

Regional Strategy for Universal Health Coverage

health needs met affordably for all
through social protection
in service delivery
for evidence-based decisions

Goal
Equity
Efficiency
Institutions and capacities

Regional Strategy for Universal Health Coverage



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Organization**

Regional Office for South-East Asia

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Abbreviations and acronyms

ANC	antenatal care
BPL	Below Poverty Line
CBHI	community-based health insurance
CCSS	Caja Costarricense de Seguro Social
DRG	diagnosis related group
DSF	Demand-side financing
HDI	Human Development Index
HLP	High-Level Preparatory
HSS	health systems strengthening
HTA	Health Technology assessment
MDG	Millennium Development Goal
NHIS	National Health Insurance Scheme
NHPSP	National health policy strategy and planning
NSO	National Statistical Office
NTP	National Tuberculosis Programmes
PHC	primary health care
RSBY	Rashtriya Swasthya Bima Yojana
SEAR	South-East Asia Region
SHI	social health insurance
UHC	universal health coverage
VAT	Value Added Tax
ARV	antiretroviral
BOK	operating cost assistance
CHPS	Community-Based Health Planning and Service
DFID	United Kingdom Department for International Development
DOT	directly observed treatment
EQUITAP	Equity in Asia-Pacific Health Systems
GDP	gross domestic product
IHPP	International Health Policy Program
MHVS	Maternal Health Voucher Scheme
MoH	ministry of health

MoPH	ministry of public health
NCD	noncommunicable disease
NGO	nongovernmental organization
NHIA	National Health Insurance Authority
NHP	national health policy
OOP	out-of-pocket
PMTCT	Preventing mother-to-child transmission (of HIV/AIDS)
PNC	Postnatal Care
SEARO	WHO South-East Asia Regional Office
SYP	Syrian Pounds
TB	tuberculosis
UC	universal coverage
WHO	World Health Organization
WPRO	WHO Western Pacific Regional Office

Executive summary

This Regional Strategy for Universal Health Coverage was unanimously endorsed by the Sixty-Fifth Session of the Regional Committee for South-East Asia (Resolution SEA/RC65/R6) in September 2012. The Strategy recommends four Strategic Directions for advancing universal health coverage (UHC) in the South-East Asia Region (SEAR) that emerged from background work and were agreed to in consultation with Member States:

Strategic Direction 1. *Placing primary health care-oriented health systems strengthening in the context of universal health coverage.* Countries in SEAR have defined UHC in different ways and are at different levels of achievement, with the common goal of improving equity in health. 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 with what level of government subsidy or covered at what cost to households).

The *definition* and *principles* of primary health care are relevant to inform strategic policy choices along these three dimensions: a benefit package that gives priority to the health needs of the poor and public health, delivered using appropriate technology and at sustainable cost. Using this definition, significant progress on UHC is possible at low cost and in resource-constrained settings. A pragmatic way forward is to 'phase-in' UHC, starting with primary health care priorities to eliminate avoidable systems inequities and inefficiencies; and, scaling-up and extending to more comprehensive coverage as requisite systems and institutional capacities are developed.

Strategic Direction 2. *Improving equity in financial coverage.* Out-of-pocket payment (OOP) for health in SEAR is the largest component of total health expenditure and highest among all WHO regions. OOP is a key driver of health-related inequities in the Region - evidence shows that countries that have progressed well on UHC have reduced OOP to less than 1/3 of total health expenditure, with government financing at the core of health spending at about 5% of gross national product (GDP). Experience suggests that the way forward on reducing inequities is through social protection - shifting to mandatory pre-payment and consolidated pooling using tax-based funding and/or social insurance contributions. Importantly, these options have been

implemented successfully for UHC even in low- income settings. In SEAR, there is potential to raise additional financing for health through a higher share of government revenue and/or earmarked contributions to social health insurance.

Strategic Direction 3. *Improving equity and efficiency in service coverage.*

In addition to improving equity in collection and pooling of resources, better financing must also use resources raised equitably and efficiently – this purchasing function is equally important for UHC and determines which services are provided and at what cost and, therefore, who accesses them. In SEAR, there is push-away from low-cost alternatives to high(er)-cost curative care driven by the dominance of private providers, the increasing burden of noncommunicable diseases (NCDs) and the availability of high-end technology. Associated with this are four broad areas of systems inefficiencies:

- ◉ Expenditure on *medicines* is the largest component of OOP in SEAR and experience highlights the importance of increasing public investment in medicines, improved prescribing practices including use of generics and better price control.
- ◉ Experience also shows that alternative provider payment methods have been used effectively to ‘correct’ the health systems incentive structure to influence the type of service, cost of provision and overall performance of *human resources for health* in both the public and private sectors.
- ◉ In a decentralized *service delivery organization*, potential inequities between decentralized units need attention and may be minimized through e.g. the use of a needs-based allocation criteria for central funds. Further, it is also important to review administrative decentralization from the perspective of health systems needs – some functions may not be appropriate for decentralization e.g. procurement of medicines.
- ◉ An effective response to address all these issues requires strengthening of regulation and overall systems *governance*.

Strategic Direction 4. *Strengthening national institutions and capacities for universal health coverage.*

National health policy strategy and planning (NHPSP) is key to the UHC effort in countries. Both process and content need to be strengthened so as to use NHPSP more strategically for UHC. Critical capacity gaps exist in NHPSP in SEAR countries - in evidence-based decision making; resource planning; process management; linkages between all health-related plans; and, monitoring and evaluation.



Introduction

Introduction

This Regional Strategy for Universal Health Coverage was unanimously endorsed by the Sixty-Fifth Session of the Regional Committee for South-East Asia (Resolution SEA/RC65/R6) in September 2012. Previously, in May 2012, at the Sixty-fifth World Health Assembly, the Director-General, Dr Margaret Chan announced UHC as a WHO priority for her second term in office (2012-2017).

Countries in the WHO South East Asia Region (SEAR) have made significant contribution to UHC with respect to both conceptual thinking as well as implementation. The focus in NHPSP has been on improving equity in health as the core of UHC. To assist in this effort, this Regional Strategy systematically documents technical issues and international experience as a practical reference to advancing UHC, for both Member States and WHO.

The Strategy was developed in consultation with Member States¹ and experts from within and outside the Region². Background documents were commissioned to study the UHC situation in each SEAR country; and, on relevant technical areas.³ The document also draws upon existing WHO work, notably the *Health financing strategy for the Asia-Pacific Region (2010-2015)*⁴ and the World Health Report 2010 *Health Systems Financing: The Path to Universal Coverage*⁵ as well as related Regional Committee and World Health Assembly resolutions.

As noted above, equity lies at the centre of UHC, both conceptually and in country efforts. In the South East Asia Region, OOP is the key driver of inequities in health as well as overall household poverty. OOP is, in fact, the most regressive way of financing health but is the largest component of health expenditure in the Region and is highest in SEAR as compared with other regions. Therefore, countries are considering health financing as a lead area of reform for UHC and this topic is examined first. However, the Strategy emphasizes that reforming financing *mechanisms* alone shall not be adequate for UHC – links between the financing *function* and other system areas need critical attention as well for improving *both* financing and

1 Regional Consultation on Universal Health Coverage, April 16-17 2012, WHO SEARO New Delhi.

2 Expert group meeting on the Regional Strategy on Universal Health Coverage, March 22-24, 2012 Bangkok.

3 Background documents to be published separately as journal articles.

4 http://www.who.int/health_financing/documents/cov-wprosearo-strategy2010/en/

5 Full document available on <http://www.who.int/whr/2010/en/>

service coverage. Accordingly, the Strategy discusses linkages between the financing function and broader health systems as well - however, separate and in-depth analysis of each systems building block is beyond the scope of the current work as requested by Member States.

Also, the Strategy is developed so as to be relevant for UHC all SEAR countries. For this, while individual country contexts are quite different, a set of issues may be identified which includes challenges for each country:

1. *Health context:*

- a. The epidemiological and population transition: an unfinished public health agenda of high mortality and morbidity from low-cost preventable and communicable causes; an increasing burden of high-cost NCDs; and, an ageing population.
- b. Health systems: high OOP, the majority of which goes towards the purchase of medicines; and, a large and mostly unregulated market-driven private sector that dominates service provision and also influences the production and deployment of human resources as well as cost of services in the system.

2. *Socio-economic context:* a large and poor informal sector, still mainly in rural areas but rapidly increasing in urban areas and with a significant burden of social determinants of health.

3. *Policy context:* health as a key determinant of economic growth is still not effectively advocated for and fully reflected in national development policy and especially budgets.

This Strategy document is organized around four Strategic Directions for advancing UHC in SEAR. These areas emerged from background work and were agreed to in consultation with Member States - a conceptual Strategic Direction; two technical Strategic Directions; and, one Strategic Direction for action:

- ***Strategic Direction 1. Placing primary health care-oriented health systems strengthening in the context of universal health coverage.***
- ***Strategic Direction 2. Improving equity in financial coverage.***
- ***Strategic Direction 3. Improving equity and efficiency in service coverage.***

- ◉ **Strategic Direction 4. *Strengthening national institutions and capacities for universal health coverage.***

Each section includes the situation in SEAR as relevant for the Strategic Direction, related technical issues, relevant country examples and the suggested way forward on UHC for SEAR. A final section consolidates recommendations from each Strategic Direction.



Strategic directions

STRATEGIC DIRECTION 1

Placing primary health care-oriented health systems strengthening in the context of universal health coverage

Key messages:

- ◉ Countries in SEAR have defined UHC in different ways and are at different levels of achievement, with the common goal of improving equity in health.
- ◉ 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 with what level of government subsidy or covered at what cost to households)
- ◉ The *definition* and *principles* of primary health care are relevant to inform strategic policy choices along these three dimensions: a benefit package that gives priority to the health needs of the poor and public health, delivered using appropriate technology and at sustainable cost.
- ◉ Using this definition, significant progress on UHC is possible at low cost and in resource-constrained settings.
- ◉ A pragmatic way forward is to 'phase-in' UHC, starting with primary health care priorities to eliminate avoidable systems inequities and inefficiencies; and, scaling-up and extending to more comprehensive coverage as requisite systems and institutional capacities are developed.

The purpose of this first section is to provide a practical framework for developing a UHC strategy that is relevant in different country contexts. It establishes the conceptual continuum from primary health care (PHC) oriented health systems strengthening (HSS), as has been already emphasized by Member States and WHO, to the current effort on UHC.

Primary health care-oriented health systems strengthening

The Alma-Ata Declaration (1978)⁶ defines primary health care as ‘essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance’. The principles of PHC are identified as:

- relevance to country context, evidence and experiences
- addressing promotive, preventive, curative and rehabilitative care needs of the community
- prioritizing the poor and vulnerable within improved comprehensive health care for all
- empowering communities
- supported by an effective referral system
- relying on a health team with a skill mix that can respond to the health needs of the community in their specific socioeconomic context
- involving all health-related sectors

Twenty five years after the adoption of the Alma-Ata Declaration, the Fifty-sixth World Health Assembly (WHA) reinforced PHC and its ultimate goal of Health For All. Subsequently, to achieve this goal, the World Health Report 2008⁷ identified four reform areas for PHC-oriented HSS:

1. reducing exclusion and social disparities in health (universal coverage reforms);
2. organizing health services around people’s needs and expectations (service delivery reforms);
3. integrating health into all sectors (public policy reforms);
4. pursuing collaborative models of policy dialogue (leadership reforms).

6 Declaration of Alma-Ata (1978), available on http://www.who.int/publications/almaata_declaration_en.pdf

7 The World Health Report 2008 - primary Health Care (Now More Than Ever), <http://www.who.int/whr/2008/en/>

Defining universal health coverage

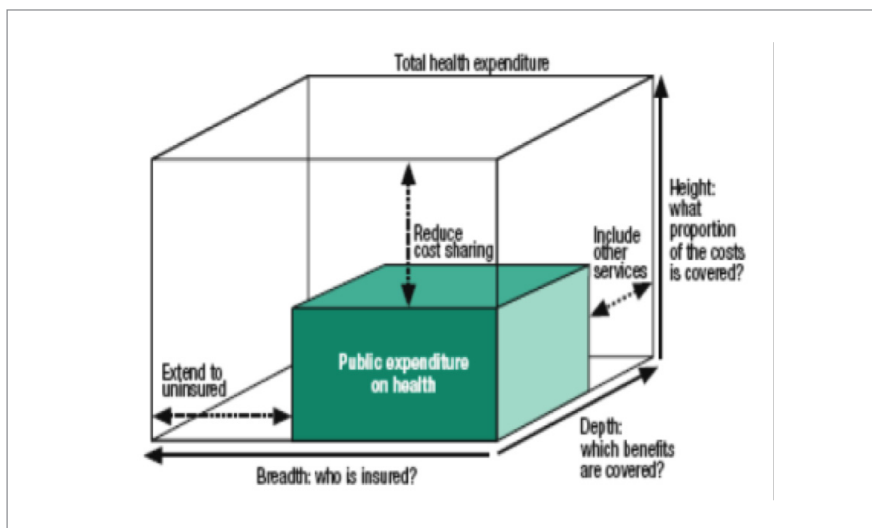
World Health Report 2010⁸ identifies the goal of universal health coverage as being ‘to ensure that all people obtain the health services they need without suffering financial hardship when accessing them’ and defines UHC as having three dimensions:

1. *universal* or a population dimension (who is to be covered)
2. *health* or a service delivery dimension (covered with which services)
3. *affordability* or a financing dimension (covered with what level of government subsidy or covered at what cost to households)

These dimensions are depicted in Figure 1 below.

UHC so defined resonates with the Declaration of Alma-Ata and, like PHC, seeks to address ‘gross inequality in the health status of the people’. It is now over three decades since Alma-Ata, and UHC – in both concept and practically – must, of course, capture new and emerging challenges including the complexity of multiple influences on health and health systems. Nevertheless, the definition and principles of PHC remain very valid for making strategic choices for UHC.

Figure 1: Three ways of moving towards UHC



Source: WHO 2010.

8 World Health Report 2010, Health systems financing: the path to universal coverage, available on <http://www.who.int/whr/2010/en/>

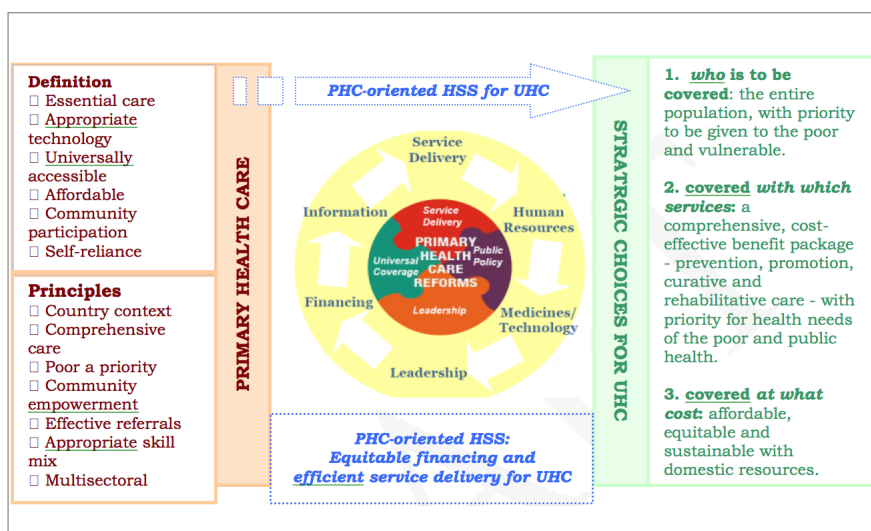
Primary health care-oriented health systems strengthening in the context of universal health coverage: A conceptual framework.

The definition and principles of PHC-oriented HSS provide important guidance for policy decisions along the three dimensions of UHC:

1. *who* is to be covered: the entire population, with priority to be given to the poor and vulnerable in the initial 'phasing-in' of UHC.
2. covered *with which services*: a comprehensive, cost-effective benefit package that balances prevention, promotion, curative and rehabilitative care, with priority for the health needs of the poor and public health services.
3. covered *at what cost*: affordable, equitable and sustainable, using domestic resources.

Figure 2 presents this discussion visually.

Figure 2: Primary health care-oriented health systems strengthening in the context of universal health coverage: A conceptual framework



Universal health coverage in SEAR and other regions

Countries in SEAR have prioritized different services in their UHC benefit packages and are at different stages of progress. For example, Nepal has committed to deliver a pre-determined set of maternal and child health

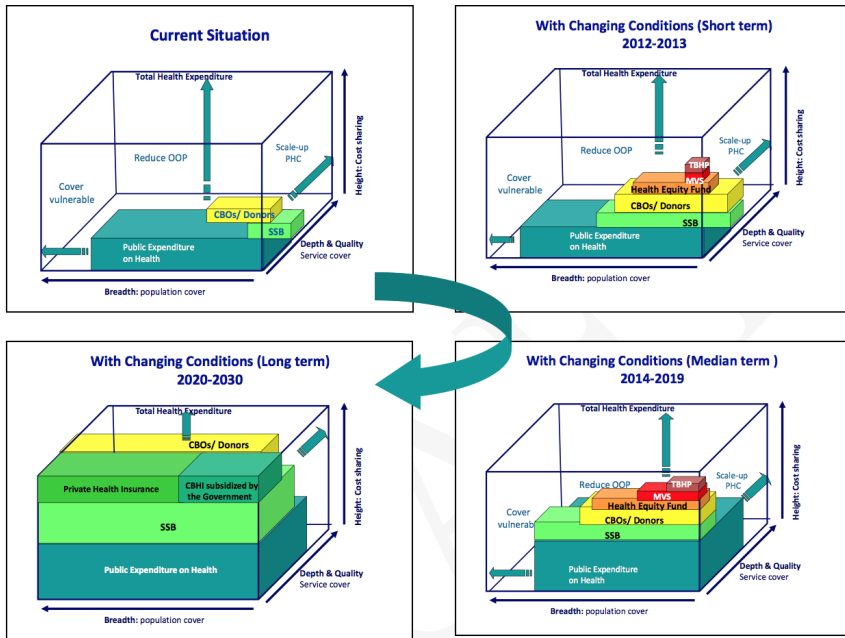
services to the entire population, with the poor prioritized for all other services; in contrast, Thailand provides a more comprehensive service package for its entire population. It is therefore difficult to make a meaningful comparison between countries as UHC is based on national priorities. However, in general terms vis-a-vis coverage with affordable and quality services to address the majority of health needs of their populations, it may be noted that five countries in SEAR have made significant progress towards UHC: Bhutan, Indonesia, Maldives, Sri Lanka and Thailand. Other countries have achieved some success with a more restricted service package for targeted populations. All SEAR countries are now attempting to scale-up and expand their UHC effort with the common goal of improving equity in health.

In practice, no country (with the exception perhaps of the Nordic states) guarantees UHC in its entirety – a fully subsidized/affordable and exhaustive service package for the entire population – and, in as much, UHC is sometimes referred to as an ‘aspiration’. However, significant progress on UHC has been demonstrated at low cost and even in resource-constrained settings – Thailand and Costa Rica were both recognized as having reached UHC at about US\$5000 GDP per capita at purchase power parity, classified as low-to-middle-income countries.

Way forward on primary health care-oriented health systems strengthening for UHC in SEAR

The pragmatic way forward is a *phased approach*, especially in the context of low-income settings with weak health systems – starting with PHC priorities and addressing avoidable inequities and inefficiencies; and, scaling-up and extending services to more comprehensive coverage as requisite institutions and capacities are strengthened. Box 1 shows one such proposal for ‘phasing-in’ UHC developed by Myanmar.

Box 1. Planning ‘phasing-in’ of UHC in Myanmar.



Source: WHO SEARO 2012.

STRATEGIC DIRECTION 2

Improving equity in financial coverage

Key messages:

- OOP in SEAR is the largest component of total health expenditure and highest among all WHO regions. OOP is a key driver of health-related inequities in the Region – evidence shows that countries that have progressed well on UHC have reduced OOP to less than 1/3 of total health expenditure, with government financing at the core of health spending at about 5% of GDP.
- Experience suggests that the way forward on reducing inequities is through **social protection** – shifting to mandatory pre-payment and consolidated pooling using tax-based funding and/or social insurance contributions.
- Importantly, these options have been implemented successfully for UHC even in low- income settings.
- In SEAR, there is potential to raise additional financing for health through a higher share of government revenue and/or earmarked contributions to social health insurance.

The way systems are financed is a key determinant of equity in health. Health financing, in fact, influences equity in all three dimensions of UHC: who has access to services; access to which services; and, access at what cost. Consequently, a number of SEAR countries are revising their health financing policy and strategy to lead national UHC efforts. This section discusses mechanisms for equitable financing that could provide sustainable social protection for UHC - the financing functions of revenue collection and pooling of funds.

Briefly, the key health care financing functions are:

- **Revenue collection** concerns the sources of funds, their structure and the means by which they are collected.
- **Pooling** of funds addresses the unpredictability of illness, particularly at the individual level; the inability of individuals to mobilize sufficient resources to cover unexpected health care costs; and, consequently,

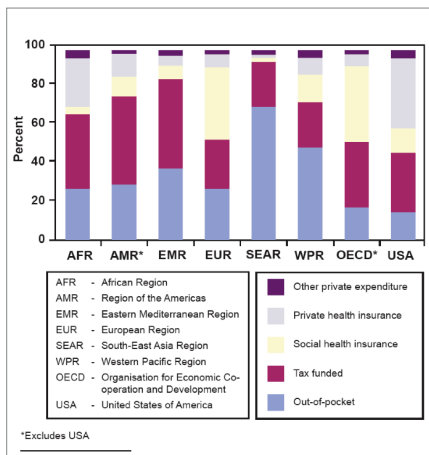
the need to spread health risks over as broad a population group and period of time as possible. Collection and pooling methods are specific to financing mechanisms and the key determinant of equity in health.⁹

- ◉ **Purchasing** relates to the transfer of pooled resources to health service providers in such a way that appropriate and efficient services are available to the population. Accordingly, this financing function is discussed in detail in relation to service delivery in the next section.

Out-of-pocket spending is the main cause of health inequities in SEAR

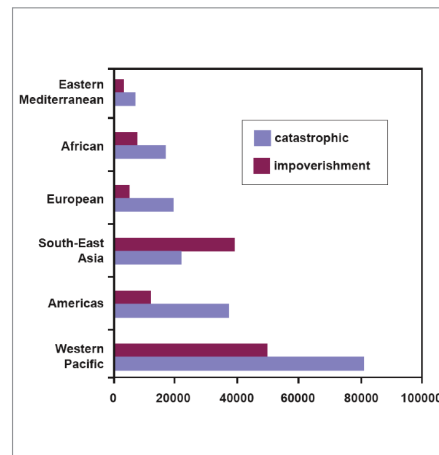
Figure 3 shows that over 60% of financing in SEAR is from OOP spending – the highest among all regions. Further, SEAR is the only Region where health-related impoverishment is higher than catastrophic spending¹⁰ implying that even low-cost access pushes households into poverty (Figure 4). And, Figure 5 breaks down the composition of spending for each SEAR country.

Figure 3: Out-of-pocket spending on regions (2005)



Source: K Xe et al 2007

Figure 4: Health-related catastrophic health across spending and impoverishment, (2007)



Source: K Xe et al 2007

OOP is the most regressive way to finance health and international experience clearly shows that countries that have made significant progress

9 For more details on financing mechanisms see Technical Note 1.

10 WHO defines catastrophic spending as 40% or more of the household's non-food consumption expenditure.

towards UHC have reduced OOP to one-third or less of total health spending and to increased government spending to close to 5 % of GDP.

As in Figures 6 and 7 below, it is important to note again that this can be achieved in low-and low-to-middle-income settings.

Figure 5: Composition of health spending in each SEAR country (2010)

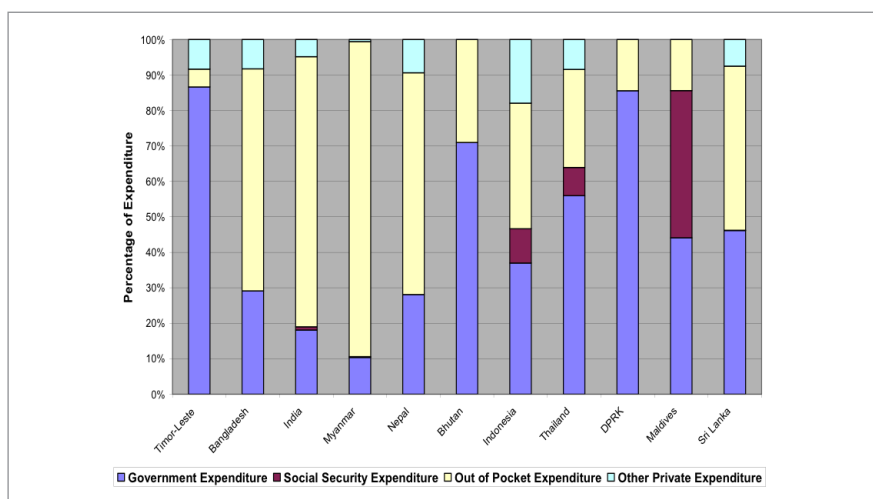
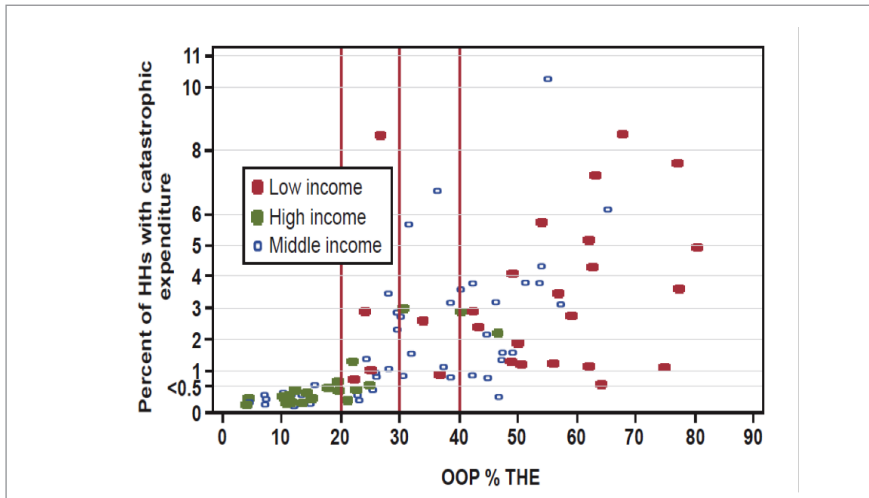


Table 1: Govt health expenditure as % of GDP (2010)

Country	2010
Bangladesh	1.2
Bhutan	4.5
DPRK	N/A
India	1.2
Indonesia	1.3
Maldives	3.8
Myanmar	0.2
Nepal	1.8
Sri Lanka	1.3
Thailand	2.9
Timor-Leste	5.1

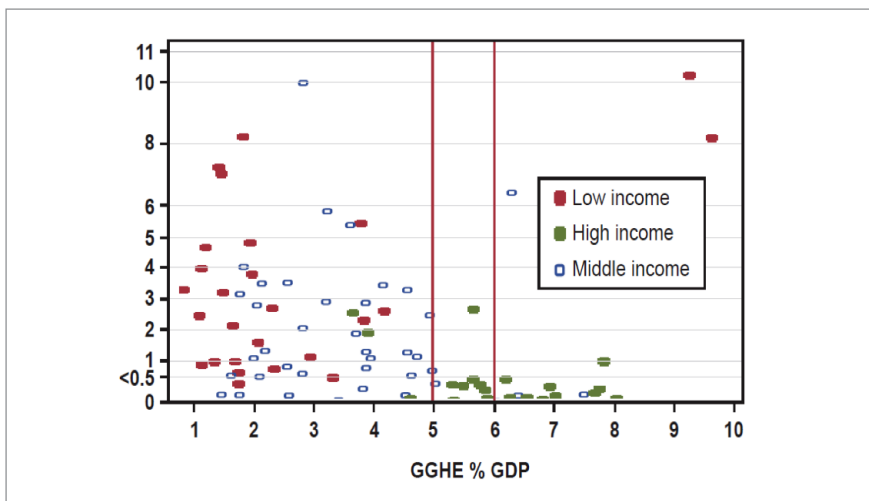
Source: NHA 2011

Figure 6: % of households with catastrophic expenditure versus OOP in total health expenditure



Source: K Xe et al 2007

Figure 7: % of households with catastrophic expenditure versus govt. spending in total health expenditure



Source: K Xe et al 2003

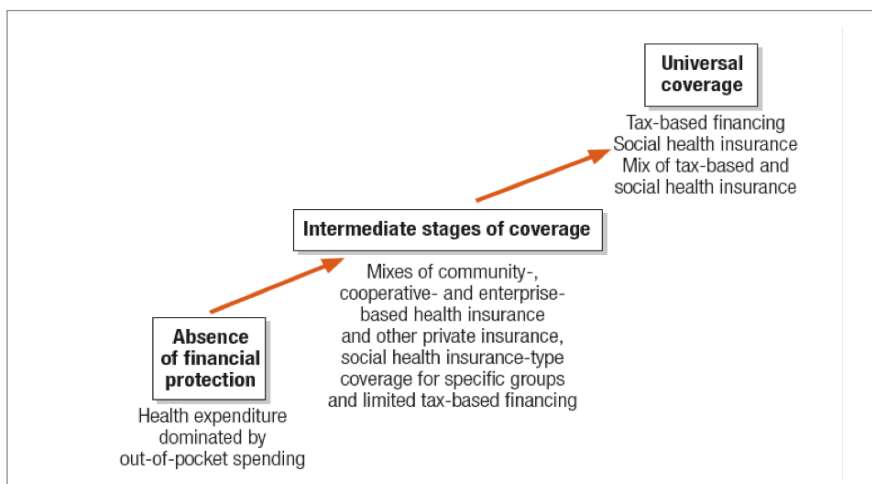
Options to move away from OOP to social protection

International experience provides useful lessons in shifting away from OOP to social financial protection for health. Figure 8 illustrates a simplified three-stage path of this shift that has evolved without concerted international effort to accelerate social protection for UHC – countries in SEAR are now looking to fast-track through/from the intermediate stage towards UHC.

At the centre of the concept of social protection are cross-subsidies from the healthy, young and rich to the sick, old and poor – and financing mechanisms that support this are general government revenues and social health insurance¹¹ based on the following attributes that define them:

1. Mandatory payments – either taxation or contribution to social insurance to optimize resource collection.
2. Pre-payment and pooling of resources.
3. Consolidated pools to reduce fragmentation and improve financial feasibility of social protection.

Figure 8 Three stages of social protection for UHC



Source: Carrin et al 2007

¹¹ For more details on financing mechanisms see Technical Note 1.

It is useful to note here that:

1. Taxes and insurance contributions may be pooled together in a mixed system of financing – how resources are raised does not restrict the way in which they may be pooled.
2. Social insurance is a useful option to supplement tax-based financing in a consolidated health fund. Earmarked tax contributions for health are in fact the common boundary between tax-based and contributory social insurance schemes.

Significant progress on social protection has been made in SEAR and in similar contexts internationally:

- **Ghana** has linked community-based health insurance to a national scheme in an intermediate stage of transition in health financing for UHC.¹²
- **Sri Lanka** has made good progress in UHC based on general government revenues and continues to use this as a basis for the final stage to UHC.¹³
- **Costa Rica** has achieved UHC anchored by government financing through a three-party mandatory health insurance scheme.¹⁴

Where the wider economic and fiscal context allows for only low levels of tax collection or mandatory insurance contributions, as in some SEAR countries, targeted community schemes have the potential to provide protection for access to a limited pre-identified set of services and could also help households understand the benefits of pre-payment and pooling to develop a 'culture' of investing in risk protection. Perhaps a more important impact of such schemes has been in improving utilization of services including overcoming social barriers to access.

It is important to ensure that the design of community-based initiatives allows consolidation into larger pools in the medium term as in Ghana – fragmentation of health systems financing must be avoided and is, in fact, a very real threat especially if, as often is the case, such schemes are donor-funded.

12 For more details see for example <http://www.jointlearningnetwork.org/content/ghana>

13 For more details see for example Withanachchi and Uchida (2006)

14 For more details see for example <http://www.health-policy-systems.com/content/11/1/28>

Targeted social protection with respect to groups covered, services included and level of financial protection offered has been useful in shifting away from OOP:

- ◉ **Bangladesh** has used demand-side financing coupled with good quality service provision at low cost to consolidate the second stage of the transition towards UHC.¹⁵
- ◉ **India** has had some success in financial risk protection for hospital care targeted at below-poverty level households.¹⁶

A shift away from OOP payments to alternative financing mechanisms can provide better social protection. It is important to flag here that this is because of the way resources are collected and pooled by these mechanisms, however, further effort shall be needed to raise additional resources for health and, in fact, collection and pooling processes associated with social protection mechanisms could themselves entail substantial administrative costs.

Additional resources for health

As presented in Table 1, government health expenditure in SEAR needs to be stepped up to match levels in countries that have made good progress on UHC.

One set of limitations on government expenditure arise from macroeconomic and fiscal constraints. Analysis for SEAR countries indicates that there is scope to increase health spending from general government revenues as well as mandatory contributions to social health insurance.¹⁷ More practical constraints are making an evidence-based case for increased allocations for health in ‘competition’ with other areas of social development; and, demonstrated weaknesses in collection mechanisms including tax structures and collection.

Countries have also successfully used innovative financing to raise additional resources for health – ‘sin tax’ being a particular example whereby ministries of health have claimed a share of (increased) taxes on the sale of

¹⁵ Balabanova et al (2011).

¹⁶ Rashtriya Swasthya Bima Yojna (RSBY), India http://www.rsby.gov.in/about_rsby.aspx.

¹⁷ For more details see Technical Note 2.

commodities with a direct impact on health, notably alcohol and tobacco. Also, experience suggests that resources raised in this manner are limited and most effective when put to specific use – ‘sin tax’ in Thailand amounts to only about 2% of the health budget and is used specifically to support prevention and promotion activities. Box 1 summarizes findings for innovative financing options from international experience.

External assistance is another source of additional funding, however, the thrust of this Strategy is reliance on domestic resources that are sustainable and allow countries to drive the UHC effort. Nevertheless, it is acknowledged that external assistance could play an important role in bridging financing gaps in the short/medium term, but it is still critical that these resources be aligned with the overall national UHC strategy and not fragment this effort by focusing on donor priorities.

Way forward on improving equity in financial coverage for UHC in SEAR

1. **Reducing out-of-pocket spending is critical.** Universal health coverage will most likely only be in sight when direct household payments for health are reduced to 30% of total health expenditures.
2. **Consolidated pooling.** Countries can make faster progress towards universal coverage by introducing forms of pre-payment in large pools that avoid fragmentation in the health financing system to support effective risk protection.
3. **Mix tax and social health insurance with mandatory contribution.** Taxes and social insurance contributions are the most equitable way to finance health - their underlying principle permits social protection. Further, implemented and combined at national level, they have the potential to create the largest pool of resources for health – while the mechanisms may have different resource collection mechanisms, this does not prevent the resources from being pooled into a single health fund.

Box 2. Summary findings on domestic options for innovative financing

Options	Fund-raising potential*	Assumptions/examples	Remarks
Special levy on large and profitable companies – a tax/levy that is imposed on some of the big economic companies in the country	\$\$–\$\$\$	Australia has recently imposed a levy on mining companies; Gabon has introduced a levy on mobile phone companies; Pakistan has a long-standing tax on pharmaceutical companies	Context specific
Levy on currency transactions – a tax on foreign exchange transactions in the currency markets	\$\$–\$\$\$	Some middle-income countries with important currency transaction markets could raise substantial new resources	Might need to be coordinated with other financial markets if undertaken on a large scale
Diaspora bonds – government bonds for sale to nationals living abroad	\$\$	Lowers the cost of borrowing for the country (patriotic discount); have been used in India, Israel and Sri Lanka, although not necessarily for health	For countries with a significant out-of-country population
Financial transaction tax – a levy on all bank account transactions or on remittance transactions	\$\$	In Brazil there was a bank tax in the 1990s on bank transactions, although it was subsequently replaced by a tax on capital flows to/from the country; Gabon has implemented a levy on remittance transactions	There seems to have been stronger opposition from interest groups to this tax than others (32)
Mobile phone voluntary solidarity contribution – solidarity contributions would allow individuals and corporations to make voluntary donations via their monthly mobile phone bill	\$\$	The global market for postpaid mobile phone services is US\$ 750 billion, so even taking 1% of that would raise a lot of money; relevant to low-, middle- and high-income countries (33)	Establishment and running costs could be about 1–3% of revenues (33)
Tobacco excise tax – an excise tax on tobacco products Alcohol excise tax – an excise tax on alcohol products	\$\$	These excise taxes on tobacco and alcohol exist in most countries but there is ample scope to raise them in many without causing a fall in revenues	Reduces tobacco and alcohol consumption, which has a positive public health impact
Excise tax on unhealthy food (sugar, salt) – an excise tax on unhealthy foodstuffs and ingredients	\$\$–\$\$\$	Romania is proposing to implement a 20% levy on foods high in fat, salt, additives and sugar (34)	Reduces consumption of harmful foods and improves health
Selling franchised products or services – similar to the Global Fund's ProductRED, whereby companies are licensed to sell products and a proportion of the profits goes to health	\$	Selling franchised products or services from which a percentage of the profits goes to health	Such a scheme could operate in low- and middle-income countries in ways that did not compete with the Global Fund
Tourism tax – a tourism tax would be levied on activities linked largely to international visitors	\$	Airport departure taxes are already widely accepted; a component for health could be added, or levies found	The gain would vary greatly between countries depending on the strength of their tourism sector

* \$, low fund-raising potential; \$\$, medium fund-raising potential; \$\$\$, high fund-raising potential.

Source: *WHA 2010*

Once resources are collected and pooled more equitably and efficiently, they must also be spent equitably and effectively – the next section examines improving service delivery for UHC so that health systems encapsulate both 'more money for health as well as more health for money'.

STRATEGIC DIRECTION 3

Improving equity and efficiency in service delivery

Key messages:

- In addition to improving equity in collection and pooling of resources, better financing must also use resources raised equitably and efficiently – this purchasing function is equally important for UHC and determines which services are provided and at what cost and, therefore, who accesses them.
- In SEAR, there is push-away from low-cost alternatives to high(er)-cost curative care driven by the dominance of private providers, the increasing burden of NCDs and the availability of high-end technology. Associated with this are four broad areas of systems inefficiencies:
 - Expenditure on *medicines* is the largest component of OOP in SEAR and experience highlights the importance of increasing public investment in medicines, improved prescribing practices including use of generics and better price control.
 - Experience also shows that alternative provider payment methods have been used effectively to ‘correct’ the health systems incentive structure to influence the type of service, cost of provision and overall performance of *human resources for health* in both the public and private sectors.
 - In a decentralized *service delivery organization*, potential inequities between decentralized units need attention and may be minimized through e.g. the use of a needs-based allocation criteria for central funds. Further, it is also important to review administrative decentralization from the perspective of health systems needs – some functions may not be appropriate for decentralization e.g. procurement of medicines.
 - An effective response to address all these issues requires strengthening of regulation and overall systems *governance*.

The principles of equity and efficiency in resource collection and pooling must be carried through in the purchase of services for the entire health

system to be strengthened for UHC. It is therefore important to reiterate that the UHC-related health financing reform needs to look beyond financing mechanisms alone to the *entire* financing function including key linkages with other systems building blocks.

In SEAR, each element of the health context - increase in NCDs, a market-driven private sector dominating provision and weak regulation - interacts with and reinforces the others to create pressure on systems costs as well as pushes provision away from low-cost alternatives (including public health) to high(er)-cost curative care. Box 3 summarizes the top 10 causes of systems inefficiencies from international experience – the top four relate to medicines and technology; the next four to human resources; and, the last two to regulation.

This section discusses how countries have successfully addressed these inefficiencies through four efforts:

1. Improving access, affordability and effective use of medicines.
2. Improving human resource performance in both public and private sectors.
3. Improving service delivery structures.
4. Improving regulation.

Here too, it is important to again note that these are not independent actions, but rather, require an integrated and reinforcing policy response – e.g. reimbursement through social health insurance coupled with credible regulation could be a strong reinforcement for implementation of an essential drugs list.

Improving access, affordability and effective use of medicines

India is facing a “70-70” dilemma where OOP is 70% of total health expenditure of which 70% is on the purchase of medicines. There are, in some cases, over 1000 different preparations of the same medicines and, as in Nepal, there can be a multi-fold variation in retail prices – one study in Nepal found local procurement prices of medicines 300% higher than central procurement prices.¹⁸ Also, irrational use of medicines in the Region

¹⁸ Assessing Fiscal Space for Health in Nepa, World Bank 2011 available on <https://openknowledge.worldbank.org/bitstream/handle/10986/12371/682600ESW0WHIT0epal0Final0July02011.pdf?sequence=1>

is estimated at 50%. Further, there is the increasing availability of high-cost interventions in response to NCDs. Action on medicines and medical technology alone can significantly impact the equity and efficiency of the health system for progress on UHC.

Box 3. Top 10 causes of systems inefficiencies from international experience

Source of inefficiency	Common reasons for inefficiency	Ways to address inefficiency
1. Medicines: underuse of generics and higher than necessary prices for medicines	Inadequate controls on supply-chain agents, prescribers and dispensers; lower perceived efficacy/safety of generic medicines; historical prescribing patterns and inefficient procurement/distribution systems; taxes and duties on medicines; excessive mark-ups.	Improve prescribing guidance, information, training and practice. Require, permit or offer incentives for generic substitution. Develop active purchasing based on assessment of costs and benefits of alternatives. Ensure transparency in purchasing and tenders. Remove taxes and duties. Control excessive mark-ups. Monitor and publicize medicine prices.
2. Medicines: use of substandard and counterfeit medicines	Inadequate pharmaceutical regulatory structures/mechanisms; weak procurement systems.	Strengthen enforcement of quality standards in the manufacture of medicines; carry out product testing; enhance procurement systems with pre-qualification of suppliers.
3. Medicines: inappropriate and ineffective use	Inappropriate prescriber incentives and unethical promotion practices; consumer demand/expectations; limited knowledge about therapeutic effects; inadequate regulatory frameworks.	Separate prescribing and dispensing functions; regulate promotional activities; improve prescribing guidance, information, training and practice; disseminate public information.
4. Health-care products and services: overuse or supply of equipment, investigations and procedures	Supplier-induced demand; fee-for-service payment mechanisms; fear of litigation (defensive medicine).	Reform incentive and payment structures (e.g. capitation or diagnosis-related group); develop and implement clinical guidelines.
5. Health workers: inappropriate or costly staff mix, unmotivated workers	Conformity with pre-determined human resource policies and procedures; resistance by medical profession; fixed/inflexible contracts; inadequate salaries; recruitment based on favouritism.	Undertake needs-based assessment and training; revise remuneration policies; introduce flexible contracts and/or performance-related pay; implement task-shifting and other ways of matching skills to needs.
6. Health-care services: inappropriate hospital admissions and length of stay	Lack of alternative care arrangements; insufficient incentives to discharge; limited knowledge of best practice.	Provide alternative care (e.g. day care); alter incentives to hospital providers; raise knowledge about efficient admission practice.
7. Health-care services: inappropriate hospital size (low use of infrastructure)	Inappropriate level of managerial resources for coordination and control; too many hospitals and inpatient beds in some areas, not enough in others. Often this reflects a lack of planning for health service infrastructure development.	Incorporate inputs and output estimation into hospital planning; match managerial capacity to size; reduce excess capacity to raise occupancy rate to 80–90% (while controlling length of stay).
8. Health-care services: medical errors and suboptimal quality of care	Insufficient knowledge or application of clinical-care standards and protocols; lack of guidelines; inadequate supervision.	Improve hygiene standards in hospitals; provide more continuity of care; undertake more clinical audits; monitor hospital performance.
9. Health system leakages: waste, corruption and fraud	Unclear resource allocation guidance; lack of transparency; poor accountability and governance mechanisms; low salaries.	Improve regulation/governance, including strong sanction mechanisms; assess transparency/vulnerability to corruption; undertake public spending tracking surveys; promote codes of conduct.
10. Health interventions: inefficient mix/ inappropriate level of strategies	Funding high-cost, low-effect interventions when low-cost, high-impact options are unfunded. Inappropriate balance between levels of care, and/or between prevention, promotion and treatment.	Regular evaluation and incorporation into policy of evidence on the costs and impact of interventions, technologies, medicines, and policy options.

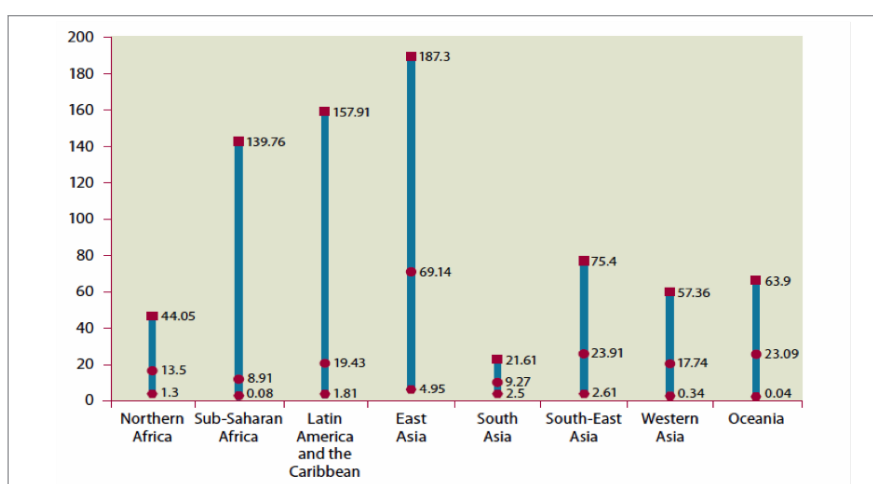
Source: WHO 2010.

There are three interrelated issues that SEAR countries may consider ‘quick -wins’ for equity and efficiency for UHC:

- 1. Public sector expenditure on medicines.** Figure 9 compares per capita public expenditure on medicines among regions and indicates especially low government investment in South Asia.

2. Pricing of essential medicines. The high price of medicines, particularly in the private sector, is another key barrier to access to affordable essential medicines in developing countries. Limited data are available on the mark-ups applied to the cost of the production of medicines as they move through the supply and distribution chains. In countries for which such data is available, results show that these add-on costs can be particularly high in the private sector – Table 2 indicates that India has the widest range and one of the highest maximum mark-ups in the private sector.

Figure 9. Per capita public expenditure on medicines (2007)



Source WHO (2008)

Table 2. Producer and consumer margins in medicine prices in select countries (%)

Country	Public sector markup	Private sector markup
China	24-35	11-33
El Salvador		165-6 894
Ethiopia	79-83	76-148
India		29-694
Malaysia	19-46	65-149
Mali	77-84	87-118
Mongolia	32	68-98
Morocco		53-93
Pakistan		28-35
Uganda	30-66	100-358
United Republic of Tanzania	17	56

Source:WHO 2008.

A key contributor to these add-on costs are wholesaler and retailer mark-ups and Box 4 illustrates measures to contain these costs using the example of South Africa's policy and institutional reform, in conjunction with increased public expenditure on medicines.

Box 4. Measures to rationalize the pricing structure of medicines in South Africa.¹⁹

In South Africa, a Pricing Committee was set up within the Ministry of Health with clearly defined functions to monitor and regulate drug prices. Committee members included health economists, pharmacoeconomists, representatives from the Department of Finance, the Department of Trade and Industry, the Procurement Unit of the Department of Health, the Department of State Expenditure, and consumer representatives. The Committee had the following responsibilities:

- Enforce transparency in the pricing structure of pharmaceutical manufacturers, wholesalers, and providers of services, such as dispensers of drugs, as well as private clinics and hospitals.
- Enforce a non-discriminatory pricing system.
- Replace the wholesale and retail percentage mark-up system with a pricing system based on a fixed professional fee.
- Supply all drugs at the primary care level free of charge.
- Levy a fixed affordable co-payment for drugs supplied by the State at the secondary and tertiary levels.
- Establish a system of exemption for patients without the resources to meet such payment to ensure that they are not deprived of treatment.
- Develop a database to monitor the cost of drugs in the country in comparison with prices in developing and developed countries.
- Price increases to be regulated.
- Where the State deems that the retail prices of certain pharmaceuticals are unacceptable and that these pharmaceuticals are essential to the well being of any sector of the population, make them available to the private sector at acquisition cost plus the transaction costs involved.

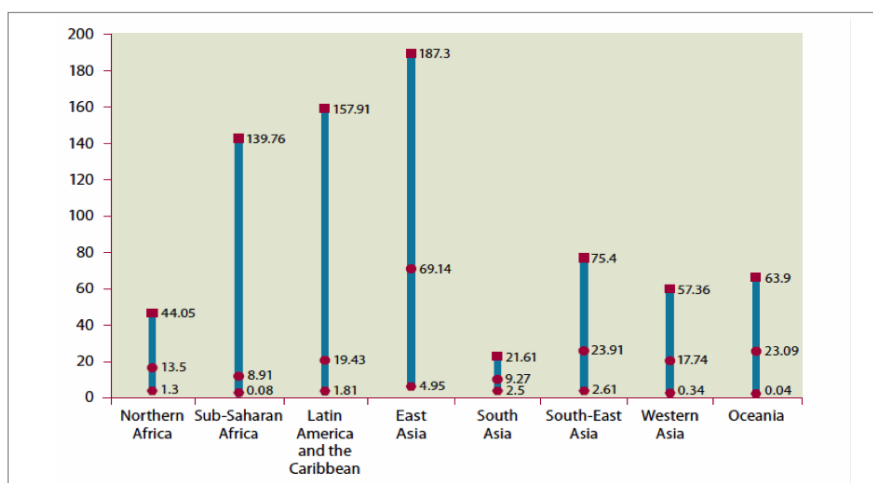
- 3. Generic substitution.** Generically equivalent products are priced substantially lower than originator brand medicines and, increasing the use of quality-assured generic medicines is, therefore, an important strategy for improving the affordability of medicines. A range of policy options are available to promote the use of generics, including allowing pharmacists the flexibility to dispense a generically equivalent product

¹⁹ For full details see *National Medicine Policy for South Africa* <http://www.doh.gov.za/docs/>

in place of a prescribed originator brand listed on the prescription, with appropriate information to the patient. Legal provisions to allow and encourage generic substitution, particularly in the private sector, are relatively neglected in South and South-East Asia (Figure 10). All countries in SEAR have developed an essential medicines list and this is a potential entry point for policy on the pricing, procurement and use of medicines.

In addition, there is also the issue of irrational use of medicines and inappropriate use of high-cost technology creating inefficiencies in service delivery as well as driving up the cost of care. Therefore, medicines and medical technology reform needs to be accompanied by better HR practices and international experience indicates that the effective use of alternative provider payment methods could support improved performance in both the public and private sectors. This is discussed below. Further, effective implementation of medicines and medical technology policy will also, critically, require effective regulation. This is also discussed below.

Figure 10. Percentage of countries with legal provisions to allow/encourage generic substitution in the private sector (2007)



Source: WHO 2008.

Improving provider performance in both public and private sectors

A key component of health workforce performance, as defined by the WHR 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 been found to be one major underlying reason for health workers leaving the health profession or contributing to health workforce outmigration²⁰. In the same vein, literature reviews on nursing supply found a positive relationship between wage and labour supply²¹.

Financial incentives have also been used successfully to address rural-urban health workforce distribution – a key HRH challenge in SEAR. Several studies point to salaries and allowances as two leading factors that influence retention in rural areas²². The use of financial incentives is also one of the recommendations of the WHO Global Policy on increasing access to health workers in remote and rural areas through improved retention²³.

Table 3 summarizes options available to change the incentive structure of a health system to improve HRH performance.

Table 3. Types of financial incentives

Provider payments (see details in Table 5)
Other direct financial benefits e.g. pension, insurance
Indirect financial benefits e.g. subsidized transport, child care, loan

Source: Adams & Hicks, 2000

Payment methods have the biggest impact on the incentive structure in service provision and thereby on provider performance. Importantly, provider payment methods are useful to contract in/out services from the private sector as well. For example, Bangladesh and India have used a three-party partnership between the public, private and NGO sectors to scale up DOTs: the government scaled-up its programme of subsidized access to treatment including medicines by contracting in private providers based on capitation-based payment, with NGOs contracted in for monitoring service delivery²⁴. Thailand has used a mix of capitation and diagnosis-related groups (DRG) based global budgets for cost containment in hospitals²⁵ – a useful experience for Maldives given its health systems financing crisis caused by a new insurance scheme with provider choice and fee-for-service reimbursement.

20 OECD (2008); World Health Report (2006).

21 OECD (2008).

22 WHO (2010).

23 WHO (2010).

24 For more details see SEARO 2009.

25 For more details see Limwattananon et al., 2005 and Suraratdecha et al., 2005.

Table 4 presents general advantages and disadvantages of each payment method. And, as Figure 11 indicates, institutional capacities will be a key determinant of feasibility in implementation of any chosen method.

Table 4. Advantages and disadvantages of alternative provider payment methods

Payment mechanism	Advantages	Disadvantages	Ways of minimizing disadvantages
Salary	Predictable expenditure Low administrative costs	Possible underprovision and/or poor quality of care Little incentive for efficient behaviour and productivity unless linked to performance	Peer review of provider practices Link part of payment to performance
Capitation	Incentive for technical efficiency and preventive care Administration costs reasonably low	Incentive for underservice Possible cream-skimming (attracting low-risk patients) Possible cost shifting (referral to another provider)	Adjust payments to risk Monitoring and peer review of provider practices (including referral patterns) Patient choice of provider
Fee for service	Incentive for technical efficiency (where fee schedules are fixed)	Incentive for overprovision and cost escalation High administrative costs	Global caps and/or adjusting fee to keep within resource limits
Budget allocation	Predictable expenditure and tight control Low administrative costs	Limited direct incentives for efficiency unless linked to performance Can lead to underservicing and cost shifting	Link part of payment to performance Monitoring and peer review
Per diem	Some incentive for technical efficiency	Incentive to extend length of stay and/or increase number of admissions	Global caps/budget limits Lower fees for longer stays
Case-based (includes diagnosis related group payments)	Strong incentive for efficient operation	Unpredictable expenditure Relatively high administrative costs Incentive for cream-skimming	Adjust for case mix, i.e. by grouping people according to their use of resources

Source: Carrin and Hanvoravongchai, 2002.

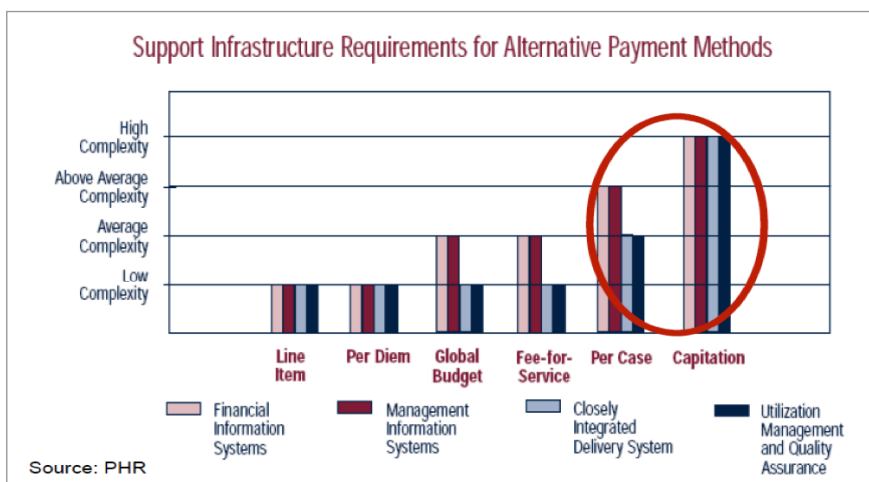
While there is potential for the health financing function to support strengthening of HRH for UHC through its purchasing component, of course this alone shall not be adequate. WHO has used a systematic assessment of good practices to develop 16 evidence-based recommendations for policy-makers on production, recruitment, deployment retention and performance

of HRH especially in underserved areas which may be grouped under four categories:²⁶

1. *Appropriate financial incentives.*
2. *Educational interventions* (such as targeted recruitment from rural background, building schools closer to where services are needed, implementing clinical rotations in remote and rural areas, revising curricula to address the needs of rural and remote populations, and providing relevant continuous professional development programmes).
3. *Professional and personal development* (improve living and working conditions, outreach support, career development programmes, professional networks and public recognition measures).
4. *Regulatory interventions* (compulsory service or bonding schemes, enhanced scope of practice, producing different types of health workers, and subsidized education in return of service).

Elaboration on items 2–4 are beyond the scope of the present discussion but detailed consideration shall be central to any HRH strategy developed to contribute to a comprehensive UHC policy.

Figure 11. Complexity in implementing alternative provider payment mechanisms



26 For more details see WHO (2010); Scott et al. (2011).

Improving service delivery structures

A common feature of the service delivery structure in SEAR is decentralization. In India, for example, health has always been a state subject; the unit of detailed planning in Myanmar are townships. Overall decentralization is implemented on the basis of geo-administrative considerations and decentralized health systems have been established using the same principles, however, these may not be appropriate for health system needs. Two aspects are important for both equity and efficiency here:

1. Ensuring equity across decentralized units with respect to central budget allocations for health by using appropriate criteria for central budget allocations (rather than flat rate transfers). This would be useful for example, for Myanmar where a recent study showed significant variation in health and health systems status of township and associated needs for central allocations²⁷.

Cambodia uses a 'costed-norms' approach for budget allocation to sub-national levels. Based on standard norms for establishing facilities, allocations are guided by the average cost of running a health facility in the district, multiplied by the number of facilities of that type in the district. An adjustment for patient workload has been included to prevent disincentives to treating additional patients.²⁸

Colombia has used a needs-based formula for resource allocation coupled with earmarking for health to successfully maintain equity across the system. The central government allocates general funds to municipalities on the basis of size of population, adjusted for poverty level, unmet basic needs, quality of life indicators and locally-generated revenue. A portion of these funds is then fixed for health services.²⁹

Uganda allocates its national budget among districts using a formula based on population size; the inverse of the Human Development Index (HDI) to include social determinants of health; and, the inverse of per capita donor and NGO spending to ensure that the full resource envelope for each district is taken into account in the allocation of government funds.³⁰

27 WHO (2012).

28 Bossert et al., 2003.

29 Rocha et al., 2004.

30 Semali and Minja, 2005.

2. Improving efficiency through appropriate decentralization of systems functions and services. e.g. decentralization of procurement of medicines in Nepal in line with overall administrative decentralization has been identified as one possible factor in significantly higher prices at sub-national levels. Decentralization as appropriate for health versus other considerations is important for SEAR countries to review.

A review of decentralized service delivery in Indonesia in 56 districts of 7 provinces found the share of public activities to be between 2.9% - 12.1% of the budget raising concerns on achieving national and MDG targets. In 2010, the government 'recentralized' funding for select public health programmes, channelling monies directly to 9 500 health centres through Operating Cost Assistance (BOK) to be utilized for e.g. transport, snacks, simple maintenance but not for salaries, capital investment or curative care. An evaluation of health centres for 2011 showed a strong correlation between Operating Cost Assistance and improved programme performance.³¹

Improving regulation and governance

'Regulation' is among the primary responsibilities of any functioning health system. Governing a health system requires tools that guarantee proper implementation of the programmes and policies, and provide clear procedures in order to ensure accountability³². In health care systems where the private sector has an important role, the regulatory functions of the ministries of health are of paramount importance to ensure that quality, equity and efficiency are attainable³³.

Any intervention towards achieving UHC, by definition, would affect all aspects of a health system. Achieving UHC in a country requires protection of users against financial risks from health care utilization, implementation of appropriate provider payment mechanisms that ensure efficiency and quality, and provision of health care in an equitable manner that considers geographical variations and social and cultural diversities. Effective regulation of a health system then entails answering some basic questions:

31 World Bank 2007 available at <https://openknowledge.worldbank.org/bitstream/handle/10986/6347/425300PUB0ISBN1Same0as0report038772.txt?sequence=2>

32 WHR (2000), Murray and Frenk (2000).

33 Mills et al (2002).

Table 5. Important regulatory processes for achieving UHC

Regulatory processes	Examples
What to regulate	Market entry Price Quantity Distribution and market structure
Who to regulate	Providers - doctors and pharmacists Institutions - clinics, pharmacies, diagnostic services, third-party payers Technologies - medicines, devices
How to regulate	Licensing Minimum wage standards Health-care tariffs and fee standards Incentives and sanctions Certificates of need Health services regionalization Health technology assessment Prevention of and response to corruption

Source: McPake (2002).

In the context of UHC, it is important to focus on the ‘market entry’ of providers, institutions and insurers. Several countries in the Region lack appropriate licensing procedures, both for the providers and institutions. This is one of the main reasons behind inefficient use of limited resources, and a reduced public trust in the health system. Certain countries face an unregulated higher education industry, including schools of medicine, in which health professionals are trained without proper overseeing of the quality and numbers.

Prudent use of health intervention and technology assessment and health services regionalization approaches can improve the efficiency of services use, and the effectiveness of care. Lack of appropriate incentive structures for equitable distribution of providers throughout a country is one of the main reasons why the countries lag behind UHC objectives. Regionalization may also improve equitable access to the services via better distribution of the providers.

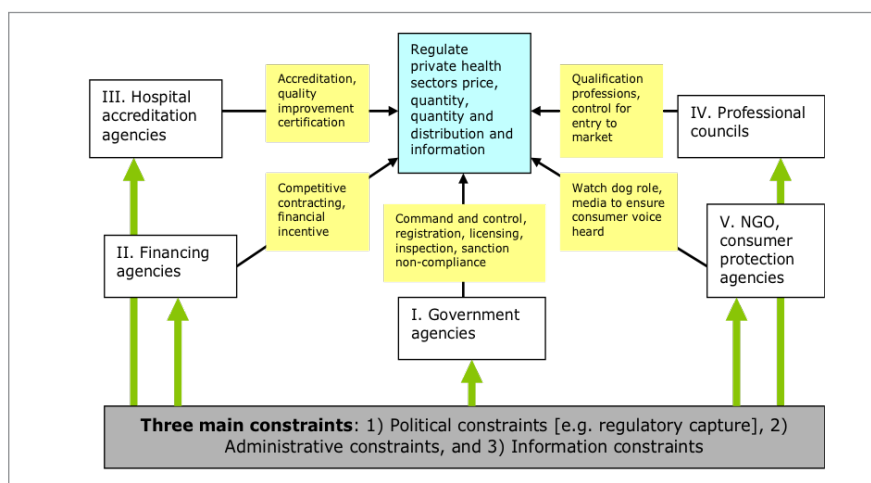
Market mechanisms are not suitable for identifying fair pricing and fee scheduling structures in the health system. As countries expand the role of the private sector in the health system, they need to implement intelligent (and yet

easy to administer) pricing mechanisms. Provider payment approaches should provide incentive for improving efficiency and access for vulnerable groups.

Achieving UHC requires extensive resource mobilization. Without proper regulatory functions, resource mobilization on its own may result in nothing other than further inefficiency, and perhaps corruption, in health systems. Proper regulation of health systems is an important factor in achieving UHC.

In systematic assessment of country capacity in regulating the health-care sector in low- and middle-income countries, three key constraints for improving public-private partnership were found to be political constraints, administrative constraints, and information constraints³⁴. There is an urgent need to develop effective strategies at the global level to effectively deal with the private sector in view of its increasing role in providing health services. Figure 12 proposes a conceptual framework of key regulators, mechanisms and constraints.

Figure 12. Conceptual framework of key regulators, mechanisms and constraints



Source: Tangcharoensathien et al 2002

Regulation is of course only one aspect of governance – other aspects are discussed under Strategic Direction 4 below as part of broader national health policy, strategy and plan development, implementation and monitoring and evaluation.

³⁴ Tangcharoensathien et al 2002.

Way forward on improving equity and efficiency in service delivery

1. Affordable access to *medicines* could be a key strategy for quick wins on equity and efficiency for UHC in SEAR. This shall require increased government spending on medicines with better price controls and use of generics backed by strong regulation.
2. Effective use of provider payments to create the 'right' incentives in the systems to strengthening *human resources* especially in underserved areas - production, recruitment, deployment, retention and performance of HRH including on cross-systems issues like changing provider behaviour on irrational use of medicines.
3. Decentralization of *service delivery* organization and health systems functions broadly needs to be examined more in the specific context of health needs rather than simply mirror overall administrative decentralization. Importantly, there are cross-cutting implications here as well e.g. a strategy for affordable access to medicines is best supported by centralized procurement.
4. Within *governance*, regulatory measures with credible enforcement shall be particularly important to support health systems strengthening for UHC – aligning who, what and how to regulate effectively and overcoming political, administrative and information barriers to effective implementation.

The discussion in this and the previous section clearly brings out the critical role of adequate capacities and institutions for UHC – to make technically efficient policy choices and implement, regulate and evaluate these effectively. The next section presents some best practice elements in strengthening national policy, strategies and planning processes.

STRATEGIC DIRECTION 4

Strengthening national institutions and capacities for UHC

Key messages:

- National health policy strategy and planning is key to the UHC effort in countries.
- Both process and content need to be strengthened so as to use National Health Policies Strategies and Plans (NHPSP) more strategically for UHC.
- Critical capacity gaps exist in NHPSP in SEAR countries - in evidence-based decision making; resource planning; process management; linkages between all health-related plans; and, monitoring and evaluation.

Member States have underlined NHPSP as a key platform for consolidating a systematic UHC effort in the context of complex health systems and multisectoral determinants of health³⁵. This section examines the national health plans in SEAR against recommended best practices to identify capacity needs for UHC in the Region.

Best practice elements in NHPSP

Following are recommended best practice elements for NHPSP from international experience³⁶:

- 1. Sound process.** There is evidence that NHPSP are more realistic and more likely to be implemented effectively if they are developed inclusively, involving all relevant stakeholders. It is important to create consultative groups and consultation platforms early on in the process, so that these may be utilized at each stage of the NHPSP and strengthened with successive NHPSP processes – ideally, to be strategic, these should be aligned with country political/institutional cycles.

³⁵ World Health Assembly Resolution 64.8

³⁶ WHO SEARO 2010

2. **Realistic.** NHPSP need to be realistic - they must reflect the country context and constraints in entirety i.e. the health and systems context as well as the wider socio-economic and political context within which health is placed.

Box 5 illustrates how Thailand has used evidence-gathering for establishing sound process and realistic NHPSP.

Box 5. Thailand: Robust situations analysis and inclusive priority setting

Twelve months prior to the end of each NHPSP, a critical situation analysis is conducted and documented as the annual Thai Health Report with public access to all information. Ministry of Public Health monitors diseases and service delivery outcomes at national and sub-national levels, including resource tracking (National Health Accounts with multisectoral coordination). The National Statistical Office updates on household and community perceptions and status through regular socio-economic surveys, health and welfare surveys as well as specific surveys for priority programmes and populations. The National Economic and Social Development Board provides a platform for consultation on the health impact of activities in health-related sectors. Together, these provide complete, relevant and quality evidence on all dimensions of health - physical, mental, spiritual health; the social and economic; and, sector performance.

3. **Comprehensive, balanced and coherent content** of NHPSP

- *Comprehensiveness:* The extent to which the evidence-based situation analyses included in NHPSP address all health and the health systems issues; and, the proposed strategies and specific objectives address all identified problems.
- *Coherence:* The extent to which the proposed strategies in NHPSP are aligned with the priorities identified from evidence-based situation analyses; and, disease-specific national plans are aligned/consistent with national health strategies and plans.
- *Balance:* The priority given to various health and systems issues in line with findings of evidence-based situation analyses on their significance for health outcomes.

Box 6 illustrates how Thailand planned and implemented a comprehensive, coherent and balanced national health plan across health systems areas – for financing lead UHC reforms. The illustration also shows alignment to education as a health-related sector through a common medium term

expenditure framework (MTEF) as well as to the broader policy directions on poverty and the National Economic and Social Development (NESD) plan.

Box 6. Thailand: Comprehensive, coherent and balanced NHPSP

Medium term plan for National Economic and Social Development (NESD) Common MTEF with education. Policy vision and area of reform: PHC based Universal coverage		Comprehensive strategy for service delivery					PHC areas
		Governance	Health information	Human resources	Pharma/ Tech/Infra	Service delivery	
Policy direction: Reduction in inequities * Effective administration * Experience with insurance * Capacity to draft/lobby for forwarding-looking legislation and regulation. * Health plan linked to NESD Plan with a common MTEF with education		* Capacity for evidence-based policy and M&E	* Shortage of doctors in primary care units and inadequate management mechanisms in place for redeployment	* Successive governments strengthened infrastructure for PHC based comprehensive care in 90% of districts	* Provider payment mechanism (capitation) reinforced primary care * Prevention and health promotion neglected * Provider choice restricted	People centred care Health in all policies	
		<i>Comprehensive strategy for service delivery, led by financing reform and reinforced by requisite capacities/actions across the sector; and, further, reinforcing other PHC policy areas.</i>					
		Financing					
		* Strategy: Govt financed care with a 30 baht contribution per visit from beneficiaries.					
		* Redirection of funds to primary care left many hospitals with large deficits					

National health planning in SEAR

National planning processes and plan documents of six SEAR countries were assessed with ministries of health against these best practice elements to identify key capacity needs³⁷. Summary findings are discussed here.

Clearly, countries in SEAR have well established processes for NHPSP – national, sub-national and programmes, health plans as well as broader development plans. These are structured around health systems issues and priority programmes nested within three timelines:

1. 10+ years that capture long-term vision for health and development.
2. Five-year medium-term strategies and plans that are more sector-specific and linked to a medium-term expenditure framework.
3. Annual operational plans linked to sector budgets for each fiscal year.

Responsibility for NHPSP in all countries is with the Ministry of Health (MoH). NHPSP is therefore an important platform for carrying forward a national UHC agenda in the context of complex health systems and multisectoral determinants of health.

37 WHO SEARO 2010.

Findings from SEAR on NHPSP best practice elements

1. *Sound process*

Both *consultation and dissemination* of plans are most systematically done within MoH and at higher levels. Inclusion of other stakeholders, especially health-related ministries beyond MoH, is still limited.

2. *Realistic*

- *Situation analyses* are quite complete with respect to the health status and demographic and epidemiological trends in the country. Broader health systems and contextual issues - political, economic and social determinants of health - remain less adequately analyzed for their implications for health.
- *Institution and capacity* strengthening is not focused upon in national health plans. Planning is usually for current *structures* of ministries of health rather than being more strategic and responsive to multisectoral population health *needs*.
- *Health information systems* have limited capacity to generate quality and complete information for evidence-based national health planning. This has impacted not only the situation analyses on which planning are based, but monitoring and evaluation of the plan as well. Importantly, where evidence-based planning has been institutionalized, it has added credibility and supported ministry of health leadership in a multisectoral effort to improve health.
- *Tools* available could be used more effectively to inform national health planning e.g. costing of national plan for linking these to budgets. Gaps related to weak information systems mentioned above are a critical constraint but equally limiting is inadequate capacity or use of relevant tools and techniques to process this information for evidence-based planning.

3. *Comprehensive, balanced and coherent content*

The inadequate use of evidence impacts comprehensiveness, balance and coherence in national plan content. Specifically:

- *Vertical linkages within the Ministry of Health* downwards to health systems, sub-national and programme plans and upwards to national

health policy are *relatively* well consolidated in national health plans, especially with respect to *medical* aspects.

- Service delivery improvement particularly as scaling-up of programmes is a stated priority in all cases studied. Other areas of health systems strengthening – human resources, medicines and technology and health information systems are also noted in all plans. However, health financing and governance issues are not similarly covered. Moreover, inclusions tend to be description of situations rather than evidence-based analyses for strategic planning, capturing synergies between systems function and programme linkages for reinforcing contributions to UHC.
- *Linkages beyond health* remain weak – (a) particularly with national budget/finance aspects; (b) with health-related sectors; and, (c) with the overall development agenda, especially with respect to using this as a common platform to link with health-related sectors, including to initiate joint budgeting. *Leadership of MoH in public policy* is in fact not well established and experience suggests that institutionalized, inclusive and evidence-based NHPSP processes have been important in building the credibility and leadership of MoH in health.

WAY FORWARD on strengthening national institutions and capacities for UHC

1. Strengthen evidence-based and inclusive situation analyses and priority setting to inform UHC policy decisions.
2. Improve resource planning and programme budgeting, especially to linking costed plans to different funding scenarios.
3. Better process management include requisite legislation and regulation.
4. Establish coherence between the NHPSP and sub-national, programme and operational plans.
5. Institutionalise performance monitoring, evaluation and feedback.



**Summary:
Way forward**

Based on consultations with Member States and experts on the situation in SEAR countries, international evidence and technical issues related to UHC, following are the recommendations to advance UHC in SEAR countries:

A conceptual Strategic Direction:

1. Primary health care-oriented health systems strengthening

The pragmatic way forward is a ***phased approach***, especially in the context of low-income settings with weak health systems – starting with PHC priorities and addressing avoidable inequities and inefficiencies; and, scaling-up and extending services to more comprehensive coverage as requisite institutions and capacities are strengthened.

Two technical Strategic Directions:

2. Improving equity in financial coverage

- ◉ *Reducing out-of-pocket spending is critical.* Universal health coverage will most likely only be in sight when direct household payments for health are reduced to 30% of total health expenditures.
- ◉ *Consolidated pooling.* Countries can make faster progress towards universal coverage by introducing forms of pre-payment in large pools that avoid fragmentation in the health financing system to support effective risk protection.
- ◉ *Mix tax and social health insurance with mandatory contribution.* Taxes and social insurance contributions are the most equitable way to finance health - their underlying principle permits social protection. Further, implemented and combined at national level, they have the potential to create the largest pool of resources for health – while the mechanisms may have different resource collection mechanisms, this does not prevent the resources from being pooled into a single health fund.

3. Improving equity and efficiency in service coverage

- ◉ Affordable access to *medicines* could be a key strategy for quick wins on equity and efficiency for UHC in SEAR. This shall require increased government spending on medicines with better price controls and use of generics backed by strong regulation.

- ◉ Effective use of provider payments to create the 'right' incentives in the systems to strengthening *human resources* especially in underserved areas - production, recruitment, deployment, retention and performance of HRH including on cross-systems issues like changing provider behaviour on irrational use of medicines.
- ◉ Decentralization of *service delivery* organization and health systems functions broadly needs to be examined more in the specific context of health needs rather than simply mirror overall administrative decentralization. Importantly, there are cross-cutting implications here as well e.g. a strategy for affordable access to medicines is best supported by centralized procurement.
- ◉ Within *governance*, regulatory measures with credible enforcement shall be particularly important to support health systems strengthening for UHC – aligning who, what and how to regulate effectively and overcoming political, administrative and information barriers to effective implementation.

One Strategic Direction for action:

4. Strengthening national institutions and capacities for universal health coverage

- ◉ Strengthen evidence-based and inclusive situation analyses and priority setting to inform UHC policy decisions.
- ◉ Improve resource planning and programme budgeting, especially to linking costed plans to different funding scenarios.
- ◉ Better process management to include requisite legislation and regulation.
- ◉ Establish coherence between the NHPSP and sub-national programmes and operational plans.
- ◉ Institutionalize performance monitoring, evaluation and feedback.

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Technical notes

Technical Note 1: Main mechanisms for health systems financing

Sources: Various

1. Government funding along with government provision in health has been justified on three grounds:

- health is a human right¹ that all citizens of a country are entitled to.
- social values and principles explicitly require health and development policy to protect the poor and vulnerable.
- in terms of economics, markets fail to provide public health goods² and goods with externalities³. In both cases it is difficult to identify individual benefits from consumption and hence fix a price to be charged, violating a key market principle. Significantly for health, preventive and promotion as well as some public health services have these characteristics. Also importantly for health, markets exclude those without the ability to translate needs into demand by paying market prices for services i.e. the poor.

Government spending is the most equitable means of collecting resources for health. Government revenues are mainly from pre-paid taxes - the tax structure will determine the exact extent of equity in resource collection. However, the presence of a large informal sector constrains efficiency and feasibility of tax collection in developing contexts. A limited tax base has implications for adequacy of overall funds and the share of health in general revenues - increasing budgetary flexibility or fiscal space⁴ for health will require capacity to negotiate for higher allocations (in competition with other social sectors) and possible additional taxation for health, as well as improved efficiency in using available resources. External assistance may be considered as an interim measure. (Deficit financing through borrowing is an additional option - although this is

1 Article 25 of the Universal Declaration of Human Rights 1948, available at <http://www.un.org/en/documents/udhr/>

2 Public goods are characterized by non-exclusion e.g. it is difficult to exclude anyone from the benefits of 'consuming' public health information, and therefore, it is not possible to identify the price to be charged to each consumer, breaking down the market for such goods.

3 Certain goods have externalities - positive or negative spillover effects. Smoking has been established to have significant negative impact on non-smokers through passive/secondary smoking. Again, it is difficult to establish the exact health costs of this negative externality and charge for it - in the case of tobacco, public acknowledgement of the negative externality itself has been a challenge against strong market elements.

4 Fiscal space for health is determined by general revenues, public sector efficiency, domestic and international borrowings and external assistance.

not recommended on grounds of macro stability and is not likely to be undertaken by governments to finance health or social development).

Being national in scope, government revenues are potentially the largest pool of resources available for health. And, again, with requisite governance and leadership, these resources may be allocated equitable and efficiently. Increasingly, government financing is being separated from government provision, allowing public authorities to be purchasers of services, using appropriate allocation and provider payment mechanisms to improve efficiency and performance in the system. Importantly, this has allowed public resources to be used for purchase of services from the private sector - a strategy that could be cost-effective in scaling-up coverage (rather than expanding the public sector service network), subject to adequate governance.

2. Health insurance is an alternative pre-paid mechanism that can be either mandatory or voluntary.

(i) ***Mandatory or social health insurance*** is backed by legislation that requires citizens to contribute to these schemes. Contributions are based on the principles of social solidarity - on community ratings or the average expected cost of health service use by the entire population covered (versus individual rating). Further, contributions may also be tailored to income levels with the government subsidizing the poor. So far, in terms of revenue collection, mandatory social health insurance is similar to general revenues, as both may be collected through payroll taxes. The difference is that social insurance schemes are managed by an insurance fund and have defined sets of rights for those insured. There may be a single or several insurance pools and, in so far as mechanisms are put in place for sharing risks between funds, a larger 'virtual' pool may be created with a standardized minimum benefit package across all funds secured by legislation. Social insurance is then the next most equitable financing mechanism with respect to protecting the poor and with potential to offer an equitable benefit package. Finally, these funds must be managed to be financially feasible which, in turn, would require efficiency in the purchase of services.

(ii) Feasibility and levels of resources raised through mandatory contribution are limited in developing countries for the same reasons as with taxes. However, the growing formal sector in the Region

provides a very real opportunity for ministries of health to consider improving health financing through social health insurance.

- (iii) **Voluntary** contributions to private insurance are different from mandatory social insurance in their critical underlying principle of individual risk rating for contributions. Further, profit-driven fund management results in 'cream-skimming' whereby insurance companies favour those with lower than average risk rating for enrolment and, increase premium/co-payment amounts to safeguard against adverse selection and moral hazard - enrolment by those whose expecting an increasing need for health care and disincentive for those insured to maintained a healthy lifestyle. From the perspective of private providers, there is a strong incentive to over-price and over-supply (supply induced demand), raising overall costs in the health system. While corrective legislation and appropriate use of payment mechanisms may be used to redress these problems, private insurance will not provide an equitable alternative for health financing with respect to protecting the poor or improving access to public health services. This option is best suited as top-up for those who have the means to afford it and choose to opt out of public provision of health services.
- (iv) **Community-based health insurance** is usually an 'add-on' to income generation schemes and is based on the principles of social insurance - social solidarity - but is voluntary to the extent that joining the income generation scheme is voluntary, but once signed up, contribution to health insurance is mandatory. Being implemented in low-income settings, these contributions tend to be nominal, with the main funding coming from subsidies from the income generation scheme and/or government grants. The fund is managed by the overarching institution - usually a nongovernment organization - which could also negotiate with providers on both cost and quality of services. However, given the size of the pool as well as the contributions, community health insurance can only be financially feasible with a limited benefit package - sometimes covering just transport for physical access to public services - and, as a result, also has limited influence over providers. Also, these schemes tend to fragment health systems financing. Nevertheless, they play an important role in protecting the poor and, if aligned at the right stage, they do have the potential to effectively facilitate a broader national social insurance scheme.

3. **Out-of-pocket payments** are direct fee-for-service to the providers at the point of use. Such spending is not routed through a financing intermediary - the government or insurance fund. This mechanism is the least progressive means of financing health with no potential to influence equity or provision of services.
4. **External assistance** may be in the form of grants or loan channelled through the government budget or provided directly to implementing agencies including NGOs. External assistance can play an important role in bridging financing gaps in the short/medium term, but it is critical to align these with the overall UHC strategy and not fragment this effort by focusing on donor priorities.
5. **Demand-side financing** targets improvements in utilization of a set of primary care services among the poor by increasing the purchasing capacity of households. Cash transfers are made to households, conditional on these being used for a pre-determined set of services from designated providers - the 'conditionality' is usually enforced through vouchers which the beneficiaries use to claim the benefit package, which the provider subsequently redeems for cash payment from the government. The schemes usually allow choice of provider which could give some leverage to the beneficiary with respect to demanding quality care and also promote positive competition among providers. What is important to note here is that these schemes are usually managed and subsidized by the government – although some schemes require a nominal contribution from beneficiaries – and so are really part of public investment. Also, to be effective, a network of providers must exist in the first instance and communities need to be empowered adequately to claim the benefits. This is a useful way to stimulate very targeted demand, but which would need to be managed in the longer term through more sustainable mechanisms.

Technical Note 2: Fiscal space analysis for SEAR

Source: WHO SEARO (2012)

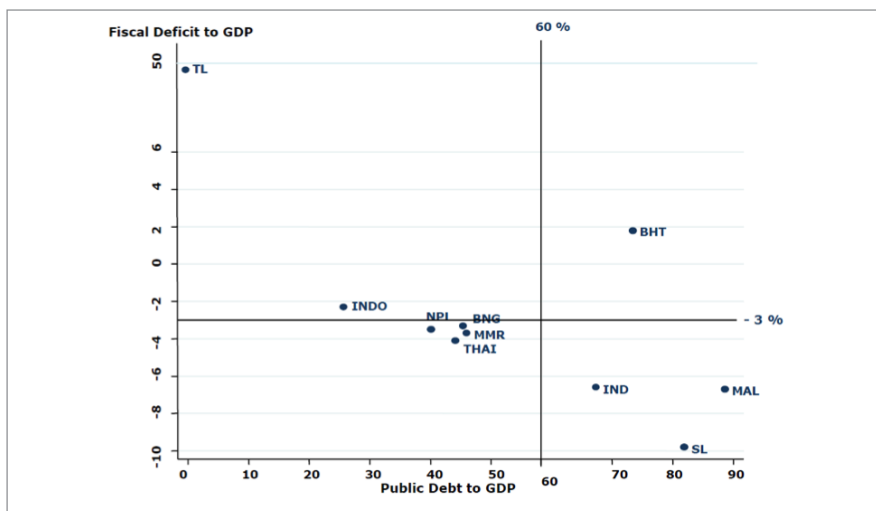
Public financing for health is now seen as a major tool for achieving better health outcomes. While the quality of spending is an important factor, the challenges of raising additional resources for health remains a core issue in developing countries.

The need to meet the MDG (Millennium Development Goals) goals and concerns regarding equity and efficiency in the health sector on the one hand, and the impact of the recent global economic crisis on the other, has resulted in fiscal space being seen as a key concern. SEAR countries have not been too badly hit by the global economic crisis. Moderate to strong macroeconomic fundamentals and timely countercyclical fiscal policies have enabled most countries of the Region to ride the crisis. However, given the low development base in many countries in this group, social sector spending remains a parameter that needs to be watched

Four indicators are used to understand fiscal space: (1) Fiscal deficits (desirable 3% or less), (2) Government debt-to-GDP (desirable 20% or less), (3) Revenue-to-GDP (desirable: 13% or more), and (4) Aid-to-GDP (desirable: 5% or less).

Apart from Timor-Leste – which has high fiscal deficit and very low public debt-to-GDP because of its petroleum revenues and income – all the other nine countries have fairly low fiscal deficit but high public debt-to-GDP ratios. In fact as represented in Figure 1 above, it almost seems that there is an inverse relation between these two indicators – higher the public debt ratio, lower is the fiscal deficit and vice versa. Most of the countries have favourable values of both indicators. Indonesia has the lowest public debt-to-GDP ratio, but higher fiscal deficit than Bangladesh, Nepal and Thailand.

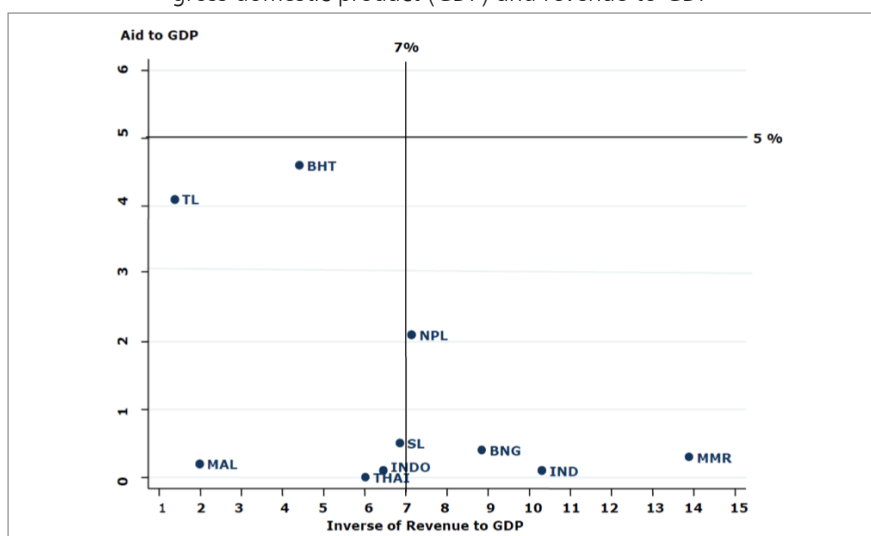
Figure 1: Relative position of ten countries of the WHO South-East Asia Region, in terms of ratios of fiscal deficit to gross domestic product (GDP) and public debt to GDP⁵



5 WHO SEARO Workshop on Evidence Based Priority Setting for UHC Bangkok Thailand, 10-14 December 2012 Macroeconomics and Health. Indrani Gupta, Institute of Economic Growth

As for aid-to-GDP and the inverse of the ratio of revenues to GDP, Maldives has the most favourable situation with respect to both these parameters. , Bhutan, Indonesia, Sri Lanka, Thailand and Timor-Leste are also within limits in these two variables. Bangladesh, Indonesia and Nepal are doing quite poorly in one or the other indicators. Most of the South Asian countries have manageable aid-to-GDP ratios, but not very favorable revenue-to-GDP ratios. The analysis depicted in Figure 2 below, indicates that South Asian countries have generally shown progress and buoyancy, but inflation and fiscal debt have remained two important concerns, limiting fiscal space.

Figure 2: Relative position of ten countries of the World Health Organization South-East Asia Region, in terms of Official Development Assistance (ODA) to gross domestic product (GDP) and revenue to GDP⁶



Effectiveness of health spending is always an important way of getting additional fiscal space, especially in the South Asian countries. However, if UHC is to be the step forward, then almost all these countries need a much higher level of health spending. There is considerable scope to garner such resources domestically in SEAR, either through strong tax reforms at the current levels or introducing additional levies in a progressive and innovative manner. However, additional revenues are only one among many other preconditions that would be required to achieve good practices in health financing.

6 WHO SEARO Workshop on Evidence Based Priority Setting for UHC Bangkok Thailand, 10-14 December 2012 Macroeconomics and Health. Indrani Gupta, Institute of Economic Growth

The Regional Strategy for Universal Health Coverage endorsed by the Sixty-fifth Session of the WHO Regional Committee 2012 .The Regional Strategy documents technical issues and international experience in a systematic manner for use as a practical reference by both Member States and WHO as SEAR moves forward on UHC. It was developed in consultation with experts from within and outside the region and highlights equity as its core objective and the principles of primary health care (PHC) as the starting point for reform.



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