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Agenda item 5

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Round tables: lessons learned in world health

Report by the Secretariat

1. Four public round tables for ministers of health took place during the Fifty-second World Health Assembly on the following topics:
 - C Priority setting in the health sector: challenges to ministers, 18 May (dealt with in two simultaneous meetings)¹
 - C Investment in hospitals: dilemmas facing ministers, 18 May²
 - C Finding the money: dilemmas facing ministers, 19 May (dealt with in two simultaneous meetings)³
 - C HIV/AIDS: strategies for sustaining an adequate response to the epidemic, 19 May.⁴
2. A summary of the main issues raised during the discussions is given in the following paragraphs.⁵

PRIORITY SETTING IN THE HEALTH SECTOR: CHALLENGES TO MINISTERS

3. The importance of focusing on the fundamentals of good public health, and ensuring equity of access was recognized from the outset. However, the dominant theme thereafter was that priority setting is a complex and primarily political process. Although there is a need for more systematic, rational and transparent approaches, ministers have to cope with competing demands from different constituencies.
4. An assumption underlying the discussion was that ministers of health are able to set spending priorities. But it was recognized that they are far from being the only actors. In countries with a heavy debt burden, for example, the overall level of resources for the social sector may be constrained. In addition, conditionalities imposed by lenders often influence how funds are spent within the health sector. It was also noted that in many countries the ministry of finance is the main arbiter of how national funds are spent, and that ministries of health

¹ Document A52/DIV/4.

² Document A52/DIV/5.

³ Document A52/DIV/6.

⁴ Document A52/DIV/7.

⁵ Summary records of the round tables will be issued at a later date and will subsequently be incorporated in document WHA52/1999/REC/3.

have limited room for manoeuvre. Health priorities need to be “marketed” in terms that will appeal to ministries of finance and others.

5. Priorities are often based on explicit values - such as universal access to health care. The problem arises when resources are insufficient to fund those values. Countries then have to start thinking about priorities within priorities.

6. It is important to remember that stated priorities have to be matched by actual patterns of spending. This is often more difficult in decentralized systems where central government has less control over local authorities.

7. In the developing world, not only are resources scarce, but also circumstances are unpredictable. It is hard to stick to agreed priorities for government spending when emergencies arise - through man-made or natural causes. Sometimes these emergencies are acute, for example a major flood. In other cases, they are more insidious - as in the case of the HIV/AIDS epidemic in Africa which has had a significant impact on patterns of spending. In countries affected by conflict, better health care may only be a priority for governments when peace has returned.

8. Although government plans are prepared for the long-term (5 to 10 years), short-term needs are often more pressing and determine actual resource allocations. For example, if, in a small country, the main national hospital is in disrepair, it is hard not to divert funds in order to solve the problem - even if they have to come from primary services. Only a few countries acknowledged the need for continuing systematic review of priorities.

9. The financial crisis that has affected East Asia has not only made national priority setting more complex, it has also meant for some countries a closer relationship with donors, many of whom have their own sense of priorities.

10. In the countries of the former Soviet Union, the change has been even more dramatic: it is difficult to think about priorities at all when the national health budget has declined from US\$ 150 to just US\$ 40 per capita. It was suggested that in former command economies the first task was to change the attitude of the public and professionals who have previously been used to the State providing everything for free. Priority setting requires that everyone should recognize that they have a responsibility to participate in difficult decisions about how scarce resources should be used.

11. Health needs vary in most countries. National-led priority setting must allow for local decision- making.

12. Building consensus around national priorities is critical, but so is leadership. It is part of the task of politicians to explain and defend spending decisions.

13. The suggestion that there needs to be a shift in thinking in favour of processes - ensuring procedural rights - rather than focusing exclusively on defining the precise nature of entitlements, was confirmed by the discussions.¹ Priority setting does not work without effective consultation.

¹ See document WHA52/DIV/4.

14. Consultation processes need to be well designed and should not be used just to “rubber-stamp” decisions that have already been made.
15. It was clearly recognized that donors influence priority setting in significant ways. Two difficulties were identified. Firstly, donors have their own agenda, which may run counter to national priorities. Second, donor funding is concentrated on particular types of spending - making overall national decision-making more difficult.
16. The effectiveness of development assistance could be improved by ensuring that it is not provided on an ad hoc basis, but as part of an overall public expenditure plan which identifies health as a priority sector.
17. The consensus was that these problems could be overcome through longer term and more robust partnership arrangements. Some ministers spoke explicitly about sector-wide approaches, but many others talked about the need for joint and negotiated priorities.

INVESTMENT IN HOSPITALS: DILEMMAS FACING MINISTERS

18. Governments have a prime responsibility to provide quality health care to all its people. Access to hospital care therefore has to be universal, equitable and affordable. Ministries should not divest themselves from this responsibility.
19. Explicit hospital policy in health sector reform is of critical importance, as is the need for balanced development of a health facilities network in order to reach remote and rural populations, and to improve the interface between hospitals and primary health care. There is no single package of solutions, and the simple replication of foreign approaches may result in an additional burden. Countries must be prepared to build on what they actually have. Restructuring of services should respond to a country’s priority needs and occur within the framework of national capabilities and resources in order to ensure sustainability.
20. In many countries, a large proportion of health care delivery is provided by the private sector, and especially not-for-profit providers. Ministries should coordinate the overall national health policy and provide a framework in which the private sector can participate and contribute to the delivery of care for the entire population. The challenge to achieving optimal health care delivery is that of ensuring complementarity between the public and private, and for-profit and not-for-profit, sectors. Regulation is necessary, but it should not stifle innovation, and a system of appropriate incentives is needed.
21. With regard to the provision versus the purchase of hospital services, participants noted that where private providers are available and contracting is possible, this option may potentially curb costs and improve quality. However, concerns regarding equity and accessibility for the poor persist, and the relevance of this particular issue for countries with a limited private sector is marginal. Key factors in making contracts work, both with private for-profit and not-for-profit institutions, are institutional capacity, political will, and real competition in awarding contracts. Ministries must also have mechanisms to ensure quality and assess performance.
22. With the trend towards increased autonomy, a professional health-related background is an asset for a hospital manager. The essential point, however, is to have specific management training and good management

skills. In general, good management should be guided by ethics, technical and administrative competence, and professionalism. Involvement of the community in managing its hospitals is crucial.

23. Discussion focused on whether governments should divest themselves from service provision and alternatively develop contractual arrangements with public and private providers, and on optimal planning and management of hospitals and hospital resources, the governments' role and responsibilities in ensuring appropriate public and private balance, intercountry and regional cooperation in specialized service provision.

24. Obstacles to efficient operation of hospitals include the loss of skilled personnel due to poor career opportunities and insufficient remuneration, and the burden of maintaining physical assets and health care technology. Rational planning, acquisition and use of technology, especially expensive and sophisticated equipment, and provision of adequate maintenance services is needed. Innovative mechanisms for improved sustainability of hospitals include cost recovery schemes, revolving and special funds, and earmarked taxes, the overall effectiveness of which has not yet been fully assessed.

25. New concepts, approaches, techniques and methodologies should be supported by evidence, and the void in hospital research should be urgently filled. Further studies should address the complexity of different types of hospital systems in a changing sociopolitical environment, new financing mechanisms and advances in health technology. Challenges of globalization, redistribution and regulation will need urgent, focused attention and development of mechanisms and skills to cope with these challenges in the field of hospital investment and management. WHO should cooperate with countries in exchanging ideas and experiences, and distilling lessons from successes and failures. A concerted international effort is required to support countries in this critical area.

FINDING THE MONEY: DILEMMAS FACING MINISTERS

26. Generally, as GDP per capita rises, so does the portion of GDP spent on health and the public sector share of that expenditure. Many health systems are segmented, with different "health systems" for different social groups, often leading to poor care for the poor. An innovative view is to move from this segmented organization of the health system to a more functional one that recognizes different roles for the public and private sectors in the different functions.

27. Sources of financing the health sector include households, companies, nongovernmental organizations, and donor agencies, together with the moneys collected by governments, social security agencies, insurance funds, or directly by providers. Ministers of health compete with other ministers for their annual budget allocation, and need to be able to convince their government of the importance of health as an investment in development.

28. External funding is important in many developing countries, and several participants reported innovative government-donor partnerships, such as sectoral, rather than project, assistance, or the creation of health "trust funds" to finance specific inputs or services.

29. Although participants felt that countries should move more towards prepaid approaches, the feasibility and desirability of various financing options (social health insurance, community-based schemes) depends very much on the local context. Perhaps the most difficult and contentious issue for ministers is the role of user fees. Most countries, but not all, charge fees in publicly owned health facilities. Some participants attributed this to a recognition that government revenues are not sufficient to fund all needed services. Others identified the potential

role of fees in limiting demand for services and for influencing consumer behaviour (for example “steering” people towards primary care providers rather than hospitals). However, both poorer and richer countries are aware that the fees involve a conflict between the need to mobilize additional revenues and the need to ensure access to care for those who need it, especially since measures to exempt the poor have proven difficult to implement. This is perhaps the primary dilemma to be addressed in health financing policy.

30. Approaches to better managing the money and increasing efficiency include:

C changing provider arrangements (such as greater hospital autonomy, performance-linked contracts);

C changing the role of ministries of health (more rule setting and regulation, and less provision);

C moving from subsidizing the supply of services to subsidizing the demand for services (i.e. vouchers);

C changing health workers’ behaviour, by new health worker employment and incentive arrangements, for example delinking from the civil service;

C increasing regional cooperation between small countries, for example for insurance schemes, drugs;

C generating intelligent partnerships between the public and private sectors;

C capping costs in areas such as drugs; promoting use of generics;

C making better use of resources by investing in preventive and primary level services.

31. “Moving” health targets (new diseases, ageing populations) make it harder for ministries of health to get the balance right between finding resources and spending the money. Managing scientific and political considerations is important. Globalization is creating problems for poor countries, in particular through free trade agreements and migration of health workers. Rich countries have a responsibility in this respect.

HIV/AIDS: STRATEGIES FOR SUSTAINING AN ADEQUATE RESPONSE TO THE EPIDEMIC

32. The challenges faced by ministers was illustrated by the situation in a southern African country where a state of emergency has been declared in relation to HIV/AIDS. Seroprevalence has reached 22% in adults. Hospitals are overburdened and no strong community structures exist to support people living with HIV/AIDS.

33. High-level government commitment to HIV/AIDS is a prerequisite for an effective and sustainable national response. Other essential response elements include community-based activities grounded in a strong public health system; a multisectoral approach; extensive public education; promotion of 100% condom use, especially with vulnerable groups such as sex workers; and life skills training for schoolchildren, enabling them to protect themselves.

34. Denial and complacency are attitudes which have seriously impeded timely and effective action. A key government responsibility is to be the leading advocate of open and accepting attitudes towards HIV/AIDS at all

levels. Education for prevention of HIV and sexually transmitted infections, together with open discussion of sexuality in schools is needed to provide young people with the knowledge and skills they need to protect themselves.

35. The involvement of people living with HIV/AIDS in advocacy and public education has been shown to be highly effective in terms of social support and the fight against discrimination and secrecy.

36. The existence of two categories of citizens in relation to access to proven treatments should not be tolerated. The *Fonds de Solidarité thérapeutique internationale* has been established as a first step towards addressing equity of access to antiretroviral treatments to prevent mother to child transmission of HIV and eventually to treatments for HIV-related illness. Partnerships with civil society, international organizations, national governments and the private sector will be required for financial and technical support of this initiative.

37. International solidarity is needed in the development of drugs and vaccines. In order to ensure wider access to antiretrovirals, countries require support from international organizations in negotiating lower prices with industry. Countries in the same region should negotiate together rather than separately for better access to drugs. Industry involvement is necessary to broaden access to drugs for HIV/AIDS.

38. There is both a moral obligation and direct self-interest in supporting a concerted effort to develop a vaccine applicable to all viral strains. A multimillion dollar investment in development of vaccines and microbicides is required.

39. The allocation of funds made available for the global HIV/AIDS effort requires urgent examination by the international agencies concerned. The amounts of money allocated to consultancies, conferences and workshops in relation to activities in countries should be evaluated.

40. Prevention of mother to child transmission is seen by many as the priority area that should benefit from access to antiretroviral drugs. Participants requested WHO to cooperate with countries in providing the full support required for relevant interventions: functioning antenatal and child health services; provision of antiretrovirals; voluntary counselling and testing; family planning; and support for alternative feeding. Some participants reported that HIV-positive mothers were counselled on the risk of transmission of infection through breastfeeding without, however, provision of the other elements of support mentioned above. Most of these mothers depend on breastfeeding for the survival of their children. Those who can afford breast milk substitutes often lack clean water and cooking facilities to prepare them safely. Participants called on the international community to support interventions to prevent "bitter" deaths - which mothers know can be avoided today with available technology.

41. Notification of partners, with agreement from the person living with HIV, is part of counselling procedures in certain countries. In a number of countries, when agreement cannot be obtained, doctors are advised not to interfere. Guidelines have been issued on conditions which must be met for notification of partners by health professionals when explicit consent cannot be obtained. It was clear that there is no agreement regarding named reporting and partner notification without the explicit consent of the infected persons.

42. Shared confidentiality in which a close friend or relative is involved with the consent of the person concerned in counselling, is a promising approach which seems to increase acceptance of disclosure to others and allows for better coping and planning for the future.

43. Participants expressed concern that the rights to privacy of a person living with HIV may be in conflict with the rights of others to protection. The key to this issue lies in good counselling, leading to voluntary notification, and in fighting discrimination and stigma.

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