Health and finance ministers and high-level officials from 27 countries came together with development partners for a two day roundtable convened by the World Health Organization (WHO) and the World Bank. In her opening remarks, the WHO Director-General (DG), Dr Margaret Chan, emphasised that interest in and support for Universal Health Coverage (UHC) is gaining momentum not only in ministries of health. She noted that the recent adoption of a UN General Assembly resolution on UHC placed the goal of moving closer to UHC high on the development agenda as well. Country demand for support has increased, with over 70 countries requesting WHO technical assistance to help them move towards UHC in the last year. Tamar Manuelyan Atinc, World Bank (WB) Vice President for Human Development, reported strong interest in UHC in developing countries, with more than 30 middle-income countries implementing programs that should push them down the road toward UHC, and many more low- and middle-income countries considering similar programs. The World Bank is working closely with countries on the path to achieving UHC, by helping them build healthier, more equitable societies, as well as improve their fiscal performance and country competitiveness – towards the goals of ending extreme poverty and boosting shared prosperity.

The main message in the opening session was that the core idea of UHC, that everyone should have access to good quality health care without incurring financial hardship, offers a way forward for all countries. It was also noted that UHC is as much a journey as a destination, and that all countries start that journey from a different place and face different challenges along the way. However, despite the different challenges faced, the experiences of the many countries that are moving towards UHC indicate that some form of prepayment and pooling of resources, coupled with an emphasis on primary health care and broader health system development, are integral ingredients of successful transitions. The DG ended the opening session by stressing that simply raising more money for health does not guarantee sustainable systems designed to deliver UHC; efficient use of resources and control of costs is also essential.

Roundtable 1 focused on individual countries’ experiences with undertaking financing reforms to progress towards UHC. A range of approaches to funding the extension of health care coverage were discussed, from setting aside a part of the state budget, to raising extra money through earmarked value-added taxes, or through ‘sin taxes’, to setting up the necessary institutional framework to support prepayment and pooling of financial resources. It was clear that one of the biggest challenges faced by low- and middle-income countries is ensuring coverage with health services and financial risk protection for the poor and the informal sector. The experience of many countries is that it is difficult to raise insurance premiums from the informal sector and the poor are generally unable to contribute financially, so general government revenues have had to be used to ensure that these people can obtain the health services they need without the risk of financial ruin. Various strategies were described including the use of government revenues to ensure access to free or subsidized health services, or to pay the health insurance contributions for these groups of people.

Some countries described how they have sought to expand coverage to the informal sector through voluntary health insurance schemes, sometimes combined with government subsidies. However, it
was noted that these approaches create or reinforce fragmentation in funding where separate schemes exist for the formal sector or civil servants while the problem of the poor being unable to contribute sufficient funds to make these schemes viable remains. This raised broader issues regarded as important for towards UHC – e.g. social cohesion and social attitudes to solidarity, which are considered critical, as is political leadership from the highest levels of government.

There was broad recognition of the fact that extending coverage to the poor and vulnerable in many countries will require an increase in health expenditure. Options for raising more funds for health were described drawing on the experiences of Laos, Ghana and the Philippines. Laos has collected revenue for health from royalties, taxes and dividends from operations in the hydropower and mining sectors. Total revenue has risen from 12.5 percent of GDP in 2006 to a projected 17.3 percent of GDP in 2012 with a portion going to health. Ghana has also similarly increased its value-added tax rate by 2.5 percent with the additional revenue going to its national health insurance scheme. New taxes on alcohol and tobacco have been introduced in the Philippines with the proceeds specified to fund the expansion of health insurance to the poor. This option was made politically feasible by presenting sin taxes as a ‘win-win’ formula in which unhealthy behaviours are discouraged while money is raised to fund the health system. The ministry of finance was also influenced by arguments about the costs that would be incurred by the health system if these unhealthy behaviours were not reduced.

Several participants stressed in particular the importance of cooperation between health and finance ministries, a recurring theme throughout the two days of discussion. Representatives from finance ministries stressed the importance of getting the most out of the resources allocated. Achieving UHC is not simply a question of raising more money for health, but also of reducing waste and allocating resources effectively. The discussion of optimal resource use was also linked to a discussion of quality of care, where the need for the right incentives to improve quality was generally recognized as critical given that efforts in extending coverage can be undermined if the care provided is so poor that it discourages people from seeking care. This raised issues of health system strengthening notably with regard to human resources, an issue that was taken up later in the afternoon.

Ensuring resources for a wider mix of health services beyond hospital-based curative care, and notably for prevention and promotion, was highlighted both as a way of getting more health for the money but also as an important recognition of the social determinants of health. The increasing burden of non-communicable disease (NCD) and demographic ageing means there is a need to address the causes of illness (and wellness) that fall within the scope of ministries other than health, such as the ministries of education, transport and environment.

In the afternoon, roundtable 2 focused on the way countries balance the pursuit of multiple goals such as increasing population and service coverage, while trying also to expand coverage against financial risk. It was clear that it is not only important to find the appropriate balance, but to communicate to the population what they are covered for in terms of services and costs. The countries that seem to do best in this regard put considerable emphasis on transparency, notably by using health impact indicators to show where the system is working, and, just as importantly, where it is not, where it is under strain, where it can be improved.

Several participants noted the importance of making sound promises to their citizens for the provision of affordable quality health services, but noted the challenges of prioritising in the face of scarce resources. Countries also noted the importance of informing their citizens of their rights. Chile, for example, not only makes an explicit promise to provide diagnosis and treatment but provides a claims system for people who feel that a promise has not been kept.
How each country defines the set of health services that it intends to cover reflects its particular epidemiological and demographic context as well as other system constraints or goals, another reason why UHC has to be tailor-made and cannot be applied on a one-size-fits-all basis. Furthermore, in decentralised states, such as Mexico, where different regions have different health needs, this has implications for resource allocation. The DG of WHO pointed out that to understand these different needs, it is vital to listen to the local communities, and to make adjustments accordingly. In addition, when designing the set of services to which people will be entitled and the costs they will be asked to bear, as well as thinking about how to expand services over time as more resources become available, ministers and ministry officials need to seek the inputs of all stakeholders, while recognising that each may have vested interests that need to be aligned or balance with the needs of the population.

There was general agreement that for promises to translate into actions with long term effects, they have to be backed by sustainable funding, which brought the discussion back to the importance of the relationship between the ministries of health and finance. It appeared that many countries are making efforts to improve the dialogue between the two ministries and the ministerial-level participation at this meeting from both sectors was encouraging. Some participants talked about building partnerships such that “the two ministries now dance together”. While it is clear that interpersonal relationships are an important factor, others talked about demonstrating good use of resources with arguments to use the money “wisely not wildly”. The World Bank VP emphasized that by presenting health as an integral part of an overall development agenda, in which better health, especially when supported by better education, and gender equality, feeds into increased economic output, which in turn feeds into better health.

The final session of the day was devoted to a discussion of the importance of health system strengthening to ensure that the health services provided are widely available and of good quality. Health financing modifications by themselves will be insufficient. Developing sufficient, well trained and motivated human resources for health, located in the right places, was cited as one of the most important issues, and some representatives, including the Minister of Health from Zambia, called it priority number one in developing a health system capable of delivering UHC.

Developing and strengthening human resources for health is clearly essential for the delivery of good quality health care, but also to improve overall efficiency in health system performance. It was evident that for many low- and middle-income countries the main challenge with regard to human resources is training and retaining staff. The Minister of Health from Sierra Leone, for example, said that her country has just one school and has to send people abroad in order to get training, while importing doctors and nurses from Cuba and Nigeria in order to meet capacity requirements. Other countries reported a surplus of training capacity. The Minister of Health from Egypt, for example, talked about producing 10 000 doctors a year, half of whom leave the country in order to look for work in countries paying higher salaries.

Overall, the low- and middle-income participants reported a dearth of adequately trained and motivated doctors and nurses, and there is a clear need for solidarity at inter-country, regional and global levels to address the problem. The Japanese representative said that his country has committed to training and upgrading 100 000 health workers for Africa, but on the whole the perception among the participants was that a ‘brain drain’ situation prevails in which the already limited number of health workers in developing countries often migrate to high-income countries in search of better wages. The WHO Global Code of Practice on the International Recruitment of Health Personnel was developed in order to establish principles and practices that would minimise such destabilising effects.
of health personnel migration on a country’s health system but agreement on its application has been
difficult to reach.

The moderator noted that at the core of the health personnel migration issue is the incentive of
trained health professionals to move. Education is an important form of empowerment, and countries
clearly struggle not only to retain doctors and nurses within their systems, but to make sure that they
go where they are needed inside the country that has trained them. Brazil’s representative presented
the typical case, saying that trying to get doctors to go to and then stay in remote rural areas to
which they are assigned is difficult. Various solutions to this problem were discussed, including
financial incentives such as special geographical allowances, but also incentives related to job
satisfaction such as multi-skill training, and task shifting. The moderator pointed out that ‘freedom’ or
professional autonomy was also a great motivator for doctors working in remote rural areas in
Thailand, and that the MOH did what it could to promote it. He also emphasized the importance of
training doctors with ‘heart’, that is to say a fundamental commitment to the communities they serve,
and pointed out that the MOH trains staff in Thai to make the doctors with less heart less easily
exportable. It is also perhaps worth pointing out that doctors and nurses in Thailand make a
contractual commitment to a fixed term of service in rural areas when enrolling for medical education.

Another key focus of the later afternoon discussion was the importance of reducing inefficiencies
associated with resource wastage. The discussion started with the need to optimize procurement
practices and the role of strategic purchasing and contracting and economies of scale. Other issues
discussed included the costs of procuring medicines and irrational use of medicines. The experience of
using health technology assessment to guide decisions over the appropriate use of new technologies
was presented, with particular reference to Thailand’s Health Intervention and Technology
Assessment Program (HITAP).

Discussion on the role of the private sector and of public/private partnerships in delivering the health
services (prevention, promotion, treatment, rehabilitation and palliation) promised as countries move
closer to UHC elicited a wide range of experience in the room from countries where the private sector
played a dominant role in service delivery to countries where reliance on or engagement with this
sector was minimal. The DG commented that experience shows that both the public and private
sectors have weaknesses and strengths, the public sector enjoying greater trust while the private
sector, in some settings, performing more efficiently. Critically the government needs to play a
stewardship role, to ensure the efficient provision of quality health services (e.g. through setting and
regulating national fee schedules).

The first session of day two focused on the need to monitor and evaluate progress towards UHC in
order to ensure progress and to promote accountability at the national and global levels. The
moderator identified several key issues, the first of which was how to measure progress towards UHC
and ultimately how to assess the health impact (e.g. linkages between population health and
expansions in coverage). Choosing the most suitable indicators of performance is challenging because
UHC is multi-faceted and complex, while monitoring and evaluation (M&E) works best when the
results generated can be interpreted and presented simply. The World Bank VP reflected on the
importance of developing indicators and transparency in monitoring towards better accountability.

It was clear that for a number of countries, gathering robust data is a challenge in the context of
weak health management information systems (HMIS). However several countries were able to offer
experiences that demonstrate the possibility of implementing HMIS in resource-constrained settings.
Nepal, for example, offered insights into the challenges of running a paper-based HMIS in a country
with thousands of health facilities scattered over what is often extremely difficult terrain. Despite the
dependency on paper, Nepal manages to centralize information gathered at the local facility level, and conducts regular reviews of this information as well as producing an annual report that is used in formulating policy. The Ghana representatives described how, with the support of development partners, the country has been able to develop the ICT capacity to collect data which is used to inform policy.

Several participants noted that M&E plays an important part in providing evidence for understanding how existing systems can be improved. The Minister of Health for Thailand, for example, pointed out that effective M&E serves not only to measure progress, but to promote sustainability of the system by allowing for continuous revision and streamlining to ensure greater efficiency. He also underlined the value of M&E as a tool for managing expectations, informing the public of established targets and goals. A sound evidence base and objective interpretation of data was also cited as an important part of encouraging accountability, an area where civil society has an important part to play.

The discussion then turned to ways to make UHC monitoring resonate as part of an international development agenda, for example by making progress towards UHC one of the post-2015 development goals, an idea for which there appeared to be wide support. It was acknowledged that careful thought would have to go into how a UHC goal would be formulated to include both aspects of financial risk protection and access to quality health services covering an appropriate mix of prevention, promotion, treatment, rehabilitation and palliative care. However, it was also agreed that an umbrella goal such as UHC would allow countries to pursue the unfinished agenda of the health-related MDGs as well as attack the increasing problems associated with non-communicable diseases and injuries. In response to country demand, WHO and the World Bank are developing a monitoring framework to support countries in tracking their progress toward the goal of UHC.

The last discussion of the second day focused on what development partners (DP) are doing to support the UHC processes, and returned to the issue of the proposal of UHC as a major goal for the post-2015 development agenda. Participants included representatives from the Rockefeller Foundation, the UK Department for International Development (DFID), Germany (representing the Ministries of Health and Development Cooperation), and Save the Children UK. The picture that emerged from the discussion was of an international development landscape that is beginning to reflect the importance of UHC as a development objective. The Rockefeller Foundation is focusing efforts on putting UHC on the international agenda and acknowledged the transition from the relatively recent focus/action on communicable diseases to a broader focus on how health systems are organised and financed. Save the Children UK stressed the value of working within the framework of a UHC agenda as a way of including an important focus on single health issues such as the health of children, but doing it in a way that captures broader dimensions such as equity and human rights.

With regard to UHC as a post-2015 development goal, some participants felt that the UHC concept (the right to be able to use good quality health services when needed at an affordable price) is well understood by the general population.

Several participants noted that civil society organizations (CSOs) could play a bigger role in promoting and explaining what UHC means. It was clear from the discussion that DPs can do more to align their support with the needs of aid recipients, along the lines of the IHP+. The representative from the African Development Bank (AfDB), for example, said that support needs to be based on country experiences and has to fit in with country processes and priorities. It was also noted the organizations that are partners in the Providing for Health (P4H) network apply these principles by working in a collaborative fashion to support countries seeking technical and policy support to move closer to UHC.
Discussion from the floor stressed the importance of countries sharing experiences and offering support to each other. The realisation that developing countries themselves are development partners too, was a view echoed by many. In particular, the Thailand representative pointed out that there are already a plethora of networks working on UHC at the global and regional level, and that their work could be supported by DPs giving the right advice while remembering that there are no one-size-fits-all UHC solutions. He added that it was crucial for DPs to support capacity building over the long term to help countries achieve UHC, noting that in his experience investment in the right institution at the right time can have a massive impact.

In her concluding remarks, the WB VP reaffirmed the importance of UHC and stated that the main challenges for the future were how to expand coverage to the informal sector and to the poor, while achieving depth of coverage (covering a higher proportion of the costs), and improving the quality of services. With regard to finance, she stressed the principle that nobody should be excluded, which will mean that whether or not a country adopts a system of prepayment and pooling there will also be a need for subsidy which will mean committing more public resources. She then called on the participants from health ministries to do more to advocate for health, while supporting health in all policies by engaging colleagues in other sectors. Finally, she called for the development of M&E capacity, to be able to assess progress, but also to arrive at a core set of indicators for UHC that can feed into the push to make UHC one of the important health goals in the post-2015 development agenda. Wrapping up the meeting, the WHO DG said she was encouraged to see so many ministers of health and finance in the same room. She stressed the need to find ways to facilitate experience-sharing among countries, and reminded the participants that UHC must be home-grown and based on capacity building and self-reliance, along the principles of the IHP+. Finally she called for guidance on how to measure progress towards UHC, as clear indicators of progress will be needed to stay focused and ensure progress towards UHC in the future.