THIRD MEETING OF THE TECHNICAL ADVISORY GROUP ON UNIVERSAL HEALTH COVERAGE FOR THE WESTERN PACIFIC REGION

13–15 November 2018
Manila, Philippines
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MEETING REPORT

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NOTE

The views expressed in this report are those of the participants of the Third Meeting of the Technical Advisory Group on Universal Health Coverage for the Western Pacific Region and do not necessarily reflect the policies of the conveners.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for Member States in the Region and for those who participated in the Third Meeting of the Technical Advisory Group on Universal Health Coverage for the Western Pacific Region in Manila, Philippines from 13 to 15 November 2018.
Annex 1. List of participants, Technical Advisory Group members, resource persons, observers/representatives and Secretariat

Annex 2. Agenda

Keywords: Universal coverage / Delivery of health care / Healthcare financing
SUMMARY

Universal health coverage (UHC) is a vision of all people obtaining quality health services without suffering financial hardship. Achieving UHC is the central focus of WHO’s 13th General Programme of Work and a specific target of the Sustainable Development Goals (SDG3.8). Without UHC, countries will not be able to sustain progress and reach other health-related and broader development targets. In 2015, the 66th session of the Regional Committee for the Western Pacific endorsed the regional action framework *Universal Health Coverage: Moving Towards Better Health* (WPR/RC66.R2).

The Universal Health Coverage Technical Advisory Group (UHC TAG) was established by the WHO Regional Office for the Western Pacific to provide advice to WHO and Member States to advance UHC in the Western Pacific Region. The first UHC TAG meeting in 2016 provided an overview of the three key levers for change – service delivery, health financing and governance – identifying challenges and actions to advance UHC. Discussions at the first meeting emphasized the need for WHO to support Member States in collecting and using policy-relevant evidence to drive health system performance as well as for Member States to strengthen health system functions such as supervision, coordination and accountability. Broad similarities were recognized across Member States in the challenges they faced and the priority areas they identified. A typology of countries emerged on this basis: high-income countries, transitional economies, small Pacific islands and highly decentralized countries.

The second UHC TAG meeting in 2017 built on issues raised by Member States at the first meeting. The second TAG meeting did this using an emphasis on quality and safety and on (i) service delivery models for demographic and epidemiological transitions in relation to service delivery, (ii) health technology assessment, and (iii) priority-setting and resource allocation in relation to health financing and governance. The first UHC baseline monitoring report was also presented, which highlighted gaps in health information systems.

Drawing on the regional baseline report for monitoring UHC and the SDGs, and the identified gaps in data concerning equity, the third UHC TAG meeting focused on equity within the UHC dimensions of service delivery, financing and governance. Equity is core to UHC and the SDGs, and previous meetings have highlighted that, despite dramatic improvements in health and health systems in the Region in recent decades, these achievements have not yet benefited all population groups. Thus, health inequities risk the sustainability of progress made towards UHC. UHC draws attention to people and communities, calling for health systems that are equitable and responsive to the needs of diverse population groups, particularly those left furthest behind.

The third Meeting of the Technical Advisory Group on Universal Health Coverage for the Western Pacific Region was held in Manila, Philippines, from 13 to 15 November 2018. The objectives of the meeting were:

- to review country progress on UHC and highlight the facilitators and barriers for progress;
- to share lessons and identify further actions to advance UHC, with a particular focus on health equity in health system governance, financing and service delivery; and
- to advise on priority areas for UHC in the next year in the Western Pacific Region.
The key issues and messages arising from the meeting are as follows.

1. **Country progress on UHC**
   - Although most countries are generally making great progress towards UHC, progress is inconsistent across the Region and within countries.
   - There is a growing recognition and acknowledgement that equity gaps exist, which threaten progress towards UHC in all countries.

2. **Opportunities for advancing UHC**
   - There has been recent recommitment to strengthening primary health care (PHC), 40 years after the Declaration of Alma-Ata.
   - PHC is the most effective, efficient and equitable approach to enhance health, making it a necessary foundation to achieve UHC, but it appears to be unevenly resourced across the Region and within countries.
   - There is growing support across the Region to give vulnerable communities a voice, including through co-design of health services and development of the workforce from those vulnerable communities.
   - There is strong interest in and evidence of learning from each other (including across the Region, across subregional groupings and from country to country) on common policy and implementation issues often irrespective of a country’s socioeconomic status. Examples include role delineation, hospital autonomy, workforce development, pharmaceutical price negotiations and quality.
   - While observing the above, we also see the declining participation by high-income countries (HICs) and note that upper middle-income countries (UMICs) benefit greatly from learning from HICs as well HICs from each other.
   - Equity gaps are different in different contexts requiring context-specific and granular analysis and action.

3. **Risks for advancing UHC**
   - Health systems are social and political systems; economic and commercial drivers can be regressive and may impede progress to UHC.
   - All health systems, regardless of income level, are facing financial pressures, whether related to economic slowdown, demographic changes, health sector budget cuts or donor exits.
   - The growth in incidence in noncommunicable diseases (NCDs) is presenting challenges for Member States, including for their economies and sustainable financing, and the burden on family and carers and the health system.
   - Accelerating UHC relies on strong leadership and management capacity at all levels to navigate the diverse and sometimes complex currents of change. This capacity does not exist in all countries.
There are both opportunities and risks for UHC presented by eHealth and mHealth innovations, but we must be cautious about some of the commercial drivers and at times insufficient donor coordination that may challenge cost-effectiveness and health equity.

### 4. UHC TAG mechanism
- The UHC TAG mechanism has assisted in monitoring and reviewing action, advising on options for improvements, and in providing a regional platform for sharing experiences and country-to-country and peer learning.
- The TAG meetings have increased the focus of the WHO Regional Office and country offices on country needs.
- Noting the progress on UHC being made in the Region, and the growing engagement with the UHC TAG mechanism for monitoring and peer learning, the TAG mechanisms should evolve to provide more specific country assistance to further accelerate understanding of country progress (including future scenarios and sequencing of action), testing and exploring scale-up and adaptation of innovations in the country, and engaging in regional peer learning and monitoring mechanisms.
- This more specific country assistance should include engaging in in-country diagnostic and review processes (drawing on quantitative and qualitative data) and policy dialogue that engages stakeholders in health as well as other relevant sectors (such as finance).

#### Recommendations for Member States

Member States are encouraged to consider the following:

1. Review existing health reforms, policies and programmes – both demand and supply – using equity as a lens to improve attainment of existing priorities.
2. Develop processes to prioritize future policies, programmes and technologies (eHealth/mHealth, digital health, new pharmaceuticals) for PHC and other interventions, ensuring selection of those with the greatest potential to improve health outcomes equitably at an affordable cost.
3. Review existing data for their potential use for the above and for more effective monitoring of health system performance for continuous improvement.
4. Note that as economic factors and other drivers can be regressive in some contexts, rigorously analyse decisions for potential regressivity, for example public–private partnerships (PPPs), demand-side financing mechanisms (including vouchers and health insurance) and privatization, including of hospitals.
5. Develop subregional or country-to-country cooperative strategies for equitable oversea medical treatment while exploring ways to build local capacity where appropriate and strengthen local prevention and early intervention to reduce costly oversea treatments in the longer term.
6. Review policy and governance arrangements for oversight of quality and equity in both the public and private health service delivery sectors.
7. Encourage subregional and country-to-country peer learning on key policy and implementation topics using digital technology, study tours, bilateral exchanges and professional networks, and consider financing through fellowship funds and other sources, including mutual learning between HICs (such as digital health, cost containment, ageing) as well as between HICs and UMICs (such as health technology assessment, ageing,
NCDs, policy and governance arrangements for oversight of quality and equity in both the public and private health service delivery sectors).
(8) Consider annual reporting on progress towards UHC to Cabinet and Parliament and in appropriate public forums.
(9) Coordinate donor support effectively.

The UHC TAG participants are encouraged to consider the following:

1. Debrief on the outcomes of this third UHC TAG meeting with relevant senior policymakers.
2. Establish a network in-country of participants of the various regional and global meetings on UHC, health system strengthening and SDGs to accelerate progress.

**Recommendations for WHO**

WHO is requested to assist Member States to do the following:

1. Evaluate the equity implications of their reforms, policies and programmes and in turn audit its own programmes with regard to equity and leverage this to mobilize change in countries.
2. Address health equity, seeking a balance between supply-side interventions (such as role delineation policy) and demand-side interventions (such as health literacy), based on granular analyses of who is excluded.
3. Evaluate the implications and costs of Member State reforms, policies and programmes and support optimizing the potential offered by eHealth/mHealth and digital health for primary health care, as well as screening and early detection programmes to advance UHC.
4. Harness and assess technologies and other innovations, including new pharmaceuticals, with a view to prioritizing those interventions with the greatest potential to improve health outcomes equitably and at an affordable cost.
5. Strengthen prevention and early intervention through primary care.
6. Strengthen Member States’ awareness and analysis of the impact of decisions and ways of mitigating potential regressivity and risks for UHC, including in particular contexts such as PPPs, demand-side financing mechanisms and privatization.
7. Improve quality of data and capacity to use existing data sources better for improving health system performance.
8. Encourage subregional and country-to-country peer learning on key policy and implementation topics and facilitate generating ideas on modalities and funding.
9. Use legislation and other governance mechanisms to ensure oversight of quality of public and private provision.
10. Coordinate donor support more effectively.

WHO is requested to consider the following:

1. Make progress towards UHC a standing agenda item on the agenda of the Regional Committee and World Health Assembly.
2. Use its convening function to build subregional and multi-country partnerships for countries to learn from each other (including high- to middle-income, high to high, middle to middle, and other constellations) such as exploring mechanisms to enhance mutual learning between HICs (such as digital health, cost containment, ageing) as well as between HICs and UMICs (such as health technology assessment, ageing, NCDs, policy.
and governance mechanisms to oversight quality and equity in both the public and private health service delivery sectors.)

(3) Convene Member States and partners to facilitate subregional or country-to-country cooperative strategies for overseas medical treatment.

(4) Develop greater capacity to assist integrated consideration of financing and service delivery strategies, which are tailored to the different context of Member States, including their history, current funding strategies and structures of service delivery.
1. INTRODUCTION

1.1 Meeting organization

Universal health coverage (UHC) is a vision of all people obtaining quality health services without suffering financial hardship. Achieving UHC is the central focus of WHO’s 13th General Programme of Work and a specific target of the Sustainable Development Goals (SDG3.8). Without UHC, countries will not be able to sustain progress and reach other health-related and broader development targets. In 2015, the 66th session of the Regional Committee for the Western Pacific endorsed the regional action framework *Universal Health Coverage: Moving Towards Better Health* (WPR/RC66.R2).

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The third UHC TAG meeting brought together high-level policy-makers from the ministries of health of 20 Member States, TAG members, partner organizations, WHO country offices and members of the WHO Secretariat. The list of participants is available in Annex 1. The structure of the meeting and format of sessions enabled countries to draw on the advice of TAG members, share experiences, and identify short-, medium- and long-term priorities to advance UHC with an equity focus. The programme of activities is available in Annex 2.
1.2 Meeting objectives

The objectives of the meeting were:

- to review country progress on UHC and highlight the facilitators and barriers for progress;
- to share lessons and identify further actions to advance UHC, with a particular focus on health equity in health system governance, financing and service delivery; and
- to advise on priority areas for UHC in the next year in the Western Pacific Region.

2. PROCEEDINGS

2.1 Opening session

The opening session set the stage for the discussions to follow and underscored the importance of accelerating progress towards UHC in the Western Pacific Region.

Today, half of the world’s population cannot attain essential health services. In the Western Pacific Region, 900 million people still live under US$ 2 a day and 70 million are pushed into poverty due to catastrophic health expenditures. Despite dramatic improvements in health outcomes and health systems in the Region in recent decades, these achievements do not yet benefit all population groups equitably and, thus, risk the sustainability of progress made; many people are still being left behind. Therefore, the UHC TAG meeting is timely in advising WHO and Member States on how to deliver on this goal to reach UHC by 2030.

Equity is fundamental to UHC; one cannot achieve UHC without equity. Equity is the mission and the backbone of WHO and its goal to attain the highest possible level of health for all people. Equity has likewise been a core focus of UHC discussions since establishing the UHC TAG. Previous UHC TAG meetings have purposefully highlighted health equity and the socioeconomic basis of health. Poor health and well-being are a result of the unequal distribution of power and resources. Poverty, poor education, a lack of local services, gender, housing and other factors together entrench and amplify poor health.

UHC draws attention to people and communities, calling for health systems that are equitable and responsive to the needs of diverse population groups, in particular those left furthest behind. Advancing this agenda means tackling barriers to access to health services, whether financial, physical, geographic, educational or cultural, especially those faced by socially excluded and disadvantaged groups. In this context, UHC does not stand apart from or in parallel to efforts in specific health programmes. Rather, it constitutes a platform on which to bring health and development efforts together, whether related to the unfinished Millennium Development Goals agenda or newer health challenges and their determinants. It is a whole-of-system approach to improving health system performance and sustaining health gains for all with the overarching goal of leaving no one behind. This is highlighted by the regional action framework *Universal Health Coverage: Moving Towards Better Health*, stressing the interrelation between health financing, service delivery and health governance as components of UHC.

The importance of this agenda was also underscored by the discussions in Astana at the 40th anniversary of the Declaration of Alma-Ata. Comprehensive, integrated primary health care (PHC) remains one of the most important mechanisms for delivering greater health equity and achieving health for all. Strong primary health care services are crucial for addressing the underlying social determinants of health; and are key for reaching UHC.
2.2 Poster walk: Journey of UHC towards equity

During the session, 20 countries presented their journey towards UHC. Countries were grouped into three groups: higher-income countries, transitional economies and small Pacific islands. The session aimed at improving understanding of country priorities and progress on the way towards UHC and what countries have achieved based on the working priorities identified during previous TAG meetings. Participants had the chance to discuss each country’s UHC road map and how equity can help prioritize actions.

Overall, countries are making progress relating to the priorities and objectives identified in 2016/2017. Areas of progress included monitoring for UHC, service delivery transformation, and improved financing and governance arrangements. Improvements in health monitoring and health management information systems were commonly reported, while telemedicine and mHealth interventions provide innovative solutions. Good practice examples of country journeys towards UHC included: NCD screening programmes in Brunei Darussalam and Kiribati; PHC strengthening in Papua New Guinea, China and Viet Nam; and minimum benefit/essential service packages in Cambodia and the Lao People’s Democratic Republic.

Nevertheless, challenges persist and can hinder progress towards UHC. The health systems of most countries are strained from increased health expenditure related to the rise of NCDs and demographic changes. Issues that need to be addressed include limited resource allocation and high out-of-pocket payments, fragmentation of the health system, inaccessibility and lack of social infrastructure, and the lack of community involvement. Moreover, a lack of qualified human resources in rural settings persists. Ensuring access and services can be particularly challenging in remote island settings, which additionally struggle with costly oversea treatment referrals. These challenges go hand in hand with a need to strengthen PHC systems. While a lot of health policy documents exist pertaining to concepts such as UHC – and more specifically equity – knowledge on how to translate these concepts into comprehensive actions is lacking. WHO has a key role to play in supporting countries to build capacities for UHC.

2.3 Plenary: Equity and UHC

The session introduced the focus on equity in this year’s TAG meeting. A panel composed of ministry of health representatives from China, Singapore and New Zealand as well as TAG members shared examples of what health equity means and how equity can be used as a lens to prioritize and frame actions towards UHC. Using an equity lens can help countries identify those who are already or are likely to be left behind. This goes beyond the poor and includes those marginalized by other factors such as gender, ethnicity, age, disability, distance from health facilities or those in the prison system.

Equity is a key priority and guiding principle for all three countries. In New Zealand, health equity is one of four strategic priorities for the health system next to PHC, mental health and child well-being. The Government will use indicators of well-being in addition to gross domestic product for the next budget planning. However, inequities persist regarding access to mental health care. The Chinese Government launched the Healthy China 2030 plan to improve population health. Health-care reform aims to provide affordable and accessible health services to the entire population. Despite the efforts to include marginalized groups, it is in practice difficult to reach them and to include them in policy development. Singapore is using a system to track the health-care indicators for all subgroups of the population. This could challenge assumptions regarding who is actually left behind in Singapore. To improve population health, the Government envisages a shift from acute care towards primary care as well as means-tested subsidies, which are progressive and geared towards the poor.
There was consensus within the panel that community engagement is key to learn what patients want and need in order to make services more accessible. This information cannot be gained from quantitative health data but requires dialogue and involvement of civil society in decision-making processes. This goes hand in hand with accountability instruments to address rights at the grass roots and capacity-building as well as economic empowerment of civil society.

2.4 Side event: AMR and equity

A brown bag session was held as a side event focusing on how antimicrobial resistance (AMR) makes people poorer and sicker as part of observing World Antibiotic Awareness Week.

Three resource persons acted as invited speakers. Dr Christina Ramos, an infectious diseases specialist of Philippine General Hospital of the University of the Philippines discussed how AMR impacts the lives of patients. She mentioned that multidrug-resistant organisms are usually found in tertiary hospitals such as Philippine General Hospital. Due to drug-resistant microorganisms, patients tend to stay longer at the hospital (weeks to months), which results in high cost or government subsidy.

Following this, Dr Naoko Ishikawa, Coordinator of HIV, Hepatitis and Sexually Transmitted Infections in the WHO Regional Office for the Western Pacific, tackled the topic of drug-resistant gonorrhoea and how it makes people sicker and poorer. Dr Ishikawa showed a global map with levels of drug-resistant gonorrhoea as well as country data on the drug-resistant (e.g. ceftriaxone and azithromycin) isolates. In countries such as the Republic of Korea, Mongolia, China and Japan, up to 70% of isolates had developed resistance. She also emphasized the importance of gonorrhoea resistance surveillance including data from low- and middle-income countries.

The third resource person was Dr Masaya Kato, Program Area Manager for the WHO Health Emergencies Programme in the WHO Regional Office for the Western Pacific. He also discussed AMR and health security as well as hospital events/outbreaks. AMR has become a critical public health threat globally and regionally. Because treating drug-resistant pathogens is getting harder and sometimes impossible, costs due to longer hospitalization and outbreaks are rising, usually with high morbidity and mortality.

Dr Socorro Escalante, Coordinator of Essential Medicines and Technologies in the WHO Regional Office for the Western Pacific, finished the session by emphasizing the complexity of AMR and proposing participation in the AMR pledge as an action to combat AMR all together.

2.5 Marketplace: Actions to reduce health inequities

The marketplace session provided an opportunity for countries to share experiences, knowledge and best practice examples in terms of equity in service delivery transformation, governance, financing and/or monitoring and evaluation. Twelve countries presented posters of their practice examples.

The main themes presented by countries were around strengthening PHC (Cambodia, Papa New Guinea), improving services for NCDs and older persons (Brunei Darussalam, Singapore, Tonga), as well as optimizing service delivery (China, Federated States of Micronesia, Samoa). Government priorities seem to facilitate improvements in the areas of service delivery and PHC, which are closely intertwined.

Some countries presented actions to improve access to specific health services: Vanuatu presented interventions to improve access to neglected tropical diseases, Fiji highlighted reforms to improve access to mental health services, and Mongolia presented the Healthy Liver Programme. Another
interesting aspect about optimizing health services was innovative solutions such as the biometric health information system that has been introduced recently in the Federated States of Micronesia. The poster from Viet Nam moreover described the improved mechanisms for centralized procurement of vaccines and medicines to enable access to essential medicines and vaccines for the entire population.

The marketplace session provided an effective opportunity for participants to exchange information and lessons learnt. The discussions suggested that countries in the Region are undertaking reforms to deliver more equitable and people-centred integrated health service, within current data and resource constraints.

2.6 Plenary: Improving attention to equity in health service delivery

The session introduced a framework for thinking about service delivery transformation that leaves no one behind and examples of actions needed for an equity focus in service delivery transformation. Health service delivery lies at the core of UHC and puts people at its centre. People-centred service delivery requires balancing appropriately between the trade-offs involved in increasing both access by all to and the quality of services while containing service costs. When costs are well managed and quality is high, equity of access is improved. Timely access and appropriate use of services, in turn, have the potential to improve the efficiency of the system and reduce costs. Achieving UHC is therefore about finding the optimum balance of quality, access and cost to ensure that all populations are able to use affordable, good-quality health care when they need it. This is put to the test when considering the trends faced by most countries in the Region, such as an ageing population and rising NCDs. When health delivery systems fail the patients, this can erode trust in the health system and the government.

Ensuring equitable access to quality services will require action on both demand- and supply-side barriers. Supply-side barriers limit service availability and thereby access. For example, service location, limited opening hours and long waiting times are aspects inherent to the health system that hinder service uptake. Demand-side barriers influence the capacity and/or willingness of individuals, families or communities to attend and use services. Demand-side barriers may be as important as supply factors in hindering patients, families and communities from obtaining treatment and engaging with the health system. For example, education and literacy, including information on health-care choices and services, can determine the extent to which a person is able or willing to access the health system. Demand-side factors are linked to the underlying determinants of health and the conditions in which a person is born, grows, lives and works.

To guide the group discussion, the plenary focused on three core dimensions of service delivery transformation: strengthening the people-centredness of services, the continuum of care and provider competency (the three Cs). The TAG highlighted that people-centredness needs to be expanded to include community-centredness.

2.7 Group work: How to improve equity in health service delivery

During the session, participants discussed actions to ensure an equity focus in service delivery transformation and potential bottlenecks. General problems discussed in the groups included poor quality of care, unaffordability of medicines, inadequate financial protection and a lack of (equity) data. To improve quality and address health workforce issues, countries take action in various forms, for example the implementation of a role delineation policy, capacity-building for nurses (specialised nurse practitioners) or defining a minimum package of care.
In all countries, certain groups of the population have unequal access to health services. Pacific island states commonly report challenges regarding providing care for remote island populations. Other countries are experiencing similar problems with providing services for rural communities. These challenges go hand in hand with the need for improved workforce retention and providing more specialized care in remote areas. Actions suggested by countries during the group work included mobile outreach programmes, financial protection of the most vulnerable group and financial mechanisms to incentivize provider retention in rural areas. A general trend that is observed in countries is the restructuring of their health systems towards PHC.

Providing adequate health services for patients with NCDs, mental health disorders and older persons remains a challenge for all countries in the Region. People living with chronic diseases often face catastrophic health expenditures and high out-of-pocket payments. Most countries are struggling with screening, management and ensuring long-term care for patients with chronic diseases and receive little financial support due to donor preferences. HICs also face the challenge of leaving nobody behind; examples include older persons in Japan, unregistered foreign workers in Malaysia or individuals with mental health problems in New Zealand. In Macao SAR (China), the opening hours of public services are mismatched with the working hours of casino workers who struggle to access health services. Countries can benefit from assessing who is really left behind to challenge common assumptions, but this requires high-quality disaggregated data using numerous stratifiers such as social, demographic and geographic characteristics.

Participants highlighted the importance of engaging communities to ensure that services are competently delivered and acceptable to patients. This can positively impact health-seeking behaviour. Examples from Viet Nam and Solomon Islands illustrated that traditional beliefs are often not recognized by health providers, leading, for example, to women delivering at home or with traditional healers. Governments should improve the health literacy of the population and set incentives for health-seeking behaviour. For instance, Singapore is providing screening results at health providers to ensure medical follow-up. Moreover, governments need to involve all health providers, including faith-based organizations, civil society and the private sector.

### 2.8 Reflections Day 1

During this session, TAG members, resource persons, participants and observers reflected on their most important learnings or most thought-provoking moment of the day. Within the groups, the three Cs – the strengthening the people-centredness of services, the continuum of care, and provider competency – had been expanded by multiple other Cs, such as coordination, collaboration, coverage, consensus, comprehensiveness, co-creation, community, closeness and cost-effectiveness. This conversation further demonstrated that equity is a complex, multidimensional concept.

In some countries, the basis for an equitable health system seems to be a carefully delineated health system with clear structures and referral systems that cover the whole population, while taking note that some people or groups are missing out. The same applies for countries that subsidize health care, for example specialized services for the entire population, highlighting equality rather than equity. Other countries are targeting vulnerable groups with subsidies to ensure access to care, which might not target the most disadvantaged of the population. To ensure that subsidies target the right group and to make evidence-based decisions, governments need good data. To really capture who is left behind and why, countries need to go beyond quantitative data and use outreach and qualitative methodologies.
Countries conceptualize who is left behind very differently: Some countries focused on geography (remoteness), migrants and age, while others focused on service categories or patient groups such as for mental health and NCDs. Generally, there was agreement that certain groups are being left behind because health systems are failing to adapt to demographic changes and needs. Another take-home message was that there is rarely just one group left behind but mostly several – yet these populations may be very different from one country to the next. This in turn requires a range of interventions with various partners, for example governance interventions, policy interventions, partnership agreements with nongovernment or faith-based organizations, financial interventions, service-targeted interventions and health workforce interventions. Finally, a general recommendation was that countries should include the vulnerable groups that are left behind in the discussion and policy design.

2.9 Plenary: Using finance and governance levers to advance equitable access to health services with a focus on highly specialized care and high-cost medicines

During the plenary session, countries presented their strategies and challenges in ensuring equitable access to health services with a focus on high-cost specialized care and medicines, such as anti-cancer and hepatitis treatments. The presentations focused on how governance, regulations and financing levers were used to improve equitable access to needed health care.

In the Region, approximately 20 million people are impoverished annually because of out-of-pocket expenses. Pharmaceuticals constitute a considerable share of these out-of-pocket expenditures. Countries are already employing a variety of financial protection measures, such as health insurance or voucher systems, but financial levers are not enough. It takes good governance to maximize the impact of financial levers. Governance is complex but necessary to outline not only what each institution’s role is in a health-care system, but how that institution should operate according to UHC attributes. Strengthening legal frameworks for health (including a clear and consistent regulatory presence) improves the operationalization of good governance.

Kiribati presented their health system arrangements to provide a basis for discussion. The Government stressed that major constraints are financial constraints, lack of reliable and comprehensive data, and poor coordination. The Government of Kiribati therefore aims to improve the coordination of funds, capacity-building and introducing eHealth.

Samoa presented their anti-cancer treatment programme, which is under pressure due to a lack of knowledge and the traditional belief system of the population, the lack of a national screening programme and weak health infrastructure, as well as limited treatment options in the country. Without a national screening programme, one national nongovernment organization plays an important role by promoting early treatment-seeking. Due to the absence of cancer prevalence data, there is limited political will for investing in early screening. Samoa has two different oversea treatment schemes with a set of criteria that is overseen by a committee. While oversea treatment in New Zealand is paid by the Government, patients need to cover their own airfare, accommodation and transport. Otherwise, the Samoan Government will cover all costs, including airfare and additional costs, for treatment in India. The process of approval for oversea treatment takes time; hence, a patient’s cancer may already be at an advanced stage by the time the patient arrives or may die before reaching a doctor. The Samoan Government highlighted the need to strengthen its cancer awareness programmes through community involvement, investing in a national screening programme and improving its oversea referral system.
2.10 Group work: How to use finance, law and governance levers to advance equitable access to medicines and other services

Participants discussed practical examples and options of how financing, regulations and governance levers can facilitate equitable access to essential services as exemplified by access to medicines. The Philippines described legal mechanisms that could be used or were available to control drug prices. China highlighted its use of monopsony power to improve prices on expensive cancer-related drug treatments, and redistribution of funds from high resource (usually urban) to low resource (rural) centres. Japan raised the issue that while services are affordable, the health insurance scheme is still struggling to fund expensive medications such as for cancer.

Participants discussed the important role of PHC in improving equitable access. Participants expressed challenges in building a case to support the reallocation of financial resources from curative services towards PHC. In the Federated States of Micronesia, the challenge is identifying a benchmark (e.g. how much should be spent on PHC versus tertiary care). Having a target number was seen as a good way to help policy-making advocacy. Viet Nam has passed a law to direct 30% of tax revenue towards preventive/primary health care. The Government is also advocating directing 20% more social health insurance spending (currently 4%) towards PHC to improve equity.

Subsidies for the poor or other vulnerable groups were discussed as an equity tool. Cambodia’s health financing system, for instance, is pro-poor and covers the poorest 20% of the population. Yet, poor people underutilize the public health system for which they are covered. One action of the Government is to expand the benefit package to cover treatment for NCDs for the poor. A number of countries highlighted the importance of having comprehensive methodologies in place to better measure wealth and thus allocate funds by identifying “poor” households in need of financial assistance. Keeping some form of copayment, rather than free services, incentivizes patients to take care of themselves and prevent overuse of services.

The presentation of Samoa’s cancer treatment and oversea referral programme during the plenary prompted many groups to discuss similar issues within their countries. There are financing and accountability challenges in the use of oversea medical treatment but also opportunities to create shared standards for care, to develop oversea specializations and to negotiate on price and delivery of care. Solomon Islands described how inefficiency of referrals needs to be critically considered as almost 30% of referrals are returned without treatment. This has led the Government to consider telemedicine as part of their service delivery reform. Cancer screenings should only be set up if there is a financing scheme in place that ensures access to treatment. A comprehensive cervical cancer screening programme with oversea treatment such as the one in Macao SAR (China) can yield results, with zero fatalities reported from cervical cancer since 2015. The system will be expanded for colorectal cancer.

Countries also discussed methodologies and challenges in deciding which drugs to place on an essential medicines list and how to decide which drugs outside of that list should be purchased. These included having committees to review new drugs, individual case-by-case referrals for patient access to drugs, government subsidies for exceptional drug procurement, pooled procurement, drug fee schedules and export of care.

2.11 Side event: To advance UHC, what should come first – advocacy or funding?

Sustaining momentum for UHC so that it remains at the forefront of the global development agenda in the coming decade will require both advocacy and funding. The question discussed during the side event was which of these should come first.
The side event convened funders, country policy-makers and WHO to debate this topic, where they drew on experiences and examples of policy/advocacy and communications activities their organizations have been involved with to advance UHC. Various arguments were put forward including: advocacy should come before funding because it provides the vision, articulates the agenda and helps people understand where to spend the resources; and funding should come before advocacy because it stimulates the generation of research evidence to inform advocacy. The event closed with an electronic voting by the audience, who decided that based on the arguments presented funding should come before advocacy.

2.12 Plenary: How to identify who has been left behind and why

The plenary focused on the capacity in countries for equity-focused monitoring and the ways in which available evidence can be used to drive actions to reduce health inequities. Key evidence gaps for tracking health equity were identified, and possibilities to overcome them were addressed.

Monitoring is key for promoting accountability for progress towards equity in UHC. It is important to establish health information systems with the capacity to disaggregate data to identify and monitor health inequalities. An analysis of health inequalities based on existing data from the Lao People’s Democratic Republic, Solomon Islands and Australia was presented. The analysis focused on uneven progress in reducing maternal mortality in the Lao People’s Democratic Republic, the impact of geographic isolation on health-care access in Solomon Islands and differential health outcomes for Aboriginal and non-indigenous people in Australia.

The Australian Government responded that it is concerning that the indigenous people are disadvantaged. While most of the indigenous population is in rural areas, geography is not the only factor. Such data are very valuable for policy and programme decision-makers. The Lao People’s Democratic Republic also stressed that the data based on the district health information system (DHIS2) is limited and that the data are facility- not community-based. Community-based data would give policy-makers a more realistic picture on which to base their decisions.

There are information gaps in every country, resulting in policy-makers taking action with incomplete information. However, countries need to maintain a balance between trying to close information gaps and making the best of the data currently available. Focusing on measuring equity should go hand in hand with actions to close the current gaps operationally. There is arguably enough data and evidence on what drives inequity for countries to begin addressing the issues.

2.13 Group work: How to use information systems to identify and respond to those furthest behind

Building on the previous discussions, the groups examined in more depth the factors that can contribute to people being left behind. Participants elaborated on the actions that are being taken to address this issue including through enhanced capacity for equity-focused monitoring.

Participants described sources of health-related information, including broader data collection processes, such as census and household income surveys. Other sources of data included electronic patient health records and paper health records. There were processes for periodic data collection, such as the national household targeting system for poverty reduction in the Philippines, and monthly reporting processes from rural locations in Kiribati and Fiji. The Federated States of Micronesia is also establishing a hospital information system that links to outreach services and maps data from other sectors such as education. Participants further described processes in place specifically to collect...
data from harder-to-reach populations such as the Chinese poverty survey that collects both health-related and socioeconomic data.

Generally, HICs collect more sophisticated data disaggregated according to demographic factors, health usage, geography and ethnic groups. Disability-adjusted life years (DALYs) are also used to inform policy-makers about which health programmes to target. In New Zealand, indicators are currently being developed for well-being, and a public consultation is part of the process to ensure data are meaningful. New Zealand further takes a life-course approach by cross-referencing data to predict which families will likely become unhealthy in order to invest early.

Some middle-income countries said that the data collected were often based on donor priorities. Several countries face the challenge of the data collected not being utilized and a lack of capacity to analyse data as well as gaps in completeness and quality of data. All countries described data on access as helpful. Data on outcomes, however, were seen as a big challenge as not a lot of clinical data are collected. Participants highlighted that the data systems are not perfect, and some populations are falling through the gaps including isolated rural populations, indigenous populations, rural–urban migrants and migrant populations.

Interoperability of data was described as an issue, and attempts are being made across the Region to interlink information systems including raw data sharing in Japan and a memorandum of understanding in Kiribati between the Bureau of Statistics and the Ministry of Health. The interoperability of data systems was emphasized as a barrier to efficient use of data, and coordination and collaboration between related authorities. Coordination of data systems was highlighted as a necessary component to guide genuine evidence-based policy-making. Systems that collect both quantitative and qualitative data are necessary to ensure that policy-makers are able to contextualize the information. Furthermore, budgets are mostly not allocated based on cost-effectiveness or needs assessments but are a political process, often with little flexibility in budget lines.

2.14 Reflections Day 2

During this session, TAG members, resource persons, participants and observers reflected on their most important learning or most thought-provoking moment of the second day.

The challenges discussed on the second day similarly affect high- and middle-income countries. Even if countries cover 95% of the population, the missing 5% pose a challenge for the health system. This is particularly relevant for efforts to eradicate diseases as the “left-behind” group can reinfect the whole population. Furthermore, several participants praised the side event on advocacy and stressed that advocacy is important to raise awareness on issues and raise the priority of the UHC agenda with politicians and governments.

From the previous break-out session, participants concluded that there is a lack of information on who is being left behind and the underlying causes. Governments need to put more emphasis on collecting data to inform decision-making processes. In this regard, the importance of qualitative data to provide more contextual data was highlighted. Even with the data available right now, governments can do more to improve access for vulnerable groups.

2.15 Group work and helpdesk

During the morning of the last day of the TAG meeting, country representatives and country office staff developed the UHC priority actions for their own countries. TAG members and resource persons split up and supported countries with the development of UHC priority actions. During this session,
countries also took time to sit down with other countries to discuss and exchange on issues of their interest. The priority actions were collected and printed on posters for presentation by the countries.

2.16 Presentation of country priorities

Countries presented their priority actions based on their road map for UHC. The actions were split into three main areas: (i) service delivery, (ii) finance, governance and law, and (iii) equity-focused monitoring.

Country priority actions regarding improved service delivery focused on improving the identification and servicing of marginalized population groups. Another common area for action was the clarification of roles in the health system through, for instance role delineation policies, as well as improving the distribution, training and retention of health workers. Clarification or adaptation of the essential benefit package was identified as a priority by several countries. Countries put emphasis on implementing quality improvement policies or programmes as well as strengthening PHC. Island nations are particularly concerned with improving their geographical outreach and oversea referral systems. Several countries specifically aim to provide better services – screening and treatment – for NCDs on the primary care level and plan to implement outreach activities for marginalized groups. Some countries are planning to have outreach services for older persons.

Regarding finance, governance and law, countries prioritized several actions such as improving frameworks for the procurement of drugs and health technologies and institutionalizing health technology assessments for decision-making processes. Some countries aim to strengthen their public financial management system, while others – depending on the progress of the country – plan to implement or strengthen their national health protection schemes. One aspect of this is to conduct a costing of the essential service package. To improve quality of care, countries are considering introducing or strengthening incentives for providers through financing structures. Moreover, countries are seeking better and more equitable ways to allocate subsidies for health services. Regarding governance arrangements, countries aim to improve licensing and regulation frameworks to keep up with new forms of health services. Several countries are aiming to better coordinate and regulate work with (development) partners or enable direct engagement with private sector providers to assist in the equitable delivery of health services.

All countries are committed to improving their equity-focused monitoring, either through making better use of their current data or by strengthening their health information system with regard to equity. For instance, countries suggested using existing data for in-depth analysis on who is being left behind and partner with academia to get a more detailed analysis of existing data. Several countries also mentioned the benefit of introducing qualitative surveys.

2.17 TAG recommendations and closing

The UHC TAG shared its conclusions and recommendations for Member States and WHO (see below) and asked the participants of the meeting to provide feedback and reactions.

There were few comments on the recommendations. One point that was highlighted by the participants was that the recommendations need to be viewed as a menu that countries can choose from. The implementation of the recommendations is highly dependent on the political situation and reform processes in each country.

In the closing remarks, it was stressed that equity is the overall goal of society that goes beyond health. The Region has a lot of political will to make improvements in health. It is very positive to see that
some countries already are making steps towards expanding their health protection towards non-citizens such as migrant workers. Even countries with small populations with vast territories or island nations are investing greatly to provide services to their populations.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

3.1.1 Country progress on UHC
- Although most countries are generally making great progress towards UHC, progress is inconsistent across the Region and within countries.
- There is a growing recognition and acknowledgement that equity gaps exist, which threatens progress towards UHC in all countries.

3.1.2 Opportunities for advancing UHC
- There has been a recent recommitment to strengthening PHC, 40 years after the Declaration of Alma-Ata.
- PHC is the most effective, efficient and equitable approach to enhance health, making it a necessary foundation to achieve UHC, but it appears to be unevenly resourced across the Region and within countries.
- There is growing support across the Region to give vulnerable communities a voice, including through co-design of health services and development of the workforce from those vulnerable communities.
- There is strong interest in and evidence of learning from each other (including across the Region, across subregional groupings and from country to country) on common policy and implementation issues, often irrespective of a country’s socioeconomic status. Examples include role delineation, hospital autonomy, workforce development, pharmaceutical price negotiations and quality.
- While observing the above, we also observe the declining participation by HICs and note that upper middle-income countries (UMICs) benefit greatly from learning from HICs as well HICs from each other.
- Equity gaps are different in different contexts requiring context-specific and granular analysis and action.

3.1.3 Risks for advancing UHC
- Health systems are social and political systems; economic and commercial drivers can be regressive and may impede progress to UHC.
- All health systems, regardless of income level, are facing financial pressures, whether related to economic slowdown, demographic changes, health sector budget cuts or donor exits.
- The growth in incidence in NCDs is presenting challenges for Member States, including for their economies and sustainable financing, and the burden on family and carers and the health system.
- Accelerating UHC relies on strong leadership and management capacity at all levels to navigate the diverse and sometimes complex currents of change; this capacity does not exist in all countries.
There are both opportunities and risks for UHC presented by eHealth and mHealth innovations, but we must be cautious about some of the commercial drivers and at times insufficient donor coordination that may challenge cost-effectiveness and health equity.

3.1.4 UHC TAG mechanism

- The UHC TAG mechanism has assisted in monitoring and reviewing action, advising on options for improvements, and in providing a regional platform for sharing experiences and country-to-country and peer learning.
- The TAG meetings have increased the focus of the WHO Regional Office and country offices on country needs.
- Noting the progress on UHC being made in the Region and the growing engagement with the UHC TAG mechanism for monitoring and peer learning, the TAG mechanisms should evolve to provide more specific country assistance to further accelerate understanding of country progress (including future scenarios and sequencing of action), testing and exploring scale-up and adaptation of innovations in the country, and engaging in regional peer learning and monitoring mechanisms.
- This more specific country assistance should include engaging in in-country diagnostic and review processes (drawing on quantitative and qualitative data) and policy dialogue that engages stakeholders in health as well as other relevant sectors (such as finance).

3.2 Recommendations

3.2.1 Recommendations for Member States

Member States are encouraged to consider the following:

- Review existing health reforms, policies and programmes – both demand and supply – using equity as a lens to improve attainment of existing priorities.
- Develop processes to prioritize future policies, programmes, technologies (eHealth/mHealth, digital health, new pharmaceuticals) for PHC and other interventions, ensuring selection of those with the greatest potential to improve health outcomes equitably at an affordable cost.
- Review existing data for their potential use for the above and for more effective monitoring of health system performance for continuous improvement.
- Note that as economic factors and other drivers can be regressive in some contexts, rigorously analyse decisions for potential regressivity, for example public–private partnerships, demand-side financing mechanisms (including vouchers and health insurance) and privatization, including of hospitals.
- Develop subregional or country-to-country cooperative strategies for equitable overseas medical treatment while exploring ways to build local capacity where appropriate and strengthen local prevention and early intervention to reduce costly overseas treatments in the longer term.
- Review policy and governance arrangements for oversight of quality and equity in both the public and private health service delivery sectors.
- Encourage subregional and country-to-country peer learning on key policy and implementation topics using digital technology, study tours, bilateral exchanges and professional networks, and consider financing through fellowship funds and other sources, including mutual learning between HICs (such as digital health, cost containment, ageing) as well as between HICs and UMICs (such as health technology
assessment, ageing, NCDs, policy and governance arrangements for oversight of quality and equity in both the public and private health service delivery sectors).

- Consider annual reporting on progress towards UHC to Cabinet and Parliament and in appropriate public forums.
- Coordinate donor support effectively.

The UHC TAG participants are encouraged to consider the following:

- Debrief on the outcomes of this third UHC TAG meeting with relevant senior policy-makers.
- Establish a network in-country of country participants of the various regional and global meetings on UHC, health system strengthening and SDGs to accelerate progress.

### 3.2.2 Recommendations for WHO

WHO is encouraged to assist Member States to do the following:

- Evaluate the equity implications of their reforms, policies and programmes and in turn audit its own programmes with regard to equity and leverage this to mobilize change in countries.
- Address health equity, seeking a balance between supply-side interventions (such as role delineation policy) and demand-side interventions (such as health literacy), based on granular analyses of who is excluded.
- Evaluate the implications and costs of Member State reforms, policies and programmes and support optimizing the potential offered by eHealth/mHealth and digital health for primary health care, as well as screening and early detection programmes to advance UHC.
- Harness and assess technologies and other innovations, including new pharmaceuticals, with a view to prioritizing those interventions with the greatest potential to improve health outcomes equitably and at an affordable cost.
- Strengthen prevention and early intervention through primary care.
- Strengthen Member States awareness and analysis of the impact of decisions and ways of mitigating potential regressivity and risks for UHC, including in particularly contexts such as public–private partnerships, demand-side financing mechanisms and privatization.
- Improve quality of data and capacity to use existing data sources better for improving health systems performance.
- Encourage subregional and country-to-country peer learning on key policy and implementation topics and facilitate generating ideas on modalities and funding.
- Use legislation and other governance mechanisms to ensure oversight of quality of public and private provision.
- Coordinate donor support more effectively.

WHO is requested to consider the following:

- Make progress towards UHC a standing agenda item on the agenda of the Regional Committee and World Health Assembly.
- Use its convening function to build subregional and multi-country partnerships for countries to learn from each other (including high to middle, high to high, middle to middle, and other constellations) including exploring mechanisms to enhance mutual learning between HICs (such as digital health, cost containment, ageing) as well as between HICs and UMICs (such as health technology assessment, ageing, NCDs, policy and governance mechanisms to oversee quality and equity in both the public and private health service delivery sectors.)
• Convene Member States and partners to facilitate subregional or country-to-country cooperative strategies for oversea medical treatment.

• Develop greater capacity to assist integrated consideration of financing and service delivery strategies, which are tailored to the different context of Member States, including their history, current funding strategies and structures of service delivery.
ANNEXES

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Annex 2. Agenda

<table>
<thead>
<tr>
<th>Day 0</th>
<th>Time</th>
<th>Day 1, Tuesday 13 November</th>
<th>Time</th>
<th>Day 2, Wednesday 14 November</th>
<th>Time</th>
<th>Day 3, Thursday 15 November</th>
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</thead>
<tbody>
<tr>
<td>8:00- 8:30</td>
<td>Secretary meeting</td>
<td>8:00- 8:30</td>
<td>Photo recap from Day 1</td>
<td>8:40- 8:40</td>
<td>Secretary meeting</td>
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<tr>
<td>8:30- 9:00</td>
<td>Registration</td>
<td>8:30- 8:45</td>
<td>Plenary 1: Opening</td>
<td>8:45- 9:45</td>
<td>Help desk to support national strategies and policies</td>
<td></td>
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<tr>
<td>9:00- 10:00</td>
<td>Plenary 1: Opening</td>
<td>10:00- 10:20</td>
<td>Group photo and coffee/tea break</td>
<td>9:45- 10:00</td>
<td><em><strong>,coffee &amp; tea to be provided on the side</strong></em></td>
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<tr>
<td>10:00- 10:20</td>
<td>Breakout 1: Journey of UNC</td>
<td>10:20- 11:20</td>
<td>Plenary 2: How to use equity to frame priorities</td>
<td>10:30- 11:30</td>
<td>Plenary 4: Using finance and governance levers to advance equitable access to health services with a focus on highly specialized care and high cost medicines</td>
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<tr>
<td>11:30- 12:30</td>
<td>Plenary 2: How to use equity to frame priorities</td>
<td>12:30- 13:30</td>
<td>Lunch</td>
<td>12:30- 13:00</td>
<td>TAG members’ meeting continued (closed lunch)</td>
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<tr>
<td>12:30- 13:30</td>
<td>Lunch</td>
<td>13:00- 14:00</td>
<td>Marketplace: Actions to reduce health inequities</td>
<td>13:30- 14:30</td>
<td>Plenary 7: Country presentations</td>
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<td>13:30- 14:30</td>
<td>Plenary 3: Improving attention to equity in health service delivery</td>
<td>14:30- 15:30</td>
<td>Coffee/tea break – participants move to breakout rooms</td>
<td>14:30- 16:00</td>
<td>Coffee/tea break</td>
<td></td>
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<tr>
<td>14:30- 15:30</td>
<td>Coffee/tea break – participants move to breakout rooms</td>
<td>15:30- 16:45</td>
<td>Breakout 3: How to improve equity in health service delivery</td>
<td>16:00- 16:45</td>
<td>Plenary 8: TAG recommendations and closing</td>
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<tr>
<td>15:30- 16:45</td>
<td>Breakout 3: How to improve equity in health service delivery</td>
<td>16:45- 17:00</td>
<td>Plenary Reflections from day 1 including breakouts 1 &amp; 2</td>
<td>16:15- 17:00</td>
<td>Plenary Reflections from day 2, including breakouts 3 &amp; 4</td>
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<tr>
<td>16:45- 17:00</td>
<td>Plenary Reflections from day 2, including breakouts 3 &amp; 4</td>
<td>17:00- 18:00</td>
<td>TAG member’s meeting (closed)</td>
<td>17:00- 18:00</td>
<td>TAG member’s meeting (closed)</td>
<td></td>
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