Recognizing that health systems need to respond better and faster to people's demands in a changing world and continuing relevance of primary health care (PHC) and the values of Alma-Ata Declaration, a Regional Meeting on Health-Care Reform for the Twenty-first Century was held in Bangkok, Thailand, on 20-22 October 2009.

There are many notions of health-care reform. In general, health-care reform is an effort to increase effectiveness, efficiency, accessibility and responsiveness of the health system in order to improve health equity. However, most of the reforms undertaken in general and in developing countries in particular, focus on medical care. Thus, reform in financing of the health-care is directed mostly for achieving universal coverage of the population for curative and rehabilitative care i.e. medical care whereas very little, if any, reforms devoted to improve preventive and promotive care.

The regional meeting aimed at to develop consensus on strategies for health-care reform for the South-East Asia Region; to review and build consensus on a strategic framework for health-care reform; to identify the role of public health institutions and networks in education, training and research for health-care reform, and to identify ways to take forward the strategic framework for health-care reform.

The meeting made recommendations for Member States regarding administrative review to ensure improvement in governance and leadership, health infrastructure development, improvement of service delivery, multidisciplinary team and other factors. WHO was asked to support healthy public policy, such as health impact assessments, share health workforce management information, develop a forum to discuss task shifting and develop guidelines, and to support Member States to include NGO/SEAPHEIN in PHC capacity building.
Health-Care Reform for the Twenty-first Century in the South-East Asia Region

Report of the Regional Meeting
Bangkok, Thailand, 20-22 October 2009
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Acronyms and abbreviations

AIIMS All India Institute of Medical Sciences
ANM Auxiliary Nurse Midwife
BIMS Bhutan Institute of Medical Sciences
BRAC Bangladesh Rural Advancement Committee
CBHW Community-Based Health Worker
CBI Community-Based Initiative
CHC Community Health Centre
CHV Community Health Volunteer
CHW Community Health Workers
EHC Essential Health-Care
FCHV Female Community Health Volunteers
GNH Gross National Happiness
HFA Health For All
HP Health Post
ICT Information and Communication Technology
KJPS Komisaun Jestaun Programa Suco (Management Commissions for Village Programmes)
MDG Millennium Development Goal
MoH Ministry of Health
<table>
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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>MoPH</td>
<td>Ministry of Public Health</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental Organization</td>
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<td>NHSO</td>
<td>National Health Security Office</td>
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<tr>
<td>NITM</td>
<td>National Institute of Traditional Medicine</td>
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<tr>
<td>NRHM</td>
<td>National Rural Health Mission (India)</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>RIHS</td>
<td>Royal Institute of Health Science</td>
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<tr>
<td>SEAPHEIN</td>
<td>South-East Asia Public Health Education Institutes Network</td>
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<tr>
<td>SISCa</td>
<td>Servico Integrado da Saude Comunitaria</td>
</tr>
<tr>
<td>SRM</td>
<td>Strategic Route Map</td>
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<tr>
<td>STUP</td>
<td>Specially Targeted Ultra Poor</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>VO</td>
<td>Village Organization</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>WHO-SEARO</td>
<td>WHO Regional Office for South-East Asia</td>
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Executive summary

The Regional Meeting on Health-care Reform for the Twenty-first Century in the South-East Asia Region was held from 20 to 22 October 2009 in Bangkok, Thailand.

The overall objective of the regional meeting was to develop consensus on strategies for health-care reform for the Twenty-first Century in the South-East Asia Region. The specific objectives were to review the health-care challenges in the Region; review and build consensus on a strategic framework for health-care reform; identify the role of public health institutions and networks in education, training and research for health-care reform; and identify ways to take forward the strategic framework for health-care reform.

Over 110 participants representing Member States of the South-East Asia Region, nongovernmental organizations, UN agencies, and bilateral agencies as well as other stakeholders attended the three-day meeting.

The meeting was inaugurated by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia. Dr Sathaporn Wongjaroen, Deputy Permanent Secretary, Ministry of Public Health, Royal Thai Government read the message of His Excellency, Dr Witthaya Keawparadia, Minister of Public Health, Royal Thai Government. The keynote speeches were delivered by Dr Fernando S. Antezana Aranibar, former Deputy Director-General, WHO/HQ; His Excellency Mr Lyonpo Zangley Dukpa, Minister of Health, Royal Government of Bhutan; and Dr Amorn Nondasuta, President, Foundation of Quality of Life, Thailand.

The working paper on Health-Care Reform for the Twenty-first Century in the South-East Asia Region: A Strategic Framework was presented by Dr Myint Htwe, Director, Programme Management, and WHO-SEARO. The paper focused on the strategic framework of health-care reform addressing the twenty-first century challenges in the South-East Asia Region.
The technical sessions were focused on different aspects of health-care reform and were organized under four themes:

(1) Governance
(2) Health workforce development and management
(3) Community empowerment
(4) Public health institutions and networks

Panel discussions were held on these topics through presentation of a main paper for each topic and supplemented by country experiences in respect of each topic.

Group discussions were organized and focused on the same themes for participants to develop recommendations to further the process for health-care reform in the twenty-first century.

Conclusions

Health-care reform proposed is to promote public health and balance the medical and curative aspect with health promotion and disease prevention. The countries agreed on the strategic framework and there is a need to review the health policy, particularly the health structure. There are many health workforce aspects, namely pre-service and in-service training, management, multidisciplinary teams, more attention to community-based health workforce and task shifting to fill necessary posts. Community participation and the need for community empowerment and community education were discussed. Public health education is another important aspect as are the quality of education and the network.

Recommendations

For Member States:

(1) Administrative review to ensure improvement in governance and leadership
(2) Health infrastructure development to strengthen capacity of policy implementation
(3) Improving service delivery from the demand side as well as the supply side
(4) Pursue multidisciplinary team approaches and task shifting
(5) Ensure international standards of education and training

For WHO:

(1) Improve opportunities of experience sharing
(2) Support for healthy public policy such as health impact assessment
(3) Share health workforce management information and experience
(4) Develop a forum to further discuss task shifting and develop guidelines
(5) Support Member States to include nongovernmental organizations/SEAPHEIN in PHC capacity building
1. Introduction and background

A Regional Conference on Revitalizing Primary Health-care (PHC) was organized from 6 to 8 August in 2008 in Jakarta, Indonesia. The conference, among other things, had advocated a shift from a focus on service delivery to a developmental and people-centered approach in the context of social, political and economic situation. As a follow-up of this conference, the Regional Meeting on Health-Care Reform for the Twenty-first Century was organized.

Over 110 participants representing Member States of the South-East Asia Region, nongovernmental organizations, UN agencies, and bilateral agencies, as well as other stakeholders, attended the three-day meeting.

2. General objectives

To develop consensus on strategies for health-care reform for the twenty-first century in the South-East Asia Region.

3. Specific objectives

(1) To review the health-care challenges in the Region.

(2) To review and build consensus on a strategic framework for health-care reform.

(3) To identify the role of public health institutions and networks in education, training and research for health-care reform.

(4) To identify ways to take forward the strategic framework for health-care reform.
4. **Inaugural session**

In his opening remarks, Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia, stated that this high-profile meeting is a part of initiatives within the broader framework of revitalization of primary health-care and public health initiatives in WHO-SEARO, being organized to develop a roadmap and an agenda for health-care reform in the Region.

Health-care reform is needed because important public health problems are still prevailing and new challenges are emerging due to factors such as climate change, the global economic downturn, emerging infectious diseases including H1N1 and the rapid emergence of noncommunicable diseases.

This meeting would identify necessary changes in the health system to ensure universal access to health services for all people and to chalk out a roadmap for effecting these changes in the South-East Asia Region. This would help accelerate progress towards better equity and social justice in health.

There is a need for strategies that call for country-wide application of PHC principles for all people including the poor, the vulnerable and the marginalized. PHC should be made a cornerstone for orientation of health system strengthening that takes into account the entire range of health problems and health needs, particularly undeclared morbidity, silent diseases, and unknown health risks and vulnerability.

Health-care reform needs to be embedded in sociocultural, economic and political contexts; it must be sustainable and address strategic directions aimed at:

(i) a balance of care between preventive and curative, promote people to stay healthy to lead a socially and economically productive life and support a people-centered movement for consumer protection;

(ii) taking into account human dignity and participatory processes by strengthening the role of civil societies especially at local levels;

(iii) strengthening the health system at all levels with a greater focus on governance leadership and decentralization;
(iv) developing the potential role of community-based health workers and community health volunteers in the system and the role of partnerships through a public-private; and

(v) the significant challenge of resource allocation to ensure equitable distribution at national and subnational levels.

5. **Opening address**

The Deputy Permanent Secretary, Ministry of Public Health, Royal Thai Government, delivered the opening address on behalf of His Excellency, the Minister of Health, Ministry of Public Health, Royal Thai Government. In his address, His Excellency stressed that although health is a human right, inequities in various dimensions still persist within the countries of the global Region. In view of the adverse effects of the global financial crisis, social health protection of consumers is urgently needed. Health-care system reforms for achieving universal coverage have been going on in Thailand for three decades. However, quality of services and equity issues still need to be taken care of and support given to secondary and tertiary as well as the first-level primary care.

Although health-care reforms should be country-specific, such meetings provide ample opportunities to learn from each other and eventually come to a common regional framework for reforms.

6. **Keynote speeches**

(i) **H.E. (Mr) Lyonpo Zangley Dukpa, Minister of Health, Royal Government of Bhutan**

His Excellency stated that South-East Asia is a region of paradoxes. But notwithstanding paradoxes, the Region can draw on common strengths and opportunities. There are numerous health-care challenges, such as:

(i) human resource shortages in health;
(ii) inequality and inequity of health-care access;
(iii) wastage and fragmentation of health-care;
(iv) poverty and health-care;
(v) changing demographic profile;
(vi) negative health impacts of globalization and global warming;
(vii) emerging and re-emerging of burden of diseases; and
(viii) sustainable health-care, which calls for health-care reform in the present day that put priority of material comforts, which will be difficult for financial support in developing countries.

The concept of Gross National Happiness (GNH) offers an alternative paradigm for development based upon the principles of balance and harmony in pursuit of socioeconomic progress with “happiness” as its ultimate goal. The concept is centered on nine domains consisting of time-use, living standards, good governance, psychological well-being, community vitality, culture, health, education and ecology; this is in line with the holistic definition of health by WHO.

(ii) Dr Fernando Antezana Aranibar, former Deputy Director-General, WHO

Health for All (HFA) is a universal inspirational goal of basic importance to humanity and hence the pursuit of Health for All is a moral imperative. Review of health-care systems is going on in most countries in the world. There are advances in medical technologies on the one hand, and also numerous health challenges:

(i) pursuing partnerships in health-care delivery;
(ii) development of policy based on a solid foundation of science, ethics and human rights as well as social and economic well-being;
(iii) equity, related to health as a human right;
(iv) recognition of traditional medicine as part of the health system;
(v) the central place of health in development;
(vi) poverty reduction strategies; and
(vii) health work-force needs being faced by countries around the world have necessitated the need for reforms.
If these challenges are to be met, efforts must be made in three
directions, namely, the Health For All (HFA) value system should be truly
established globally; health needs to become central to development; and
sustainable health systems must be developed.

We can be very optimistic in view of the positive results of health-care
reform in the SEA Region. The challenges are:

- national and global political will should be built;
- the required resources should be made available (financial and human);
- essential technologies need to be made universally accessible (including essential pharmaceutical products and vaccines);
- human resources are to be properly trained, allocated, recognized and compensated;
- communities must understand and cooperate to achieve solidarity and equity in health and the rational use of health services.

(iii) Dr Amorn Nondasuta, President, Foundation of Quality
of Life, Thailand on “The Use of Strategic Route Map in
Revitalizing Primary Health-Care”

Continuous reforms in health-care systems during the last three decades
have been responsible for success in various dimensions of health-care,
particularly universal coverage of population with primary health-care
services. The focus has been on health-service delivery and comparatively
less progress has been achieved in community involvement, intersectoral
collaboration and strengthening district health systems. There is a need to
strike a balance between “services” and “development” in primary health-
care and for this a strategic change is required to shift towards
development. The vision of a strategic route map (SRM) is: “People are able
and willing to take care of their own and their family’s health, their
environment and their society, with faith and determination”.

This strategic innovation recognizes synergistic effects of the three
variables of “organization, finance and manpower”, and takes into account
the complementarities between technical and social interventions. The strategic route map helps:

- empower the community to decide on its goal and destination, and then set out to realize them in a rational way;
- link together activities of all parties, creating “synergistic effects”; and
- induce a paradigm shift in both officials and the public.

7. Presentation

Health-Care Reform for the Twenty-first Century in the South-East Asia Region: A Strategic Framework

Dr Myint Htwe, Director, Programme Management, WHO-SEARO presented draft strategic framework for health-care reform. He stated that health-care systems have been undergoing changes in order to address health challenges. The Regional Conference on Revitalizing Primary Health Care held in Jakarta in August 2008 reaffirmed that primary health-care is the right approach to strengthen health systems. The major challenges for health-care in the countries of the Region are:

(i) A high disease burden;

(ii) weak health systems, including

- weak public health services in health promotion and primary prevention
- mismatches of health workforce and skill mix
- fragmented health-care without referral back-up

(iii) imbalances in health expenditure.

These challenges are further influenced by urbanization, climate change, globalization, commercialization and information technology.

Health-care reform for the twenty-first century should aim for health for all through a people-centered care. The seven essential principles are:
equitable care, engaging all stakeholders, community empowerment, effective care, evidence-based and efficient care, and ethical care.

A strategic framework for health-care reform (Figure 1) would address major challenges from a public health perspective.

**Figure 1:** Strategic Framework for Health-Care Reform for the Twenty-first Century

The framework encompasses four components:

(i) Governance including health policy, healthy public policies, decentralization and public-private partnership.
(ii) Health workforce management – community-based health workers (CBHW) and community health volunteers (CHV), education and training, multidisciplinary health team.

(iii) Community empowerment – education, volunteers as change agents, links to income generation.

(iv) Public health institutions and networks – innovative education, use of information and communication technology, role in education, training and research.

Successful reforms in these areas and health-care financing will ultimately result in more responsive and people-centered care. Health-Care Reform is a complex process involving many dimensions; does not take place in isolation; is country-specific; and involves a rational, unbiased, systems approach and holistic thinking.

8. Technical discussions

The discussions related to health-care reforms were organized in panels under four themes:

(1) Governance: health policy including resource allocation, healthy public policies, decentralization of health services and public-private partnership

(2) Health workforce development and management: recruitment, deployment, task shifting and multidisciplinary health team

(3) Community education and empowerment

(4) Role of public health institutions and networks in education, training and research

9. Panel discussions

Panel A: Governance: health policy including resource allocation, healthy public policies, decentralization of health services and public-private partnership

Moderator: Dr. Carissa Etienne, Assistant Director-General, Health Systems and Services, WHO Headquarters
Main Paper: Dr Somsak Chunharas, Thailand

- In comparison to countries with well-established health insurance systems, where health care reform was mostly about increasing access/coverage and cost containment, health-care reforms in the Region where most countries does not have health insurance for majority of the population, would have to be reoriented toward primary health-care with strong emphasis on community empowerment, decentralization and formulation of healthy public policies through other development sectors.

- Policies related to health-care financing exist in the countries of Region. These include health as part of the social security system, excise tax for health promotion, and national health insurance using tax funds.

- Community financing such as revolving funds for specific purposes such as sanitation, nutrition and drug funds have been able to fill the funding gap; in addition to generating finances, it is also a community empowerment mechanism.

- Policies related to decentralization should have a convergence of views and requirements between central and decentralized structures. In most countries in the Region, decentralization normally has three key characteristics, namely, local election for local administration; the authority to make use of a certain proportion of national income to carry out those functions agreed upon by the central authorities (as stipulated in the decentralization); and, the responsibility to continue to provide certain “public services” in place of the central ministry.

- Similarly, the policies related to public-private partnership should follow debates on the exact roles of the public and private sectors, including NGOs and civil societies, both in terms of funding and provision of services.

- The call for healthy public policies and action beyond the health sector started with Alma-Ata (1978) and was furthered by Ottawa Charter (1986), Second International Conference on Health Promotion in Adelaide (1998), Concept of Health in All Policies by Adelaide “Thinkers in Residence Programme Conference” (2007) and the Commission on Social Determinants of Health (2008).
Opportunities and possibilities to develop healthy public policies exist, but the challenge for counties is how to bring in highly diverse partners in others sectors to better see their roles and impact on health of population.

Agriculture, food safety and security, water and sanitation, and tobacco production are some of the areas where such policies are to a large extent being framed. Institutions, civil societies and media have to take the lead in organizing public debates and creating a favourable environment for enactment of such policies.

Country experiences

1. **Decentralization** Dr Laksono Trisnantoro, Indonesia

Decentralization in health-care carried out in Indonesia since 2001 can be described as pendulum, which has swung from centralization to decentralization. There have been many policy changes but there has been hardly any meaningful change in governmental authorities at various levels. The commitments of central and local governments of varying levels have led to four scenarios, one of which envisages a same level of commitment at different levels, from central and local levels in respect of the decentralization in health.

2. **Public-private partnership** Mr Naresh Dayal, India

Public-private partnerships in India centered around the National Rural Health Mission consists of one safe motherhood initiative, the Chiranjeevi scheme of utilization of private nursing homes in Gujarat, emergency response service in collaboration with the emergency medical research institute in Andhra Pradesh, management of primary health centres in Arunachal Pradesh by NGO’s, and a mobile boat clinic in Assam. However, in all cases the resources for the partnership have had to be provided by the government.
3. Health in All Public Policies (including Social Determinants of Health) Dr Saroj Jayasinghe, Sri Lanka

Sri Lanka has a long record of tackling social determinants of health. Sri Lanka has a history of health improvement as an upstream determinant of health: free education, food subsidies, minimum wage, maximum working hours. Three levels of healthy public policy are:

- National level or regional level policies where a “whole government” initiative for intersectoral action was attempted;
- Intersectoral action such as vertical disease-based programmes; and
- Local-level initiatives at the local government or village level, exemplified by: (i) integrated rural development programmes; (ii) the Sarvodaya Movement – empowerment process of village community by NGOs; (iii) the state-sponsored Gemidiriya community development and livelihood improvement project; and (iv) crisis-oriented intersectoral action mobilized to overcome a crisis situation, such as post-tsunami reconstruction, post-conflict reconstruction and internally displaced persons.

4. Policy reform in health-care delivery including referral systems
   Dr Pongpisut Jongudomsuk, Thailand

Thailand has passed through three significant periods of health reforms. The first two phases of reform were related to increasing coverage of health-care infrastructure and health-care financing mechanisms. In the third phase (at present), health-care reforms have shifted its focus to strengthening primary care. In the five main areas of health-care reform initiatives are: improving primary care infrastructure by additional capital investment; capacity building of primary care staff; financing reform to allocate sufficient resources to primary care and to enhance performance of primary care staff; strengthening referral systems; and development of family medicine in both concept and practice, which is suited to the country context.
Discussions

During the presentations, the following points were noted:

- Governance means accountability, responsiveness, transparency, and rule of law. Many of governmental structures do not have the capacity for good governance. It is, therefore, essential to identify the contents and mechanisms to ensure good governance.

- Any health-care reforms process in the countries of the Region must support/create a balance between public health and medical services, even though it is well known that health services in the countries are generally skewed heavily in favour of medical/curative care.

- Decentralization is generally a part of public policy and succeeds only when centralized and decentralized levels have clarity about roles and shared understanding. Decentralization in one sector such as health has limited chances of success if it is not a part of an overall decentralization process.

- For public–private mix initiatives to succeed, it is important that they collaborate comprehensively, meaning not only in providing services but also in financing of services and programmes. Otherwise, the role of the private sector will be limited to providing services using funds from the public sector which amounts merely to contracting of services. Different models of public private mix including, corporatization and outsourcing, may need to be developed.

- Mechanisms for formulating healthy public policy and implementation of multisectoral action need to be developed in the country. The commitment of all stakeholders for this task is vital.

Panel B: Health Workforce Development and Management: Recruitment, Deployment, Task Shifting and Multidisciplinary Health Team

Moderator: Dr George Fernando, Sri Lanka (former Director, Health Systems Development, WHO-SEARO)

Main Paper: Dr Lalit Nath (paper prepared by Dr Deoki Nandan)
There is a strong positive correlation between health workforce density and coverage of services. Shortages, maldistribution, lack of HRD policies, deficiencies in education and training infrastructure and processes, inadequate opportunities for career development, lack of performance-based incentives and compensation systems including social recognition for workers in rural and remote populations, appropriate skill-mix and functioning of multidisciplinary teams, are some of the problems that need to be attended to. In view of the shortages of workforce, task shifting to other categories of workforce and improving the skill mix of workers as members of multidisciplinary health teams has a potential to address some problems. In addition, mechanisms for accreditation of courses, registration of manpower and proper functioning of regulatory bodies (councils) needs to be strengthened.

**Country experiences**

1. **PHC in Timor-Leste: Lessons Learned from Integrated Community Health Services (SISCa)**

H.E. Dr. Nelson Martins, Minister of Health, Timor-Leste

The SISCa programme, an integrated health assistance programme providing services in the areas of health promotion, prevention of disease, treatment for sickness and rehabilitation, was launched in 2007. It takes place once a month in every village in all 13 districts. This programme was to be carried out by community leaders together with community members, women and youth organizations and churches to mobilize the community so that the target groups are ready when the health providers/workers came for health posts (HPs) and community health centres (CHC). SISCa is composed of health workers and members of communities. SISCa posts have been established in 602 villages across Timor-Leste and the Ministry of Health has organized simulations (ideal examples of how a SISCa should be conducted) in 12 out of 13 districts. In its operation, the first challenge is to improve the reporting system from CHC level up to the national level. The second challenge is to improve the coordination at district level through district health councils. The third challenge is to reinforce community involvement through the establishment of Management Commissions for Village Programmes-Komisaun Jestaun Programa Suco (KJPS) and a well-run health volunteer programme.
2. **Community health clinics** Dr A.M. Nuruzzaman, Bangladesh

Health sector challenges in Bangladesh are similar to other countries in the Region. Health-care infrastructure has been taken to the people through establishment of community clinics, one for each 6000 people, in rural areas. It has improved effectiveness and efficiencies of health services.

Job descriptions of peripheral workers of the Health and Family Welfare Department are being integrated, with the addition of more preventive and promotive aspects. Training materials are being developed. Populist community clinic management committees have been formed and local government institutions are being given the responsibility of providing stewardship to these clinics.

3. **Multidisciplinary health team and task shifting**

Mr Dorji Wangchuk, Bhutan

The task of developing multidisciplinary health workers requires all doctors, nurses, technicians and health workers to perform more than one type of job. The Bhutan government tried to integrate traditional medicine with health-care; develop multidisciplinary health workforce and equal opportunities for training and career advancement; and improve quality, equitable distribution, recruitment and retention. Health workers work as a team at different levels, complementing or substituting for each other’s responsibilities depending on the need for effective delivery of primary health-care services. The Royal Institute of Health Science (RIHS) and the National Institute of Traditional Medicine (NITM) are taking care of the needs for production of manpower; the Bhutan Institute of Medical Sciences (BIMS) is being opened in collaboration with the All-India Institute of Medical Sciences (AIIMS), New Delhi to address the shortage of medical doctors in the country.

4. **Community-based health workers/community health volunteers**

Ms Shareefa Manike, Maldives

Health-care for rural populations is provided through community health workers (CWHs), female health workers (FHWs) and traditional birth attendants (TBA). In the early 1990s, members of CWHs decreased for many reasons. Although the training of CHWs has continued at the same level, retaining them in the job has been a problem as the trained CHWs
shifted their roles towards other areas such as management and policy-making. In order to achieve and sustain the MDG goals 4 and 5, the country should develop and upgrade different health-care providers with a focus on community-based public health professionals and community nurses. Unless local teams of health-care providers are available to deliver the care at different levels of health facilities, the provision of consistent care to people at the island and atoll levels will not be sustained.

**Discussion**

During the presentations, the following points were noted:

- In view of shortages and maldistribution of health workforce, planning and management of multidisciplinary team of public health professionals, workers and volunteers, their interdisciplinary training and task-shifting must be given greater attention in the public health system.

- Retaining workers, particularly community-based health workers are the most critical dimension of health workforce management. To address this critical problem, appropriate career ladder paths for each category of health workforce (such as public health professionals), specification of a period of posting in difficult areas and increasing their eligibility for training for higher categories of jobs are essential. For community-health volunteers, social recognition and other incentives (such as opportunities to access micro credit schemes) are important.

- A critical mass of public health professionals, career pathways and attracting good quality personnel for the public health system are critical inputs for effective and efficient functioning of the health system.

- There is a need to integrate workforce from traditional systems of medicine as members of the multidisciplinary health team of health workforce.

- Comparative analysis of CHWs and CHVs in the countries in the South-East Asia Region on all dimensions including training, retraining and compensation and its review from time to time
will be useful to support countries as well as improving regional efforts in health workforce reform.

- Distance learning programmes utilizing Information and Communication Technology (ICT) for various categories of health workforce in view of the shortages will be beneficial. Improving health management, including leadership capabilities of professionals and workers at all levels, is a critical input for efficient and effective public health systems.

**Panel C: Community education and empowerment**

**Moderator:** Dr B.D. Chataut, Nepal

**Main paper:** Dr Kya Win, Myanmar

- Community-based initiatives (CBI) are a move from conventional unconnected sectoral activities towards a more holistic approach to development. Due to the emerging socioeconomic situations and increasing levels of public awareness, there is a demand for empowering communities in their efforts towards becoming more self-sufficient in decision-making and designing strategies including the health sector for their future. There has been a remarkable change from the earlier framework of community involvement/participation to present-day community empowerment trends. Community empowerment involves: initiation and processing by activists in the community; a concerted process of mobilization; orientation regarding the purpose and benefits of community mobilization and empowerment; defined roles of stakeholders and community; help and assistance from partners for relevant aspects; commitments by all partners; ownership of the programme and underlying objectives; and confidence in the capacity of the community to act.

**Country experiences**

1. **Volunteer as change agent, Dr Nilambar Jha, Nepal**

Community health volunteers (CHV) acting as change agents started in 1988 and had covered all 75 districts of Nepal by 1995. They are selected at the local level, trained appropriately and given essential supplies they now serve a population of 150 to 400.
Payment to them now is for training and special campaigns but they receive priority for training as Auxiliary Nurse Midwife (ANM) officers and are provided free curative services at the local level. They are supervised by in-charge of local health facilities, local health management committees, district public health officials and national programme managers. Their link to the health system is informal. Studies have proved their utility in several dimensions. However, questions related to salary and career development still remain unanswered.

2. **Income generation and community empowerment**  
   Dr Faruque Ahmed, Bangladesh

- Bangladesh Rural Advancement Committee (BRAC’s) poverty alleviation programme has been organized around a microfinance scheme that emphasizes village organization (VO) formulation; functional literacy, social and legal rights; skill training in income-generating activities, microcredit offered without collateral; and other health and sanitation inputs.

- The VO’s have acted as pathways to women’s empowerment in socioeconomic and health areas.

- BRAC’s community development programme based on VO’s provided a foundation for the development of CHVs called Sahasthya Shebikas, who are the foot soldiers of essential health care (EHC) services. Later on, a programme entitled “Challenging the Frontiers of Poverty Reduction – the Specially Targeted Ultra Poor (STUP)” addressed the bottom 10% of the population in terms of their economic condition and established support programmes in health, social development and advocacy, gender, quality, action learning, human rights and legal services.

3. **Community education**  
   Dr Alok Mukhopadhyay, India

Genuine development is not possible where the community passively receives health-care judged appropriate by others. For effective and sustainable action, Panchayats (village councils) assisted by local NGOs play a crucial role. Decentralization opens up enormous possibilities of involving school teachers, local leaders and traditional birth attendants (TBA) who can become extra workforce for strengthening human resources.
4. Community empowerment using Strategic Route Map (SRM)
   Dr Narongsakdi Aungkasuvapala, Thailand

Although there are many challenges for sustainable health system development, motivating people to take care of their own health depends on three key components: service providers (including networks of service providers), managers, and the people themselves. The most important thing to attain healthy communities, the critical success factor, is the people’s behaviours. Shifting from service delivery to the development approach can improve people’s participation. The critical success factors of behavioural changes are social measures and a community surveillance system. The strategic route map (SRM), a blend of technical and social intervention, rests on three pillars of community strength: community participation, fund and manpower. Ministry of Public Health (MoPH) and the National Health Security Office (NHSO) jointly organize training programmes to empower people to use SRM as an important tool for management. Strengthening community empowerment using SRM as a tool for change acts as a catalyst for reaching the goal of behavioural change.

Discussion

During the presentations, the following points were noted:

- Substantial work needs to be done to understand clearly the process of community empowerment and its utilization for achieving the ownership of programmes in communities; civil societies, NGOs and media have a crucial role to play in this process.
- Mechanisms to harness energies of the community, civil societies and NGOs should be evolved particularly to address national disasters and communal strife in some countries.
- The use of SRM as a tool for community empowerment needs to be experimented within countries.

Panel D: Role of Public Health Institutions and Networks in Education, Training and Research

Moderator: Professor SK Akhtar Ahmad, Bangladesh

Main Paper: Dr Phitaya Charupoonphol, SEAPHEIN, Thailand
Workforce size and its spatial distribution, critical shortages of trained workforce, and training occurring in isolation and not in an interdisciplinary manner are major challenges in the countries of the Region. There is a great variation in terms of qualitative and quantitative dimensions in training institutions’ faculty competencies and courses offered in the region. There is a need for more opportunities: for public health education and training programmes and effective career ladders within the public health systems; innovative recruitment and marketing strategies for careers in public health; use of information and community technologies particularly for initiating distance learning courses; and increased collaboration and partnership between institutions and public health services.

**Country experiences**

1. **Innovative education and task shifting** Dr Mark Zimmerman, Nepal

Nepal family practice doctors is an illustration of what ‘task shifting’ can perform. They are general practitioners trained in all areas with strong emphasis on surgical and obstetric care. By deploying these family practice doctors in the district hospitals, they can perform the comprehensive obstetric care for 24 hours a day, seven days a week.

2. **Information and communication technology in education/training,**
Dr Wansa Paoin, Thailand

Information and communication technology (ICT) can be used as an efficient tool to facilitate not only education and training of health workers, including continuing education in developing countries, but also for improving consultation with other members of the health team to support evidence-based diagnoses and treatment of patients and to tackle health problems in difficult geographical areas, particularly where there is shortage of workers. Building good ICT infrastructure needs strong policy support and ICT manpower.

3. **Role of research in education and training for health-care reform**
Dr Hasbullah Thabrany, Indonesia

Health-care reform is a continuing process to improve access, effectiveness, efficiency, equity and sustainability of services. The new elements/interventions introduced must be relevant and timely. Health-care reform
should be evidence-based. It is of two types: (1) dealing with the magnitude of the problem and preventability; and (2) involves cost-effective strategies known earlier as operation research. There is an additional requirement for funds for carrying out research. The key to success lies not only in the content of reform but also how it is handled and used. The lack of evidence-based priorities in funding in a country acts as an impediment for the initiation of and progress in research.

Discussion

During the presentations, the following points were noted:

- Public health institutions need qualitative and quantitative strengthening of their infrastructure and processes. Networking is an important tool in such a strengthening process.
- Strengthening of institutions and networks needs to be furthered in respect of nursing as well as other institutions concerned with education and training of paramedical and auxiliary manpower.
- Mechanisms for accreditation and efficient functioning of regulatory and registration bodies such as councils of all categories of health workforce need to be put in place.
- Public health institutions have to strengthen their capacities for training in policy analysis, review and formulation, besides strengthening health management and leadership training.
- Further work is needed in multidisciplinary training and training for task shifting.

11. Group discussions

The purpose of the group discussion was to reflect on the key issues for health-care reform. The participants were divided into four groups and were asked to discuss issues relating to the themes under panels A, B, C and D. The reports of each group are summarized below:
Group 1: Governance

(1) Strengthening of governance, one of the six building blocks of health systems, is crucial for carrying out health-care reforms.

(2) In view of the multisectoral nature of determinants of health (including social determinants of health) formulation of healthy public policies in addition to formulation/reformulation of health policies is an important facet of reforms. Health impact assessment (HIA) is an important tool for this task.

(3) In view of the adoption of a people-centered approach in health-care reforms, decentralization in all its dimensions (structural, functional and financial) throughout the administrative hierarchy and more particularly at the local level in a country-specific context is likely to yield higher dividends in the outcome of reforms.

(4) In view of the enormous magnitude of health problems as seen through epidemiological transition and the double burden of disease, the public sector alone cannot handle the problems and, therefore, its services must be supplemented by the private sector (including NGOs) in the spirit of public private partnership.

Group 2: Health workforce development and management

(1) Health being a labour-intensive industry, management and development of health workforce through all stages of planning and development from entry to deployment, retention in service and eventual exit from the system, require greater attention of policy-makers and health administrators.

(2) In the context of the revival of primary health-care, the most critical categories of workforce are community health workers (CHWs) who make up most of the peripheral workers of the formal health system, and community health volunteers (CHV), who provide a link between families and communities with the health system.

(3) Initial training and refresher training of these workers, along with appropriate incentives including social recognition for volunteers
and availability of career pathways, will considerably help in retaining them in the system, apart from their utility in furthering community empowerment processes.

(4) CHWs and CHVs, along with all peripheral public health workers who provide promotive, preventive and curative services to families and communities (particularly in remote areas), should be trained to work in a multidisciplinary manner at all levels. Additional incentives need to be provided for working in remote areas, and the policy should be established that they would be transferred to other (less remote areas) following completion of a set period of service in the remote area.

(5) Keeping equity principles in mind and in the context of scarcity and maldistribution of skilled HRH, there is a critical need to explore the possibility of task shifting/adding additional responsibilities. In principle, the Region could benefit from task shifting (if done appropriately). However, all the relevant WHO guidelines (proper training, regulations, appropriate selection and adequate finance) must be strictly followed.

**Group 3: Community education and empowerment**

(1) Community empowerment is the process of increasing the capacity of people to take informed decisions about their health needs and also leads to their ownership of health programmes. Community education is an important factor in community empowerment.

(2) Community empowerment and education is a two-way process. It is necessary for both communities and the health sector to understand and work with each other for common goals.

(3) In order to enable community members to play their critical role, technical know-how needs to be utilized at all stages of planning, implementation and evaluation of health programmes.

(4) The process of “community empowerment” must involve several sectors to reflect local social, cultural and traditional factors that have an impact on health.
Group 4: Public health institutions and networking

(1) Public health institutions have an important role to play in policy analysis, policy formulation, review and reformulation of policies. In the context of people-centered health-care reforms, their role in training, refresher training, continuing education and health research is also crucial.

(2) Public health institutions need to be strengthened qualitatively and quantitatively to carry out the programmes for pre-service, in-service and continuing education for professional development of health workforce at all levels.

(3) In order to harness the potential of each of the public health institutions, it is necessary to develop networking mechanisms within and among countries for improving the quality of their programmes.

(4) Since there is a big gap between the requirements of training and continuing education of the entire health workforce and the availability of public health training institutions (currently with limited capacity), use of ICT mechanisms and launching of distance learning programmes should be considered.

12. Conclusions

After the panel and group discussions, the participants presented the following conclusions. The countries agreed on the strategic framework and the specific conclusions as follows:

(1) There was a need to review the government structure for effective and good governance.

(2) Management of health workforce is to be improved with regard to multidisciplinary training and measures to retain workers at the community level.

(3) More attention needs to be given to community health volunteers and community-based health workers in the Member States as they are the backbone of the country’s health system.
(4) Task shifting of the health workforce is to be considered according to the needs and requirements of each country.

(5) An effective multidisciplinary team at all levels is needed for delivering health-care services to meet the holistic needs of the community.

(6) Community participation is limited in health programmes in several countries; hence, community empowerment and education are needed to enhance the capacity of the people to take informed decisions about their own health and their ownership of health programmes.

(7) The process of community empowerment must involve several sectors to reflect local, social, cultural and traditional factors that impact health.

(8) Public health institutions and related organizations should play an active role in policy analysis, formulation and implementation within the context of PHC revitalization and people-centered care.

(9) There is a need for public health institutions and related organizations to implement core functions of public health education, training and research, including continuing professional development.

13. Recommendations

For Member States:

(1) Administrative review should address organizational structure to ensure governance and stewardship; health financing to achieve effective care and strike a good balance in resource allocation for preventive and curative care; policies and strategies on community education and empowerment; and strengthening of partnerships for health promotion.

(2) Develop information infrastructure and databases and strengthen capacity for health system research and its linkage to policy implementation.
In terms of service delivery, countries should consider the quality of service provision and effectiveness of the referral system; encourage community involvement and consider income generation; strengthen community-based initiatives; and strengthen health education/health promotion units.

Pursue multidisciplinary team approaches and task shifting, where appropriate.

Ensure international standards of education/training in primary health institutions/organizations; revise the curriculum to impart competency-based education/training and continued professional development; and strengthen programmes by providing adequate functional resources for research, particularly on operational research.

For WHO:

Improve opportunities for sharing experiences and function as a resource centre to collect regional and global experiences on primary health-care.

Support public health policies, including health impact assessment studies and provide technical support to Member States to implement community education and empowerment.

Share evidence-based information and experience regarding recruitment, deployment and retention of community-based health workers and community health volunteers and include health-care reform in the health system observatory.

Establish a forum to further discuss the issue of task-shifting and development guidelines accordingly.

Support Member States including NGOs/SEAPHEIN in capacity building in primary health research, health system performance assessment and formulation of collaborative Member State studies and health-care reform.
14. Closing

After presentation of conclusions and recommendations, there was a request to Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia for supporting efforts in Region to promote critical mass of public health professionals, their career paths in terms of cadres and constitution of a dedicated group of public health and other professionals in each country to initiate and sustain health-care reforms in the countries of the Region.

In his closing remarks, the Regional Director stressed that since the organization of the Regional Conference on Revitalizing Primary Health Care in Jakarta, Indonesia in August 2008, WHO organized a Regional Consultation on Self-Care in the Context of Primary Health-Care in Bangkok in January 2009 followed by the current meeting. Another meeting on decentralization is proposed to be held in 2010. These and other initiatives being planned are likely to contribute to the reform process.

Health-care reform is a long process and countries and WHO/SEARO will work jointly toward this goal in a spirit of partnership. He assured the countries that WHO/SEARO will respond positively to requests from countries for providing technical assistance to further the process of health-care reform. He then declared the regional meeting closed.
Annex 1

Health Care Reform for the 21st century in the South-East Asia Region: A strategic framework

Preamble

The overarching goal of health systems and health care is to promote, restore and maintain health in an equitable manner. This includes efforts to influence determinants of health as well as more direct activities to improve health. Health care, therefore, encompasses promotive, preventive, curative as well as rehabilitative aspects.

However, efforts to improve health in an equitable manner face many challenges, i.e. socio-cultural, physical and economic. The issue of access to appropriate facilities in terms of distance, affordability and responsiveness is an example. A majority of people feel that health is precious, only when they are sick or their health is compromised. Health information is not easily accessible by the people, whether it is concerning health care, health technology, health promotion or disease prevention. On one hand, while health technology is so advanced that various organ transplantations are possible, and health science has successfully mapped genes; people are dying from easily preventable and curable diseases.

The quest for greater efficiency, fairness and responsiveness to the expectations of the people that systems serve have brought about three generations of health systems reforms in the 20th century. The first generation saw the founding of national health care systems and the extension to middle-income nations of social insurance systems in the 1940s and 1950s. However, by the late 1960s the rising costs of hospital-based care, its usage by the better-off, inaccessibility by the poor and rural population of even the most basic services heralded the second generation of reforms promoting primary health care as a means of achieving affordable universal coverage. In 1978 primary health care was adopted as the strategy for achieving the goal of Health for All, reinvigorating efforts to bring health care to people everywhere. The primary health care approach though adopted widely brought mixed results. Though community participation was one of the tenets of PHC, the movement focused almost exclusively on presumed health care
needs of the people and did not emphasize enough attention to their demand. Therefore, the third generation of reforms now underway in many countries is driven by the idea of responding more to demand, assuring access for the poor and emphasizing financing, rather than just provision within the public sector. Meanwhile, market-oriented health care was pushing the health system to be more skewed to medical care.

Recognizing that health systems need to respond better and faster to people’s demands and to the challenges of a changing world and that the values of the Alma-Ata Declaration to adopt the PHC approach to achieve, health for all (HFA) may respond to the people’s demand and expectations, the World Health Report 2008 emphasized the renewal of PHC with four sets of reforms. The reforms aimed to refocus health systems towards HFA are: (a) universal coverage reforms to improve health equity, (b) service delivery reforms to make health systems people-centered, (c) leadership reforms to make health authorities more reliable, and d) public policy reforms to promote and protect the health of communities.

A Regional Conference on Revitalizing PHC held in Jakarta in August 2008 reaffirmed that PHC is the right approach to strengthen health systems and address national health needs. Furthermore, a shift from a focus on service delivery to a developmental, people-centered approach keeping in mind the social, political and economic context was advocated.

There are many definitions of health system/health care reform. In general, health care reform is an effort to increase effectiveness, efficiency, accessibility and responsiveness of the health system in order to improve health equity.

However, most of the reforms undertaken in general and in developing countries in particular, are aimed at addressing these components of reforms with the focus on medical care. Thus, reform in financing of the health care is directed mostly towards achieving universal coverage of the population for curative and rehabilitative care i.e. medical care whereas very little, if any, reforms we are devoted to improve preventive and promotive care i.e. public health programmes without neglecting medical care. The same holds true of reforms in health workforce. The focus of reform in this area is usually on those who are working at the institutional level, leaving those who are based at the community level.

This strategic framework has been developed with a public health perspective. Although financing of health care constitutes a very important component of health care reform, this strategic framework does not discuss it at length. The reason is that many forums have been convened to deliberate on this issue and Member
countries have agreed to reduce out-of-pocket payment through pre-payment scheme either by adopting a tax-based or a social health insurance model. Reform in public policies is indispensable in any type of health care reforms; without this, the reform loses its legality leading to its premature failure.

A strategic framework for Health Care Reform for the 21\textsuperscript{st} Century in the South-East Asia Region should draw upon the recommendations of the important regional consultations and conferences and the challenges the Region faces. The current regional meeting will focus on four important areas. These are: policy, community education, empowerment and health workforce.

**What should be the aims of Health Care Reform for the 21\textsuperscript{st} Century in the South East Asia Region?**

The changes in our way of life brought about by urbanization, climate change, globalization, commercialization and information technology are creating opportunities and also have implications for population health. The changing nature of health problems and the considerable and often growing health inequalities between and within countries exert tremendous pressure on the already weak health systems. Therefore, health systems have to meet the challenges of the changing needs and reform to meet the expectations of the people.

Health care reform for the 21\textsuperscript{st} century, therefore, aims to achieve health for all through people centered equitable care, ensuring universal coverage and social protection eventually improving health status and health equity. In other words the vision for health care reform is a healthier population with good living and working conditions, healthy living environment, suitable housing, good personal health practices and coping skill, affordable health services accessible to all, and prevention of illness, injury and death.

There is a substantial body of evidence on the comparative advantages, in terms of effectiveness and efficiency, of health care organized as people-centred care. Despite variations in the specific terminology, its characteristic features (person-centeredness, comprehensiveness and integration, continuity of care, and participation of patients, families and communities) are well identified. Care that exhibits these features requires health services that are organized accordingly, with close-to-client multidisciplinary teams that are responsible for a defined population, collaboration with social services and other sectors, and coordinating the contributions of hospitals, specialists and community organizations\textsuperscript{4}.
The seven essential principles of people-centered care are:

1. **Equitable care.** In a global community where boundaries are disappearing, there should be no boundaries preventing people from the opportunity to improve their health.

2. **Engages all stakeholders.**

3. **Community empowerment.**

4. **Effective care.** Interventions should lead to better health outcomes, both quantitatively and qualitatively. This requires care, whether in the clinical or public health setting, to address the five key issues, namely, access, safety, quality, affordability and satisfaction.

5. **Evidence-based and empathic.** The people-centered approach requires health providers, organizations and systems to approach health care holistically, balancing the biomedical model with a humanistic perspective. Evidence and technology must be used within the context of compassionate and caring relationships that value people and the totality of their health experience and include provisions for emotional and psychosocial support. It mandates the restoration of connectedness in all health care interactions.

6. **Efficient care.** Health care provided in a coordinated and timely manner. Waste should be minimized.

7. **Ethical.** Grounded in a respect for human rights and recognition of the integral role of health for human development and happiness, the people-centered approach invokes transparency and accountability.

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**Major challenges for health care in the South-East Asia Region**

South-East Asia is home to 26% of the global population. In 2004 the estimated population of the Region was 1.672 billion. Of these about 30% were below the poverty line. Many were in inaccessible rural areas and in urban slums. The Region faces the double burden of disease and effects of climate change.

The major health care challenges are: high disease burden, low health expenditure – particularly public health expenditure, and weak and inefficient health systems.
1. High disease burden

As per 2004 estimates, the SEA Region accounts for over 29% of the disease burden in terms of disability-adjusted life years (DALYs) lost and over 26% of the mortality worldwide. A further analysis of the burden shows that 41.7% is due to communicable diseases, maternal and perinatal conditions and nutritional deficiencies (Group I conditions); 45% due to noncommunicable conditions (Group II conditions); and 14% due to injuries (Group III conditions).\(^a\)

Of the total estimated deaths in 2004 in the Region, 37% were due to communicable diseases (Group I conditions) followed by 50.4% due to noncommunicable diseases (Group II conditions) and 25% due to injuries (Group III conditions). In this Region 24% of deaths were in children aged less than 15 years compared to 8% in the low- and middle-income countries of the Western Pacific Region\(^b\).

WHO projects that over the next 10 years, 89 million people will die from chronic diseases in the Region, while deaths from infectious diseases, maternal and perinatal conditions, and nutritional deficiencies combined would decrease by 16% and deaths from chronic diseases would increase by 21%\(^c\).

2. Weak health systems

Health systems are weak and fragile in many countries of the Region. Some of the responsible factors are outlined below:

(a) Weak public health services particularly in health promotion and primary prevention

When death due to noncommunicable diseases has surpassed death due to communicable diseases, there is an urgent need to give more attention to health promotion and disease prevention. There are three levels of prevention: primary, secondary and tertiary. Primary prevention inhibits the development of disease before it occurs. Secondary prevention halts the progression of a disease at its

\(^a\) Group I: Communicable, maternal, perinatal and nutritional conditions; Group II: Noncommunicable diseases; and Group III: Injuries

\(^b\) (a review of The Global Burden of Disease: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020 editor: Christopher J L Murray and Alan D Lopez)
incipient stage and prevents complications. Tertiary prevention attempts to reduce resultant disability and restore functionality\(^8\).

The “Iceberg of Health Problems” depicted in Figure 1 illustrates where we currently stand in terms of health promotion and primary prevention\(^9\). Our health care priorities are driven by “what we can see” i.e. the declared morbidity which constitutes only 10% of the iceberg of health problems. The larger part of the iceberg (90%) which “we can not see”, which is the domain of public health and PHC doesn’t receive its due attention. It is this part of the iceberg that is important to deal with if we want to reduce the disease burden.

\textbf{Figure 1}

\begin{center}
\includegraphics[width=0.5\textwidth]{iceberg.png}
\end{center}

We are dealing with undeclared morbidity, silent diseases, known risk and vulnerability only partially, e.g. health promotion efforts and primary prevention tools like immunization and vaccination. A lot of research is needed in these areas particularly to address unknown risk and vulnerability.
(b) Mismatch of health workforce

The major focus in most Member States of the Region is to rectify the disproportion of health personnel working at the institutional level for medical care vis-à-vis the community level workers including health volunteers delivering public health services. There are problems of skill-mix to provide quality care and task-shifting in times of changing needs. Other mismatches include insufficient attention to involve the workforce from other sectors or disciplines beyond health.

There is also a problem of distribution of the health workforce, e.g. concentration in urban areas. This matter is further aggravated by continual external and internal migration.

The health workforce accounts for 40% to 50% of total health expenditure in the Region.

Shortages of health professionals and a lack of systematic deployment and incentives policy are increasingly being observed in some countries in the Region.

The greatest shortage of healthcare professionals, in terms of numbers, is in Bangladesh, India and Indonesia. However, in relative terms, countries such as Bangladesh, Bhutan and Timor-Leste have the lowest levels of skilled health-care personnel, each with less than 20% of births attended by skilled health staff. This is due to the inequity of health workforce distribution as well as the low small business administration (SBA) utilization due to the technical and socio-cultural barriers in the community. Meanwhile, countries with the lowest relative need have the highest number of health workers.

Another challenge is training in both pre-service and in-service areas especially for community-based health workers that have less opportunity for in-service education.

(c) Fragmented health care without referral back up

Most public health interventions (health promotion and disease prevention) are delivered at the primary level of care. The referral care concept assumes that there is a continuity of care from the individual and primary level of care at the community supported by medical care at the hospital. For example, if a delivery ends up with haemorrhage; to save her life, the woman should quickly be transferred to a hospital for blood transfusion and Cesarean section. However, in
most Member countries in the Region, the woman faces three delays; no access to good midwifery care at community level, cannot be transported quickly to the hospital and once she reaches the hospital, does not get immediate care (like blood transfusion) let alone Caesarean section. That is why even while the number of skilled birth attendants and the skilled birth attendant rate is rising steadily, the reduction of maternal death rate is not as high as expected.

Excessive specialization of health care providers and the narrow focus of many disease control programmes fragments health care and services, particularly for the poor. Realizing that development aid adds to this fragmentation by financing certain disease programmes only, many global health initiatives like the Global Fund and GAVI are providing health systems strengthening windows while financing the programmes. Efforts are essential to provide continuity of care through a holistic approach.

Continuity of care from the individual and primary level in the community to medical care at the secondary and tertiary levels is crucial to support public health programmes (health promotion and disease prevention). Failure to do so may result in improper perception of primary health care i.e. primary health care as low quality care for the poor and the rural population. Therefore, the link between the primary, secondary and tertiary levels of care through a proper referral backup is essential.

3. **Imbalances in health expenditure**

Out-of-pocket payments (OOP) constitute the largest share of total health spending in the Region. This is a key constraint on the systems goal of equity and efficiency. Systems that rely on OOP as the main financing mechanism are not able to direct available resources to priority areas nor influence type, cost or quality of service provision.

Conceptually as well as from country experience, the most equitable means to financing is through government revenues. However, in low-income settings, the volume of public resources available for health is often severely limited. As Table 1 shows, health expenditure depends on private expenditure. Total expenditure as a percentage of GDP is only 3.4% and per capita government expenditure on health was only 29 US dollars in 2006.
Table 1: Health Expenditure in the South-East Asia Region in 2000 and 2006

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2000</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total expenditure as % of GDP*</td>
<td>3.6%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Private expenditure on health as % of total expenditure</td>
<td>72%</td>
<td>66.4%</td>
</tr>
<tr>
<td>Per capita total expenditure on health (PPP int $)</td>
<td>$58</td>
<td>$85</td>
</tr>
<tr>
<td>Per capita government expenditure on health (PPP int $)</td>
<td>$16</td>
<td>$29</td>
</tr>
</tbody>
</table>

Source: World Health Statistics 2009
*WHO recommends a minimum 5% of GDP

The minimum expenditure recommended by the Commission on Macroeconomic and Health is $34 (PPP int $) for essential interventions comprising of HIV/AIDS/TB/Malaria, childhood infectious diseases, maternal and perinatal conditions, micronutrient deficiencies and tobacco-related illnesses.

But, whatever minimal health expenditure is incurred it is also usually skewed to medical care resulting in public health (preventive and promotive) programmes getting much less than its required despite clear evidence in the ability of such programmes to significantly reduce disease burden. Further, in most Member States of the Region there is evidence of allocative and technical inefficiency that makes the limited funds available even less effective.

Strategic framework for health care reform

The challenges of a high disease burden, weak health systems and low public health expenditure accompanied by inefficiency require comprehensive health care reforms. A strategic framework for health care reform as outlined in Figure 2 would address major aspects of the challenges from a public health perspective. It

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* Allocative inefficiency occurs when more health funds are allocated less cost-effective interventions — for example, allocating an unnecessary or high proportion of funds to medical care as opposed to public health interventions. Overall, public health interventions (disease prevention and health promotion) are more cost effective than medical care (treatment of cases and rehabilitation of disabilities).

Technical inefficiency occurs when we choose sophisticated technologies instead of available appropriate technology or choose unnecessary sophistication, also when tasks that can be done by relatively less trained health care providers are done by highly trained workers and specialists.

(adapted from “Frequently asked questions”, meeting paper in the Regional Conference on PHC revitalization WHO SEARO 2008)
encompasses four components namely: public policy, health workforce, education and community empowerment. This, however, is not all inclusive. Other aspects like the all important health financing which would be a major component of any reform is not discussed in detail as many forums have been convened to deliberate on this issue.

**Figure 2:** Strategic Framework for Health Care Reform for the 21st Century

- Improved Health Status + Equity
- Universal Coverage + Social Protection
- People-centered care

### Governance
- Health policy
- Healthy public policies
- Decentralization
- Public-private partnership

### Health Work Force Management
- CBHW + CHV
- Education and training
- Multidisciplinary health team

### Community empowerment
- Education
- Volunteers as change agent
- Link to income generation

### Public health institutions and networks
- Innovative education
- ICT in education and training

### Health Systems Challenge
- High disease burden
- Low health expenditure
- Weak health system
- Inefficiency

1. Governance including health policy, healthy public policies, decentralization and public-private partnership

Governance involves overseeing and guiding the whole health system, private as well as public, in order to protect the public interest. It requires both political and technical action, to reconcile competing demands for limited resources in changing circumstances of rising expectations, more pluralistic societies, decentralization or a growing private sector.
Health policy

A reform in health care may have the connotation of reform for the care of the sick population. It needs to be reiterated that the emphasis should be on the care of the whole population through promoting health and preventing diseases by reducing risks with an appropriate balance between curative and rehabilitative care.

Reforms in public policy comprising of health policy and healthy public policy are key considerations for health care reform for the 21st Century. Reforms in public policies are indispensable to improve health care. The important health policies and healthy public policies that can influence the performance of health care are outlined below.

(a) Universal coverage and health care financing policy

The way health is financed is a key determinant of equity and the efficiency of a health system, particularly its capacity to provide universal coverage.

Restructuring health financing through appropriate reform, including an associated review of relevant links with other systems building blocks, is an effective means of progressing on universal coverage. Three ways of doing this based on publicly-guided health spending are:

- increasing the population covered by subsidized care;
- increasing the proportion of total cost of care that is subsidized; and/or
- increasing the types of services included in the benefit package.

The health spending itself will need to be funded from government revenues with possible supplements from alternative pre-payment contributory schemes like social insurance which complement the goal of social protection. Thailand provides a good example of the use of health financing reforms to phase-in universal coverage as outlined above.

In general, health expenditure as a percentage of GDP and total health expenditure per capita in Member States of the Region needs to be increased. Third-party payment through health insurance is preferable to user fee/out-of-pocket expenditure. National Health Accounts (NHA) continues to be an important mechanism for data collection and health policy-making. It is also indispensable for
monitoring and tracking outcomes of health sector policies. Therefore, NHA needs to be urgently institutionalized.

**NHA experience**

Some constraints to NHA institutionalization are: understanding the link of NHA to policy use, absence of political will, lack of participation by non-government actors, low technical capacity, lack of resources and absence of clear strategy on institutionalization. Institutionalization of NHA requires putting institutional arrangements (e.g. regulations, committee), systems (e.g. reporting system, human and physical resources) and processes (e.g. tools for data collection, analysis and interpretation) in place such that it is used routinely to collect, present and disseminate validated financial information on health using the internationally accepted NHA tool.

As highlighted, in the Region out-of-pocket payments constitute the largest share of total health spending. OOP causes inequities in access to care and inequities in health status. The challenge is to shift OOP expenditure to mechanisms that provide social protection, especially for the poor.

A mixed financing mechanism anchored in government revenues and supplemented by contributions to a social insurance pool would appear to be a viable option to meet the equity challenge of OOP payment. Moreover, these alternatives have the potential to improve efficiency of both state and non-state service provision in line with national goals through strategic purchasing mechanisms like provider payments and contracting.

As regards health insurance, tax-based health insurance and social health insurance are the most equitable insurance schemes. In addition, for the haves, private health insurance can supplement the former schemes for additional benefits and better amenities. Community health insurance usually prevails in small communities with a limited benefit package.

It must be recognized that policies that put medical care high on the health agenda will result in much higher budget allocated to medical care than for public health leading to allocative inefficiency. Medical care that is usually high-tech intensive can also lead to over-sophistication of care resulting in technical inefficiency.
Decentralization

Decentralized systems facilitate health service delivery suited to local needs and have been identified as a means of achieving health equity through many reform initiatives across the world. There are different forms of decentralization described in literature, such as de-concentration, devolution, delegation and privatization**

The need to have effective management of decentralization of health care within the context of national health sector reforms and ensuring equity in access to health care was the background of a resolution titled “Decentralization of health care and strengthening district health systems to ensure equity in access and

** Decentralization—is seen as a process in which the authority resources and functions are transferred from the central government agencies to other institutions at the periphery of the national system with decision making largely vested with the people. The following are various forms of decentralization:

1. **De-concentration** involving shifting of workload or expertise without decentralizing the decision-making power from the central government to regional or district offices within the structure of the Ministry of Health. Since de-concentration involves the transfer of administrative rather than decision-making power, it is seen as the least extensive form of decentralization; it has been the form most frequently used since the early 1970s. For the Ministry of Health it implies imbuing local (for example district) management with clearly defined administrative duties and a degree of discretion that would enable the local officials to manage without constant reference to ministry headquarters.

2. **Delegation** refers to transfer of functions and responsibility to the local level to achieve greater efficiency by increasing cost control, flexibility and responsiveness. The ultimate responsibility remains with the central government, but its agents have broad discretion to carry out its specific functions and duties. In the health field delegation has been used to manage teaching hospitals, for example. Delegation has also been used to organize the provision of medical care financed by social insurance. Delegation is not compatible with de-concentration. If the management of entire national health services is delegated to a separate organization, the role of the ministry of health would be confined to strategic and policy issues.

3. **Devolution.** In the stricter sense is the closest to the complete form of decentralization, in which the lower levels, with respect to resource control, policy formulation, implementation, monitoring and evaluation, achieve autonomy. Devolution is the creation or strengthening of sub-national levels of government that are substantially independent of the national level in respect to a defined set of functions. They normally have a legal status, recognized geographical boundaries and a number of functions to perform. To raise revenue and control expenditure in the health sector devolution implies much more radical restructuring of the health service organization than de-concentration.

4. **Privatization.** Involves the transfer of government functions to voluntary organizations or to private profit making or non-profit making (or NGO) organizations with a variable degree of government regulations. Since many governments cannot afford any major expansion of health services, even maintaining existing services, they need to seek alternative sources of financing and service provision. Financing mechanisms may include free service delivery by nongovernmental organizations, indirect or third-party payment in the form of various insurance schemes or increase direct consumer payment or “cost recovery” (though with substantial public funding), while the options for service delivery may involve NGO and voluntary organizations providing services or greater reliance in the private sector. Privatization can range in scope from leaving the provision of goods and services entirely to the market to “public-private partnerships” in which government and the private sector cooperate to provide services or infrastructure.

(Source: Technical discussions on management of decentralization of health care SEA/PDM/ M ee.t.39/TD/1.3 26 August 2002)
efficiency of quality health care” adopted by the WHO Regional Committee for South-East Asia in 2002.

Most countries in the Region have adopted decentralization. However, it has to be remembered that decentralization is a policy tool rather than an end in itself.

(c) Public-private partnership (PPP)

A large and varied private sector plays a dominant role in health care in the South-East Asia Region - in terms of both financing and provision of services. Evidence indicates that households in the Region rely on private provision even for essential services like maternal and child health care; and, that this is financed through high OOP payments – more so than anywhere else in the world. However, much of this activity is unregulated and does not contribute effectively to the national health agenda.

Poor people use private providers because of shorter distance, more flexible hours, shorter waiting times, better quality or greater availability of medicines than in public facilities, despite the direct costs they have to pay.

Where the role of the private sector is already large, the relative costs and benefits of effective engagement for universal coverage compared with scaling-up public provision is an option for serious policy consideration. Such mixed strategies would need appropriate modalities for partnership and new capacities to be developed on both sides.

Government capacity in strategic engagement of the private sector in health was discussed and a resolution adopted by the sixty-second session of the WHO Regional Committee for South-East Asia in September 2009.

Laws, regulations and rules to encourage or restrict providers or protect clients, set the standards, allocate the resources and define the package, licensing and registration of facilities, accreditation and involvement of professional organization/council need to be considered. India's experience of public-private partnership in TB control is a good example.

Healthy public policy/health in all policies

Health in all policies or healthy public policy in other sectors' policy can have a positive health impact. For example, a higher tobacco tax will increase revenues as
well as help improve the public health. An effective poverty reduction strategy, a
food safety policy, an environment policy, population policy and an effective
female education policy will also help improve health. Healthy public policy has
been advocated since the Ottawa Charter in 1986 though without satisfactory
results.

Health Impact Assessment (HIA) has been developed to facilitate healthy
public policy at all levels – community, national and international levels.

Social Determinants of Health (SDH)

Societies that enable all citizens to play a full and useful social, economic and
cultural role will be healthier than where people face insecurity, exclusion and
deprivation. Good health involves reducing levels of educational failure, reducing
insecurity and unemployment and improving housing standards.

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<tr>
<th>Classic determinants of health</th>
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<td>Income and social status</td>
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<td>Social support networks</td>
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<tr>
<td>Education and literacy, e.g. health literacy</td>
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<td>Employment/working conditions</td>
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<tr>
<td>Personal health practices and coping skills</td>
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<td>Healthy child development</td>
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<td>Health services</td>
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<td>Gender</td>
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<td>Culture</td>
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(Source: Ilona Kickbusch et al “Policy innovations for health” 2009)

Preparing adequately for new health challenges – such as obesity and to
address the changes already under way, societies need to constantly rethink their
approach to health policy. Health sustainability is as important as environmental
sustainability. Policy innovations for health are needed to address the classic
determinants of health, such as education, work, housing, transport and particularly equity.

It is now well understood that SDH is the root cause of inequity in health. Therefore, **healthy public policy or health in all policies** is crucial to address the root causes of ill health since it will improve the conditions under which people live and have a positive impact on the health of the people.

Health in all policies is a manifestation of multisectoral collaboration forged through partnership, setting aside sectoral egoism and protection of profession.

Various initiatives have been taken to advocate healthy public policies. In the South-East Asia Region, the Prince Mahidol Award Conference in January 2009 had the theme “Mainstreaming Health into Public Policies”. This is another notion for promoting healthy public policy.

### Health policy reform experiences

**Latin America experience:** The social policies that have developed in most Latin American countries are rooted in a similar development model. They are responsible for some of the most significant features of the relationship between state and society, as well as for incorporating a particular power structure into an institutionalized system. This pattern of structured social interactions is manifested in the following characteristics of the health sector:

- stratification and/or exclusion of certain population groups;
- fragmentation of institutions;
- a narrow and fragile financial basis, relying mainly on contributions from salaries; and
- strong actors with vested interests represented in the political arena. The demand for health care reform arose when it became apparent that this pattern was incompatible with expanding the coverage, increasing the efficiency, and improving the quality of health care services in a context of financial shortage. Moreover, the movement of Latin American societies toward more democratic and pluralistic political regimes strengthened the demand for reforming the state and its traditional links with different groups in society.
In the Asian context, the economic crisis resulted in policy change for Indonesia where a "social safety net" was introduced into the system. In Thailand, the political context where a populist government supports a prepared health care reform movement led to a surge of universal health care coverage.

In Thailand, previous experience (existing Thailand’s public risks protection scheme when universal coverage /UC was introduced: Civil servant medical benefit scheme, Low income card scheme, voluntary health card scheme and social security scheme) investment in health care was essential for implementation of the UC scheme. Over several decades, comprehensive health care coverage had been achieved through developing infrastructure in rural areas, where two-thirds of Thailand’s population lives. Although beds (public and private) and doctors are concentrated in Bangkok, successive governments have built up primary health care centres (which do not have doctors or beds) in all sub-districts and community hospitals (10-120 beds) in more than 90% of districts. In addition, an effective administrative system meant that 45 million people could be registered under the universal coverage scheme within four months.

In 2001, Thailand greatly expanded government-funded coverage to the uninsured through implementation of its “30 Baht health scheme.” The programme’s goals were to provide equal access to quality care according to the individual’s needs, regardless of income and socioeconomic status. An important aspect of this plan was that no individual would be required to pay more than 30 baht (about US$0.84) per visit for either outpatient or inpatient care, including drugs. Each person must register with a public health unit (that is, a health centre or community [public] hospital) in his or her residential area and use it as a primary point of contact before getting a referral for secondary care (that is, at a provincial hospital). This primary care unit functions as a gatekeeper and helps control the cost of medical care. The latest finding was that this social insurance has added nearly 14 million people to the system and achieved near universal coverage without compromising access for those with prior coverage and no informal payment system (no other payment need to be made by the clients) has emerged.

Indonesia’s health care reform was an adjustment to a decentralization policy launched by the government in 1998-1999. It coincided with an economic recession that triggered government changes with public demand for reform. The essential new component introduced was increasing health care access for the poor.

Despite a substantial increase in public health spending in recent years, overall health spending in Indonesia remains low and continues to be inequitably distributed between and within provinces, while analysis also reveals major inefficiencies. Often significant resources at the local level remain unspent, while the need for health spending remains high.

Within the current civil service and decentralization regulations, local governments have limited authority in managing their staff. The current fiscal transfer formula contains a fiscal incentive to expand staff levels. This has led to substantial increases in the number of teachers and is likely to be having a similar effect on health sector staffing. Lack of local authority and accountability hinders the development of a more efficient and well-distributed health...
workforce at the district level, resulting in some health centres being overstuffed while others face staff shortages.

The government’s Askeskin health programme for the poor aims to protect both poor and near-poor households from catastrophic expenditures and, despite inefficiencies and mis-targeting, appears to be achieving results. Between 2005 and 2006, the share of people sliding into poverty due to healthcare spending declined from 1.2% to 0.9%.

Increasing health spending, decentralization and the Askeskin programme have yet to translate into clearly improved health outcomes. In part this is due to a lack of demand resulting from shortcomings in health literacy and relatively high non-medical costs (opportunity and transportation costs, as well as user fees). It is also due to inefficiencies in the health system itself, such as high levels of absenteeism and shortcomings in health workforce education, together with low quality infrastructure and geographic disparities.

However, poor health outcomes are also a consequence of weakness in Indonesia’s public financial management, including difficulties in making investments early in the fiscal year and stronger incentives to hire staff than invest in operations and maintenance. Last but not least, low levels of spending on other determinants of health outcomes — such as improved water and sanitation, female literacy and early child nutrition — is also a crucial factor in Indonesia and adversely affects health outcomes17.

2. Health workforce development and management

Health workforce includes private as well as public sector health workers, unpaid and paid workers and lay and professional cadres. There is a strong correlation between health workforce density and service coverage and health outcomes. To have a workforce which is available, competent, responsive and productive, training programmes need to be designed well, production capacity needs to be scaled up, the workforce organized well for an effective service delivery at the different levels (primary, secondary and tertiary) of the system and workers retained within the dynamic local and international labour markets18.

As a strong human infrastructure is fundamental to face the current as well as future health care realities, the way the health workforce is trained, deployed and managed is crucial to meet the challenges of the 21st century. The role of the individual, community and sectors other than health needs to be recognized and advocated.

Doctors, nurses and health professionals are important in the health system. Till date planning and education/training of the health workforce is prioritized more on those working in institutions doing mainly curative and rehabilitative care. This
trend should be reversed. The focus should be on training and involvement of the frontlineers, community-based health workers and community volunteers.

One human resource strategy to tackle the health workforce crisis and maximize capacity to provide HIV prevention, treatment and care services is task-shifting, which entails delegating specific tasks, where appropriate, from highly qualified health workers to other health workers. In 2008, 49 of 93 reporting countries (53%) indicated that they had developed policies to address human resource shortages through task-shifting strategies. In sub-Saharan Africa, the corresponding percentage among reporting countries was 63%. Evidence is growing on the experience and results of scaling up task-shifting approaches. A recent article reviewed current evidence and concluded that task-shifting can improve access to, coverage of and quality of health services at comparable or lower costs than traditional delivery models. However, such approaches require political and financial commitment and careful attention to health service organization. Another article describing the experience of Médecins sans Frontières in using task-shifting in efforts to scale up antiretroviral therapy in Lesotho, Malawi and South Africa noted that the strategy had enabled increased access to life-saving treatment, improved the workforce skills mix, increased the efficiency of health systems, enhanced the role of communities, saved costs and reduced attrition and international brain drain. However, it also drew attention to the ongoing challenges of maintaining quality and safety, addressing professional and institutional resistance and sustaining motivation and performance. Concurrently, evidence is emerging that lessons learned from task-shifting in HIV are being applied in other settings as a means to cope with health workforce shortage. For example, given the enormous shortage of surgeons and anesthesiologists in Africa, efforts have been made to shift tasks in the area of surgical services\textsuperscript{19}.

Further, other categories of the workforce like epidemiologists, nutritionists, entomologists, statisticians etc. and workforce from other disciplines such as sociologists, anthropologists, psychologists and economists are important to mount a multidisciplinary and multi-sectoral health team.

(a) **Community-based health workers (CBHWs) and community health volunteers (CHVs)**

CBHWs are health care workers who are part of the formal health organization, and have undergone formal training to carry out a series of specified roles and functions, spend a substantial part of their working time actively reaching out to the community, discharging their services at the individual, family or community level.
They may be doctors, nurses, midwives, public health inspectors or family health visitors.

CHVs are usually people who live in the community and volunteer to do the work for the community or were selected from communities and are answerable to the community. They undergo shorter training than professional workers, do not receive salaries, but may receive financial and other incentives. They are predominantly involved in health promotion and prevention of health problems, supported by the community and the health system but are not necessarily a part of its formal organization. In some countries, CHVs are basically village members who work on a voluntary basis and are called village health volunteers.

CBHWs and CHVs play a crucial role in the health of the individual and community particularly in rural and hard-to-reach areas, promoting community and population health through provision of primary health care. They are also a bridge between the community and the formal health services. They have been involved in excellent community work and need to be recognized and promoted. Their inputs have been invaluable in facing emerging diseases and emergencies.

(b) Education and training

Education and training has a central role in producing appropriate health workforce, in terms of both numbers and skills, to scale up coverage of health care. To facilitate this, innovative approaches in education and use of ever developing technology need to be explored and adopted.

(c) Multidisciplinary health team

Utilization of a multidisciplinary health team (e.g. sanitarian, nutritionist, statistician, sociologist, anthropologist, traditional health practitioner) in the delivery of health care service can make a difference, especially in remote areas where there is a shortage of doctors and nurses.

There are potentials to resolve the shortage and uneven distribution using the task-shifting approach. Task-shifting can be delegation of work to less specialized workforce to perform services for particular groups of people (such as care for AIDS patients at the community), as well as a specific targeted procedure to reach the necessary coverage (such as mass cataract operation or sterilization for family planning).
Training and team support is the key back up. However, there are many challenges particularly challenges from the specialized workforce, litigation for malpractice as well as insurance coverage. Wider challenges in relation to the recruitment, deployment and retention of all categories of this workforce in the light of revitalizing primary health care should also be anticipated.

3. Community empowerment

Individuals and the community need to be empowered to achieve people-centered health care or for health care to adopt a developmental approach rather than the service approach. Literacy/education combined with income generation play a crucial role in community empowerment.

Thailand’s experience with the Strategic Route Map (SRM) illustrates this approach, moving from health for all to quality of life for all. If people are properly empowered, they are able to identify problems of the community, identify strategies to tackles the problems and implement those strategies or actions themselves.20.

(a) Education

One of the important factors in empowerment is education. Community education can flourish with a certain enabling environment. Access to information through various channels radio, television, newspapers, social network through internet, will improve community knowledge and practice to respond to the new challenges. Undoubtedly, literacy in all sectors of the population plays a crucial role in individual and community empowerment.

(b) Volunteers as change agents

Community health volunteers can be effective change agents because they are from the community, understand community cultures, beliefs and practice and the community trusts them and are willing to listen and follow their advice.

India’s experience in the use of community volunteers in excluded communities to provide nutrition and other health programmes and services demonstrates the potential of community volunteers as behaviour change agents supported by intensive communication and regular capacity building. Another
experience in Jamkhed, India, for health promotion through multi-sectoral approaches mobilized the community for development, emphasizing the beneficial traditional practices and eliminating harmful ones\(^1\).

There are also experiences in the developed countries of successful hypertension and screening programmes supported by volunteers as behaviour change agents\(^2^2,2^3\).

(c) Link to income generation

Community empowerment in health is also linked to community schemes for income generation. The Bangladesh Rural Advancement Committee (BRAC) uses a micro-credit scheme for poverty alleviation and empowerment of the poor. The micro-credit scheme provides inputs for development including in the health area\(^2\).

In India, SEWA’s Vimo scheme and design innovation encompass a cashless payment mechanism to promote quality health care services and equity for members. SEWA’s preventive and promotive health activities are fully integrated within the insurance programme, a unique approach to promoting primary health while improving programme efficiency\(^2\).

4. Public health institutions and networks

Public health institutions and networks have a very important role in health care reform. In many Member countries public health institutions are yet to be developed.

At the district level public health institutions include the district health office and their infrastructure: the district hospital, district public health laboratory, health centres and their networks.

At the state/province or sub-national level, public health institutions are state/province public health offices, school of public health and public health referral laboratory.

Public health associations at the district, sub-national and national levels as well as the public health autonomous bodies are in a dynamic relationship, a network with the public health institutions.
Public health institutions based on their level and role play a major part in health equity. Innovative education, use of technology and research will enhance the development of human resources that are required to reform health care.

(a) Innovative education

Innovative education would empower the health workforce, in pre-service as well as in in-service training. In this context, education and training may be imparted in decentralized settings and focus on improving district health systems. Training should cover managerial, communication and behaviour intervention aspects that ultimately lead to people-centered care or responsive health care.

The issues that education and training face currently are quality assurance of the training, inappropriate settings and methods, and availability of teaching staff with field experience.

Distance learning can be a useful mechanism for health workers’ pre and in-service training.

Medical schools and departments of preventive and social medicine/community health/community medicine also need to reform their curricula and teaching methods to produce graduates with appropriate public health knowledge and skills.

Public health education can be improved by collaboration and networking among public health institutions. In the Region, the South-East Asia Public Health Education Institutes Network (SEAPHEIN) is a platform to share experiences and best practices to support public health education development.

(b) Use of information and communication technology

There is potential for the use of information and communication technology (ICT) for health workforce education, training and health care delivery. The internet can be useful for sending timely reports. It has a potential for telemedicine, and teleconference. Even the mobile phone can be used to improve communication using short messages or twitter.
However, internet is not yet effectively used in countries of the Region. Some challenges and constraints to include are level of computer literacy, computer accessibility and the limited capacity in using English.

(c) Role in education, training and research

Public health institutions and networks have a crucial role in education, training and research reform. Public health workers can be trained at the district health office for capacity building on data collecting and data analysis. Public health school students can join socio-economic surveys or household survey; they can learn the process of health rules and regulations in parliament. Service availability mapping is one of the ways of practical training to identify the gaps of health service access to improve health service equity.

On the other hand if public health institutions and networks are active in education, training and research (particularly operational research), there will be stronger case with the data collected and analyzed for the decision makers to use.

Conclusions

The strategic framework discussed above covers the following:

1. Governance

The central role of governance in improving performance of the health systems has been universally acknowledged. It follows that successful reforms in governance will undoubtedly support other areas of reforms in bringing about desired outcomes.

The emphasis should be on the care of all population through promoting health and preventing diseases by reducing risks with an appropriate balance between curative and rehabilitative care.

Reforms in health policy including in resource allocation is of utmost importance to achieve an appropriate balance in terms of financial and human resources for public health programmes and medical care.

Decentralization will further improve the efficiency, effectiveness, and responsiveness as well as referral system of the health care delivery.
Healthy public policy or health in all policies is indispensable to attain sustainable health and in properly addressing social determinants of health.

Sustained advocacy along with consistent implementation of healthy public policy or health in all policies is indispensable in light of the current efforts in incorporating social determinants of health to attain sustainable health development.

Improved engagement with the private sector will contribute to the achievement of universal coverage.

2. Health workforce management

Advocacy for a change in emphasis for better planning of production, deployment and retention of health workforce toward those based at the community level instead of health workforce working in institutions is required.

A multidisciplinary health team that includes disciplines from outside the health sector such as sanitation, sociology, anthropology, psychology and economics is indispensable in health care reform in general and in reform where the emphasis is on public health programmes in particular.

Task-shifting is a good means to maximize use of scarce human resources and scale up health care.

3. Community empowerment

Community empowerment is very important in efforts to move from a service delivery approach to a development approach within the context of PHC revitalization.

Women are central to community empowerment.

Appropriate education level and sustained income generation schemes are pre-requisite for attaining community empowerment in health.

Empowerment includes role in decision-making, application of self-care and traditional medicine and to become a change agent.
4. Public health institutions and networks

Public health institutions and networks have an important role to play in health care reform.

Public health institutions and networks can lead to innovative approaches in education and in the use of information and communication technology.

Public health institutions and networks can also carry out operational research for informed policy decisions for implementing health care reform.

Successful reforms in governance, health workforce, community empowerment, public health institutions and health care financing will ultimately result in more responsive or people-centered care and improved health status in an equitable manner.

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Annex 2

Panel A

Governance: Health Policy including resource allocation, Healthy Public Policies, Decentralization of Health Services and Public-Private Partnership

Dr Somsak Chunharas, Secretary-General, National Health Foundation, Thailand

Introduction

Health-care reform refers to efforts/movement in various countries aiming at improving different aspects of health systems (efficiency, equity, responsiveness, etc). It has different specific meanings and encompasses different aspects depending on countries context and situation. On the whole it is more about health-care delivery system rather than the broader concept of health system that goes beyond health-care delivery.

In most western countries with established health insurance for the majority of the population, health-care reform was mostly about improving the health insurance system in at least two aspects, increasing access/coverage and cost containment, i.e. improving equity and efficiency. The term was popularized by the movement in the United States to cover the uninsured, especially during the Clinton’s administration. It became well-publicized internationally again under the Obama administration after the election coupled by economic crisis in 2008. Many European countries also attempted health-care reform in different aspects. For example, the United Kingdom emphasized on reducing waiting time at the referral level and quality of care. France, Germany and the Netherlands attempted cost containment to better cope with the high cost new technologies and changing demography.

For countries in Asia, especially those in WHO’s South-East Asia Region, major health-care reform agenda has not been about improving health insurance coverage, mainly because most countries in the Region did not have health insurance for a majority of the population, neither financed by tax nor through individual contributions to a social security system and
private insurance. The most common issue of health-care reform is about health system reorientation based on primary health care (PHC) with emphasis on community participation. Many countries have put efforts into expanding health coverage through the development/ improvement of health systems based on PHC, such as community-based health workforce development\textsuperscript{iii}, introducing users' charges, improving health information systems, etc\textsuperscript{iv}. Certain countries have gone to the extent of introducing universal health-care coverage to their populations', bringing the agenda of health-care reform to the attention of those looking after the overall fiscal health of the countries for fear of not being able to meet the open-ended nature of demand for health-care. Another more recent aspect is decentralization in health brought about by general administrative reform in certain countries such as Indonesia\textsuperscript{vi}, the Philippines\textsuperscript{vii} and Thailand\textsuperscript{viii}. The other aspect is multisectoral actions for health introduced since the Alma-Ata Declaration\textsuperscript{ix}.

This last aspect of health-care reform (multisectorality and health) is one of the important trends of health (care) reform that is worth exploring further, especially for countries in SEAR. On the one hand it could focus mainly on how the health delivery system can work more closely with other sectors and thus multisectoral “collaboration” could be the focus as mentioned in the Alma-Ata Declaration. On the other hand, it can be about how other sectors can function differently to have positive impact on health. Such a concept of “multisectoral actions for health” was usually referred to as “healthy public policy”, introduced in the Ottawa Charter on Health Promotion since 1986\textsuperscript{x}. More recently the need for involving other sectors was highlighted through the report of the Commission on Social Determinants of Health, with an emphasis on equity in health\textsuperscript{xi}. The needs for other sectors to understand health and reorient their policies for better health outcomes is becoming more and more evident and poses a real challenge for future health (care) reform. Introducing universal health insurance coverage as Thailand did in 2002, or comparable attempts in other countries in SEAR or WHO’s Western Pacific Region e.g. Philippines, China, Malaysia has shown clearly the need to get the ministry of finance or social welfare on board to create an effective, efficient, responsive and equitable system. Another model of health (care) reform effort involving the financial ministry is the attempt to introduce an earmarked tax through an excise tax on tobacco and alcohol to be used for health development\textsuperscript{xii}. This paper will discuss four main aspects of health reform pertinent to countries in SEAR, but go beyond the health-care delivery system. These are public
policy reform (especially tax for health finances), decentralization, private-public mix and healthy public policies through other development sectors.

Public Policy and health care finances

Health financing reform has been one of the common agenda items of health reform in most countries, whether they are trying to introduce or increase health insurance or not. Common approaches in health finances leading to changes in public policy about tax include establishing social security with health benefits as a part of the package, at least for those workers in the formal sectors; excise tax for health promotion or health development; and a national health insurance system using general tax money. There are another two forms of health-care financing that do not directly involve public policy about tax; users’ charges and community (revolving) funds. All these are either in addition to the existing “health sector budget” or can replace totally the existing health sector budget.

Most countries in SEAR depended mainly on the public sector as their health-care provider. Most of them are financed through annual budget taken as a part of the overall annual government budget. The proportion of annual budget for health services through the public sector varied from 1-7% of total government budget. Many countries also introduced users’ charges of varying degree as supplemental sources of financing for public sector facilities. There may be an exemption policy for certain groups of population too poor to pay for users’ charges. Some countries may also depend on external aids. For those seeking health-care in the private sector, they mainly pay from out-of-pocket for each individual visit.

Social security has been another sources of health-care financing for workers in the formal sector in those countries that have established a social security system as a public safety net to provide various public welfare related to work (in addition to health benefits). The types of health benefits offered depend on the premium collected, the proportion of counterpart contribution by the employer and the government, and the service purchasing model introduced by each social security system. In most countries in SEAR, this form of health-care financing covered only less than 50% of the population because a majority of the workers are still in the non-formal sector either as self-employed, agricultural workers, or working in settings where employers tried to save costs as much as possible by not providing social insurance.
Excise tax has been another form of tax enacted through explicit public policy to mobilize money for health actions. In most cases, it is only a small portion of the overall excise tax. For example, Nepal introduced excise tax collected to finance health services. Thailand imposed a 2% excise tax over alcohol and tobacco and set up a health promotion fund aiming at using the earmarked tax for health promotion activities and services. The Thai Health Promotion Fund has been successful in mobilizing civil society as well as various sectors other than health to participate actively in promoting health through various types of innovative actions.

General tax for universal health insurance has been introduced only in Thailand as a form of health-care reform since 2002. This gave the Thai people coverage by either one of the three systems of health insurance, paid fully or partly from general tax. The largest subsystem is the most recent system of “gold card holders” covering about 65% of the population (poor and non-poor) financed fully from general tax. It entitles the covered population to a reasonably generous health benefit package with few exceptions. It also allows them to use either public sector or private sector providers where available and applicable. The three insurance systems received different proportion of general taxes and are administered by three different organizations with varying knowledge and expertise in managing health insurance, not to mention different age and health risk mixes, and thus had different unit cost for their covered population. Some other countries introduced health insurance coverage for many groups of population financed by general tax, but the health benefits offered varied depending on the budget spent and the service purchasing model adopted. The prospective lump-sum payment on capitation basis to health-care providers based on an agreed size of population that will allow a reasonable economy of scale and risk distribution has been one of the commonly used models which has made cost containment easier to enforce, although the quality dimension has to be guarded carefully.

Community financing has been another form of health-care financing introduced mainly as a way to mobilize community participation, rather than as a way to mobilize a sizable of budget to pay for health services. There are a number of models of community financing for health, but most are set up without the need to change public policy on tax. The most common form of community funds was community revolving funds – quite popular during the early phase of the primary health-care movement. They are funds set up through individual contributions from community members for specific purposes such as sanitation improvement, nutrition, and drug
funds. They were managed by committees set up within the community. Thailand introduced health-care funds as a supplemental source of funds to offset financial barriers when using health services. This was discontinued when the universal coverage policy took effect. Community savings funds for health and welfare have been another common form of community funds aiming at providing welfare to its members. The types of welfare offered depending on the size of the fund and the policy set by the communities themselves. In general, community funds were used for activities and services taken within the community. Only certain types of community funds are used to pay for health services provided at the health facilities level. Community funds, thus, serve as an interesting tool to mobilize community participation, either to reduce financial barriers to care or to address health risks amenable to community-based interventions.

The choice of health-care financing and its implication for public policy on taxation will vary from one country to another. Such decisions would be facilitated by information on national health expenditure, which should be based on good national health accounts. For the time being, only a few countries in SEAR have a good national health accounting system. Existing health information systems do not include this as an integral part of the system. Data on national health expenditure could be a subset of a national account for GDP, which may not yield detailed information for proper health financing analysis and development of policy options. However, a good health accounting system is also quite complex and needs a specialized team to establish and maintain it. Apart from the relatively complex methodologies requiring use of multiple sources of data and estimation to yield an overall picture, the issue of institutionalizing for continuity is a big challenge for national health accounts.

The overall challenges in public policy dealing with financing for health include but are not limited to the following:

1. Universal coverage of health insurance will involve discussion about the roles of public finance, and thus macro policy on tax and health spending and the role of the public sector in health-care provision. Such discussion is complex and would require a good analysis of various alternatives as well as the existence of other sources of finances (such as a social security system and the present use of the health budget). Long-term feasibility and the possibility of cost containment is always an issue of concern and would need to be well analysed and planned.
(2) Introducing an earmarked tax is against normal fiscal practices, even for such services that have a relatively large proportion of “public good” characteristics, whether it is an earmarked tax for health insurance or an excise tax earmarked for health promotion activities.

(3) In those instances where available budget for health may make it possible for countries to introduce universal coverage of health insurance through changes in resource allocation (budget as well as manpower), it may be more feasible to start universal coverage without embarking on a debate about public finance policy in general. However, the critical component in making such changes is always the salary and status of those health personnel working in the public sector, which normally constitute a big portion of the overall health budget available and would make it relatively difficult to reallocate to meet universal coverage - especially if the main strategy is always to involve public private-partnership in health-care provision after the universal coverage policy.

(4) Community financing also requires clear public finance policy support. One of the common issues is whether the community fund is to be considered as another variant of a “bank-like” entity - or in the case of certain countries, another “cooperative” and thus subjected to “tax responsibility”. Most governments in SEAR encouraging community finance as a form to mobilize community participation saw this effort not as a “financing institution” at the community level because the main feature is not about money lending and borrowing. However, in certain cases, “micro-credit” might feature prominently and thus will require a thorough discussion of the tax responsibility of such community-based funds. The MoH played a crucial role in such cases to discuss with relevant ministries to ensure the expected outcome of the use of community finance for health in the most effective way, given the multiple possibilities and angles of social benefits. Another aspect of public policy and community health funds is the tax exemption policy that may be used to promote a significant contribution to community health funds and to use as another source of funds. Many other policies could also be introduced, such as the tambon health fund in Thailand, which is a counterpart funding mechanism for national health insurance.
and tambon administration, made possible because of the decentralization policy initiated in 2000.

(5) The crucial policy directions that need to be kept firmly in mind are to ensure technical efficiency by setting the right proportion between health promotion, disease prevention and curative services. This is regardless of whether countries are embarking on universal coverage through general taxation (public finance reform) or reforming the use of existing budget within the ministry of public health.

**Decentralization**

Decentralization is normally a “public policy” and not a “health policy” i.e. it has not started from the health rationale but rather those of political nature. Whether a country decides to have a decentralized or centralized public administration system or not is very much an issue of countries’ own socioeconomic and political development. The “model” of decentralization depends also on countries’ contexts. Broadly speaking, it could be merely a form of deconcentration or delegation of central authority to the peripheral units within the overall centralized administrative structure. It can also be to the extent that local governments are established through general local election with full authority to allocate resources made available to them or put under their jurisdiction through taxation policy. Such local governments may also have the power to introduce local variants of legal tools, even contradicting to the laws at the central level. In most countries in SEAR, decentralization normally has three key characteristics: local election for local administration, the authority to make use of a certain proportion of national income to carry out those functions agreed upon by the central authority (as stipulated in the decentralization act), and the responsibility to continue provide certain public services in place of the central ministries (the most common being health and education). So, in any countries where governments attempted or planned to decentralize, it was unavoidable that the health sector would have to be involved, and one crucial concern will always be whether the roles in health would be improved or deteriorated under the new local administration. The example of the Philippines attempting decentralization with the deterioration of health services under the new local administration is one of the cases in point\textsuperscript{xvi}. A more comprehensive review focusing on decentralization and
health done by the World Bank ended on a cautious note despite continued decline in key health indicators\(^{\text{vii}}\).

For most MoHs, the issues of decentralization posed a great challenge in many aspects and thus led to relative reluctance to decentralize. The pace the MoH adopted in creating a smooth and effective transition seemed to vary from one country to another and also from one government to another within the same country. The interruption of health services provision under the local administration may reflect the lack of capacity on the part of the local administration as much as the lack of support from the central ministries and the government as a whole. However it is quite evident that countries in the Region will undergo decentralization policy with the pace of socioeconomic and political evolution observed in most countries. Some of the crucial issues that need to be taken into consideration to ensure smooth and effective decentralization include but are not limited to the following:

1. The nature of the decentralization model and its implications for the health sector are key to the ultimate success. The ministry of health needs to take an active leading role towards the design of the most effective model, unbiased by political partisanship. Academic institutions may also play a critical role in providing information and research studies to help inform the debate. Such a design process will also benefit from a certain degree of participation by stakeholders not limited to the local administration/governments representatives.

2. Capacity building is crucial. Whatever designed model for decentralization has been chosen, the crucial step is to have a systematic capacity development plan. The desirable model of decentralization may need to be implemented in phases and thus need continuous leadership to allow capacity building along the lines of the designed model rather than allowing political interests to interrupt the gradual strengthening efforts.

3. The overall political backup needs to be strong and continuous. One of the challenges or risks to effective decentralization is a change of mind among the political leaders coming into power.

4. The monitoring and evaluation framework is key to creating a common vision and goals as well as setting key milestones to allow stakeholders with diverse interests to see how the
decentralization is going and where it is leading to. Such a framework will have to include at least three key aspects: the overall system design (model of future health system under decentralization), expected health outcome and benefits to the people, and crucial system performance indicators during the transition phases.

5) Involving the public in the debate of decentralization: It is crucial that the public not see decentralization as the strictly government’s business i.e. it is up to the central government to decide whether to decentralize or not and what model/design they will choose. The basic assumption of decentralization is to create “responsiveness” to the needs of the people at the local level. If local administration is created only through agreement between the central and local administration, the “sensitivity” to the needs of the people will be lost. The local election process does not guarantee that those winning the election will be responsive to the health needs and not just the expressed demand of the population.

6) There is a threat that decentralization in health will lead to a fragmented health-care system and curative bias in spending in health, because health benefits can be easily exploited to serve political gain by fulfilling the immediate health demands of the rural population, who are relatively poor and without means to sustain their livelihood and also laden with disease burdens of various types.

Private-public partnership

The roles of governments in economic development in general and in health in particular have been an issue of both intellectual debates and practical importance. Most economic theories saw the state as the one who should abstain from playing any direct role in economic production activities and whose crucial role was to “facilitate” fair competition among various actors, consumers and providers of goods and services. However, it was obvious that governments have to do more than just setting norms and standards, rules and regulations. Its decisions will certainly affect positively particular groups of actors, while having a negative impact on the others. In health-care it is even more controversial what role governments should take in ensuring equitable, efficient and quality health-care. Most governments
in developing countries, SEAR countries included, see governments as key
service providers through networks of public facilities paid for from general
taxes and managed by ministries of health. When looked at from the
“financing” and “provision” points of views, the roles of government
become more diverse, and governments could adopt the position of either
paying for health without providing health-care but not bearing significant
financial responsibility. As mentioned, most developing countries saw a
clear separation between the roles of the public and private sectors in both
finance and provision of health services. The choice of what roles
governments should adopt depends on the political reality in each country.
The debates about the most recent health-care reform in the United States
is a good example of what should be the roles of the government in a
country with a long history and belief in “less government” while examples
in health policies of other developed countries show something
different.

The matrix of health-care financing and provision provides a good
analytical framework for clarifying the overall roles of governments in
health-care.

<table>
<thead>
<tr>
<th>Financing</th>
<th>Provision</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Most public health programmes and/or measures to address social determinants of health</td>
<td>Countries with public finance using private providers as one of the providers (e.g. GP in the UK, or the use of NGO’s to reach the marginalized groups)</td>
</tr>
<tr>
<td>Public</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>Out of pocket payment (OOP) or copayment at public facilities</td>
<td>Private insurance or OOP or copay at private facilities</td>
<td></td>
</tr>
</tbody>
</table>

The consideration of the roles of governments and what roles for the
private sector goes beyond the classical issue of market or state failure.
It is quite obvious from many countries’ experiences that the issue of
private-public mix should make use of the new concept of health in which
health is not only about health services and treatment of illnesses (the
iceberg analogy) but rather about the broader issues of social determinants
and social justice. In this respect, the role of private sector is not merely to
provide services according to people’s demands but rather to be a “partner
in health development”. The roles of the government and private sector in this respect do not treat health services the same way as any other type of “economic production activities”, where market forces would be crucial in deciding the proper mix of roles between the public and private sector.

The roles of public and private sectors thus can be seen through two major sets of actions. The first is health services provision and the other is health development activities which include relatively well-established activities in “population-based health-care” as well as the more recent emphasis on “addressing social determinants of health” which may involve other groups of civil society without classical public health knowledge and expertise. The roles of governments (public sector), in fact are also not limited to financing (or not financing) such activities, but whether they should take more active roles in certain areas or play a regulatory role or facilitate and build capacities of those concerned. On the other hand, the adoption of the new concepts of health also brought in the other major (not-for-profit) “private actors in health”, which is civil society and not only the health-care providers”. In this respect, it might be useful to adopt a three-dimensional framework to analyse and define the proper mix of the private and public sectors in health development: roles and functions (from direct actions to facilitating roles), types of actions (individual-based health-care provision, population-based health programme/interventions, addressing social determinants of health), the last dimension being types of actors (public or private – for-profit or not-for-profit). Another key area of private-public partnership is in education and production of health-care personnel. Production of health professionals should not be seen as another “education activity” but rather take into consideration the utilization dimension. Thus, it is important that the roles of the private sector be seen from this angle as well, and not only in terms of educational quality concerns.

<table>
<thead>
<tr>
<th></th>
<th>Public sector</th>
<th>Private for profit providers</th>
<th>Private not-for profit providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive services/roles</td>
<td>– logistic supportive</td>
<td>– subcontracted by public sectors e.g. information services, logistic management</td>
<td>– subcontracted/commissioned by public sectors</td>
</tr>
<tr>
<td></td>
<td>– technical supports e.g. training, information support</td>
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</tbody>
</table>

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Direct services provision

<table>
<thead>
<tr>
<th></th>
<th>Public sector</th>
<th>Private for profit providers</th>
<th>Private not-for profit providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>- addressing Social determinants</strong></td>
<td>- Sanitation improvement by local government (or health centre personnel)</td>
<td>- not applicable</td>
<td>- housing for the poor (can be financed by public sector or by philanthropists, grants from abroad, etc)</td>
</tr>
<tr>
<td></td>
<td>- housing improvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>- population-based services</strong></td>
<td>- campaign to raise health awareness</td>
<td>- subcontracted by public sectors</td>
<td>- grants from or subcontracted by public sector e.g. HIV counselling, awareness campaign</td>
</tr>
<tr>
<td></td>
<td>- diseases surveillance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- health surveys</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>- individual-based services</strong></td>
<td>- curative services</td>
<td>- services for those with out of pocket payment</td>
<td>- mostly preventive services e.g community care for disabled, elderly, marginalised population</td>
</tr>
<tr>
<td></td>
<td>- preventive services such as vaccination, ANC, etc</td>
<td>- services according to &quot;service package&quot; determined by public sector purchasers</td>
<td></td>
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</tbody>
</table>

Countries will need to take into consideration the following issues when trying to develop a proper private-public partnership in health:

(1) Defining the proper mix of roles between the public and private sector, adopting the right conceptual framework (financing vs. provision, new concepts of health, and the need for
governments to play active facilitating roles, if not direct service provision). The exact proper mix of roles will be determined by the reality of health-care financing of the health sector, the historical development of the public sectors and private sector in each country, and the socioeconomic and political reality looking towards the future in each respective country.

(2) Developing a proper regulatory framework to guide the relationship between both sectors in the desirable direction is crucial to the success of public-private partnership, no matter what proper mix of roles has been defined. One of the controversial or difficult areas is what regulatory framework to adopt in order to motivate the private sector to act in a not-for-profit manner, especially those involved in health services provision.

(3) Reorienting or building up capacity of the public sector to allow it to play proper roles in regulation as well as facilitating roles is important in countries where public sector has been used to providing health services directly and hardly see the needs or possibilities of involving the private sectors, whether for-profit or not-for-profit.

(4) There is a need to develop public policy and financing or regulatory tools that will allow civil society to grow and play an active role in health, especially health promotion and disease prevention or in supporting families and communities for more cost-effective and quality health-care at the family and community level.

Healthy public policies

The logic and rationale for healthy public policies as an integral part of health development is clear if health is seen as going beyond the mere absence of diseases, and that good health is the result of many sociopolitical and economic factors and activities. The call for action beyond health-care provision started with the Alma-Ata Declaration which not only called for community participation but also multisectoral collaboration for health. Another landmark call for such approaches is the Ottawa Charter citing “healthy public policies” as one of the five strategies for health promotion. The most recent report by the global Commission on Social Determinants
Health reiterated the importance to bring other development sectors to play active roles to achieve better equity in health. In fact the increasingly globalized economy, communication and culture has emphasized critical the roles of other sectors on the health of the people and the roles of health sector.

The challenge for countries, especially developing countries, is how to bring in the highly diverse partners in other sectors to better see their roles and impact on health of the population. But more critical is to work with them to reorient their sectoral policies to avoid a negative impact on health, or better still, to help make people healthier. It is worth mentioning that countries in SEAR or many other developing countries have had national socioeconomic mechanisms to set directions for economic and social development in their countries, but there seemed to be little or no interaction or concern as to how the two aspects of development will be interrelated. In certain cases when it comes to weighing between economic gain and health impact, the former seems to be favoured at the expense of the latter. Foreign investment with potential (and subsequent) hazards on health and environment, tobacco sales and taxes against tobacco control, access to drugs in the light of free trade agreements, and cash crop production with use of chemicals and pesticides versus comprehensive agricultural practices are good examples of public policies with health implications that need to strike a new balance if health is to be placed higher on the agenda in overall development policies.

Opportunities and possibilities to develop healthy public policies exist in almost all countries. The most critical factor seems to be the lack of evidence and information in guiding policy decisions of various actors. In countries with more diverse players in public policy debates and development, such information could come from academic institutions through systematic research programmes. In countries with less resources, the health policy development units in the ministry of health need to work closely with the central or other sectoral policy units to analyse as well as propose alternatives for public policies that will bring the best balance between economic gain and health outcomes. One of the interesting approaches is health impact assessment, which encompasses crucial analytical tools that will bring health impact more clearly into the context of various development policies. Unfortunately, such capacity in policy analysis is still very lacking.
Crucial sectors that need to be made aware of and contribute more positively for health depend on each country’s economic and political focus. The most receptive policy issues at present seem to be those dealing with environment and health, including the issue of global warming. This is the result of “global interest and communication”; but may have relatively less importance compared to the more pressing policies that lead directly to health such as tobacco production and sales, access to clean water and sanitation, safe and healthy agricultural policies, and food security and safety policies. Basic to all public policies that have crucial bearing on health are public policies against poverty (prevention or alleviation), one of the key non-health MDGs that has a tremendous impact on health\textsuperscript{xxiv}. Another area is education policies, especially on female education which still needs to be further improved within countries in the Region\textsuperscript{xxv}. With increasing noncommunicable diseases resulting from life-style changes, especially those dealing with physical activities and improper consumption, demand creation through various forms of marketing has been seen as a crucial entry point for reducing prevalence of such conditions. One of the crucial but controversial public policies towards NCD control has been regulation of industry, especially the marketing aspect of “unhealthy food”\textsuperscript{xxvi}.

Although healthy public policies are crucial to cope with the changing trends in the demographic, epidemiological and economic development environment with clear implications for the health of the people, countries in SEAR have had little experience in such areas of policy development. The following lines of actions could be considered as a start to working towards more healthy public policies for countries in SEAR.

(1) Identifying units either in academic institutions or within the ministry of health where analysis and development of alternative development policies could take place. Capacity building may be needed, both in general policy analysis and policy development, and also particularly for health impact assessment and alternative policy formulation and analysis. Proper support will be needed for capacity building, knowledge production, and knowledge dissemination and utilization.

(2) Mechanisms for multisectoral policy debates and development need to be enriched and reoriented by information and knowledge on development policies and health, either from other countries’ contexts or from studies within countries. It
takes time to develop country-specific studies and information, especially where capacity is limited. Therefore, time should not be wasted waiting for such capacity to mature but rather debates need to be created among various sectors as a way of introducing new conceptual thinking and policy frameworks for country development. In Thailand, a national health assembly has been created through a national act for health reform and has provided a forum for debates and recommendations on such issues as trade and health, chemical and pesticide sales and regulation, etc xxvii.

(3) Civil society and media have crucial roles to play in advocating for a development paradigm shift. It is important to broaden the participation in public policy debates. Countries should aim at creating a participatory public policy process that could bring in various stakeholders in the society, namely academicians, policy-makers, media and the public xxviii. Linking evidence and research in the policy debates is also crucial, keeping in mind to involve both those in the authoritative power and the society at large xxix. Media plays a crucial role in communicating such evidence to the broader stakeholders in society beyond those who have the opportunities to participate directly in such debates.

(4) Efforts could be made to create healthy public policy development at the local level. This depends on the degree of decentralization in countries. It is worth mentioning that healthy public policies need not be seen as involving solely “national” policies but rather “policies at various levels” xxx. Health impact assessments could also be done by the community and brought into the higher level of policy debates xxxi.

Conclusion

The four key areas of public policies mentioned above are crucial to health (care) reform in countries. It is worth emphasizing that for countries in SEAR, the scope and aim of health reform should go beyond merely reforming the health-care delivery system as it has been in most cases of the developed countries. This is not because of the different stages of health system development but rather due to quite different concepts and paradigms in health and the roles of health authorities in the respective countries. While most developed countries have separated authorities/
ministries dealing with various development issues that are quite strong and have been able to achieve remarkable results when it comes to environment that also have positive impact on health, without having to discuss about healthy public policy. Most of them were also relatively settled as to what should be the roles of government in health-care and in health financing; some of the more complicated relationship between trade and health still need to be better linked and balanced. On the other hand, the health-care concepts of countries in SEAR have benefited from the PHC concepts and the fact that countries have not been too affluent and thus over-expanding and advocating for more curative services, but rather working through community participation and balanced community-based development. This provides great opportunities for countries in SEAR to move public policies for health to support the health reform in a new direction that will be more socially and community oriented rather than medically biased.

References


Health Sector Reforms and MDGs

The South-East Asian Region (SEAR) faces manifold challenges in meeting the health-care needs of its population. The major challenges include high disease burden (both communicable and noncommunicable), low health expenditures, and weak and inefficient health systems. The annual per capita government expenditure on health in the Region is still low compared to the minimum recommended by the Commission on Macroeconomics and Health of $34 for essential interventions. Health sector reforms are critical to improve health systems performance and achieve the MDGs in health. Health workforce is an important component for reforms, which have not received adequate attention in these countries, despite the fact that WHO has been in forefront of advocating for such measures for several years. In order to achieve the MDGs in health, we should ensure that every person in every village in SEAR has access to a skilled, motivated and supported health worker.

This paper highlights some of the key issues in the workforce management reforms in the South-East Asia Region with specific attention to development, recruitment, deployment, task shifting and multidisciplinary health team and a dynamic agenda for action.
Health Workforce: Key challenges in development and effective utilization

Human resources for health are defined as “the stock of all individuals engaged in the promotion, protection or improvement of population health”. This includes both public and private sectors and different domains of health systems, such as personal curative and preventive care, non-personal public health interventions, disease prevention, health promotion services, research, management and support services. Human resources actually engaged in the health system can be referred to as the health system workforce or health workforce. Health workforce with special reference to primary health care (PHC) includes within its scope a wide range of personnel engaged in delivery of PHC. This should necessarily include the band of grass-roots level and most peripheral providers who are the “first contact” of care, nursing personnel, paramedics, health managers and primary care physicians.

The workforce density in SEAR is 4.3/1000 population in comparison to more than 19/1000 for Europe and America. In India, a large number of practitioners of indigenous systems of medicine (AYUSH - Ayurveda, Yoga, Unani, Siddha and Homeopathy) are also working in the government and private sector. Despite some improvement in the development of human resources for health in the Region, there are issues related to numerical and distributional imbalance, inadequate training and technical skills, improper deployment, inefficient skill mix of health workforce (often coupled with poor personnel management), nonexistent career structures, inadequate staff supervision, lack of motivation, poor working environment and lack of opportunities for personal development. There is absence of a well-defined human resource development policy in many countries, and even if exists, it does not address key elements such as forecasting for human resource for health, deployment and career progression, compensation and retention of health workers. The policies also do not address issues of transfers, promotions, continuous education and on-the-job skill development to retain the talent.

Another challenge is related to capacity building of health workforce, which includes a lack of needs-based training for different categories of staff, apathetic attitude towards training (especially in-service training), inadequate training infrastructure and training skills, absence of pre-service and induction training, and duplication of efforts by different agencies.
without much integration. There are many non-training issues such as lack of a mechanism for follow-up after training, mismatch between training and job profile, and lack of a system for monitoring performance related to training. Low motivation levels in the absence of conducive working environments and rampant political interference in matters of transfers and promotions, rewards and punishments create further problems.

There are also problems of skill mix to provide quality health care and task-shifting in times of changing needs. Insufficient attention is given to involving workforce from other sectors or disciplines other than health. A relative shortage of health workforce in rural areas and lack of systematic deployment and an incentive policy are observed in some countries. Recruitment and selection of health workforce are usually centralized, and do not bring as many local or locally trained personnel as would lead to greater stability and ownership. In a poor resource setting, decentralization in recruitment, selection and deployment of HRH is of utmost importance. There is a need to have local cadres and link development of HRH with area-specific requirements. Another issue is related to brain drain of skilled workforce, particularly, doctors and nurses. This creates additional imbalances that require better workforce planning, attention to issues of pay and other rewards, and improved management of the workforce.

**Addressing Challenges: A framework for action**

**Policy-level interventions.** India has proposed constitution of a National Council for Human Resources in Health (NCHRH) to address all issues comprehensively in terms of policy guidance and mechanisms. Similar mechanisms can be explored by other countries. This kind of body should aim at prescribing standards with a view to proper planning and coordinated development of health workforce in the country, qualitative improvement of such education in relation to planned quantitative growth, the maintenance of a national live electronic register of health workforce and to provide for an overarching framework for the regulation of health workforce in the country, and proper maintenance of norms and matters connected therewith. Qualifications and eligibility criteria and selection process for different cadres of health workforce need to be reviewed in relation to their job requirements. An effective human resource management information system is also essential for projecting the future health workforce requirements in countries.
Investing in Development of HRH: This entails strengthening of training institutions, certification/accreditation of training institutions, fine-tuning syllabi as per the epidemiological needs of the population and also newer and appropriate technologies in health. In order to equip health workforce with adequate skills, their training should be organized in a decentralized setting, in close proximity with the public health and social environment for providing broad-based community health care. A large army of community health workers needs to be recruited and deployed at community level after providing required pre-service training. There is a considerable gap between the institutes that produce manpower (i.e. medical colleges, nursing schools, etc) and the user of this manpower (i.e. ministry of health). There need to be efforts to match the curriculum of different categories of workforce to the requirement of the health services.

HR management in a decentralized programme environment, including recruitments: In order to identify prospective health workforce at community level who have the knowledge, skills and disposition to be effective on the ground, the recruitment should be made at community level. To ensure community acceptance, selection should be mediated through community structures whereby trusted members of the community are identified. However, care should be taken to build fair, equitable and nondiscriminatory systems that produce the right candidates with the most potential to serve the community needs.

Establish well-defined systems of continuing education and skills upgrading on a regular basis: Training should not be seen as a punishment to some and reward to others. New options for education and in-service training of health-care workers are required to ensure that the workforce is aware of and prepared to meet the community’s present and future health needs. Community health workers should be oriented to the basic science of health promotion, disease prevention, treatment and care. Through pre-service trainings, the community health workers should be educated on priority interventions they will undertake, which in turn is dependent on the epidemiology of diseases within their communities. It is also important to develop practical skills of health workforce in communication, motivation, provision of quality care and ability to transfer skills to others, data analysis and interpretation, etc. Implementation of CME programmes, computer networking of training institutions, promotion of IT-based e-health, and telemedicine can go a long way in achieving this.
Highly transparent, dependable referral systems: A strong referral system will require clear guidelines or standards of referral, good communication and transport systems and an adequate number of highly trained workers at the referral system. In order to make the health care at community level more effective, it is important to have highly functional, transparent, and dependable referral systems, so as to enable health workers to refer patients for appropriate care. They should be empowered and supported to help facilitate access to social service providers – in education, ICDS (Integrated Child Development Services) social welfare, rural development and panchayat departments, etc.

Compensation systems: Can there be reforms in terms of modes of compensation? Health workforce should be provided salary incentives and other rewards to address issue of retention in rural areas. Part of the wage compensation should be linked to performance on key results areas such as achievement in immunization coverage, institutional deliveries, and so on. The social recognition of health volunteers in their communities and the appreciation of their efforts by health service personnel are necessary. The provision of certificates, badges and uniforms enhances their self-esteem and social status. Countries in the Region may also celebrate "National Village Health Volunteer Day" as in Thailand. Performance-based incentives like that of ASHAs (Accredited Social Health Activist, a village-based female health volunteers) in India can be worked out with community-based built-in checks to counter over-reporting of performance.

Career progression of health workforce should be given due importance. Preference should be given to those who are already working in the field. For instance, preference should be given to ASHAs during selection of Anganwadi workers, AWWs (workers under the ICDS), Anganwadi workers into ANMs (Auxiliary Nurse Midwife) and ANMS into staff nurses would create motivation among those who join the system and ensure resident health workforce. Similar arrangements to retain doctors and specialists who volunteer to serve in rural areas for some years helps in meeting critical human resource needs where they are most needed.

Task-shifting - as an option

Experience in countries like Brazil has shown that task-shifting can indeed make a vital contribution to building sustainable, cost-effective and equitable health-care systems. At the primary health care level, nurses can
perform many of the functions reserved for doctors. For example, nurses can focus on noncommunicable diseases and various measures such blood pressure checking, blood sugar examination, identification of risk factors, etc. Multipurpose health workers (female) can perform several functions performed by nurses like identification of risk cases, assistance in conducting delivery, immunization of children, providing first aid, health education etc. Male health workers could be involved in sanitation, hygiene, identification of population at risks, health education activities, social mapping, collection and use of epidemiological data for local planning etc. Pharmacists in PHC can perform many of the curative care functions such as treatment of common ailments, preventive services and immunization of children. Many of the functions performed by multipurpose workers can also be shifted or shared with community-level health workers, for example ASHAs in India.

While task-shifting or task-sharing, the requisite skill mix should be developed through continuous training, and the roles can be redefined to meet pressing needs at community level. Multi-skill training of existing workforce should also supplement the efforts. Doctors of indigenous systems like AYUSH (Ayurveda, Yoga, Unani, Siddha & Homeopathy) in India are being provided training for jobs to be performed by medical officers at primary health centres (PHCs). Multipurpose workers can be given multi-skill training on a set of support services of the PHC. However, the legal and quality of care issues related to multi-skilling and task-shifting need to be taken into consideration.

Another reform initiative tried out in India has been the multi-skilling of medical officers as anaesthetists and obstetricians. The medical officers are trained for 18 weeks in life saving anaesthetic skills (LSAS) which enables them to work as anaesthetists at the First Referral Units (FRUs). Similarly doctors are trained for 16 weeks in Emergency Obstetric Care to allow them to function as obstetricians at the FRUs.

There are many issues involved with the task-shifting strategies such as resistance from professional associations, quality issues, lack of policies and regulatory framework, and insufficient support of the multiple stakeholders. It needs to be decided by the country/state as to what functions can be shifted and to whom. Legal environment in the countries to facilitate the task shifting and stakeholders’ agreement for the acceptance of task shifting are required.
**Health workforce reform in India**

- Training of ASHAs, ANMs, nurses, lab technicians, medical officers
- Multi-skilling of medical officers
- Contracting in health workforce on local criteria
- Performance-based incentives to health workforce
- Hard area/difficult area allowances in rural areas
- Integration with AYUSH systems
- Involvement of nongovernmental sector

**Multidisciplinary team**

In delivering primary health care services to meet holistic needs of the population, there is a need to have effective multidisciplinary health teams. The multidisciplinary team is required to work with workforce from various sectors to achieve the common goal. In designing any health action/intervention at the community level, it is important that the inputs of experts from other fields like sociology (to include social perspectives), economics (to keep in mind the resource constraint) and psychology (there is an increasing burden of mental illnesses, and many conditions such as accidents and injuries may be related to psychological makeup of a person and substance abuse). In many countries there is separation of different components of health under different ministries. Unless there is good collaboration between these ministries, the overall scenario of health is not likely to improve.

The experience of Bhutan involving multidisciplinary health teams including a sanitarian, nutritionist, statistician, sociologist, and traditional health practitioners in delivery of health services to tackle the shortage and uneven distribution of health workforce at the community level should be recognized. The multidisciplinary team members should be trained on community-based approaches including health promotion, community empowerment and communication skills. Disciplines like health administration, health information technology, health marketing, health economics, community health management and hospital management need to be encouraged. Training and orientation of all medical and paramedical personnel on the public health issues will also go a long way in the management of diseases and epidemics. New courses of three years duration like the B.Sc. (Health Sciences), vocational courses on public health and related disciplines may be introduced for addressing the increasing need of human resources for public health.
Community involvement

Experiences in the Region have already shown that communities can play an important role in ensuring availability of the service providers appropriate to the level of facilities. The civil society organizations can educate the community and empower them to demand their rights. There is scope and an urgent need to activate, strengthen and engage Panchayats to monitor health services and health workforces in place. The community, community-based organizations, field-based organizations, NGOs and Panchayats need to come forward to build the confidence of the health workforce and ensure their safety and security. Improvement is badly required in infrastructure, mobility, security and educational facilities.

Conclusion

Health workforce management at the primary level calls for flexibility and new ways of thinking about the problem. Countries of the South-East Asia Region need to ensure that national human resource plans address the critical shortage. It is essential that specific competencies and enabling environments required for providing basic primary health care are fully developed and implemented. These need to be adequately financed to address the number, quality, training, distribution, motivation and retention of health workers, and need to be appropriately monitored. Given the shortage of supply of qualified health workforce in the Region as well as various demand-side barriers faced by the poor to reach the formal health system, there is an imminent need to accelerate implementation of evidence-based and sustainable strategies to increase access to primary health services and continue documenting innovative and complementary approaches such as task-shifting/ sharing of tasks, and fostering a team approach with midwives and other health professionals capable of carrying out such services, including non-clinical and community health volunteers. There is a need to look at delivery of health care as a management issue which needs multidisciplinary teams to tackle it for effective delivery.
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Community-based Initiatives (CBI) are a move from the conventional, unconnected, sectoral activities towards more holistic approaches to development wherein health is considered as an objective that should be pursued using all available means. The paper and the presentation will be touching on two areas, namely: (A) "Health for All by the year 2000" and one good example of community empowerment by PHC approach and (B) discussion on health-care reforms.

As a retired health administrator, I have to say “our days or over”, but allow me to revisit our era i.e. Health for All by the year 2000 (HFA 2000) in which the fundamental principle of EQUITY and the approach is by Primary Health Care (PHC).

Primary Health Care (PHC)

The principles of PHC are: (1) equitable distribution; (2) community participation; (3) intersectoral coordination; and (4) appropriate technology.

Responsibilities for health are classified into:

| (1) Individual responsibility | - self-care in health |
| (2) Community responsibility  | - for the people, by the people |
| (3) Government responsibility | - from womb to tomb |
| (4) Global responsibility     | - policy, technology and resources |

UN agencies, INGOs and donors

Then, let us go to the Health for All policy of WHO that has mentioned this objective in its constitution. "The objective of WHO is the attainment by all people of the highest possible level of health. The goal of
Health for All by the year 2000 embodies this objective and emphasizes the highest possible level of health. At the minimum, all people in the country should have at least such a level of health that they are capable of working productively and participating actively in social life and community activities.

Due to emerging socioeconomic issues and increasing levels of public awareness, there is a demand for empowering communities in their efforts towards becoming more self-sufficient in decision-making and designing strategies for their own future, including health sector.

By judging the above statements, we have realized that the PHC approach will provide health care direct to the community at all levels. That was why health-care providers, in accordance with PHC approach organized the community to participate in health programmes. But health-care providers as well as beneficiaries were not yet impressed with the newly introduced health system in the beginning of the HFA period. Later on, gradual improvements of community participatory roles were developed by better approaches and problem-oriented health procedures.

Themes of health services can be categorized as follows.

- It should be organized to serve the entire population and not merely selected groups. Health services should cover the range of **preventive, promotive, curative and rehabilitation services**.
- It should provide health care to the vast majority of underserved rural people and urban poor with the PHC services supported by a proper referral system.

During the HFA 2000 period, some community related jargons in use included community participation, community involvement and community-based actions. These terms reflected the nature of the community involvement. HFA 2000 period was too early to assign community an empowerment role. Before assignment, communities need to get good awareness, training and capacity-building on the PHC approach to implement satisfactorily.

Health contributes to the social and economic development of a community; simultaneously, improved health is one of the outcomes of the same development. It has been observed that improvement in health of a community has a synergistic effect on the productivity and outcomes of
other (non-health) sectors and enhances both the local and national economy, thus creating a two-way plan to address the issues of the health and poverty. Experiences have shown that establishing a social infrastructure and ensuring the effective use of services assist in the overall development of a community. Organized communities are able to work in harmony and make joint decisions. Without organization they can disintegrate and hold conflicting opinions.

By following the HFA 2000 Strategy, Myanmar had carried on its own country programme, named the People's Health Plan (PHP), in four yearly phases up to 2000. Now, I will take a little time to talk about a success story on health development by community participation and empowerment. That was happened in Myanmar, achieved by a small town called Ayadaw, which won the WHO Sasakawa Health Prize in 1986 as co-winners, together with two distinguished health personnel.

In Myanmar, HFA 2000 Strategy was conducted through the People's Health Plan approach in 1978 as four year mid-term plans and covered most of the townships in Myanmar. Programmes are:

Four major services programmes -
(1) Community health care
(2) Disease control
(3) Environmental health
(4) Hospital care

Four support programmes -
(1) Health education
(2) Health manpower development
(3) Logistics and maintenance
(4) Health Laboratory

While equal emphasis was given to all townships, Ayadaw achieved particularly outstanding successes in its health development activities, by the Ayadaw People's Health Plan Committee (ATPHPC). The task of the committee was to take the leadership role and implement assigned
development of health activities within its township, hand in hand with village branch committees. I will briefly explain how Ayadaw has emerged as role model of healthy townships by the conduct of community involvement.

Ayadaw township profile

Ayadaw is a small town situated in Upper Myanmar within the dry zone belt where the rain fall is just 25 inches per year. It covers 1223.8 square kilometers and the soil is sandy and less fertile. The total population is 150,300 (as of 1986). The number of villages and wards are 161. The main economy was based upon agricultural outputs which were totally depended on seasonal rains. As an extra water supply, only 8% of the total need for cultivation was available from existing water sources and irrigation systems.

Education

2 High Schools, 3 Middle Schools and 81 Primary Schools. Literacy rate is over 85%. (Improvement after literacy campaign in 1972)

Health

Existing health institutions are – (2)16 bedded Civil Hospitals, (4) Rural Health Centres, and (16) Sub-Rural Health Centres. and (1) Maternity and Child Health Centre.

After extensive discussions at the planning meetings, ATPHPC was formed and assisted by the Divisional Health authorities and Township Health authorities, community leaders had drawn a prioritized township health plan suitable for their needs.

Overview of Ayadaw's activities

The ATPHPC acted well in a leadership role and organized the community to implement in a proper way. The community is the best judge of its own problems and to undertake appropriate action for their solution. They were exposed to learn critical awareness, monitoring, cost effectiveness and effective use of resources. The community leaders also interacted with
other people from various walks of life to be able to share information and learn from their experience.

The committee had given highest priority to water supply and adopted the slogan *We want water, not gold*. The water shortage had affected economic growth as well as healthy lifestyles in Ayadaw. By building tube wells, sanitary latrines and garbage disposal facilities in each village, access to water was achieved by 1985, reaching a level of 97.2% of the entire population and access to basic sanitation (sanitary latrines) was achieved for every household by 1986.

There have been no commonly accepted health priorities for all of the townships. Only by discussions and brainstorming, can we get the prioritized health problems as an entry point in respective townships. As for Ayadaw, scarcity of water was their major problem. That was a good example of making an entry point to gain community participation by prioritizing their health needs. With acceptance, they had willingly provided their services and resources (manpower, money and material). By adding technology and material assistance from the government, health-care providers and UN agencies, Ayadaw had completed the prioritized water and environmental sanitation project within a few years with flying colors. The immediate consequences were: improved personal hygiene and good environmental health; also, good sanitation made a visible reduction of waterborne disease outbreaks. Simultaneously, by efforts of the community, other PHC programmes were also improved to a satisfactory level.

Among the other achievements of the committee were the following:

1. Dramatic reduction of seasonal disease outbreaks including gastrointestinal infections and worm infestations.
2. High coverage of Expanded Programme on Immunization (EPI).
3. Most of the deliveries were conducted by midwives, trained auxiliary midwives and traditional birth attendants.
4. The incidence of chronic communicable diseases like leprosy, trachoma and malaria were being brought under control.
5. Every village in the township now had Volunteer Health Workers (Community Health Workers), subsidized and supervised by the village administrative council.
(6) Introduction of a Joint Nutrition Support Program (JNSP) has activated the community, to get awareness and improve habits of eating balanced diet.

(7) Corporative health clinics were financed by village corporative societies, and funds for health development activities were raised by communities themselves through a variety of local finance schemes.

(8) More funds were raised by the committee, from wealthy families living in or out of the township.

(9) The committee helped to raise the adult literacy rate to over 85% and encouraged literacy through wide circulation of periodicals, books and newspapers.

(10) Improvement of health in families creates a better, productive life in many ways.

(11) In some villages where there are artisan wells, surplus water had been used to irrigate cash crops.

(12) Economic status of the communities has been raised due to technology inputs and better water supply.

**WHO, SEARO acknowledged Ayadaw's performances**

In 1984, I was assigned as Deputy Health Director of Sagaing Division. I found ATPHPC working with, Basic Health Staff (BHS), gaining momentum and achieved many targets year by year and it became a model town of Sagaing Division. I have to conduct many official tours to Ayadaw with WHO and UNICEF officials to observe the committee's conduct and achievements. They found their performance very satisfactory and health plans were improving. They gave more encouragement and technical advice. In 1985, officials from the Regional Office for South-East Asia visiting Ayadaw had suggested the committee compete for the 1986 WHO Sasakawa Health Prize with the theme of Ayadaw's health development based on the community participation. Basically, the committee's interest was focused only on their own welfare and healthy living. They never dreamed of prizes or awards out of their achievements; but they were very happy to know that their achievements were not without recognition. Thus the office of the Sagaing Divisional Health prepared Ayadaw's full report on
community-based activities and submitted it to WHO Headquarters in time. To the best of my knowledge, I think this is the one of the rare awards given to a community for their community empowerment.

Community education and empowerment

I will carry on from past community achievements to present day community empowerment trends. The sense of community emerges from the determination and inspiration of the individual. The process of empowering the roots of the community requires commitment at all levels, with the understanding that the community is the best judge of its own problems and possesses the ability to undertake appropriate action for their solution. Members of the community should be trained to work with others and provided with opportunities to make decisions and evaluate results. The culture of sharing responsibility may be promoted through the development of local leadership and providing access to resources.

Community participation and empowerment involves:

- Initiation and processing by some activists in the community.
- Concerted process of mobilization.
- Orientation regarding the purpose and benefits of community mobilization and empowerment.
- Defined roles of stakeholders and community.
- Help and assistance from partners for relevant aspects.
- Commitments by all partners.
- Ownership of the programme and underlying objectives.
- Confidence in the capacity of the community to act.

Role of community in community-based initiatives (CBI)

For future trends in CBI, communities are mobilized and empowered to undertake their own development with the technical and material support of stakeholders and partners. Being the primary participant of the whole process, they are obliged to determine terms of reference for their own
development, outlining short-term and long-term targets and earmarking the role of each partner through the social contract, if possible. The objectives of the social contract are:

- Achieving Health for All by ensuring equity in health opportunities and improving health outcomes through health awareness, healthy lifestyles and disease prevention.
- Facilitating socioeconomic development for social elevation, limiting social disabilities, reducing poverty and improving the quality of life of the people.

Empowering poor people and needy communities, improving local governance, providing public infrastructure and services, and enabling dynamic, equitable private sector growth are all required to meet the Millennium Development Goals. For health systems, commitment to reach the health-related MDGs has two main implications. First, the delivery system must do a better job of reaching the poor, who tend to live in remote rural areas and urban shanty towns. Second, schemes for financial protection must be in place to ensure that the cost of health care, especially catastrophic expenses, do not themselves cause poverty. Since HFA emphasizes the highest possible level of health, each country will have different targets, which depend on current status of health and their social and economic condition. Therefore, the PHC activities that need to be implemented in order to achieved HFA goals will vary from country to country. As a vision, HFA does not need a concrete timeline as in the case of MDGs adopted by world leaders in 2000. We can consider health MDGs as the mission or objective of HFA till 2015, and simultaneously as proxy indicators to HFA.

**Health Care Reforms for community empowerment**

Reform basically means amendment; improvement. A real change that can improve the population’s health should consist of reform in the health sector according to human lifestyle changes and the epidemiological pattern of diseases. The salient feature of the health-care reform vision is a health promoting community: a healthier population with a good living and working conditions, healthy living environment, suitable housing, good personal health practices and coping skills.
There is a wide disparity in the income distribution in ASEAN countries. Epidemiological studies have established the fact that disparity in the distribution of income strongly correlates with ill health among the lower-income groups irrespective of per capita GNP. This is referred to as socioeconomic inequalities in health.

Some areas of health care reform at the community level will be based on:

(1) Community mobilization

- By sensitizing the community to needs, rights and existing development status.
- By facilitating the transition of the community from the traditional, passive approach to actively playing a role.
- By training for planning, implementation and management of community-based actions and projects.
- By strengthening participation and sustaining momentum towards achieving the goal of sustainable development.

(2) Capacity-building and educational training

- For community leaders as part of their empowerment to take up a new role and manage the programme.
- To get five fundamental capacities: Competent, Relevant, Efficient, Adequate and Effective work practices.
- To conduct non-formal education and literacy campaigns.
- To give health education trainings and workshops on basic planning and implementation procedures.

(3) Organizational development (OD)

- To help the community to become organized and develop networks to formulate collective and coordinated actions.
- To work on democratic principles, based on the roles agreed by all members.
➢ To improve and strengthen community leaders and volunteers by OD measures which include organizational analysis, strategic planning, implementation and evaluation, and learning by experience.

(4) Innovative education and public health education

➢ To empower the health workforce, in pre-service as well as in in-service training. Training should cover managerial, communication and behaviour intervention aspects.

➢ Health and medical institutions need to reform their curricula and teaching methods to produce graduates with appropriate public health knowledge and skills.

➢ To promote the use of information and communication technology (ICT) for education, training and health care service delivery as providers.

(5) Volunteers as change agent

➢ As there are many people who like to help others on a voluntary basis, the community organization is more viable to be joined by volunteers as community health volunteers (CHV).

➢ As community leaders, who are active people, living in the community and willing to serve the community without expectation of profit or reward, they will be involved in health promotion and prevention of health problems and in emergency situations as leaders.

(6) Income-generation and fund-raising producers

➢ To create capital funds through mobilization of community savings, profit-sharing, cost-sharing and donations.

➢ To collect funds from wealthy people living in and out of the native place.

➢ To encourage micro financing systems supported either by the government or other sources.
As HFA remains as ultimate goal of health development, the World
Health Report 2008 on "Primary Health Care: Now More Than Ever"
advocates four areas of PHC reforms through health system strengthening
namely: (i) universal coverage; (ii) service delivery; (iii) public policy; and
(iv) leadership. The concept paper of this meeting has already covered most
of the weakness and problems requiring reforms.

While more resources and efforts should be focused on provision of
essential or basic health care at the first point of contact with the health
system, development of various sophisticated hospitals as referral facilities
should also receive appropriate attention in programme planning.

The end

As we all know, health-care is an ongoing implementation process for the
benefit of the community.

Lastly, I want to quote the last lines of Lord Tennyson’s poem "The
Brook":

And out again I curve and flow,
To join the brimming river,
For men may come and men may go,
But I go on forever.

Yes! the same is true of us, "For men may come and men may go,
But the provision of health care goes on forever".
Annex 5

Panel D
Role of Public Health Institutions and Networks in Education, Training and Research
Dr Phitaya Charupoonphol, Dean, Faculty of PH, Mahidol University, Thailand

Introduction

As a result of epidemiological, demographic, social and technological transitions with increasing globalization, natural disasters, and emergency situations, health-care workforce education and training reform is critically needed, particularly for the South-East Asia (SEA) Region. Currently, SEA is experiencing not only traditional hazards e.g., infectious diseases, occupational injuries, emerging infectious diseases, such as Ebola and avian influenza, but also new environmental hazards, such as global warming and climate change; disaster, bio-terror events, injuries and violence; food security, and refugee health issues. All these make it imperative to have strong support for public health and enhanced investment in public health education and training (Profiling Public Health Workforce in Countries of the South-East Asia Region, WHO 2006).

Since 1999 the Calcutta Declaration on strengthening and reforming public health education, training and research have been established. Accreditation guidelines for Public Health Institutes and the International Forum of South-East Asia Public Health Education Institutes Network (SEAPHEIN) were developed in 2002 and 2004, respectively. Currently, the principles of PHC still remain valid, the need to strengthen health systems using PHC approach has been recognized, and the need to develop a sustainable community-based health workforce has arisen. Public health initiatives of the twentieth century significantly enhanced longevity and the quality of life. But, in the new millennium, public health threats loom as large as ever. The UN Millennium Development Goals (MDGs) to be attained by 2015 place health at the heart of development, thus providing an opportunity for concerted action to improve global health. Thus, this paper aims to strengthen role of public health institution to tackle
these challenges in the years to come in the light of the rapid global change in all spheres. In addition, several strategies are recommended to develop and maintain a diverse health workforce competent for primary health care development (PHC) in SEA Region countries.

SEA Regional Public Health Education: Current Situation and Challenges

In the South-East Asia Region, an adequate supply of well-prepared public health professionals is essential for an effective public health system. Over the past decade, the adequacy of the public health workforce, both in terms of the number of workers and their skills and competencies have been seen as challenges in the public health system for the 21st century. Currently, several SEA countries have been facing several challenges, including (1) workforce size in general and the geographic distribution of these professionals, especially in rural communities; (2) critical shortages of those trained to meet the current health needs of the growing and increasingly diverse and changing population in this Region, particularly older adults; and (3) training among disciplines occurs in isolation and, is not interdisciplinary, which is necessary for affordable and cost-effective primary care service delivery. These challenges raised a concern about training needs of public health education in the Region and how to link public health education to practice, which should respond to national health priorities and countries' public health practices, and requires by in-service public health officers.

The greatest shortage occurs in six countries of the South-East Asia Region, more predominantly in Bangladesh, India and Indonesia. In addition to overall shortages of health workforce there is also a maldistribution of health workers within each country, with a propensity for higher density in urban than in rural areas. A study of salient features of public health workforce in Bangladesh was carried out by the National Institute of Preventive and Social Medicine (NIPSOM). Similar to other countries of the Region, Bangladesh had a high rate of annual turnover among public health nurses (6.25%), followed by public health engineers (4.59%), public health physicians (2.88%) and health educators/promoters (2.14%), and public health dentists (0.37%). Whereas the total public health workforce of Bangladesh was 135291 persons in 2005. Approximately 7.3% of this workforce was formed by 30 categories of public health
professionals, 39.5% by 15 categories of public health technical staff, and 53.2% by just 11 categories of public health ancillary staff. It was also found that NGO health workers were involved in conducting public health activities.

As the public and private public health training institutes/facilities in Bangladesh had produced 2158 postgraduates in different disciplines of public health, mainly with part-time and guest lecturers, with a cumulative annual enrolment capacity of around 200, there is not adequate demand from students. Non-formal training for different levels of field workers in public health sector on emerging and re-emerging public health problems has been conducted by five national-level public health institutes, including four public sectors and the Expanded Programme of Immunization (EPI).

In Bangladesh, continuing professional development needs more opportunities for existing public health professionals, both in their areas of expertise and in broader public health issues, and skills development in communication, collaboration, leadership and management development. For example, the priority training areas identified by public health physicians and public health dentists were management, quality assurance, professional skills, budgetary training and operational research. Priority areas were updating knowledge, arsenic problems and low cost technology; behavioural change communication (BCC); counseling and leadership training by public health engineers, public health nurses, and health educators.

In Nepal, health workforce development was in line with health systems strengthening by the primary health-care approach. Nepal’s experience in community health volunteer development and partnership-building with the health services in the TB programme was recognized. The important role of community-based health workers and the community-based volunteers is evidenced in successful implementation of the DOTS programme and successful cure rates in the TB programme. The importance of the health workforce in disaster management and rehabilitation programmes is also reiterated. The guidelines and health workforce strategic plan are developed to ensure that the country’s health needs can be met and people will receive better health-care.

In the context of monitoring the health-related Millennium Development Goals (MDGs) and the emergence of new infectious diseases, the Field Epidemiology Training Programmes (FETP) in Thailand were cited
as a good example of how to link education and practice. A regional network such as the South-East Asia Public Health Initiative can serve as a platform for public health education reform (Viroj Tangcharoensathien and Phusit Prakongsai, 2007).

Recommendations for health-care workforce education and training reform

A review of public health education in the WHO South-East Asia Region in 2005 showed that despite the existence of several postgraduate courses in India, Indonesia and Thailand, and undergraduate courses in other countries, there is a great variation in institutes and courses offered in the Region. Challenges include quality assurance, teaching standards and faculty members’ competency in practical field experience, especially in public health management and outbreak control. The absence of policy-relevant research or publication of staff in public health faculties indicates the weakness of public health education and its dissociation from real-life public health policies and practices. Some recommendations are now proposed:

Increase governmental funding for primary care reinvestment

Most countries have data for the public/state sector, whereas there is inadequate data for the private sector, nongovernmental organizations, community-based health workers (CBHWs) and traditional medicine practitioners. In addition, there are impediments such as imbalances in numerical and geographical distribution, lack of appropriate competencies, lack of any incentive to motivate the HWF to provide services in remote areas, and ineffective HWF management capacity, among others. Thus, primary care reinvestment would be a potential means to address workforce shortages for primary care health professions; assist disadvantaged students to enter health professions; improve national health workforce; reduce disparities in health status; improve the quality of health services; and offer culturally and appropriate health services for diverse populations.
Provide more opportunities for public health training and education

More opportunities should be provided for public health training and education that are accessible to senior staff of district and local health offices, particularly those in leadership positions within governmental agencies. Effective “career ladders” within public health systems should be identified to assist in developing similar upgrading opportunities, particularly in shortage occupations. Provide public health workers with support and assistance to further their education, both graduate and undergraduate, related to critical public health skills and competencies. This could include tuition reimbursement, release time, and increasing the availability of distance education or web-based course offerings. Scholarship or loan repayment programmes should be created to provide support in return for a commitment to work in local public health offices/agencies with shortages of public health workers.

Innovative recruitment and marketing strategies for careers in public health

Learn more about what attracts potential public health workers to the field and use this information to develop innovative recruitment and marketing strategies for careers in public health. For example, dual training opportunities should be created, particularly for those with racial/ethnic and geographic disparities in public health workforce distribution by coupling public health graduate training with others, especially medicine, nursing, dentistry, veterinary medicine. In addition, degree-oriented training and post-graduate opportunities should be focusing on hands-on experience.

Encourage collaboration and partnership development

The attainment of the highest levels of health by the people requires different categories of HWF. Thus, it is imperative to strategize to deploy the right skill mix and the right numbers in the right places. The required number and categories of HWF can only be projected and calculated by strategic planning. Encourage schools of public health, public health training centres, and other educational programmes to be more responsive to the
recruitment and training needs of local public health agencies, particularly those in remote locations. Identify and describe models of collaboration or “best practices” between academia and public health practice. The attainment of the highest levels of health by the people requires different categories of HWF.

Multistakeholder mechanism is required for holistic development of the national HWF corpus. Thus, strategic planning should give an opportunity for involvement of all stakeholders. Provide incentives to encourage collaboration between relevant educational programmes and local public health agencies.

Information and communication technology

Time constraints and resource limitations have been experienced by the majority of the 11 Member countries of the South-East Asia Region. Currently, Information and communication technology, such as distance learning courses, have been developed to meet training needs of the health workers. In Malaysia, about 200 electronic training courses were designed for professionals, both pre- and in-service. Problems encountered by the HWF in most countries include incomplete information on the health workforce situation, lack of uniformity in classification and standardization of data, which result in inability to use health workforce data for appropriate national HWF policy formulation and for making meaningful comparisons and sharing of HWF information between Member States.

Build capacity to attract and fund graduate level professional education

The improvement and transformation of health-care systems depend entirely on a workforce adequate in size and effectively trained and supported. There is substantial and alarming evidence that the current workforce lacks adequate support to function effectively and is largely unable to deliver care of proven effectiveness in partnership with the people who need services. Thus, improvement of care should be established to provide funding to accredit doctoral, postdoctoral and internship programmes for interdisciplinary training for underserved populations (e.g., older adults, children, chronically ill persons and victims of abuse and trauma) in rural and urban communities.
Encourage collaboration between relevant educational programmes and local public health agencies

Encourage schools of public health, public health training centres, and other educational programmes to be more responsive to the recruitment and training needs of local public health agencies, particularly those in remote locations. Identify and describe models of collaboration or “best practices” between academia and public health practice. Provide incentives to encourage collaboration between relevant educational programmes and local public health agencies.

Given the MDG stakes, public health education and competency at various levels are needed to translate evidence into policy and to implement and evaluate programmes. In addition to the public health aspects of the MDGs, the emergence of new infectious diseases and multidrug and extensive drug resistance pose serious demands for scaling up surveillance as a key public health competency, especially in the light of avian influenza threat and implementation of the International Health Regulations (2005).

On-the-job in-service training, context-specific continuing education programmes and short courses, distance and self-directed learning packages, and postgraduate university-level courses have become popular means to foster public health competencies. By 2007, 34 countries had established Experience of Field Epidemiology Training Programmes (FETP). FETP in Thailand, established in 1980, has applied the concept of “linking education and practice” in its programme which has recently developed into a training course for other countries in the Region. Trainees spend 25% of their time in the classroom and 75% in the field and “learning by doing”. For example, they conduct outbreak investigation and control. They have become the backbone of epidemiological surveillance and broader public health responses in Thailand. The programme was a key player in the Ministry of Public Health in response to both the outbreak of SARS in 2003 and to AIDS epidemics. After 2009, FETP trainees and graduates were able to detect several new avian influenza cases through the review of clinical signs and symptoms, which were subsequently confirmed by reference laboratories. In response to avian influenza threats, the programme played a vital role in coordinating 1070 surveillance and rapid response teams nationwide, which was triple the number of national and international trainees.
Conclusion

A workforce shortage has been globally recognized as a major mismatch between population needs and the available health workforce in terms of overall numbers, relevant training, practical competencies and sufficient diversity (World Health Report 2006). Given the MDG stakes, challenges of re-emerging infectious diseases and the increasing complexity of chronic noncommunicable diseases, it is the right time to revisit public health education. A regional network such as the South-East Asia Public Health Initiative can serve as a platform for public health education reform.

The workforce is arguably the most important input to any health system and has a strong impact on overall health system performance; hence, the strategic nature of health workforce issues, in several senses. The health workforce is a strategic element in almost any type of desired reform outcome. It is everyone’s responsibility to lead a healthy global society.

References

Annex 6

Opening Remarks by Dr Samlee Plianbangchang
Regional Director, WHO South-East Asia

Excellencies, distinguished participants, honorable guests, ladies and gentlemen,

I am very pleased to welcome you all to the Regional Meeting on “Health-Care Reform for the 21st Century”. This is one of our “high-profile” regional meetings on the current topics of our “priority concerns” in health-care. The primary purpose of these meetings is to advocate for policy and strategy changes in the health-care systems.

I overwhelmingly thank all participants for sparing their valuable time to attend the meeting. I specially welcome our distinguished keynote speakers H.E. Lyonpo Zangley Dukpa, Minister of Health, the Royal Government of Bhutan. Lyonpo Zangley Dukpa has been in the mainstream of the “Gross National Happiness” movement in Bhutan since its inception. The movement is now internationally known and followed; H.E. Dr Fernando S. Antezana, former Deputy Director-General of WHO, former Chairman of WHO Executive Board and former Minister of Health of Bolivia. Dr Antezana was Deputy Director-General of WHO when the Organization underwent a reform process in the light of the global changes during the 1990s, a process that inspired the new paradigm of public health today. Dr Amorn Nondasuta, President, Foundation for Quality of Life, and former Permanent Secretary for Public Health, the Royal Thai Government. Dr Amorn was the pioneer of PHC development of public health-care in Thailand during 1980s which had been a lesson for many countries in Asia. He has also been a key supporter of the health-care reform in Thailand.

I sincerely thank them for their interest, time and valuable contribution to this meeting. We look forward to their inspiring and thought-provoking keynote speeches.

Excellencies, distinguished participants,
It is time to revisit “Health-Care Reform” to identify necessary changes in our systems that are needed to ensure universal coverage of health services for “all people” and to chalk out a road map for effecting those changes in countries of South-East Asia Region during this Century. This is with the view to accelerating progress towards:

- better equity and social justice in health; and
- a universal coverage of, and unlimited accessibility to, health services for “all people” in all countries.

We will appreciate that these broad objectives of health-care development will need to be achieved, among others, through:

- full community participation and involvement, and
- multisectoral and multidisciplinary actions.

We need this reform because several important public health problems still prevail in countries of the Region and we are currently facing a multitude of new challenges that need more robust health-care systems to tackle. These challenges stem from the various crises of our times, such as:

- climate change,
- the global economic downturn,
- emerging infectious diseases, including pandemic Influenza A(H1N1), and
- fast emergence of Noncommunicable diseases.

We should take these crises as another opportunity, to move one more step forward to strengthen our health-care systems; make our health services delivery stronger, more relevant, and more responsive to the changing health problems and needs of the entire population in the community.

We are now at another milestone in a long road to secure improved health for all people, for which the achievements of equity and social justice in health need critical re-examination. Attempts to reach the hard-to-reach, or to reach the unreached, must be intensified through innovative strategies. Overriding priority has to be accorded to health-care reform in the national political agenda—the agenda that ensures substantial change in
the health-care system to the innovative strategies; changes in the way health-care and services are planned and provided. We need the strategies that call for country-wide application of the PHC principle to ensure adequate health-care for all, including the poor, underprivileged, vulnerable and marginalized. These strategies must ensure the balanced development of health-care, with right mix of the preventive and curative services.

PHC should be made the cornerstone for reorientation of national health-care systems, the systems that take into account the entire range of health problems and health needs.

Major health problems include:

- mortality or deaths,
- morbidity, declared or undeclared by suffering people,
- silent diseases, diseases at early stage, and
- health risks and vulnerability, both known and unknown.

We need health-care systems that adequately recognize the role of sociocultural, economic and environmental determinants of health that prevail in a particular community. These determinants profoundly impact the health of people of all strata. We need health-care strategies that:

- recognize the important role of “local governments” and “civil society”; in the management of “decentralized” health services delivery systems,
- adequately recognize the important role of “community health workers” and “community health volunteers”; who serve the majority of the population at the grassroots levels.

Attempts to reform the health-care system are not new. The reforms have been conceived and pursued worldwide in various forms for decades. During the recent past, there have been strategic developments in countries of the Region, in strengthening health-care systems based on PHC principle. These experiences will be shared during the course of this meeting. However, a lot more needs to be done in these reform processes to ensure health for all people everywhere, regardless of their social or economic
status. Big gaps in health status and in health situations are still prevalent everywhere.

The reforms have to continue to ensure health-care systems that are robust enough to effectively face emerging health challenges. More combined efforts of all sectors and disciplines are needed for successful health-care reform for the 21st century.

To effectively harness these combined efforts, able leaderships are indispensable. Such leadership can coordinate the work of various sectors across disciplinary lines, and is without “professional prejudice”, neutral and balanced enough to pursue the reform process successfully.

In this reform process, we should expect changes, among others, in:

- health policy development, with emphasis on balanced care between preventive and curative;
- the care that promote people to stay healthy, to lead a socially and economically productive life;
- health systems infrastructure and its governance, with emphasis on decentralized health services delivery to ensure reaching the hard-to-reach or to reach the unreached population;
- the development of human resources for health, with emphasis on workforce in the area of public health, primary care and primary health-care.

And even more important is the fact that the reforms should lead to significant changes in allocation of health resources, changes that ensures their equitable distribution, at both national and sub-national levels.

The reforms should lead to effective protection of health consumer through:

- improvement in ensuring the “people’s right” to unlimited access to quality health-care, and
- better recognition of “pride” and “dignity” of consumers in the process of health services delivery.
“Healthy public policies” should be further promoted in the reform process. These are policies whereby individual sectors seriously take into account “health concerns” in their development activities. Public-private partnership should be another important area for our attention in any discussion of health-care reform. Public-private partnership is not new. But its realization is yet to be achieved. The private sector should be motivated to take more responsibility in areas of public health and primary health-care. In managing health-care systems, there should be clearly defined roles of:

- governments at all levels,
- service providers—either public or private, and
- consumers of health services.

Ladies and gentlemen,

To achieve all these and others in the health-care reform process, what is essential is “unwavering political commitment and support”. “Untiring efforts” are needed for advocacy at policy level for strategic change; and for actions at the operational level.

Once again, I thank all of you for your kind attention to this meeting. I wish you, interesting and fruitful deliberations during the course of this meeting. I wish the meeting all success, and wish you all an enjoyable stay in Bangkok.

With these words, I declare the Regional Meeting on Health-Care Reform for the 21st Century open.

Thank you very much.
Annex 7

Programme

**Day 1: Tuesday, 20 October 2009**

- Address by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia
- Inaugural address of His Excellency Mr Witthaya Keawparadai, Minister of Public Health, Royal Thai Government – to be delivered by Dr Sathaporn Wongjaroen, Deputy Permanent Secretary, Ministry of Public Health, Royal Thai Government
- Nomination of the Chair, the Co-Chair and the Rapporteur
- Introduction of participants and announcements
- Group photograph

*Health Care Reform for the 21st Century in the South-East Asia Region: A Strategic Framework - Dr Myint Htwe, Director, Programme Management, WHO-SEARO*

- Keynote speech on Health Care Reform for the 21st Century by Dr Fernando S. Antezana Aranibar, former Deputy Director-General, WHO
- Keynote speech on Health Care Reform for the 21st Century by His Excellency Mr Lyonpo Zangley Dukpa, Minister of Health, Royal Government of Bhutan

**Parallel session 1 – Panel A and Panel B**

**Panel A: Governance: Health Policy including resource allocation, Healthy Public Policies, Decentralization of Health Services and Public-Private Partnership**

**Moderator:** Dr Carissa Etienne, Assistant Director-General, Health Systems and Services, WHO/HQ

**Main paper:** Governance: Health Policy including resource allocation, Healthy Public Policies, Decentralization of Health Services and Public-Private Partnership : Dr Somsak Chunharas, Thailand

**Country experiences:**

- Decentralization
  Speaker: Dr Laksono Trisnantoro, Indonesia

- Public-private partnership
  Speaker: Mr Naresh Dayal, India

- Health in all public policies (including Social Determinants of Health)
  Speaker: Dr Saroj Jayasinghe, Sri Lanka
Policy reform in health care delivery including referral system  
Speaker: Dr Pongpisut Jongudomsuk, Thailand

Panel B : Health Workforce Development and Management: Recruitment, Deployment, Task Shifting and Multidisciplinary Health Team

Moderator: Dr George Fernando (Sri Lanka), former Director, Health Systems Development, WHO -SEARO

Main paper: Health Workforce Development and Management: Recruitment, Deployment, Task Shifting and Multidisciplinary Health Team: Dr Lalit Nath, India (Paper prepared by Dr Deoki Nandan)

Country experiences:

PHC in Timor Leste: Lessons learned from Integrated Community Health Services (SISCa)  
Speaker: H.E. Dr Nelson Martins, Minister of Health, Timor-Leste

Community health clinics  
Speaker: Dr A.M. Nuruzzaman, Bangladesh

Multidisciplinary health team and task shifting  
Speaker: Mr Dorji Wangchuk, Bhutan

Community-based health workers/Community health volunteers: Maldives’ experience  
Speaker: Ms Shareefa Manike, Maldives

Day 2: Wednesday, 21 October 2009

Reflections of day 1

Keynote speech on “The Use of Strategic Route Map in Revitalizing Primary Health Care” by Dr Amorn Nondasuta, President, Foundation of Quality of Life, Thailand

Parallel session 2 – Panel C and Panel D

Panel C : Community Education and Empowerment

Moderator: Dr B.D. Chataut, former Director-General of Health Services, Nepal

Main paper: Community Education and Empowerment : Dr Kyaw Win, Myanmar

Country experiences:

Volunteer as change agent  
Speaker: Dr Nilambar Jha, Nepal

Income generation and community empowerment  
Speaker: Dr Faruque Ahmed, Bangladesh

Community education  
Speaker: Dr Alok Mukhopadhyay, India

Community empowerment using Strategic Route Map  
Speaker: Dr Narongsakdi Aungkasuvapala, Thailand
Panel D: Role of Public Health Institutions and Networks in Education, Training and Research

Moderator: Professor SK Akhtar Ahmad, Bangladesh

Main paper: Role of Public Health Institutions and Networks in Education, Training and Research: Dr Phitaya Charupoonphol, SEAPHEIN, Thailand

Country experiences:

Innovative education and task shifting
Speaker: Dr Mark Zimmerman, Nepal

Information and communication technology in education/training
Speaker: Dr Wansa Paoin, Thailand

Role of research in education and training for health care reform
Speaker: Dr Hasbullah Thabrany, Indonesia

Plenary - Briefing for group discussion and other announcements

Day 3: Thursday, 22 October 2009

Reflections of Day 2

Group presentation and discussions

Meeting of Drafting Group (Rapporteurs and WHO Secretariat)

- Presentation of draft recommendations by the Rapporteur
- Discussion
- Closure
Annex 8

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Report of the Regional Meeting

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Recognizing that health systems need to respond better and faster to people's demands in a changing world and continuing relevance of primary health care (PHC) and the values of Alma-Ata Declaration, a Regional Meeting on Health-Care Reform for the Twenty-first Century was held in Bangkok, Thailand, on 20-22 October 2009.

There are many notions of health-care reform. In general, health-care reform is an effort to increase effectiveness, efficiency, accessibility and responsiveness of the health system in order to improve health equity. However, most of the reforms undertaken in general and in developing countries in particular, focus on medical care. Thus, reform in financing of the health-care is directed mostly for achieving universal coverage of the population for curative and rehabilitative care i.e. medical care whereas very little, if any, reforms devoted to improve preventive and promotive care.

The regional meeting aimed at developing consensus on strategies for health-care reform for the South-East Asia Region; to review and build consensus on a strategic framework for health-care reform; to identify the role of public health institutions and networks in education, training and research for health-care reform, and to identify ways to take forward the strategic framework for health-care reform.

The meeting made recommendations for Member States regarding administrative review to ensure improvement in governance and leadership, health infrastructure development, improvement of service delivery, multidisciplinary team and other factors. WHO was asked to support healthy public policy, such as health impact assessments, share health workforce management information, develop a forum to discuss task shifting and develop guidelines, and to support Member States to include NGO/SEAPHEIN in PHC capacity building.