P4H Social Health Protection Network

Annual Report

for the period

May 2012 - April 2013

P4H Social Health Protection Network

2012/13 Annual Report

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Executive Summary

2012/13 saw increased demand for support as countries begin to get to grips with universal health coverage and recognize the size and complexity of the challenge faced. A number of factors seem to be driving increased interest in UHC/SHP, notable among them increased prosperity in those countries benefiting from globalisation. This has put UHC/SHP on the radar of governments that might previously have considered it an unaffordable luxury, and has also made UHC/SHP a key factor in a number of elections.

Five more countries approached P4H partners for support in developing a UHC/SHP agenda in 2012/2013, bringing the total number now working with the network to 23. Each of these countries struggles with its own issues, but the basic building blocks for a successful transition to UHC/SHP are invariable, starting with effective, equitable and sustainable financing. Much of the work done by P4H in 2012/13 has focused on the development of national health financing strategies that are based on the realities of what countries can afford, and are in line with social and economic development objectives.

Countries seeking to embrace UHC/SHP have never been more eager to learn, and there was a significant increase in demand for P4H-organised educational events in the form of workshops, seminars and conferences. The P4H network sponsored, organized, or otherwise facilitated more than 20 such events in the past twelve months. Much of the educational work done by P4H partners last year was directed at clarifying the funding issues countries face, but the network also offered support with country-specific studies, technical support to help countries establish national health accounts, and capacity development and support that has included assigning countries international advisers on health financing policy.

Lack of resources, financial and otherwise, remains one of the main obstacles to moving forward on UHC/SHP. For countries struggling to find the resources to begin implementation of UHC/SHP policies, the P4H network has been able help co-ordinate the support offered by development partners using the inform and involve principle to bring support in line with need, notably in Benin, Burkina-Faso, Chad, Côte d'Ivoire, Kenya, Mali, Rwanda, Senegal, Tanzania and Zambia in Africa, and in Bangladesh, Cambodia, India, Indonesia, Mongolia, and Nepal in Asia. Furthermore, some countries are looking to overcome resource constraints through regional initiatives, a notable example of this approach being the East African Community (EAC) countries. The P4H network sponsored and facilitated a workshop on EAC regional harmonization in September.

Several countries expressed an interest in innovative sources of funding for UHC/SHP, many inspired by the example of Gabon which has used levies on mobile phone revenues and money transfers to fund care for the countries poor. P4H has met the demand for information with workshops such as the series devoted to health financing concepts and techniques that was part of the three day mission in Abidjan in October organised by P4H partners for the Government of Côte d'Ivoire.

In working with the many countries that are struggling with inherited problems and constraints, one of the biggest challenges faced by P4H is the tendency for countries to lose sight of the overall UHC/SHP agenda in their eagerness to harvest low hanging fruit. This often expresses itself in

coverage solutions for easily 'captured' group such as civil servants or the military. The scheme introduced by Togo last year is a good example. Bangladesh is one of several resource-poor countries struggling with this issue, and P4H partners involved in supporting the country's transition towards UHC/SHP, spent most of 2012 working with the Government on a Health Care Financing Strategy, which, among other things, sought to achieve the right mix of prepayment and pooling mechanisms. Benin is another country that has wrestled with the scheme-based approach to developing UHC/SHP, and has now abandoned earlier plans to establish a constellation of institutions to cover specific target groups after intensive consultation with P4H partners.

Benin was also an opportunity for the P4H to demonstrate its capacity to encourage multisectoral collaboration. The same was true of Mongolia, where the local P4H partners were able to deliver a coordinated and structured stakeholder consultation process. In November the Minister for Population Development and Social Protection of Mongolia sent the P4H network a letter of appreciation for its work there.

One of the most effective ways to encourage multisectoral engagement is to establish inter-ministerial committees to foster dialogue and to harmonise the agendas of the ministries of health, finance, labour, social welfare, and local governments. P4H partners have supported the establishment of such committees in Benin, Chad, Haiti, Kenya, Lao PDR, Tanzania and Uganda.

Besides harmonization through better coordinated activities, P4H also worked to encourage coherent support from DPs by acting as a dialogue platform. This capacity was exploited in September of last year when P4H was able to facilitate exchanges between the Delegation of the European Union to Zambia and other network members in discussions regarding the proposed development of social health insurance (SHI) for civil servants in Zambia. The P4H network also served as a neutral platform for dialogue in India in February 2013 allowing DPs to discuss how the development community could better collaborate in order to improve support for UHC. Subsequent to the meeting the partners agreed that the P4H network would be a useful platform of exchange in India going forward.

In seeking to respond to the rapidly changing UHC/SHP landscape and to prepare P4H for the future, the P4H CD initiated a survey of its members in June 2012, the findings of which served as the basis for discussions at a P4H Special Steering Group Meeting held in Paris in October 2012. The partners confirmed their commitment to the P4H network approach, identifying the main benefit of participation as the greater coherence afforded by collaboration, both within and among the development partners across sectors and levels. They also reaffirmed their belief in the basic organizational principle of ad-hoc governance that allows P4H to use a flexible and evolving network approach to accommodate the different interests and strengths of the diverse development partners involved, while at the same time allowing customised responses to countries' individual needs. The SG also reaffirmed its commitment to a flexible ODA approach, based on the coordination of members' technical support, a platform for dialogue, information exchange and capacity development, and a marketplace for collaboration and complementary investments for scaling up support and filling gaps. Finally, there was broad agreement about the importance of jointly advocating for high level commitment to UHC, promoting a multisectoral strategic approach with inclusive stakeholder involvement.

1. General trends in UHC/SHP

A year characterised by increased demand for support as countries begin to get to grips with universal health coverage.

Interest in universal health coverage (UHC) and social health protection (SHP) has never been greater. In 2012 there were no fewer than four high-level international events held in Bangkok, Kigali, Mexico and Tunis that focused on the importance for national governments of working towards some form of UHC for their citizens. UHC was also the topic of a Ministerial-level meeting convened by the World Health Organization and the World Bank in February 2013, which assembled representatives from ministries of health and finance to share lessons learnt and challenges faced. The recent adoption of a UN General Assembly resolution on UHC - co-sponsored by more than 90 countries - has also placed the goal of moving closer to UHC high on the development agenda, while simultaneously underlining the importance of a multisectoral approach to achieving it. There are also increasing calls for UHC to be adopted as a key development goal going forward.

National expressions of interest in moving towards UHC/SHP include a number of 'open commitments' made at international forums, including several endorsements by countries of the Bangkok Statement at the Prince Mahidol Award Conference in January 2012, and East African Community countries committing themselves to UHC/SHP in the Kigali Ministerial Statement in September 2012.

Increased interest in UHC/SHP has been accompanied by a broad recognition of the size and complexity of the challenge faced. This is a positive, recent development as far as the P4H network is concerned – a sign of serious commitment to the UHC/SHP agenda on the part of the countries involved. Countries seeking to embrace UHC/SHP have never been more eager to learn, and P4H partners[1] have had a busy year fielding requests for collaboration and technical support. There has also been a significant increase in demand for P4H-organised, and sponsored learning events, such as workshops, trainings and conferences, where representatives can share experiences and discuss the challenges they face.

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[1] As of May 2013 the P4H network includes the World Health Organization (WHO), the International Labour Organization (ILO), the World Bank (WB), the African Development Bank (AfDB), and France, Germany, Spain, Switzerland and the USA. France participates through the MAE (French Ministry of Foreign and European Affairs), the AFD (French Development Agency), and the GIP SPSI (French International Health and Social Protection Agency). Germany is represented by BMZ (German Federal Ministry of Economic Cooperation and Development) but the collaborating partners at implementation level are the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and the KfW Entwicklungsbank. Spain is represented by AECID (the Spanish Agency for International Cooperation), a public entity within the Ministry of Foreign Affairs and Cooperation, responsible to the Secretariat of State for International Cooperation (SECI). Switzerland is represented by the SDC (Swiss Agency for Development and Cooperation) which is Switzerland's international cooperation agency within the Swiss Federal Dept of Foreign Affairs. The USA participates through USAID (the United States Agency for International Development).

The P4H Social Health Protection Network: a global network for UHC and SHP

One of the biggest challenges faced by countries seeking to embrace UHC/SHP is developing a plan of action in the face of incoherent information and advice. It is not unusual, for example, for different government departments to pull in different directions as stakeholders seek to protect their own interests. At the same time, the different approaches and agendas pursued by development partners can lead to incoherence if not outright interference in support efforts, while the support provided frequently fails to recognize the complexity of the issues faced or is packaged as one-size-fits-all solutions that are imposed on countries regardless of their specific needs.

Using a lean steering and coordination structure (a small WHO-hosted, Geneva-based Coordination Desk and several Focal Points that serve as interfaces to coordinate communication and interaction among the members) the P4H network brings together a broad mix of development partners and investors in SHP/UHC, combining different mandates, purposes, strengths and sector affiliations. Relying on the 'inform and involve' principle, the P4H network seeks to bring coherence to the process of UHC/SHP development by providing: a platform for information exchange and dialogue; a mechanism for coordination of multi-/bilateral technical support across sectors and cooperation levels; and a marketplace for collaboration and complementary investments for scaling up support and filling any support gaps, in particular for developing capacity for UHC/SHP.

It is important to note that the P4H Network is by no means limited to supporting health sector development. P4H members cover a wide range of expertise and experience in: health systems financing (WHO and WB); social security, including social health protection, labour market issues, alleviation of health related poverty (ILO); human development (e.g. AfDB or the French Ministry of Foreign Affairs); poverty reduction and social protection (e.g. the German Federal Ministry of Economic Cooperation and Development); civil society and private sector inclusion (USAID); and implementation and capacity development expertise (GIZ). Furthermore, P4H combines the political commitment and financial contributions of its bilateral members with the respective normative and technical support of the multilateral members and the wealth of expertise, experience and connections of the affiliated bilateral implementing organisations, AFD, GIPSPSI, GIZ and KfW.

Increasing national wealth in those countries that have benefited from the globalisation of manufacturing and trade, and increased demand for primary materials, has put UHC/SHP on the radar of governments that might previously have considered it an unaffordable luxury. In the past there has been a tendency for governments of many low- and middle-income countries to focus more on the costs of UHC/SHP than on the benefits. With increasing prosperity, some governments are re-examining the issue, often under pressure from their electorates.

The value of a commitment to UHC at the ballot box has been proven several times in the past year, notably in Senegal, where the May 2012 presidential election delivered a government committed to prioritizing UHC. The government followed through on that commitment in November with the establishment of the Délégation Générale à la Protection Sociale et à la Solidarité Nationale (DGPSSN), an autonomous institution with responsibility for coordinating the implementation of the new administration's policies on UHC and pensions for vulnerable groups. The first contact between DGPSSN and the P4H coordination desk took place in February 2013, during a joint WHO/ILO regional exchange workshop.

The increase in political support for UHC/SHP is a trend which the P4H partners are keen to support. Because the transition to UHC/SHP involves a range of complex technical challenges, it is easy to lose sight of the political dimension, but it is of crucial importance for three main reasons. First, a degree of social solidarity is required to develop UHC, given that any effective system of financial protection for the whole population relies on the readiness of the rich to subsidize the poor, the young to subsidize the elderly, and the healthy to subsidize the sick. That solidarity depends to a certain extent on the prevailing political discourse, which depends on political leaders. Second, the transition to UHC/SHP involves changes to the status quo which can easily impinge on specific interests. For example, the decision taken by the Philippines Health Insurance Corporation (PhilHealth) to implement a switch from fee-for-service to case-based payment (a switch supported by GIZ, WB, EU, ADB, etc for many years) was undertaken despite significant resistance from medical professionals. Without high-level political commitment, the transition to UHC/SHP can easily stall or drift with stakeholders failing to reach agreement or putting up obstacles to change. Third, high-level political commitment is essential to making the transition to UHC/SHP a priority, keeping the issue on the front burner in policy making and implementation, and ensuring that government funding goes where it is needed. In the Philippines case, the Aquino administration put aside PHP 33 billion (US$820 million) in 2013 to fund PhilHealth's coverage of the poor and near-poor, a group representing 40% of the total population.

For these reasons P4H works hard to raise awareness about UHC/SHP beyond the technical level, to promote high-level political commitment. This was borne out by the network's efforts in Tanzania in 2012**,** where P4H partners, who had previously focused on essential technical-level work, turned their attention to engaging the political executive, a process that started with a meeting with the Permanent Secretary of the Ministry of Health and Social Welfare (MOHSW) in April. Since then the health financing strategy agenda has become a top priority for the government, and the MOHSW's dedicated Health Financing Unit has seen access to top officials improve. In August 2012, at the suggestion of P4H partners, the Permanent Secretary of the MOHSW established an Inter-ministerial Steering Committee (ISC) for the health financing strategy comprised of representatives of the key ministries and offices responsible. The ISC has since endorsed a work plan that was drafted with P4H partners' support.

Of course political support for UHC can also waver when competing priorities prevail, and there are several example of countries where this has occurred in the past year. For example Uganda, a country which has made significant progress in developing a health financing agenda aimed at supporting UHC/SHP, saw some loss of momentum in 2012. Kenya too lost ground, the political situation and competing priorities such as the New Constitution and devolution, acting as a brake on progress. Nevertheless, P4H has continued to support both countries in their progress towards UHC/SHP, notably carrying out a health financing strategy review in Kenya, which, now that the elections are over, will hopefully serve as a springboard for reviving the process, while in Uganda GIZ undertook a situation analysis which will be the basis of ongoing P4H/Ugandan dialogue. It is also encouraging to note that Uganda officially requested support in the drawing up of a health financing strategy at the beginning of May 2013.

The main aim of P4H

The main aim of P4H efforts is to promote coherent, enhanced support for the creation and extension of sustainable health and social protection systems for UHC/SHP, based on the values of universality and equity. This means coherent, enhanced support for:

- ✓ reducing direct payments (out-of-pocket payments) for health services;
- ✓ raising sufficient funds domestically for health;
- ✓ improving efficiency, effectiveness and equity in the use of resources;
- ✓ fostering coherence between economic, health and social objectives;
- ✓ integrating health financing reform efforts with countries' economic, health and social protection frameworks.

2. P4H making a difference on the ground

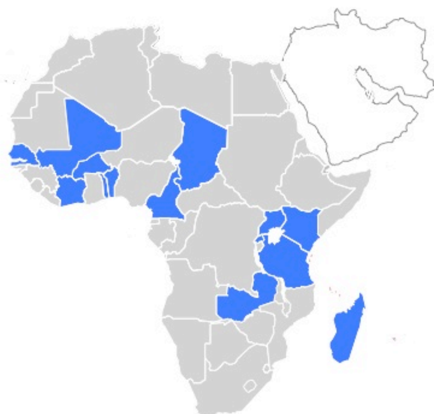
As already noted, increased interest in UHC/SHP has translated into more country demand for support in 2012/13. Typically, the P4H network becomes involved at the national level, with two or more P4H partners responding to a country's call for support. *Using the inform and involve principle* (see box) those P4H partners can then turn to other P4H members for regional and global level support where this is considered appropriate. Ideally, the involvement of P4H members is guided by a country-owned roadmap for UHC/SHP, which sets out the milestones, and the roles and responsibilities of the various stakeholders that will ultimately bring about meaningful change. A joint support plan then allocates different support activities to specific members, and sets a timeframe for implementation.

The P4H Golden Rule: Inform and Involve

By using the simple 'inform & involve' principle, the P4H Network builds on the already up-and-running and planned UHC/SHP interventions of its partners across a range of sectors by, for example, sharing a plan of operation, the terms of reference (TOR) of a planned study or mission, or a request for support from a national partner. By discussing opportunities for collaboration and how best to coordinate different activities at an early stage, P4H seeks to reduce incoherence and avoid duplication of effort while at the same time encouraging available synergies.

Five more countries approached P4H partners for support in developing an SHP/UHC agenda in 2012/2013. There are now a total 23 countries working with the network, albeit at different levels of engagement and intensity, including: Benin, Burkina-Faso, Cameroon, Chad, Côte d'Ivoire, Kenya, Madagascar, Mali, Rwanda, Senegal, Tanzania, Togo, Uganda and Zambia in Africa, Bangladesh, Cambodia, India, Indonesia, Laos, Mongolia, Nepal, Philippines, in Asia and Haiti in Latin America.

SUPPORT IN AFRICA



SUPPORT IN ASIA

Each of these countries struggles with its own issues, but the basic building blocks for a successful transition to UHC/SHP are invariable, starting with effective, equitable and sustainable financing. P4H can add value in four ways (see box) but much of the work done by the P4H Network starts with supporting countries in the development of a national health financing strategy that is based on the realities of what they can afford, is in line with social and economic development objectives, and builds on a consensus about how to achieve the goals set. In 2012/13 P4H partners worked with countries to address five basic challenges to achieving that first step.

The value-added of P4H

P4H is committed to managing diversity and encouraging coherence. Moving towards UHC/SHP raises complex issues and involves difficult choices. It also concerns a broad range of actors and stakeholders in various sectors, and thus requires technical and political solutions to harmonise different interests and values.

P4H adds value to joint network responses in four ways:

By ensuring political commitment. The countries that have come farthest along the road towards UHC share a number of attributes, the most notable being optimal political commitment. The promotion of high-level political commitment to and ownership of UHC/SHP initiatives is a key aspect of P4H support and a precondition for its successful involvement.

By connecting different sectors. P4H encourages a broad-based, multisectoral approach to UHC/SHP that fosters coherence across the areas of health, social protection, finance, poverty alleviation, and sustainable development, countering the natural tendency for stakeholders to address challenges solely from their own perspective.

By improving the quality and dynamics of support. Working in multi-disciplinary teams composed of experts from a wide variety of backgrounds, including health systems, health economics, social protection, sustainable development, and public policies, P4H promotes a balanced mix of strategic options and recommendations, while at the same avoiding duplication of effort, notably the time and resources wasted with parallel UHC/SHP project streams. P4H also supports and promotes DP harmonisation, and ensures the optimal mix of the financing instruments made available by the partners.

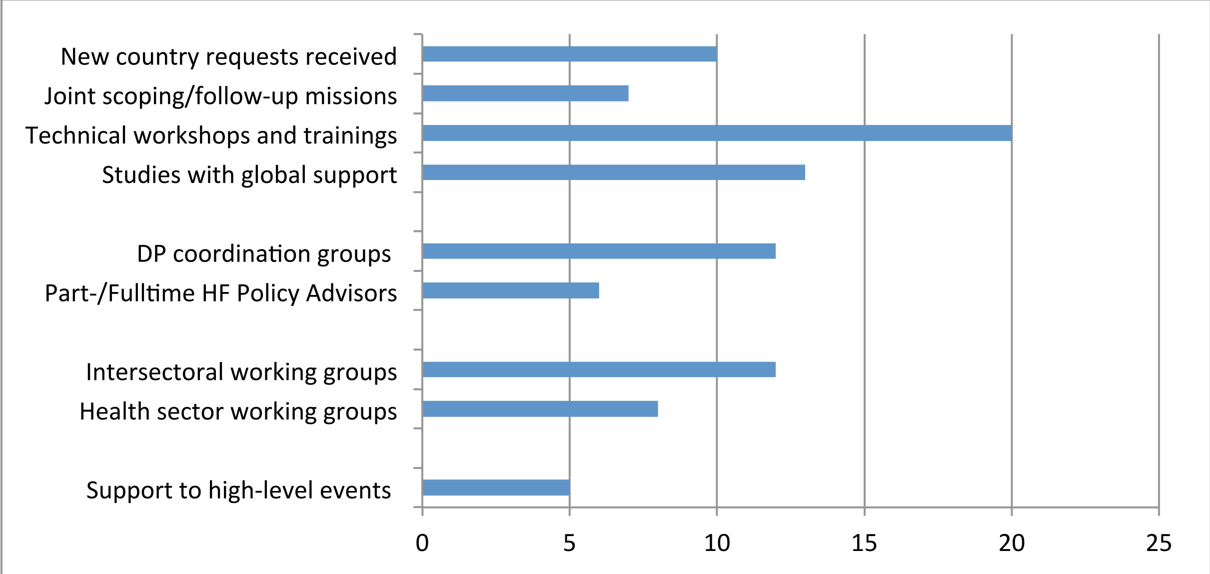
By scaling up support. The P4H network assists in scaling-up on-going support with the financial resources made available by its bilateral P4H members. These additional resources may be used to complement support activities and foster collaboration among network members at the country level, and thus serve as an indirect incentive for collaboration and harmonisation of support.

P4H working to improve understanding of UHC/SHP.

As already noted there has been a significant increase in demand for information about UHC/SHP in the past year as countries become more serious about initiating reforms. In February 2012, for example, recognizing the need for basic understanding of SHP and health financing principles, concepts and best practices, the Rwandan Ministry of Health (MoH) asked P4H partners for a curriculum on SHP for technical staff in its Health Financing Unit (HFU) and a Community-based Health Insurance (CBHI) Management Course for district CBHI managers. P4H partners GIZ and WHO jointly supported the initiative using materials from existing courses, tailored to the country's needs. In the same month the Nepalese Ministry of Health and Population (MoHP), GIZ, USAID and the World Bank, organized a 10-day course on Health Systems Strengthening and Sustainable Financing that was partially funded by the P4H partners and attended by sixty participants from the MoHP, other ministries, international NGOs, and external DPs, and representatives from the private sector. The course focused on decentralization and health financing in Nepal. Overall P4H sponsored,

organized, or otherwise facilitated more than 20 educational events in the form of workshops, seminars and conferences in the past twelve months (table 1).

Table 1. Examples of P4H Network Support Activities 2012/13



Germany/BMZ through GIZ has made capacity development for UHC/SHP a priority with their Sector Project P4H, an initiative focused on supporting human capacity development (HCD). In 2012, the Sector Project P4H developed a systematic approach to HCD that is to be piloted in Cambodia in 2013. The Sector Project P4H also collaborated with the World Bank Institute (WBI) to scale up and adapt the WBI's Flagship Course on Health Sector Reform and Sustainable Financing. The core of this collaboration is the customization of the Flagship Course for three regions of the world: East Africa, South-East Asia, and South Asia (specifically Bangladesh), and the usual focus on policy-makers is supplemented with content aimed at local teaching institutions.

In some cases, P4H facilitates peer-learning encounters as in the sub-regional conference organized by WHO and ILO in Ouagadougou, Burkina Faso, in February 2013 where line ministries from Burkina Faso, Benin, Togo, Côte d'Ivoire, Mali and Senegal came together to learn from the UHC/SHP-building experiences of two other southern hemisphere countries, India and Thailand.

In many instances these initiatives are more than simply opportunities to learn and inform, and offer stakeholders a chance to share their vision of UHC/SHP. This was certainly true of the workshops organised and facilitated by P4H in Mongolia in 2012, for example. The workshops were attended by a multi-stakeholder group that discussed UHC challenges including revenue collection, the design of the benefit package, the role of private health insurance, and the integration of primary health care in the insurance package. Key issues were identified and addressed in a long-term draft policy paper for national health insurance, which reflected different visions and strategies, and was accompanied by an action plan for implementation. Mongolia's Ministry of Population Development and Social Protection (MPDSP, the former Ministry of Labour) followed up on the workshops by organizing a National Forum on Social Insurance Reform in Ulaan Baatar in October, an event that was attended

by 400 national participants from regional and local authorities as well as a number of international guests.

Knowledge exchange can also be a powerful tool for encouraging coherence in country-level efforts to develop UHC/SHP, one of the core P4H objectives. In December P4H partners supported the participation of Tanzania's ISC for health financing strategy (which had been set up at the suggestion of P4H partners, and using P4H partners' contacts) in the World Bank institute's Flagship Course on Health System Reform and Sustainable Financing, partly to encourage ISC members to see their stakes, or the stakes of their ministries, in the context of overall SHP/UHC reforms, and to develop a vision accordingly. Going forward, the ISC is going to be crucial to the development of UHC/SHP in Tanzania, endorsing key steps on the way to establishing the final health financing strategy. This will involve taking some critical and not always easy decisions, notably with regard to the reform of the country's health insurance architecture. The participants in the World Bank Course received training from leading experts on various aspects of health financing reform, while facilitated group work and case studies allowed the group to develop an in-depth understanding of the key areas of health financing reform in their own country.

P4H supporting countries confronting resource/capacity issues.

Many of the countries working with the P4H network see the lack of resources, financial and otherwise, as the main obstacle to moving forward on UHC/SHP. One key question recurs: where is the money to come from? Part of the above-mentioned capacity development activities done by P4H partners last year was directed at clarifying the funding issues countries face, but the network also offers support with country-specific studies, an example of which being the fiscal space study proposed in Kenya as part of the Health Financing Strategy review conducted at the request of the Kenyan government in March of 2012.

P4H partners supported Chad in its efforts to get a clear picture of its capacity to finance UHC by sending an international adviser on health financing policy in November 2012. The adviser was contracted by GIZ on behalf of the Swiss Cooperation and his first task was to help the health financing technical committee to draft a comprehensive health financing situation analysis. Prior to that, WHO had started providing technical support (scheduled to run from 1st September 2012 to 30 April 2013) to the Ministry of Health (MoH) to establish the country's first national health accounts (NHA). The NHA will allow for a better understanding of the health financing situation in the country and will contribute to the development of a national health financing strategy for UHC.

For countries struggling to find the resources to begin implementation of UHC/SHP policies, the P4H network has been able help co-ordinate the support offered by development partners. This has been one of the focuses of P4H efforts in Haiti over the past year, for example, efforts which began with a joint P4H scoping mission in April 2012 that brought together PAHO-WHO, the ILO, the World Bank, the Inter-American Development Bank, France and representatives from the P4H Coordination Desk. The government of Haiti is committed to extending social health protection to all citizens, but domestic resources are very limited. Financial support from DPs will therefore be needed in the initial years of implementation.

Following the inform and involve principle, P4H partners spread the word regarding Haiti's situation and the USA, Canada, Brazil, Cuba, and UNICEF expressed an interest in getting involved. In order to bring this support in line with need, it was necessary to address a number of issues, including external partners' occasionally spotty understanding of health financing concepts and best practices, and the lack of fundamental data needed to clarify the health financing challenges that Haiti faces. P4H partners launched a DP coordination process to encourage the exchange of information regarding the health financing aspects of the DP's efforts to improve harmonization. Going forward PAHO-WHO will play a major role in consolidating and maintaining this coordination process.

Other countries are looking to overcome resource constraints through regional initiatives, a notable example of this approach being the East African Community (EAC) countries. In September the Government of Rwanda, one of the driving forces for a harmonized EAC agenda in moving towards UHC, convened a ministerial conference in Kigali, the objective of which was to highlight various approaches to developing SHP systems for the EAC region, and to recommend policy options in developing the regional mechanisms needed to build a strong and harmonized system of SHP. The event was supported by EAC member states, and the P4H members WHO, GER/GIZ, SDC, as well as the Belgian Technical Cooperation (BTC), and USAID.

The P4H coordination desk facilitated a working group of a workshop on EAC regional harmonization, and participants outlined a number of desired outcomes, including: a common vision for all EAC member states with regard to attaining universal coverage; the strengthening of SHP; and the fast-tracking of UHC. To attain the first of these outcomes it will be necessary for part of the regional strategy to be committed to providing guidelines and standards for the harmonization process. The participants also expressed a desire to see the strengthening of SHP and benefit packages, the harmonization of quality standards across the region, and the portability of benefits across the five partner states.

The EAC Secretariat proposed that a study on regional harmonization, including a situation analysis and feasibility study on options for harmonization of the social health protection systems, be undertaken to support the meeting to decide on policy and strategy scheduled for March/April 2013, preparatory to implementation beginning in July 2013. It was also considered advisable to develop guidelines for the harmonization process so that the member states all move in the same direction. Finally, it was considered essential that the multiple sectors, civil society organizations, and research institutions be involved.

Another emerging trend is an interest in innovative financing mechanisms. Several countries expressed an interest in carrying out studies regarding innovative sources of funding for UHC/SHP in 2012. These include so-called 'sin taxes', earmarked VAT, or special taxes on 'cash-cow' businesses. The tremendous success of Gabon in generating income for UHC by introducing levies on mobile phone and money transfer companies has been widely noted and will doubtless inspire several of the countries working with the P4H network in the future. P4H supports such initiatives with workshops such as the series devoted to health financing concepts and techniques that was part of the three day mission in Abidjan in October organised by P4H partners for the Government of Côte d'Ivoire. Typifying the high-level commitment to SHP/UHC shown by the Côte d'Ivoire administration, the Minister of Employment and Social Affairs, the Minister of Health, and a Presidential Adviser for

health and family attended the workshop on the first day, where innovative financing techniques were the main focus.

P4H promoting country-specific solutions to inherited problems and constraints.

One of the reasons that one-size-fits all UHC/SHP solutions are seldom helpful is that each country comes to the planning table with a different set of inherited structures, biases and traditions. Countries with health systems that have grown out of the Soviet-era Semashko model, such as Mongolia, tend to struggle with a large hospital infrastructure that eats up a substantial part of the resources. For many of the Francophone countries of West Africa that have been influenced by the historical development of SHP in continental Europe, one of the main obstacles to the development of UHC/SHP is over-reliance on Community Based Health Insurance (CBHI) schemes which has sometimes created a vacuum in policy responses to the coverage challenges faced. Where valuable CBHI approaches do exist, P4H partners support their integration into systematic UHC/SHP strategies. Other countries struggle with a rubble of internally contradictory legislation that has been accumulated over years of incoherent, ad-hoc policy-making. The majority of countries that the P4H network engages are struggling with capacity issues that reflect decades of underfunding and neglect, and health-care coverage which, if it exists at all, is highly-fragmented.

In addressing these and other issues, the P4H network strives to move away from isolated capacity-building activities to a more structured and systematic approach with interventions that cover a broad range of activities, and include health financing, legal, social and economic issues, as well as system and sector-wide thinking and re-thinking. P4H partners also look to foster synergies among different work streams at the national level, but also related to DP activities, and finally to support and promote multisectoral dialogue to make sure that all sectors are pulling in the same direction.

One of the biggest challenges faced by the network's partners is the tendency for countries to lose sight of the overall UHC/SHP agenda in their eagerness to harvest the lowest hanging fruit. This often expresses itself in coverage solutions for specific population groups, more often than not including a health insurance component, based on either voluntary or obligatory contributions, and targeting an easily 'captured' group such as civil servants or the military. The scheme introduced by Togo last year is a good example. Togo started to pay for the health services covered by its national health insurance scheme (Institut National d'Assurance Maladie - INAM) in March. Available only to Togolese civil servants during the first phase of deployment – it is hoped that extension to the informal sector will come later – INAM covers approximately 300,000 people out of a total population of 6.7 million.

While such schemes provide an obvious benefit to the beneficiaries, experience shows that they tend to work less well for informal sector workers, and typically exclude those who are too poor to contribute. In countries where as much as 80% of the population can be categorised as informally employed and/or poor, this poses an obvious problem: the universal part of UHC is lost, and by favouring one group, future progress towards UHC/SHP can be compromised. So great care has to be taken when introducing health insurance schemes into the larger UHC/SHP system, and governments need to be realistic about what they can contribute, and how they affect the overall UHC/SHC endeavour.

Bangladesh is one of several resource-poor countries struggling with this issue, and P4H partners involved in supporting the country's transition towards UHC/SHP, spent most of 2012 working with the Ministry of Health and Family Welfare's (MOHFW) Health Economics Unit (HEU) on a Health Care Financing Strategy (HCFS) which, among other things, sought to achieve the right mix of prepayment and pooling mechanisms. This was a challenging process, made all the more so by the disparate views, and interests of the various stakeholders involved. After a period of intense consultation between the HEU and P4H partners which sought to identify a clear strategic through-line taking into account the various inputs, the HFS that was produced retained a tax-financed component, and a set of SHP schemes which includes a health equity fund, a formal sector SHP scheme, an SHP scheme for the poor (SSK), and a community-based insurance scheme for the informal sector. The MOHFW approved the strategy in October.

Whether or not this kind of fragmentation in SHP schemes will serve Bangladesh's needs is open to question, and there is some concern among P4H members regarding the likelihood of a protracted 'experimental phase' which could add to rather than reduce the fragmentation of the country's financing mechanisms. The next step for the country will be the development of an Investment Plan (IP) that lays out the implications of implementing the HCFS, including costs and systems readiness/capacity and institutional needs. The IP is expected to provide feasible and sustainable options for the road ahead. Joint support of the P4H network members for the IP will include strengthening the HEU, by providing international experts, for example, a rapid health systems analysis and assessment on specific issues such as costing and the facilitation of consultations to build consensus on a 2013/14 operational plan.

Benin is another country that has wrestled with the scheme-based approach to developing UHC/SHP, but has now abandoned earlier plans to establish a constellation of specific institutions to cover specific target groups, an approach that would have cast in stone a highly fragmented UHC/SHP system. Facilitated by the P4H CD, a group of P4H partners went to Benin in February 2012 to discuss the issue with national stakeholders. After several days of intensive dialogue, the P4H partners proposed a number of recommendations, including the abandonment of the fragmented architecture posited in the original plans for a universal health insurance scheme (Régime d'Assurance Maladie Universelle – RAMU). Since then RAMU has been reoriented to cover the general population with a single health services package.

Collaboration on the project is coordinated by a WHO regional policy adviser, who was recruited as per one of the P4H team recommendations. Deployed from the WHO sub-regional office, the adviser goes to Benin for a fortnight mission every 6 weeks to work on technical and strategic issues, to share information, and to propose ways forward. He is also responsible for sharing situation statements with the rest of the network. The legal framework for RAMU is still in the process of being drawn up, but an important step was taken in May 2012 with the creation of a management agency, the Agence Nationale d'Assurance Maladie (ANAM). The process of developing a Health Financing Strategy was started in November 2012, and has thus far focused on strategic & technical issues. The more political issues, including issues that touch on specific interests, will be raised in the process of writing a document that aims at clarifying the interventions needed in moving towards universal coverage.

P4H network encouraging collaboration among different stakeholders.

As already noted, moving toward UHC/SHP often involves reform that impinges on the specific interests of stakeholders, whether inside or outside government. This means that any reform undertaken needs to be planned in consultation with different parties, the main objective being to counter the natural and understandable tendency for stakeholders to address challenges solely from their own perspective and to foster collaboration. P4H members are particularly well placed to encourage multisectoral collaboration, drawing on years of experience working with a range of counterparts in different ministries, development and planning commissions, employers and employee associations, and civil society organizations.

In Benin, the P4H network has been able to encourage consideration of SHP as a national issue by a range of stakeholders, including the Prime Minister's office, the Ministry of Labour, the Ministry of Finance, the Ministry of Social Affairs, and the Ministry of Planning & Development. This has allowed stakeholders to think outside their usual boxes (the Ministry of Health seeing the issue through the lens of exemption schemes, for example, and the Ministry of Labour through the lens of universal health insurance) in order to engage in a truly multisectoral process of reflection. The Social Protection Policy is now being developed under the leadership of the Ministry of Planning & Development, and is connected with the Health Financing Strategy. Though the Ministry of Health is still largely leading both the development of the Health Financing Strategy & the RAMU in Benin, the connections with other stakeholders exist and can be activated when needed.

One of the most effective, but seldom easy, ways to encourage collaboration is to establish inter-ministerial committees to foster dialogue and to harmonise the agendas of the ministries of health, finance, labour, social welfare, and local governments. P4H partners have supported the establishment of such committees in Benin, Chad, Haiti, Kenya, Lao PDR, and Uganda, and last year, as already noted, supported Tanzania in the establishment of the ISC.

Another useful approach is to bring in a trusted outsider to ensure that all parties get a fair hearing. This was the approach taken by P4H partners in Mongolia, where they have been providing technical support for health financing and SHP to various national stakeholders, including the Social Insurance General Office (SIGO), the Ministry of Population Development and Social Protection (MoPDSP, formerly the Ministry of Social Welfare and Labour) and the Ministry of Health (MOH). Prior to the change of government in the summer of 2012, there was a lack of consensus regarding several aspects of health system reform, including a proposed gatekeeper function for the primary health care system, the autonomy of public health service providers and the status of their employees, and funding arrangements between the MoH and MoPDSP and Ministry of Finance.

When the MoPDSP approached the local P4H partners for help in developing a long-term strategy for the SHI system, the partners turned to their global-level P4H counterparts to see if a neutral facilitator could be found to help with the process. The intention was to ensure unbiased, structured, and continuous support from a neutral broker who could deal with the different interest groups and help maintain the political commitment and ownership of the stakeholders. A broker was found and the P4H partners were able to deliver a coordinated and structured stakeholder consultation process and ensured the permanent and equitable participation of all relevant stakeholders in future

consultations. After a year of close collaboration of national stakeholders supported by P4H partners, the SHI policy was approved by the Council of Ministers in April 2013. In November the Minister for Population Development and Social Protection of Mongolia sent a letter of appreciation to the P4H network, highlighting the importance of the intended SHI reform and of coordinated support for the formulation of the Long Term Policy.

In Tanzania, P4H partners supported the participation of government departments who have a stake in the process in the World Bank institute's Flagship Course on Health System Reform and Sustainable Financing. In March 2013, the MOHSW, supported by P4H partners, brought stakeholders together once again by reaching out to health financing and SHP stakeholders from the private sector, including civil society organizations, labour unions, employer organisations, social and private health insurers, health service providers, academia and development partners. The aim of the initiative was to familiarize stakeholders with the health financing reform agenda, so that they can then develop their own positions for consideration as part of the consultation process in the preparation of Option Papers for the nine reform areas that have been identified by the above-mentioned ISC.

Apart from encouraging collaboration, such initiatives can also bring greater clarity to the process of UHC/SHP reform. This is true of Côte d'Ivoire, for example, where collaboration and broad agreement regarding objectives has led to clear allocation of duties in the approved health financing strategy for UHC. The MoH will be in charge of assuring the availability of quality services, while the Ministry of Employment and Social Security is to supervise the creation of a unified public purchasing fund covering at least the poor, children less than 5 years old and pregnant women.

P4H encouraging coherent support from DPs.

Unfortunately, competing stakeholder interests also exist at the development partner level, and are one of the causes of incoherent support. Other causes include the different approaches and agendas pursued by DPs which can lead to incoherence if not outright interference in support efforts. Such challenges are only compounded by the shifting priorities and frequent staff changes within DPs, some of which also lack the capacity required to fulfil their mandates. Finally, the support provided frequently fails to recognize the complexity of the issues faced or is packaged as one-size-fits-all solutions that are imposed on countries regardless of their specific needs.

One of the ways the P4H Network supports coherent DP activity is through the **inform and involve** principle described above. *The network can also act as a dialogue platform, bringing together the partners to discuss new initiatives as they arise.* This function was exploited in September of last year when the Delegation of the European Union to Zambia contacted P4H CD, asking for help in identifying experts to help Zambia's MOH support the introduction of social health insurance (SHI) for civil servants, a project that was getting the support of the Clinton Health Access Initiative (CHAI). P4H CD pointed out that the introduction of SHI with a focus on civil servants raised a lot of questions, and at the same time contacted partners that were likely to have a stake in the issue, including WHO, the WB and GER/GIZ to make them aware of the SHI project. Neither WHO nor the WB supported the idea of introducing an SHI scheme for civil servants, arguing that SHI schemes, while clearly of value, need to be seen in the broader context of a country's UHC/SHP goals. After exchanges of email

over several weeks, P4H organized a teleconference in which the different parties to the project were able to discuss their views regarding Zambia's needs, and in particular whether it was necessary to explore alternative sources of funding such as sin taxes, or make better use of the resources already available. In the end the parties to discussion agreed to move forward with a coordinated approach.

Working coherently with other networks and initiatives

An important part of encouraging coherent DP support for countries is being aware of the other partnerships, networks and initiatives undertaking work not dissimilar to the P4H network's efforts. In fact a number of the P4H members participate in other groupings and initiatives such as the Social Protection Floor Initiative (SPFI), IHP+, Harmonisation for Health in Africa (HHA) or JLN. The P4H network aims to complement these alliances and mechanisms, and leverages synergies whenever possible.

The Social Protection Floor Initiative and P4H. The SPFI is one of the nine UN joint initiatives to cope with the effects of the economic crisis and is co-led by the International Labour Office and the World Health Organization. It involves a group of 17 collaborating agencies, including United Nations agencies and international financial institutions. The multisectoral approach of P4H connects SPFI activities and the UHC agenda in the health sector. Ideally, the SHP component of the SPFI's work would be handled by the P4H network where possible.

IHP+ and P4H. IHP is limited to applying the Paris Declaration Principles to the health sector in order to accelerate progress towards the health MDGs. Synergies with P4H arise where, for example, a Joint Assessment of National Health Strategies leads to the development of a health financing strategy, which would be supported by the P4H network members.

Harmonisation for Health in Africa and P4H. The HHA coordination mechanism is limited to the African region and to the health sector. Countries approaching UHC from the health sector perspective may forward their request to the HHA secretariat or to any P4H member. HHA and P4H then inform each other in order to present a coordinated response. However, given that P4H approaches UHC/SHP from a multisectoral perspective, other sector ministries, such as a Ministry of Labour or Social Welfare, can forward requests for support to P4H.

The Joint Learning Network for Universal Health Coverage and P4H. JLN is a network of practitioners and policymakers from low- and middle- income countries that learn from one another, jointly solve problems, and collectively produce and use new knowledge, tools, and innovative approaches to accelerate country progress toward UHC. JLN focuses on practitioner-to-practitioner hands-on learning and does not engage in policy advice, while P4H seeks coherence in ongoing and planned multi/bilateral development cooperation. However, JLN activities may well complement the capacity development activities of P4H.

Overall, the various alliances described share similar principles and in practice there is more potential for synergy than duplication. In order to strengthen such synergies and to improve coordination, the P4H Coordination Desk regularly interacts with the secretariats of other alliances to ensure information exchange and the harmonisation of activities.

The P4H network also served as a neutral platform for dialogue in India where both national and development aid stakeholders have taken very different approaches in the past and where a climate of mistrust has hindered progress on the UHC front. In February 2013 the World Bank asked the P4H network to facilitate a DP meeting to review ongoing discussions in India regarding support for UHC. The meeting was attended by WHO, UNICEF, World Bank, GIZ, DfID and USAID, and had two main objectives: to get a better understanding of how each DP was engaged and to discuss how the development community could better collaborate in order to improve support for UHC. Subsequent to the meeting the partners agreed to make additional efforts to improve information sharing, using the P4H network as their exchange platform. They also agreed that the P4H network would be a useful platform of exchange in India.

The value of such consultations is not limited to harmonising planned and ongoing initiatives and avoiding duplication of effort; they also help partners define, and take advantage of the different strengths and mandates of the individual members. Finally they also help the group define and achieve objectives, which may include jointly advocating for high-level commitment to UHC, promoting a multisectoral strategic approach with inclusive stakeholder involvement.

3. P4H adapting as it moves forward

In seeking to respond to the rapidly changing UHC/SHP landscape, the P4H Network is currently confronted with a number of strategic challenges. To stimulate discussion on these issues, in June 2012, the P4H CD initiated a survey of its members, the findings of which then served as the basis for discussions at a P4H Special Steering Group Meeting that was held in Paris on 11 October 2012.

The partners confirmed their commitment to the P4H network approach, identifying the main benefit of participation as the greater coherence afforded by collaboration in the network, both within and among the development partners across sectors and levels. They also reaffirmed their belief in the basic organizational principle of ad-hoc governance that allows P4H to use a flexible and evolving network approach to accommodate the different interests and strengths of the diverse development partners involved, while at the same time allowing customised responses to countries' individual needs, founded on the Paris declaration principles. In many ways this flexibility is the core strength of P4H, and what makes it different to more formalized partnerships.

The same commitment to flexibility was also reflected in the Steering Group's agreement to retain a horizontal organizational structure, with no hierarchy among members, and total autonomy for each. P4H brings together a number of powerful institutions, which is of course another of its strengths, but to function optimally it has to guard against the power struggles that can easily arise where there is an organizational 'ladder'. The reality of the environment that P4H faces, is that different countries face different problems, and all P4H members can make vital contributions at different times, sometimes in surprising ways. Using the inform and involve principal that underlies all of P4H's efforts, and relying on all participants making contributions as and when they can, P4H can maximise its potential to effect meaningful, positive change.

The SG also reaffirmed its commitment to a flexible ODA approach, based on the coordination of members' technical support, a platform for dialogue, information exchange and capacity development, and a marketplace for collaboration and complementary investments for scaling up support and filling gaps. Finally, there was broad agreement about the importance of jointly advocating for high level commitment to UHC, promoting a multisectoral strategic approach with inclusive stakeholder involvement.

SHP/UHC

Social Health Protection (SHP) is defined by the International Labour Organization (ILO) as a series of public or publicly organized, and mandated private measures addressing the social distress and economic loss caused by the reduction of productivity, reduction or cessation of income, or the costs incurred in paying for health care. The objective of SHP is thus to provide universal access to affordable, available quality care, to provide financial protection to cover the costs of that care and income lost as a result of illness.

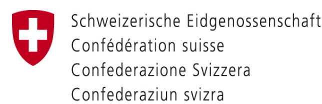
Universal Coverage, or Universal Health Coverage (UHC), is defined by the World Health Organization (WHO) as coverage ensuring that everyone has access to the good quality promotive, preventive, curative and rehabilitative health services they need, without being exposed to financial hardship.

Convergence: the concepts of UHC and SHP are very close in that they both focus on guaranteeing essential health care to the whole population while at the same time protecting people from financial hardship due to the costs incurred in seeking that care. SHP goes a step further by addressing the problem of income lost due to illness. In practical terms, this means that for the collaborative work of the P4H network, UHC and SHP–are more or less interchangeable terms.

With regard to P4H's positioning relative to the development aid environment, there was some discussion about the possibility of 're-branding' the network (currently referred to as the 'P4H Social Health Protection Network') by introducing the acronym 'UHC' into the network name. In the end it was decided that the case for changing was weaker than the argument for retaining what has, for some, become a familiar brand. It is also perhaps worth noting that 'SHP for all' or 'Universal SHP' comes closer to expressing the aspirations of the P4H network, since it also includes ill-health related income support, something that UHC *per se* does not address. In order to reflect our commitment to supporting countries that are keen to move towards UHC, the decision was taken during the October 2012 Steering Group meeting to explicitly mention UHC in any text describing the network. One of the outcomes of this debate was a useful definition and comparison of SHP and UHC produced by the ILO and WHO (see box).

P4H Social Health Protection Network

The P4H members:



Swiss Agency for Development and Cooperation SDC

P4H implementing partners: