Day One – Friday 7th October

1. Introduction and first session: Capacity building for health system research in Asia-Pacific, International Perspectives

Participants on day one were primarily in-country partners; HPHF Hub staff and a small number of technical advisors. Kris Hort outlined the aim of session one: to provoke interest in better linking research and policy and to bring together some recommendations about future programs/mechanisms on research capacity building.

Barbara McPake’s presentation on DFID experience in research capacity building described DFID’s previous arrangement of funding academics within universities and the subsequent development of Knowledge Programs and research program consortia, including international partners. Some of DFID’s work to build health economics capacity internationally in the 1990s included: a Bangladesh research partnership which closed due to internal divisions and a Brazil partnership which experienced problems with the capacity of institutions to absorb newly trained senior researchers. Some lessons were highlighted from these experiences: it is better for research partners to choose each other, rather than for these partnerships to be imposed; capacity building works best over the long term and needs to operate at multiple levels: individual, institutional, organisational. This is now reflected in DFID’s capacity building strategy.

Kris Hort presented on strategies for capacity building for health systems research in LMIC: lessons and ideas from ICDDR,B. The presentation is downloadable from the HPHF Hub website.

Participant comments from this session:
- It is important to reduce the gap between researchers and policy makers.
- Research institutions need to be more proactive in advocating for use of evidence.
- Assured long-term funding is key.
- There is a need to involve MoH policy-makers through building the capacity of MoH and building links between MoH and researcher institutes.
- Independent researchers play an important role.
- Capacity building at networks/linkages/partnerships level is important but often neglected.
- Capacity building for researchers to communicate with policy-makers would be useful.

2. Needs for research capacity - experiences so far from a researcher perspective

During the second session for the day, some HPHF Hub partner organisations from the Asia-Pacific region shared their experiences of research capacity building.

Shita Dewi from University of Gadjah Madah:
Some examples of partnerships for the Center for Health Service Management at UGM over the years have included:
- A WHO-supported program providing support for nursing and midwifery at primary care and secondary care levels;
- Joining the Equitap network for building capacity in equity research;
Participation in World Bank Institute Flagship program in 2005, commissioned to conduct Flagship program for Indonesian participants. Individual capacity building. Enabling discussion and relationships with academics;

Asia Network programs - e.g. Public-Private Partnerships course; and

The relationship with Nossal Institute – importance of understanding institutional capacity and pace of work. Shita had a two week secondment working at Nossal Institute and writing a chapter of a book, which was very worthwhile. The partnership with the Nossal goes beyond research, to how to move the research into the policy agenda.

**Ir Por – National Institute of Public Health, Cambodia.**

PowerPoint presentation outlining a range of health systems capacity building initiatives in Cambodia including funding to institutions, workshops, short-courses, e-learning, peer support, mentoring.

Key points:
- There are few long-term capacity building initiatives in Cambodia.
- It is important to match capacity building with need/demand.
- There is a general lack of interest from policy-makers in research.
- Health practitioners’ and policy-makers basic research capacity building is neglected.

**Sharon Biribo – Fiji National University**

Key points:
- Fiji lacks a critical mass of health professionals, as well as financing and time.
- External funding and priorities drive research and often once funding ends, people are lost – capacity is not institutionalised.
- Research training is being undertaken with MoH to develop research at the four divisional levels. FSMed have supported this through a joint workshop, and MoH-trained staff are working within research centres.
- FSMed work to align research with the National Strategic Plan.
- A policy unit is being built within Fiji MoH.
- FSMed regularly receive enquiries from the region to assist in research skills which they are often unable to meet due to a shortage of staff.
- Ways to utilise alumni are being considered – for example, using them as researchers and contact points. Also considering tapping into other Universities in the region.
- Other institutions can help through mentorship and guidance, links with technical institutes.
- Accredited courses are important to fit in with career pathways.
- Capacity building is being measured by tracking research that flows on from training, numbers of publications from the region, inclusion in authorships, inclusion of data generated by institutes, ensure acknowledgement of in-country contributions.

**Tran Thi Mai Oanh – Health Strategy and Policy Institute, Vietnam**

PowerPoint presentation outlining HSPI’s role in the research to policy process, experiences of capacity building and suggestions for improvement.

3. **Recommendations for development partners for future capacity building for health system research**

Key discussion points on research capacity building issues:
- Capacity building should include the development of institutions.
- A mix of both internal and external support for capacity building is needed.
• Aid effectiveness principles should apply to capacity building in research: country ownership and leadership, alignment with country priorities, coordination and harmonisation, common results framework.
• How to involve capacity building in the Asia-Pacific Observatory activities?
• Specific TOR could be developed for AusAID research centres to include a program of applied research relevant to policy decision making.
• Low rates for local researchers compared with international consultants are problematic.
• It would be interesting to look at the different funding models used by different institutions – what are the pros and cons of different models?
• What are the roles of professional organizations of doctors and nurses in linking research to policy?

4. NCD policy development in Bangladesh
Dr Dewan Alam from ICDDR,B in Bangladesh presented on NCD Policy development and particularly on research utilising a matrix developed by Helen Robinson and Krishna Hort. ICCDR,B have not done any critical assessment of the framework yet, but there seems to be scope for improvement, particularly in terms of the qualitative elements – how objectively can results be presented? At what point do we know when elements are inadequate, adequate? Example for awareness scores ‘3’, is that adequate or not? Need to have some type of quantitative measurement by which to place or score a country, qualitative measures may not be useful.

5. Brief recap by Barbara McPake on Health Systems frameworks
Barbara McPake gave an overview of the ‘dynamic responses’ health systems model.

6. Strategies for hospital reform in Low and Middle Income Countries
Kris Hort provided a brief introduction about the role of hospitals, and how they engage in broader sector reform. Shita Dewi from University of Gadjah Madah presented on experiences of hospital reform in Indonesia and then Khuong Anh Tuan presented on Implementation of Hospital Autonomy in Vietnam.

Comments:
• Case studies present an entrepreneurial response to greater autonomy of hospitals – something which planners don’t always expect.
• Regulations relating to surpluses and deficits are needed.
• In Indonesia, profits are re-invested in developing the hospitals, investing in service provision and hospitals are allowed to borrow in cases of deficits.
• In Vietnam, if there is a surplus, must spend 25% in hospital HR (staff salaries specifically). In term of deficits, hospitals try their best to avoid incurring deficits. Charge fees for services not covered by insurance.
• Key to the hospital autonomy question is what it means to be a for-profit entity and how that should be regulated.
• There is a need for more clarity on line between for-profit and not-for-profit, difficult to distinguish between both based on behaviour.
• It was interesting to see how certain outcomes of privatising could be seen as both positive and negative – for example, the increase in CT scans may be a positive, but they could also be unnecessary.
Day Two – Monday 10th October

1. Overview
Tamara Khosla from AusAID gave an update on the Knowledge Hubs for Health initiative.
Key points:
- Dissemination and monitoring and evaluation are the current priority for the Initiative. AusAID also needs to improve its own engagement with the Hubs.
- Early engagement of stakeholders is key.
- It hasn’t yet been decided if the design of the next phase for the hubs will be market-based or designed in house by AusAID.
- Links with ARC/NHRMC (centres of excellence model) are being considered.
- A competitive tendering process will commence in 2012.
- The focus areas for the next phase are likely to be Health Systems Strengthening, Maternal and Child Health and disease prevention.

2. Tapping the potential of Health Policy networks: examples from Asia and the Pacific
Presentations on Asia Health Systems network (Laksono Trisnantoro, UGM); Pacific NHA networks: Martina Pellny (WPRO); Pacific Health Information Network: Maxine Whittaker (HIS Hub); Pacific HR network: Graham Roberts (HRH Hub).
General comments:
- Networks have the strength to be able to engage and advocate for policy (collective voice) and engage in policy dialogue.
- Networks contribute to strategic direction, capacity building and communication.
- Pacific networks are relationship-based and more informal whereas the Asian network (ANHSS) is restricted to select organisations – challenge of expansion and membership to networks.
- An untapped network is the large number of alumni from Australian universities who are in positions various health Ministries across the Pacific.
- Networks are trying to package information but still the challenge remains of reaching busy senior policy-makers through the plethora of information. How can policy makers access information effectively?
- Translating global evidence for local policy and vice versa is a challenge.

3. Working Groups: How can the existing networks better contribute to evidence based policy making?
Two questions were identified for group discussions:
1. What can networks contribute to evidence based policy making in each context?
2. What management support do networks need in each context?

Group 1: In-country networks in Asia
Group discussions were chaired by Shakil Ahmed and key discussions were presented by Khim Keo Vathanak.
1. What can networks contribute to evidence based policy making in each context?
Capacity development; technical assistance; pooling in-country resources; reducing duplication in in-country research studies and increase efficiency; avoiding conflicting messages; facilitating links with international networks; providing different policy options; knowledge translation and advocacy

2. What management support do networks need in each context?
Financial resources; Human resources: coordination and translating technical issues into policy languages considering the country context; support for meetings.

**Group 2: Inter-country networks in Asia**
1. What can networks contribute to evidence based policy making in each context?
Regional network can speak on common issues in public health and should think about norms and standards; Link with formal inter-country policy-makers associations.

2. What management support do networks need in each context?
Financial; Full-time professionals for managing network activities; flexible management for long life network.

**Group 3: Pacific networks**
1. What can networks contribute to evidence based policy making in each context?
Legitimising activities, and engaging in policy; Increased confidence to engage with govt and with donors; Helps advocate (not be a lone voice), can interact with policy in culturally appropriate way; Coordination to help synthesise and reduce duplication; Exchange of technical information; Element of motivation/competition; May not be the best provider of training: except for a standardised course (e.g. health reform course and Asia HSS Network). Perhaps their better role in training is in reaching consensus on course content and curriculum; Communication to support shared terminology and understanding.

2. How the hubs could contribute to networks?
Hubs can do a better job of coordinating and communicating between the networks that they relate to – to do reduce their impact and calls for time from countries. Avoid creating more networks, be aware of what exists. Don’t expect the networks to coordinate the hubs, hubs should coordinate first. Secretariat functions. Link to SPC is critical.

**From Engaging the non- state sector to stewardship of mixed health systems: regulation**
Papers on the non state sector from India, Indonesia, Vietnam & Papua New Guinea were presented. At the end of this session, a presentation was made on the stewardship of mixed systems.

Discussions focused on types of health systems at the different levels and managing public-private mix health systems at the macro and micro level. Discussion highlighted regulation, tax subsidies and private insurance as key issues for mixed health systems. Clear policies are needed for the private sector at macro and micro levels. The roles of community and users in shaping the policy, regulation and stewardship function were also highlighted during the discussions. Questions were raised about the very limited role of private sector in service delivery for the poor and disadvantaged populations. The experience of Eastern European countries in the privatisation of hospitals could be referred to.

**Day Three – Tuesday 11th October**

1. **Strategies to achieve equity and universal coverage in health care**
Three presentations were made in the morning session.
1. Marco Roncarati provided an update on social protection strategies. The paper highlighted issues of equity, social protection, cost and good governance, which is important to provide protection at reasonable cost.
Key points:
   - Achieving universal coverage is important even more so as income levels increases. Equity should be in relation to need – as some have greater needs such as vulnerable groups: migrants, poor, women, young people, disability etc
2. Martina Pellny, WPRO provided an update on WHO strategy on universal coverage (UC). The presentation highlighted key findings from the World health report on UC. Some of the key points discussed were:

- UC is not a new concept – it links to WHO constitution in 1948 and Alma Ata in 1978
- Financial risk protection is needed as there is high burden of catastrophic expenditure (affects 150m per year) as reported in WPR – 80 m (2008 figures). Out of pocket expenditure (OOP) is more than 60% in Cam, Lao, Vietnam and approximately 50% in China.
- Some of the solution are to:
  - raise funds – more money for health
  - reduce out-of-pocket – more equity in health
  - more efficient use of resources – more health for the money
  - Reduce OOP reliance by
  - switching to prepayment
  - must have about 4-6% of GDP as compulsory prepayment contributions for UC
  - community insurance okay early, but needs to be on a track to consolidate and merge funding pools
  - special arrangements for the poor – free, subsidies, vouchers

3. Shakil Ahmed provided an update from a recent conference in Malaysia. Key points discussed after the presentation included:

- WHO has identified a minimum package for UC with some provision for HIV/AIDS and NCDs but it does not include expensive medicines.
- The issues of price control, pharmaceutical, medicines, excess profit, cost were discussed.
  Interventions needed includes taxation, govt subsidy, tax incentives
- The cost for medicines could be reduced, as in India with the use of the generic brands. Presently the average cost of the UC package is based on averages only and is country specific.
- Although the UC debate is not new, progress should be noted, particularly in terms of the consensus among different players such as WB, WHO, IKO, ESCAP, Oxfam regarding UC.
- A key question is about the quality of care – is there a way to compare the quality of services according to socio-economic status. Is there a consensus for the quality of care issue?
- Work is needed directly with the various government departments particularly with Ministry of Finance (MoF). The Ministries themselves may pose barriers to UC.

2. In-depth examination of progress/strategies in Cambodia, Laos and Indonesia.
Soewarta Kosen presented on Indonesia’s maternal health insurance scheme. Key points:

- Health insurance is for the poor, but only used by 40m of 76m eligible poor. There is provision of universal maternity benefit. Poor people have access to it if not covered by any other scheme. It is delivered through physician, midwife, puskesmas, maternity clinic, hospital.
• One major bottlenecks is supply and placement of trained staff.

Ros Chun Eang presented on the UC situation in Cambodia. Key points:
• There is a fragmented system for financing – user fees (not cost recovery) and exemptions, a number of health equity funds, voucher schemes and CBHI,
• There is a move to compulsory social health insurance – one for private sector employees, and the other for civil servants.
• Health equity funds (HEF) cover 80% of the poor – preparing expansion with CBHI (covers 1%, all small donor-supported projects) and consolidation.
• A draft master plan for Social Health Protection from 2008 is being revised.
• Challenges include persisting poverty (sustainability – currently donor funded), limited understanding of prepayment, low levels of quality of care, local technical/institutional capacity for SHI.

Chansaly Phommavong made a presentation about the situation in Lao PDR. Key points:
• There are presently four social health protection schemes since 2002, with varying ministries, participants, compulsory vs voluntary – including SHI/CBHI/HEFs.
• Four schemes cover only a small proportion of target populations, only one that is close to full is SHI for civil servants, 80% of poor are mostly not covered.
• Roadmap of organizational, funding, operational, membership and provider tasks to achieve integrated social health protection by 2020.
• Recent developments include:
  – more channels of payment (reduce direct patient payments) and
  – increased govt investment – agreed at 9% of total government expenditure
  – commitment of a supplementary budget for free maternal care, going to govt Nov 2011 – guidelines and policies now drafted, with local costing
  – expansion of HEFs to more districts

Key points discussed after the presentation included:
• Fragmentation is an important issue. How to secure funding for long term sustainability?
• Quality of health care, understanding of prepayment, voluntary contribution to UC, maybe a NGO could provide technical competency.
• CBHI really could contribute to UC. A problem is the governance of funding of these schemes.
• There is a problem of geographical inequities as well as income-related inequities of access.

3. How can development assistance engage with and support health system policy making/ reform?
Beth Slatyer presented on AusAID’s approach to health in developing countries.
Soewarta Kosen presented on the roles of development assistance in supporting health systems policy formulation and reform in Indonesia.
Laksono Trisnantoro presented on how Indonesia’s non-state providers study influenced policy
Net Neath from Cambodia presented on policy engagement in Cambodia. Some key points:
• The capacity of MOH to take a lead in policy formulation is limited.
• There is no think-tank to provide recommendations to policy makers.
• Research institutions have limited input in supporting policy decision making.
• The health information system remains weak.
• Suggested process: Establish an MoH think-tank – with NIPH, DPHI, Sub-TWCG to provide policy recommendations to TWGH and receive priority issues from TWGH.
Bouaphat Phonvisay from Lao PDR spoke on aligning the work of the sector working groups to support health policy making/reform in Lao PDR.

Key points discussed after the presentations:

- There are supply and demand issues in research for policy making – there are issues relating both to the capacity for provision of good evidence; and with the capacity of MoHs to demand evidence.
- China has multi-ministerial policy drivers.
- Research can be improved by understanding/documenting use of evidence in policy-making.
- What does aid effectiveness mean in this space? Own national policies to advance/improve policy capacity/research capacity/investigator led capacity/research institutes etc; developing longer term research capacity/analysis – more straight forward for donor partners to support
- Health policy often follows the money - “The Money” may be volatile, unpredictable; health policy also often follows the politics
- Development partners still often cautious about using national government expenditure systems to deliver.

4. Hub perspectives and experiences in engaging with policy

Representatives from each of the Knowledge Hubs presented on their experiences to date in engaging with policy. Some key points for consideration:

- Context does matter; complex policy environments – respect and learn;
- Clarity of aim of policy intervention;
- Capacity in-country to implement policy;
- Partnerships – who is mandated or sought to provide policy advice;
- Development partners – how to advocate to use resources more effectively;
- What is policy change and practice change;
- How do you get base line, mid line and end line measurements?

5. Reflections on Technical Review Meeting and Closing

Reflections from Barbara McPake:

- The TRM has reflected impressive work and partnerships.
- The external review of the Hubs indicated a gap between research and policy.
- AusAID to be commended for understanding the importance of this kind of investment;
- The Hub concept must be much more than the written outputs and encompass the ‘software’ of getting evidence to policy – trust and relationships.
- The label ‘hub’ suggests that Australian institutions are in the centre and partners the spokes – this does not reflect the reality that south-south relationships are part of these arrangements.
- The TRM included a range of interesting and useful discussions and sophisticated debate, and demonstrated less of a drive by by international (or outside) actors and more by countries.

Closing comments from Kris Hort:
Thanks to: external resource people and others who participated; country partners - who have really made this event; impressed by quality, depth of thinking; standard of presentations; Hub team – particularly Jodie, Melissa, Hub partners; Barbara McPake.