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COUNTRY VISITS

(Report of the Sub-Committee of the Regional Committee on Programmes and Technical Cooperation, Part I)

The Sub-Committee of the Regional Committee on Programmes and Technical Cooperation met from 17 to 19 June 1996 to review and finalize the report on the country visits made by four of its members to New Zealand and Viet Nam within the framework of item (5) of its terms of reference, with regard to WHO's collaboration in the field of health systems reform. The attention of the Regional Committee is drawn to the findings and recommendations of the Sub-Committee presented in this document.

1. INTRODUCTION

The Sub-Committee of the Regional Committee on Programmes and Technical Cooperation held its eleventh meeting in Manila from 17 to 19 June 1996. The terms of reference of the Sub-Committee are set out in Annex 1.

A list of members attending the meeting is found in Annex 2.

The report to the Regional Committee is on the country visits made by four of the Sub-Committee's members to New Zealand from 4 to 7 June, and to Viet Nam from 10 to 14 June. It summarizes the Sub-Committee's observations, conclusions and recommendations. Dr Mohamad Taha Arif acted as Chairman and Dr Isamu J. Abraham acted as Rapporteur for the country visits. The visits were undertaken within the framework of item (5) of the terms of reference, with particular reference to WHO's collaboration in the field of district health systems.

The meeting was opened by Dr S.T. Han, Regional Director. Dr Isamu J. Abraham was elected Chairman of the meeting and Dr Mohamad Taha Arif and Mrs Annie Homasi as Rapporteurs.

2. REVIEW AND ANALYSIS OF WHO'S COLLABORATION WITH COUNTRIES: REPORT ON THE COUNTRY VISITS NEW ZEALAND AND VIET NAM

2.1 Perspectives and findings during the country visits

Within the framework of item (5) of its terms of reference, the Sub-Committee reviewed and analysed WHO's collaboration with Member States in the field of health systems reform.

In the course of reviewing the report of the members' visits, the Sub-Committee made a number of comments, suggestions, conclusions and recommendations, which are reflected in the final report of the country visits adopted by the Sub-Committee and presented as Annex 3 of this document.

Within the constraints of time and the availability of relevant information, the members reviewed examples of health systems reform implemented according to the principles defined by WHO.

The Sub-Committee noted some distinguishing features of the health systems reform in New Zealand and Viet Nam:

(1) The central government and ministries are playing a vital role in formulating a clear vision for health in the future and providing strong leadership to promote this vision throughout the health services as well as in the community.

(2) A key aspect of the reform measures is ensuring a more equitable and appropriate care available for all, according to need, within available resources.

(3) The reform measures are placing a stronger emphasis on improving quality of care. The initiatives involve equally the quality of a service, its appropriateness, and cost.

(4) Contemporary reforms in the health system emphasize consultation with both the providers of care and the community in order to make sure that the health technology available is properly used.

3. CONCLUSIONS

(1) Quality of health care is being improved in both countries. Efforts are being made to reorganize curative and primary health care services as part of the reform process. Through involving the community in health care provision and delivery, the health status of people is being improved.

(2) There is a need for government commitment to direct resources to improve the quality of health through reform. However, the targets of their efforts vary according to the health situations of these countries.

(3) There is a need to make changes in the allocation of resources for health promotion, for health education, and public health infrastructure development, to ensure equitable distribution of resources.

(4) Market mechanisms and privatization are two important elements of success in reforming the health system.

(5) Certain fundamental goals and objectives have been articulated for health service improvements through the reform process; documentation of these initiatives is important for promotion and evaluation.

4. RECOMMENDATIONS

Recommendations to Member States:

(1) Resources should be appropriately and equitably provided to cover health services at all levels.

(2) Efforts should be made at the international level to share information on countries' experiences in making use of resources and infrastructure to promote quality health services.

(3) An effective information system should be an integral part of monitoring the outcome and impact of reform.

(4) Countries should continue to promote their efforts to facilitate training, manpower development and licensing through coordination between various ministries such as health, education, planning, and finance.

Recommendations to WHO:

(1) WHO should continue to work closely with ministries of health in both countries to review, upgrade, and enhance health service policies that promote health systems reform.

(2) WHO, other international organizations and agencies, including nongovernmental organizations, bilateral and multilateral partners should facilitate and support an evaluation process of health care systems during their reform.

(3) WHO should facilitate visits of management-level personnel within the Region to learn how each country addresses health facility management, training of personnel, manpower development, and licensing standards.

(4) WHO should provide input through the approaches expressed in the document *New horizons in health* and in other technical working papers, to support health systems reform and implementation.

The Sub-Committee proposed that, subject to finalization of details at the time of the Regional Committee session in September 1996, the topic to be reviewed in 1997, in the context of item (5) of its terms of reference, should be new, emerging and re-emerging diseases. The Sub-Committee also proposed that Cambodia and either Papua New Guinea or Vanuatu should be visited in 1997, subject to the agreement of the governments concerned.

ANNEX 1

TERMS OF REFERENCE

The terms of reference for the Sub-Committee on Programmes and Technical Cooperation are as follows:

(1) To review, analyse and make recommendations on the development and implementation of the General Programme of Work as it affects the Western Pacific Region, especially in setting priorities and addressing policy issues.

(2) To examine and approve for submission to the Regional Committee the periodic regional reports on monitoring and evaluation of the regional strategy for health for all by the year 2000.

(3) To study and provide policy guidance on specific issues related to the health-for-all strategy which may be requested of them by the Regional Committee.

(4) To make recommendations to the Regional Committee on the action to be taken in the Western Pacific Region to develop national self-reliance in matters of health by fostering technical cooperation among countries or areas in the Region in ways that are relevant to the population.

(5) To undertake country visits to review and analyse the impact of WHO's cooperation with Member States and/or observe developments in relation to the implementation of the regional strategies for health for all.

ANNEX 2

LIST OF MEMBERS

CAMBODIA**	Dr Oum Sophal Director National Centre for Hygiene and Epidemiology Phnom Penh Cambodia
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**Members who undertook country visits to New Zealand (4-7 June) and Viet Nam (10-14 June) and attended the meeting in Manila (17-19 June).

Annex 2

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*Members who attended the meeting in Manila.

**Members who undertook country visits to New Zealand (4-7 June) and Viet Nam (10-14 June) and attended the meeting in Manila (17-19 June).

ANNEX 3

REPORT ON COUNTRY VISITS

1. INTRODUCTION

Members of the Sub-Committee visited New Zealand and Viet Nam from 4 to 15 June 1996. The purpose of the visits was to examine how New Zealand and Viet Nam use health systems reform as a strategy to achieve their health development, and to review and assess the role of WHO collaboration in support of the country's health system reform initiatives. Dr Mohamed Taha Arif was elected as Chairperson and Dr Isamu J. Abraham as rapporteur.

1.1 Role of the Sub-Committee

The Sub-Committee of the Regional Committee on Programmes and Technical Cooperation provides information, analysis and recommendations to the Regional Committee on technical aspects of health development in the Region. The terms of reference require the Sub-Committee, *inter alia*, to report on countries' progress towards achieving the health-for-all goals, to submit periodic regional reports, to provide guidance on the strategy as requested, to make recommendations, and to undertake country visits.

1.2 Health systems reform

The current phase of the health-for-all movement is popularly known as the era of health systems reform. The definition and language of reform are still developing. Health systems reform involves multidisciplinary efforts, unlike many of the previous eras which typically emphasized a single facet of health, for example health technology, financing, community participation or quality assurance. Reform involves using a group of measures to achieve a goal. The original principle and strategy of health for all was multidimensional in scope, while the practical interventions were focused on one dimension. This is a period of great challenge for health leaders; they will need to manage a multiplicity of factors in directing the health system to its desired goals.

Annex 3

The fundamental health goals for most countries have not changed significantly over the past two decades. There has, however, been improvement in the ability to articulate those goals, so that now most national health development goals include some of the following:

- improved equity of access to health care;
- a mechanism to contain the increasing cost of health care; or
- improvement in the quality of care.

The variety of health care systems in the Region is reflected in the diversity of reform initiatives. There have been many valuable lessons learned during the last two decades of health for all. More effective information sharing will allow use of the valuable lessons of the past.

These lessons include:

- the significant role that a central government must play in providing the vision for health;
- introduction of competition among providers;
- fostering a diversity of public and private providers in clinical services;
- selective use of user fees;
- the need to discourage third party reimbursements;
- mixed financing arrangements, from compulsory social insurance to general tax revenue; and
- the advantages of setting fixed budgets for hospitals or institutions by patients or case.

Most health systems around the world are dealing with the following issues:

- increasing the resource allocation to prevention and promotion activities;
- defining and providing a basic package of clinical services;
- understanding the link between the method of financing and the utilization of resources, quality of care and control of costs that result, and

Annex 3

– equity, targeting care to those most in need.

Each of these issues raises certain aspects of the current health system for consideration. These aspects must be addressed if the reform proposal is to have an impact.

Resource allocation: The distribution of the total health resources must be changed to reflect the priorities of disease prevention and health promotion. This has been an issue for 20 years. Now there is a clearer understanding that there are significant structural constraints, such as subsidies, medical practices and individual beliefs and behaviours, that persistently override normal resource allocation planning decisions. If fundamental influences in the health system's behaviour and culture are not addressed, change will be marginal.

Basic package of clinical services: The "package" concept refers to the assumption that the public resources, if not the total resources, spent on clinical care must be limited. It also refers to the better understanding of the limited effectiveness of most biological technology, particularly clinical and as to how difficult it is to assess success. Therefore, society needs to decide how much of the total resources for health are allocated to clinical care.

Links between financing and utilization of resources: Financing is now understood to be a complex multidimensional issue. Financing is not a matter of what money is available, but of where and how money is made available for care. This relationship varies from country to country. The negative impact of third party reimbursements, the limited value for user charges, and the low administrative cost of using a general revenue tax for health have been important lessons. Each method of financing has a significant political and social component. It is now apparent that the concerns of quality of care and the ability to control costs are significantly influenced by the method of financing and reimbursement. There is growing interest in structuring a harmonious mix of public and private health care services.

Equity: The fundamental structures and attitudes of the health system and society contribute to a country's ability to achieve equitable care on the basis of need. In the short term, some methods of targeting have improved system performance. However, these measures may not be influencing some of the underlying issues which, in the long-term, are the determining factors that will influence the sustainability of change.

Annex 3

1.3 WHO collaboration

WHO's collaboration with countries is normally in one or more of the following types of activities:

(1) strengthening of national capabilities (technical and managerial);

(2) transfer of appropriate information and technology;

(3) generation or mobilization of resources; or

(4) promotion of research and development.

WHO's direct involvement in any activity with the government will be in one or more of the following forms of cooperation: provision of technical staff and consultants, fellowships, local costs, meetings, research, contractual services and supplies and equipment.

2. NEW ZEALAND

2.1 Background

Members of the Sub-Committee visited New Zealand from 4 to 7 June 1996.

New Zealand is a country in the South Pacific with a population of 3.5 million people. The main ethnic group comprises people of European origin (80%), indigenous Maori origin (13%), Pacific island Polynesian origin (5%) and Asian origin (2%). The country has a total area of 269 062 square kilometres, and consists of two main islands, the North Island and the South Island.

New Zealand has a primary-product, export-based economy. It has a high per capita gross domestic product in 1995/1996 estimated at US$ 16 850. The total public funding for health is currently around 5.8% of gross national product. Total public funding for health and disability services in 1995/1996 was around US$ 3.6 billion, excluding the treatment and compensation of accidents.

Annex 3

2.1.1 Health status

Morbidity and mortality patterns are generally similar to those in other developed countries. Life expectancy at birth for males (72.9 years) and females (78.7 years) has improved. Over the past two decades Maori life expectancy has increased significantly and Maori infant mortality rates have continued to decline. However, Maori life expectancy and mortality rates are still worse than those of non-Maori. Lifestyle factors play an important part in explaining the Maori mortality rates. Obesity, cardiovascular disease and the complications of diabetes mellitus are particular problems for both Maori and Pacific islanders.

2.1.2 Health services

History:

Before 1938, government involvement in health care was minimal. Since 1938, the role of the state in health care has been much more comprehensive. The health care system has been largely publicly funded and New Zealanders have had universal access to care according to need. A radical reform in the health sector was implemented in 1993 following a succession of minor reforms in controlling and containing subsidized fee-for-services expenditure on health benefits in some areas.

Current health policy and strategy:

The Government is determined to direct its resources and policies at improving the health, well-being and independence of New Zealanders, and at getting the best health outcomes for every health dollar spent. It wants to help New Zealanders to stay well or, if they do fall ill or develop a disability, to get the treatment and support they need.

The aim of the health system is to provide choice for consumers of health care. Services are provided by a mix of publicly owned, privately owned and voluntary providers. Publicly owned hospitals provide most secondary medical care, while most primary care is provided by publicly-subsidized but privately-owned general practices. The extensive voluntary sector primarily provides community care. Private health insurance, despite its wide coverage (over 40% of families) accounts for only about 6.2% of total health expenditure.

Annex 3

The new structure established to implement the reforms is as follows:

- replacement of area health boards which had acted as purchasers and providers of both personal health services and public health services with:
  - four regional health authorities (RHAs) purchasing all personal health and disability support services and public health services;
  - 23 Crown health enterprises (CHEs), each centred on a major public hospital, as the new publicly owned providers;
  - a National Advisory Committee on Health and Disability Support Services which assesses the effectiveness and priority of health and disability support services and advises on which services should be publicly funded;
  - a Ministry of Health that provides overarching policy advice to the Government, negotiates with and monitors purchasers on the Government's behalf and administers public health regulations;
  - a separate monitoring agency to monitor CHEs for the Government's ownership interest.

2.2 Visits and findings

A number of facilities were visited in Wellington and Auckland.

2.3 WHO collaboration

Health systems reform in New Zealand has not required extensive WHO collaboration. However, WHO input like the *New horizons in health* document, which suggests new directions in public health, and the Healthy City initiatives were felt to have been very useful. The reform has drawn on the experiences of the health systems reform in the United Kingdom and the Netherlands.

Annex 3

2.4 Conclusions

(1) New Zealand health leaders have been able to create a vision, and articulate certain fundamental goals and objectives for health service improvement, through the reform process. These include:

- improved equity of access to health care;
- a mechanism to contain the increasing health care cost, and
- improved general quality of health care.

(2) The Government's attention to the priorities of disease prevention and promotion of health in addition to the current emphasis on clinical care is reflected in the budgetary allocations to these areas.

(3) Equity and quality assurance in health are fundamental to a country's ability to achieve good health for its people. Other underlying issues such as sociocultural factors which influence good health need to be considered.

(4) Holding consultations is a key strategy in allowing communities to influence health services to people. Quality of care is built into the health delivery system through intersectoral cooperation and efforts.

(5) Both the Government of New Zealand and the Ministry of Health are determined to direct resources and improve health through the reforms. This is to ensure the best outcome for the Government's financial resources for health care expenditure.

(6) There is a valuable role for WHO in the provision of technical cooperation, technical staff support, facilitation of an intercountry exchange programme and exchange of experiences of reform.

2.5 Recommendations

(1) The proportions of funds allocated to public health, clinical care and other special programmes in mental health, rehabilitation care, research and care for indigenous people should be reviewed in the light of the priorities of disease prevention and health promotion.

Annex 3

(2) The lessons learnt from the New Zealand model in the early stages of planning and initiating the reform process to increase its effectiveness should be made available to the Region. An evaluation process of the reform measures has not been instituted and would be valuable to other countries interested in this issue.

(3) The Region's leaders and decision-makers should make all efforts to secure community views in their future health systems reform initiatives.

(4) Effective information system and performance monitoring should be an integrated process to monitor the progress and the outcome of the reform. Deliberate attempts should be made at the international level, national level, and local level to effectively monitor health systems reform planning and implementation.

3. VIET NAM

3.1 Background

Members of the Sub-Committee visited Viet Nam from 10 to 15 June 1996.

The Socialist Republic of Viet Nam covers a total area of 331 114 square kilometres and lies along the western shore of the South China Sea, bordered by Cambodia, China and the Lao People's Democratic Republic. It is composed of 53 provinces and cities, which are divided into 558 districts and 10 173 communes. The total population was 75 509 500 inhabitants in 1994.

The population of Viet Nam belongs to 56 ethnic groups: among them the Kinh represent 85% of the population. About 80% of the total population live in the countryside.

In 1995, Viet Nam's per capita gross national product was US$ 220. The total public expenditure on health in 1995 was 3.6% of gross domestic product, and the health budget per capita in 1995 was about US$ 3.

Annex 3

3.1.1 Health status

Like other developing countries, communicable diseases and malnutrition still remain the main public health problems in Viet Nam. Among the leading causes of morbidity and mortality in Viet Nam are diarrhoeal diseases, acute respiratory infections, tuberculosis, dengue fever, and malaria. Accidents are increasing.

3.1.2 Health policy and strategy

There have been several revisions and additions to the health policy since 1988 as follows:

- Socialization and legislation of health care: The fifth Congress of the seventh National Assembly approved the health laws and regulations proposed by the Ministry of Health on 30 June 1988;

- Reorganization of curative care services with more participation by the private sector: Regulations were adopted governing the practice of the private sector on 29 April 1989;

- Change of public health practices: The introduction of new public health practices and concepts and working methods into various activities of the health sector;

- Increased equity in health care: Development of health insurance since 1992 and the establishment of a two-tier system of drug procurement (the subsidized and the market system).

3.1.3 Health system

There are four levels in the health system:

- National level: The Ministry of Health, including national institutes of specific disciplines, and national hospitals. The Ministry is responsible for health policy and strategy development, and the coordination of primary health care programmes and projects.

Annex 3

- Provincial level: Provincial Health Bureau, including provincial health centres (special disciplines) and general hospitals. They are responsible for the technical implementation of primary health care programmes in the provinces.

- District level: District health centres responsible for the coordination of primary health care activities. District hospitals and intercommunal polyclinics provide primary health care services.

- Commune level: Commune health stations are responsible for primary care and public health activities in the commune.

3.2 Visits and findings

A number of facilities were visited in Hanoi and Ho Chi Minh cities and in one province.

3.3 WHO collaboration

WHO has contributed much to the development of health in Viet Nam. The Ministry of Health officials recognized this contribution and were appreciative of WHO's consistent support. The WHO Representative's Office has been established in Hanoi for many years and has coordinated, overseen, and helped implement specific WHO-supported programmes in the country. Visits by consultants or WHO staff are requested from time to time to support the implementation of the selected programmes. Under the programme of cooperation worked out between the Government and WHO, the following were carried out:

(a) Training of human resources for health: through the visits of short-term consultants, fellowships, local and intercountry training courses.

(b) Supplies and equipment: Provision of medical equipment to specific health programmes. WHO support will be needed for development of health information systems and computerization in the future.

(c) Community health programmes and projects: primary health care, malaria control, leprosy control, the expanded programme on immunization and poliomyelitis

eradication campaign, elimination of iodine deficiency disorders (goitre control), control of diarrhoeal diseases and others. WHO has contributed to the formulation of policy guidelines, management and implementation of such programmes.

In addition, WHO has also initiated linkages to extrabudgetary partners such as intergovernmental agencies and nongovernmental organizations (NGOs) from other countries. The cooperation and support from these have been very useful in specific health programmes.

WHO has contributed to the development of technical guidelines for malaria case management. The Malaria Department in Viet Nam has made significant progress in research on malaria treatment using Artemisinin.

3.4 Conclusions

(1) Under the leadership of the Government, health services and health promotion are regarded as priority issues under the reform process.

(2) The objectives of the reform in Viet Nam took into account WHO's efforts under the health-for-all strategy to secure equity of access, and to improve quality and efficiency of health care in Viet Nam. The transition to reform is being addressed in phases.

(3) Positive elements of reform included: a policy to promote private sector participation in health care; regulation of pharmaceutical sales; user fee and insurance development; and rationalization of the pharmaceutical industry as an aspect of health care financing.

(4) The reorganization of curative care and primary care services has improved to a certain extent in Viet Nam. Increased community participation resulted from the efforts under the reform to involve the community in health care delivery.

(5) The compulsory insurance plan which was implemented in 1992 is experiencing several drawbacks which continue to pose challenges for the health system.

(6) Infectious diseases such as malaria continue to be a major health threat to Viet Nam. The health system is in need of technical and financial support to contain this threat.

Annex 3

(7) Through several policies implemented during 1989-1992, the Ministry of Health has been able to make major changes in its training efforts to promote primary health care at the provincial, district, and communal levels.

(8) International organizations or agencies such as WHO, UNICEF and various nongovernmental organizations, donor countries, bilateral and multilateral agencies have supported several of the country's health programmes (e.g. the expanded programme on immunization, malaria control and nutrition programmes) that have directly supported primary health care at provincial, district and community levels. The encouragement of the Government of Viet Nam has been important in these collaborative endeavours.

3.5 Recommendations

(1) Training should be integrated with the work of other ministries such as education, planning and finance. The Government should consolidate its efforts and involve the different ministries in training, qualification evaluation, database sharing, and accreditation of health professionals in the country.

(2) There should be increased community participation in health care delivery under the reform.

(3) The Ministry of Health should seek to make adequate investments in human and material resources as noted in the report, for example, Cho Ray Hospital should continue to be upgraded to serve as a referral facility, centre of excellence, and as a training institution for students and professionals of the country.

(4) Technical and financial support from agencies such as WHO should be requested to support operational research and help to contain the threat of disease.

Annex 3

4. ACKNOWLEDGMENTS

The members of the Sub-Committee wish to acknowledge with heartfelt sincerity the hospitality and great assistance rendered to them by the Governments and the peoples of New Zealand and Viet Nam.