UHC2030 Technical Working Group on Sustainability, Transition from Aid and Health System Strengthening

No. 2

Report from the second face-to-face meeting
3 November 2017, Montreux, Switzerland

uhc2030
International Health Partnership

Contents

1. Executive summary

The opening session of the meeting was a **recap of the first face-to-face meeting held in March 2017.** In preparing for this, a mapping of working group member policies on transition had revealed differing understanding and application of the transition concept and that while sustainability definitions also varied most tended to have focus on increased coverage and health outcomes/impact.

During the first meeting, country feedback on and discussion of concepts emphasized the need to place transition work within the broader financing, macro-fiscal, institutional and political context of a country moving towards UHC. Availability of funding is not the binding constraint in most countries. Sustainability in relation to transition should be understood as a constraint, not as a goal. We are trying to maximize health system goals, subject to the constraint of living within our budget. This framing is important as it shifts the focus from sustainability to efficiency and effectiveness – a more useful and practical basis for action. Furthermore, it is important to frame the sustainability question right. This question should not be: "How can we sustain the donor-supported programme?", but rather: "How can we sustain effective coverage of priority interventions?". The first meeting ended with major work areas being sketched out and the agreement to seek further input from countries to underpin the work and next steps.

Key messages from countries

The second session included a presentation of the findings of a desk-based country consultation that gathered input from key informants in seven countries: Nepal, Kyrgyzstan, Myanmar, Papua New Guinea, Sri Lanka, Zambia and Panama. The countries are at different social and economic stages – five are LMIC, one is LIC, and one is HIC – and they present different stages of transition from external finance. **Six cross-cutting health system strengthening themes emerged from the findings: coverage of vulnerable populations, governance of central programmes, domestic revenue generation, private sector participation, mutual accountability, and donor capacity.**

The MOH representatives reiterated that transition needs to be seen within the overall context of each country moving towards UHC. This should take into consideration projected economic growth and any support or resources the country is likely to have on its journey towards UHC. There are immediate priorities, such as assuring the supply of commodities, cold chain items, ARVs, etc, but importantly, it can be challenging to get a good overview of the gaps. These include institutional gaps, governance and policy issues, as well as direct technical gaps. It will be helpful for countries to have better tools to project this picture, in order to allow for good planning as well as advocacy at the national level.

MOF representatives raised the importance of public financial management (PFM) systems in relation to transition. Ensuring sufficient public resources to the health sector relies on a strong dialogue between MOH and MOF. This is operationalized through the budget and the PFM systems. Various laws and processes are important – budget law, accounting law, procurement law, and the national assemblies. **The interface of PFM systems, transition and ongoing health finance reform is important;** for example, harmonizing government line item funding and good

health information systems and reporting. Countries also underlined the need to institutionalize national health accounts and strengthen systems for expenditure tracking.

Both MOH and MOF representatives raised the issue of predictability of external finance: unpredictable donor funding reduces efficiency and affects accountabilty. Donor financing does often not seem to be subject to firm contractual obligations in the way that other contracting is, and is sometimes only weakly binding for governments. Here, going through the MOF at the contractual stage could be helpful. The work on national health accounts and tracking external resources clearly is important. The working group can be helpful in thinking through how to restructure incentives in partnership agreements. How do we structure the incentives to get the changes we are aiming for?

There are some good practice examples, such as transitioning the health equity fund in Cambodia and the government-created standard operating procedures system for PFM. Countries underlined that there may be opportunities for using good practice from donor-supported programmes to inform overall UHC efforts. These could include good practice and innovations on systems for accountability.

More thinking is needed on how to strengthen systems for quality management and the capacity of institutions. In Cambodia it took ten years to strengthen government systems and transfer the health equity fund, and to take over the purchasing function. Contracting is underused as an accountability mechanism and there is need to strengthen the capacity of purchasers for this. Mutual accountability continues to be important and should be kept in the UHC2030 agenda.

Global Health Advocates have recently completed a study on transition from external finance that includes country analysis from three countries: Nigeria, Côte d'Ivoire, and Vietnam. Key findings include: (1) **The transition agenda is highly political with limited analysis of this part** to date. (2) **Multiple transitions from external finance are happening simultaneously.** The study estimates that 24 countries will be transitioning from two to four external funding streams in the next five years. Transition criteria at present do not take into account changes in eligibility for other funding streams. (3) **There is need for coordinated planning related to transitions.** The combination of weak political will to harmonize at the global level and fragmentation in national systems amplifies the challenges countries face. (4) **There is need for a stronger system lens in work on transition** to strengthen sustainability and efficiency. Efforts are supply-driven and frequently happening in parallel with duplications. The strong focus on GNI in the eligibility criteria results in a lack of acknowledgement of the health system vulnerability. (5) There is need to strengthen mutual accountability for transition processes. **It is unclear how the results of transition processes are monitored.**

The working group can add value by **facilitating a high-level political discussion on the needs related to transition.** There is also need to revitalize the discussion on development effectiveness and analyze how the different work streams can best be integrated to an overall system approach and avoid piecemeal solutions. For new finance instruments considerations on transitions need to be built in at the design stage.

Regional perspectives

The WHO office of the Western Pacific presented recent work on transition including **a regional framework** for moving from vertically funded priority programmes to integrated and domestically financed service delivery. Four main action areas have been identified: first, to **map and confirm core programme elements and service delivery arrangements** looking for opportunities to improve efficiency; second, to **strengthen financing institutions to make better use of available resources.** This includes looking across the incentives in the different financing schemes to determine the roles, for example defining the role for health insurance in a mixed system and adapting PFM systems accordingly. The third area of action calls for an **increase in domestic finance.** This includes, for example, facilitating good engagement between MOH and MOF, good budget utilization and links to planning. The last action area is to **govern the transition process better.** This includes planning the transition process in a phased manner, building consensus through a transparent and participatory process, and establishing oversight and monitoring.

Discussion and closing remarks

The country implications of transition from different donors are also specific and different. It is important to maintain this granularity. **When thinking of the system-wide implications for governance of donor-supported programmes, channels of financing is one issue, but the service delivery model also requires attention. Institutional support is critical and the issues around defining the right model of services are key.**

The minimum level of health system readiness for insurance schemes was raised. Synchronizing eligibility criteria for external finance with health system vulnerability was mentioned. Can we think of developing a methodology that brings health system and programme people together? **How can we frame UHC plans and ensure that those working on programmes and service delivery share a common vision?**

This cannot be a large agenda; we need to align it to ongoing work. Nor can this be a purely technical agenda, but one that bridges from the technical to the political. We discussed the framing of the sustainability question and that it is important to sustain coverage of priority interventions with financial protection. Can we make some type of high-level endorsement of this? If so, a lot could follow on from that. We should not shy away from the political agenda; this is very important. Internal alignment of development partners is a priority: how can we ensure that what we agree in Geneva or Washington is actually what happens in the countries in question?

Transition criteria are important. There is pressure to come up with objective criteria that are applicable globally, but this may have severe consequences in some countries. **Can we work out some best practice principles and ways to translate these into country-specific approaches?**

Lastly, can we **communicate complicated issues in a nuanced manner** in such a way that brings attention to the priorities? Civil society is often good at this. We need to devise a very good communication strategy.

UHC2030 2018–2019 work plan deliverables

Based on discussions, the following deliverables were evolved as part of the UHC2030 2018–2019 work plan. These will be elaborated in more detail by the group in 2018.

Expected Outcome	Indicator	Deliverable	Lead
Consensus built on the sustainability objective in relation to transition from external finance – to mean sustained coverage of priority interventions for UHC with financial protection	Collaborative agenda on sustainability and transition taken forward by different stakeholders	Produce 2 knowledge-sharing products/briefs on sustainability- and transition-related health system topics, co-authored by some WG members. By 2018. Guidance and good practice principles for sustainability and transition from external finance by end 2018 to support political and technical influencing. Initiation of coordinated country support for transition in 3 countries embedded in UHC country plans, under country leadership and supported by all key actors by end 2019.	Transition and Sustainability TWG

2. Recap from the first meeting

Midori de Habich and Kara Hanson, Co-Chairs of the Working Group

This presentation recalled the key messages from the first meeting and started with **the mapping of working group member policies** conducted prior to the first working group meeting in March 2017. The findings highlighted differing understanding and application of the transition concept and that while sustainability definitions also varied, most tended to have focus on increased coverage and health outcomes/impact. There seemed to be limited work on multiple transitions in one country and limited work on effectiveness of transition policies over time across programmes focusing on the health sector as a whole. There also appeared to be limited advocacy on UHC at country level and minimal political engagement on the implications of a sector-wide transition. Furthermore, transition provides an opportunity to identify what health system strengthening is needed. There was evolving consensus to work towards a focus on sustained coverage of priority interventions in the sector rather than programmatic sustainability.

In March the **key messages** included an emphasis on transition and sustainability being a matter of national ownership and therefore the government of each country needs to be in the driving

seat. Accountable leadership is required to coordinate all efforts and design an orderly transition process with emphasis on strengthening the capacity of institutions and optimally linking with the wider system and UHC. Engagement of multiple stakeholders is needed: different line ministries and sectors, civil society, providers – both public and private – and citizens.

Countries also emphasized that there are multiple transitions from external finance ongoing with multiple transition assessments and there is need for a more orderly process. Countries are interested in how to use the resources in the most efficient manner that can benefit the population as a whole. Transition is not only an issue of financial resources but also of technical assistance, opportunities for cross-country learning on UHC, and advocacy opportunities for UHC. Countries recognize that in some instances external funding may help convince the government on certain priorities, for example of work for marginalized groups. Capacity of the recipient country is most important and sustainability should be regarded as the ability to achieve the agreed health system objectives. Currently, many countries have weak regulatory frameworks to cater for financing non-state actors within the public health system. For long-term sustainability, capacity at the district level can be critical to ensure minimum standards, and programme and managerial capacity.

From discussions in March on **concepts and unit of analysis,** some of the key observations included the following. Transition from donor funding should be understood within broader financing, macro-fiscal, institutional and political context of a country moving towards UHC. Availability of funding is not the binding constraint in most countries. Focus should be on the need to address how funds are allocated and used. Sustainability requires a dual focus: first, the need to diversify funding and mobilize domestic funding (equitably) and second, the ability to use available funds efficiently (manage expenditures better). These are issues that *all* countries should be addressing. Transition is therefore an entry point that brings a political opportunity to renew efforts on this.

Sustainability in relation to transition is a constraint, not a goal. We are trying to maximize health, responsiveness, and financial protection, *not* fiscal sustainability. In other words, we are trying to maximize health system goals, subject to the constraint of living within our budget. This framing is important and shifts the focus from sustainability to efficiency – a more useful and practical basis for action.

In the past, donor funding for MDGs often led to vertical programmes, with resulting inefficiencies (parallel structures and systems, by the donor or programme). There is a risk that these structures and fragmentation will remain as donor support declines. How can we avoid this trap? Part of this is efforts to get the sustainability question right. This question is not: “How can we sustain the donor-supported programme?”, but rather: “How can we sustain effective coverage of priority interventions?”. We cannot do this with multiple, parallel systems of procurement, information, and governance, or a distorted HR system, etc.

UHC brings the opportunity to reshape the financing and service delivery systems in a holistic way. All priorities and interventions fall within the health system. Transition should be focused on sustaining and increasing effective coverage of priority interventions. This involves examining how priority programmes/interventions can be integrated into the benefit package and covered under UHC arrangements. The unit of analysis should be the system, not the programme or disease.

Transition brings a political opportunity. On the one hand, mobilizing public resources (equitably) is driven by taxpayer choice and citizen voice; on the other hand, efficiency improvements are driven by rules and regulations, procurement systems, rights and entitlements that should be governed by systems of accountability. Strengthening the governance functions (sometimes weakened by donor programmes) and national institutions should be central to transition plans and support.

In the first face-to-face meeting, the **major work areas were sketched out** (see meeting report, 30–31 March 2017). In order to further underpin priority work areas for the group it was **agreed to seek further feedback from countries** on where global action on transition has most potential to add value.

3. Country perspectives

Henrik Axelson, Thinkwell

This session presented the findings from a country consultation study undertaken to gather inputs from seven countries on health system issues related to transition. The paper was commissioned based on the recommendation of the March meeting of the working group to better underpin its direction by increasing country input, complementing country membership and direct input in the group.

The study was desk based and gathered input from key informants in seven countries: Nepal, Kyrgyzstan, Myanmar, Papua New Guinea, Sri Lanka, Zambia, and Panama. The selected countries are at different social and economic stages – five are LMIC, one is LIC, and one is HIC – and present different stages of transition from external finance.

Six cross-cutting health system strengthening themes were identified: coverage of vulnerable populations, governance of central programmes, domestic revenue generation, private sector participation, mutual accountability, and donor capacity.

The first theme relates to the risk that **vulnerable populations stand to lose substantial coverage** currently supported by external finance, resulting in a loss of financial protection and an increase in out-of-pocket payments (OOP). Both political will and capacity of governments to contract with non-state providers are an issue. In moving forward to address government capacity, inclusion of vulnerable groups in transition discussions is important.

The second theme relates to the issue related to **governance of central programmes.** Donor funding has often mandated strong centralized planning and management for key donor-supported programmes (e.g. immunization, family planning, HIV). As financing mechanisms mature and donor funding seizes the programme, governance will need updating as countries move on with strengthening mechanisms for strategic purchasing or fiscal decentralization. Currently, countries may lack the processes to prioritize key public health programmes within such processes.

The third theme relates to the capacity to increase **domestic revenues to replace external finance.** Demonstrated efficiency gains are often a pre-requirement for increased resources. There is need to

strengthen MOH capacity to use evidence in the budget advocacy process. The political dimension of budget advocacy and MOH ability to do broad-based advocacy also need strengthening.

The fourth theme relates to the **role of the private sector in UHC.** In many transition countries the private health sector is growing. Regulatory systems are often weak and market-shaping opportunities are not leveraged to their potential. The private sector is often focused on low-hanging fruit, providing curative services for the wealthy section of the population. There may be opportunities for public–private partnerships in relation to services for low-income and vulnerable populations.

The fifth theme relates to **mutual accountability for the transition process.** Most donors do not consider health system readiness indicators as part of their transition criteria. There are no clear implications if the roles and responsibilities established in a transition process are not respected. Transition frameworks do not allow for countries to hold partners accountable if they provide insufficient support throughout the process, delay disbursements of transition grants, or provide confusing/incorrect information on what is expected of the country.

The sixth and final theme relates to the **capacity of donors/development partners.** Countries have raised a number of gaps and capacity issues related to the transition process. However, to be able to address this, capacity is also needed on the development partner side. Partners need to ensure that, individually or collectively; they have capacity to support countries technically on transition, in a way that is grounded in a sound understanding of an individual country's projection and capacity to move towards UHC. They also need to ensure there is capacity on their side to fulfil country compacts. Capacity strengthening is needed for all development partners, not only donors, but also for example civil society to understand concepts and core issues and system-wide implications related to transition.

Nhim Khemara, Deputy Director General of Budget, Ministry of Finance, Cambodia

Cambodia has become a LMIC following almost two decades of robust economic growth. For the past few years the country has enjoyed robust economic growth (in the range of 7% annually). Health expenditures by source divide into three categories: OOP payments (62%), government financing (18%), and DAH (20%).

Moving towards UHC is a high priority for Cambodia and in line with this, public domestic resources for health have increased, supported by robust economic growth and PFM reforms. Public domestic financing for health has increased from 1.4% in 2013 to an expected 2% of GDP 2018. Coverage of the health equity funds was 3m people in 2017 and is expected to reach 7.6m in 2018.

There are more than 20 donors and 100 NGOs active in the health sector. Donor financing is reducing, both in proportional and absolute terms. Between 2014 and 2016, external finance reduced from USD241m to USD170m. Disease programmes (TB, HIV, malaria, immunization) are still very reliant on external finance, with external finance covering on average 70% of their costs.

Country ownership, good coordination and planning are central to ensuring sustainability of achievements supported by external finance. The Sector-Wide Integrated Management (SWIM) has been operational for several years. Over this period government share in financing the health equity fund has steadily grown from an initial 10% to 50% and is expected to reach 80% in the next few years.

Both domestic and external resources are subject to review in the annual budgeting process, in order to avoid overlaps and duplication. Predictability of external finance is still a challenge. There is growing focus on ensuring external finance runs through government PFM systems for sustainability, efficiency and visibility. Examples of this are the health equity fund and the new GF grants. It is important to screen incoming externally funded projects to ensure consideration has been given to sustainability of efforts and integration within government systems and overall efforts.

Building institutional capacity, both technical and managerial, is important. In the case of the health equity fund a new government agency (PCA) has been established with planned systematic transfer of skills and know-how. For disease programmes, transition plans need to ensure that capacity of government entities is strengthened to ensure technical and managerial skill transfer to avoid jeopardizing the achievements already made. Creation of parallel project structures that are not aligned to government systems must be avoided.

Government has also taken over funding some non-governmental projects in service delivery. There are important lessons from this process on the need to ensure knowledge transfer from work supported by non-governmental entities to the public system.

Key challenges faced by Cambodia related to transition include the unpredictability of donor transition; in particular, the lack of information from donors that are not using government systems. This reduces efficient use of the resources and affects accountability. Lessons from transitioning the health equity fund can be a best practice example and the government-created standard operating procedures system for PFM has also been considered a good practice. Integrating vertically funded and managed programmes within mainstream government systems is still a challenge, but there are successful steps, for example PR transition to government recipient. In general, strengthening financial planning, technical skills and institutional capacity are all areas that are being worked on.

The working group should support efforts to make transition better planned to allow time for financial and institutional sustainability of investments.

Kotsaythoune Phimmasone, Deputy Director, Department of Finance, Ministry of Health, Lao PDR

The People's Democratic Republic of Lao became a LMIC some years back, triggering external partners in the health sector to start a transition process. The country faces the double burden of communicable and non-communicable disease. Key issues include high OPPs, currently at around 45%, and there is a high turnover of staff in the MOH, which makes it difficult to maintain institutional capacity – at times to the point of hampering continuity of reforms.

Transition is not only a matter of a change in revenue channels. The MOH is undertaking restructuring in relation to transition. Under the leadership of the Department of Planning, the MOH is increasing the capacity in ministry departments that will be taking over work from projects that are currently donor supported.

We have been discussing the importance of PFM systems. Ensuring sufficient public resources to the health sector relies on a strong dialogue between MOH and MOF. This is operationalized through the budget and the PFM systems. Various laws and processes are important – budget law, accounting law, procurement law, the national assembly – and the interface of these and health finance reforms is important; for example, harmonizing stronger health information systems and good reporting with the government line item funding. We would like to institutionalize national health accounts and strengthen the overview within the system.

In accelerating health sector reform in Lao, collaboration with external partners continues to be important. The SWAP is a good forum that needs to continue. To support longer-term health sector reforms in Lao we would like to continue collaborations with development partners, but the exact areas of collaboration may need further thinking.

Ani Harutyunyan, Head Finance and Economic Development, Armenia

In Armenia external financing is small, constituting less than 5% of total health expenditure (THE). GAVI and GF are transitioning and their finance is reducing. Integration of data on external finance into the national budget systems is of key importance.

We introduced specific policies on transition adopted by parliament. Following on from this, we have put transition plans into the MTEF in collaboration with MOF. Within this we have overall projections that also cover transition data aiming to fully replace external finance with domestic public funding.

GAVI and GF have been very helpful in both collaborating with MOF on ensuring availability of quality data and in advising on monitoring and advocacy.

We have introduced programme-based funding but note that externally funded programmes have good systems of monitoring. We think there are opportunities for using such lessons from donor-supported programmes for overall UHC efforts.

Mark Blecher, Chief Director, National Treasury, South Africa

For South Africa, like many other countries, financial implications of transition are not as important as programmatic issues. Here a lot of detailed work is needed.

Ownership for donor-supported programmes is in many cases weak, so even if the funding is replaced the government manager may not feel he or she owns the priorities or programmes.

From the treasury perspective, **fiscal space** is important. In South Africa we have had to find resources for increased coverage of ARVs for a population of 6m, up from 3m. After doing the calculations, we concluded that we could afford this.

Predictability is a key issue, and for external financing this is often limited. Donor financing often does not seem to be subject to firm contractual obligations in the way other contracting is. This type of financing is sometimes only weakly binding for government. Here, going through the MOF at the contractual stage could be helpful. The work on national health accounts (NHA) and tracking domestic and external resources is valuable. Tracking of DAH is often extremely challenging and improvements are important.

Development partners often set up parallel systems, for example on **procurement.** PEPFAR helped us see that we could get better prices; but pooled procurement needs to be inside the system otherwise this disappears when the external funds cease There have been issues regarding a shortage of good **professionals;** government systems are sometimes not so good at recruiting and maintaining staff. Here donor support has helped, for example in creating public–private partnerships

We are moving forward with the integration of HIV within domestic budgets, service delivery and finance strategy. Civil society has also been helpful – government can be lazy and small investment can be very helpful to improve the demand side.

The working group can be helpful in thinking through how to restructure incentives in partnership agreements. How do we structure the incentives to get the changes we are aiming for?

Daniel Osei, Head of Budget, Ministry of Health, Ghana

When Ghana became a MIC and transition from DAH started, we were not well prepared. There were immediate challenges like purchase of commodities, cold chain items, ARVs, etc but, importantly, we did not have a good overview of the gaps. We have since worked to get an overview of all the transitions that were planned and the related implications.

First, there were **institutional gaps,** such as the need to put in place regulatory frameworks for the units tasked with taking on the work done by donor-supported entities. There were challenges to bring all the stakeholders together.

Second, there were **governance and policy issues** that we examined to see how they could become most effective post transition within PFM systems and decentralized management systems.

Third, there were **technical and human resource gaps;** donors had not only been providing funds, but also support on planning, monitoring and supervision. We also needed to build the advocacy with MOF, and find a way to bring them better into the picture.

Transitions need to be considered within the overall contexts of countries moving towards UHC. This should take into consideration projected economic growth and what constraints and what support and resources the country is likely to have on its journey towards UHC. It would be helpful for countries to have better tools to project this picture, in order to allow for good planning as well as advocacy at the national level.

Toomas Palu, Manager for Health, Nutrition and Population Global Practice, East Asia and Pacific Region, World Bank

It is important to think of transition as an opportunity to negate on health system strengthening issues and to place the focus on coverage of priority interventions for UHC as opposed to programme focus. This takes us to the integration agenda mentioned by all panellists.

Transitioning may require a different pace for different parts: the core part of service delivery can be transitioned first while another part, for example social contracting, may require more time. With regard to reducing levels of overall DAH, perhaps the focus of the remaining DAH should be on areas that the ministry may have more difficulty in taking over, for example social contracting. Roadmaps should be worked out, planning overall needs and what is needed when.

Increasing fiscal space is reliant in part on decisions outside the sector, for example parliament, but MOH can influence this through efficiency improvement, for example. Optimization tools have been developed for previously supported donor programmes like HIV and TB, and they can be helpful.

Transition also relates to governance and whether this will weaken post transition where strong government departments have been supported by external finance. This relates to the strategic purchasing function, and ensuring that while moving to integrate donor-supported areas into basic benefit package BBP within MCH and communicable disease for example, focus on outcomes is not lost, while ensuring objective and evidence-based priority setting.

More thinking is needed on how to strengthen systems for quality management, including monitoring and strengthening capacity of institutions. In Cambodia, it took ten years to strengthen government systems and transfer the health equity fund, and take over the purchasing function. South Africa mentioned mechanisms of contracting; this is an underused accountability mechanism and there is need to strengthen the capacity of purchasing systems.

Mutual accountability continues to be important and should be kept in the UHC2030 agenda. There are windows of opportunity when funding and planning cycles of partners open and it is important to take advantage of those.

Bruno Rivalan, Head of France Office, Global Health Advocates, France

Global Health Advocates have recently completed a study on transition from external finance that included country analysis from three countries: Nigeria, Côte d'Ivoire, and Vietnam. Key questions behind the work included understanding better, the **rationale behind transition, who is impacted and how agencies are supporting the transition framework they use.**

Firstly, the transition agenda is highly **political with limited analysis of this part** to date. Globally DAH has stagnated and donors are focusing their efforts more narrowly. There is increased demand for attribution and demonstrating impact in conjunction with competition for resources with other areas such as climate change, migration and discussion on new financing modalities and instruments.

Secondly, multiple transitions from external finance are **happening simultaneously.** The study estimates that some 24 countries will be transitioning from two to four external funding streams in the next five years. In some countries, GAVI and GF transitions are happening in parallel. There is limited information available in the public realm on how bilateral transitions are planned, criteria, etc. Transition criteria at present do not to take into account changes in eligibility for other funding streams.

Thirdly, there is **need for coordinated planning** related to transitions. There is limited political will at the global level to harmonize, despite commitments. Fragmentation also persists in national systems with misalignment between budget and programme planning cycles, and combined, these make country planning more challenging.

Fourthly, there is **need for a stronger system lens** in work on transition at country level to strengthen sustainability and efficiency. Currently efforts are supply driven and frequently happening in parallel with duplications. The strong focus on GNI in the eligibility criteria results in a lack of acknowledgement of the health system vulnerability. There is need to rethink the eligibility criteria.

Lastly, there is need to strengthen mutual accountability for transition processes. It is unclear **how the results of transition processes are monitored.** Some partners, for example GAVI, have specific support to the post transition period but in many cases overall accountability is unclear and highly influenced by partner systems.

The working group could add value by **facilitating a high-level political discussion on the needs related to transition.** There is also need to revitalize the discussion on **good development effectiveness** and analyse how the different work streams can best be integrated to an overall system approach and avoid patch solutions. For new finance instruments considerations on transitions need to be built in from the design stage.

4. Regional perspectives

The Regional Committee of the WHO Western Pacific in October 2017 endorsed a *Regional Framework for Action on Transitioning to Integrated Financing of Priority Public Health Services*. The background is country needs related to transition from external finance and a risk that service coverage for key populations could be jeopardized.

The Western Pacific region is diverse in economic and social contexts. Progress has been made in controlling communicable and vaccine-preventable disease, while non-communicable disease is on the rise and populations are aging. Several countries are experiencing fast economic growth with increasing demand for quality health services. Government spending on health has been low in many countries but is increasing while OOPs are still high. Financing is a mix of public and private sources with a significant part of this coming from external sources in some parts of the region, particularly the Pacific. Financing for priority programmes has been reducing. There is need for more flexible financing and integrated service delivery, together with a better mechanism of working across sectors.

The regional resolution approved calls on member states to secure public health functions and capacities to detect, respond and prevent priority diseases, and develop, implement and monitor transition plans within national policy processes – and not address transition within parallel processes.

Within the **regional framework** for moving from vertically funded priority programmes to integrated and domestically financed service delivery, four main action areas have been identified. **The first is to map and confirm core programme elements and service delivery arrangements looking for opportunities for integration. The second is to strengthen financing institutions to make better use of available resources. This includes looking across the incentives in the different financing schemes and determine the roles, for example for health insurance in a mixed system and adapting PFM systems. The third area of action calls for an increase in domestic finance. This includes, for example, facilitating good engagement between MOH and MOF, good budget utilization and links to planning. The last action area is to govern the transition process better. This includes planning the transition process in a phased manner, building consensus through a transparent and participatory process and establishing oversight and monitoring.**

There are several challenges. To start with, looking across the system can be difficult but joint programme evaluations involving the different stakeholders can be helpful. Moving to domestic financing requires absorption of programme staff and merging of staff management systems. Different contracting, functional and technical aspects can make this challenging. For services, what are the non-negotiables and where can efficiencies increase? In considering coordination across finance schemes, a good overview of which services are being covered where is important, aligning the next steps to PFM systems. Contracting with non-state providers is important; this often covers key areas such as outreach and prevention. Procurement and supply management is another big area of integration.

Securing core capacities on essential public health functions requires a whole-of-system approach. This needs to be supported by a well-planned, phased transition together with an implementation roadmap that incorporates mapping service delivery, fund flows and oversight mechanisms and links to broader health sector reform.

5. Discussion and closing remarks

The transition from external finance and related integration agenda can be both an opportunity and a risk. One example is Nigeria, where the setup of a basic health-care provision fund to support UHC development was at times seen to be competing for resources with efforts to raise revenue for transition-related gaps. Another example is China, which integrated TB financing into the pooled finance following a somewhat lengthy process. Some services lend themselves better to integration to pooled finance than others. There is need to think of a mix of funding channels and payment mechanisms. The mind-set and focus of staff working on disease control and those engaged in health system reform often differ. The process of transition and related integration can therefore provide a great opportunity to bridge this – if it is well managed. It would be good if this group could help share such lessons.

The country implications of transitioning from different donors' financing are specific and different. We need to maintain this granularity. When thinking of the system-wide implications for governance of donor-supported programmes, channels of financing is one issue, but the service delivery model also requires attention. Institutional strengthening can be critical and the issues around defining the right model of services are key.

GNI is not a good indicator of governance. We need to work further on eligibility criteria that continue to be based largely on GNI. We need to share lessons from OECD countries on their systems for social contracting, including PFM implications. It was surprising not to see **procurement** issues raised. This is a big area of concern for GF as well as other donors. There are regional innovations on procurement that countries and regions may benefit from sharing.

It is not that difficult to integrate HIV services into pooled financing and the basic benefit package (BBP). However, vulnerable populations often do not have access to the insurance systems where they exist. This is where social contracting becomes very important. This is broader than transition, and relates more generally to integrating disease programmes into systems for UHC. When donors support disease programmes and/or pooled finance, efforts should be made to integrate the two. Certain services, for example treatment, can be integrated, while others may need outsourcing and PFM issues be addressed accordingly.

There is need for more clarity on the issues around integration to the BBP. There are many preconceptions about what health insurance means. **TB and HIV will have large externalities and services have to be available on a non-contributory basis. The purpose is to take advantage of the larger contracting system. This is not a question of answering to the revenue gap question but a way to improve the efficiency.** Sometimes the programmes do a better job of contracting. We are not, however, talking about all HIV services; for example, in Tanzania being integrated to health insurance systems that today are only available to a minority of the population.

Countries are concerned with revenues when it comes to transition. It is natural that countries look to insurance system integration. Health insurance systems typically do not fund public health programmes or public health institutions and there are many complexities. **The access issue is critical, as is the process of identifying the core elements in service delivery and linking them to the wider system; and then balancing efficiency and protection of the achievements made.**

Yesterday minimum level of health system readiness for insurance schemes was mentioned. The GF mentioned eligibility and Global health advocates spoke about vulnerability of the systems not being reflected in the eligibility criteria. It may be simplistic but can we think of developing some sort of health system index, a methodology that brings health system and programme people together? **How can we frame UHC plans and ensure that those working on programmes and service delivery are fully on board?**

We need careful consideration of the prioritization process; we should not to come at this with data from one disease. **Donor-funded programmes are rich in data, while there is missing evidence for other diseases/conditions.** This is a complex picture with many moving parts.

OECD is looking to strengthen their work on **transparency of DAH,** including its targeting, and is keen to work together with other partners on this.

PEPFAR currently does not have a specific transition policy, mainly because of the funding model that is tied to congressional approval. In the 13 priority countries, focus is on analysing the current responsibilities and how they might change, discussing with the MOH and MOF capacity needs and plans to take over responsibilities. PEPFAR also works with other donors, for example GF on transition-related data.

Closing remarks

Toomas Palu, World Bank and Joe Kutzin, WHO

Ultimately, it is the country level that matters and global work should support the countries. Can we think of entry points and products that can help countries address the real issues? Could UHC2030 help leverage other platforms such as the Joint Learning Network? There is need for better coordination at the country level and it is time to intensify our collaboration on how financing can be better aligned. We need to bridge to the political level and for this civil society involvement is really important to help push the agenda. Hopefully, by next year we will have modest work plan and some products that countries find helpful.

We should reflect on what the priorities are. Who are we trying to influence? What are the limited sets of things where this group can make a difference? **This cannot be a large agenda; we need to align to ongoing work. This cannot be a purely technical agenda, but one that bridges from the technical to the political.**

How the sustainability question is framed is important, sustaining coverage of priority interventions with financial protection. Can we make some type of high-level endorsement of this? If so, a lot could follow on from that. We should not shy away from the political agenda as this is very important. Internal alignment of development partners is a priority: how can we ensure that what we agree in Geneva or Washington is actually what happens in the countries in question? What is the high-level political mechanism that can strengthen this accountability?

Transition criteria are important. There is pressure to come up with objective criteria that are applicable globally, but this may have severe consequences in some countries. **Can we work out some best practice principles and ways of how this can translate into country-specific approaches?** What would be the institutional changes needed?

Lastly – communication is a priority. How can we communicate complicated issues in a nuanced manner in a way that brings attention to the priorities? Civil society is often good at this. We need to devise a very good communication strategy.

Annex one: Participants at the second face-to-face meeting of the UHC2030 Technical Working Group on Sustainability, Transition from Aid and Health System Strengthening meeting

3 November 2017

Eurotel Montreux, Grand Rue 81, 1820 Montreux, Switzerland

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Annex two: Provisional agenda of the second face-to-face meeting of the UHC2030 Technical Working Group on Sustainability, Transition from Aid and Health System Strengthening

3 November 2017

Eurotel Montreux, Grand Rue 81, 1820 Montreux, Switzerland

1. Country perspectives	
8:45–9:00	Registration and welcome coffee
09:00–09:30	**Welcome, opening remarks and recap of previous meeting** • Midori de Habich, former Minister of Health, Peru, Co-Chair • Kara Hanson, Professor of Health System Economics, London School of Hygiene and Tropical Medicine, Co-Chair
	Chair/Facilitator: Midori de Habich, former Mnister of Health, Peru
09:30–10:00	**Country consultation** Findings from country consultation paper on transition, HSS and UHC • Henrik Axelson, Thinkwell • Yogesh Rajkotia, founder and CEO, Thinkwell
10:00–11:00	**Panel: Country perspectives on transition and UHC** • Cambodia: Nhim Khemara, Deputy Director General of Budget, Ministry of Finance • Lao: Dr Kotsaythoune Phimmasone, Deputy Director, Department of Finance, Ministry of Health, Lao PDR • Armenia: Ani Harutyunyan, Head of Finance and Economic Development • South Africa: Mark Blecher, Chief Director, National Treasury • Ghana: Daniel Osei, Head of Budget, Ministry of Health
11:00–11:30	Discussants: • Toomas Palu, World Bank • Bruno Rivalan, Global Health Advocates, France
11:30–11:45	COFFEE/TEA BREAK
	Chair/Facilitator: Kara Hansen, London School of Hygiene and Tropical Medicine
11:45–12:05	**Transitioning to integrated financing for priority public health services** • Annie Chu, WHO Regional Office for the Western Pacific
12:05–12:30	Feedback and discussion
12:30–13:30	LUNCH

2. How can work on transition help countries sustain and expand services to achieve UHC? Next steps for the collaborative agenda	
Breakout sessions	
13:30–13:45	Introduction to group work – Clare Dickinson, consultant
13:45–15:15	**How can work on transition help countries sustain and expand services to achieve UHC?** • **Priority content** – (the *what*) What is the priority work on transition that can help sustain and expand services for UHC? • What are the **vehicles and mechanisms** (the *what* and *how*?)? For example, identification of some activities and identification of the *mechanisms* through which activities/outputs may be met, such as country level work, global level work, development of sub groups (the *how*) Group 1: moderator: Xu Ke, WHO Group 2: moderator: Somil Nagpal, World Bank Group 3: moderator: Mark Blecher, South Africa Treasury
15:15–15:30	COFFEE/TEA BREAK
	Chair/Facilitator: William Savedoff, Centre for Global Development
15:30–16:30	**Reporting back and plenary discussion**
16:30–16:50	**Summary** • Toomas Palu, World Bank • Joe Kutzin, WHO
16:50–17:00	**Concluding remarks** by Midori Habich and Secretariat

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