THIRD WHO BIREGIONAL WORKSHOP ON HEALTH FINANCING POLICY FOR UNIVERSAL HEALTH COVERAGE IN ASIA

25–28 June 2018
Ho Chi Minh City, Viet Nam
MEETING REPORT

THIRD WHO BIREGIONAL WORKSHOP ON HEALTH FINANCING POLICY FOR UNIVERSAL HEALTH COVERAGE IN ASIA

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The views expressed in this report are those of the participants of the Third WHO Biregional Workshop on Health Financing Policy for Universal Health Coverage in Asia 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 WHO Biregional Workshop on Health Financing Policy for Universal Health Coverage in Asia in Ho Chi Minh City, Viet Nam from 25 to 28 June 2018.
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Keywords:

Healthcare financing / Regional health planning / Universal coverage/ Asia
SUMMARY

Countries need a strong primary health care (PHC) system to progress towards universal health coverage. A strong PHC system means having effective coverage of interventions to be delivered by front-line services and facilitating financial protection. PHC reforms – including how health systems are organized to reorient service delivery towards PHC and how services are financed – are critically important.

The Third WHO Biregional Workshop on Health Financing Policy for Universal Health Coverage in Asia, jointly organized by the World Health Organization (WHO), the Asian Development Bank and the World Bank, was held from 25 to 28 June 2018 in Ho Chi Minh City, Viet Nam. The workshop emphasized strengthening strategic purchasing for PHC in both the Western Pacific Region and South-East Asia Region, given the numerous PHC reforms in countries, with a focus on implementation issues and promising practices. A total of 90 delegates attended, of which 53 were country representatives who were mid- to senior-level policy-makers working on health-related issues from health or finance ministries and national health insurance or social protection agencies.

The workshop served as a platform for sharing experiences and expertise on strategic purchasing for PHC. It enabled open discussions about country experiences and challenges, as countries implement public financial management (PFM) reforms applicable in health, operationalize strategic purchasing mechanisms and undertake reforms to strengthen PHC. Discussions focused on: (i) PHC financing and utilization trends in the regions; (ii) PFM for PHC performance; (iii) using purchasing schemes for PHC; and (iii) PHC financing reforms alignment.

Moving forward, it is recommended that Member States continue to: strengthen linkages between health financing policy and PFM, with a focus on PHC performance; work towards PHC financing that would ensure coverage of health services as well as alignment of financial incentives across all levels of care and with service delivery goals; and monitor and account for PHC financing. To support Member States, WHO, with other development partners, shall continue to: assist Member States in strengthening strategic purchasing for PHC; coordinate the work of the regional offices with country offices and headquarters to ensure focused, relevant, practical and context-based approaches; and continue the collaboration in health financing between the WHO regional offices, WHO headquarters, the Asian Development Bank and the World Bank.
1. INTRODUCTION

1.1 Meeting organization

The Third WHO Biregional Workshop on Health Financing Policy for Universal Health Coverage in Asia, which was held from 25 to 28 June in Ho Chi Minh City, Viet Nam, focused on strengthening strategic purchasing for primary health care (PHC) and health financing systems in both the World Health Organization (WHO) Western Pacific Region and South-East Asia Region. This is the third biregional workshop on health financing policy jointly organized by WHO, the Asian Development Bank and the World Bank.

The first workshop was held in Manila, Philippines, in 2016 and highlighted issues in health financing in general, including revenue collection, pooling and purchasing. The second workshop was held in New Delhi, India, and focused on resource allocation and strategic purchasing. Based on feedback from participants, a deeper understanding of strategic purchasing, more country examples and cross-country learning were recommended for future events. For the third workshop, the emphasis was on strategic purchasing for PHC with a focus on implementation issues and promising practices in countries.

The workshop was attended by 90 delegates, of which 53 were country representatives, 7 were temporary advisers, 12 were Secretariat staff, and 11 were extended Secretariat staff. Country representatives consisted of mid- to senior-level policy-makers from the departments of financing, policy or planning under the health ministry, from the finance ministry working on health-related issues, and from national health insurance or social protection agencies.

1.2 Meeting objectives

The objectives of the workshop were:

1) to follow up on action points and assess emerging challenges from the second WHO biregional health financing policy workshop;

2) to share experiences across countries and improve intersectoral collaboration on aligning budget to priorities, financing primary and specialized care, contracting providers, and conducting monitoring and evaluation payment systems; and

3) to identify and assess ongoing policy options relevant to the country context in moving towards strategic purchasing.

2. PROCEEDINGS

Plenary and technical discussions were devoted to the thematic areas of (i) PHC financing and utilization trends in the regions; (ii) public financial management (PFM) for PHC performance; (iii) use of purchasing schemes for PHC; and (iii) PHC financing reforms alignment. The following subsections summarize the highlights of the proceedings.

2.1 Opening session

The opening session underscored the importance of having a strong PHC system and outlined the importance of the workshop in promoting the policy dialogue between ministries of health, ministries of finance, and health insurance or social protection agencies.
It also emphasized that, while there is no universal definition of PHC, its core functions often include:

- delivering a broad spectrum of preventive, promotive, curative and palliative care across the life-course;
- delivering affordable health services within people’s communities;
- connecting patients with trusted providers who address their ongoing health needs throughout their lives; and
- serving as a hub to refer patients to specialists as needed.

2.2 PHC financing and utilization trends in the regions

The current PHC funding scenarios in in the regions were discussed during the plenaries, identifying the most common challenges and presenting current innovations. Some Member States have implemented health financing reforms to improve PHC performance, including service delivery networks, paying incentives together with capitation, and increasing funding to improve front-line services, among others. But health systems are still dominated by hospital care and many services that could be delivered at PHC facilities are being provided at hospitals. Innovations in PHC service delivery, as emphasized, are needed for reasons of sustainability and equity. Special focus on PHC payment mechanisms is needed if the system wants to shift care outside hospitals. This is fundamental for system sustainability.

2.3 PFM for PHC performance

Discussions focused on what a strong PFM system that underpins health service delivery systems provides in terms of prioritization in resource allocation and spending efficiency. Specifically, a strong PFM system allows for sufficient and appropriate allocation of resources, facilitates and smoothen fund flows, and enhances transparency and accountability for results. The concept of performance-based budgeting was also introduced and lessons learnt from countries implementing it were discussed, including key challenges and necessary preconditions for countries to consider when moving towards performance-based budgeting.

2.4 Using purchasing schemes for PHC

Plenaries highlighted pharmaceuticals as the leading cause of household out-of-pocket expenditures in both regions. Member States have been combining strategies to increase access to medicines through supply-side solutions, reimbursements (in case of having a purchasing scheme) and capping medicines prices. However, results seem not encouraging. Furthermore, some Member States have established and/or expanded national health insurance as part of their efforts towards universal health coverage and improving system efficiency and effective coverage.

2.5 PHC financing reforms alignment

During the sessions, the representatives discussed and highlighted: service delivery changes towards stronger PHC, PFM changes for PHC financing and service delivery changes, and alignment and realignment of financial incentives to reinforce service delivery model oriented to population outcomes. The discussions emphasized the importance of having coherent financing and payment policies that can achieve higher levels of safety, effectiveness, patient-centeredness, timeliness, efficiency and equity, recognizing that the appropriate PHC financing and payment models will have health systems-level impact.
3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

3.1.1 PHC financing and utilization trends in the regions

A strong PHC system means having effective coverage of interventions to be delivered by front-line services and facilitating financial protection. The increasing prevalence of noncommunicable diseases (NCDs) requires a shift from hospital orientation to PHC, whereby PHC will be at the forefront of the NCD response, even as progress is sustained on other priority public health services and private sector engagement is increased.

PHC and hospital-based care are intertwined. Better PHC reduces demand for hospital-based care, while good PHC means linking to specialized secondary prevention that is often stationed at the hospital.

A number of countries in both WHO regions are undertaking PHC-related reforms. These reforms may focus on service delivery strengthening or enhancements (i.e. organization at the local level, definition and establishment of essential service “packages”, and human resources development) and/or health financing (i.e. governance, including institutional arrangements, funding flows, resource mobilization), and purchasing mechanisms (e.g. insurance, linking with performance). Furthermore, within PHC, fragmented funding should be merged and/or who pays for what must be clarified. Between PHC and hospital care, clarity of roles is critical as the system shifts towards more cost-effective PHC.

The appropriate PHC financing and payment models will have health systems-level impact. It could create incentives across the health system to: manage population health; encourage PHC utilization; address issues of access, quality and equity in service delivery; provide safety nets for financial protection; foster the efficient use of resources; and even avoid inappropriate services and expenditures in upper levels of care.

Payment models should facilitate strong universal access to a broad network of PHC facilities without significant financial burden. Alignment of provider payment mechanisms is fundamental to ensure system efficiency. Special focus on PHC payment mechanisms is needed if the system wants to shift care outside hospitals. This will be fundamental for system sustainability. The financing and payment outside of PHC (i.e. prevention, vertical programmes, hospital financing and pharmaceuticals) should be examined and aligned to PHC financing.

3.1.2 PFM for PHC performance

At the core of PFM is how public budgets are formulated, disbursed and accounted for. A strong PFM system can enable effective health financing policy implementation and health service delivery. Most health financing reforms have PFM implications, but the unique characteristics of the health sector can create tension with the PFM system.

The following are some of the key messages from the PFM discussions:

- Multiple sources of funding at the PHC level (e.g. government budget, internal funds, health insurance funds) all have implications for budget execution, financial reporting and accountability for the use of funds and monitoring results.

- Funds need to be channelled to the health sector. Appropriate resourcing, planning and budgeting are therefore required to meet defined health needs and allow for risk pooling.
Stakeholders (e.g. government, parliament, donors) need a reasonable assurance on intended purpose, outcomes and value for money through external auditing.

- Finding the right balance between control and flexibility is critical. PFM can ensure cost containment and fiscal sustainability, but the health system needs flexibility in reallocating across services and programmes, to incentivize providers to achieve quality and efficiency, and contract the private sector.

- Some countries have embarked on budget reforms, which are focused on improving policy-based budgeting, credibility of the budget and transparency. The instrument used in many countries for policy-based budgeting is the medium-term expenditure framework.

- Two main budgeting methodologies used are line-item budgeting and programme-based budgeting. The latter formulates the budget around related services and activities for a strategic purpose known as a programme. It links planned expenditures to clearly determined results and improved service delivery within the mandate of an agency. Each programme’s performance is measured by outcomes, outputs and cost.

- Budget structure is also critically important. Programme budgets in health could be based on outputs, level of care, organizational mandate and diseases/population groups. Coherence between how budgets are formulated (e.g. programme-based budgeting) and how they are spent, reported and accounted for (e.g. whether still by inputs) is important to avoid any potential mismatch between programme logic, contracting and payment mechanisms.

- Furthermore, having a clear performance framework that consolidates programme performance information and financial information is vital. This requires a sound and streamlined logical framework that can be built into existing monitoring and evaluation. It is also important to balance accountability requirements with capacities to monitor and evaluate.

### 3.1.3 Using purchasing schemes for PHC

Medicine expenditures comprise a majority of out-of-pocket payments. In most countries, the poor spent proportionally more of their total budget on medicines. Several policies have been in place to help stem this issue, including: supply-side policies (free access to a list of essential medicines, usually supplied through public distribution channels); demand-side policies (reimbursing patients or facilities for medicines dispensed to users); and market-based solutions (regulating prices and mark-ups to make medicines affordable). Supply-side solutions depend on robust procurement and supply chain systems. A precondition is to have a public sector that has a big share of the health market.

Many countries in the regions are establishing and/or expanding national health insurance as part of their efforts to accelerate universal health coverage. National health insurance also helps: address government health sector inefficiencies; enable access to needed health services including primary care services; and align the private health sector to support government objectives. Several Member States have used their national health insurance systems to introduce broader primary care services. However, most countries have not fully integrated primary care services into their national health insurance, despite its great potential to widen primary care services. Addressing the bottlenecks and barriers to national health insurance coverage would be crucial in ensuring that this potential is met.
3.1.4 PHC financing reforms alignment

Health systems must shift from PHC with narrow task profiles to an engaged integrated PHC (public health, individual health and social services) – underpinned by proactive population health management with larger multidisciplinary primary care teams and a working coordination system with specialists. The way in which NCDs are managed will continue to change over time and alter the relationship of hospital services to primary care, the role of the hospital and the shape of the networks required. The potential or increasing regionalization of specialist care will also improve the quality of specialist care close to the patient.

Most often, traditional provider payments – fee-for-service, capitation, salary, global budget or diagnosis-related groups – are often poorly aligned with priorities such as improving quality or delivering care more efficiently. Also, it is important to develop financing and payment systems for PHC that: (i) align with payment systems at other service delivery levels and create both opportunity and incentives to provide better integrated people-centred health care; (ii) have financial incentives aligned at all levels of care to reinforce orientation to population outcomes; (iii) and address the different needs associated with the rise of NCDs. Furthermore, the financing and payment outside of PHC (i.e. prevention, vertical programmes, hospital financing and pharmaceuticals) should also be aligned to PHC financing, and altogether oriented/reoriented towards population outcomes.

Incremental approaches have been used to address weaknesses in base payment mechanisms and the interface across them. These approaches involve retaining base payment mechanisms and adding on further elements, such as pay for coordination, pay for performance and bundled payments for specific conditions. These approaches tinker at the margins without actually addressing the root cause of the incentive alignment problem. This is insufficient to dramatically transform the way services are delivered and calls for bolder changes to be made to the way in which health services are purchased.

3.2 Recommendations

3.2.1 Recommendations for Member States

Member States are encouraged to do the following:

1) Continue to strengthen linkages between health financing policy and PFM, with a focus on PHC performance.

2) Work towards PHC financing that would ensure coverage of health services, incentives aligned across all levels of care and with service delivery goals.

3) Monitor and account for PHC financing.

3.2.2 Recommendations for WHO

WHO is requested to do the following:

1) Continue support to Member States in strengthening strategic purchasing for PHC as follows:
   a. Based on country needs, facilitate further discussions and policy dialogue with in-country stakeholders.
   b. Continue to provide technical support in the areas mentioned above tailored to country contexts.
c. Facilitate sharing of experiences and promising practices among Member States through various channels including regional workshops, publications and other knowledge products.

2) Coordinate the work of the WHO regional offices with country offices and headquarters to ensure focused, relevant, practical and context-based approaches.

3) Build on the workshop, including incorporating multiple uses of the workshop to engage with health financing experts, and continue the collaboration in health financing between the WHO regional offices, WHO headquarters, the Asian Development Bank and the World Bank.
ANNEX 1

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<table>
<thead>
<tr>
<th>TIME</th>
<th>25 JUNE (MONDAY)</th>
<th>TIME</th>
<th>25 JUNE (TUESDAY)</th>
<th>TIME</th>
<th>27 JUNE (WEDNESDAY)</th>
<th>23 JUNE (THURSDAY)</th>
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<tbody>
<tr>
<td>08:30 - 09:00</td>
<td>Registration</td>
<td>09:00 - 10:00</td>
<td>1.1 Opening session</td>
<td>10:30 - 11:00</td>
<td>Group photo and coffee break</td>
<td>12:00 - 13:00</td>
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<tr>
<td>09:00 - 10:00</td>
<td>1.1 Opening session</td>
<td>09:30 - 10:30</td>
<td>2.1 Plenary discussion</td>
<td>11:00 - 12:00</td>
<td>1.2 Plenary discussion</td>
<td>13:30 - 14:15</td>
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<td>• Opening remarks</td>
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<td>• Health sector experience</td>
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<td></td>
<td>• Introduction of participants and facilitators</td>
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<td>• Experiences from SEAR and WPFR</td>
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<td>• Overview of workshop objectives</td>
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<td>• PFM in health financing and service delivery</td>
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<td>• PFM Financing and Utilization Trends in the Region</td>
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<td>10:00 - 10:30</td>
<td>Coffee break</td>
<td>10:30 - 11:30</td>
<td>2.2 Plenary discussion</td>
<td>11:30 - 12:30</td>
<td>3.2 Plenary discussion</td>
<td>15:30 - 16:15</td>
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<td>• Service delivery impact - China and Thailand</td>
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<td>12:00 - 13:00</td>
<td>Lunch</td>
<td>12:30 - 13:30</td>
<td>2.3 Panel discussion</td>
<td>13:30 - 14:30</td>
<td>3.4 Group work discussions and presentations</td>
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<td>• Performance monitoring frameworks of program-based budgeting</td>
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<td>15:30 - 16:30</td>
<td>4.1 Plenary discussion</td>
<td>16:00 - 17:00</td>
<td>1.5 Group work discussions and presentations</td>
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<td>14:15 - 15:00</td>
<td>1.4 Group work discussions</td>
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END OF WORKSHOP