

Stories

From
The Field

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on UHC





About the Joint Working Team for universal health coverage

The Joint Working Team for UHC promotes bottom-up processes owned by the country in order to achieve UHC.

Our approach facilitates flexibility and a more agile way of working. It emphasises cross-organizational collaboration to support each WHO Country Office to develop and implement UHC country support plans in close collaboration with Member States.

This harnesses the power of our collective energy, technical skills and knowledge at global, regional and country levels to focus on implementing UHC in countries, where the impact is the greatest.

The UHC Partnership is supported by the European Union, the Grand Duchy of Luxembourg, Japan, Ireland, France and United Kingdom.

Welcome to 'Stories From The Field'

the WHO magazine about how countries all around the world are working to achieve universal health coverage (UHC)



Photo: @WHO

The Joint Working Team for UHC at WHO has collaborated with colleagues in Regional and Country Offices to bring you these inspiring stories of change.

The stories demonstrate how health systems are getting stronger and providing better quality services, how care at the primary level is expanding and becoming more effective and accessible, and how communities and citizens are engaging with governments in meaningful ways to influence health policy and practice.

All this contributes greatly to make progress towards UHC; the goal that we are all striving for to ensure that everyone around the world has access to the health care they need, without being driven into poverty because of the cost.

Of course, the impact that we are seeing is not achieved by WHO alone. We work in close association with governments and other national health stakeholders in their endeavours to achieve better health outcomes for the population. We hope these articles give a flavour of how we work and what we can all achieve when we work strategically together.

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If you don't have time to read every word, you might like our 60-second summary at the end of each article!



Oman leads the way in patient safety: improving service delivery for UHC

Oman is showing regional leadership in the Eastern Mediterranean Region by adopting the Patient Safety Friendly Hospital Initiative to improve the safety of health care in public and private hospitals nationwide.



Hospital staff and WHO team during a visit for the external evaluation of Nizwa Hospital, Oman Photo: WHO.

Oman is taking patient safety very seriously, and the Ministry of Health is keen to tackle the issue head on. Following a best practice meeting on patient safety organized by WHO, the Ministry showed a high level of commitment and interest in the implementation of the Patient Safety Friendly Hospital Initiative to improve the safety of health care in public and private hospitals nationwide, and a roadmap of actions was developed.

We are very proud in Oman to be leaders in patient safety. Patients have the right to receive safe treatment in safe institutions and by safe and well- trained clinicians and health care providers.

HE Dr Ahmed Mohamed Obaid
Al Saidi Minister of Health, Oman.

The Sultanate of Oman has made significant progress in the field of quality and patient safety over the past decade. There has been continuous collaboration with WHO, specifically in developing and implementing patient safety tools.

Dr. Ahmed Al-Mandhari, WHO Regional Director for Eastern Mediterranean Region

Supportive evaluation

As the patient safety movement had originated from within Oman, the Ministry and hospitals felt a strong sense of ownership over the initiative.

When their new patient safety practice settled down, they were ready to ask for external observers from WHO in order to see if they were complying with the requirements or not. WHO carried out an external evaluation in four hospitals with the aim of providing support. It was not an inspection or audit; rather the process recognized achievements and provided guidance on how to move forward.

Now the work is being implemented in a further 26 hospitals, almost 90% of the main hospitals in Oman. Eight hospitals have now been evaluated by WHO for patient safety; coverage will later increase to all the remaining hospitals in Oman including public and private by 2020.

Through trust and consistent support and because WHO colleagues work with hospital staff in a manner that shows them they are moving forward, together they are achieving concrete change in patient safety.

Other important activities are also taking place. For example, a patient safety curriculum is now operating at health science-related universities so that future health professionals have a good foundation to continue a patient safety culture when they practice in hospitals in future.

Oman also has an annual day to celebrate the awareness of the importance of patient safety, where health practitioners can showcase their achievements in and share good practice.

Patient Safety Friendly Hospital Initiative

The initiative started with advocacy and capacity building and assigned focal points for each team from different hospitals. Hospital staff started working at the operational level, and had continuous contact with the WHO Country and Regional Offices.

They were always able to get guidance if they needed to know more or required clarification about how to deal with infection prevention and control, the safe management of drugs, or how to involve patients.

“ The Ministry was very receptive to us when it came to what to do first, what preparation is needed, how to communicate, how to build the capacities, how to continue mentoring the teams working on the ground and how to recognise efforts and good performance,” said Mondher Letaief, Regional Advisor, WHO EMRO.

The implementation of the pilot project in four hospitals in Oman was a milestone in the quest of the Ministry’s Quality Assurance Center to achieve patient safety in its health care institutions.

“ We already have many quality parameters in place but what is new and unique in this initiative is the word ‘friendly,’” said Ms Seeniua Biju, the Chief Operating Officer and country head of Aster Al Raffah Hospitals and clinics.



OMAN

FACT

Almost 90% of the main hospitals in Oman are now taking part in the Patient Safety Friendly Hospital Initiative to improve safety in public and private hospitals nationwide. This improves service delivery to support UHC.

WHY IT MATTERS

Each year globally, millions of patients die or are injured because of unsafe and poor quality health care. Most of these deaths and injuries are avoidable.

EXPECTED IMPACT

All hospitals in Oman will improve practice in patient safety and quality of care, ultimately improving health and saving lives.

IN PRACTICE

The Ministry of Health is highly committed to the Patient Safety Friendly Hospital Initiative. WHO worked with the Ministry and hospitals nationwide to provide tools, training and technical support about patient safety.

The Rural Pipeline Project covers all 12 communes and key development sectors of the Diffa region: educational, health, agro-forestry- pastoral and fisheries. It offers us the means to bring out an important middle class and to build together a united and prosperous Diffa region.

Head of the Arab Group of N'Guigma, Diffa



Niger A strong health workforce, a strong economy: all working together

Niger, a West African country with a population of 21.5 million, is setting a strong example to the world. A range of ministries and sectors are completely engaged and working together in new ways to strengthen the health workforce and improve socio-economic development in general. They are taking into consideration important issues such as education, employment, finance, nutrition, mother and child health and agriculture.

National Action Plan

Over the past year, political actors and technical staff from different sectors in Niger collaborated and produced the 'National Action Plan for investment in health and social sector employment and growth in economic health 2018-2021'.

It focuses on the needs of the population and capitalises on existing national, sub- regional and international initiatives.

Now, Niger is set to implement the plan, starting with a rural pipeline project in the Diffa region.

Diffa rural pipeline project

A 'rural pipeline' is a systemic approach to inclusive community development to promote the resources of a region. In the Diffa region, a pilot project aims to train and provide decent employment opportunities for young people and women. It will also strengthen the resilience of education, health and productive systems by removing socio-cultural barriers.

It focuses on interventions with high inter-sectoral impacts including: investments in infrastructure and human resources in education; vocational training of young people in sectors with decent jobs including health and agriculture; recruitment

of trained graduates and support for creation of small and medium enterprises; increased access to and use of maternal and child health care services; investments in irrigation, product processing and the creation of agro-pastoral and fisheries micro-enterprises.

The Diffa rural pipeline project, costing an estimated US \$ 17.8 million, will be piloted for four years from 2018-2021.

At the end of this period, interventions will expand to the seven other regions of Niger, taking into account their specific realities. This scaling up will be linked to the next Economic and

Social Development Plan of Niger 2022 - 2026.

For health, it is hoped that the pilot project in the Diffa region pilot will result in:

- 300 health graduates trained and recruited in health facilities in the Diffa region
- 12 mutual health associations to ensure universal health coverage for populations in the 12 communes of Diffa.

Local community members in Diffa are very supportive. Here are some reflections from those involved so far.



There is a strong economic argument that when a population is healthy, it is more productive and the economy is more likely to flourish.

We, the traditional leaders of the Diffa region – having actively participated in the amendment of the document of the Rural Pipeline Project – give our total approval to its ideals. We thank the high national authorities for the special attention they are giving our region.

Mariama Chipkaou, Director of the Promotion of Girls' Schooling in Niger

From global to local

In March 2016, the UN Secretary-General set up a High Level Commission on Health Employment and Economic Growth. Former French President Francois Hollande and former South African President Jacob Zuma co-chaired the Commission and the World Health Organization, the International Labour Organization and the Organization for Economic Cooperation and Development (OECD) served in a vice-chair capacity; this naturally promoted a highly inter-sectoral approach.

WHO facilitated national discussions about how to make it happen, and provided technical support to each country to develop its own national health workforce and economic growth strategy.

Importantly, WHO, ILO and OECD also facilitated regional dialogue between countries and drafted a global action plan to support implementation of the Commission's recommendations called 'Working for Health'.

In May 2018, in collaboration with the ILO, an inter-ministerial meeting took place in Abidjan, Cote D'Ivoire to adopt a regional health workforce investment plan. Ministers of Health and Finance (or their representatives) from the WAEMU countries gathered and made a commitment to implement the recommendations of the High-Level Commission, the first region in the world to do so.

The Southern African Development Community (SADC), comprising 16 countries, is now looking to do the same and WHO is supporting them in a similar way to WAEMU.

How did it all start?

In Niger, motivation to strengthen the health workforce is strong. The population is growing rapidly in Niger, and there is pressure on the Government to invest in socio-economic projects and create decent jobs, particularly for young people and women.

Niger also has a worryingly high maternal and newborn mortality rate in comparison to other countries in the region. There is a strong economic argument that when a population is healthy, it is more productive and the economy is more likely to flourish.

So improving maternal, newborn and child health and strengthening the resilience of the health system are main priorities of the Action Plan. Furthermore, under this plan women and young people in particular have greater opportunities to enter the health labour market rather than other employment sectors.

The Commission made ten key recommendations for states to stimulate and guide the creation of at least 40 million new jobs in the health and social sector, in order to reduce the announced shortage of 18 million health professionals, mainly in low- and lower-middle-income countries, by 2030.

The West African Economic and Monetary Union (WAEMU) – comprising Benin, Burkina Faso, Cote d'Ivoire, Mali, Niger, Senegal, Togo – was keen to take up the challenge set by the Commission. How could each country develop a national health workforce investment plan?



Members of the Communal Office of Youth of Diffa after a National Youth Camp. Photo: Communal Office of Youth of Diffa, December 2018.

Niger takes action

Niger was the first country to take up the challenge presented by the Commission. It engaged a range of sectors and Ministries in order to adopt the Commission's recommendations at the highest level of decision-making, translating them into the National Action Plan for investment in health and social sector jobs and economic growth 2018-2021.

“The National Action Plan provides adequate responses to the challenges of health human resources, taking a systemic approach to strengthening the other pillars of the health system. That's where its strength lies! In the long term, we expect a marked improvement in the maternal, neonatal and infant morbidity and mortality indicators for Niger,” said Dr Idi Illiassou Mainassara, Minister of Public Health.

The inter-sectoral nature of the High-Level Commission highly influenced the way Niger approached its National Action Plan. Cabinet Ministers and the Secretaries General of Ministries in charge of employment, health, planning, higher education, civil service and finance led the process.

They facilitated a national workshop to identify priority interventions based on the ten recommendations of the Commission, and adapted them to Niger's realities and policy documents. They then established a small technical working group for operational planning and budgeting of selected interventions, and devised a communication and advocacy strategy for mobilising stakeholders and resources.



Health worker in a fistula hospital in Niger © 2015 Cambey Mikush, Courtesy of Photoshare.

We are very excited about the high- impact interventions in the Diffa Rural Pipeline Project in favour of school attendance and retention of girls at school and the empowerment of their mothers. We remain all mobilized to ensure a better tomorrow for girls, teenagers and women in the Diffa region.

Mariama Chipkaou, Director of the Promotion of Girls' Schooling in Niger

A cross-sectoral committee will monitor the implementation of the Plan, and includes the President, the Prime Minister's Office and 15 departments. It is co- chaired by the Ministries of Employment and Health. Ministers for Budget, Planning, Employment and Health led the first meeting of donors supporting the Plan and further meetings will take place with the Minister of Finance and heads of bi- and multi-lateral agencies.

The President has now signed a law for the National Action Plan, which has been adopted. Implementation has begun and here are some examples of what the Plan contains:

- 11,500 permanent and temporary jobs to be created in the health and social sector, including 216 physicians, 1,400 nurses, 864 midwives, and 1,440 other health professionals.
- 147 health facilities to be built, 50 medical clinics and 10 non-governmental organizations to be part of a public-private partnership for primary health care in underserved areas.
- 1.8 million additional people in under-served areas (9% of the total population), to be closer than 5km to a health facility, to increase health coverage from 48-58%.

“The President of the Republic, His Excellency Mr. Mahamadou Issoufou, congratulated us for having provided Niger with a real operational tool allowing significant progress towards the achievement of the SDGs, in particular towards the effectiveness of social protection, at the heart of which is universal health coverage. It also pays particular attention to the success of the Diffa Rural Pipeline Project,” said M. Mohamed BEN OMAR, Minister of Employment, Labor and Social Protection.



NIGER

FACT

Niger is the first country in the West African Region to take up the recommendations of the High-level Commission on Employment in Health and Economic Growth. A range of Ministries and sectors are working together in new ways to strengthen the health workforce and improve socio-economic development.

WHY IT MATTERS

Inter-sectoral efforts to support UHC are essential. In Niger, investments in infrastructure and human resources for health, education, agriculture, fisheries and micro-enterprises will contribute to a comprehensive approach to socio-economic development and UHC.

EXPECTED RESULTS

The creation of 11,500 health jobs; 147 additional health facilities; and 1.8 million additional people covered in under-served areas.

IN PRACTICE

WHO, ILO and OECD served as vice-chairs of the High-level Commission on Employment in Health and Economic Growth and then facilitated regional and national discussions about how to put recommendations from the Commission into practice, working closely with various Ministries in Niger.



Belize Moving towards UHC with integrated care services

Integrated health care for women and children, with its emphasis on people- and not illness-centered services, is one of the main focuses of the Matron Roberts Polyclinic in Belize. This primary care clinic provides comprehensive services to 24,000 people in the southern part of Belize City, an area with one of the highest rates of unemployment and gun-violence in the small Central American country.

This is just one example of integrated primary care services that are developing right across Belize. The services improve access to quality care, ensure a continuum of care and use resources more efficiently. It is part of a strategy to achieve universal health coverage.

Ashanti Gill arrived at the Matron Roberts clinic by bus one morning. Her eight-month pregnancy and two-year old son made walking there difficult, but little Erik had been suffering with a cough and fever the night before and needed a check-up. "He wasn't feeling well all night and barely slept," said Ashanti.

That day Ashanti was visiting the outpatient clinic but previously she had been referred to the prenatal care department for her next appointment and follow-up. Integrated care lies at the very heart of Matron Roberts Clinic. The polyclinic offers a wide-range of integrated services including laboratory blood tests, nutritional advice, family planning, breastfeeding counselling, cervical cancer screening and pharmacy, all in the same place.

The idea is to offer as many services as possible in the least number of visits. If patients have to go elsewhere for an analysis, the likelihood is that they just won't do it. This is why it is vital that we offer them here. Many patients leave the polyclinic after receiving a consultation, laboratory results and medicines. This enables us to better manage cases.

Dr. Karl Jones, Medical Coordinator at Matron Roberts.

Following her appointment and before going to the pharmacy to pick up the medication prescribed by the doctor Ashanti said that for her:

“This is the best clinic in Belize. It is clean, the staff are friendly, the doctors are friendly.”

Ashanti is due to give birth at the Karl Heusner Memorial Hospital (KMH), the only specialized referral hospital in the country, and another example of an integrated health network.





Integrated health services improve access to quality health care, the efficient use of resources, and ensure continuity of care through better coordination between the different levels of care, from primary care in the community to more specialized care.

Covered by public health insurance

In 2001, Belize put in place a National Health Insurance (NHI) scheme as a financing and purchasing mechanism of primary care level health services, from both public and private providers. It is currently financed with government revenues through the Ministry of Health (MoH) and its governance falls under the Social Security Board (SSB).

The scheme was initially limited to the poorest regions in Belize city, then progressively extended to the southern region and some districts in the north of Belize. After 17 years in place the scheme is still considered a pilot and is pending to be extended to a cross-national level. Since it was launched, coverage has extended and many achievements can be identified mostly related to the introduction of doctor-based groups practice for primary clinical care and higher staff-to-patient ratios.

Payment is linked to performance, based on pre-established "key performance indicators" and well defined standards and protocols of treatment, including for non-communicable diseases. Satisfaction surveys conducted regularly show raising patient satisfaction among the covered population.

However, challenges remain and are mostly related to the partial NHI implementation restricted to some geographical areas, which has created inequities and promoted fragmentation at the health facilities level hindering continuity of care and creating a dual health services provision and purchasing of primary care health services.

The Matron Roberts Polyclinic is run by the Government of Belize and serves patients who are covered by two insurance schemes; one from the Ministry of Health and the other the National Health Insurance (NHI) scheme. At the polyclinic, the same health personnel provide services to patients covered by both types of insurance.

The co-existence of both systems within the same health facility presents challenges in terms of administrative efficiency, but also has advantages.

This includes defined protocols and a transparent, results-based system that incentivizes efficiency and has a positive impact on quality of care. Matron Roberts has been recognized for its work with an NHI public provider excellence award.

PAHO/WHO has provided technical cooperation to Belize for years in areas such as policy, legislation, hospital administration, integrated networks, and strengthening the first level of care in order to ensure that the country's health system is empowered and resilient.

Dr Noreen Jack, PAHO/WHO
Representative in Belize

By taking this path, the country is seeking to expand access and health coverage to all people, leaving no one behind.

Continual improvements

Alexy Rosado has been the Manager at the polyclinic for more than seven years. Since assuming the role, she has worked to ensure improvements in the quality of care, including in basic infrastructure (for example, new flooring) and the implementation of incentives for staff to improve their attitudes towards both patients and the working environment. According to Rosado, one of the remaining challenges is to reduce wait times.

“Doctors see between 150 and 200 patients per day. We want to improve wait times and provide a faster triage. This is part of our strategic plan,” said Rosado.

Matron Roberts employs 47 professionals and health personnel. According to Rosado this number,

“is never enough to cover the health needs of the population, which is why we also do home visits and referrals.”

In order to address the country-wide issue of limited availability of health personnel, which is also a challenge experienced all over the world, the Ministry of Health recently launched its first Strategic Plan for Human Resources for Health, prepared with support from PAHO/WHO.

Stronger health systems for UHC

Providing integrated health services is a strategy promoted by the Pan American Health Organization (PAHO), regional office for the Americas of the World Health Organization (WHO), in Belize to achieve universal health coverage with an emphasis on primary care. These services improve access to quality health care, the efficient use of resources, and ensure continuity of care through better coordination between the different levels of care, from primary care in the community to more specialized care.

In the late 1990s, Belize initiated a health sector reform program with the aim of modernizing the country's health care system. In 2001, the country launched the National Health Insurance (NHI) scheme and has been working since then, with PAHO/WHO support, to expand access and improve quality of care.

“PAHO/WHO has provided technical cooperation to Belize for years in areas such as policy, legislation, hospital administration, integrated networks, and strengthening the first level of care in order to ensure that the country's health system is empowered and resilient. The Organization is also an implementing partner in a five-year Ministry of Health and European Union project that will allocate almost seven million Euros to strengthening the country's health system,” said Dr Noreen Jack, PAHO/WHO Representative in Belize

The initiative focuses on evaluating health reform and re-organizing the health system; the adoption of “smart” (green and disaster-safe) interventions in community and regional health care facilities; improvements in service provision, the model of care and the Health Information System; and the expansion of the national health insurance scheme, among other aspects.

By taking this path, the country is seeking to expand access and health coverage to all people, leaving no one behind.



BELIZE

FACT

Belize is providing more integrated people-centred health services to make progress towards universal health coverage, through a primary health care approach.

WHY IT MATTERS

Implementing national health insurance throughout Belize and preventing fragmentation at health facilities level will help eliminate inequalities and ensure quality and timely health services.

EXPECTED RESULTS

Increased access to affordable people-centred health care services for the population, including better quality and continuity of care from primary care to more specialised care.

IN PRACTICE

The Government of Belize has worked with PAHO/WHO for years to build a strong health system for UHC.



Georgia Building an efficient and transparent financing system for UHC

In 2013 Georgia introduced a new 'Universal Health Care Programme', so that the population could access health services and not have to pay out-of-pocket. The new UHC Programme was supported by a substantial increase in public spending on health to meet people's needs. Georgia urgently needed better tools to ensure that public funds were efficiently used. What was the solution?

Minister of Health, David Sergeenko attending the opening ceremony of a renewed health clinic. Increased financial access of patients to medical services has had a positive impact on the development of medical institutions.



Here is the story of how the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia (MoIDPLHSA) and the Legal Entity of Public Law (LEPL) Social Services Agency (SSA) worked closely with the WHO Regional Office for Europe to improve the purchasing and payment system of health service providers.

With significant support of the UHC Partnership and the WHO Regional Office for Europe, we are committed to take tangible steps towards UHC by introducing DRG- based payment and a strategic purchasing system. This will ensure delivery of cost-effective, transparent and patient-oriented quality health services without people experiencing financial hardship.

David Sergeenko, Minister of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia.

Diagnosis Related Group system

The MoIDPLHSA is focusing on strategic purchasing by the LEPL SSA to obtain better value for money and is planning to establish the 'Diagnosis Related Group' (DRG) system as a way to pay providers for services. This helps to create a more efficient and transparent financing system, essential for quality of care and moving towards universal health coverage.

The DRG system categorizes patients treated at hospital into similar diagnosis groups and then relate each group to the costs or resources it takes to treat them.

The logic of the groupings takes into account the patients' principal diagnosis, age, sex, complications, comorbidities, procedures and other factors such as weight on admission in newborns and discharge status. Patients under one DRG will require approximately similar hospital resources, and therefore similar funding.

Implementing the DRG system will improve the efficient use of resources within a hospital, increase the transparency of hospital services, and enable the SSA to monitor the performance of hospitals, thereby contributing to improving the level of quality of care.

Stages for establishing the DRG

1 In mid-2017 the MoIDPLHSA made a decision to move to the DRG system and as Georgia is using the same surgical procedures classification system as Nordic countries, it chose NordDRG (Nordic); this makes the transition to the new system much easier.

2 WHO conducted a feasibility study in 2017 to be sure that the NordDRG system was suitable for Georgia. The results of the feasibility study were encouraging; no major obstacles were found. Georgia already had a digital patient-level claims system, which included all the necessary information for the DRG system. However, efforts were needed to further improve data quality in parallel to implementing the new system.

3 In early 2018, the MoIDPLHSA and SSA developed a comprehensive DRG transition strategy and implementation plan.

4 By the end of 2018, the Nordic Casemix Center had developed the Georgian version of the NordDRG system. WHO provided training for the MoIDPLHSA, SSA and hospitals to enable them to understand the basics of the DRG system.

5 In 2019 the transition to the new system will begin. Initially, selected big hospitals will start testing the DRG system to validate changes in the claims management process. Then there will be preparations for a 'shadow funding' period in 2020 to develop the DRG pricing and reimbursement policy.



September 2018: training on DRG system implementation was conducted for selected pilot clinics.



We are pleased that Georgia has already gained an official license for the use of the NordDRG system, which will be launched in the pilot mode in 2019.

David Sergeenko, Minister of Health

Background

Georgia's health system has been evolving since the country's independence from the Soviet Union in 1991. The system was highly decentralized and extensively privatized under reforms implemented between 2007 and 2012.

The health sector was deregulated and most Government spending on health was channeled through private insurance companies which covered services only for target groups such as people living under the poverty line, internally displaced populations, the military, children under five and older people; only about one third of the total population.

The other two thirds of the population had access to very limited services through vertical programmes, had to buy private health insurance or had to pay for any service out-of-pocket when they used it. This had an impact on patients, whose out-of-pocket payments for health services were very high, leading to financial hardship for many people. It provided the rationale for the political decision to move towards universal health coverage.

In 2013, the newly-elected Georgian Government introduced the Universal Health Care Programme, which led to unprecedented expansion in health service coverage.

Nearly the entire population was entitled to publicly-financed health care. It was all made possible by a substantial and essential increase in public funding for the health system that was channeled through a single purchasing agency (the SSA).

To make the health system financially sustainable in the longer term, the Government realized that it needed to use its limited resources more effectively.

The 2016 WHO report on "Active purchasing for universal health coverage in Georgia: situation analysis and options for improvement", provided key recommendations on how to integrate vertical programmes with UHC programmes and how to implement strategic purchasing.

The report also suggested moving from a very detailed and complicated payment system with different tariff setting principles to a system which allowed for better case grouping for payment, which could be applied to all UHC-program-funded inpatient care.

As a result, Georgia started searching for efficient and transparent systems to strengthen the SSA's role as a strategic purchaser of health services.

Technical assistance in the area of health system strengthening that includes work on introducing the DRG payment system is labour intensive. The WHO Country Office coordinated the work so that it was delivered in a smooth, efficient and consolidated way.

Marijan Ivanuša, WHO Representative, Georgia.

Strong collaboration

A strong partnership between the MoIDPLHSA and the UHC Partnership at WHO has led to greater capacity to improve the health financing system by strengthening the strategic purchasing and supporting implementation of the DRG.

WHO worked with the MoIDPLHSA to develop the capacity of the SSA (the purchasing agency) to enhance efficiency in the organization and delivery of publicly-financed health services.

So far, Georgia's Universal Health Coverage Programme is making good progress towards its goals of universal access to health services without financial hardship.

Evidence shows that the use of health services has increased, financial barriers which prevent people from accessing services have been reduced, and financial protection for households has improved for services targeted by the Programme.

On average, there were 3.6 outpatient visits per capita per year in 2017 compared to just 2.3 in 2012, and hospitalization rates have seen a steady increase from 11.3 per capita in 2012 to 14.2 per capita in 2017. Out-of-pocket spending of total health expenditures has declined from 73% in 2012 to 54% in 2017.

A survey conducted by the US Agency for International Development in 2014 showed that 80.3% of surveyed beneficiaries were satisfied with their outpatient service and 96.4% expressed satisfaction with hospital level emergency care within the Universal Health Care Programme. The most recent household survey conducted in 2017 also revealed positive trends in use of health services and reduction of out-of-pocket expenditures.

Now, the DRG needs to play its role to ensure that public funds continue to be efficiently and transparently used to delivery health services to the population.



The MoH and WHO meet to discuss women's reproductive health and maternal and child health issues, current and future programmes and challenges.



GEORGIA

FACT

Georgia has just introduced a more efficient and transparent health financing system to improve the purchasing and payment of health service providers. It will soon introduce the 'Diagnosis Related Group' system for hospitals.

WHY IT MATTERS

Implementing the system will improve the efficient use of resources within a hospital, increase the transparency of hospital services, and enable monitoring of hospital performance. This contributes to improving the quality of care.

EXPECTED RESULTS

Improved health service coverage (outpatient visits and hospitalisation) for the population and reduced out-of-pocket payments through implementing the DRG pricing and reimbursement policy.

IN PRACTICE

The Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia and the Social Services Agency worked closely with the WHO Regional Office for Europe to implement the work.



Iran Training hospital managers for better service delivery in the Islamic Republic

In the Islamic Republic of Iran, the Ministry of Health and Medical Education (MOHME) is taking universal health coverage (UHC) very seriously. Access to quality health services is at the heart of achieving UHC, and improving hospital performance is an important entry point.

Progress to date is exciting. In less than two years, all general managers in hospitals in Iran have been trained in management and leadership skills. As a result, the quality of care in hospitals is already improving. The tailored course entailed 28 days of training in 7 modules over a period of 8 months.

The experience in Iran has been so successful that the programme is being replicated in Iraq and Afghanistan, with 25 trainers from each country initially participating. Modules are now being contextualized for each nation. There are also plans to extend this to Oman and Jordan in 2019.

In Iran, the combination of clear national vision and commitment from the MOHME and a strong supporting role from WHO is now transforming practice in public hospitals.

“ The training programme was created as a national programme with strong commitment from the MOHME and dedicated resources, building on national policies with a focus on supporting and implementing national priorities,” said Dr Hossein Salarianzadeh, Management Development and Administrative Revolution Center, MOHME.

WHO is collaborating widely with the Ministry of Health and Medical Education of the Islamic Republic of Iran towards achieving UHC as a common objective. In this endeavor improving quality of care and performance of hospitals is one of the critical areas in which WHO as the leading international partner on health and wellbeing is involved.

“ Capacity building of public sector hospital on management and leadership will ultimately strengthen the quality of health care services for all Iranians across the country,” said Shadrokh Sirous, National Professional officer, WHO Country Office Iran

The training programme has increased my capacity to use data to support dialogue with physicians. I have learned to introduce indicators in several departments which facilitates the solving of problems.

Dr. Ali Khorsand, Imam Reza Hospital, Mashhad University of Medical Sciences



Operating room in Iranian hospital

Tailored training leads to results

The MOHME has been working closely with WHO to deliver this nationwide training for all hospital managers. A range of national and international experts developed the programme over time, and it was then tailored to the Iranian context based on feedback from hospital managers themselves. The approach emphasized peer learning and the sharing of experiences so that modules were entirely appropriate for the context.

Following the training programme, we have greater focus on hospital productivity and quality improvement, illustrated by several projects that hospital managers have implemented themselves as a result of having participated in the programme.

Mojtaba Alizadeh, Shahid Chamran hospital, Isfahan University of Medical Sciences

The training programme significantly improved my knowledge and skills and changed my attitude to be more confident and proactive. I'm better equipped to lead other management team members and challenge 'business as usual' so that we can improve performance.

Dr Mehdi Barzegar, Hospital Manager, Mohab-e-Kosar hospital, Iran University of Medical Sciences

By implementing this programme, we witnessed improvements in the quality of services, increased efficiency of public hospitals in the field of financial and human resources, and satisfaction of people and service providers.

Dr Mohammad Agha jani, Chancellor of Shahid Beheshti University of medical sciences and ex-Deputy of Curative Affairs-MOHME

How did the work evolve?

In 2015, WHO EMRO conducted a regional training programme on hospital management. It included modules on the role of hospitals in the health system, leadership, strategic thinking and governance, financial management, human resource management, quality improvement, hospital information management, supply chain management and emergency and disaster management.

Five Iranian colleagues took part and were keen to establish something similar in Iran. The MOHME got involved to drive the process and decided to adapt it to the unique context of Iran. The effort in Iran started with a comprehensive situation analysis of the hospital sector to assess the required competencies and training needs.

A two-day consultation was held with national and international experts from the MOHME and WHO staff from all three levels: HQ, regional and country office.

International facilitators and national trainers collaborated to develop the core content of the modules and 100 national trainers (academics and hospital managers) were carefully selected to attend a Training of Trainers programme.

Adapting to Iran's context

The training modules were then adapted to fit the Iranian context by a national team, and each module required about ten trainers for nationwide coverage.

A pilot phase initially trained 30 hospital managers and then training was rolled out to all hospital managers in Iran. In total, about 700 hospital managers were trained through 2 rounds of training in 10 hubs across the country.

“It was a structured process to develop the training programme, with contributions from international experts yet customized to national needs,” said Dr Eric de Roodenbeke, international course facilitator, International Hospital Federation.

“We gained a new perspective from the international trainers and an understanding of adult learning technique through ‘learning by doing’ and continued to adapt modules based on feedback from participants,” said Dr Mehdi Jafari, Head of National Health Managers Development Institute (HMDI) and national trainer.

“One of the main objectives of the course is to empower managers to manage all resources properly. The course is important in relation to the professional competence of managers, in their selection and appointment,” said Dr. Seyed Ali Sadro Sadat, ex-Deputy of management and resources development-MOHME.



Training of hospital managers- Human Resources Management Module, Hub of Mazandaran University of Medical Sciences, Mazandaran, I.R. Iran.

A team of trainers including academics and hospital staff was essential to establish a mix of theoretical and practical points of view. As the training emphasized peer learning and adaptation to the local context, there was a strong sense of ownership over the process.

Involving all key stakeholders allowed them to share their experiences and understanding, and have a precise knowledge of what this programme should look like. This really helped with the speed of the process. The nature of the programme also allowed hospital managers to network and share their experiences.

“The training programme helped to establish a ‘direct channel’ between the hospital managers and the MOHME that was lauded by hospital managers and facilitated better coordination, integration, group formation and guidance,” said Dr Ali Maher, Ex Technical and Planning deputy of curative affairs, MOHME.

Thanks to the strong administrative and logistics support provided by the MOHME, the roll-out of the training programme nationwide went very smoothly. Strong collaboration between WHO’s three levels also supported the process effectively.

“While the County Office and Regional Office very closely supported the MOH at all stages, HQ provided more punctual support and helped align with international perspectives on hospitals of the future, within the Framework of Integrated and People Centered Health Services (IPCHS) that was approved by WHA in 2016,” said Dr Ann-Lise Guisset, WHO HQ Services Organization and Clinical Interventions unit.

Looking to the future

“By implementing this programme, we witnessed improvements in the quality of services, increased efficiency of public hospitals in the field of financial and human resources, and satisfaction of people and service providers,” said Dr Mohammad Aghajani, Chancellor of Shahid Beheshti University of medical sciences and ex- Deputy of Curative Affairs-MOHME.

This success had an impact. Shortly after the course took place, MOHME established the Health Managers Development Institute - a national centre of excellence in health management - to train all managers in the health sector. Currently, it is working to train all hospital directors using the same methodology of training of trainers and roll-out nationwide.

The MOHME is also aware that it needs to ensure the skills gained through the training programme are sustained and reinforced. By establishing communities of practice and peer groups and facilitating the creation of a professional association for hospital managers, much can be achieved.

“The training of hospital managers, using an adult learning approach, is a step forward in the professionalization of hospital management,” said Dr Hamid Ravaghi, Regional Advisor, Hospital are and Management Unit, WHO EMRO.



IRAN

FACT

In under two years, all general managers in hospitals in Iran have been trained in management and leadership skills and are improving quality of care as a result.

WHY IT MATTERS

Access to quality health services is at the heart of achieving UHC, and improving hospital performance is an important entry point.

EXPECTED RESULTS

Patients experience improved quality of health care, hospitals are more efficient, and patients have greater satisfaction with services.

IN PRACTICE

The Ministry of Health and Medical Education worked closely with WHO to deliver the nationwide training. Iran's experience has been so successful that the programme is now being replicated in Iraq and Afghanistan.



Philippines UHC Act: a new dawn for health care

It is a time for celebration in the Philippines. President Rodrigo Duterte has signed a Universal Health Care (UHC) Bill into law (Republic Act No. 11223) that automatically enrolls all Filipino citizens in the National Health Insurance Program and prescribes complementary reforms in the health system. This gives citizens access to the full continuum of health services they need, while protecting them from enduring financial hardship as a result.



Witnessing the ceremony were H.E. Rodrigo Roa Duterte, President of the Philippines (seated, center) and (seated, left to right) Hon Karlo Alexei Nograles, Cabinet Secretary; Hon Gloria Macapagal-Arroyo, Speaker of the House of Representatives; Hon Vicente Sotto III, Senate President; Hon Salvador Medialdea, Executive Secretary. Also present were Hon Angelina Tan, Chair of the House Committee on Health (second row, sixth from the right) and officials and staff of the Department of Health, Philippine Health Insurance Corporation, and WHO. Photo: PCOO-PP.

By automatically enrolling our citizens into the National Health Insurance Program and expanding PhilHealth coverage to include free medical consultations and laboratory tests, the Universal Health Care Law that I signed today will guarantee equitable access to quality and affordable health care services for all Filipinos.

President Rodrigo Duterte, 20 February 2019

UHC is a political choice

In the Philippines, like elsewhere, universal health coverage is foremost a political choice. The UHC Act embodies this choice, and was carried by a broad coalition of parliamentarians across the political spectrum.

This is how the Senators talked about UHC. The first two quotes demonstrate why UHC is necessary to meet the challenges that citizens face when in need of health care.

“ During our visits to hospitals in different provinces, my own eyes have seen the deplorable state of our countrymen – in hot and cramped wards, enduring the lack of government support. It is sad that our fellow citizens who, rather than be healed, are worried about being infected with the illness of another patient.” Senator Ejercito, Chair of the Health Committee

“ The majority of Filipinos only consult a doctor when their illnesses are already at their worst because of the lack of government support to the health department.

According to our Department of Health, up to 54% of the country's health care spending in 2016 came from out-of-pocket expenses. That means Filipino families still account for the lion's share, they still carry the biggest burden when their loved ones seek treatment for whatever sickness they have. That weight should not be theirs to carry alone. In fact, they should not have to carry that weight at all.” Senator Angara, Chair of the Ways and Means Committee:

And here is what the Government hopes will change as a result of the Act.

“ We believe Filipino families must be afforded a safety net in times of dire need and this is why I am proud to cosponsor the Universal Health Care Bill. One of the main provisions in the bill is every Filipino's automatic inclusion into the National Health Insurance Program.

Through this provision, we seek to protect people from the financial burden of paying out of their own pockets. It reduces the risk of people being pushed into poverty because it will help cushion the impact of having to use the family's savings or of borrowing money to pay for health care services.” Senator Binay, Co-author of the Bill

“ Senate Bill No 1896 will pave the way for all Filipinos' inclusion in our National Health Insurance Program, either as direct or indirect contributory members.

This means that all Filipinos can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose them to financial hardship.

Our goal is to achieve full 100 percent coverage in the most expedient way possible, expand our health benefit package, and bring more doctors to remote communities.” Senator Villanueva, Co-author of the Bill



Conferees of the House of Representatives and the Senate of the Philippines headed by Hon Angelina Tan and Hon Joseph Victor Ejercito, respectively (seated, second and third from left) give the “thumbs up” sign together with officials and staff of the Department of Health, Philippine Health Insurance Corporation, Senate, House, and WHO on 27 November 2018 after reconciling House Bill 5784 and Senate Bill 1896, the precursors of the Universal Health Care Act.

From left to right: Hon Ralph Recto, Senate President Pro-tempore; Hon Francisco Duque III, Secretary of Health; Dr Roy Ferrer, acting President and CEO of the Philippine Health Insurance Corporation (PhilHealth); and Hon Joseph Victor Ejercito, Principal Sponsor of the UHC Act in the Senate (listen to projections of financial impact of the draft UHC bill from Ms Nerissa Santiago, acting Senior Vice President for Actuarial Services of PhilHealth (center)).



WHO's role throughout was to be the steady voice which, stepping back from the political deliberations, provided objective technical information on which policy decisions should be based.

Why now?

Parliamentarians and health stakeholders have made concerted efforts to pass a UHC bill for the past two years, but in reality, the Philippines has experienced a 50-year process of health reform, under different names. The UHC Act is the culmination of decades of progress, and two years of dedicated political and technical work.

It is the first UHC Act of its type in the Western Pacific region; this is particularly remarkable considering the strong presence of the private sector in the Filipino health system existing in parallel with a fragmented and devolved government health service. The Act prescribes system reforms in accordance with the multiple financing and service delivery mechanisms at work in the Philippines.

Developing and refining the bill

WHO's global drive for UHC came at an opportune time to advocate and inform the consultation and drafting process of the Bill in the Senate during the second half of 2017. By that time the Bill had already passed the House of Representatives. In order to get it passed through the upper house, the Bill needed technical refinement to ensure that it was comprehensive, practical and feasible, and would eventually achieve universal health coverage.

WHO Philippines, in close liaison with the WHO Regional Office for the Western Pacific, gently steered the process in the areas of people-centred integrated service delivery and health financing, drawing on experiences from other countries and regions with positive UHC experiences. This included the UK's National Health Service model, China's model of devolved health service provision and PAHO's expertise in service delivery networks in US-influenced health systems.

From February 2018, WHO contributed to a series of public hearings involving a wide range of stakeholders, including citizens and civil society organizations. Four public hearings took place across the country in Cebu, Davao, Legazpi, and Lingayen. WHO participated throughout in the sometimes heated and political debates as a neutral advisor by providing a dose of practical realism to the proceedings. This helped Parliamentarians focus on meaningful and sustainable solutions.

In July and August 2018, the Senate started convening technical working groups to discuss the content of the bill. Senators and other invited stakeholders, such as the private sector, civil society and WHO, read through the entire bill line-by-line and offered feedback from a diverse range of perspectives. WHO country, regional and headquarters

representatives shared detailed knowledge about the coordination of service delivery, financial flows and health systems governance, acting as a gentle guide in the background. WHO also produced a formal position paper which proved instrumental in guiding the Bill's redrafting process.

In October 2018, the bicameral hearings took place to hammer out the final version of the Bill. Here, conferees from the Senate and the House of Representatives sat together and discussed the bill, including some of the controversial points such as financing and local government autonomy. Flurries of emails and on-the-spot telephone conversations to key stakeholders in the provinces added a touch of drama but were essential to gain approval for implementation; without the support of local government stakeholders, the Bill could not be put into practice.

WHO's role throughout was to be the steady voice which, stepping back from the political deliberations, provided objective technical information on which policy decisions should be based. One example of this was the issue of local government autonomy. Since 1991, devolution and management gaps have been stated as a reason for fragmented health services. The UHC Act contains provisions that

consolidate local health systems and provide for a shared bank account. This was initially controversial, as local government units were skeptical about its potential effectiveness. WHO was able to share the experience of China, with its similar scale and devolved systems, to demonstrate that it was indeed possible and desirable to implement these reforms. This support was instrumental to the Government, in order to pass such provisions.

The role of communication to wider audiences and the Senate also played a major role. Many stakeholders, including the general public, followed WHO's social media accounts and asked critical questions. When some stakeholders expressed negativity about the whole process, WHO was able to provide reassurance by providing examples of particular meetings and moments of real progress. In addition, the focus of World Health Day in 2018 was UHC, and although it took place in April, the theme carried weight throughout the entire year and powerfully supported the discussions preceding the passing of the Bill.

We believe Filipino families must be afforded a safety net in times of dire need and this is why I am proud to cosponsor the Universal Health Care Bill. One of the main provisions in the bill is every Filipino's automatic inclusion into the National Health Insurance Program.

Senator Binay, Co-author of the Bill

Implementing the Act

Senator Recto's speech at the Senate speaks volumes about the need to take UHC as a systematic approach. Here, the challenges of implementation are evident.

“ Senator Recto

We may give every Filipino a PhilHealth card, but it is useless if there is no facility they can present that card to for treatment.

We may erect hospitals with gleaming glass and steel, but if there are no doctors and other health professionals who will staff and run them, then what we have built are white elephants.

We have many modern curative facilities, but when the sick are continuously dumped on them because we have neglected the promotive and the preventative aspects of medicine, then we have failed to address the roots.

We may have a cadre of health professionals scattered nationwide, but if drugs are expensive, then the road to wellness is blocked.

We may have a built a network of hospitals but if they are not constantly infused with funds, then they cannot function fully due to budgetary anaemia.

What is my point? The challenges are interrelated, linked together in one body politic. So the cure must not be compartmentalized, but comprehensive. So, as I have said, this bill is a tapestry of solutions, composed of many threads.



Conferees of the House of Representatives and the Senate of the Philippines headed by Hon Joseph Victor Ejercito (foreground) and Hon Angelina Tan (background, seated) conducted public hearings to reconcile House Bill 5784 and Senate Bill 1896, the precursors of the Universal Health Care Act.

From a technical perspective, the major reforms of the Act will consolidate existing yet fragmented financial flows, increase the fiscal space for benefit delivery, improve the governance and performance of devolved local health systems and institutionalize support mechanisms such as health technology assessment and health promotion. In the first half of 2019, the Department of Health and the Philippine Health Insurance Corporation will produce the operational guidelines on how to carry out the provisions of the Act; and WHO will contribute what it can, where appropriate.

From the population's perspective, when implemented effectively, the Act will mean all Filipinos get the health care they need, when they need it, without suffering financial hardship as a result. Although there is much work to be done to implement the UHC Act, it takes a critical step towards achieving health for all in the Philippines. It is a new dawn for health care and real progress towards achieving UHC.

Our goal is to achieve full 100 percent coverage in the most expedient way possible, expand our health benefit package, and bring more doctors to remote communities.

Senator Villanueva,
Co-author of the Bill



THE PHILIPPINES

FACT

The Philippines has just signed a Universal Health Care Bill into law that automatically enrolls all Filipino citizens in the National Health Insurance Program and prescribes complementary reforms in the health system.

WHY IT MATTERS

In 2016, 54% of health care spending in the Philippines was attributable to people paying out-of-pocket. This needs to change. Like elsewhere, universal health coverage is foremost a political choice. When implemented effectively, the Act will mean all Filipinos get the health care they need, when they need it, without suffering financial hardship as a result.

EXPECTED RESULTS

A drastic reduction in out-of-pocket payments and catastrophic expenditures through which people become impoverished as a result of paying for health care.

IN PRACTICE

The UHC Act was carried by a broad coalition of parliamentarians across the political spectrum. WHO advocated and informed the consultation and drafting process of the Bill in the Senate during the second half of 2017, gently steering the process in the areas of people-centred integrated service delivery and health financing.





Samoa Revitalising primary health care and tackling non-communicable diseases

Samoa may be a small country of only 200,000 people, but it is facing a large problem: non-communicable diseases (NCDs) in this tiny South Pacific archipelago are reaching epidemic proportions.

An estimated 50% of the population between the ages of 18 and 64 is at high risk of developing diabetes, cancer, chronic respiratory disease or cardiovascular disease. In response, the government of Samoa is tackling the problem through a primary health care approach. Through the PEN Fa'a Samoa initiative, the government is bringing interventions such as awareness campaigns and health screenings to the community.

Facing up to NCDs

The problem of NCDs marks a shift in the public health landscape of Samoa. Historically the largest public health concerns were infectious and parasitic diseases. Today, however, half the population has at least three of the five risk factors that can contribute to developing NCDs: smoking, elevated blood pressure, high body mass index, poor diet and low levels of physical activity.

Many people at risk for or living with an NCD remain undiagnosed because rates of detection and referrals to care remain low.

Over the last 30 years, the government of Samoa focused on modernizing clinical services. This led to a centralization of services and a hospital-based model of care. Dealing with the rapid rise in NCDs, however, requires a different approach - one which combines population-level screening, community engagement and long-term chronic disease management.

The government recognizes that the current model of care is not well equipped to respond to this public health crisis. It cannot meet the demands placed on the health system from increasing numbers of people requiring long-term care and support for chronic disease management. Addressing the NCD epidemic requires action at individual and community levels to strengthen promotive, preventive and curative services.

As a first step, the government has decided to integrate the two existing health structures: the Ministry of Health (MoH), responsible for policies, surveillance and monitoring, and the National Health Service (NHS) which oversees service delivery. These reforms have been passed into law, but given a shortage of available resources, their reintegration will be a gradual process.

PEN Fa'a Samoa has been important not only for addressing Samoa's NCD crisis, but also because it has stimulated the search for a model of health care which can better address needs in preventive and promotive services. From that perspective, PEN Fa'a Samoa could be considered as an agent of change leading to reforms of Samoa's health care system away from a hospital-centric model to one based on primary health care.

Rasul Baghirov, Country Director Samoa, WHO





Blood pressure testing at a village screening campaign in Samoa.

PEN Fa'a Samoa

The Samoan government enlisted the assistance of the WHO Country Office for Samoa in mapping the way forward for the implementation of a primary health care model. Putting a focus on NCDs was seen as a way to catalyze health system transformation, revitalize primary health care services in the community, and support existing human resources.

PEN (package of essential non-communicable disease interventions) is a prioritized set of cost-effective strategies for the prevention, early detection and management of key NCDs. These interventions are designed to be easily delivered in resource-constrained settings.

Through a series of meetings and workshops, the NHS, the Ministry of Health and WHO adapted the interventions to the Samoan context, and PEN Fa'a Samoa was born.

In traditional Samoan culture, each village or community has its own governance structure and hierarchy. This includes the Komiti Tumana, or women's committees, and by working through them to deliver prevention, detection, and referral services, the PEN Fa'a Samoa initiative seeks to incorporate the PEN interventions into Samoan culture and traditions.

Piloting community approaches

The first phase of work was to develop specific national guidelines for the initiative, which would include individual, peer, family and community mobilization components. WHO worked with the health authorities to develop the criteria and the tools that women volunteers of the Komiti Tumana and health care workers would use for assessment, monitoring and referral.

Then the MoH launched a pilot programme involving seven villages. Members of the Komiti Tumana were approached to assist in carrying out village-wide screening campaigns.

These women's committees have existed since the 1920s and are therefore especially well positioned to help raise awareness and facilitate the testing part of the campaign. Working with and through the Komiti Tumana was the best way to ensure that the NCD initiative would be well received by villagers.

The women's committee volunteers, who showed a great deal of support for the initiative, were paired with health care workers to create cross-disciplinary outreach teams.

WHO provided training to the volunteers and paired each volunteer with a health care worker. Outreach teams invited the entire adult population of each village to participate in the screenings. The women's committee members collected demographic information and basic health data while the health care workers measured blood pressure, blood glucose and cholesterol levels.

At the end of the campaign, village-wide public meetings were held and the overall, anonymized assessment of results was presented to the whole village. The teams also followed up with individuals deemed to be at high risk.

Going forward

Since the initial pilot phase, the PEN Fa'a Samoa has expanded to include 15 villages. There are plans to scale up the programme throughout the country. However, a number of challenges exist, not least of which is the issue of funding. The pilot was carried out with funding received from WHO. While the government is funding the overall programme, it is seeking supplemental funding from a donor or development partner.

Anecdotal evidence suggests that participating in this initiative has been a positive experience for the women of the committees and that villagers responded well to the women's role as community facilitators.

To date, the women's participation has been on a voluntary basis, but it is widely acknowledged that this approach is not sustainable, and there is a high level of turnover among the volunteers. The MoH will develop more detailed terms of reference for the role of facilitator and will consider the option of adding other components to the role of the facilitator, such as nutrition and infant monitoring.

92%
of the population
across the seven pilot
villages were screened,
and 45% of those
identified as being
“high risk” were
referred to a clinic
for further care.

By working with the Komiti Tumana, the government has been able to integrate these interventions into traditional Samoan culture. This can be seen in the success of the screening campaigns - 92% of the population across the seven pilot villages were screened, and 45% of those identified as being “high risk” were referred to a clinic for further care.

Nonetheless, the fact remains that Samoa has one of the highest rates of excess weight in the world, with more than half of the population considered overweight or obese. Testing and treating alone will not be enough. Much more needs to be done to address some of the root causes of the epidemic such as poor nutrition, lack of knowledge, and sedentary lifestyles.

The increasing numbers of people - and communities - affected by non-communicable diseases, with the concomitant economic and social repercussions, will require strong action and considerable resources, both human and financial. The success of the PEN Fa'a Samoa initiative makes it clear any solutions to these issues must come from the Samoan people themselves and be rooted within Samoa's strong cultural traditions.



SAMOA

FACT

The government of Samoa is tackling non-communicable diseases (NCDs) through a primary health care approach, bringing interventions such as awareness campaigns and health screenings to the community.

WHY IT MATTERS


NCDs in Samoa are reaching epidemic proportions. About half the population aged 18-64 is at high risk of developing diabetes, cancer, chronic respiratory disease or cardiovascular disease. Action is needed at individual and community levels.

EXPECTED RESULTS

A drastic reduction in the population's risk of developing major NCDs through revitalizing primary health care services in the community.

IN PRACTICE

The Ministry of Health and the National Health Service worked with WHO to map the way forward for a primary health care model, which was adapted to the Samoan context. National guidelines were developed and a pilot project began.



Tunisia Citizens and civil society engage in health policy

Citizens and civil society in Tunisia have got true ambition for 'health for all'. They are engaging with the government and national health policy formulation processes in dynamic new ways to promote quality health care for all citizens.

Societal Dialogue for Health System Reform

After the Jasmine Revolution in 2011, Tunisia's citizens and civil society had new opportunities to take part in the political decision-making processes of its Government.

One occasion was the Societal Dialogue for Health System Reform, a large-scale consultation process between the Government and its citizens on a variety of health topics.

The process ultimately leads to informed policy decision-making that takes into account citizens' concerns.

Societal Dialogue: Phase 1 and 2

WHO, through the Universal Health Coverage Partnership, supported both phases of the Societal Dialogue. In Phase 1, civil society and citizens contributed to constructive, but also heated, debates about how to reform the health system to ensure that all Tunisians had the right and access to quality, affordable health care.

The phase ended on a high note in 2014 in Tunis with the conclusion of the National Health Conference and the adoption of the Tunisian White Paper for the Health Sector: 'White Book for Better Health in Tunisia'. This set out to align the Tunisian health system in line with the aspirations of its citizens. After a gap in activity, Phase 2 of the Societal Dialogue began in July 2017; the delay was due to political and administrative changes in the Tunisian government.

However, civil society pressure and the reorganization of the country's political outlook meant that the dialogue continued undeterred and reinvigorated. The Phase 2 objective is to translate the recommendations of the White book into Tunisia's first-ever participatory National Health Policy for 2030. The process is currently active and civil society and citizen juries are just as active and pivotal as before. Their tireless involvement is true testimony to the power of participatory governance, which can be harnessed for common objectives such as health sector reform.

“The power of inclusive and participatory processes such as the Societal Dialogue for Health must not be underestimated. On the contrary, it must be further encouraged. It shows that a more participatory, equitable and evidence-informed decision-making process can lead to strong policy options supported by and beneficial to all. The final outcome, a National Health Policy for Tunisia, should substantially improve the health status and the wellbeing of Tunisian citizens,” said Dr Yves Souteyrand, WHO Representative of Tunisia

All participants are willing to own the new National Health Policy for 2030 and its implementation will be a success.

Dr Hela Ben Mesmia, Ministry of Health, Tunisia

During the inter-regional meetings one can feel how the atmosphere has changed thanks to the Societal Dialogue. Meetings like this would never have been possible before the revolution. Now, the room is buzzing, participants are committed and eager to find common ways to spur the progress.

Dr Hela Ben Mesmia,
Ministry of Health, Tunisia

Societal Dialogue: Inter-Regional Meeting Series

A key part of Phase 2 is the Societal Dialogue through Inter-Regional Meeting Series. These meetings bring together Government representatives, citizen jury participants and other civil society representatives to discuss policy options for the National Health Policy.

Between July and September 2018, four inter-regional meetings took place. One of these was a gathering of 130 people in Monastir, including non-governmental organizations, journalists, health professionals, parliamentarians and citizen jury participants to focus on potential reforms in health financing. In the spirit of the Societal Dialogue, they collectively assessed the existing health financing system and reflected on ways to make it more equitable and efficient in the future.

The positive, peaceful and productive process of the Societal Dialogue demonstrates that it is a critical tool in the development of the new National Health Policy, which is the first post-revolution.

The process is popular and successful. In Phase 2, 24 regional meetings took place between July 2017 and March 2019. All the meetings enabled collective discussion of key aspects of the draft National Health Policy through a true dialogue process among government, citizens and civil society organisations. A National Health Policy and the successful completion of Phase 2 will cement an important step for advancing health for all in Tunisia.



TUNISIA

FACT

Tunisia has organised a series of engaging meetings between government representatives, civil society organisations and citizens eager to discuss and make decisions about the national health policy.

WHY IT MATTERS

Finding common ground on health policy issues and ways to make progress will result in a stronger national health system, in line with the aspirations of its citizens. It will substantially improve the health of Tunisian citizens.

EXPECTED RESULTS

Communities are empowered, citizens take action and responsibility for health decisions, and the national health policy and plan is responsive to citizens' needs.

IN PRACTICE

The Tunisian Ministry of Health, with support from WHO's Universal Health Coverage Partnership, have organised two phases of the Societal Dialogue for health system reform. This includes an extensive series of debates and inter-regional meetings.



Participants at a Societal Dialogue. Photo: WHO.



Ukraine Championing universal health coverage through health financing reform

In the city of Kostiantynivka in the Donetsk region of Eastern Ukraine, the primary health care (PHC) centre is experiencing a big change. Its funding has doubled as a result of a new government financing model. The salary of a physician has tripled, and nurses have experienced huge leaps in salary. Importantly, the changes in the system aim to improve access to services for patients. The same is happening in other successful PHC centres across the Ukraine.



In the past year, the majority of PHC facilities have moved to this new financing model. Primary health care is available both in large cities and in the smallest villages. Before this, nearly half of all Ukrainians could not afford to seek health care.

Now there is progress towards better access to primary health care services, which are free of charge to all.

So what is the new financing model and why is it so effective?

It was critical to give patients a free choice of provider, to ensure competition among public and private providers, and to introduce eHealth instruments and transparency at each consecutive stage of the reform. These changes established a new social contract, which is the most important shift in the system. Under new rules a primary care physician has tripled his income not because of salary premium from the government, but due to his or her hard work and support from the patients. This meritocracy is what really matters in the new transformed system.

Pavlo Kovtonyk, Deputy Ministry of Health of Ukraine

Starting with primary health care

The transformation of the health and financing system began to unfold gradually with a focus on primary health care and ongoing support from national and international partners including WHO, World Bank, USAID UNDP, and UNICEF.

The Government of Ukraine introduced the mechanism of per capita payments in order to contract primary health care providers with the principle that the “money follows the patient”. This is a well-known approach internationally, but a new step for Ukraine. For each patient who enrolls with a physician, the state guarantees a clearly defined list of primary health care services that will be provided free of charge.

Rather than simply changing how the funds are distributed, it was very important for the government to create and secure the new institutions crucial for introducing UHC; namely the National Health Service of Ukraine (NHSU), which was established on 1 April 2018. The NHSU transfers money to the health facilities on a per-capita basis. The budget of the PHC centre is calculated based on the number of enrolled patients, regardless of the number of visits or services used by the patient, and the patient does not need to make any further payments. This makes primary health care accessible to all citizens and reinforces the commitment of the Government of Ukraine to provide financial protection and deliver integrated people-centred services to each and every Ukrainian.

To date, nearly 26 million Ukrainian citizens (two-thirds of the population) have already chosen their physician and the National Health Service has paid more than UAH 6 billion (more than USD 222 million) to health facilities under these contracts.

The vast majority of primary health care facilities now receive more funds than under the old financing model, which was based on grants from central to local budgets. The government budget for PHC services has increased significantly, demonstrating serious commitment to UHC and PHC.



All things considered, this is a very optimistic time for people's health in Ukraine.



Background to the health reforms

In 2015, the Government of Ukraine initiated massive reform of its entire health system, to move towards universal health coverage (UHC) and improve the health outcomes of the population. The Ministry of Health of Ukraine first focused on health financing reform and improving information systems.

In October 2017, the Parliament of Ukraine adopted a law on 'Government Financial Guarantees of Healthcare Services'. The law was developed and finalized with technical support from WHO. It created a new framework for health financing which aims to reduce high out-of-pocket expenses for people who seek medical care.

According to the Health Index, in 2018, a quarter of Ukrainians did not receive medical services due to lack of personal funds and nearly a half said it was difficult or impossible for them to find the means for treatment. For 17% of respondents, the high cost of treatment was a financial barrier to seeking outpatient care.

The National Health Service of Ukraine was established to support the practical implementation of the new law. The NHSU is a purchaser of health services from public (and eventually private providers) based on the State Guaranteed Benefit Package currently under development. This is a complete break with the past as now the state no longer automatically funds medical institutions, but pays for specific health services based on contracts between the NHSU and providers.

“Ukraine is a new champion of UHC in the WHO European Region demonstrating steadfast political commitment, evidence-informed reform design, innovation, impressive speed of implementation and inspiring attention to communication. The establishment of a single payer NHSU – as an autonomous purchasing agency - funded from general taxes is an innovative approach in Eastern Europe to provide state mandated coverage. It recognizes the outdated nature of payroll taxes and its negative impact on the labor markets and economic growth. The new explicit benefit package and new contractual approaches with health care providers will create transparency in resource allocation and balance efficiency with equity considerations. Benefits are already beginning to emerge. I am optimistic if Ukraine continues on this path for the coming years, health system performance will dramatically improve and tangible benefit for the population and health workers will be visible,” said Melitta Jakab, senior health economist at the WHO Regional Office for Europe.

As a result of the health finance system transformation at primary health care level, there are changes in the prestige of primary care physicians. Now PHC providers receive an acceptable legal income from the state, enjoy appropriate conditions for work and have

opportunities for continuous professional development.

According to Oleg Petrenko, people are starting to trust their physicians and follow their recommendations. The statistics back this up. The latest Health Index survey showed that 76% of people are satisfied with their physician. Mr Petrenko believes that in the long run greater trust in physicians will result in the prevention of non-infectious diseases, improved immunization coverage, and people adopting healthier lifestyles.

“WHO and development partners welcome the efforts of the Ukrainian Government in transforming the health system, including health financing. The changes – including revision of health financing regulation, creation of National Health Service, and proceeding with strengthening primary care and access to affordable medicines – are in the right direction to move towards universal health coverage. Constant efforts are needed from all stakeholders to improve the population's health. In parallel, we need also to have a broader approach to health and wellbeing, address the determinants of health and value the central role of health in the development agenda. WHO has been proud to support health system reforms so far and we are ready to continue to do so in the future,” said Dr Jarno Habicht, WHO Representative to Ukraine.

What does success look like?

 Oleg Petrenko, Head of National Health Service of Ukraine



We have set clear transparent rules for all primary health care facilities. And we have wonderful examples of how facilities and their employees took advantage of the new opportunities. The primary care center in the town of Illintsi, Vinnytsia region, was one of the first to conclude a contract with NHS and move on to a new financing model. Under the new mechanism, it receives twice as much money as in previous years. As a result, the salary of a physician has increased almost threefold.

Everyone has already understood that money won't come to a facility other than with patients who choose their physician. It is necessary to create proper conditions for physicians and patients. In the Baltic Primary Care Center in Odesa Oblast, a single contact center was established to make all appointments, and now the queues remained in the past.

In Zhytomyr, an independent review system was set which allowed each patient to comment the services and ask questions using the QR code. Renovated buildings, open reception areas, areas for parents with children, accessibility for low-mobility groups of people – the best demonstration of the real changes in health care facilities.”

Future plans

Now that the first phase of the transformation of PHC financing has been practically completed, and most facilities are working under new rules, what next?

In 2018, WHO conducted an assessment of the “Affordable Medicines” reimbursement programme - which currently provides free medicines to many Ukrainians with chronic conditions - and made policy recommendations. The government has extended the programme into 2019 and allocated state budget, allowing patients to maintain treatment without experiencing financial hardship.

In 2019, changes to the health system will continue at the level of outpatient care and hospital care. In 2020, the new financing law will apply to all levels and types of medical care. The Medical Guarantee Program - a state-guaranteed health care package - will start functioning as another step towards bringing Ukraine closer to universal health coverage. All things considered, this is a very optimistic time for people's health in Ukraine.



UKRAINE

FACT

In Ukraine, over the past year, the majority of primary health care centres have moved to a new financing model. These facilities have doubled their funding, and more patients have better access to services.

WHY IT MATTERS

In 2018, before this change, nearly half of all Ukrainians could not afford to seek health care. Now primary health care is available in the largest cities and the smallest villages with two thirds of the population registered with a physician.

EXPECTED RESULTS

Access to primary health care free of charge, and a stronger health system with better funded health centres and better paid health workers.

IN PRACTICE

The Government of Ukraine is transforming health and finance systems gradually, with a focus on primary health care and ongoing support from national and international partners including WHO.

Sri Lanka Primary health care on the road to UHC

The Sri Lanka Medical Association has been working with the Ministry of Health and Indigenous Medicine (MoHIM) and WHO to bring about much-needed change in the Sri Lankan health system to focus on primary health care (PHC) in order to achieve UHC.



Sri Lanka's journey to UHC

Sri Lanka's journey to UHC More than 50 years ago, before the 1978 Alma Ata Declaration, the country made a commitment to provide primary health care to its citizens.

The need for comprehensive and expanded financial and geographical access was clear, and Sri Lanka prioritized community health and successfully met the needs of that time.

The system specifically catered to maternal, child health and communicable diseases and delivered exceptional progress in maternal and child health.

It also successfully eliminated several communicable diseases such as malaria, filariasis, neonatal tetanus, measles and polio.

However, like many other lower-middle income countries, Sri Lanka is now undergoing an epidemiological transition, with a rise in non-communicable diseases, a rapidly ageing population, changing societal expectations of health care and urbanization.



Public Health Midwives in Sri Lanka are frontline PHC workers. Photo: WHO.

A parliamentarian signing a national UHC pledge following an advocacy session. Photo: WHO



Dr Ruvaiz Haniffa,
President of the SLMA
Photo: SLMA

Change is inevitable and necessary.

Meet a change-maker working on the ground who shares WHO's vision of universal health coverage. Dr Ruvaiz Haniffa, President of the Sri Lanka Medical Association (SLMA) reflects on progress in Sri Lanka.

“ The SLMA, the Ministry of Health and WHO share the same vision of a need to shift from disease-oriented care to people-centered care. Change cannot happen overnight. We first wanted people to understand why we need to change and we needed to engage policymakers - the people with the power to decide on change.

WHO supported SLMA to host a parliamentary session with over 65 parliamentarians to sensitize them to the concept of UHC and take steps necessary for Sri Lanka to fulfil SDG3. The highlight of this event was the signing of the UHC pledge by parliamentarians, representing all political parties in the country. WHO has expanded our horizon, by providing us a global platform to learn from others and build on what we have. They are a resource we simply can't do without.

Health is a human right because people don't seek health care when they want it; they seek it because they need it. It's a need and it's our job as health care providers to provide them quality care.

Dr Ruvaiz Haniffa, President of the Sri Lanka Medical Association (SLMA)

We had the international expertise we needed because WHO was able to find us the right people for the right job, and their technical guidance was invaluable. For example, at the parliamentary session we had Dr Somsak Chunharas, President of National Health Foundation and former Deputy Minister of Health in Thailand speak. That sharing of experiences is exactly what we needed. "SLMA, in collaboration with the Ministry of Health and WHO, also studied the gaps in the system and the different needs of different demographics. We have meticulously followed the health-seeking behaviour trends of the population. Based on these studies it became apparent that most people seek health care in an ambulatory setting as opposed to a hospital-based setting.

Since 2008, several models of care have been tested to nudge the system to change. An integral component of Sri Lanka's early health care was the robust and effective nature of Primary Health Care services. Sri Lanka is at a turning point and it must turn to its roots and facilitate the need to restructure services. We feel certain that we can attain UHC through a PHC model, however when we looked at our health care delivery it is predominately hospital-based.

WHO has expanded our horizon, by providing us a global platform to learn from others and build on what we have. They are a resource we simply can't do without. We know their commitment to the health and wellbeing of the citizens of Sri Lanka, and Dr Tedros himself celebrated World Health Day here in Sri Lanka. They believe we can do this and it is our time to prove them right.

As President of SLMA my personal vision is to ensure all health care providers are well-rounded individuals with a hunger to better provide for our people. WHO is a constant source of support for us, sharing their best practices, their lessons learnt and bringing in international expertise to Sri Lanka; they are like a friend you call when in doubt."

Strengthening PHC

The Ministry of Health recognizes that the health system needs to change to sustain its gains and continue its journey towards UHC. Business as usual is not an option for Sri Lanka. The country has endorsed strengthening PHC as the means of addressing the emerging challenges to UHC.

WHO has supported the development of an Essential Services Package and the service delivery model based on the Cabinet-approved policy on health service delivery for UHC. This ensures that all populations have guaranteed access to a package of quality services throughout the country.

The Sri Lankan Ministry of Health identified WHO as the technical lead adviser in the PHC reorganization and WHO rallied support by engaging various stakeholders across sectors.

A key player is the Sri Lanka Medical Association (SLMA), the oldest professional medical association in Asia.

Starting in 2018, SLMA partnered with WHO to take forward the UHC agenda by organizing a series of activities from policy advocacy to raising awareness of health providers in the field.

WHO provided close mentoring and resources for SLMA to increase awareness of health providers on UHC during their provincial meetings and academic sessions.

In July 2018, an advocacy session on UHC was organized in the Parliament of Sri Lanka, resulting in Parliamentarians making a UHC pledge.



Photo: Photoshare



SRI LANKA

FACT

Sri Lanka has endorsed primary health care to address the emerging challenges to achieve universal health coverage.

WHY IT MATTERS

Business as usual is not an option for Sri Lanka. It is experiencing a rise in non-communicable diseases, a rapidly ageing population, changing societal expectations of health care and urbanization.

EXPECTED RESULTS

All populations have guaranteed access to a package of quality care throughout the country.

IN PRACTICE

The Sri Lankan Ministry of Health, in close partnership with the Sri Lankan Medical Association and WHO, developed an Essential Services Package and a service delivery model for PHC. An immediate next step was to organize an advocacy session in the Parliament resulting in the signing of a National UHC pledge.

The new Dispensary Strengthening Programme is a major improvement allowing us to provide various services from different public health programmes, all at the same time. It also allows us to detect illnesses that otherwise might be missed. Mathias Pelep, 91, village leader of Wapar

Micronesia Improving primary health care

A primary health care approach is helping ensure that Micronesia's 100,000 people – scattered across hundreds of islands in the Pacific Ocean – are able to receive a comprehensive package of care. WHO is working with local governments, communities and development partners to support this outreach programme.

The Dispensary Strengthening Programme

This Government programme extends services to more than 100 000 people scattered across hundreds of islands covering 2.6 million square kilometres of the Pacific Ocean. Today, villagers are happy to receive health care at outreach clinics in their own village.

We are finding illnesses that were not being detected before this programme.

Cutelynn Eliou, a health assistant at the dispensary in Pohnlangas.

Revitalizing existing centres

Previously, more than 90 dispensaries were set up in the Federated States of Micronesia to serve as primary health care centres. Health workers would dispense medications and other medical supplies and were trained to offer services in health promotion, disease prevention and basic treatment.

However, due to financial constraints, limited supervision and a lack of resources for travel, the dispensary system was unable to deliver adequate services to people in remote areas. Often, health workers could do little more than give out medicines to people in the immediate area.

The Dispensary Strengthening Programme began as the Government recognized the inadequacy of this set up, especially with the increasing burden of non-communicable diseases such as hypertension and diabetes.

The Dispensary Strengthening Programme brings health workers to remote communities to provide comprehensive outreach services to tackle a variety of health needs. It was launched in June 2017 as a demonstration project in Mdolenihm Municipality, Pohnpei State as part of the country's efforts to advance UHC.

The Department of Health Services of Pohnpei State leads the programme with support from the national government, the World Health Organization (WHO), the International Organization for Migration, the Japan International Cooperation Agency and the Island Food Community of Pohnpei.

Improving coordination for people-centred care

Health workers travel to communities to provide care that includes: screening for NCDs, TB, leprosy and cervical cancer; health education; basic treatment; and dispensing of medications.

The programme also collects biometric data, which is shared with drug dispensary and hospital information systems, to support care continuity and follow-up.

“The demonstration programme shows great potential. First, they've taken outreach programmes for non-communicable diseases, maternal and child health, HIV, and TB – which were accustomed to working in isolation – and brought them together as one multidisciplinary team that travels together to provide comprehensive services,” says Dr Eunyoung Ko, WHO Country Liaison Officer in the Federated States of Micronesia, who led a situation analysis and supported the development of guidelines for integrated outreach services.

Engaging communities in programme design

Community engagement has been key to the early success of the demonstration programme. The Government health team consulted community leaders, including the paramount chief and village chiefs, to identify priorities and expectations.

“The discussions we had with health officials before this programme was launched were very important and the activities you are seeing today are based on the planning that we took part in. This is our second outreach visit, and I think we are finding hidden illnesses that weren't being detected before this programme,” said Mathias Pelep, the 91-year-old village leader of Wapar.

Going forward, WHO will continue to work closely with the Government in monitoring the programme and in conducting a cost analysis to support its expansion to other municipalities.



MICRONESIA

FACT

A primary health care approach is helping ensure that Micronesia's 100,000 people – scattered across hundreds of islands in the Pacific Ocean – are able to receive a comprehensive package of care.

WHY IT MATTERS

Transport between the islands is expensive, and people and communities are getting infrequent and fragmented health care.

EXPECTED RESULTS

The population can access a comprehensive package of care at primary level, including for NCDs, at affordable costs.

IN PRACTICE

Improved access to services are a result of strong collaboration between local governments, communities, development partners and WHO, a robust situation analysis, a set of guidelines and a capacity building programme.



Photo: WHO



Greece The rapid rise of primary health care

In just one year, Greece has established nearly 100 new community-based primary health units, free at the point of access and known locally as Topikes Monades Ygias or TOMYs. In a few months, around a million people will benefit from the new services.



L-R: Dr Andrea Xanthos, Minister of Health; Dr Zsuzsanna Jakab WHO Regional Director for Europe; Dr. Tedros Adhanom Ghebreyesus, WHO Director General.

The units are key elements of the newly designed primary health care system and are the first point of contact and the main coordinator of care for people in the area.

Here, multidisciplinary teams of general practitioners/family doctors, paediatricians, nurses, health visitors and social workers provide health care for people in a continuous

manner, looking at disease prevention, health promotion, diagnosis, treatment, monitoring and care. The new units will also have clear referral mechanisms. This is a major change from the otherwise fragmented network of different public and private health providers, primarily specialists, providing care upon request and with little coordination. The impact is keenly felt.

I am 80 and I live in Metamorfosi, Attica. TOMYs are clearly a big, big, big service and a major breakthrough in health. I found a setting that was very friendly and pleasant. At the TOMY, I definitely don't pay for anything. From my place, the TOMY is ten minutes by car. Better health for all!

Pantelis Leosis

Collaboration reaps rewards

Greece's health system was deeply affected by the financial crisis, which had a direct impact on access to health services, quality of care and financial protection. Pressure from the crisis revealed long-term problems in areas such as health governance and primary health care provision.

The Greek health authorities, in close collaboration with WHO Europe and other stakeholders, analysed the progress of health reform in Greece and made recommendations for its future direction and improvement.

Close collaboration between WHO and the Greek Ministry of Health began five years ago in 2013 when WHO Europe set up a Health Reform Support Programme and a Project Office, with financial support from the European Commission. This year a WHO Country Office opened in Athens.

Standing shoulder-to-shoulder with the Ministry of Health, we have made significant efforts that will continue to contribute to improving the health of the Greek people, including the most vulnerable.

Dr Zsuzsanna Jakab WHO Regional Director for Europe

In 2016, the Greek Government developed the Primary Health Care Roll-out plan and implementation started after the new law on PHC was passed in August 2017. With much celebration, the very first TOMY opened in Thessaloniki, Evosmos in December 2017 and now there are currently 98 units in operation. Each unit has a capacity to serve approximately 10 000 people.

“ This is a reform that aims to shift the focus from treatment to prevention. It is an evidence-based response to the health systems crisis and to societal demand for the elimination of health inequalities,” said Minister of Health Andreas Xanthos.

Dr Hans Kluge, Director of the Division of Health Systems and Public Health at WHO Europe, congratulated the Greek authorities and the communities.

“ Real fundamental health reforms are possible in Greece and they are happening now, not in the far future”, he said.



GREECE

FACT

Nearly 100 PHC units, able to each serve 10,000 people, have opened in Greece in the past year. One patient describes it as a "major breakthrough in health."

WHY IT MATTERS

Greece's health system was deeply affected by the financial crisis, with a direct impact on access to health services, quality of care and financial protection.

EXPECTED RESULTS

Vast improvement of access to affordable health services nationwide, and there is a shift of focus from treatment to prevention.

WHO'S ROLE

WHO stood 'shoulder-to-shoulder' with the Greek Ministry of Health, working at first from the Regional Office to support an EU-funded PHC project in Greece. WHO has now opened a Country Office in Athens, and supported the roll-out of this nationwide PHC effort.



Libya The highs and lows of medicine supplies

In Libya, a pioneering project has vastly improved the country's medicines supply chain management and health information system. The work has really made a difference to the country's health system.



Dr Hana Shtwei from the Ministry of Health stands proud as she recalls her training on how to improve the medicines supply chain management in Libya.

“I was fortunate to be among those selected for a workshop in Tunis, led by WHO experts on setting up a national Pharmacovigilance strategy. With expert input during the workshop, we were able to fine tune our 'yellow card' reporting scheme, to better capture relevant information on adverse drug reactions.”

Dr Shtwei works for the Pharmacovigilance Department and in just a couple of years, has seen how support from WHO and the EU-funded Strengthening Health Information System and Supply Chain Management project (2016-2018) has really made a difference to the country's health system.

Over the last few years, there have been extensive shortages of medicines and medical supplies, low stocks of vaccines and a lack of trusted information about the health situation and the supply chain. In reality, medical supply chain management and the health information system were almost non-existent. Yet today things are really looking up.

“The workshop helped to guide us, as Libya's national centre, on how to disseminate Pharmacovigilance within Libya. A few of us have since visited several hospitals and given basic awareness training on the concepts of Pharmacovigilance. We have also been able to fix 35 focal points in various hospitals to support the data collection process,” she says.

Such progress is no small feat in a country that has experienced great turmoil since the 2011 civil war. It was left with the legacy of a deeply under-developed health system.

In 2011 and 2012, Libya's health authorities acknowledged that two main areas in the health system were particularly neglected: medical supply chain management and the health information system.

However, the country was still facing turbulence and conflict and it was almost impossible to tackle the problem.

It took until the latter part of 2016 before the Strengthening Health Information System and Supply Chain Management Project could get underway to start building institutional and individual capacities to reform supply chain management and integrate these reforms within the Ministry of Health.

As part of the Health System Strengthening Project, WHO has supported people at all levels - from those working daily in health care all the way up to Ministries - to improve their practice.

Advocacy and raising awareness complemented the technical work, and WHO set up meetings between key country pharmaceutical stakeholders to make progress on some instrumental issues.

We are all new to this important concept and we realise that more training is definitely needed to help improve our knowledge base, and to allow us to create a stronger network within the international Pharmacovigilance community.

Dr Hana Shtwei from the Ministry of Health

A high-level consultation brought together WHO colleagues, stakeholders from pharma and non-pharma sectors, the Food and Drug Administration, and other Ministries to try to better coordinate actions across the nation.

Recommendations included ensuring better quality and availability of data, good governance, and improved coordination between stakeholders, enhancing technical capacity in critical areas and developing a comprehensive National Medicines Policy.

Since August 2017, a supply-chain working group of mid-level managers have come together once a month to discuss how to collaborate and make progress.

It's definitely a challenge to keep things moving in Libya's unsettled context. WHO is building institutional capacity, but still recognises the challenges that people face and continues to provides support where necessary.

The changes have been evident to all involved in the project. There has been a meaningful shift in relationships and a new and shared vision and drive for progress by country stakeholders.

There is now a Libyan Essential Medicines List to improve access to essential medicines and reduce costs, which is currently waiting for endorsement by the Ministry of Health. Libya's National Drug

Regulatory Agency is now strengthening its regulatory function by abiding to international standards, particularly in issuing marketing authorizations for products through the WHO SIAMED software.

The EU-funded Strengthening Health Information System and Supply Chain Management Project is pioneering in a country still facing complex challenges of lack of stability and political will, poor governance and a dearth of the instrumental components that a health system requires to function. It seems even more important therefore to continue the good work.

“We are all new to this important concept and we realise that more training is definitely needed to help improve our knowledge base, and to allow us to create a stronger network within the international Pharmacovigilance community. I know the Strengthening Health Information System and Supply Chain Management project is coming to an end soon, but we need the continued technical support that WHO offers, especially in Pharmacovigilance,” says Dr Hana Shtwei.



LIBYA

FACT

A meaningful shift in relationships and a new vision for progress is driving Libya's health information system and medical supply chain management. A pioneering project is building capacity throughout the system.

WHY IT MATTERS

Libya was left with the legacy of a deeply under-developed health system. Extensive shortages of medicines and medical supplies, low stocks of vaccines and a lack of trusted information about the supply chain have been common place.

EXPECTED RESULTS

The population has better access to safe and essential medicines, and the health system is strengthened.

IN PRACTICE

Thanks to close collaboration with national authorities and financial support from the European Union, WHO experts have been able to strongly advocate for improved supply systems and have supported people at all levels - from medicines warehouses to Ministries - to improve management practice.



LUXEMBOURG
AID & DEVELOPMENT



Irish Aid
An Roinn Gnóthaí Eachtracha agus Trádála
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UKaid
from the British people



What does change look like on the ground?

“ My name is Jumah Asad, and I work in the Shara El-Zawya Tripoli MSO warehouse. I left school at 15, and did not receive any formal training to work as a storekeeper.

I have been working in this warehouse for over ten years, and things have slowly deteriorated, particularly after the 2011 conflict.

Our senior management team informed me and other storekeepers about the WHO EU-funded Strengthening Health Information System and Supply Chain Management project which looks to assess warehouses in Libya.

I did not realise that an assessment would be so in-depth and valuable.

The WHO team that came to assess the 15 stores in Tripoli composed of four technical areas: structural, electrical, mechanical and pharmaceutical. I did not realise that an assessment would be so in-depth and valuable.

While accompanying the team I came to appreciate how necessary it is to have an evidence-based assessment to inform potential refurbishment. I didn't know that temperature, humidity and even sun-light can affect medicines in a bad way. Even health and safety was a new concept to me.

I don't have basic tools to reach the ceiling to change light bulbs. I understand that it's not possible for external organisations to refurbish the whole warehouse, but having some basic equipment available would help me perform better in my job.

I would like to see the work WHO is doing on supply chain management continued, as they only just started helping us make changes.

“

Do not think achieving UHC is someone else's job. Let me remind you that after all, UHC starts with you.

Dr Tedros, Director-General, WHO

