Globally, at least 400 million people still do not have access to one or more essential health services, according to a report just published by WHO and the World Bank. Achieving universal health coverage (UHC) is a South-East Asia Region priority and has a critical place in the new Sustainable Development Goal for health. Making progress on universal health coverage means ensuring that all people receive the quality, essential health services they need, without suffering financial hardship. To date, there has been much international attention on financing for UHC. Less attention has been given to ways to improve coverage with quality health services—which has to happen in parallel with sound financing strategies if real progress towards UHC is to be made.

This focus, however, is beginning to shift. In the Region, in addition to addressing health financing for UHC, there have been commitments to improve access to essential medicines and to strengthen the health workforce. During this Regional Committee, patient safety and UHC will be discussed as well as community–based service delivery. In addition, a WHO draft global strategy on people-centred and integrated health services has just been released for public consultation for submission to WHO governing bodies in 2016.

This background paper for the Ministerial Round Table summarizes:

- The draft WHO global strategy on people-centred and integrated health services and its five main directions: empowering and engaging people; strengthening governance and accountability; reorienting the model of care; coordinating services; and creating an enabling environment.

- Progress on activities to strengthen the health workforce in South-East Asia.

The following issues may assist discussion by ministers on strengthening the health workforce and expanding delivery of effective services:

- What progress is being made in expanding delivery of quality, essential health services to those who have not been getting them? What have been the major obstacles?
• What experience is there in delivering more people-centred and integrated services?

• Are the actions being taken to strengthen the health workforce in the Region helping to improve the production, distribution, retention and performance of health workers in Member States? Are there opportunities to further accelerate progress?

The attached working paper to be presented to the Ministerial Round Table was submitted to the High Level Preparatory (HLP) Meeting for its review, and was noted.
Introduction

1. Globally, at least 400 million people still do not have access to one or more essential health services, according to a report on Tracing Universal Health Coverage just published by WHO and the World Bank. Achieving universal health coverage (UHC) is a South-East Asia Region (SEAR) priority and has a critical place in the new Sustainable Development Goal for health. Making progress on universal health coverage means:
   - ensuring that all people receive the quality, essential health services they need
   - without suffering financial hardship.

2. To date, there has been much international attention on financing for UHC. Less attention has been given to ways to improve coverage with quality health services - which has to happen in parallel with sound financing strategies if real progress towards UHC is to be made.

3. This, however, is beginning to change. In the Region, UHC is one of seven flagship priorities, with a focus on improved access to essential medicines and strengthening the health workforce. This Regional Committee is discussing patient safety and UHC, and community-based service delivery. A WHO draft global strategy on people-centred and integrated health services is now out for public consultation with a view to submitting it to WHO’s Governing Bodies in 2016.

4. Health services cannot be delivered without health workers. Although progress has been made on HRH since the World Health Report 2006 ‘Working together for health’, challenges remain in South-East Asia Region in terms of low investment; discrepancies between demand and supply of health workers; and in workforce planning. Shortages, maldistribution, limited skills and poor working environments remain common concerns.

5. The Ministerial Round Table is invited to discuss the following topics: experience with expanding delivery of services to uncovered populations; making services more people-centred and integrated; and progress on strengthening the health workforce.

WHO global strategy on people-centred and integrated health services: the five main directions

6. The draft health services strategy calls for a fundamental ‘paradigm shift’ in the way health services are managed, funded and delivered. It argues that this is urgently needed to respond to challenges faced by health systems today and tomorrow, as people live longer, and the burden of costly chronic conditions requiring multiple, complex interventions continues to grow. It also makes the case for health systems being better prepared and able to respond to emergencies.

7. It argues that without a more people-centred and integrated approach to health services, health care will become increasingly fragmented, inefficient and unsustainable. It builds on the legacy of Alma Ata, and makes reference to existing regional strategies, including the regional resolution on revitalizing primary health care and its strategy on UHC. It stresses that there is no single best model of service delivery as impact and risks of different approaches are affected by local circumstances. The draft strategy aims to be relevant in different country contexts.
8. ‘People-centred health services’ consciously adopt the perspectives of individuals, families and communities, and see them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways.

9. ‘Integrated health services’ are services that are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at different levels and sites of care within the health system, and according to their needs, throughout their life.

10. **Five strategic directions** are outlined, to make services more people-centred and integrated:

   1. empowering and engaging people
   2. strengthening governance and accountability
   3. reorienting the models of care towards primary health care
   4. coordinating services
   5. creating an enabling environment.

**The five strategic directions: what they may mean in practice in SEAR countries**

11. SEAR countries have made considerable progress in improving coverage for services related to the health MDGs, but there remains more to do. Attention to health services for chronic conditions is increasing, and makes different demands on the organization, management and financing of health services. There are concerns about inequalities in access; safety and quality of care - of both public and private providers; as well as value for money and efficiency. The frequency of natural disasters in the region, most recently in Nepal, means policy-makers are regularly reminded of the importance of well-prepared and resilient health systems that can deliver services in emergencies. What follows are some examples to illustrate what these five directions may mean in practice, to stimulate discussion and exchange of experience at the Ministerial Roundtable.

12. **Empowering and engaging people.** Examples of interventions in the document are: improved health literacy; shared decision-making; access to personal health records; supporting self-care and personal care planning; community participation; community delivered care, patient and user groups. There is considerable experience in SEAR in community engagement within specific programmes; with community-based health care services (SEA/RC68/17); with community- and national level health committees and assemblies.

13. **Strengthening governance and accountability.** This involves promoting transparency in decision-making and robust systems for accountability of service providers and managers. Examples are given in the document of approaches such as patient charters; collecting and acting on user experiences; decentralization; contracting, performance-based financing. In SEAR, there is experience with health technology assessments to facilitate more transparent decision-making; with contracting, and with different forms of decentralization, to mention just three approaches.
14. **Reorienting models of care towards primary health care.** Examples in the document include scaling up family medicine; community health workers; community-based multidisciplinary teams; integrated mental and physical care and ehealth. SEAR Member States’ health policies position PHC as their basic model, backed up by secondary and tertiary health care services. However, expenditure data show that hospital care dominates in terms of budget allocation. Importantly, there remain challenges with the bypassing of primary care services, and with ensuring safe, effective and affordable services by public and private health care providers, for both ambulatory and inpatient care.

15. **Coordinating services** is defined in the draft strategy to be about reducing fragmentation and improving coordination of care around people’s needs at every level of care. It is about establishing health care networks that may include public and private providers. It is about ensuring a continuum of care. It includes integrating vertical programmes of care, and traditional medicine, into modern health care systems. The rise in noncommunicable diseases increases the importance of well-coordinated services. Today, many patients with – for example – hypertension and diabetes mellitus in SEAR countries are lost in the follow-up, only to appear later with life-threatening and costly complications.

16. **Creating an enabling environment** that brings together the many different stakeholders needed to undertake transformational change. The strategy lists the different elements of an enabling environment: strong leadership; shared vision; dedicated resources for implementing change; supportive organizational culture; and reorientation of the health workforce.

### Health workforce strengthening in SEAR: progress and remaining challenges

17. **Political commitment to the decade for strengthening of human resources for health in SEAR continues.** In late 2014, a regional meeting on HRH strengthening held in Bhutan launched a Decade for HRH strengthening in SEAR, 2015–2024. Member States agreed to focus in particular on transformative education and rural retention.

18. **There is a major but not exclusive focus on transformative education and rural retention.** In 2015, three countries have organized national technical consultations around country action plans for strengthening transformative education and rural retention. In Sri Lanka, the consultation provided the impetus for the Ministry of Health to publish its Strategic Plan on HRH. Indonesia has launched a major initiative to address health workforce distribution in rural/remote areas.

19. The Expert Advisory Group report on the WHO global Code of Practice for international recruitment of health personnel was discussed at the Sixty-eighth World Health Assembly. It confirmed the Code’s continuing relevance. The second round of national reporting is now underway and six SEAR Member States are reporting. An inter-country workshop was held in July 2015 to support national reporting.

20. **WHO has developed a Minimum Data Set for a health workforce registry.** One critical component of the human resource information system (HRIS) is the health workforce registry. While registries exist in some form in most countries, they are often not standardized, updated,
reliable, centralized nor in electronic form. Maldives has initiated the creation of a minimum data set in 2014 with support from WHO.

21. There is more attention to increasing the evidence base for health workforce development. The Asia-Pacific Action Alliance on Human Resources for Health (AAAH) recently completed a call for proposals on research related to strengthening faculty capacity. The health workforce was also one of the four topics being considered for further research by the Asia-Pacific Health Systems and Policies Observatory Board in June 2015.

22. A WHO global health workforce strategy is in development. A complementary strategy on nursing and midwifery in the context of the global health workforce strategy is also being drafted.

23. Nursing and midwifery activities at country, regional and global levels continue.
   - Revisions to auxiliary nursing and midwifery education; nursing and midwifery curricula. WHO publications on ‘Midwifery educator core competencies’; midwifery educator core competencies adaptation tool.
   - Recommendation by Chiefs of Nursing and Midwifery and heads of WHO Collaborating Centres for Nursing and Midwifery in South-East Asia to monitor and evaluate implementation of national nursing and midwifery plans, including workforce deployment and retention.
   - Events, partnerships: The Asia-Pacific Emergency and Disaster Nursing and Midwifery Network meeting focused on mass casualty management, reproductive health and mental health; regional meeting on strengthening midwifery to improve maternal and newborn health.
   - National policy development for nursing and midwifery developed in Bhutan, 2014; and in the Maldives in 2015.

Conclusions

24. The draft WHO global strategy on people-centred and integrated health services provides a stimulus to review the extent to which current service delivery arrangements in countries are enabling access to effective and safe services by all those that need them. At the same time, actions are being taken to accelerate progress on health workforce strengthening in SEAR. Together, these should help to expand delivery of effective services, under the overall goal of advancing universal health coverage.

25. The following issues are proposed to assist discussion during the Round Table:
   - Much progress has been made in coverage of services related to the MDGs since 2000, but significant gaps remain. What strategies are already being used to expand delivery of quality essential services to those who have not been getting them?
• What recent experience is there in delivering more people-centred and integrated services? Do the five directions outlined in the global strategy provide a useful framework for planning future health services, which will lead to improved access to quality essential services?

• Are the actions being taken to strengthen the health workforce in SEAR helping to improve the production, distribution, retention and performance of health workers in Member States? Are there opportunities to further accelerate progress?