Annual Report

for the period

May 2013 - April 2014

P4H Social Health Protection Network

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Executive Summary

World Health Organization and World Bank commitments to supporting the development of UHC, and ongoing discussions regarding the possible setting of UHC targets as part of a post-2015 global health agenda, have kept UHC issues on the front burner this year. Momentum is also beginning to build on the SHP side, as evidenced by the work of the ILO/WB-chaired Social Protection Inter-Agency Cooperation Board, which held its first workshop in June 2013 and collaborated with the Government of Thailand in a Social Protection Assessment exercise that was completed in May 2013.

The regional focus on UHC/SHP is also increasing, particularly in Africa and the Middle East, while at the national level an increasing number of governments are exploring UHC/SHP possibilities, many of them turning to the P4H network for help in doing so. The number of countries now working with the P4H network has risen from 23 to 33, including 8 countries that have only recently begun the process of developing a UHC/SHP agenda.

Sub-Saharan Africa continues to be the main focus of P4H network activity, no fewer than 19 countries currently engaged in UHC/SHP planning or reflection, including newcomers - Burundi**,** Democratic Republic of Congo, Ethiopia, and Mozambique. In Asia a total of eight countries are working on UHC/SHP agendas in consultation with or supported by P4H network members, including newcomer Myanmar, which made a promising start in developing a UHC/SHP agenda, and Mongolia which has something of a breakthrough year. Finally, 2013 saw the opening up of a new continent for the P4H network with the AFD scoping mission in Colombia, in which the P4H coordination desk participated.

A number of new challenges are emerging as the global UHC/SHP picture evolves, among the most significant – maintaining momentum for reform beyond the planning phase. Countries that have spent the past several years working on roadmaps for change are approaching the point where the realities of implementation must be faced. In some cases progress on UHC/SHP has actually come to a halt after achieving approval of a Health Financing Strategy. There appear to be several reasons for this, among the most notable a tendency for governments to prefer an incremental approach to expanding coverage rather than committing to UHC/SHP wholesale.

The P4H network remains committed to supporting countries as they work through these issues, advocating the highest level political commitment and multi-sectoral stakeholder involvement. The network currently has 6 part-time or full-time policy advisors in place. Network members also regularly undertake follow-up missions, and in many countries offer continual support for the technical and inter-sectoral working groups that have become a mainstay of country-level initiatives to advance the UHC/SHP agenda.

Broadly speaking, demand from P4H portfolio countries has focused on several areas, starting with support regarding the **definition and costing of benefits packages.** Typically discussions focus on the trade-off between providing a smaller benefit package covering everyone, or broader benefits for selected groups with possible expansion to other population segments as fiscal space improves.

Demand for **fiscal space analysis** has also been significant as countries struggle to clarify both what they can afford and what they are ready to pay for, the latter reflecting the reality that UHC is often just one of several competing national priorities. Countries also continue to explore the possibility of developing innovative sources of funding, but it is clear that while these mechanisms already play an important part in mobilizing new resources in some countries, raising more domestic funds through public financing is an essential factor in achieving UHC/SHP advances. *Calls for increased government spending – a perennial of public health discourse – are being made with greater insistence as UHC/SHP deadlines approach and countries recognise that achieving equity is a core UHC challenge which cannot be met without greater financial commitment.*

Because most countries committed to developing UHC/SHP build on earlier schemes there is also considerable demand for **assessment and clarification of the 'overall architecture'** of the national health financing landscape and the foundations that need to be put down to enable UHC to develop smoothly over the coming decades. Tackling the issue of fragmentation early on is essential since it becomes much more difficult to harmonise or merge various schemes under a national UHC approach further down the line, when schemes have developed their own identity and dynamics.

Going forward, and as countries begin to implement UHC/SHP policies, it seems likely that there will be increased demand for **UHC Assessment**, an exercise carried out for the first time in Kenya last year. There will also be a greater need for UHC assessment if UHC becomes one of the goals of the post-2015 development agenda. WHO and WB have already started working in this area, notably producing a framework on *measuring progress towards UHC*. However, experience shows that a comprehensive UHC assessment will also need to address the political dimension.

Limited UHC/SHP-literacy at the country level continues to be a significant issue and the P4H network has strengthened its commitment to **capacity development** by supporting the provision of technical workshops and short training programmes, but also with a number of new initiatives, including a 'Leadership for UHC' course. The part played by politics in the development of UHC is increasingly a topic of conversation in discussions between P4H Network partners and officials and stakeholders in the countries with whom they work, but thus far countries have done little in the way of systematic analysis in this area. Crucial to winning the political argument with regard to UHC/SHP is the capacity to demonstrate the benefits of embracing it. In order to do this UHC advocates require meaningful, comprehensible UHC indicators. The overarching, multi-sectoral nature of UHC presents a number of challenges in this regard, and may be one of the reasons for the lack of progress on UHC in some countries, governments and donors tending to fund easily quantified programmes such as Malaria control. Better UHC indicators would also help countries establish exactly where they currently stand, where the gaps are, and where efforts need to be focused.

Finally, the P4H network, in its capacity development activities, boldly entered cyberspace last year with the launching of E-learning versions of the World Bank institute (WBI) Flagship course on Health Systems Reforms and Sustainable Financing, and the WHO Advanced course on Health Financing for LIC and LMIC. P4H network partners are also working on a UHC interactive guide, while the P4H CD launched a protected intranet site which now allows P4H members to share information and discuss UHC/SHP developments in countries of interest across member organisations.

1. General trends in UHC/SHP

A year characterised by sustained interest in UHC/SHP, but new challenges are emerging, notable among which the need for governments to start showing results.

The burgeoning interest in UHC/SHP described in last year's P4H Social Health Protection Network annual report[1] has largely been sustained. World Health Organization and World Bank commitments to supporting the development of UHC, and ongoing discussions regarding the possible setting of UHC targets as part of a post-2015 global health agenda, have kept UHC/SHP issues on the front burner. Momentum is also beginning to build on the SHP side, as evidenced by the work of the ILO/WB-chaired Social Protection Inter-Agency Cooperation Board (SPIAC-B), which is composed of representatives of international organizations and bilateral institutions and is committed to enhancing global coordination and advocacy on social protection issues. SPIAC-B held its first WB-organized workshop in Washington in June last year and collaborated with the Government of Thailand in a Social Protection Assessment exercise that resulted in a report published in May 2013.

Regional focus on UHC/SHP is also increasing, notably in Africa where a series of consultations among more than 50 African countries held over the past three years resulted in the publication of a common position in March 2013 which called for a reformulation of MDGs post 2015, including a focus on "universal and equitable access to quality healthcare". In the Middle East a WHO-organized conference held in Dubai in December 2013 was attended by around 150 policy- and decision-makers and health system experts from ministries of health, finance, economy, planning and development, the idea being to share international experiences with regional policy- and decision-makers to assist them in devising a clear vision for health system reform to achieve the goal of UHC.

SHP/UHC

Social Health Protection is defined by the 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 Health Coverage is defined by WHO as coverage ensuring that everyone has access to the good quality promotive, preventive, curative, rehabilitative and palliative health services they need, without being exposed to catastrophic expenditure in seeking care. *The concepts are similar but SHP has the added dimension of addressing the problem of income lost due to illness. As far as the collaborative work of the P4H network, especially in countries with low levels of formalization is concerned, UHC and SHP-are more or less interchangeable terms.*

[1] http://p4h-network.net/wp-content/uploads/2013/03/2013_07_10_P4H_Network_Annual_Report_May2012-Apr2013.pdf

At the national level an increasing number of governments are exploring UHC/SHP possibilities, many of them turning to the P4H network[2] for help in doing so. Focal areas of P4H network activity in the past year include analytical work on benefits and costing, and fiscal space analysis to determine what governments can afford. As countries progress towards implementation there has also been increased demand for analysis and assessment of the way existing schemes/pools and funding mechanisms (often established in the name of UHC/SHP) relate to each other. This kind of analysis is essential to establishing a clear UHC vision, and improves countries' chances of avoiding the pitfalls of fragmentation further down the road. The number of countries now working with the P4H network has risen from 23 to 33, including 8 countries that have only recently begun the process of developing a UHC/SHP agenda.

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 and equity in the use of resources;
- harmonizing economic and social objectives;
- integrating health financing reform with health sector reform, and ensuring that the development of national health plans through processes such as the International Health Partnership (IHP+) are consistent with and complement the development of health financing strategies for UHC/SHP, and vice versa;
- linking health financing reform with a country's social protection framework.

Limited UHC/SHP-literacy at the country level continues to be a significant issue and the P4H network has maintained its commitment to capacity development, not only through the provision of technical workshops and short training programmes, but with a number of new initiatives, including a 'Leadership for UHC' course designed to strengthen leadership skills in the areas of developing a

[2] As of May 2014 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 is represented by US Agency for International Development (USAID).

UHC/SHP vision, communication and dialogue, coalition mechanics and results-orientation. Also of note is the development of e-learning versions of the World Bank institute (WBI) Flagship course on Health Systems Reforms and Sustainable Financing, and the WHO Advanced course on Health Financing for LIC and LMIC – online learning being an obvious way to meet growing demand. To further broaden the spectrum of available resources for capacity development, P4H network partners are also working on a UHC interactive guide.

The P4H network itself is becoming better at information exchange, notable developments being the initiation of a continually updated intranet site that allows P4H members to share information and discuss UHC/SHP developments in countries of interest, and the continued development of specific networking tools such as (P4H / Coordination Desk)-moderated round table discussions. Finally, the network has seen a bump in resources, notably with Switzerland's commitment of CHF 8.5 million until 2017 (part of which will support a new CD post) and the opening of a new CD office at World Bank HQ in Washington.

Increasing complexity in an evolving UHC/SHP landscape

While interest in UHC/SHP continues to grow, a number of new challenges are emerging as the global UHC/SHP picture evolves. One of the greatest is maintaining momentum for reform beyond the planning phase. It appears that, for many of the countries working with the P4H network, the UHC/SHP honeymoon (i.e. the planning, discussion, consensus-building phase) is coming to an end. Countries that have spent the past several years working on roadmaps for change are approaching the point where the realities of implementation must be faced.

A number countries in the P4H country portfolio have already approved, or are in the process of approving Health Financing Strategies, but thus far only Bangladesh, Indonesia and Senegal have drawn up implementation plans. However, many countries are now looking at the reality of having to implement strategies hitherto the subject of discussion only, sometimes under the pressure of promises made at the ballot box, or expectations raised during the planning period. Some of the countries approaching, if not already straddling, self-imposed UHC/SHP deadlines are still wrestling with fundamentals. Indonesia, for example, which made a commitment to introducing SHP as of 2014, is discussing ways to cover non-poor informal sector workers. In other countries, already complex situations have been further complicated by unfolding events. In Bangladesh, for example, the death in April 2013 of over 1000 garment workers in the Rana Plaza building collapse has focused attention on a scheme designed to provide health insurance for the workers in the ready-made garment sector at the risk of compromising broader UHC objectives by further fragmenting the health financing landscape.

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.

Of greater concern, perhaps, is the fact that *a number of countries have seen progress on UHC/SHP slow to a halt after the planning phase*, and in particular after the approval of a Health Financing Strategy. This appears to be happening either because the strategy (or parts of the strategy) was not 'concrete' enough, and required further fine-tuning, or because insufficient attention has been paid to contextual issues such as the prevalence of decentralised funding/risk pools or due to the silent dissent of stakeholders who may have signed up to plans which they in fact oppose. Broadly observed is a tendency for governments to prefer an incremental approach to expanding coverage rather than committing to UHC/SHP wholesale, a commitment that generally entails the setting up of new institutions, and, of course, significant new investment in health care systems. The P4H network remains committed to supporting countries as they work through these issues, advocating the highest level political commitment and multi-sectoral stakeholder involvement.

Calls for increased government spending – a perennial of public health discourse – are being made with greater insistence as UHC/SHP deadlines approach and countries recognise that achieving equity is a core UHC challenge which cannot be met without greater financial commitment. One of the clearest messages to emerge in the past year is that progress towards UHC will be compromised unless there is a significant increase in public financing for health. Discussions about how much and where to get the funds for UHC has become one of the highest priorities in the country discussions, and it is noticeable that some P4H members, notably WHO and WB, have become more vocal in arguing that increased public financing plays a crucial role in the development of UHC.

In a number of countries it is apparent that progress towards UHC/SHP could be greatly accelerated through high-level political leadership. Politics has of course always played an important part in the development of UHC systems, and as implementation deadlines approach, the positions of different interest groups, and the politicians that represent them, tend to come to the fore. The part played by politics in the development of UHC is increasingly a topic of conversation in discussions between P4H Network partners and officials and stakeholders in the countries with whom they work, but thus far countries have done little in the way of systematic analysis in this area. For example, the issue was specifically addressed by the P4H mission team in Kenya in November 2013, which recommended that a political analysis[3] be undertaken "to inform the HFS development process".

[3] The World Bank's piloting of *UNICO, UNICAT* [UHC programme and capacity assessment tool] and *UHC for Inclusive and Sustainable Development* case studies carried out in 2013 made great strides in uncovering the political and leadership aspects of UHC and, once published, could be useful tools if integrated in ongoing (P4H supported) strategy and implementation processes.

While it is clear that inadequate UHC capacity is a matter of concern at all stages and in all aspects of the UHC development process, the problem presents itself in particular ways for politicians. It is one of the central tenets of the P4H approach that high-level political support is essential for progress on UHC (see box), but where that support is not based on a clear understanding of the technical challenges faced or the stakeholder interests involved, it can actually be counterproductive. In Benin, the RAMU UHC scheme, a project which continues to be high on the presidential agenda, had its fourth official launch in June 2013 despite the absence of accompanying legislation. In Senegal, UHC was officially launched in September 2013 in a ceremony that included the symbolic handover of a cheque for CFA 50 million to eleven regional unions of Mutual Health Insurance Schemes and the announcement of State support for such schemes covering 50% of the cost of caring for contributing members, and 100% of costs of caring for the poor. However, the fact that Mutual Health Insurance Schemes still cover less than 10% of the population, despite the high-level support they receive, suggest that actual progress on UHC in Senegal is going to require some rethinking.

Political leaders find themselves faced with a range of challenges, notable among which stakeholders, institutions and organizations that may not share a common vision of UHC or of how to move forward, sub-optimal communication and cooperation between ministries, and varied levels of understanding and/or conflicting interests between different government and private sector stakeholders. It is to support leaders in dealing with these different challenges that the new 'Leadership for UHC' course was put together by GIZ and the World Bank Institute (WBI) in October 2013 (see below).

The P4H network adds value in various 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 serving as a 'one-stop shop' for countries*, with the network members' various country offices serving as entry points to a wide range of skills and services;
- *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.

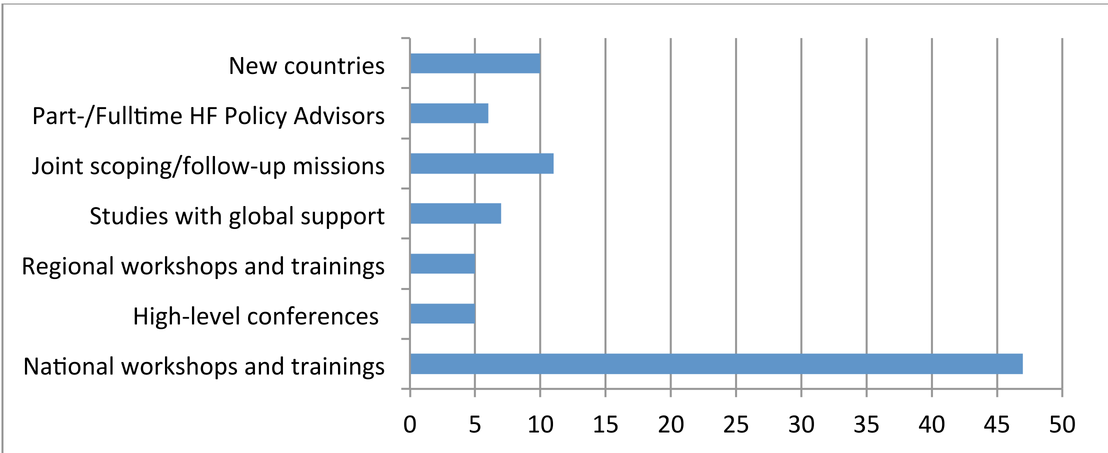
Crucial to winning the political argument with regard to UHC/SHP is the capacity to demonstrate the benefits of embracing it. In order to do this UHC advocates require meaningful, comprehensible UHC indicators. The overarching, multi-sectoral nature of UHC presents a number of challenges in this regard, a fact that is of more than just academic interest, since it appears that the lack of progress on building equitable and sustainable systems comes with a tendency discuss UHC relative to individual vertical health programmes (eg. Maternal and Child Health activities or Malaria control), and to allocate funds to such programmes simply because results are easier to quantify. (It is also worth noting in passing that the development of useful UHC indicators is important if UHC is to become one of the goals of a post-2015 development agenda).

The net result of the past years developments is an increase in the complexity of the task of moving forward on UHC/SHP. Put simply, talking about reform is easier than implementing reform, and while it is clear that each country is different from the outset, it appears that contextual particularities are only fully realized when it comes to UHC/SHP implementation. It is for this reason that, going forward, the P4H network's focus on country support will be more relevant than ever.

2. The P4H network coming together to make a difference

Each country struggles with its own issues, but the steps required to transition towards UHC/SHP are invariable, starting with effective, equitable and sustainable financing. 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 the past year P4H network partners have been active in helping governments establish where exactly they stand on health care provision, which benefits to provide and at what cost, and how to make services accessible to everyone. 2013/14 saw a number of exciting new developments in the area of capacity development, including web-based initiatives designed to improve countries' access to UHC/SHP knowledge and lessons learned.

Table 1. Examples of P4H Network Support Activities 2013/14



Focal areas of P4H network activity in 2013/14.

Benefits and costing*: In the past year there has been widespread demand for support regarding benefits packages and the cost of providing them. Typically discussions focus on the trade-off between providing a smaller benefit package covering everyone, or broader benefits for selected groups with possible expansion to other population segments as fiscal space improves*. Work on benefits and costing has been a key part of the work going on in Nepal, for example, where WHO agreed to support the Ministry of Health and Population on the development of a benefit/service package in accordance with the division of labour agreed between P4H members. WHO is also working on costing, and shared its first cost estimates of the proposed Essential Health Package in February 2014. The broader issue faced by Nepal is how to reconcile the current 'free care' benefits with the suggested benefits for the proposed health insurance scheme. Benefits and costing were also an important focus of discussions in Kenya in November 2013 when a P4H Mission met with consultants who were in the process of undertaking a UHC assessment exercise. The P4H Team provided a visualisation of various benefit options to deepen the understanding of the various trade-offs available. In Tanzania, the Ministry of Health and Social Welfare endorsed a health services costing study that was commissioned by the Ministry and funded jointly by GIZ and USAID. Again, options have been prepared as input for the upcoming development of a Health Financing Strategy. In Benin and Burkina Faso, WHO has supported the development and use of simple simulation and cost/benefit arbitrage tools by the technical teams in charge.

Fiscal space analysis*: There has been considerable demand for P4H partners support with fiscal space analysis this year, mainly related to the two key UHC questions: 'can we afford it?', and 'do we want to pay for it?', the latter question reflecting the reality that UHC is often in competition with other national priorities.* For instance in Tanzania, KFW and AfDB contracted consultants to carry out a fiscal space analysis that started in March 2014. A fiscal space analysis was also undertaken in Kenya by WB, which in October 2013 shared a final draft of a study on fiscal space and policy options for targeted intergovernmental transfers which focused specifically on the health sector. Fiscal space discussions and options (especially the very tricky issue of removing oil subsidies in an oil producing country) were also at the centre of the Joint P4H mission in Yemen in May 2013. Unfortunately, the agreed on roadmap, including work on fiscal space, could not be implemented due to the security situation.

Establishing the fiscal space available to finance UHC is clearly a valuable exercise in itself, and may sometimes be helpful in pushing governments to spend more on health, but it is only one component of discussions about health care finance. Such discussions continue to be central to UHC/SHP deliberations in every country, where the focus on financing mechanisms and resource mobilization strategies is at least as important as discussions of what the government itself can afford. Many countries continue to explore the possibility of developing innovative sources of funding such as sin taxes or targeted levies on cash generating industries, while others are looking at possibilities for private sector involvement. A dialogue between WHO and the AFD was launched at the end of 2013 on how to best design and carry out studies on innovative financing for UHC in Francophone Africa. Needless to say, all of these mechanisms can, and in some countries already do, play an important part in mobilizing new resources, but it is increasingly clear that *raising more domestic funds through public financing is an essential factor in achieving UHC/SHP advances.*

Efficiency improvement: Among the P4H partners, it is broadly accepted that efficient use of available resources is critical condition to support UHC. In this regard, WHO has taken an initiative to review effects of health financing and health systems reforms aimed at efficiency improvement. Currently, the review has started in 5 countries in Africa (Burundi, DRC, Ethiopia, Ghana, and South Africa), 4 countries in America (Chile, El Salvador, Mexico and Uruguay) and 2 countries in Asia (China and Republic of Korea). Country experiences in addressing health system efficiency and lessons learnt from this review are expected to be synthesized and publicised to support country level actions and reforms to support of UHC.

Overall architecture*: Because most countries committed to developing UHC/SHP build on earlier schemes there is also considerable demand for assessment and clarification of how existing and planned funding mechanisms and pools relate to one another, and what needs to be done in order to move towards UHC*. A key consideration here is the 'overall architecture' of the national health financing landscape and the foundations that need to be put down to enable UHC to develop smoothly over the coming decades. This has been a central issue in Bangladesh, where the range of financing mechanisms, existing and envisaged for the future, risks fragmenting resource collection, pooling and service provision, and is incompatible with the 'single national fund' idea as proposed in the agreed Health Financing Strategy. Notable in this regard are the SSK scheme, which is intended to provide coverage for the poor, and the RMG scheme for workers in the textile industry. In order to avoid the development of disparate benefit packages or variant enrolment and administration procedures (which can lead to duplication of effort and increased inequalities) it is helpful for governments to establish the same rules and principles for all planned schemes. Tackling the issue of fragmentation early on is essential since it becomes much more difficult to harmonise or merge various schemes under a national UHC approach further down the line, when schemes have developed their own identity and dynamics. In Mali, the recently developed Health Care Financing policy specifically tackles the issue of fragmentation, addressing the UHC issue in a ten-year time frame.

In Tanzania, WHO was called upon to facilitate a workshop that was organized by GIZ in cooperation with the Ministry of Health and other P4H partners, to go through a set of options papers related to different aspects of health financing, and to help synthesize a more coherent set of overall options for the future architecture of the health financing system. Participants from the health ministry, the Prime Minister's Office, representatives from the existing health insurance schemes in the country, academia, NGOs and development partners, focused on three main options and a strong consensus emerged regarding the role to be played by a common/equalizing fund, a shift towards output-based financing wherever possible and a universal essential benefits package for everyone.

Decentralisation is another form of fragmentation, and has become a hot topic in Kenya, since decentralisation has established 47 new funding pools (one per County). The question of how to address the issue of decentralised funds comes up in all countries where the health budget has been devolved to local governments. In Francophone Africa, the hottest topic related to the general architecture of national health financing systems has been the combination and/or merging of existing maternal and child health exemption schemes with the soon-to-be-deployed universal health insurance schemes. This issue is of particular interest for the AFD which is implementing a new

French initiative called I3S (Initiative Solidarité Santé au Sahel) which is designed to fund health services for children under five years of age.

UHC assessment: Going forward, and as countries begin to implement UHC/SHP policies, it seems likely that there will be increased demand for expertise, evidence, and measures of progress towards UHC. Similarly, there will be a need for sharper UHC assessment if UHC becomes one of the goals of the post-2015 development agenda. WHO and WB have already been doing some interesting work in this area, notably producing a framework on measuring progress towards UHC that was presented at the Global UHC Conference in Tokyo, 5-6 Dec 2013. The ILO provided observations on the framework. An indication of how important guidance on UHC assessment is likely to be in the future is offered by Kenya, where a recent country-led 'UHC situation assessment' was conducted. The assessment relied on a technical tool based on health financing functions rather than a comprehensive assessment based on the three dimensions of population-, service- and cost coverage, and as such lacked the broader UHC perspective. It was followed up by a synthesis report broadening the UHC assessment with a focus on strategic options. The ILO is also working with P4H partners in the context of the SPIAC-B to develop assessment tools for social protection including health protection. Experience shows that UHC assessment will also need to address the political dimension.

***Capacity development*:** As noted above, the lack of UHC capacity - at the level of people, organisations and the system - continues to be a major challenge for many countries and 2013/14 saw a number of exciting new developments that offer hope for change, including some interesting web-based initiatives designed to improve countries' access to UHC/SHP knowledge and lessons learned.

On the level of individual capacity development, the German and Swiss-funded Sector Project P4H is collaborating closely with the World Bank Institute and WHO, offering a range of capacity development activities, including a suite of training and knowledge exchange events that is being scaled-up and improved to cover UHC/SHP practitioners at all levels. The training formats for technical and advisory staff are based on the World Bank Institute's Flagship framework that has been adapted to a UHC/SHP perspective. Working in collaboration with WHO, the ILO also organized training courses in 2013/2014, including courses on Social Health Protection that addressed inequities in access to health care.

The reach of the courses is being significantly increased with the development of e-learning versions. Greater use of the web is also key to the new internet gateway to UHC/SHP evidence, trainings and reform strategies which is being developed by WHO. The gateway will not only offer access to existing resources, but also embed them in the framework of a reform-process oriented guide. The aim will be to help users to develop an understanding of UHC/SHP reforms as a holistic process rather than as a patchwork of individual technical solutions, the emphasis being on 'system thinking', and the needs of society as whole, as well as the importance of managing complexity. Such concepts are key to P4H network value-added. The platform will also link different development partners' capacity development activities. Also of note in this regard is the development of an Interactive Guide to UHC which is to be integrated into the P4H website and once operational will support the role of P4H as the platform for support to UHC reforms. The Guide will serve as a didactic gateway for knowledge

exchange, systematic update of web-based resources and event-follow policy and technical support that is suited to individual country settings. The basic aim of the initiative is to facilitate the process of turning UHC reform theory into UHC reform practice.

Learning to lead. For leaders, a completely new format has been developed in collaboration with the leadership teams of the GIZ Academy for International Cooperation and the World Bank Institute. The Leadership for UHC course represents a break with previous capacity development initiatives which have tended to focus either on technical skills or have been fairly broad and general in scope. The course will address issues such as the lack of communication and cooperation between technical experts and the political leaders responsible for making UHC happen, and the lack of awareness on the part of policy-makers with regard to the challenges faced by those who have to implement their policies at the local level. The course will also address the 'how' and 'who' aspects of reform, in other words how to drive processes forward, build strong coalitions towards shared goals, and co-create innovative solutions across institutional and sectoral boundaries. The course will be integrated into ongoing reform processes and focus on learning through practice. It blends short face-to-face trainings with mentored practice phases over a 6-12 month period. The first edition is planned to kick off in July 2014 for Eastern and Southern Africa, a second edition for Southern and Eastern Asia is planned for 2015.

Peer to peer. Because of the importance of peer to peer knowledge exchange in capacity development, P4H network partners continue to support events designed to bring together countries to share UHC/SHP experiences. In April/May 2013, the African Development Bank AfDB in collaboration with GIZ, the World Bank and other partners, organized a visit by African delegates to India to attend a Knowledge Event which brought together representatives from Ministries of Finance, Health, Industry and Trade as well as pharmaceutical manufacturers, and development partners to discuss India's progress in pharmaceutical policy, R&D, manufacturing, financing, procurement and distribution. In July 2013, working in collaboration with the World Bank Institute and WHO, GIZ organized a mixed capacity-development, South-South knowledge exchange event for 14 Anglophone sub-Saharan African countries that was hosted in Kenya. The event was extremely well-received and offered a prime example of P4H partner collaboration. It was also well integrated into ongoing strategy processes in the countries involved. The Ugandan team, for example, presented some of their lessons learned and insights in their subsequent national UHC workshop. Also in July 2013, in cooperation with the African Development Bank, P4H organized a South-South knowledge exchange event for several Asian and African countries that was hosted in Zambia. P4H support included financing for participants and faculty, and moderation. The event offered key insights into the reforms undertaken in Asian countries. In December 2013 a regional exchange workshop, organised by P4H in collaboration with the West African Economic and Monetary Union and Community of Practice, and held in Benin brought together 13 francophone countries to consider/discuss "Financial Access to Health Services".

Filling the capacity gaps. Finally, last year also saw GIZ initiating a participatory method for a UHC Capacity Gap Analysis and Capacity Development Planning. Started in June 2013, the basic idea of the initiative is to systematize the approach to investment in UHC/SHP. To date, information on where

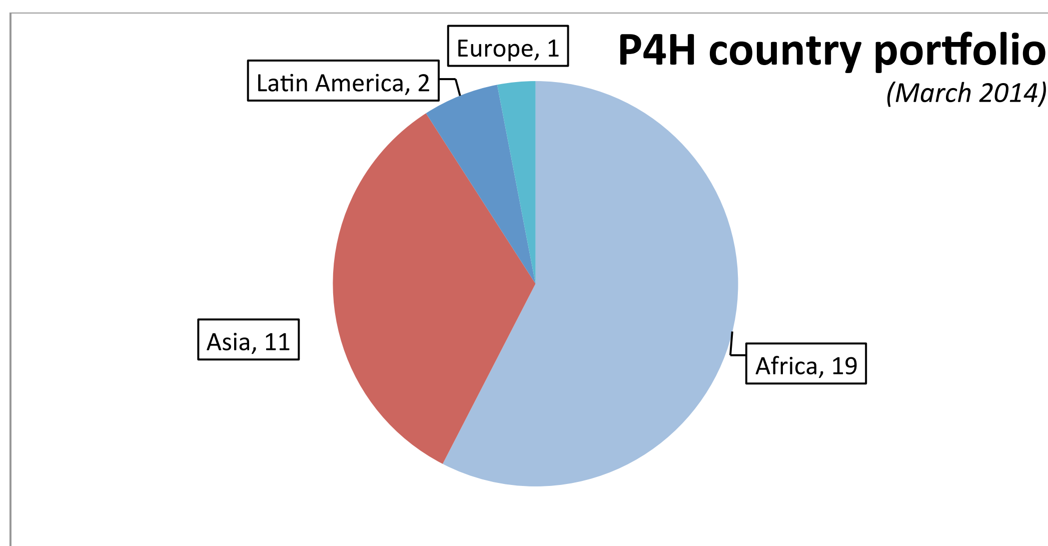
to invest in order to close capacity gaps at the systemic, organizational and staffing levels has been lacking, and the new gap analysis and planning method is designed to help P4H partners better direct their investment efforts. Implemented together with country and P4H partners, the approach will deliver a locally owned Capacity Development (CD) Plan, which will serve as a platform to streamline efforts and to prioritize the most acute capacity bottlenecks.

In the area of human resources for health, the ILO has actively supported WHO, notably in the context of the Global Forum on Human Resources for Health, and has been working the WB, USAID and others on an Human Resources for Health Global Strategy.

3. P4H making a difference on the ground.

Typically P4H network involvement begins at the national level, with two or more P4H partners responding to a country's call for support. Respecting *the inform and involve principle* those P4H partners can then reach out to other P4H members for regional and global level support where this is needed. Ideally, P4H member efforts are guided by a country-owned roadmap for UHC/SHP, which sets out the milestones to be reached, and the roles and responsibilities of the various stakeholders involved. By the same token, P4H member support in developing this or that policy should not be seen as approval of or agreement with the particular approach taken; P4H is there to support countries committed to developing their own solutions. A joint support plan is then drawn up allocating different support activities to specific members, and setting a timeframe for implementation.

The following country examples have been chosen to illustrate where P4H networking made a difference, connected sectors, and increased the coherence and dynamics of the support process. The cases may also serve as good practice examples for P4H network 'pipeline' countries, which we will strive to offer similar levels of network support.



As countries progress towards implementation, P4H member involvement typically deepens, often involving the assignment of policy advisors on a part-time or full-time basis. The P4H network currently has 6 part-time or full-time policy advisors in place. Network members also regularly undertake follow-up missions, and in many countries offers continual support for the technical and inter-sectoral working groups that have become a mainstay of country-level initiatives to advance the UHC/SHP agenda. As already noted, 2013/14 saw accelerating demand for support from the P4H network, with 10 new countries approaching P4H partners for support in developing an SHP/UHC agenda. This brings the total of number of countries working with the network at different levels of engagement and intensity to 33.[4] Notable newcomers include states facing a number of particular challenges such as Democratic Republic of Congo and Yemen.

Africa

Sub-Saharan Africa continues to be the main focus of P4H network activity, no fewer than 19 countries currently engaged, albeit at different levels of commitment and intensity, in UHC/SHP planning or reflection. Newcomers from the region include:

- **Burundi,** which started the UHC/SHP ball rolling with the financing of a situation analysis paper on the health financing landscape in August 2013; the paper will support P4H partner efforts to develop an evidence-based Burundian Health Financing Strategy in 2014 – the ILO is also providing advice on policy design and costing support for the introduction of UHC;
- **Democratic Republic of Congo**; WB invited the P4H Coordination Desk to attend a development partners meeting on health financing in DRC in January 2014; simultaneously, WHO provided legal advice on a UHC draft bill; all parties agreed that the development of a health financing strategy for UHC was needed, and should inform the next version of the UHC bill;
- **Ethiopia**; Ethiopia is about to launch a Social Health Insurance scheme, and is running several Community Based Health Insurance pilots in the country. The enrolment of Ethiopian leaders and policy makers in the upcoming P4H Leadership for UHC programme may provide an excellent opportunity to explore and initiate joint support activities towards UHC/SHP.
- **Mozambique**; in December Mozambique reached out to the P4H network for support in the development of a Health Financing Strategy. WHO, the WB and USAID are part of a task force, currently co-chaired by DFID and WHO, and have assisted with the development of an action plan for strategy development. The Ministry of Health would like to complement these efforts with a long term advisor and has issued a request for support to P4H via the Swiss Development Cooperation. From a P4H Network perspective, it will be important to

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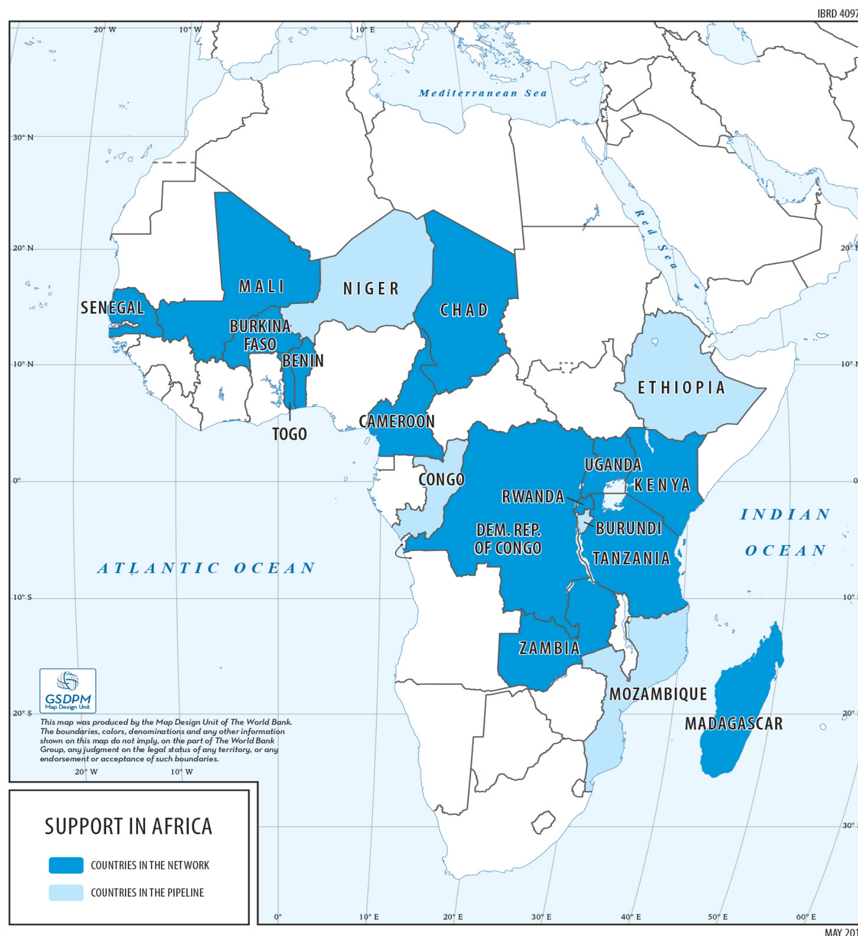
[4] As of May 2014, the 33 countries working with the P4H network are: Bangladesh, Benin, Burkina-Faso, Burundi, Cambodia, Cameroon, Chad, Congo, Colombia, Côte d'Ivoire, Ethiopia, Haiti, India, Indonesia, Kenya, Kosovo, Kyrgyzstan, Lao PDR, Madagascar, Mali, Mongolia, Mozambique, Nepal, Niger, Philippines, RD Congo, Rwanda, Senegal, Tanzania, Tajikistan, Togo, Uganda, Yemen and Zambia.

link these efforts in the health sector with the ongoing activities of the Social Protection Floor supported by ILO.

*Sub-Saharan countries where P4H network partners have been particularly active in the past year include **Benin**, where the RAMU*[5] *UHC project continues to be high on the presidential agenda.* This despite a challenging year that started with RAMU's official launch (for the third time) in March of 2013 which was followed by a fourth launch in June. At that time RAMU was presented as a health insurance scheme covering low-income and destitute people that would soon be available for all. Unfortunately, a number of issues remained unaddressed, including the absence of accompanying legislation, a healthcare financing strategy, and RAMU strategic guidelines. Another matter of concern was the limited capacity of the agency managing RAMU (ANAM[6]), which was created by decree in 2012 and was still in the preparatory stages of implementation.



P4H Network Support in Africa

Using an explicitly P4H approach, WHO, WB, USAID, and partners from Belgium, Switzerland and France have come together to provide the Benin authorities with the strategic and technical input needed to move RAMU forward. Other partners are also supporting the process, including the UNDP, UNICEF, UNFPA, and the EU. A complete evaluation of the challenges faced by the health-care

[5] Régime d'Assurance Maladie Universelle.
[6] L'Agence Nationale de l'Assurance Maladie.

financing system was finalized in July 2013, resulting in a recommendation to create a Technical Working Group to study strategic options for RAMU, as well as implementation guidelines. The TWG was subsequently created by decree and staffed with people from different ministries and sectors, led by representatives from the Ministry of Health.

A series of events were co-organized by P4H in December 2013, including the presentation of a draft healthcare financing strategy to national stakeholders and international observers which resulted in useful feedback on how to improve the strategy. In January, a meeting of the Ministry Council was largely dedicated to the cost and financing of RAMU. The meeting was based on financial simulations developed by the TWG and resulted in the government calling for RAMU to be financed through a 15 billion FCFA (US$30 million) cash injection from the government. Going forward, Benin needs to pass legislation to support RAMU, and boost staffing levels at ANAM.

*P4H network members have also jointly been active in **Kenya***, where the April 2013 election was followed by renewed interest in moving the UHC agenda forward. A meeting of the Inter-agency Coordination Committee on Health Financing was convened in the immediate aftermath of the election to discuss, among other things, the provision of free maternal health care and the abolition of user fees for basic and intermediate levels of care, as well as the reform of the National Hospital Insurance Fund.

The upshot of those discussions was the decision to form technical working groups to look at UHC, National Hospital Insurance Fund reform, and accreditation and regulation. In May the first technical working group was created to define 5-year targets for increasing service and population coverage, and for reducing direct payments. The group focused on drawing up targets with regard to revenue generation, risk pooling and purchasing of services, and was also tasked with carrying out a review of existing institutions with a view to proposing the institutional arrangements that will be necessary to attain the above-mentioned objectives. The group also hired three local consultants who undertook an assessment of the UHC situation in Kenya, and were to propose a set of options that the country can pursue in moving towards UHC. Because a global standard, and tools for UHC situation analysis (which capture both the technical and political aspects of UHC) are still evolving, the assessment was limited to a technical analysis based on the health financing functions and did not produce any new evidence or insights on the way forward. *For the sake of impartiality, and to ensure the involvement of different stakeholders,* the Ministry of Health subsequently brought in an external team of P4H network members to synthesize the three 'UHC assessment' reports and to develop an options paper for feasible UHC reform. P4H network members GDC (GIZ/KfW), WHO, WB and USAID answered the call, developing a draft options paper which was presented to the Ministry of Health’s top leadership in April 2014.

*The past year has also seen progress in preparing the development of a health financing strategy for **Tanzania**, where the P4H network has made a significant contribution, notably by providing financing and technical support for 10 health financing reform studies, including studies on health insurance market options, a minimum benefit package, and inclusion of the poor.* The studies have not only served to sharpen the focus on key UHC/SHP issues but have given the Inter-ministerial Steering

Committee and Ministry of Health and Social Welfare a solid basis for informed decision making going forward.

P4H also organized a series of four key health financing strategy development workshops, culminating in a health financing reform option's consolidation workshop in Dar es Salaam, that allowed for a narrowing down of health financing reform options and paved the way for consultations with regional and parliamentary stakeholders slated to take place in 2014.

Other notable achievements include capacity strengthening of key Ministry of Health and Social Welfare Health Financing Unit staff (and staff in other key ministries) through the provision of targeted training and information exchange initiatives. Also worth noting is the fact that key actors from the National Health Insurance Fund, the Ministry of Health and Social Welfare and WHO were able to attend an Africa Knowledge Exchange on National Health Financing Strategies for Universal Health Coverage in Kenya in Nanyuki.

*In **Uganda** P4H was able to play an important role in bringing together separate UHC/SHP endeavours, enabling the country to move forward on UHC/SHP reform*. The year began with the Ugandan Ministry of Health renewing its request for P4H support in May 2013, stating that teams within the ministry had been established to work on the drafting of a health financing strategy. The Ugandan Ministry of Health has, intermittently, been working on a health financing strategy with the support of WHO, GIZ and the WB since 2012, and progress has been somewhat hampered by the existence of a second, parallel, drafting process, supported by former Vice President and current Presidential Advisor on Health and Population. In June the Ministry of Health team working on the health financing strategy participated in a regional training workshop in Kenya on health financing organised by the World Bank Institute in collaboration with WHO and GIZ, and funded by GIZ/P4H.

A P4H mission in July helped to bring the above-mentioned separate work streams together and paved the way for the joint organisation and facilitation of a 2-day national stakeholder workshop. With over 100 participants, the workshop turned out to be the year's UHC headline event, involved both drafting teams, and was supported by the P4H members WHO, WB, GIZ USAID and the P4H Coordination Desk. The new Minister of Health (HE Dr. Ruhakana Rugunda) used the workshop to express his commitment to UHC, and to emphasise the need for effective, efficient and equitable use of resources for health, and the importance of leadership and stewardship. He also proposed establishing an inter-ministerial committee to debate health financing reforms as he recognized the importance of multi-sectoral collaboration in moving the agenda forward.

Asia

Asia continues to be an important focus of P4H network member activity, with a total of eight countries working on UHC/SHP agendas in consultation with or supported by P4H network members, including newcomer Myanmar, which made a promising start in developing a UHC/SHP agenda, and Mongolia which had something of a breakthrough year largely due to the efforts of P4H network

partner Germany. Cambodia reinitiated work on UHC/SHP, while other countries, notably Bangladesh and Indonesia are working on major strategic issues as implementation deadlines approach.

P4H partners have been particularly active in ***Bangladesh*** *in the past year reflecting momentum in the country on UHC/SHP issues. After the development and approval of the Health Care Financing Strategy in October 2012, Bangladesh continued to move forward with its UHC/SHP agenda in 2013, notably by developing an implementation plan intended to provide feasible and sustainable options for the road ahead*. The implementation plan includes the strengthening of the Health Economics Unit within the Ministry of Health and Family Welfare, notably through the provision of international experts, and a rapid health systems analysis and assessment regarding specific issues such as costing. P4H partners worked with the Government and other stakeholders and facilitated consultations to build consensus on a 2013/14 operational plan. The objective is that the Health Financing Resource Task Group, which is staffed by health ministry and development partner representatives will ensure the integration and alignment of the implementation plan with the national planning process as well as facilitating broader multi-sectoral stakeholder involvement.

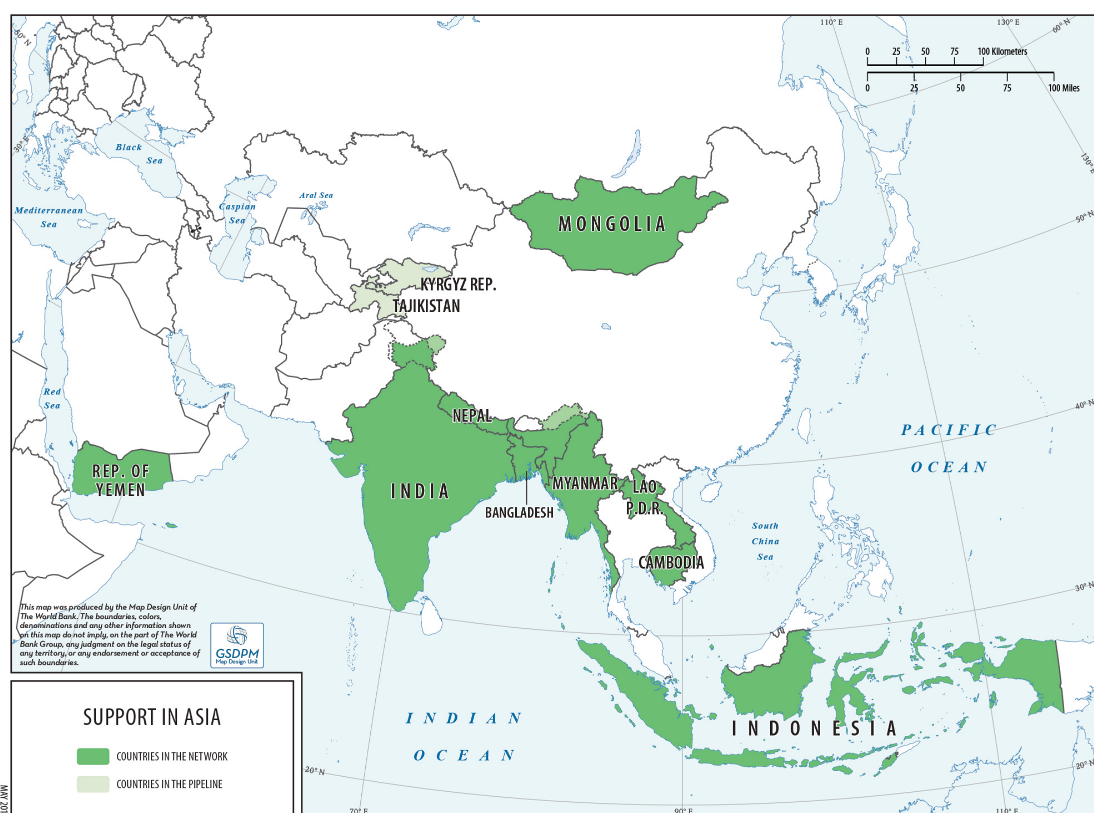
Another key development in Bangladesh is the highlighting of the importance of developing viable and sustainable SHP options as part of the broad UHC/SHP agenda. Concerns about SHP came into sharp focus in April 2013 when an eight-story garment factory collapsed killing more than 1,000 people. P4H network partners held a special session on November 3rd 2013 to discuss the National Social Protection Strategy and its link with the Health Financing Strategy. Subjects under discussion included a proposal to cover the needs of Ready Made Garment Workers (RMG). Among the many challenges highlighted was the current safety net portfolio which includes 95 schemes, fragmented across various sectors, geographical areas, ministries, overlapping objectives and beneficiaries.

This was followed by another meeting of P4H members in November 2013 to discuss updates on the proposed SSK *(*Social Health Protection designed to improve access of the poor population to hospital services, to reduce direct payments and to improve efficiency of quality hospital care) and RMG (health insurance for the workers in the ready-made garment sector) schemes. A commonly expressed concern was the need to integrate existing and new SHP initiatives into the overall UHC/SHP framework.

In order to increase coherence of UHC/SHP-related policies across sectors, the P4H members initiated contact with the Social Protection working group. Subsequently, a first draft of the National Social Protection Strategy was circulated among stakeholders, the idea being to elicit comment and stimulate dialogue between stakeholders in the health and social protection sectors. The circulation of the draft also presented an opportunity for any adjustments needed to ensure coherence between the National Social Protection Strategy and the Health Care Financing Strategy. P4H members were invited to comment or provide feedback through the UN Social Protection Theme Group which met in November to discuss the matter.

More recent activities include the Health Economics Unit and Ministry of Health and Family Welfare, with the support of WHO, WB and GIZ/KfW convening a national workshop on UHC in Bangladesh in February 2014. The main aim of the workshop was to build consensus around ways to move forward across a range of sectors. Getting stakeholders from other sectors on board would help galvanise broader ownership which is clearly required to move the national UHC agenda forward. Several high-

level speakers presented insights and experiences from their own journeys on the road to UHC. Prior to the workshop, the P4H CD organised an informal meeting at the WHO country office providing the visiting P4H team with an update on the current situation in the country and giving them an opportunity to informally exchange views on each other's perspectives and positions. The CD then moderated a roundtable discussion intended to generate practical recommendations and next steps regarding the implementation of the Health Financing Strategy 2012-2023. The discussion was structured in four sessions: resources and how to make a case for health[7]; pooling for UHC; benefits package development; and supply side issues. While the discussion addressed a broad range of crucial issues concern was expressed regarding the recycling of what have, to some, become over-familiar themes. The WB representative suggested that the Health Economics Unit propose that the Ministry of Finance make a funding commitment to cover the approximately 50 million poor that need coverage. A few days later, the Minister of Health made a public announcement stating that he would fight for a substantial increase in the health budget.



P4H Network Support in Asia

*After a period of inactivity **Cambodia** reinitiated work on UHC/SHP by calling for support in the development of the **National Social Health Protection Fund,*** which will operate under the Ministry of Health and act as the health insurance scheme for the informal sector population. In the first week of July, GIZ P4H Sector Project (the P4H team inside GIZ head office) representatives visited Cambodia

[7] Although nominal spending on health in Bangladesh has steadily increased in recent years, total health expenditure as a percentage of GDP has actually declined, while direct out of pocket payments, at around 64% of the total, remain high.

to respond to the Ministry of Health request. The mission resulted in a recommendation to conduct a functional analysis of institutional arrangements and support requirements. The assessment was undertaken in October of 2013 with the aim of elaborating the organisational structure and determining the staffing requirements for establishing the National Social Health Protection Fund, one of the three social health protection institutions envisaged. September and October 2013 also saw the financing of an option paper for the establishment of a National Social Health Protection Fund, to shift the administration of the Health Equity Funds (a mechanism to finance poor households' access to health care) from a foreign-funded NGO into the domestically-funded public system.

Cambodia also saw the drawing up the first joint working paper on an eventual health financing policy. The paper was presented to the Minister of Health who passed it on to the Council of Ministers in view of the inter-sectoral nature of the issue. It is hoped that a policy document will be signed by the Prime Minister in 2014. However the political deadlock that has prevailed since the elections of July last year means that progress on policy issues has generally been slow.

Nevertheless, Cambodia has made significant progress in regard to developing structures for collaboration, coordination and alignment. Notable in this respect was the reinstatement of the Contact Group, a forum for information exchange between bilaterals, mutlilaterals, NGOs, NGO Networks, or philanthropic organisations. Meetings are held on a monthly basis and are well attended, with P4H handling the secretariat function. Meanwhile a collaboration arrangement between GIZ, ILO, AFD and WHO that was endorsed under a memorandum of understanding, has been reconfigured to focus on the formal sector social health protection scheme known as the National Social Security Fund, under the Ministry of Labour and Vocational Training. Finally, a sub-technical working group focused on health financing (part of a coordination mechanism between the government and development partners) is in the process of being created. For the inclusion of other players an additional forum, known as the Exchange Group has been created, comprising the Australian Department of Trade and Foreign relations (the biggest donor in the health sector), WB, Germany, USAID, Koica and WHO. The country P4H advisor takes on the secretariat function.

ILO has also been active in Cambodia, reviewing and offering technical advice on the legal documents required for the implementation of social health insurance to ensure conformity with the provisions of the ILO's Social Security Standards, and consistence with Cambodia law and regulations. ILO also initiated work on provider payment for social health insurance, and worked on defining the referral system for the social health insurance scheme, projects which were completed by the World Bank and the AFD. Finally, ILO worked in collaboration with AFD on the development and refinement of an Information System Database designed for short and mid-term solutions.

*In 2011 the Government of **Indonesia** made a commitment to providing UHC to all citizens from 2014 onwards, making this year something of a red letter year for the country*. Since 2011 various milestones have been passed, notable among which the drawing up of a Roadmap for Universal Health Coverage which is to be the key guiding document for implementation of reform in the coming years. However, the government is still working on the issue of how BPJS Health (the national UHC scheme) will cover the non-poor informal sector.

Following protracted discussion and several workshops concerned with the informal sector, the government held a High Level Forum on Expanding Coverage to the Informal Sector in Yogjakarta,

Indonesia from 29 September to 2 October 2013. The Forum was supported by GIZ, AusAID, and the Joint Learning Network and was designed to highlight the experiences and lessons learned from countries such as Korea, Thailand, Viet Nam and the Philippines. Policy discussions focused on the question of contribution financing versus subsidies, the characteristics of informal workers, and the challenges presented by contribution collection and/or contribution assistance to the non-poor informal workers. A Policy Brief by the National Development Planning Agency, BAPPENAS, summing up the results of a study conducted to analyze the main challenges and recommendations for expansion of social health protection to informal workers in Indonesia was also presented. There were also contributions from WHO and the WB, notably a paper on the informal sector and UHC, which was a first attempt to synthesize the global evidence.

In other significant developments, GER/GIZ conducted a midterm evaluation of their social protection support programme in April/May. The CD was invited to join the mission to review the German contribution to the Indonesian SHP/UHC agenda as well as the P4H-initiated 'Partnership for Universal Health Coverage' (comprising WHO, the World Bank, ILO, GIZ, AusAID, JICA, USAID and the JLN) chaired by WHO Indonesia and launched in Jan 2012. The CD subsequently reported that while The Partnership for UHC was appreciated by the partners as a useful forum for dialogue and information exchange, it had yet to serve as a mechanism to facilitate the coordination of support activities. Recommendations on how to move forward with the partnership as a valuable supporter of the UHC roadmap process were shared with the group.

*For **Mongolia** the big event last year was the September 3 launch of its long-term strategy for the development of Social Health Insurance*, the fruit of considerable efforts on the part of the Government of Mongolia supported by P4H partners Germany and WHO over the past three years. The P4H partners have worked to strengthen dialogue among the stakeholders and improve the system's operations and governance. As a result of Germany's consensus-brokering efforts, relations between the Social Insurance General Office, the key ministries, and the social partners have improved dramatically, staffing levels have doubled, and new procedures are being rolled out across the country following a one-year pilot programme. This collaboration experience was documented and publicised through the German Health Practice Collection in December 2013, supported by the German Federal Ministry for Economic Cooperation and Development.

The long-term strategy document included a foreword thanking government organizations, social partners, international organizations and international consultants from WHO and the GIZ P4H Sector Project. Particular appreciation was reserved for GIZ's contribution of financial and professional assistance. The strategy outlined six strategic objectives in key areas of health insurance development: health insurance coverage, revenue, benefit package, healthcare quality and purchasing, governance, health insurance organization and private insurance.

In the same month an international conference on Social Health Insurance development in Mongolia was held in Ulaanbaatar. Organized by the Ministry of Health, Ministry of Population Development and Social Protection and State Insurance General Agency with the support of WHO and GIZ, the conference focused on the promise and challenges of SHI and emphasised the importance of learning from international experience. WHO provided technical and financial support and invited experts

from countries with similar experiences such as Lithuania, Moldova, The Philippines and Vietnam to share their experiences and lessons. Four parallel sessions were organized on specific areas including governance and institutional development for Social Health Insurance; the benefit package and quality of health services in the Social Health Insurance System, the Social Health Insurance reform process and social dialogue, population coverage and revenue generation. During the event, the Asian Development Bank made a statement supporting Social Health Insurance reform in Mongolia in collaboration with the government of Japan. Currently, the government of Mongolia is working on the revision of health insurance law and approached the P4H CD with a request to coordinate support among partners such as GIZ, ILO, and WHO.

*The **Myanmar** Ministry of Health kicked off its UHC project in June 2013 with a request for WHO to support the development of a UHC strategy*. A WHO expert was deployed under the umbrella of P4H to support the ministry in policy/strategy development and to review and revise existing policies and strategies as needed to support the UHC effort. The expert was also given responsibility for supporting the Ministry in the alignment of multiple development partner/donor contributions, and to serve as the P4H in-country representative.

The Ministry conducted a series of consultations on UHC throughout the year, ending with a consultation focused on the formulation of a road map and implementation plan which was organized by the Ministry of Health, with joint sponsorship by WHO and the WB. The consultation included officials from relevant departments of the Ministry of Health, non-health sector ministries, such as the Ministries of Finance, Defence, Planning and Economic Development, and Social Security Board, and a select group of partner agencies — bilateral agencies and NGOs.

Another important step was taken in January at the Second Myanmar Development Cooperation Forum at which the President of the World Bank strongly emphasized the need for Myanmar to embark on UHC, and committed US$2 Billion to the country in the form of a soft loan + grant, of which US$200 million was specifically earmarked for UHC. In an effort to link the health and social protection agendas, the forum was followed by a Social Protection working group meeting, which was attended by WHO, and a subsequent workshop focused on developing a Social Protection Strategy for Myanmar. A roadmap was agreed upon, entailing a series of workshops, and consultations to develop a social protection strategy with technical assistance from UNICEF, ILO and the World Bank. The task is to be carried out by a drafting unit within the Ministry of Social Welfare, but it was emphasized that the sectors outside the social welfare ministry, and the relevant development partners, e.g., Education, Health, Agriculture, Rural Development, etc. would be intensively engaged in the process.

***Nepal** also advanced its UHC agenda last year, starting in March 2013 when the Ministry of Health and Population approved a national health insurance policy*. Access to quality health care is a constitutional right in Nepal, but despite a policy of providing 'free care', direct payments deter many from using health services. The government sees the development of a health insurance policy as a vital stepping stone in the transition to UHC, and has been supported by P4H members WHO, the

WB, GIZ and other development partners (DFID/OPM, KOICA, etc.) offering tailored health financing options and solutions. In June 2013 a District Health Assessment – jointly undertaken by the Ministry of Health and Population and the Nepal Health Research Council, supported by GIZ and WHO – was published to inform and serve as a guide for the design of the National Health Insurance scheme.

To better coordinate development partner support, a joint meeting between the Ministry of Health and Population National Health Unit responsible for National Health Insurance scheme and external Development Partners was convened in September 2013, defining thematic areas which require further support for the implementation of the national health insurance scheme and allocating responsibilities to different partners.

Based on this division of labour, GIZ shared a report for the proposed institutional and organizational set up for the National Health Insurance scheme in January 2014. The report proposed that a new institution with the working name National Health Insurance Agency (NHIA), and employing no more than 10-15 employees, be created at an early stage of the design and implementation of the new national scheme and tasked with finalizing the design of the new scheme and preparing its implementation. Most recently WHO shared its costing of an essential health package for Nepal.

Latin America

2013 saw the opening up of a new continent for the P4H network, when, in June, the Government of Colombia requested a US$ 400 million loan from P4H partner AFD to support the implementation of health financing reform. In line with the P4H "inform and involve principle", AFD requested that the Groupement d'Intérêt Public – Santé et Protection Sociale Internationale (GIP-SPSI), the Pan American Health Organization (PAHO) and the P4H coordination desk (CD) participate in an AFD scoping mission.

In the same month the WB circulated a concept note on Reimbursable Advisory Services (RAS), with the intention of contributing to the Colombian Government's institutional capacity to exercise stewardship over the National Health Insurance System. Specifically the proposed RAS would provide technical assistance to streamline organizational arrangements and support the development and design of information systems to reduce fragmentation of the enrolment, revenue collection and pooling functions. The RAS will also provide technical assistance to introduce more refined mechanisms for allocation of resources, introducing results-based financing and a strategic framework for periodic evaluation of new health insurance policies.

In September of 2013 the Ministry of Health and Social Protection proposed a new international cooperation system designed to facilitate the coordination of international development cooperation in the Colombian health sector. The proposal focused on three main themes, one of which being support for reform in the area of health financing. A "Cooperation and International Relations Committee for Health and Social Protection" was also set up.

Colombia has made significant progress in improving coverage since 1993, but the various initiatives implemented have led to unhelpful complexity in the health financing system, while inequities in accessing affordable quality healthcare persist. The new health financing reform agenda envisages a number of changes, and notably the creation of *Salud Mia*, a new institution centralizing all resources and directly paying healthcare providers and the adoption of *Mi Plan*, a unified Obligatory Health Plan for all categories of the population, providing a wide range of services. A framework law (no. 1438) establishing the basic principles of for health financing reform was enacted back in 19 January 2011, but a parliamentary bill (no. 210-2013), necessary to enact reform, is still under discussion.

4. P4H network continuing to evolve

Essential to The P4H network's collaborative approach is the capacity of it members to communicate with one another. This capacity was greatly enhanced last year with the initiation of the **P4H Intranet**, which was launched in September 2013. Since its launch more than 500 users have been registered, including 33 country networks and colleagues at regional and global level. Unlike the publicly accessible P4H website located at p4h-network.net, the P4H Intranet website is a password-protected collaborative inter-agency workspace that is, for the present, only accessible to P4H members and selected partners involved in joint country support for UHC/SHP. Administration of the site is the responsibility of the P4H Coordination Desk.

The website currently comprises links to several sub-sections, starting with Country Pages which, as the name suggests, links to individual country pages providing easy access to a timeline populated with process and milestone entries, covering joint P4H support, contacts, events, documents, exchange, M&E and members' country summaries. Users can stay up-to-date with P4H network activities in various countries, subscribe to information sources, and contribute to the information exchange. For now Francophone country pages are mostly written in French, and are very much appreciated by Francophone users (the P4H brochure has also been available in a French language version since November 2013) but going forward we intend to have mirror pages in English.

An *Exchange Forum* link provides access to a platform for open dialogue and exchange among members on UHC/SHP. Users can view and search the forum by country and theme, read what others think and voice their own views and opinions. A *Contacts* page lists who is involved and participating in joint country support. Finally, an E*vents* page covers upcoming events, and allows users to jointly plan missions and meetings, etc.

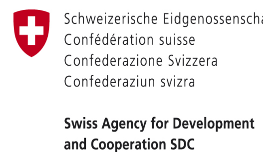
The Intranet is intended to be an evolving, interactive networking tool and should help the P4H Network to better communicate and simplify its work processes.

Increasing interest in UHC, and national and global level actions for UHC are driving a need for more coordination and collaboration among different agencies. For P4H one possible collaboration initiative could be to explore potential synergies with the Joint Learning Network which supports UHC by connecting country level practitioners seeking to collaborate and solve problems to advance their UHC agenda, and the newly established ASEAN PLUS THREE UHC network. The P4H Network

needs to take this evolving UHC/SHP landscape into consideration in its future commitments to collaborative, coherent support.

P4H Social Health Protection Network

The P4H members:



P4H implementing partners: