Background paper: why this Regional Consultation, and why now?

This consultation is being held at a time of significant change in thinking about how national governments can accelerate improvements in their people’s health, and in development in general. The Sustainable Development Goals (SDGs) were adopted by the UN General Assembly in September 2015, following extensive global consultation. There are 17 SDGs (Box 1), in contrast to the 8 Millennium Development Goals. They aim to encourage an integrated approach to sustainable development, with a focus on the most vulnerable.

Many questions are being raised. What do the SDGs mean in practice for improving health in the countries of South-East Asia? What role can Universal Health Coverage play in advancing the health goal (SDG3)? What concretely can country governments and their partners do in the next few years to accelerate progress? Does it mean changing priorities, or is it more about changing how we work on those priorities?

Box 1 Sustainable Development Goals

Health is well placed in the SDGs. The health goal (SDG3) is broad: ‘Ensure healthy lives and promote well-being for all at all ages’. In addition, health is framed as contributor to and beneficiary of sustainable development. Achieving SDG3 will depend on progress in other SDGs – poverty reduction; education; nutrition; gender equality; clean water and sanitation, sustainable energy and safer cities (Box 2).
The health goal covers several groups of targets, related to the unfinished MDG agenda concerning maternal and child health, and communicable diseases; new targets including non-communicable diseases and social determinants, and targets related to health systems and universal health coverage (Box 3). A recent paper stated ‘there are some important health issues missing from the SDGs, but not many’. It noted only two – ageing (though present indirectly through its impact on NCDs and mental health) and antimicrobial resistance – which is mentioned, but has no target.

The UN Declaration on the SDGs emphasizes that to achieve the overall health goal, ‘we must achieve universal health coverage (UHC) and access to quality health care. No one must be left behind’. This places UHC as the target that underpins and is key to the achievement of all the other health targets. The use of UHC to frame discussions on SDG3 helps make the health agenda more cohesive.

The SDGs have been welcomed by signatories to the UN Declaration for being comprehensive, ambitious and applicable to all countries. At the same time others have criticized them for proposing ‘an unattainable utopia’. A third view is that a pragmatic middle ground is possible, which sees the SDGs as an opportunity to accelerate progress in health, universal coverage and human development. What most seem to agree upon is that achieving the new health targets cannot rely on ‘business as usual’.
Box 3 Sustainable Development Goal 3 and its targets

SDG3: Ensure healthy lives and promote well-being for all at all ages

Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, medicines and vaccines for all

<table>
<thead>
<tr>
<th>MDG unfinished and expanded agenda</th>
<th>New SDG3 targets</th>
<th>SDG 3 means of Implementation targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1: Reduce maternal mortality</td>
<td>3.4: Reduce mortality from NCD and promote mental health</td>
<td>3.a: Strengthen implementation of framework convention on tobacco control</td>
</tr>
<tr>
<td>3.2: End preventable newborn and child deaths</td>
<td>3.5: Strengthen prevention and treatment of substance abuse</td>
<td>3.b: Provide access to medicines and vaccines for all, support R&amp;D of vaccines and medicines for all</td>
</tr>
<tr>
<td>3.3: End the epidemics of HIV, TB, malaria and NTD and combat hepatitis, waterborne and other communicable diseases</td>
<td>3.6: Halve global deaths and injuries from road traffic accidents</td>
<td>3.c: Increase health financing and health workforce in developing countries</td>
</tr>
<tr>
<td>3.7: Ensure universal access to sexual and reproductive health-care services</td>
<td>3.9: Reduce deaths from hazardous chemicals and air, water and soil pollution and contamination</td>
<td>3.d: Strengthen capacity for early warning, risk reduction and management of health risks</td>
</tr>
</tbody>
</table>

Interactions with economic, other social and environmental SDGs and SDG 17 on means of implementation

This is particularly true of the newer targets, and of issues such as antimicrobial resistance, which require a different approach compared with the health Millennium Development Goals (MDGs), as progress depends on action in multiple sectors. For example, to tackle antimicrobial resistance, intensified action is needed by those concerned with health, food, agriculture, regulation and trade. This emphasis on intersectoral action is of course not new, and a meeting on Health in All Policies in SEAR was held in 2013. Debates concerning the opportunities, challenges and practical significance of the SDG for health are now underway in some countries, and in regional and global institutions. Given previous experience with the MDGs, and that the SDG agenda is more ambitious but still to be achieved over a similar 15-year timeframe, many actors are urging ‘start implementation now’. However, others are still relatively unaware of this new development agenda.

This consultation aims to stimulate debate about the SDGs and how they can be used to accelerate progress in health in South-East Asia. It will then focus on the role of UHC in achieving the health SDG targets. Lastly, it will consider how to accelerate progress, given that countries are at different stages along the path to UHC. What practical steps can be taken? Who needs to be involved, and how? Conclusions will be discussed by Ministers of Health at the WHO South-East Asia Regional Committee in September 2016. Technical meetings will also follow, for example on strengthening the health workforce; medicines regulation; health financing; approaches to monitoring the health SDGs including UHC; and strengthening the health systems response to NCD management in primary health care.
A key objective of this meeting is to explore how to advance the health goal: ‘Ensure healthy lives and promote well-being for all, at all ages’, and the place of UHC within this larger effort, in the South-East Asia Region. Such a meeting cannot cover everything, and certainly not in depth. What it aims to do is stimulate discussion on the practical implications of the SDG for health, and define a clear narrative of the links between SDG3, progress on UHC and – underpinning that – health system strengthening, for this Region. In this meeting, we use the definition of UHC from the World Health Report 2010: all people receive the quality services they need, without suffering financial hardship. The diagram in Box 4 provides a simple schematic for thinking about UHC’s place in achieving the SDGs.

**Box 4**

A framework for UHC as part of the SDGs

<table>
<thead>
<tr>
<th>Results</th>
<th>Goal</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global public health security and resilient societies</td>
<td>Universal Health Coverage</td>
<td>Health Systems Strengthening</td>
</tr>
<tr>
<td>Equitable health outcomes and wellbeing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inclusive economic growth and employment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


**The key idea of UHC is that all people receive the care they need, without incurring financial hardship.**

For all countries, achieving UHC is a gradual process: coverage for a range of services increases progressively, as does the proportion of the population protected financially. The 11 countries in SEAR are at different stages along the road towards UHC.  

The first technical session of the meeting will consider who is still ‘being left behind’. Estimates of the situation in the Region have been prepared for the two key components of UHC: coverage with essential services (prevention and treatment) and protection from financial hardship. The methodology of the first global monitoring report, *Tracking Universal Health Coverage*, by WHO and the World Bank (2015)\(^9\) was used. That report estimated that globally, about 400 million people still lack access to one or more of 7 essential services.

What is the situation in South-East Asia today? Despite considerable progress over the last 10 years on the MDGs, approximately 130 million of the 400 million
people globally that still lack access to essential health services are living in the South-East Asia Region. For financial protection, available evidence suggests that the percentage of population pushed into poverty due to health spending ranges from 0.4 to 3.5% in SEAR countries, representing more than 50 million people going into poverty every year.

The meeting will first discuss what we currently know about who in this Region is not getting the services they need, and then reflect on differences in coverage and impoverishment depending on people’s income, sex and place of residence.

**UHC helps bring together the three elements of the health SDG: the unfinished MDG agenda; new health priorities and the means for achieving the agreed health targets – medicines, health workers, financing, legal frameworks; and capacity to manage health risks.**

Much of the attention and action on UHC to date has focused on health financing. Improved health financing is of course essential, but experience from countries with a history of progress on UHC confirms that health services have to be improved in parallel with better health financing to achieve significant and sustained progress. There is no point in extending financial protection from the costs of health care if the health services that are needed are either not there, or are of such poor quality that they are not used.

For this reason, the meeting’s discussion of what can be done to advance UHC will start with a focus on **service delivery**. It will examine experience with expanding service coverage for people at the beginning of their lives, and – because ageing is a growing issue in SEAR as elsewhere – later on (Box 5).

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**Box 5**

**As elsewhere in the world, the population in SEAR is ageing**

Between 2015 and 2030, the number of people over 60 years in SEAR will increase from 186 million to 312 million (a rise from almost 9% to 12.6% of the population). As a comparison, when the MDG era began in 2000, the number over 60 years old was 111 million. And by 2020, the number of people aged 60 years and over will outnumber children younger than 5 years in SEAR.

*Source: UN Population statistics.*

Given that whether one is young or old, it is quite common to have more than one health issue at the same time, the meeting will also consider how frontline services can offer more ‘integrated care’ – i.e., put people’s needs before programme needs.

Many of the interventions needed to address the different elements of the health SDG goal can be delivered through ‘frontline services’ rather than relying on more costly secondary and tertiary care. This meeting will therefore concentrate on frontline services, be they community based or facility based. This is certainly not a new idea, but it has regained attention partly because of the SDG focus on **equity**. On the whole, frontline services are often located nearer hard-to-reach
groups. New models of combined community and facility-based care are emerging. A SEARO consultation last year noted the increasing range of preventive and curative services being delivered by a growing range of service providers in the community. What are the lessons from these developments?

Altogether, experience with how to increase coverage of a wider range of services is growing, but could certainly be better documented and shared across the region. One clear message is that advancing UHC is ‘everybody’s business’ – for health workers in the community and in facilities; for managers of priority programmes; for staff in Departments of Planning and Finance, parliamentarians, NGOs, researchers and other stakeholders.

The meeting will reflect on similarities and differences in service delivery arrangements needed to ensure that people in different age groups get the care they need, be it short or long-term care (Box 6).

<table>
<thead>
<tr>
<th>Box 6</th>
<th>Accelerating coverage with equity for maternal and neonatal health: are the priority directions similar for expanding care later in life, and for other types of services?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The South-East Asia Regional Technical Advisory Group on Women’s and Children’s Health met in December 2015 to consider how to accelerate reductions in neonatal mortality in SEAR, given that the rate of decline in neonatal mortality has been slower than for child mortality overall, and that interventions to improve neonatal mortality will also contribute to further reductions in maternal mortality and prevention of stillbirths.</td>
</tr>
<tr>
<td></td>
<td>It considered the current barriers to expanding coverage, and priority actions needed to achieve high maternal and neonatal coverage with equity during the SDG era. It concluded that the clinical interventions are known, and that where more action is needed is in four broad areas: human resources; quality of care; community engagement; and greater accountability for women’s and children’s health.</td>
</tr>
<tr>
<td></td>
<td>To what extent do these priority directions resonate with those seeking to expand coverage with equity for other population groups and services? What are the commonalities and differences in action needed?</td>
</tr>
</tbody>
</table>

Source: Regional Technical Advisory Meeting on Women’s and Children’s Health, 2015.

**Adopting the SDGs, and within that UHC, does not mean that everyone is entitled to any care they want. Choices have to be made for use of public funds.**

One criticism of the SDGs is that they are unaffordable. Similar criticisms are made about UHC. The counterargument is that the SDGs – including UHC – are affordable, albeit with caveats, because they will be ‘progressively realized’ based on available resources. Countries are also able to set their own national targets. And progress is feasible and achievable wherever one is starting from. Box 7 shows what has become known as the ‘UHC cube’ – the three dimensions to consider when moving towards UHC.
In SEAR, government health spending as a share of total health spending remains low compared with other regions, though there is a recent upward trend in several countries.

What is also a fact is that, whatever the level of spending, demand for health care will always exceed available resources, and resources need to be used efficiently. Therefore, decisions always have to be made about how best to allocate resources. These decisions are taken in many different ways. Given the SDG commitment to ‘leave no-one behind’, what are the implications for priority setting and budget allocation, at least for public funds? One session will consider experience with priority setting and the extent to which these take into account gaps in care?

To address gaps in health services, and advance UHC in SEAR, concerted action is needed to strengthen the health workforce and access to medicines. What has been happening?

A half day will be spent reflecting on new developments – national, regional and global – to address persistent challenges in health worker deployment and performance (Box 8), and improved access to affordable, safe and effective medicines, again keeping the focus on frontline services.

A key question will be: where would we like to be in 2, 5 or 10 years’ time in terms of health workforce strengthening and access to medicines? Are our current strategies for human resources and medicines ‘fit for purpose’, given the aim of improving frontline services?
Many SEAR countries have focused on improving financial protection. What has been learned about how to do this?

The key to protecting people from financial hardship is to protect them from having to pay for health services out-of-pocket (OOP) at the time of use. Using OOP payment to fund health systems has a number of disadvantages, but among the most important is that it discourages people, especially the poor, from seeking care. It also increases people’s risk of impoverishment as a result of seeking care. A key step towards financial protection is therefore to reduce OOP and increase prepayment for health services. Current evidence suggests that OOP payment below 20% of total health expenditure is a good indication of reduced risk of impoverishment from health spending.

OOP payments in SEAR are still high – in 2013, eight countries in the Region had more than 30% of total health spending from OOP payments (Box 9). There is evidence of a welcome reduction in OOP payments between 2010 and 2013 in several countries, but over the same period, a rise in others. The meeting will reflect on countries’ experience with improving – and sustaining – financial protection, and how to go forward.

Improved monitoring matters; there is a real momentum in SEAR: how is this being used?

The health SDG is relatively well off in terms of measurable targets compared with the other SDGs. Wherever possible, already agreed international targets and indicators are being used. For other indicators, work is ongoing. Work has
advanced on UHC monitoring: it includes a composite measure of service coverage drawn from across other health targets and two measures of financial protection. The final list of indicators, including the overarching indicator of progress on SDG3, is to be agreed in March 2016 and will be presented in the meeting.

**Box 9**

**Out-of-pocket expenditure as % of total health expenditure in SEAR, latest available**


There is much concern about the burden of monitoring for the SDGs, but – as challenging as this seems – no-one is starting from zero. There is a wealth of experience to build on. Building on experience with tracking the MDGs, there is an opportunity to take a more comprehensive approach that includes NCDs and injuries. A sharper focus on the key health service and financial protection indicators will be valuable for policy-makers, because effective UHC tracking is central to achieving goals for poverty alleviation and health improvement. Without such information, decision-makers cannot say where they are and set a course for where they want to get to. They cannot know whether their policies and strategies are making a difference. More comprehensive approaches together with use of new technologies, judiciously introduced, provide new opportunities for accelerated information system development.

The SDGs put more emphasis on **monitoring equity** – for example, for critical subpopulations such as people living in rural areas and the poor. There is also more emphasis on **accountability** for progress. The meeting will reflect on experience in SEAR with using data to raise awareness and stimulate policy debate about reaching those being left behind.
How to catalyse progress through more or different types of political, organizational and technical action?

There is clear political commitment in the Region to the SDGs. While the discussions in preparation for the UN SDG Declaration did not always involve Ministries of Health, there was a high-level consultation on the place of health in the post-2015 development agenda in Botswana in 2013, as well as several regional consultations on the SDGs in general. Importantly last year, Ministers of Health from all SEAR countries agreed that the health SDG reflects current and future critical health challenges in South-East Asia. They also commented that the SDGs will both support and require a more integrated approach to health development, and this will be challenging but is needed, especially if inequities are to be addressed – a point reiterated in a joint statement by SEAR Member States at the WHO Executive Board in January 2016. They noted that the SEAR Regional Director’s seven flagship priorities (Box 10) fit well with the SDG agenda.

Box 10

SEAR Flagship Programmes

- Measles elimination and rubella control by 2020
- Prevention of noncommunicable diseases
- Unfinished MDG agenda: ending preventable maternal, newborn and child deaths
- Emergency risk management
- Universal health coverage with a focus on human resources for health and essential medicines
- Antimicrobial resistance
- Elimination of diseases on the verge of elimination

Political commitment more specifically to UHC in the region precedes the SDG Declaration. All national health policies and strategies already make reference to Universal Health Coverage, or the closely related concept of Universal Health Care. The Regional Strategy for UHC was endorsed in 2012, and a Regional Consultation held in 2014. Thus, in many ways, the fundamentals are there. But progress is still slower than hoped. In some cases, there are worrying trends – such as rising out-of-pocket payments for health care in some countries, which is a key determinant of impoverishment.

The big question is ‘what can be done differently, and how to change the speed of travel towards the agreed goals and targets?’ The last two sessions of the meeting will review ideas and suggestions on ‘what next’, raised in the preceding sessions, and then consider which are the biggest priorities – and how to take them forward in practical ways.

Questions will come up during the meeting, but some that have already been identified in preparation for this meeting, and in other discussions include

- Which ideas on next steps for UHC, from preceding sessions, are worth pursuing after this meeting, given the context of the SDGs? Are they
feasible? Are they essential, in order to reinforce progress on UHC as the vehicle for reaching health SDG targets? What additional political action; organizational change; analytic work is needed? Who needs to be involved?

- **Can fragmentation and competition between programmes and targets be better managed in the SDG era** by governments and their partners (in the broadest sense), compared with the MDG era? Can we find different ways for partners to contribute to and work within a country’s overall health sector strategy or plan? Can UHC be an effective unifier?

- **How can the health sector more effectively influence other sectors?** The 17 SDGs are designed to be ‘integrated and indivisible’, with recognized links between health and other goals (SDG 2, 4, 5, 6, etc.), and progress in one area dependent on progress in others. The SDG agenda gives renewed legitimacy, impetus and pressure for the health sector to influence policies affecting health in other sectors; but how can this be done, as intersectoral action has always proved difficult to maintain? What is already happening? What practical actions are possible? What can SEAR countries do differently this time compared with previous efforts at promoting more intersectoral action?

- **What additional steps can be taken to improve measurement and accountability for progress on the health-related SDGs**: what steps are needed, and by whom?


5. Health in All Policies: Report on Perspectives and Intersectoral Actions in the South East Asia Region, WHO SEARO 2013


