Advancement and Challenges of UHC
SE019 PMAC2017

Monday 30 January 2017, 14.00-17.00
Lotus 3 Conference Room,
Centara Grand at Central World

Wrap up and take home message by Viroj

PHILLIPINES

- UHC cube: fragment service by DOH/LGU, high level 92% pop coverage, but low cost coverage, 57% OOP, limited financial risk protection both IP and OP
- PHL health agenda: triple burden diseases, service delivery network, freedom to access services. Innovation: point of care enrolment, sin tax, reduce segmentation (formal informal) cover all formal employed, the informal need to consider enrolment, membership depends on payment of premium
- Service coverage: case rate payment, for negative list; PHC package from DOH budget through capitation by PhilHealth for minimum package for all life stage. Need HTA capacities, establish functional health services
- Cost coverage: from FFS to all case rate, zero balance payment for poor / near poor, Z benefit catastrophic conditions, capitation for PHC based and DRG under global budget and foxed copayment. Introduce sugar beverage tax.

MYANMAR

- Political commitment 2012/13, renewed in 2015/16 General election NLD get super majority of seat on the 8 November 2015, 86% of the seats in the Assembly of the Union (235 in the House of Representatives and 135 in the House of Nationalities)
- NHP 2017-2021 developed: pro poor UHC first, strengthen HS, for basic essential package of health services, 188 interventions
- Strengthening health services provided by the current Ethnic Health Organizations
- Consultation processes: transparent, inclusive, EHO, CSO, INGO, NGO, private sector, BHS, VHW, UHC 12 Day 2016 signed by all parties.
- 2030 to achieve UHC, without financial hardship
    - Increase access through expansion of health services,
    - Reduce catastrophic health expenditure
    - 2017-21: basic package, 2022-2026: intermediate, 2027-30 comprehensive
- Four pillars: HRH, infrastructure, service delivery including medicines, financing reform,
- Statement of good wishes: how to realize it, given Aung San high level of political leadership
- Prioritize township for investment
- Challenges
    - HRH: no accreditation, pre-service training, production only by MOHS, deployment, low salary problems, BHS and task shifting, rural retention
    - Infrastructure on MW, PHS grade 2, allow MW to do everything for all services, 35 items of jobs. Sub rural heath centers,

    - HMIS paper base, parallel report, extend to grass root communities 73K villages, 9083 sub-rural HS in the village, 11.2% covered by fix infrastructure, need out reach services,
    - HCF: fiscal space very promising but Fiscal Space for health is limited, SWAP
- Way forward
    - Prioritize township, prioritize services, inclusive township health plan, NIMU national implementation monitoring unit, similar to IHPP/HITAP.
- Summary
    - Renewed commitment by NLD government, political manifesto

National League for Democracy 2015 Election Manifesto: Authorized Translation
vi) Health
The following activities will be carried out for the emergence of a universal healthcare system:
1. We will improve and expand basic healthcare provision.
2. We will implement projects to reduce maternal and infant mortality, and we will strive to prevent malnutrition and ensure access to medicine.

THAILAND
- Legacy Three schemes: CSMBS, SHI, UCS
- Empirical evidence: improve equity, increase access, minimize catastrophic spending,
- Despite political conflicts survive 8 rival governments, six elections, two coup, thirteen PHM

LAO PDR
- MOL: Public and private employees
- MOH: the poor and informal sector
- Steady progress, good progresses,
- Financial resources,

CROSS COUNTRY ANALYSIS

Key parameters	LAO	MMR	PHL	THA
GNI per capita, US$	1,730	1,280	3,540	5,620
Income group	LMIC	LMIC	LMIC	UMIC
Lending category	IDA	IDA	IBRD	IBRD
Transition of GF, GAVI	Ongoing	NA	Advanced	Done
Fiscal space, gov tax, % GDP	15	3	13	16
Fiscal space, gov revenue, % GDP	17	6	14	20
Public Health Exp, % THE	49	27	32	80
Out of pocket, % THE	39	51	54	8
Total Health Expenditure per capita, USD	33	20	135	360
External health resources, as % of THE	32.9	8.0	1.1	3.8
Skilled birth attendance, % total birth	42	71	73	100
Doctor, nurse, midwife, per 1000 pop	1.1	1.6	1.3	2.5
Child mortality rate, per 1000 LB	67	50	28	12

Source: WDI 2016, WHS 2015,
IDA: lends money on concessional terms. Its credits have a zero or very low interest charge and repayments are stretched over 25 to 40 years, including a 5 to 10 year grace period.
IBRD: loans are non-concessional.

CONCLUDING REMARKS:

- It is moral responsibility of WHO and other IDP and networks
  - Strengthen in country institutional capacities ---with an aim to be "independent from donor influences"
    - To analyze, identify challenges, and solutions
    - To intercept policies, windows of opportunity open every 4-5 years during general election: insertion into policy manifesto
    - To design and strategize action
      - Between HSS [fixing the boat] and Financial Risk Protection [sailing the boat]
        - Fixing the boat while sailing in the rough sea
- Strengthen health systems: make it functioning and accessed by all
- Monitoring of UHC SDG3.8.1 and 3.8.2
  - Effective coverage: tracers
  - Financial risk protection:
- Challenge: Path dependence:
  - Benefit package: positive list versus negative list
  - Dominant role of private for profit sector and lack of regulatory capacities by PhilHealth,
  - Beyond population coverage, deepening financial protection by reduction of OOP as % of THE [LAO 39%, MMR 51%, PHL 54%]
- General election 8 Nov 2015, NLD get super-majority: 86% of the seats in the Assembly of the Union (235 in the House of Representatives and 135 in the House of Nationalities) –Don't lose this political opportunities


EXIT


UHC commitment by key stakeholders
UHC Day celebrations
12 December 2016
Nay Pyi Taw, Myanmar


PRINCE MAHIDOL AWARD CONFERENCE 2017
VULNERABLE POPULATIONS FOR AN INCLUSIVE SOCIETY
Advancement and Challenge in UHC
January 30, 2017