1. Opening remarks and confirmation of agenda

The P4H CD moderated the meeting. After the introduction of the participants the members confirmed the proposed agenda (see annex 1) and added the review of the "P4H Intranet terms of use" as requested by the SG members during their meeting on 3rd June.

All P4H members at TCG level were represented except for AfDB and AECID, who sent their apologies (see annex 2 for list of participants).

2. Recap of main SG discussion points and decisions

- **P4H Annual Report 2013/2014:** All SG members appreciated the draft annual report as a very useful document, which should be shared with a broader audience. Decision taken: CD to revise the content according to member's comments and circulate it for final approval, then publish the report on the website and disseminate it within and outside the Network. During the discussion, it was reminded that a P4H activity is about open information sharing and catalyzing the involvement of at least one more, however preferably all members, while no P4H member objects to this activity.
- **GFATM thematic collaboration:** The GFATM application for thematic collaboration has been approved. A small group (WHO, FRA, GER for P4H) will draft a concept note and work on common TOR.
- **UHC:** A new Leadership Development Programme (LDP) for UHC being developed by GIZ and the World Bank Institute (WBI) was presented, the group appreciated the piloting and would like to see this initiative being open for contributions from other members. This was followed by information exchange about investments in UHC by the members, updates on UHC measurement and UHC/SPF in the post 2015 agenda. WHO, ILO, WB, SDC BMZ, and USAID repeated the key messages already expressed during the P4H SG meeting held the previous day (see Annex 3).
- **Miscellaneous:** Next P4H network SG and global TCG meetings to be held in Germany in 2015.

3. Country feedback: voluntary and mandatory health insurance in national health financing strategies

The common messages of all presentations were the following:

- In terms of current situation analysis of CBHI schemes, the observed characteristics are: the very limited (and sometimes decreasing) population coverage, the very limited pooling and financial control, the diversity of benefit packages but also their strong lobbying power and positioning in the respective health financing policies, especially to reach the informal sector.
- The development of CBHI cannot be considered as a systematic approach, universality requires mandatory enrolment and subsidies. The classic/usual CBHI model has a very limited role and future in the national social health protection systems.
- The emergence in West and East Africa of a quasi-mandatory "government driven modified CBHI model" should be better documented and analysed as well as their

potential role in the "governance and decentralized functions" of larger national demand side health financing mechanisms.

Discussion:

WHO/HQ indicated its satisfaction on having discussions about content during the TCG meeting. It first stressed the importance on having clear definitions and conceptual distinctions like the one between voluntary and mandatory coverage. Private mandatory is not all bad. Compulsory sources (e.g. taxation) are key for UHC progress in most low-income countries but there are limitations in pooling that in supply line items; local accountability is a separate issue.

The main message for WHO is that CBHI has not worked anywhere (only in special cases like China, where 80% is subsidised or Rwanda). Voluntary coverage is against the physics of health financing: markets don't function well in the health sector. From this point of view, the sentence "the regional organization UEMOA dictates" is interesting: where did this come from? We can also observe that the merging of CBHI in a single pool is not happening anywhere. And if the governments have the intention to make CBHI mandatory, how would this be done? More generally, why are we still talking about CBHI while boosting public finance should be our focus.

Nevertheless, from the "capacity for UHC" point of view, CBHI can be a foundation for future development (like building the purchasing function; affiliation is not the only function to consider).

WHO/IST noted that CBHI needs community involvement; it can improve the targeting of the poor to tap the full potential of models (who are the poor, where are they?); we should not just drop models, as there are lots of specifics to be considered. Especially for a critical UHC issue: the implementation.

SDC agreed with WHO/HQ in theory about CBHI but considered that the most important question is why do people create CBHI? If one asks the people, the answers will be the lack of trust in government schemes (social accountability) and the missing quality of care. This is a global challenge and P4H is a good platform to get deeper in analysing this issue; we should also try to look at the roles of other players beyond the government.

GIZ/HQ noted the striking similarity of East and West Africa: the need for professionalization; the community involvement that comes through accountability; the ability to innovate on the delivery side (as government is much slower). It agreed with SDC that distrust in government is an important driver for CBHI.

GIZ/Cambodia noted that utilisation in CBHI is much higher than in other schemes; WHO/HQ replied that this is probably due to adverse selection.

GIZ/Tanzania pointed towards the question of what will happen to the existing schemes: it is important to include this aspect in the national health financing strategies.

4. Country feedback: universal health coverage and general social protection policies in national development

The main issues mentioned by the presenters were the following:

- The existence of conflicting streams between social protection (SP) groups and UHC groups (the willingness to create specific schemes for the poor or for the children in SP groups versus the willingness to increase pooling of funds through merging of specific schemes in UHC groups)
- The SP and UHC groups ignore each other at institutional level and this is sometimes reinforced by the various development partners involved that work against each other
- The lack of implementation of adopted national social protection policies
- How to do better in terms of collaboration across sectors (in particular how to involve MoF in both SP and UHC), of better governance, analysis and South-South activities
- More dialogue is needed between SP/SHP stakeholders

ILO/HQ noted that the presentations omitted to define key terminology such as coverage, social protection and UHC. In fact, the overall objective of health protection is universal coverage as outlined in ILO Recommendation 202 on national social protection floors. The differences noted in the presentations relate to financing mechanisms such as tax and contribution financing, that are all part of social protection when striving towards UHC. In reality countries frequently mix all available mechanisms, involving even high OOP, in order to increase overall funds for health.

[The P4H CD added that even if we have an agreement in this room, the realities in the countries might be different].

ILO and WHO should increase cooperation to provide information on pros and cons of the various financing mechanisms.

WHO/HQ explained that the presentations bring more clarity about the different perspectives in countries; that everyone is well motivated, but it still doesn't add up. This issue is less conceptual, more of a policy dialogue problem, also how countries are organized; so the question remains how to deal with the contradictions, inefficiencies and lost opportunities. There seems to be need for some short term institutional arrangement (e.g. like the National Social Security Council [DJSN] in Indonesia as noted by the P4H CD).

SDC pointed to the fact that SP and UHC are also often dealt with by separate units in our own organizations; how could the P4H group deal with this? (e.g. how to make this work in Mozambique?)

GIZ/HQ noted that it is important to cut the hedges and build up trust among the different stakeholders. There are opportunities for synergies, e.g. the health sector doesn't have to do the targeting of the poor or collecting contributions. The P4H network can play an important role in clarifying roles and responsibilities of various actors/stakeholders.

P4H CD added that we also need incentives and encouragement for coherence across sectors; we need to create, document and share “good practices” examples.

5. Country updates and review

WHO/HQ updated the group about:

- The on-going EU/WHO partnership on policy dialogue for UHC. Luxembourg joined this partnership in 2013 and many countries have been added thanks to the additional funding provided. The list of countries can be circulated upon request;
- Korea as well has decided to provide funding to WHO. The first activity carried out with this support is the HF for UHC advanced training that will take place this month in Tunis. Country support is planned for Tanzania, Lao PDR and Myanmar so far.

ILO/HQ updated the group about:

- The roll out of several SHP courses in Turin during the coming months. Inputs from other P4H members are welcome;
- The involvement of ILO in the upcoming Global Forum on human resources for health (HRH) and the expected "Global strategy for the health workforce";
- Roll out of the health pillar of the SPF in Myanmar, Zambia, Niger, Mali, Ecuador, and Senegal in cooperation with local WHO and other P4H partners.

WB/HQ updated the group about:

- The roll out of "country diagnosis" and the drafting of new "country partnership strategies" for both health and social protection sectors;
- The need to regularly get a list of actionable items from the P4H CD

AFD/HQ updated the group about:

- The current definition and implementation of the I3S projects in Niger, Senegal, Burkina and Chad (combined with Muskoka funding in this country) and the coordinated approach with the other P4H+ members;
- The support provided to Colombia in the area of SHP, both financially and technically in partnership with GIP-SPSI;
- New demands coming from emerging countries like Mexico;
- The internal AFD discussions on a potential social protection policy as the 3rd pillar of sustainable development and the links with the C2D (Contrat Désendettement et Développement, a French debt relief program) processes in recipient countries.

GIP-SPSI updated the group about:

- The annual GIP-SPSI event planned for the week of 8 December 2014, with a focus on the links between general SP policies and UHC;
- The support provided to Senegal, in collaboration with AFD on the formal sector health insurance and with ILO on the informal groups;
- A request for support from the CNaPS (Caisse Nationale de Prévoyance Sociale) in Madagascar;
- Requests for support from the Tunisia National Health Insurance Fund (mission planned in Sept/Oct 2014) and the Morocco NHIF;
- The support to Cameroon on sustainable funding for HIV/AIDS related expenditures.

GIZ/HQ updated the group about:

- The current world map of GIZ support through the GIZ-P4H project (managing the BMZ and SDC contribution to P4H);
- The elaboration and testing of the "UHC capacity development needs assessment tool";

- The internal evaluation of the GIZ-P4H project's contribution to P4H over the past 3 years (second phase) in preparation for a new phase starting in Feb 2015;
- GIZ would be happy to arrange a tel- or video conference to discuss the results of the internal evaluation.

USAID updated the group about:
- Their interest for P4H collaboration in Myanmar;
- The need for exchanges about Malawi as they are getting conflicting information.

6. P4H monitoring and evaluation

As an introduction to the M&E session, the P4H CD reminded the group about the P4H network M&E table adopted in May 2013 (see annex 5); however only few of the M&E tables have been filled out so far (e.g. Benin and Kenya by the CD, Tanzania by the country advisor/coordinator, all accessible on the P4H intranet); hence the suggestion that this should be discussed and carried out as a joint activities of the TCG.

Discussion:

SDC/HQ proposed that each P4H member could organize its own feedback but that one P4H member should be the M&E leader for a specific country. M&E is of particular importance for SDC because of the accountability to Swiss taxpayers and in order to feed the P4H annual report.

GIZ/HQ wondered if the group would have to write 3 lines or 3 pages per indicator. The consensus of the group was to try to remain rather short in the descriptive parts.

WHO/IST anticipated the difficulty to agree on the indicators notwithstanding their frequent and rapid changes. As a complement to the Swiss proposal, another way could have been: one DP would be in charge of M&E and 2 others would be reviewing. Nevertheless, the countries would be better placed to fill some of the indicators themselves (alignment and harmonization).

WHO/HQ thought that the P4H country level should do this but that it might be difficult without support.

P4H CD agreed with WHO/IST that constant M&E would be needed, that we should use the P4H intranet for this and keep the different M&E (dated) tables over time.

GIZ/Tanzania explained that the P4H local group in Tanzania could do this without major difficulties and that, as mentioned by WHO/IST, some questions could be directly asked to relevant country officials.

WB/HQ and ***GIZ/HQ*** added that the P4H CD could then circulate the filled M&E tables to the regional and global levels for additional comments.

WHO/IST concluded that the designated lead DP should do the M&E activity in a participative way with the others, including the P4H+ members.

Decision taken:
The P4H country M&E tables should be filled according to the following principles: one P4H member is designated to lead the M&E process in each country; all DPs should be consulted; DPs participate in this task in a flexible way, according to their capacity and internal setup; P4H CD will accompany the country groups as resource persons and regularly provide lessons learned from the other countries; draft country M&E tables should be available by October 2014.

The lead partners were designated as follows: SDC for Benin; WHO for Burkina; WB for Burundi; GIZ for Cambodia; SDC for Chad; AFD for Colombia; WHO for Haiti; GIZ (tbc) for Kenya; AFD for Mali; SDC for Mozambique; USAID for Myanmar; WB (tbc) for Nepal; ILO for Niger; AFD for Senegal; GIZ/SDC for Tanzania; WHO for Togo; WHO for Uganda and CHAI (tbc) for Zambia. More consultations are needed for the missing countries.

7. P4H communication

The P4H CD informed the group that the P4H Intranet was launched during the last quarter of 2013. The P4H Intranet was accessed live on the screen during the meeting and a quick presentation of the main areas and functions (including the utilization monitoring tool) was provided.

After the demo, the P4H CD explained that we are still in phase 1 of the P4H Intranet project. Initially (during the first weeks), only the P4H CD had editing rights. After a while, editing rights were given to the local/regional P4H coordinators to feed their respective country pages. And a few days before the meeting, the notification system was introduced.

At the time of the meeting, the utilization data were showing a clear increase in the use of the P4H intranet after the introduction of the notification system. Overall, around 400 out of the registered 550 users viewed P4H Intranet pages.

The P4H CD concluded by explaining that a phase 2 was under preparation: editing rights would be given to most of the users and interactive/communication applications would become available.

Decision taken:
The TCG agreed with the proposed phase 2 of the P4H intranet.

The TCG agreed to give the Focal Points until end of June to comment on the proposed "Terms of Use" of the P4H intranet (annex 6).

8. P4H joint activities at global level

First, WHO/HQ updated the group about the UHC Interactive Guide (see annex 7). The expected outputs are the following:

- Conceptualization of online UHC knowledge resource guide;

- Systematic overview and structuring of web-based resources on UHC;
- IT platform capable to support and maintain (via P4H webpage);
- Support events (meeting follow-up, e-learning);
- Training (flagship courses and training materials, WBI-WHO).

The possibility to organize in 2015 a global P4H technical exchange event (bilingual) was then discussed by the group. WB and USAID asked to collaborate with JLN and other networks if possible. USAID mentioned the fact that the next PMAC would focus on equity in UHC. SDC added that it would be important to agree on technical exchanges with well-defined topics, not only on policy aspects.

9. Miscellaneous

Next TCG meeting: if there was a critical mass of FPs attending the PMAC and/or Cape Town meeting, we could plan for an informal TCG and possibly involve the others by phone/video (it was suggested to have it either in the local WB or WHO office where video facility would be available); the next regular TCG meeting would take place after the SG meeting around the G7 in Germany in 2015.

Global P4H technical exchange event: there is a need to develop a 1-pager which outlines the idea and discuss it with the TCG; the timeframe would be either in 2015 or 2016.