Meeting on Health Systems Strengthening and Primary Health Care

Manila, Philippines
5-6 August 2008
REPORT

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Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Manila, Philippines
5-6 August 2008

Not for Sale

Printed and Distributed by:
World Health Organization
Regional Office for the Western Pacific
Manila, Philippines

September 2008
NOTE

The views expressed in this report are those of the participants in the Meeting on Health Systems Strengthening and Primary Health Care and do not necessarily reflect the policies of the World Health Organization.

This report was prepared by the World Health Organization Regional Office for the Western Pacific for governments of Members States in the Region and for the participants in the Meeting on Health Systems Strengthening and Primary Health Care held in Manila, Philippines from 5 to 6 August 2008.
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Key words:

Primary health care / Health systems / Health sector development
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<td>CEA</td>
<td>Cost Effectiveness Analysis</td>
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<td>EVIPNet</td>
<td>Evidence-Informed Policy Network</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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SUMMARY

There is increasing recognition that strong and effective health systems are necessary to achieve continued improvement in health outcomes in an efficient and equitable manner. There has been a welcome increase in funds available for health in many settings, but increased financial support alone is not sufficient to achieve the desired results. A particular concern is that in both high and low income countries there is increasing fragmentation of health systems which can lead to less than optimal health outcomes, lack of responsiveness, inefficiency, and financial risk. There is a growing consensus that health systems need to be approached in a holistic fashion. That being said it is still clear that the Declaration of Alma-Ata on Primary Health Care first promulgated in 1978 still provides the core values for strengthening health systems. There is currently a process of renewal or reaffirmation of the commitment of WHO to the principles of primary health care which is synchronous with the 30th anniversary of the original Declaration of Alma-Ata.

WHO issued a framework for health systems strengthening entitled *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes—WHO’s Framework for Action* in 2007. The WHO Western Pacific Regional Office has developed a *Strategic Plan for Strengthening Health Systems in the WHO Western Pacific Region* aimed at improving WHO's ability to respond to the health systems challenges of its Member States. *Everybody's Business* articulates four pillars to WHO's action in health systems: (1) a single health systems framework with six building blocks; (2) systems and programs focusing on results and health outcomes; (3) a more effective role for WHO at country level; and (4) solidifying the role of WHO in the international health systems agenda. The six building blocks are identified as service delivery, health workforce, information, medical products and technology, health financing, and leadership/governance. WHO has also recognized an increasing need for countries to have the capacity to analyse their health systems and to use that analysis for policy action. The development of an observatory on health systems and policies is one way of meeting that need.

The Regional Office felt the need to obtain expert advice on how to best take the agenda of health systems strengthening based on the core values of primary health care forward, how to take the concept of an Asia Pacific Observatory on Health Systems and Policies forward, and how to organize future expert technical advice on health systems.

A two-day Meeting on Health Systems Strengthening and Primary Health Care was held in Manila from 5 to 6 August 2008. A team of 11 expert advisers, seven representatives/observers from partner agencies, and a Secretariat of 28 WHO staff participated in two days of dynamic interactions. The health systems observatory was discussed as well each of the six building blocks of a health system, always keeping in mind that blocks are interrelated. The conclusions and recommendations on the Asia Pacific Observatory on Health Systems and Policies included that there was a demand and a need for such a function, that start-up should begin soon, and that there should be an initial emphasis on high quality products with selected policy briefs and country studies being appropriate initial products. Cross cutting themes in the six building blocks were identified which include capacity building, evidence, promoting dialogue, technical assistance, equity, and standardization and norms. It was also concluded that a general forum such as this was useful to provide health systems advice in a holistic fashion, but there may also be needs for more focused consultations on specific topics. Detailed conclusions and recommendations are in the text of the report and also compiled in Annex 6.

The meeting also recommended that the regional committee of the Western Pacific Region should consider adopting a resolution on health systems strengthening and primary health care and possible content for such a resolution was discussed.
1. BACKGROUND

Progress in improving health outcomes, achieving the health-related Millennium Development Goals and reaching universal access to health services as expressed by the slogan "Health for All" from the Declaration of Alma-Ata on Primary Health Care is unacceptably slow in many countries. Weak health systems have been identified as one of the main obstacles to improving health and scaling up effective health interventions. This is so even when the funding situation for health has improved. Although reasons for weak health systems vary from country to country, the common ones include inadequate human and financial resources and their inefficient use; lack of coordination and inefficient management; financial, social and geographical barriers limiting access to essential health care; and inadequate information and evidence for policy- and decision-making.

Health systems are part of the fabric of society and civic life. The core values and principles of the Declaration of Alma-Ata on Primary Health Care which was first promulgated in 1978 are still relevant, even in today's globalized world. There is increased awareness of health inequities and the damaging effects they have on individuals and society. Evidence suggests that health systems oriented towards primary health care (PHC) are more likely to deliver better and more equitable health outcomes, as well as greater public satisfaction, at lower costs than alternative delivery strategies in high-, middle-, and low-income settings.

To guide its work in responding to these global challenges, the WHO Secretariat has produced a framework entitled *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes—WHO's Framework for Action*. Building on *Everybody's Business*, which was issued by WHO Headquarters in Geneva, the WHO Regional Office for the Western Pacific has developed a *Strategic Plan for Strengthening Health Systems in the WHO Western Pacific Region*.

The regional Strategic Plan is aimed at improving the WHO response to the health systems challenges and needs of its Member States. A meeting of experts to obtain perspectives and inputs on how to strengthen health systems in the context of the core values and principles of PHC was convened in Manila from 5 to 6 August 2008. In addition to dealing with the core issues and activities in the regional Strategic Plan, the meeting also further elaborated the concept of a health systems observatory for the Region. The need for better collection, analysis and use of information on health systems is a recurring theme within the Region that the WHO Regional Office for the Western Pacific feels the need to address. The meeting was attended by 11 expert temporary advisers, seven representatives/observers from partner agencies, and a Secretariat of 28 WHO staff; two from the WHO Headquarters, 19 from the regional office and seven from country offices.

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1. Available at http://www.wpro.who.int/sites/hsd/documents/Everybodys+Business.htm
2. Available at http://www.wpro.who.int/sites/hsd/documents/Strategic+Plan+for+Strengthening+HSS+in+the+WHO+WPR.htm
3. Annex 1
2. INTRODUCTORY SESSION

The meeting was opened by Dr Shigeru Omi, the WHO Regional Director for the Western Pacific. Dr Omi reflected on his 20 years within WHO and his 10 years as regional director. He commented that the health landscape had become more complex and that health systems, a topic hardly discussed 20 years ago, is now high on the agenda. He said the Regional Office had been rather pre-occupied by, and successful in, dealing with communicable diseases with polio eradication, tuberculosis control, the control of Severe Acute Respiratory Syndrome (SARS) and preparedness for avian influenza cited as examples. He felt that the Regional Office has had less impact in the area of health systems. However, he would like to plant the seed of the Regional Office becoming a leader in this area also. He mentioned the recently released Strategic Plan for Strengthening Health Systems in the Western Pacific Region as a good first step, and he asked assistance from the gathered experts on three things: (1) their opinions on the feasibility and relevance of a regional health systems observatory; (2) their advice on what WHO should be doing to assist countries in the area of health systems; and (3) their views on mechanisms for future advice in health systems so as to sustain the current momentum.

Dr Henk Bekedam, Director of Health Sector Development, reviewed the objectives of the meeting which were to advise WHO on:

1. concrete actions to strengthen health systems in Member States building upon the regional strategic plan and on the core values and principles of PHC;

2. how to draw on technical expertise to take the health systems strengthening (HSS) and PHC agenda forward in the Region; and

3. how to strengthen its capacity in the Region to analyse, assess, monitor and evaluate priority health systems and PHC issues.

Dr Bekedam emphasized the need for advice on concrete actions and the need to provide feedback on the proposed health systems observatory. Issues of particular concern are universal access to health services, a country focus for WHO actions in health systems, moving from a WHO Secretariat perspective to a broader Member State perspective, and mechanisms for future health systems advice to WHO.

Dr Dean Shuey, Regional Adviser for Health Services Development and responsible officer for the meeting, reviewed the context for the increasing interest in health systems strengthening and primary health care. Although each country has unique issues, escalation of costs, fragmentation, lack of responsiveness and inefficiency are issues relevant to most countries. Everybody's Business is WHO's framework for action in health systems. It has four pillars of action: (1) a single health systems framework with six building blocks; (2) systems and programmes focusing on results and health outcomes; (3) a more effective role for WHO at country level; and (4) solidifying the role of WHO in the international health systems agenda. The six building blocks of service delivery, health workforce, information, medical products and technology, health financing, and leadership/governance were used to organize subsequent discussion. It was emphasized that health systems issues are interrelated and must be analyzed holistically, and should not be tackled only one building block at a time.

A PHC renewal process has been initiated in WHO by the Director-General and updated information on this was provided. The process will continue with a high-level meeting in Almaty, Kazakhstan, from 14 to 16 October 2008, which will mark 30 years after the original
Declaration on Primary Health Care. The World Health Report 2008, which is focused on PHC, will be launched at that meeting. The key elements of the Strategic Plan for Strengthening Health Systems in the Western Pacific Region, which had been distributed prior to the workshop, were then reviewed.

The workshop format of a brief introduction to a topic, followed by about an hour of discussion, and then a set of final conclusions and/or recommendations was introduced. Powerpoint slides of the presentations and conclusions from each session are in Annex 3 and the workshop recommendations are amalgamated in Annex 6.

3. ASIA PACIFIC HEALTH SYSTEMS OBSERVATORY (SESSION 2)

Dr Richard Nesbit, Director of Programme Management, introduced the topic. A one-page introductory brief was distributed in advance of the meeting. The objectives for the session were presented as: (1) how to strengthen WHO's capacity to analyse, assess, monitor and evaluate health systems and policies; (2) how to strengthen WHO's capacity to disseminate knowledge and provide advice and have improved dialogue with Member States; and (3) to receive feedback on the concept of the Asia Pacific Observatory on Health Systems and Policies.

A case was made that there is a need to bridge the gap between researchers and policy-makers and that there was a demand for the kind of information and services that an observatory could provide. The experience of the European Observatory on Health Systems and Policies was presented as a possible model. The functions of an observatory could include: (1) country monitoring as exemplified through the Health Systems in Transition Series (HiTs) of country reports; (2) analysis and policy briefs on selected topics; (3) dissemination of information and ideas through publishing, meetings, websites, summer schools and dialogue; and (4) contributing to capacity-building and networks. The scope of a proposed Asia Pacific Observatory on Health Systems and Policies would be the countries in the WHO Western Pacific and South-East Asian regions. It would require an alliance of excellence involving individuals and institutions. The need for consistent, high-quality products to build the credibility of an observatory was emphasized.

A broad and comprehensive approach to health systems would be preferred. An observatory would depend mainly on analysing existing information and studies rather than conducting primary research. Such an approach would require individuals with combined research, policy and institutional experience to provide strong peer review. Individual commitment was identified as one of the keys to the success of the European Observatory. This success was built progressively over a 10-year period. The Western Pacific Regional Office is interested in serving as the Secretariat.

The identification of initial products for an observatory was suggested as an important next step, with HiTs in selected countries and selected policy briefs being proposed as initial products. Malaysia, Hong Kong (China) and New Zealand were mentioned as countries or areas appropriate for initial studies because information and the capacity to produce quality products were felt to more available in those settings. It is likely that the WHO Regional Office for non-commercial purposes.

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4 Annex 1
5 Annex 4
Europe's template for country studies would need adaptation to be more suitable for the Region. Questions posed at the end of the session to be addressed over the next two days included:

(1) What are the highest priorities and needed initial products?
   (a) If HiTs: Which countries?
   (b) If policy briefs: Which topics?
(2) Who are the possible research collaborators?
(3) How can high quality be ensured?
(4) Who are the possible partners?

The potential Asia Pacific Observatory on Health Systems and Policies provoked a wide range of interest and comment. The overall tenor of the comments was supportive and recognized that there is a need and a demand for such a function.

General comments included questions on how an observatory would relate to existing networks in the Region, some newly formed and others long standing. There were some differences expressed about the effectiveness of some existing networks. Arrangements for an observatory should be seen to be equitable, transparent and fair so that existing institutions and networks would feel it was a situation where all were benefiting. The audience for an observatory was felt to be primarily policy-makers, but could also include existing regional groups and networks, as well as technical assistance providers from multiple organizations. Efforts should be made to determine the need for an observatory and its products based on what countries perceived as their issues of concern. Civil society, consumers and patient advocacy groups could also be part of the audience. Involving these groups would lead to a broader perspective on health development. It would also put more emphasis on disaggregated analysis and the socioeconomic determinants of health.

The potential impact of an observatory and how the needs of policy-makers are best served was discussed at length. HiTs were further defined as comprehensive and systematic studies of national health systems in transition based on a common template. Policy forums and dialogues were further defined as attempts to compare country experiences, study policy options and learn lessons of best practices. There was a consensus that HiTs-like studies are useful and a necessary first step, but noting that comparative analysis and policy dialogue with decision-makers may have more impact than HiTs studies alone on policy. Policy-makers often require information that is sometimes referred to as “quick and dirty” and there was concern that too much emphasis on quality may slow the process and actually lead to less policy impact. A balance was deemed to be necessary.

Reservations were expressed about following the European Observatory model as the Region does not have the institutional strength to support that model. There were also concerns that the emphasis on quality might exclude many valuable institutions and certain countries and potentially compromise national ownership. The key to quality was felt to be reviewers and editorial boards that are respected and fair, but also willing to hold all researchers and compilers of information to a high standard, a task that was recognized as being difficult but important. Differential branding of products was suggested. Products that reach a certain standard are official observatory products. Others might be of a lower academic standard, but would be useful to policy-makers due to the process by which they were developed. There was at least
some thought that governments like to control policy processes, which may mean controlling information, and this could affect observatory function.

Topics of potential interest included the impact of disintegrated and fragmented disease management, health care financing, antimicrobial resistance, decentralization and health systems, comparative analysis within the pharmaceutical sector (including markets, pricing and rational use) and innovations in human resources for health. There was frequent advice to choose "low-hanging fruit", which was not always clearly defined, but seemed to mean choosing topics and countries where information and research capacity existed.

There was some concern about the wide diversity of countries in the Asia Pacific region and also the large population that would theoretically be covered, although others thought that diversity was not a particular problem. Regional groupings were discussed, such as South Asia, East Asia and the Pacific, with perhaps China and India being separate cases due to their size and complexity. The relationship between the WHO Regional Office for the Western Pacific and WHO Regional Office for South-East Asia would have to be worked out further.

Conclusions

(1) A need for an Asia Pacific Observatory on Health Systems and Policies exists and there would be a demand for its outputs.

(2) HiTs and policy briefs are endorsed as initial products with the caveat that work should be policy relevant, demand driven and with a country focus.

(3) Regional adaptation of formats for HiTs and policy briefs might be necessary.

(4) Facilitating policy dialogue is an important function of an observatory.

(5) Production of quality products is crucial and that will require a strong review process and a need for transparent and strong partnerships with carefully selected individuals and institutions.

(6) Start-up should not be delayed.

Recommendations

(1) Start-up by the end of 2008.

(2) Consult countries about HiTs and policy briefs, particularly those that have been suggested as initial countries or areas for study.

(3) Focus on functions with institutional arrangements to follow.

(4) Identify partners for both implementation and support.

(5) Identify capable editors and reviewers willing to ensure quality.

(6) WHO Regional Office for the Western Pacific to develop a capacity to support start-up activities.

(7) Consider tabling for discussion at the Regional Committee meeting in September 2008.
4. TECHNICAL SESSIONS

4.1 Service delivery (Session 3)

Ms Anjana Bhushan presented the topic which focused on barriers to access to service, health as a human right, the interface between efficiency and equity, and the use of targeted or universal strategies to reach the underserved. The role of the private sector was raised as well as the tendency for benefits in health systems to be disproportionately captured by the non-poor. Specific questions posed to the discussants were:

(1) How does one best get service delivery for the marginalized?

(2) What is the role of the private sector?

(3) What needs to be done in countries with regard to service delivery to promote universal access.

(4) What is WHO’s role?

A comment was made that there is a balance between equity and efficiency and they are not necessarily mutually exclusive, i.e. there does not always have to be a trade-off. Targeting and universal strategies are complementary and each is more appropriate in different situations. Services for the marginalized depend on how multiple sectors and the government function as a whole, not on the health sector alone. It was noted that service delivery typically hits a plateau unless there are specific strategies for the marginalized. It was noted that equity is not equality. Achieving equity usually requires some form of redistribution which makes the role of the government crucial. A comment was made that a finding of the Commission on the Social Determinants of Health was that where health systems depend on broader, tax-based financing, health systems seem to do better in providing services for the marginalized and in decreasing inequity.

The private sector should not be seen as the enemy, but it is important to define the role of the government. The private sector was noted to not be homogenous and there is often a lack of information about the private sector. It was felt to be important that the government clearly define the role of the private sector in the health sector and that the private sector should not be looked at as necessarily in competition with the public sector. This is sometimes complicated as the public sector in many settings has taken on many characteristics of private service delivery, such as depending on user fees for financing.

The role of the public sector in health was felt to frequently need clearer definition. Even when the public sector is not the provider, it must be the steward. It was stated that there is often no shortage of good policies and plans, but the difficulty was in implementing policy or in scaling up pilots to be universal. Integrated services were discussed. A need for primary care gate-keeping, holistic approaches and assistance with putting services together at the level of the peripheral provider and receiver of services was expressed. There were successful stories where integration has succeeded, even in a complex environment, but only where there is good leadership. WHO was encouraged to be more engaged in defining the role of the government and in working out the tension between the public and private sector in health. It was stated that this tension will never be resolved completely and there will be a dynamic "balance of inconveniences" for defining packages, service delivery roles for different providers and what services are best delivered horizontally or vertically.
There was a consensus that WHO needs to be more engaged in helping governments develop service-delivery definitions. Particularly, it was mentioned that WHO must be active in a dialogue with disease-control programmes. The difference between public health policy and healthy public health policy was commented on, with the further comment that WHO tends to concentrate on the former.

Conclusions

1. There is a dynamic balance between equity and efficiency which continuously needs to be readjusted and is not mutually exclusive.

2. Targeted and universal services are both necessary depending on the circumstances and there will be a blend of approaches, although universality is a core principle.

3. Government must take the leadership or stewardship role in defining the balance between private and public, the feasible service delivery package, methods for scaling up, and the intersectoral balance for healthy public policy.

4. A dialogue with disease-control programmes is necessary to promote integration, sustainability and scaling up of good practices.

5. Sufficient information must be generated for service delivery to be monitored and determine if populations are underserved.

6. Working with multiple partners, including the private sector, civil society and sectors other than health, is desirable.

Recommendations

1. WHO to assist governments to define and cost basic packages of services, to make more explicit the role of different providers and different levels of the system, and to appropriately engage with the private sector and civil society.

2. WHO to assist in moving plans and strategies through to implementation and scaling up.

3. WHO should promote the role of PHC for achieving equity goals and in selecting appropriate targeted and universal approaches.

4. WHO should assist in developing more evidence of best practices, particularly in regards to gender, poverty and equity.

5. WHO to assist governments in engaging intersectorally in a more effective manner and with a wider variety of players to achieve equity goals.

4.2 Health care financing (Session 4)

Mr Dorsjuren Bayarsaikhan presented the topic which builds on the Biregional Strategy on Health Care Financing. The emphasis of WHO's health care financing work is to support adequate, sustainable and effective health financing to support improved health outcomes. Health care financing in the Region is typified by a dependence on out-of-pocket expenditure, which contributes to problems with access, equity, quality, catastrophic health expenditure and
exclusion of vulnerable groups. The biregional strategy calls for an increase in public resources for health and increased pre-payment and risk-pooling. Questions posed to the discussants were:

1. What practical steps can be taken to move from out-of-pocket to prepaid and risk-pooled health care financing systems?
2. What is pro-poor, pro-equity health financing?
3. What needs to be done in health care financing to promote universal access for all?
4. What is WHO's role in this?

General discussions regarding health care financing included comments on the perverse incentives that were common, the influence of private practice in public institutions, and the fact that females and the poor were particularly vulnerable to the ill effects of user fees. Mention was made of indirect or under-the-table payments as an issue that is frequently neglected and that the payment of health workers is intimately involved with both service delivery and health care financing. There was a consensus that decreasing the percentage of out-of-pocket expenditure is desirable in most settings, but even that can cause problems. An example of this was that elimination of fees immediately after the Chinese earthquake was followed by shortages of drugs and other essentials.

A recurrent theme was the challenges presented by decentralized health care systems, both for implementation and financing. There was a consensus that financing policy, at least, needs to be uniform and probably national with WHO playing a more vocal, even a "noisy", role. Decentralization requires technical advice that can be tailored to a situation. A cookie-cutter or one-size-fits-all model does not work as different systems are at different stages of evolution. There will be a lot of variation. Decentralization provoked many comments, some critical of the concept and others calling for more efforts by WHO and central decision makers to learn how to work with decentralized systems.

Medical financing should not be confused with health financing and public goods in health probably need to remain publicly financed and perhaps even financed centrally. A comment was made that specific expertise is needed in rather specialized areas such as sub-contracting of services. There was a lot of focus on microeconomic and household financing issues in health. However, it was also felt that WHO and ministries of health needed more competence in global and national economic issues so that the case for increased spending on health, when appropriate, could be made more effectively. In addition, a comment was made that health care financing should also look for efficiency. It was argued that there is a lot of inefficiency in systems, such as irrational drug use, that is being aggravated by the methods of health care financing.

There was agreement that the information base was not as strong as it could be. Comparative information on financing and costs was argued to be important for decision-makers. Frequently senior officials are surprised when given comparative information from other national settings. A comment was made that WHO needs to move from being seen only as an advocate to being able to provide analysis and advice based on evidence and experience. The private sector was mentioned, although specific ideas were few. As there is no one perfect financing system, or health system, a nuanced response to the needs of countries always needs to be developed. A goal is to define a balanced public-private mix to achieve social goals of equity and protection while maintaining market growth.
Conclusions

(1) There is a need for WHO to be more engaged in policy debates and dialogues on health care financing at national and subnational levels, both within the health sector and also outside the sector and to be a more effective and vocal advocate on health care financing issues, particularly the need to move away from out-of-pocket household financing of services to more universal, pre-paid and risk-pooled systems.

(2) Improved access to evidence would facilitate the policy debates and dialogues and this is a potential role for WHO.

(3) Nuanced technical assistance in a wide variety of areas, such as national health accounts, costing of services, cross national comparisons, methods to increase efficiency through financing, and national macroeconomic planning, is needed.

(4) Private sector engagement is desirable, although more specificity on this is needed.

(5) An increased capacity for health care financing work adapted to specific situations is needed in many, if not most, national settings.

Recommendations

(1) WHO to make stronger statements on desirable health care financing to improve equity, access and financial protection and to assist ministries of health in developing policy dialogues on the topic.

(2) WHO to assist Member States to build capacity to make the case for and to design and manage more equitable and effective health care financing.

(3) WHO to assist Member States in developing a solid evidence base for health care financing on a wide range of issues.

(4) WHO to assist Member States in engaging more effectively with the private sector in health care financing and a range of other topics.

4.3 Human resources for health (Session 5)

Dr Ezekiel Nukuro made the introductory presentation for the session on human resources for health. The critical importance of health workers to health outcomes was emphasized. Core issues and challenges included imbalances in numbers, skill-mix and distribution; insufficient remuneration and incentives; low standards and quality of education; and weakness in the knowledge base for management of the workforce. The health workforce has been affected by fragmentation and in some aspects, especially for continuing education, is donor driven. WHO's work in human resources is based on the Medium-term Strategic Plan 2008-2013, the Regional Strategy on Human Resources for Health 2008-2015, and the Strategic Plan for Strengthening Health Systems. The focus for the discussions was the impact of primary care workers, including family physicians, non-physician primary care providers and community health workers. Questions posed to the discussants were:

(1) How can countries develop and implement plans for a balanced workforce taking a primary health care approach?

(2) What is the role of multi-skilled teams and primary care providers?
(3) What needs to be done in countries with regard to the health workforce to promote universal access for all?

(4) What is WHO's role?

The issue of developing a multi-skilled workforce was mentioned frequently, although there were also statements that the type of workforce needed could not be identified until the package of services and where those services were to be delivered are identified. Managerial skills are frequently neglected in workforce planning. Low salaries in many countries are seen as a major issue leading to poor motivation, low productivity and to migration in some settings. It was felt that more comparative evidence needs to be gathered and made available on experiences with issues such as performance-based incentives, topping up of salaries with external funds, and supplements to work in underserved areas or with underserved populations, as a few examples. The evidence base is weak on these issues. It was mentioned that workforce planning is no longer only a central task in many countries and support to decentralized health workforce planning is an issue.

There was general agreement that human resource issues are tied closely to issues of health care financing and design of service delivery. Gender, human rights and discrimination are of importance in how the workforce provides services and also for how the workforce is organized. The issue of informal health carers, who are predominantly female, and the failure of their efforts to be measured or sufficiently acknowledged was discussed. There was general agreement that data or information was lacking on skill mix, incentives, migration, informal care giving and a host of other issues.

Migration is an issue of great concern to some countries, particularly in the Pacific and the Philippines, but also to some degree in other countries, such as Malaysia. Developing incentives not to leave, planning for migration and factoring migration in as part of human resource planning, and whether receiving countries had any obligations to sending countries were all discussed, although with no concrete resolution or suggestions on the issues. Planning to deliver core services with cadres who had fewer options to migrate was mentioned and to a degree that has been done in several countries. Migration is also an internal issue, moving from rural to urban and also moving from the public sector to the private sector and/or the medical tourism sector. Retention policies need to be part of the policy debate and WHO can play a role in facilitating that debate.

Conclusions

(1) There is a need for improved human resources evidence and data.

(2) The skill mix of staff needs to be determined in relationship to the services to be delivered, which need to be determined in relation to the burden of disease.

(3) Salaries and incentives are crucial but not the entire answer to motivation and they must take into account the complex issue of migration.

(4) Gender issues in the health workforce and in service delivery need to be acknowledged.

(5) Documentation of innovative strategies is important.
Recommendations

(1) WHO to provide support to Member States to improve the collection of basic human resource information, including skill mix and sex disaggregated data, and also consider acknowledging informal care givers as part of the human resource workforce.

(2) WHO to support Member States in improved human resources for health planning.

(3) WHO to work with Member States to mitigate the adverse effects of migration and advocate for ethical recruitment.

(4) WHO to facilitate policy dialogue and debate on issues of accountability, quality, retention, incentives and management of the health workforce.

(5) WHO to support Member States in developing standards for quality education of the health professions.

4.4 Medical products and technology (Session 6)

Dr Budiono Santoso presented the topic which covered aspects of pharmaceutical and traditional medicine, and the health technology programmes. The pharmaceutical activities build upon the Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region (2005-2010) which emphasizes rational selection, rational use, affordability, sustainable financing, reliable supply, quality and combating counterfeits, monitoring, and the effects of globalization. The health technology programme is beginning the process of developing a regional strategy for health laboratory services, and there is also an on-going blood safety programme. The traditional medicine programme is working on issues of policy and regulation, standards, quality of academic education, safety, efficacy, quality and rational use. Decentralization has presented a challenge to the implementation of policy in many aspects of both pharmaceuticals and technology. Questions presented to the discussants were:

(1) What are innovative methods for selecting, financing, maintaining, monitoring, promoting access and encouraging the rational use of medical products and technology?

(2) What needs to be done in countries with regard to medical products and technologies to promote quality and universal access for all?

(3) What is WHO's role?

Discussions were wide ranging before settling onto the specific questions. It was clear that this topic relates closely to service delivery, financing and human resources, as well as to regulatory and information functions.

Health technology assessment (HTA) and cost effectiveness analysis (CEA) were proposed as useful tools and something to which WHO could bring added value and perhaps wider acceptance. The techniques have value for both pharmaceuticals and other technologies. HTA and CEA were mentioned as a potential agenda for a health systems observatory. However, it was pointed out that this is a contentious area, that there are many competing interests, and if there is not a strong regulatory or political framework, HTA and CEA have limited influence on actual practice. The linking of pharmaceuticals and technology to health care financing and the ubiquity of supplier-induced demand were noted to be major obstacles to
rational use of both drugs and technology. A risk of HTA and CEA is that it can be seen as a means of blocking innovation, a perception that WHO would want to avoid. WHO would want to assist in setting up procedures and methods for selection, but not want to be a proponent or opponent of any particular technology.

There was general agreement that there were major issues about standards and quality in both pharmaceuticals and health technology. There was considerable discussion around the issues of counterfeits, over-prescribing, and unsatisfactory purchasing and pricing arrangements for pharmaceuticals and technology. Interest in shared information on pharmaceutical quality and pricing was expressed. The entire set of issues surrounding the interaction of the market and pharmaceuticals was felt to need further investigation. The potential benefit from shared purchasing and warehousing in the more remote and smaller parts of the Region (e.g. the Pacific) was mentioned. The role that consumer organizations and civil society can play in improving the rational use of medicines was discussed, and it was agreed that information needs to be made available to both and that in some countries, but not all, they can be effective advocates for improved practice. Higher quality drug pricing and cost effectiveness information is highly desirable. There was a brief mention of drug price regulation with no consensus reached as to feasibility or desirability. It was noted that information technology and "e-health" can be major expenses, and it was asked whether HTA and CEA are appropriate techniques to apply to those technologies. The meeting agreed that computer and information technology should not be introduced without analysis, and they are part of the health technology assessment agenda.

A need for standards and regulation in health technology, particularly laboratories, was discussed. If there are clear policies and standards, a nation can deal with decentralized implementation more successfully, rather than leaving peripheral units of government to set standards on their own. There was a call for guidelines on integration of laboratory services and also on quality issues. WHO's help in standards and quality control for primary-level laboratories would be of value and assistance with international quality assurance and comparisons for regional laboratories were seen as potentially useful.

Ethical issues around pharmaceuticals and technology were discussed. These included supplier-induced demand and the need to sell drugs or diagnostic tests to provide income for health workers. This was seen as a major and difficult-to-solve problem, particularly when the drug and technology industries become closely aligned with health professionals. The use of health technology can also have human rights implications, such as diagnostic methods that can lead to sex selective abortions or technologies that are used in the commercial aspects of transplantation.

Discussions on the role of WHO focused on providing capacity-building to develop a strong technical base in HTA and CEA for both drugs and technologies. Assisting Member States in developing regulations, policies and standards was seen as useful. Comparative information on technologies and drugs was seen as a potential area of interest to a future observatory. Quality improvement and quality assurance, particularly relating to substandard and counterfeit drugs and laboratories was seen as relevant for WHO.

Conclusions

(1) Health technology assessment and cost effectiveness analysis are needed tools, although they alone will not drive policy.

(2) Conceptual frameworks for both pharmaceutical and technology assessment are needed.
Rational use of laboratories and drugs are major issues of pressing importance in the Region.

Financing of pharmaceuticals and technology is particularly problematic in the Region, which needs to move towards financing and payment mechanisms, such as capitation and diagnosis related groups, that encourage rational use.

Incentives and ethical issues must be addressed in any regulatory framework.

**Recommendations**

1. WHO to promote and build capacity in conducting CEA and HTA (including Information Technology) as part of a holistic analysis of the health system.

2. WHO to assist Member States in promoting the rational use of drugs, laboratories and other diagnostic methods, with some emphasis on addressing multidrug resistance.

3. WHO to assist Member States in addressing issues of incentives, ethics, policy and regulation in regards to pharmaceuticals and technology.

4. WHO to develop regional comparative evidence on multiple issues related to medical products and technologies, such as pricing and quality.

5. WHO to expand collaboration with civil society, consumer and community groups, and human rights groups in this area.

6. WHO to develop global norms, standards and indicators on health technology, including quality assurance and management information systems.

**4.5 Leadership/Governance (Session 7)**

Dr Dean Shuey introduced the topic and presented the concept that field-level health workers are having difficulty in integrating the multiple streams of programmes in a coherent fashion. The increased funding from various health programmes over the recent past is welcome, but it has often led to programmes going in different directions and in many cases has created confusing and overlapping structures. A lack of aid coordination in the health sector has led to distortions, distractions, duplications and disruptions. Leadership and governance are much broader than just aid coordination, but for the purpose of this session, the discussion revolved around that topic. Questions posed to the participants were:

1. What is the role of national health planning in improving aid coordination?

2. What needs to be done in countries with regard to leadership and governance to promote universal access for all?

3. What is WHO's role?

It was restated that there are many issues other than donor coordination and that some countries, especially those with traditions of strong centralized planning, had fewer problems with aid coordination. A comment was made that donors should coordinate better among themselves, although others emphasized that ideally this is a country-led national role, not one for donors. Some felt that the United Nations theme groups worked reasonably well and suggested a similar structure for HSS. A comment was made that donor funding frequently does
not follow national priorities. The various initiatives to improve aid coordination and aid effectiveness, such as the Paris Declaration and the International Health Partnership, may have had more impact in harmonizing donor priorities and procedures than in actually aligning donor funding with national priorities and processes.

The Global Health Initiatives, particularly the Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM), came up repeatedly. Concerns were expressed that the health systems “window” has been difficult to get to work in countries. A problem is that the Global Fund is not actually present at aid coordination meetings at a national level and that the Global Fund Country Coordinating Mechanism is usually separate from existing aid coordination mechanisms. However, there was a feeling that the GFATM is becoming increasingly serious about health systems, and therefore there was a need for effective engagement with the GFATM at the global and at country levels.

It was felt that good national health plans can improve aid coordination and effectiveness. It was also expressed that a robust health plan can ward off undue external influence, although the status of the national health planning processes varies considerably. National health plans should be a process led by countries, and the planning process should be led by local priorities. WHO could assist Member States in identifying priorities. Process is crucial; something that is not always consistent with externally imposed deadlines. It was expressed that it was expecting a lot from a national health plan to provide accountability for donor funds, particularly in decentralized systems such as those that exist in some parts of the Region. There was also doubt as to whether it is appropriate to impose or require specific health outcomes, which many donors want, on a national health plan.

In summary, it was felt that donor coordination is not an end in itself; there has been some progress on aid coordination. Coordination is good but it needs to be led by a national health plan, and the process of how a national health plan is developed is important.

WHO's role was seen as varied by different participants. WHO could assist Member States in the process of national health planning and aid coordination or effectiveness. WHO could assist in priority setting. It was expressed that WHO assisting countries in national health planning should be the highest priority of WHO. A role of WHO was suggested to be ensuring that the confusion decreases at the implementation level. Some scepticism was expressed as to whether WHO could really do this, and some felt that countries themselves must take charge of the aid coordination agenda to achieve this end. WHO can document comparative experiences in aid coordination and best practices. It was also concluded that WHO needs to be involved with the Global Health Initiatives both globally and through providing technical assistance to individual Member States.

It was re-emphasized that governance issues extend much beyond just aid coordination, that they underpin the entire health sector and that much of the discussion of the other building blocks could be considered under governance. It was repeated that the six building blocks are not separate, discrete parts of a health system, but more of a method to use for analysis.

Conclusions

(1) Donor coordination is not an end unto itself.

(2) Although there has been some progress on donor coordination, it has been stronger on harmonization than on alignment.

(3) Coordination is good, but it needs to be guided by a national health plan.
(4) The process of national health planning may be as important as the precise content.

(5) National health planning may have some trouble meeting some of the expectations that it be the core aid coordination and funding mechanism.

(6) Leadership and governance are central to a health system and extend much beyond the aid coordination and aid effectiveness agenda.

**Recommendations**

(1) WHO should support Member States to develop "robust" national health planning processes.

(2) WHO country offices should have the capacity to serve as a resource centre in national health planning.

(3) WHO must play a leading role in assisting Member States to lead the aid coordination and aid effectiveness agenda.

(4) WHO has a core role in facilitating the Global Health Initiative process in the different countries.

(5) WHO should provide comparative evidence and information on national health planning processes within the Region, which might be a health systems observatory topic.

**4.6 Information (Session 8)**

Dr Reijo Salmela introduced the topic with the vision statement of the information, evidence and research cluster of WHO Headquarters and a listing of partners beyond WHO, including the Health Metrics Network (HMN), the Institute for Health Metrics and Evaluation (IHME) and the Alliance for Health Policy and Systems Research (AHPSR). The Health Information System (HIS) strategic priorities, the need for more analytic work, a framework for monitoring initiatives for scale up for better health, the WHO health systems performance framework, and information on the Evidence-Informed Policy Network (EVIPNet) were presented. Questions presented to the participants were:

(1) What are the key health information needs to assess a health system and its implementation and impact?

(2) How do we operationally define PHC to assess its implementation and impact?

(3) What can WHO do to improve capacity for strategic analysis of health systems and health systems performance in the Member States? What is the role of health policy and systems research?

(4) What mechanisms can countries adopt to promote efficient collection and analysis of disaggregated data?

A fragmented information system due to demands of partners (donors and other international organizations) is a major issue. Capacity to meet those demands is stretched at central level and even more so at peripheral levels. There was discussion about the relative role of collecting information in a routine fashion rather than depending on surveys. There was at least one advocate for strengthening the relative role of routine information which was felt to be
more feasible with improved information technology. However, a countervailing opinion was expressed that for the foreseeable future periodic surveys would be necessary for much key information. It was pointed out that surveys are still necessary in the developed world to collect crucial information.

Trying to consolidate information systems was promoted by one observer from a ministry of health. Harmonizing surveys and making them consistent within countries is crucial, as frequently two surveys in the same country may not produce data that can be used for comparison. Harmonizing surveys and methods among countries would be desirable as it would facilitate cross country-comparisons that can be quite useful. There were advocates for national plans for information systems as a first step towards harmonization and alignment and this was seen as a role of WHO. There was at least one comment about the need to clarify the respective roles of the Health Metrics Network and WHO in the context of national HIS planning.

The advantage of defining a minimum data set was discussed and a possible role of WHO in helping identify such a data set. A question was asked as to what is driving the need for information. There was also a comment that one can drown in data and that while we struggle to measure even rudimentary service delivery output there is a demand to expand other parts of the information system. The benefits of disaggregated data were noted, although it was acknowledged that disaggregation increases the burden on overstretched systems. There was an additional comment that there is a lack of information from the private sector, civil society organizations and other actors in the health field, although it was also acknowledged that this is a difficult area. Mention was also made of the fact that WHO sometimes has information that is not made widely available. This led to a discussion about Member States owning their information and sometimes WHO is not free to release it to the public domain unless it wants to jeopardize relationships with certain Member States. However, it was encouraged that maximum transparency and access to data should be encouraged.

Conclusions

(1) Health information is fragmented and excessively donor driven, and it would benefit from more coherent planning based on an assessment of information needs and capacity.

(2) The quality of information is not always high.

(3) The use and analysis of existing information are not optimal.

(4) Information that exists is not always available to all interested parties or to those who need it.

Recommendations

(1) WHO to facilitate countries in building a consensus on a minimum data set for health information and developing integrated national health information strategies and plans.

(2) WHO to work at improving the capacity for the use and analysis of information and data and bridging the gap between information and policy.

(3) WHO to advise countries on the best methods for a wide range of information needs, including health systems performance assessment and surveying.
(4) WHO to encourage more involvement of civil society in collection, analysis and use of information and to look at ways of improving data collection from the private sector.

(5) WHO to promote public access to information and survey data to the extent possible.

(6) WHO to provide assistance in defining appropriate technology for information needs in different circumstances.

5. FUTURE ADVICE TO THE WHO REGIONAL OFFICE FOR THE WESTERN PACIFIC (SESSION 9)

WHO feels the need for expert advice in the area of health systems in general in order to improve its performance in providing technical cooperation. There were a set of questions concerning:

(1) The usefulness of this meeting and format.

(2) The future structure and terms of references for any expert advisory group.

(3) Timeline for any future meetings.

(4) Innovative methods for WHO to get technical advice.

There was a comment that a similar forum to discuss health systems in general would be useful at country or subregional level. It was felt to be necessary to talk about the entire scope of health systems. It was commented that in the future, it might be desirable not to talk about all six building blocks as it tended to fragment the discussions, and may have led to less in-depth discussion. Others felt this was acceptable, as technical details would require a different group. It was also mentioned that there is no substitute for face-to-face consultations. The diversity of participants was good but could perhaps be stronger in regards to gender issues and some technical areas, as it was a bit long on financing expertise. However, it was suggested that such a meeting requires transcendent participants who can think beyond their narrower discipline.

Primary health care was mentioned as not having received much attention over the two days, although there was a response that primary health care and health systems strengthening (HSS) are seen as mutually compatible in the Regional Strategy.

Conclusions

(1) A general forum for a holistic look at health systems is useful. Narrower technical details should be dealt with elsewhere, perhaps as part of the various regional strategy reviews.

(2) Participants need to be chosen who can provide a transcendent, broader view of health systems. Continuity of participation offers advantages, particularly on following up progress on recommendations.

(3) A Member State consultation on health systems strengthening would be a logical next step if endorsed by the Regional Committee.
(4) Periodic face to face meetings are useful, but should occur when there is an event or time that is appropriate, perhaps as a regional strategy is nearing completion.

6. PULLING IT TOGETHER (SESSION 10)

6.1 Observatory

The final session gave the participants an opportunity to make final comments and recommendations on the health systems observatory concept in light of the two days of discussions. The recommendations from each of the previous sessions were also reviewed at this session. The recommendations are reported along with the write-up of each session, rather than being presented in this section of the report. The total set of recommendations are grouped in Annex 6. In addition, comments to a draft resolution on health systems strengthening and primary health care were received and will be submitted to those preparing the documentation for the upcoming meeting of the Regional Committee for the Western Pacific to be held in September 2008.

The recommendations on the observatory presented were the following:

(1) Start-up should begin soon.

(2) Need to meet to learn from European Observatory, but also to adapt the templates for HiTs to the needs of the Region.

(3) Need to consult countries that have been proposed for HiTs and policy briefs.

(4) Focus on function and determine institutional arrangements later.

(5) Strengthen partnerships

(6) Identify editors and technical reviewers willing to ensure quality.

(7) Launch the Asia Pacific Observatory concept with agreed products (HiTs and policy briefs) by the end of 2008.

It was welcomed that the WHO Regional Office for the Western Pacific is willing to take on the role of the Secretariat, although the staff is not yet identified. It was agreed that the exact form of the observatory could follow its function, but at some time more detail on the form would be necessary. It was commented that any observatory needs to work with the existing networks and should not damage them. However, it was also pointed out that the output of some of the networks was not large over the past 10 years and some were rather narrow in focus and not looking at over-all health systems issues. It was reminded that the Alliance for Health Policy Research had done one report on this topic in the past. It seemed to be well accepted that HiTs in a modified form taking into account regional sensitivities are a useful initial product and that policy briefs are also useful. However, it was repeated multiple times that comparative studies are perhaps the most useful and that the European template is not completely suitable to the Region and would need adaptation.

Potential contributors and users need to be identified and it was suggested that there would be advantages to doing this transparently. It was mentioned that how contributors and editors are
selected would send a powerful message and there was some discussion as to the feasibility of a call for proposals versus a less open selection of participants in the observatory. It was mentioned that any observatory should try to build on existing health sector reviews and it was responded that the observatory method depends greatly on existing data and studies, not primary research. It was also suggested to be an urgent issue to address the relationship with the WHO Regional Office for the South-East Asia.

Responses to the final round of comments by Dr Richard Nesbit, Director, Programme Management, were that:

1. An early role of the observatory would be to facilitate dialogue between researchers and policy-makers and WHO is in a good position for this.

2. More detailed discussions with potential initial areas or countries (Malaysia, New Zealand, and Hong Kong (China)) would have to be pursued realizing that there can be sensitivities around HiTs. It is anticipated that they will be supportive.

3. It is asked that names of institutions and individuals be proposed for initial oversight and editorial boards. The identification of key parties has begun informally.

4. Suggestions on criteria for researchers would be appreciated. It is important to have a process that can be readily explained in selecting partners, but it was re-emphasized the importance of ensuring quality products.

6.2 Review of recommendations from six building blocks

The individual recommendations from the sections on the "six building blocks" were reviewed. The actual conclusions and recommendations are included with each section. They are grouped in Annex 6. There were noted to be some cross-cutting themes to the recommendations which went across all building blocks. These included capacity-building, evidence, promoting dialogue, technical assistance, equity, and standardization and norms. The lists of recommendations were considered to be long, especially for some areas such as health care financing and there was a consensus that they needed to be combined, shortened and honed down. The specific comments are included within the appropriate sections.

It is noted that the conclusions and recommendations from this meeting are consistent with the Strategic Plan for Strengthening Health Systems in the WHO Western Pacific Region. The expert meeting was able to add more detail and specific content to the ideas in that document. There was a consensus that this could move forward for an endorsement of the concept of developing a regional strategy on health systems and primary health care by the Regional Committee.

6.3 Comments on draft resolution for Regional Committee

Discussion moved to the draft resolution on health systems strengthening and PHC to be presented at the next session of the Regional Committee. It was suggested that the resolution should be more explicit about PHC, which could be done in the preamble. An additional suggestion was to emphasize implementation and access. Others felt that "Health for All" covered access. There was also a suggestion that there needed to be more emphasis on a holistic look at health systems and not to depend on PHC principles as ensuring such a holistic approach. An emphasis on technical assistance only might be too narrow and the draft could reflect increased analytic and implementation capacity. It was also mentioned that the issue of the
observatory needs to be raised more clearly. These comments were forwarded to the drafters of the resolutions for the Regional Committee.

6.4 Concluding comments

Dr Richard Nesbit concluded by thanking everyone for contributing over the past two days to get through a concentrated agenda. The discussions were described as lively and useful, and a lot has been left for WHO to digest. It was good that country staff were able to participate, and it was helpful to the discussions and the success of the meeting. All the participants were thanked again for devoting time to this exercise.
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Medical Officer, Situation Analysis for Policy (SAP)

Ms Nazarita Tacandong
Technical Officer, PHA
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>0815</td>
<td>1. Introduction: Registration</td>
</tr>
<tr>
<td>0845</td>
<td>2. Asia Pacific Observatory on Health Systems and Policies concept</td>
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<tr>
<td>0945</td>
<td>Break</td>
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<tr>
<td>1015</td>
<td>3. Service delivery (Health Systems Observatory)</td>
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<tr>
<td>1045</td>
<td>Break</td>
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<tr>
<td>1115</td>
<td>4. Finance (Planning for out-of-pocket payments and risk-pooled systems)</td>
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<tr>
<td>1230</td>
<td>Break</td>
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<tr>
<td>1300</td>
<td>5. Health workforce (Ensuring a skilled workforce to support chronic health systems taking care providers, role of multi-tiered bases and primary care practices)</td>
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</tbody>
</table>
Objectives of the Meeting

Expert Meeting
Health Systems Strengthening and Primary Health Care

Objectives for the Meeting
1. Conceive actions to strengthen health systems in Member States building upon the regional strategic plan and on the core values of primary health care
2. How to draw on technical expertise to take the health systems strengthening and primary health care agenda forward
3. How to strengthen the Region’s capacity to analyze, monitor and evaluate priority health systems and primary health care issues (monitor and advise to member states)

Regional Strategy for Strengthening Health Systems in WPRO
- Based on Everybody’s Business
- Writing Chapter 4: what to do next
- WHO secretariat document
- PHC as guiding principle to strengthen health systems
- Vision/goal: Universal access to quality services for improved health outcomes for all

Expectations from experts meeting
- How to reach Universal Access
- Advice on what needs to be done in countries
- Advice on what WHO should be doing in the region and countries
- How to move from a WHO secretariat document to a plan developed in consultation with Member States
- Regional Consultation Meeting (Sept 2008)
- Mechanisms to advise WHO in area of health systems
- Feedback on the Asia Pacific Observatory on Health Systems and Policies
Current WHO Policy and Processes

Health Systems and PHC
Interest is Rising
but

What needs to be done in
countries and what is WHO’s role?

Context: Different in different settings,
but similarities
- Cost inflation – developed and lesser developed
- Pressure on government/social insurance
- Pressure on households
- Fragmentation of care and services
- Excess specialisation
- Excess prioritisation of assistance
- Lack of responsiveness and caring/personalisation
- Inefficiency
- Health outcomes improving but value for money?

Context: Rising levels of Health CDA

[Bar chart showing increasing levels of Health CDA]

[Diagram showing integration of service delivery for priority health programs]

[Diagram showing various health programs and their interconnections]

Value Health Programme - different directions

- Increasing concerns that
- in the field, the results are
- not proportional to the
- increased funding
- However, it may be that
- this single nurse or rural health
- worker is being sent off in
- multiple different directions.
WHO Framework for Action on HHS

1. A single 'Health systems' framework with six clearly defined building blocks
2. Systems and programmes: getting results
3. A more effective role for WHO at country level
4. The role of WHO in the international health systems agenda

WHO Framework - 6 building blocks lead to 4 goals/outcomes

- Access
- Quality
- Safety
- Equity

WHO Regional Strategies – AMRO, EURO
2007, 09, 08 – Series of meetings – PAHO, AFRO, EURO, SEARO (same week), EURIO (November)
WHO – China, Malaysia – this meeting
WPRO – seeing PHC as the guiding principles for strengthening health systems – this meeting, RCM, and an HSS/PHC process over the next 2-3 years
Alma-Ata – October 12-15 – 30 year celebration

PHC Renewal – 30 Years after Alma Ata

- DG of MOH – election manifesto – driven by discussion with countries while campaigning
- WHO Regional Strategies – AMRO, EURO
- 2007, 09, 08 – Series of meetings – PAHO, AFRO, EURO, SEARO (same week), EURIO (November)
- WHO – China, Malaysia – this meeting
- WPRO – seeing PHC as the guiding principles for strengthening health systems – this meeting, RCM, and an HSS/PHC process over the next 2-3 years
- Alma-Ata – October 12-15 – 30 year celebration

Strategic Plan for Strengthening Health Systems

1. Clearly defined strategic direction for the Division work
2. Improved resource allocation to address country office needs, identified analytic work, and better support to national health planning processes
3. Strategic actions across the six building blocks selected and approved
4. Stronger leadership emphasis by additional positions
5. Improved workforce development through better linkages

More specificity is desired – what needs to be done in countries and what is WHO's role?
Consultation working methods

- Rotating presenters, NFR by Secretary, Facilitation - no chairing
- Format
  - Presentation – brief – 5/10 minutes – pose questions
  - Discussion – interactive – brief as you get multiple chances, respond to questions and what is said
  - Conclusions and Recommendations – 20 minutes – by consensus, with dissenting opinions if not achieved
PHC in the WHO Regional Office for the Western Pacific

<table>
<thead>
<tr>
<th>PHC in WPRO</th>
<th>PHC Review in WPR – 2002 (25 yrs post AA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>- 20 Country Reports (on website)</td>
</tr>
<tr>
<td>-</td>
<td>- Done by mix of MOH staff, consultants, WHO staff</td>
</tr>
<tr>
<td>-</td>
<td>- Key informant interviews</td>
</tr>
<tr>
<td>-</td>
<td>- Checklist questionnaire and interview guide to give similar structure to all</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Six Types of Experience</th>
<th>Types of experience (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Large political/economic change affected PHC (Mongolia and China)</td>
<td>- Systematic PHC as core of health system (Malaysia and Fiji)</td>
</tr>
<tr>
<td>- Post-war countries rebuild PHC principles (Lao PDR, Cambodia, Vietnam)</td>
<td>- Hospital-based care with less PHC influence (Am Samoa, Cook Islands, Japan, Palau, S. Korea)</td>
</tr>
<tr>
<td>- Embraced PHC but struggling to maintain (Kiriti, Micronesia, Marshall's, Philippines, Samoa, Solomon Islands)</td>
<td>- Market economies but policy influenced by PHC principles (Australia, New Zealand)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Results</th>
<th>PHC Renewal – 30 Years after Alma Ata</th>
</tr>
</thead>
<tbody>
<tr>
<td>- PHC paradigm still valid</td>
<td>- DG of MOH - election manifesto - driven by discussion with countries while campaigning</td>
</tr>
<tr>
<td>- Advocacy, rights, information</td>
<td>- WHO Regional Strategies – MR1, MR2, MR3, MR4, MR5, MR6, MR7 (as we speak), MR8 (November)</td>
</tr>
<tr>
<td>- Quality of services</td>
<td>- WPRD – China, Malaysia – this meeting</td>
</tr>
<tr>
<td>- Coordination of sector – stewardship</td>
<td>- WPRD – seeing PHC as the guiding principles for strengthening health systems – this meeting, RCM, and</td>
</tr>
<tr>
<td>- Integrated approaches when added value</td>
<td>- and process over the next 25 years</td>
</tr>
<tr>
<td>- Avoid vertical vs horizontal argument</td>
<td>- Almaty – October 15-16 – 30 year celebration</td>
</tr>
<tr>
<td>- Universal access a key issue (HFA)</td>
<td>- HSS/PHC</td>
</tr>
</tbody>
</table>
Status in WHO

- No one in WHO or WPRO with PHC in job title
- Philosophy or implementation strategy?
- Global Task Force
  - Working Groups – regional offices and HQ
- Agenda Item – RC M’s 2008
- EB and WHA – 2009
Asia Pacific Observatory on Health Systems (Session 2)

Objectives for this Session
1. How to strengthen WHO’s capacity to analyse, assess, monitor and evaluate health systems and policies and related issues.
2. How to strengthen WHO’s capacity to disseminate knowledge, provide advice to and have improved dialogue with member states on health policy and systems issues.
3. Feedback on Asia Pacific Observatory on Health Systems and Policies' concept and define next steps.

The Case for an Observatory in Asia Pacific
- Policy makers in Asia and Pacific lack access to relevant evidence-based information in health systems (APHE, Dec 2007).
- Need for comparative analysis and information on health systems.
- Rapid change in the Asia-Pacific Region: economic, demographic, disease patterns and rising health care costs.

Functions of an Observatory
- Country monitoring (MHT)
  - Using systematic approach, allowing country comparisons
  - Support, monitoring, evaluation and building the evidence
- Analysis
  - Research on policy issues & policy models
- Dissemination
  - Engage in a facilitation policy dialogue
  - Making products accessible (websites, etc.)
- Contribute to capacity building in health systems analysis & policy making
- Strengthened research network in health systems

Scope of Observatory & Skills required
- Institutional alliance of excellence, contributing to informed and improved health policy making in the region.
- Develop consistent high quality products.
- Broad and comprehensive approach to health systems and policies.
- Asia (APRO and SEARCO) and Pacific.
- Academics with combined research, policy advice and institutional experience.

Institutional partnership & management
- European Observatory started with developing good QUALITY products before embarking on institutional arrangements.
- European Observatory is a partnership with Regional Secretariat based at WHO and linked with:
  - Seven national governments.
  - Centres in a number of countries (LSHM, LSE).
  - Key international organization (WHO EURO, WB, European Investment Bank).
Asia Pacific Health Systems Observatory

Interested parties
- Academic institutions: universities, institutes
- Member states
- International financial institutions: WB, ADB
- Existing networks/programmes: EVIPNET,
- Funding organizations: such as bilaterals: AusAID, JICA
- Partnerships eg AHIPR

Next Steps
- Identification of products and researchers
  - Lists for example Malaysia, New Zealand, Hong Kong
  - Building blocks - how to effectively manage health worker migration, strengthening health workforce capacity at community and primary care level
- Further strengthen partnerships and networks
- Globally end with EU OBS support
  - Update & adopt existing EU OBS template for developing countries
  - Share experience of HT writing and editing process
  - Share EU OBS template for end experience of policy briefs
  - Share EU OBS approaches to dissemination
- Thank and support authors

Questions
- What are the highest priorities and needed initial products?
  - HTs: Which countries?
  - Policy briefs: Which topics?
- Who are the possible research collaborators for these products?
- How can high quality be ensured?
- Who are the possible partners?
Service Delivery (Session 3)

**Session 3. Service Delivery and Equity**

**Topics:**
- Meeting on Health Systems Strengthening and Primary Health Care
- Tajikistan, Dushanbe, Technical Officer: Health and Development WHO/AFRO

**The Inverse Care Law**

**Availability of Good Medical Care Tends to Vary Inversely with the Need for It in the Population Served.**


**Barriers to Access to Services**

1. **Geographical:** distance, remoteness, isolation
2. **Financial:** direct, indirect, opportunity costs
3. **Low education:** knowledge, awareness
4. **Socio-cultural:** stigma, discrimination (ethnicity, gender, sexual orientation, etc.)
5. **Health systems:** low quality, unresponsiveness, discrimination, provider bias

**Why does this matter?**

- **Efficiency:** Public spending in health is captured by non-poor
- **Equity:** Health inequalities are widening
- **Human rights:** Health is a human right

**Universalism vs Targeting**

- **Universalism** can lead to better population health, more equity—but the rich often benefit more than the poor
- Mixed record: low coverage of the poor, poor quality, unresponsiveness, inadequate funding
- Where health systems are weak, universalism may be a long-term strategy
- In the short-term, targeting may be needed
- More evidence needed on cost of universal coverage in low-income countries

**Approaches to Targeting**

1. Under-served regions or areas
2. Health conditions that disproportionately affect the poor (TB, malnutrition)
3. Types of service (e.g., primary care, prevention)
4. Levels of service (e.g., primary level)
5. Population groups (e.g., migrants, homeless, women, children)
Equity and the private sector

- Examples from the Region:
  - Contracting of services to NGOs (e.g., Cambodia)
  - Church and faith-based providers (e.g., Papua New Guinea)
  - Public-Private Mix, DPS (e.g., Philippines)
- Are these more pro-poor or equitable?
- How to ensure successful implementation?
- How to manage private non-profit and private for profit providers?

Questions for discussion

- How does one best get service delivery for the marginalized—targeted or universal/integrated services?
- What is the role of the private sector?
- What needs to be done in countries with regard to service delivery to promote universal access for all?
- What is WHO's role?

Session 3 Conclusions

- Political economy need to collect evidence on equity to generate political commitment (but this can be a double-edged sword; role of evidence and its good use)
- Need to dialogue with disease control programmes on integration
- Need for WHO to work more with other ministries, intersectoral dialogue and action
- Role of governance in promoting equity in service delivery (along with attention to articulation of other building blocks)
- Scaling up of good practices (e.g., help to define appropriate packages of services)
- Role of WHO to work with countries on accountability; mechanisms, work with CSOs
Financing (Session 4)

Health Financing

- Support adequate, sustainable, equitable and effective health financing to improve health outcomes.
- Issues, challenges, policy objectives and strategic actions in 7 areas of interventions.

Regional situation

Where OOP is high, government is deprived of a potential policy tool to control costs and attain universal coverage.

<table>
<thead>
<tr>
<th>Context: Health Systems</th>
<th>Context: Demography</th>
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<tbody>
<tr>
<td>- Access and equity (financial basis)</td>
<td>- Access and equity (social basis)</td>
</tr>
<tr>
<td>- User charges/fiscal capacity</td>
<td>- Health care in countries</td>
</tr>
<tr>
<td>- Health care in urban/rural areas</td>
<td>- Cost of health care</td>
</tr>
<tr>
<td>- Health insurance coverage</td>
<td>- Vulnerable people</td>
</tr>
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</table>

Priorities for action

<table>
<thead>
<tr>
<th>Increase public resources.</th>
<th>Move towards prepaid systems.</th>
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</thead>
<tbody>
<tr>
<td>- Create public health sector to</td>
<td>- Refrain / monitor user fees.</td>
</tr>
<tr>
<td>- Decentralize health financing</td>
<td>- Expand risk and fund pools.</td>
</tr>
<tr>
<td>- Reduce OOP and improve access to</td>
<td>- Exploit social health insurance.</td>
</tr>
<tr>
<td>- Strengthen social protection</td>
<td>- Strengthen social protection.</td>
</tr>
<tr>
<td>- Introduce earmarked taxes.</td>
<td>- Introduce earmarked taxes.</td>
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<tr>
<td>- Increase taxes and regulate</td>
<td>- Increase taxes and regulate</td>
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</table>

What WHO can do?

- The Region has the highest OOP share in financing health care.
- What practical steps can be taken to move from OOP to prepaid and risk pooled systems?
- What is pro-poor, pro-equity financing?
- What needs to be done to promote universal access for all?
- What is WHO's role?

Conclusions

- There is an increasing evidence on negative effects of poorly regulated health financing systems especially in transitional economies and private providers that diminish equity, access and increase poverty. Markets cannot produce equitable health care and therefore, government's role in financing health care is essential.
- Devolution and decentralization is an important feature of reform in many countries that requires appropriate financing models at different levels of government. It is important that decentralization financing schemes are built on the same operational principles that support the implementation of national health policies and objectives such as universal coverage. While service delivery is best managed by local governments in terms of being able to reach the poor, some terms like drugs and commodities may better managed centrally because this reduces administrative burden to local governments.

Conclusions (Cont'd)

- Primary source of revenue for health financing is individual payments. Increased use of health financing arrangements that pool these payments is necessary condition to reduce OOP.
- Macroeconomics and health work is still valid to scale up essential health interventions and health investments and spending from public resources.
**Conclusions (cont-d)**

- Reduction of OOPF is necessary to attain universal access and coverage in the region. e.g., OECD country experience shows that universal coverage is attained when OOPF is less than 20% in total health financing.

- Public resources sometimes spent inefficiently. Therefore, there is a need to strengthen capacities at all levels to use available financial resources for health more efficiently and effectively.

**Recommendations**

1. WHO to make strong statements on health care financing to improve equity, access and financial protection for the poor and vulnerable.
2. WHO to provide high quality policy briefs, advice, options, evidence and best practices on health financing for better decisions (in line to the observatory functions).
3. WHO to be more engaged in national policy debates and consensus on health financing arrangements among government agencies such as Ministries of Finance, Economics, Trade, labour and Social Affairs.

**Recommendations (Cont-d)**

4. WHO to help national governments to have effective dialogues with local governments in implementing national health policies with adequate funding support.
5. WHO to strengthen the platform for debates on macroeconomics and health to increase public health spending and investments in the health sector.
6. WHO to produce health care financing cross country comparisons and comparative analysis of pro-poor and pro-equity financing schemes.

**Recommendations (Cont-d)**

7. WHO to support MoH in producing/applying evidence to have effective dialogues with other line ministries and international partners.
8. WHO to build capacities and institutional arrangements at country level (with particular attention to increasing management capacities at local levels) to implement the Regional health financing strategy and translate trainings to actions.
9. WHO to promote the reduction of OOPF and help countries with high OOPF to adopt the regional strategic target for OOPF at a level not exceeding 30% in total health financing.

**Recommendations (Cont-d)**

10. WHO to improve health financing information and evidence e.g., national and district health accounts and help national and local government to use these data for health financing policy development and implementation.
11. WHO to undertake cost analyses to ensure necessary funding resources in delivering essential health care and public health functions.
12. WHO to provide technical assistance and expertise in monitoring official and unofficial health payments and removing user fees from essential public health services such as maternal and child care.

**Recommendations (Cont-d)**

13. WHO to support countries in undertaking trainings in health financing, accounting and financial management including provider payment methods.
14. WHO to initiate debates on salary incentives of health workers to motivate the best use of their skills and experiences for effective implementation of national health policies.
15. WHO to support governments to improve laws and regulations of public and private sectors and use effectively growing potentials of private sector engagement in financing and delivery of healthy care.
Health Workforce (Session 5)

Conclusions of Consultation

- Evidence for HR, data and financing
- Mix of staff
- Training and multi-skilling
- Salaries and incentives
- Effective management of migrant health workers
- Gender
- Career pathways and payment structures for new cadre
- Document innovative strategies within the region to address the above issues

Questions for discussions:

- How can countries develop and implement plans for a balanced workforce taking a primary health care approach?
- What is the role of multi-skilled teams and primary care providers?
- What needs to be done in countries with regard to the health workforce to promote universal access for all?
- What is WHO's role?
Medical Products and Technology (Session 6)

Medical products and health technology
- Pharmaceutical program
- Traditional medicines
- Health technology

Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region (2005-2010)
- Recommended strategies & actions
  - Rational selection
  - Rational use
  - Affordable price
  - TRIPS and globalization
  - Sustainable financing
  - Reliable supply
  - Quality & combating counterfeits
  - Monitoring

What WHO is doing
- Pharmaceuticals
  - Technical support
    - National medicines policies and programs development and implementation
    - Medicines supply
    - Forecasting
    - Access to essential medicines
    - Good governance
    - Affordable price
    - Rational use
  - Information exchange mechanism
    - Regional and bilateral
    - Technical cooperation
    - International experiences

What WHO is doing
- Health Technology
  - Laboratories
    - Emerging and developing a regional strategy to strengthen health laboratory services
    - Establishing a regional network for diagnostic and laboratory activities
    - Establishing a regional network for laboratory quality systems
    - Strengthening laboratory networks
  - Blood Safety
    - Establishing and coordinating networks for the international exchange of information
    - Training laboratories
    - Technical cooperation
    - International experiences

What WHO is doing
- Traditional Medicine
  - Development and implementation of traditional medicine policies
  - Establishing and supporting regional networks for traditional medicine
  - Strengthening the quality of traditional medicine and technologies
  - Establishing and supporting traditional medicine and technology research networks
  - Promoting traditional medicine and technology research through collaboration

Questions for Discussion
- What are innovative methods for selecting, financing, maintaining, monitoring, promoting access, and encouraging the rational use of medical products and technology?
- What needs to be done in countries with regard to medical products and technology to promote quality and universal access for all?
- What is WHO’s role?
### Conclusions of Meeting

- Conceptual framework – supply & demand
- HT assessment – partner with IHTA
- Regulatory framework
- Address MDR – Labs and rational use of drugs
- Address incentive, ethics, regulatory & policy issues
- Implementation of cost effective analysis
- Expand collaboration with CS, community, HR

### Recommendations

- Decentralization
- Regional: norms, standards, indicators
- QA, standards, MIS
- Comparative analysis on pricing
- E-health, telemedicine – assess, vendor selection
Health Information (Session 7)

**Health Information**
Meeting on Health System Strengthening and Primary Health Care
Manila, Philippines
6-6 August 2009

**Information, evidence and research vision statement**
A world where information, evidence and research result in better and more equitable health outcomes.

**Partners**
Health Metrics Network
- In WPR supports 8 countries
- Assessment in 7 WPR countries (by May 98)
- Strategic plans in CAM, Lao PDR and VNM
Institute for Health Metrics and Evaluation (IHME)
Alliance for Health Policy and Systems Research

**HIS strategic priorities**
1. Advocate importance of good HIS
2. Develop policies, legislation and regulations
3. Enhance capacity to use information
4. Strengthen application of ICT
5. Harmonize and integrate data collection
6. Improve data quality
7. System maintenance

**Need for more analytic work**
Need for better analysis and evidence
- Health policy and systems analysis
- More analytic statistical reports
- Improved CHIPS and database in WPRC
- "Health in Asia and the Pacific" report

**Framework for monitoring performance and evaluation of the scale-up for better health**
**WHO Health System Performance Framework**

Adapting it for Health System Metrics

**Principle for monitoring health systems strengthening**
- Feasible measurement strategy; synthesis from different sources; estimation
- Set of core indicators; additional optional indicators
  - Monitoring
  - Compare countries
  - Within country: dimensions, equity
  - Target benchmarks
- Resonate with different needs and audiences

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**What is PAM?**

Promote systematic use of evidence in policymaking in low and middle-income countries.

Promotes partnerships at country level between policy-makers, researchers, and civil society to facilitate policy development and implementation through use of the best scientific evidence available.

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**Evidence to policy**

Objectives in the region:
- Improved capacity in health policy and system analysis
- Analytic and updated reports based on better statistics and research
- Strengthen national health research systems
- Strengthen research capacity, in particular in HPSR

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**Questions**

1. What are the key health information needs to assess health system and its performance under the PAM approach?
2. How do we operationalize definition of evidence and its implementation and impact?
3. What can WHO do to improve quality, relevance, and impact of health system and health outcomes performance in the member states? What is the role of health policy and systems research?
4. What mechanisms can countries adopt to promote efficient collection and analysis of disaggregated data?

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**Recommendations**

- Facilitate convergence of minimum data set for all health systems and its customization to 
  - Health system performance assessment (HSFA)
  - Develop capacity to utilize and analyze, identify needed information, determine relevance and feasibility under different conditions, document good practices, intelligent engagement among stakeholders (decide, policymakers, etc.)
  - Incoherent attention to evaluation in MS
  - Advise countries on standardizing survey methodologies & research questions
  - Involve CSOs in design of data collection
  - Promote public access and archiving of survey data
  - Give assistance in the development of data dictionary and standards for systems design
• ICT application to enhance routine data collection system
• Build on existing networks to strengthen HIS
• Development of repositoty on health information on health system
• Use of mix of regulation and incentives to promote data reporting by private sector
• Facilitate access to country data sets by researchers
• Support countries in developing single national HIS plan that integrates routine data, survey and qualitative data
• Build capacity to collect and analyze disaggregated data to enable equity analysis
• Bridge gap between researchers and policy makers through better training in policy-relevant research
Leadership/Governance (Session 8)

Questions – Leadership and Governance

- Lack of aid coordination has led to distortions, distractions, duplications, and disruptions in the health sector.

Conclusions of the Meeting

- GHG not at the table in national pooling mechanics – COM x
  bilateral donor committees
- National health priorities vs. international donor
- What makes a "robust" plan? National ownership, donor confidence?
- Range of planning approaches (some countries? Fundamental
  re-think needed?)
- Planning time consuming, complex – even without donors
- HQ, country office communication (not just WHO)
- Is a plan without full ownership down to operational level
  sound?
- Core business of WHO.
Results of Meeting in Sharm El Sheikh on WHO and the GHIs, 13-17 July 2008

**WHO, HSS, and the GHIs**
7 August 2008

Results of meeting in Sharm El Sheikh on WHO and the GHIs
13-17 July 2008

**Context**
- Growing international attention
- WHO - HIC principles, HSS, health outcomes
- Fresh attempts to reduce donor demands
  - Paris declaration
  - International Health Partnership
- WHO seeking to become more responsive to country needs

**Key Challenges**
- Need for explicit support - GHIs part of WHO core business
- Need to be more proactive - avoid emergency mode
- Increase WHO capacity for support in HSS
- Different skill mix - brokering, facilitating, proposal writing in complex environment
- Partnership - across departments and programmes
- Better strategic intelligence
- Tools and methods (are they needed?)

**Short term priorities (6 months)**
1. Sr. Management Support
2. Improve staff orientation on HSS in context of GHI
3. Improve direct country support - GHI focal points?
4. Joint work with partners at country level
5. Dense ways to expand TA capacity - rosters?
6. Improve access to strategic intelligence
7. Improve availability of guidelines, tools, methods
8. Health system dashboard concept - from HNN

**Beyond Six Months**
1. Maintain dialogue with GFATM/GAVI
2. Medium term WHO TA strategy - move to national health plan support
3. Increased support to national health sector strategy and plan development - increasing importance to GHI process
4. Mobilise resources to maintain increased activities

**Upcoming Deadlines**
- GAVI due date - September
- GFATM - Round Nine - call in October, due date about 20 January 2009
  - Same guidelines as Round Eight
  - Potential applicants identify by 31 Aug 2008?
Health systems strengthening is attracting increasing interest globally, including in the Asia Pacific region. Rapid economic growth, changing demographics and disease patterns, rising costs of health care, as well as political changes have all put stresses on health systems. There is an increasing need for countries to have the capacity to analyse their health systems, learn from other countries health systems and to use the analysis and information for policy action. The development of an observatory on health systems is one way of contributing to meeting that need. WHO and other partners have expressed interest in exploring alternatives for developing the health systems observatory concept in the region. Discussions have been held between staff from WPRO and staff from the Asian Development Bank, AusAID, the European Observatory, WHO Headquarters, the World Bank, governments in the region, and various individuals with health policy research experience.

Health observatories do not have a standard definition. Their functions commonly include gathering data, conducting analysis, disseminating findings, facilitating policy dialogue, as well as networking to share evidence and information. The use of data from secondary sources is preferred if such data is available, although primary research may be required if the needed data is not available. Observatories on health systems can focus on one aspect of health systems, such as financing or human resources, or take on a broader mandate across the entire health system. The latter may be more appropriate in the Asia Pacific region where fragmentation of the health sector is a particular issue in many countries. The European Observatory on Health Systems and Policy is a potential model, although adaptations in methods may be necessary.

The proposed observatory would cover the Asia Pacific region, potentially encompassing two regions of WHO. An observatory would possibly be an alliance with individuals and institutions with a small regional secretariat. WPRO is interested in hosting the secretariat. A range of skills across the spectrum of health systems would be required. Individuals experienced in research, policy analysis, and policy making would have to be identified and engaged in constructive work with and for the observatory. The individuals may be associated with institutions and organizations that are already involved in research and policy dialogue. The credibility of an observatory would depend greatly on the quality of its products and the relevance of those products to policy makers within the region.

Partnership would be important. Efforts will be made to include the capacity that exists in the low and middle income countries in the region as part of the observatory where sufficient capacity is available. Capacity building would not be the focus of the proposed observatory, although there might be cooperation with ongoing capacity development activities in the region. The emphasis will be on producing high quality products of immediate relevance to policy makers within a reasonable amount of time. Products to be considered would include country reports modelled on the Health in Transition series of the EURO Observatory, briefs on aspects of health systems policy, and comparative country studies on particular topics yet to be determined.

Further elaboration on the observatory concept would be beneficial, particularly around the specific functions of an Observatory in the Asia Pacific region, the type and format of products that would be of the most interest and usefulness to decision makers, the geographic and thematic areas of initial emphasis, methods for ensuring quality control of the products, and the means for identification of appropriate collaborators. A vibrant health systems observatory can contribute positively to the health of people throughout the region. Your assistance in refining the concept will be of immense value in getting the initial design right.
## EVALUATION SUMMARY

<table>
<thead>
<tr>
<th>9 temporary advisers or representatives</th>
<th>6 WHO staff</th>
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<tr>
<td>6 felt the logistical arrangements were excellent. One request for internet in the meeting room. One felt flight arrangement could be more accommodating and one felt invitation a few weeks before the meeting was not sufficient.</td>
<td>- Generally okay, GSM problems</td>
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<tr>
<td>- Digital screen too small</td>
<td>- Some prefer slides in advance</td>
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<th>2. Please make comments and provide suggestions for improvement on working methods for the meeting.</th>
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<td>7 were positive about the format, 1 had no comment on the format. One requested more preparation time and more background papers and also efforts to decrease set speeches (Note that the two core documents, draft agenda, and short observatory paper were delivered 1-2 weeks in advance by e-mail except for last minute replacements). One suggested small task groups for further refinement of key areas.</td>
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<td>- TG meeting concerning more details for each component of HS</td>
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<td>- More in depth analysis of issues</td>
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<td>- Integrated approach to service delivery and system wide strengthening</td>
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<td>- Follow-up on current recommendations</td>
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<td>- HR and HCF</td>
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<td>- More observatory discussion</td>
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<td>- Private sector</td>
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<td>- Capacity development</td>
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<th>3. Please make comments and provide suggestions for future topics and or areas of engagement with temporary advisers in the future.</th>
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- ANNX 5
ANNEX 6

COMPILATION OF CONCLUSIONS AND RECOMMENDATIONS

Asia Pacific Observatory on Health Systems and Policies (Session 2)

Conclusions

(1) A need for an Asia Pacific Observatory on Health Systems and Policies exists and there would be a demand for its output.

(2) HiTs and policy briefs are endorsed as initial products with the caveat that work should be policy relevant, demand driven and with a country focus.

(3) Regional adaptation of formats for HiTs and policy briefs might be necessary.

(4) Facilitating policy dialogue is an important function of an observatory.

(5) Production of quality products is crucial and that will require a strong review process and a need for transparent and strong partnerships with carefully selected individuals and institutions.

(6) Start-up should not be delayed.

Recommendations

(1) Start-up by the end of 2008.

(2) Consult countries about HiTs and policy briefs, particularly those that have been suggested as initial countries or areas for study.

(3) Focus on functions with institutional arrangements to follow.

(4) Identify partners for both implementation and support.

(5) Identify capable editors and reviewers willing to ensure quality.

(6) WHO Regional Office for the Western Pacific to develop a capacity to support start-up activities.

(7) Consider tabling for discussion at the Regional Committee meeting in September 2008.

Service Delivery

Conclusions

(1) There is a dynamic balance between equity and efficiency which continuously needs to be readjusted and is not mutually exclusive.
(2) Targeted and universal services are both necessary depending on the circumstances and there will be a blend of approaches, although universality is a core principle.

(3) Government must take the leadership or stewardship role in defining the balance between private and public, the feasible service delivery package, methods for scaling up, and the intersectoral balance for healthy public policy.

(4) A dialogue with disease-control programmes is necessary to promote integration, sustainability and scaling up of good practices.

(5) Sufficient information must be generated for service delivery to be monitored and determine if populations are underserved.

(6) Working with multiple partners, including the private sector, civil society and sectors other than health, is desirable.

Recommendations

(1) WHO to assist governments to define and cost basic packages of services, to make more explicit the role of different providers and different levels of the system, and to appropriately engage with the private sector and civil society.

(2) WHO to assist in moving plans and strategies through to implementation and scaling up.

(3) WHO should promote the role of PHC for achieving equity goals and in selecting appropriate targeted and universal approaches.

(4) WHO should assist in developing more evidence of best practices, particularly in regards to gender, poverty and equity.

(5) WHO to assist governments in engaging intersectorally in a more effective manner and with a wider variety of players to achieve equity goals.

Health Care Financing (Session 4)

Conclusions

(1) There is a need for WHO to be more engaged in policy debates and dialogues on health care financing at national and subnational levels, both within the health sector and also outside the sector and to be a more effective and vocal advocate on health care financing issues, particularly the need to move away from out-of-pocket household financing of services to more universal, pre-paid and risk-pooled systems.

(2) Improved access to evidence would facilitate the policy debates and dialogues and this is a potential role for WHO.

(3) Nuanced technical assistance in a wide variety of areas, such as national health accounts, costing of services, cross national comparisons, methods to increase efficiency through financing, and national macroeconomic planning, is needed.

(4) Private sector engagement is desirable, although more specificity on this is needed.
(5) An increased capacity for health care financing work adapted to specific situations is needed in many, if not most, national settings.

Recommendations

(1) WHO to make stronger statements on desirable health care financing to improve equity, access and financial protection and to assist ministries of health in developing policy dialogues on the topic.

(2) WHO to assist Member States to build capacity to make the case for and to design and manage more equitable and effective health care financing.

(3) WHO to assist Member States in developing a solid evidence base for health care financing on a wide range of issues.

(4) WHO to assist Member States in engaging more effectively with the private sector in health care financing and a range of other topics.

Human Resources for Health (Session 5)

Conclusions

(1) There is a need for improved human resources evidence and data.

(2) The skill mix of staff needs to be determined in relationship to the services to be delivered, which need to be determined in relation to the burden of disease.

(3) Salaries and incentives are crucial but not the entire answer to motivation and they must take into account the complex issue of migration.

(4) Gender issues in the health workforce and in service delivery need to be acknowledged.

(5) Documentation of innovative strategies is important.

Recommendations

(1) WHO to provide support to Member States to improve the collection of basic human resource information, including skill mix and sex disaggregated data, and also consider acknowledging informal care givers as part of the human resource workforce.

(2) WHO to support Member States in improved human resources for health planning.

(3) WHO to work with Member States to mitigate the adverse effects of migration and advocate for ethical recruitment.

(4) WHO to facilitate policy dialogue and debate on issues of accountability, quality, retention, incentives and management of the health workforce.

(5) WHO to support Member States in developing standards for quality education of the health professions.
Medical Products and Technology (Session 6)

Conclusions

(1) Health technology assessment and cost effectiveness analysis are needed tools, although they alone will not drive policy.

(2) Conceptual frameworks for both pharmaceutical and technology assessment are needed.

(3) Rational use of laboratories and drugs are major issues of pressing importance in the Region.

(4) Financing of pharmaceuticals and technology is particularly problematic in the region, which needs to move towards financing mechanisms that encourage rational use.

(5) Incentives and ethical issues must be addressed in any regulatory framework.

Recommendations

(1) WHO to promote and build capacity in conducting CEA and HTA (including Information Technology) as part of a holistic analysis of the health system.

(2) WHO to assist Member States in promoting the rational use of drugs, laboratories and other diagnostic methods, with some emphasis on addressing multidrug resistance.

(3) WHO to assist Member States in addressing issues of incentives, ethics, policy and regulation in regards to pharmaceuticals and technology.

(4) WHO to develop regional comparative evidence on multiple issues related to medical products and technologies, such as pricing and quality.

(5) WHO to expand collaboration with civil society, consumer and community groups, and human rights groups in this area.

(6) WHO to develop global norms, standards and indicators on health technology, including quality assurance and management information systems.

Leadership/Governance (Session 7)

Conclusions

(1) Donor coordination is not an end unto itself.

(2) Although there has been some progress on donor coordination, it has been stronger on harmonization than on alignment.

(3) Coordination is good, but it needs to be guided by a national health plan.

(4) The process of national health planning may be as important as the precise content.

(5) National health planning may have some trouble meeting some of the expectations that it be the core aid coordination and funding mechanism.
(6) Leadership and governance are central to a health system and extend much beyond the aid coordination and aid effectiveness agenda.

Recommendations

(1) WHO should support Member States to develop "robust" national health planning processes.

(2) WHO country offices should have the capacity to serve as a resource center in national health planning.

(3) WHO must play a leading role in assisting Member States to lead the aid coordination and aid effectiveness agendas.

(4) WHO has a core role in facilitating the Global Health Initiative process in countries.

(5) WHO should provide comparative evidence and information on national health planning processes within the Region, which might be a health systems observatory topic.

Information (Session 8)

Conclusions

(1) Health information is fragmented and excessively donor driven, and it would benefit from more coherent planning based on an assessment of information needs and capacity.

(2) The quality of information is not always high.

(3) The use and analysis of existing information are not optimal.

(4) Information that exists is not always available to all interested parties or to those who need it.

Recommendations

(1) WHO to facilitate countries in building a consensus on a minimum data set for health information and developing integrated national health information strategies and plans.

(2) WHO to work at improving the capacity for the use and analysis of information and data and bridging the gap between information and policy.

(3) WHO to advise countries on the best methods for a wide range of information needs, including health systems performance assessment and surveying.

(4) WHO to encourage more involvement of civil society in collection, analysis and use of information and to look at ways of improving data collection from the private sector.

(5) WHO to promote public access to information and survey data to the extent possible.
(6) WHO to provide assistance in defining appropriate technology for information needs in different circumstances.

**Future Advice to WHO Regional Office for the Western Pacific (Session 9)**

**Conclusions**

(1) A general forum for a holistic look at health systems is useful. Narrower technical details should be dealt with elsewhere, perhaps as part of the various regional strategy reviews.

(2) Participants need to be chosen who can provide a transcendent, broader view of health systems. Continuity of participation offers advantages, particularly on following up progress on recommendations.

(3) A Member State consultation on health systems strengthening would be a logical next step if endorsed by the Regional Committee.

(4) Periodic face to face meetings are useful, but should occur when there is an event or time that is appropriate, perhaps as a regional strategy is nearing completion.