 per cent of the total and, therefore, the urgent need for systematic, effective solutions to reduce such wastage;

Recognizing the importance of evidence-based policy development in health systems including the decisions on resource allocation, service system designs and translation of policies into practice, as well as reaffirming the roles and responsibilities of the World Health Organization to provide support to strengthen health research capacity and utilization in Member States;

Acknowledging the critical role of health intervention and technology assessment, as multidisciplinary policy research, in generating evidences to inform prioritization, selection, distribution, management and introduction of interventions for health promotion, disease prevention, diagnosis, treatment and rehabilitation;

Emphasizing that with rigorous research methodology and transparent and inclusive processes, assessment of pharmaceuticals, vaccines, medical devices, equipment and procedures could help address the demands for reliable information on the safety, effectiveness, quality and efficiency dimensions of the technologies when they are integrated into particular health systems;

Concerned that capacities to research and document the public health, economic, fiscal, social and ethical implications of health interventions is not well-established in most developing countries, resulting in inadequate information to guide rational policy and professional decisions;
Recognizing the importance of improved national capacity on health intervention and technology assessment and regional networking for evidence-based health policy;

1. **URGES** Member States

   (a) to consider developing national methodological and process guidelines for health intervention and technology assessment to ensure transparency, quality, and policy-relevance of related research;

   (b) to consider integrating health intervention and technology assessment into national frameworks such as those for health systems research, health professionals education, health systems development, and universal health coverage,

   (c) to use evidence generated from health technology assessments for policy decisions;

   (d) to consider collaborating with health organizations, academic institutes and other key stakeholders in the countries to formulate national strategic plans concerning capacity development for and introduction of health intervention and technology assessment research;

   (e) to identify and prioritize the countries’ gaps in regard to promoting evidence-based health policy as well as improving related research capacity, and consider seeking technical support from other Member States, international agencies and the Regional Office for South-East Asia;

   (f) to consider the potential of health systems research including health intervention and technology assessment, in contributing to national policy development, planning and implementation;

   (g) to cosponsor an agenda item to discuss the role of health intervention and technology assessment in support of universal health coverage at the 134th Session of the WHO Executive Board and the Sixty-seventh World Health Assembly; and

2. **REQUESTS** the Regional Director

   (a) to ascertain the status of health intervention and technology assessment in Member States of the Region, in terms of human resources and institutional capacity, governance, linkage between health intervention and technology assessment units/network with policy authorities, policy utilization of assessment results, and interests and impediments in strengthening the capacity;

   (b) to foster knowledge on health intervention and technology assessment among national policy-makers and other stakeholders by drawing lessons from the operation, performance and contributions of competent research institutes within and outside the Region, and transferring such experiences to Member States through appropriate channels and activities;
(c) to integrate health intervention and technology assessment concepts and principles into relevant regional strategies including, but not limited to, those on universal health coverage and rational use of medicines and health technology;

(d) to collaborate with relevant international organizations, regional networks and academic institutes on health intervention and technology assessment and to provide technical supports to Member States, in order to strengthen health intervention and technology assessment capacity;

(e) to ensure adequate technical and management competency in the Regional Office for South-East Asia that is essential for addressing the demands for support to facilitate evidence-based policy decisions in Member States;

(f) to identify and support focal points at the regional and country levels to ensure active, effective and sustainable collaboration, sharing information within and outside the Region;

(g) to request the WHO Executive Board to include an agenda item to discuss this issue at its 134th Session and further to the Sixty-seventh World Health Assembly;

(h) to report the progress and outcome of the implementation of this resolution to the Sixty-eighth Session of the Regional Committee.