Opening Plenary

June 3, 8:30 am – 9:00 am

Jonathan Quick, Management Sciences for Health (MSH)

Jonathan Quick opened the conference with a brief history of universal health coverage (UHC) and noted that the increasing momentum around UHC has made now the perfect time for action. He then quoted World Bank President Jim Kim from the 2013 World Health Assembly, "the growing momentum for universal health coverage coincides with a new chapter in the global fight against poverty."

Dr. Quick told the audience that in the global UHC conversations, access to medicines has been a major blind spot. He stressed five key points on the importance of medicines in the move towards UHC:

1. Medicines are key to ensuring health impact
2. Medicines is have been missing in finance-dominated conversations around UHC
3. Financial protection needs to look at access to medicines as an important component
4. UHC viability is dependent on proper financing and coverage of essential medicines
5. Pharmaceutical policy should be linked to other development and commercial activities

Carissa Etienne, Pan American Health Association (PAHO)

Dr.. Etienne began by acknowledging the foundational principles of the UHC movement: equity, solidarity, and human rights. However, despite a common belief in these principles, there is not a common understanding of what constitutes UHC. She stated that UHC is both a goal and process while asserting that all people have the right to receive quality health care when they need it without catastrophic expenditure. However, this must not be taken to mean that UHC only means financial protection. Rather it is only one part of a complex system that must include access to essential health services and treatments. UHC is all encompassing and must go beyond treatments to include preventative interventions as well as examine the social determinates of health.

Dr. Etienne also emphasized that UHC needs to be a process, not a task to complete. Member states often feel pressure when they are called upon to achieve UHC, but they should think of working toward UHC as a work in progress that needs strong monitoring and evaluation along the way.

She concluded by emphasizing the importance of medicines in UHC. More than one billion people worldwide do not have access to curative health care, and purchasing medicines causes more household catastrophic expenditure than inpatient and outpatient services combined as most medicines are paid for out of pocket. Ms. Etienne ended with an assertion that PAHO supports having a dialogue around medicines role in UHC as medicines are critical in the progress towards and achievement of UHC.

Perspectives from Ministries of Health and Insurance Systems Panel Discussion

June 3, 9:00 am–10:00 am

Moderator: Kees de Joncheere, World Health Organization (WHO)

Panelists: Cristian Morales, Ministry of Health (MOH), Mexico; Sayed Abu Jafar Md. Musa, Ministry of Health and Family Welfare (MOHFW), Bangladesh; Kenneth Hartigan Go, Food and Drug Administration (FDA), Philippines; Giselle Rodríquez, MOH, Costa Rica; Than Win, MOH, Myanmar; and Boshoff Steenekamp, Council on Medical Schemes, South Africa

As the panel session's moderator, Kees de Joncheere asked questions to bring out the perspectives of Ministries of Health and Insurance Systems on the topic of UHC and access to coverage. They were—

- What are your perspectives on medicines coverage and UHC in your own country?
- Who's making the decisions? Is it the Ministry of Health (MOH)? What is the role of Ministry of Finance and other government agencies involved in coverage decisions?
- What barriers do you face as you move toward UHC?

Several key themes arose out of this question and answer session:

- **Fragmentation of efforts and their relationship to governance:** In Mexico, fragmentation is the main barrier that is inhibiting progress toward UHC. For example, there are two different systems/funds that relate to the benefits package. Additionally, there are another 32 entities that have a role in decision making. For example chronic diseases, such as diabetes, hypertension, and cardiovascular diseases are main health problems in the country; however, there is not an integrated approach to addressing these chronic diseases.

- **Affordability of UHC in the context of ensuring quality care and medicines, expanding coverage to poor and vulnerable populations, and reducing out-of-pocket expenditure:** In Bangladesh, the government wants to minimize out-of-pocket expenditure, particularly for the poor, to help improve access to care. However, in many cases, doctors may prescribe more costly antibiotics to serve their own interests, which raise the cost of care. Additionally, it is hard to guarantee quality medicines with the current political environment. Because of the variety of groups supplying medications in Bangladesh, it is difficult to ascertain and ensure medicine quality. Reducing out-of-pocket expenditure in the context of rising health care costs and competing interests has proved challenging in terms of the affordability of UHC as a whole.

  Sustainability of UHC programs, even where UHC has already been achieved: In Costa Rica, sustainability was cited as one of the primary challenges of the UHC program. Many individuals and families are already covered; however, for those who cannot afford health care, the government is obligated to pay for it. Currently, there is a long waiting list for many procedures, even those that are urgent. Costa Rica has recognized a need to improve the quality of services and medicines which will require alternative funding without increasing taxes.

One participant asked about the role of other government ministries and departments that run their own health care system and the process of potentially merging these systems with national systems. Another participant asked about the most appropriate way to manage the expectations of patients and doctors alongside growing prices and volumes and services.

Challenges with Financing, Management, and Benefit Policies

June 3, 10:30 am–12:30 pm

Co-moderators: Anita Wagner, Harvard University; and Alexander Padilla, PhilHealth, Philippines

Ms. Wagner began with a brief overview of global spending on medicines per year, then looked at the challenges with medicines financing, management, and benefit policies. According to her, global expenditures on medicines have surpassed $1 trillion per year and much of this spending is shifting from high income to low/middle income countries. By 2016, emerging market economies will account for 30 percent of medicines spending. Dr. Wagner acknowledged that medicine expenditures makes up a large part of total national health expenditure, and in poorer countries, the percentage spent on medicines of medicines is even higher. The implication is that financing strategies for medicines are critical for UHC, particularly in poorer countries.

Mr. Padilla said that conversations need not center on getting more money, but instead need to focus on "getting more health for the money." He further advocated for rational and transparent decision making as countries decide what benefits to include and how to implement UHC financing strategies. Mr. Padilla based his advocacy on the assumption that there will never be enough money to pay for everything, so policy makers and implementers need to use good information and be clear on why they choose certain medicines over others.

Mr. Padilla concluded with an explanation of "SARAH," an acronym that stands for key tenets around rational decision making: S is for safety and quality of services, A is for access and availability, R is for rationality of use, A is for accountability and good governance, and H is for health system support.

Ms. Wagner ended with a discussion on medicines and health spending. She noted that medicines account for a disproportionate amount of unnecessary spending in health care and offered the following examples.

- Many of the medicines purchased are newer, brand name medicines which are more expensive than generics but not necessarily better for treating the condition. Taxes and tariffs on brand name medicines can also add to additional medicines costs.
- Bad quality products, particularly in the form of counterfeit products, is an immense waste of money.
- Inappropriate use of medicines also contributes to poor quality treatment and inefficiency. For example, 50 percent of prescriptions in primary care are for antibiotics, which is much higher than it should be at the primary care level. Low cost medicines are underutilized in chronic disease management, such as using low dose aspirin to prevent secondary cardiac events from taking place.

Following Ms. Wagner's and Mr. Padilla's session, participants divided into three groups to further discuss the concepts of financing, management, and benefits policies as they relate to the following three topics: (1) essential medicines benefits packages, (2) innovative high cost medicines and health technologies, and (3) chronic disease care.

Reports from Group Work Sessions

June 3, 11:30 am–12:30 pm

Essential Medicines Benefit Packages
Discussion Lead: Richard Laing, World Health Organization

Dr. Laing provided a summary of the group's discussion on essential medicines benefit packages. The group started their breakout session with a discussion what coverage really means. The group presented four options:

1. All benefits for all people: this option was considered unrealistic, given affordability
2. All benefits for some people: this option is present in some countries; often it is those who can pay that receive the benefits
3. Some benefits for all people: this scenario is often seen in the form of vaccinations for specific populations or age groups.
4. Some benefits for some people

Additional questions included "should all medicines on the Essential Medicines List be included in coverage," "should coverage be even more expansive," "how do you prioritize diseases that have a high public health risk," and "are preventative benefits included in outpatient care?"

Innovative High Cost Medicines and Health Technologies
Discussion Lead: James Fitzgerald, Pan American Health Association

In his summary discussion on high cost medicines and health technologies, Mr. Fitzgerald first recognized the trend of growing demand for high-complex medicines, including many cases of substituting newer, expensive medicines for existing medicines that work well. This scenario raises the need to evaluate higher cost medicines that have recently come on the market and consider the ethical and political implications of introducing them.

Mr. Fitzgerald also noted that it is important to institutionalize decision-making processes and have clear criteria for including higher priced medicines and technologies. One possible approach is to build on the Essential Medicines List (EML) processes to set criteria for medicine's use and to further build evaluation and assessment processes in LMICs for these new products. Additionally, the group explored options such as enforcing EML at the national level, establishing a process for health technology assessment, and building on international knowledge and experience.

Chronic Disease Care
Discussion Lead: Wondu Bekele Woldermariam, Ethiopia

In his plenary report out on non-communicable diseases (NCD) benefits management, Mr. Woldermariam listed five key principles that are central to NCD discussions—

1. Remember that NCDs are a systems-related issue.
2. Raise awareness on prevention as most NCDs are preventable
3. Increase access to medicines for NCDs, particularly those that are low cost, prevention-related.
4. Consider the political environment needs to be considered when discussing policy and action around NCDs
5. Start today to prevent catastrophic spending in the future

The group discussion focused on the idea that in policy discussions, chronic diseases need to be differentiated. For example, hypertension and diabetes should not be grouped with cancer because this grouping may scare off donors and policy makers. The group suggested having strategies in place so when NCD treatments are in higher demand, the evidence has already been documented.

Perspectives on Public-Private Sector Collaboration
June 3, 1:30 pm—3:00 pm
Moderator: David Lee, MSH
Panelists: Gabriel Mbapaha (Namibian Association of Medical Aid Funds); Abdulkadir Keskinaslan (Novartis); Md. Imamus Sultan (Grameen Kalyan, Bangladesh); Alan Lyles (University of Baltimore, Pharmacy Benefits Management)

Gabriel Mbapaha, Namibian Association of Medical Aid Funds
Gabriel Mbapaha started the discussion with an overview on how the public and private sectors interact in the Namibia and some of the challenges that have arisen out of this interaction. Mr. Mbapaha, CEO of the Namibian Association of Medical Aid Funds (NAMAF), brought a unique perspective on public-private collaboration. NAMAF was established by Namibian national legislation help to control, promote, and coordinate the establishment and functioning of medical aid funds in Namibia. NAMAF works to protect members of medical aid funds against abuse from both medical aid fund organizations and providers of health care services and serves as an intermediary between medical aid funds and their members.

Mr. Mbapaha explained that the growing private sector has several challenges that need to be addressed:

- Accessibility to health care in among rural and poor people is growing problem. Because Namibia's population is small and rural areas are sparsely populated by poorer households, equitable access to health care is not a norm within Namibia.
- Neighboring countries, particularly South Africa, have played a role in raising the costs of health care and medicines in Namibia.

- Costs of medicines are influenced by utilization. As such, as wealthy people increase their medicines use, it is often at the expense of the poor. Additionally, current reimbursement models do not support cost containment strategies, such as promoting and using generics. Pharmacists also tend to band together to create powerful lobby groups.

Mr. Mbapaha concluded his remarks with the assertion that reimbursement models have to incentivize desired behavior by patients and service providers to be effective at increasing access and lowering costs.

Abdulkadir Keskinaslan, Novartis, Turkey
From his experience working at Novartis, Dr. Keskinaslan was able to give first-hand advice on how the private sector can help countries work towards UHC. He identified helping with technology transfer in production, supply chain management, and assessment with the goal of achieving greater efficiency. He also suggested that countries split their health care portfolio into primary and specialty care and manage them separately. Dr. Keskinaslan then shared eight lessons from various schemes in Asia that can help inform best practices for specialty care management—

- Should be simple to implement, administer, and evaluate
- Should address true clinical need
- Appropriate care and capable of being monitored
- Provisions should be limited to a number of select outlets
- Reviews should be built-in and held at least after two years
- Should be relevant to clinical outcome
- Should set acceptable clinical response guidelines ahead of time
- Should establish who is responsible for administrative burden

Md. Imamus Sultan, Grameen Kalyan, Bangladesh
Mr. Sultan spoke about his experience with Grameen Kalyan. Grameen Kalyan administers a number of primary care programs throughout Bangladesh, including a micro-health insurance programs. Once of the key challenges that Grameen Kaylan faces is that people generally do not want to pay in advance for health insurance—he compared purchasing health insurance to buying a cell phone card that will give people bundles of prepaid minutes but that people needed more information and counseling around the value of the cards. However, many people may still not want micro-health insurance cards because quality of care in rural areas is greatly reduced by the inability to retain doctors in the health facilities.

Mr. Sultan then noted that effective public-private collaboration must be financially sustainable. To avoid problems, services and medicines cannot be offered for free for two reasons: first, free services and medicines are not financially sustainable; second, people do not value free medicines and services and therefore will not use them. Mr. Sultan also emphasized the importance of long-term planning that goes beyond the typical election cycle.

Alan Lyles, University of Baltimore, Maryland, USA
Mr. Lyles presented the audience with a strategic framework that illustrated how public-private collaboration works. The framework posits that public and private for-profit entities bring together two organizing motives: equity and profit, respectively. In the public sector, most governments have experience establishing social safety nets and setting and enforcing standards. In the private sector, companies have experience in establishing effective payment systems, minimizing perverse incentives, have strong actuarial skill to price out the likely levels of uptake utilization and consequences, and are better positioned and motivated to innovate and increase efficiency. By using the strengths listed above, Mr. Lyles stated that it may be possible to effectively collaborate and build partnerships between the two sectors for an equitable and efficient system.

Mr. Lyles emphasized the importance of covering the following areas through use of the combined skills of the public and the private sectors—

- Administration: you need an administrative system to keep track of eligible benefits, information systems, and other details that are essential for sustainability
- Clinical: you need to design programs that look at relationships between vertical programs and comprehensive benefits
- Financial: you need a financial system that can track payments received, obligations, and accounts payable

Moderated Discussion:
Following the individual presentations, Dr. David Lee led a discussion where he posed a number of questions to the panelists regarding on how governments and private sector companies can collaborate to reduce the cost of medicines. Dr. Keskinaslan provided a private sector suggestion based on his experience working with Novartis. He stated that one potential solution is to have one low net price for a country. Several participants discussed the power of using the state as a bulk buyer, thus increasing the bargaining power of individual countries to reduce costs. Another discussion covered how to provide incentives to encourage the right behavior among providers, the government, and patients. All the panelists agreed that the public sector should learn how to incentivize better to improve care-seeking behavior and provision of services and benefits.

Information Needed for Decision Making

June 3, 3:30 pm–4:00 pm
Moderator: Dennis Ross-Degnan, Harvard University
Presenters: Phil Poley, Accenture; Tariq Abu-Jaber, Harvard Pilgrim Health Care

Dennis Ross-Degnan, Harvard University
Mr. Ross-Degnan opened the session on information needed for decision making with several key framing concepts to help the audience think about the topic during the presentations and the group discussions. Those concepts are as follows—

- IT systems evolve along a continuum—some are more developed than others and will thus move at a different pace in terms of sophistication.
- These systems take a huge investment, including a large upfront capital investment and continuing budget support.
- Countries need to consider what information is critical and prioritize those pieces of information.
- Consider where medicines should fit into IT architecture—they need to be a part of an integrated system.
- A country cannot focus just on the current needs of its member pool—it also must anticipate the needs of the future member pool to ensure that the system can adapt to future needs.
- Other data outside of the insurance scheme are also needed, such as epidemiology and population equity information.

Tariq Abu-Jaber, Harvard Pilgrim Health Care

Tariq Abu-Jaber addressed some key health information issues using the tenets of good project management as the framework for his discussion. When designing insurance schemes, there must be clear outcome objectives before building and implementing. Incentives for all parties—care providers, patients, and insurance companies—need to be aligned and thought out based on a chain of behavior. Finally, Mr. Abu-Jaber stressed the importance of thinking about the concept of return on investment as there will never be unlimited funding. This suggests that designers and program managers need to think about what is needed before they begin to implement. He concluded with some guiding principles for implementers to use when thinking through and planning for implementing their programs and schemes—

- Start with the question you are trying to answer (examples)
- Design metrics that will demonstrate if program goals are met
- Identify the data needed to perform that measurement
- Ensure that you collect the required data from the very beginning

Phil Poley, Accenture

Phil Poley used his experience as chief operating officer for Medicaid in Massachusetts to deliver one key message to the audience. He emphasized the importance of looking at the customer base for an insurance scheme and understanding what each individual needs. He asserted that insurance coverage should be tailored to make sure that the right people are receiving the right services and that it is critical to incentivize good care-seeking behavior. In terms of information systems, technology solutions need to help in the long term and be flexible, open, and based on standards as opposed to one vendor's product.

Reports from Group Sessions

June 3, 4:00 pm – 5:30 pm

Information Systems for Claims Processing
Discussion Leads: Alan Lyles and Kyle Duarte, MSH

In his group report out, Mr. Lyles discussed the challenges that the group identified around claims adjudication. The summary of these challenges is as follows:

- Many countries have mixed information systems that use both paper-based and electronic based information systems.
- These mixed systems lead to fragmented data, which result in long delays and sub-optimal data for decision making.
- Despite the regulations that require claims be processed within a set amount of time (which can range from 30 to 60 days in various countries),using processing times as an indicator can be misleading. For example, a claim may only be processed in 30 days if everything is filled out correctly. Otherwise, the claim may get bounced back and the timeline will restart.
- There is a need for clinical coding specialists, particularly regarding fraud and abuse, to identify coding patters that are suspicious.

Information Systems for Patient Care
Discussion Lead: Ricardo Pérez-Cuevas, Inter-American Development Bank, Mexico

In his group report out, Mr. Ricardo Pérez-Cuevas explained that many health information systems are most often used for managerial purposes instead of using them to improve health care quality. Additionally, many health information systems are in incipient stages and vary in their levels of development sophistication. The quality of information is often substandard. Mr. Pérez-Cuevas explained that there is need to develop regulations around confidentiality of data to ensure ethical use of patient data that is entered into health information systems.

Information Systems for Public Health Data
Discussion Lead: Gavin Steel, MOH, South Africa

Gavin Steel acknowledged the multiple sources of data that are available for public health; he noted that a major challenge is the ability to triangulate the multiple data sources. These sources can include utility of procurement data, sales data, and tracking expenditures and budgets. The group discussion focused on examining data to ensure rational medicines use and as well as using epidemiological data to help make evidence-based decisions. The group discussed the importance of routine data collection, which can take place in a number of different forms including follow-up surveys and social media to help increase the accuracy and timeliness of data.

Governing the Purchase of Health Services: Key Practices to Ensure Medicine Coverage
Panel Discussion

June 4, 8:45 am–10:00 am

Moderator: Jim Rice, MSH
Panelists: Cristian Morales, PAHO; Gilles Forte (WHO), John Simon (PharmAccess and Total Impact Advisors)

As moderator for the session entitled "Governing the purchase of health services: key practices to ensure coverage of medicines," Jim Rice opened the session with an explanation that when speaking of governance, it should be recognized that it is multi-sectorial. Within these various levels, there are six mechanisms that governance encompasses to change policy: regulations, law suits, market forces, contract obligations, oversight by governing bodies and the ethics of the various players. Mr. Rice further explained that "smart governance" should improve accessibility, availability, acceptability, affordability and accountability as they relate to the delivery of essential health services. Mr. Rice concluded his brief introduction with a summary of four essential governing practices as identified by the Leadership, Management and Governance project:

- Cultivate accountability
- Engage diverse stakeholders
- Set shared direction
- Be a good steward of resources

Cristian Morales, PAHO
In his presentation, Dr. Morales framed UHC as an overarching systemic goal that is built around the notion of "social protection in health." The right to health care must therefore be a prominent part of the social and political agenda and the model of care, such as primary health care and the integration of services, needs to be carefully considered. Medicines should be selected and purchased based on evidence of impact and strong regulatory bodies should be set up to approve medicine selection as well as innovation. Dr. Morales asserted that the delivery of medicines should be patient-centered with a basis in primary health care delivery and community participation. Morales concluded with the affirmation that health systems need to revalue medicines as social goods, regulate medicines markets, ensure access to essential medicines, and promote rational medicines use.

Gilles Forte, WHO
In his presentation, Mr. Forte focused on the relationship between good governance and reducing waste and inefficiency in the area of medicines and supply change management. Throughout the supply chain, there is sufficient space for inefficiency and unethical practices that can affect the entire health system as whole. The four leading causes of inefficiency are high medicine prices and underuse of generics, procurement of substandard and counterfeit medicines, inappropriate use, and system wastage. Good governance can contribute to UHC through the reduction of inefficiencies and unethical practices and the reallocation of resources for improved access to health services and medicines. Good governance

can also establish efficient processes and enable law enforcement, improve transparency, and prevent the misuse of funding.

Mr. Forte focused on two WHO programs that work to improve governance in the pharmaceutical sector: the Medicines Transparency Alliance and Good Governance for Medicines (GGM). Dr. Forte explained the Good Governance program, which works to (1) conduct a National Governance Assessment, (2) develop a good governance framework, and (3) implement good governance interventions. Dr. Forte emphasized the importance of high political commitment and improving methods for measuring governance improvements as key elements for success.

John Simon, PharmAccess and Total Impact Advisors
Based on his work with PharmAccess, John Simon offered his view about the realities of pharmaceutical regulation in sub-Saharan Africa. According to WHO statistics, 90 percent of pharmaceutical regulatory authorities are incapable of meeting their mission because of a number of different reasons, including lack of resources and unclear laws. Additionally, there are a myriad of pharmaceutical distributors—both registered and unregistered—that contribute to increasingly fragmented systems. Given that donors and private sector companies are putting billions of dollars into health care systems, there is a high susceptibility for corruption and misuse, and the system as a whole is designed to encourage these problems. For example, 30 percent of medicines in Kenya are counterfeit.

Mr. Simon stated that a key cause of the high levels of corruption and misuse within the pharmaceutical system was the number of places along the pharmaceutical supply chain where corruption can take place. Even if medicines are inspected upon arrival in a country, the likelihood that good quality medicines will make it to the patient is low. Mr. Simon asserted that it is imperative for governments and donors to pay for performance to better incentivize the delivery of high quality medicines to the patient. Otherwise, current incentive structures will derail efforts to curb counterfeit medicines and corruption within the pharmaceutical sector.

Implementing change: Opportunities and solutions and need for collaboration

June 4, 10:30 am–11:00 am
Co-moderators: Irene Agyepong, University of Ghana; and Jim Rankin, MSH

Irene Agyepong, University of Ghana
Dr. Agyepong opened her presentation with an explanation of the two sides of policy change: the political and the technical. Agyepong asserted that policy change is a dynamic process and should be thought of as a "moving target" that takes place within health systems that are constantly changing and adapting. She said that all people within the policy change realm need to be thought of actors with agency—that individual actors act behave in response to interests and can affect whether or not seemingly beneficial policy change takes place. Actors' power involves their ability to influence and control resources, the power to take things forward, to block or resist, and to shape other people's

minds. Finally, Agyepong emphasized the importance of integrating the political and technical into an iterative process to work to make political change possible. Without the ability to navigate the politics and the people and without the right evidence-based technical strategy, policy change is not possible.

Jim Rankin, MSH
Jim Rankin opened his talk on pharmacy benefits management (PBM) with the acknowledgment that PBM for UHC is different than traditional PBM because the end goal is different for each. For UHC, the goal is to increase coverage whereas the goal for traditional PBM is the maximize profit. One key point Mr. Rankin made is that every benefit that is considered needs to be considered within the context of the health system as a whole as it may have reverberating effects in places outside the medicines arena of the health system.

Mr. Rankin then described a number of options for selecting preferred providers. One approach is to create a standard contract and the providers that accept the contract then become the preferred providers. Another approach is to choose the providers and contract with them individually. A formulary list is another management piece that governments also need to consider their. Costa Rica has an open formulary, but in many countries this option is too expensive. One of the easiest ways to decide what is included is to use the national essential medicines list. As a last point, Mr. Rankin emphasized the importance of reviewing utilization data to analyze utilization patterns to make better PBM decisions.

Reports from Group Work

June 4, 11:00 am–12:30 pm

Effective Financing Approaches
Discussion Lead: Cristian Morales, PAHO

Dr. Morales presented his group's discussion as three parts: (1) the aspects or key elements of financing, (2) challenges, and (3) solutions. Under the elements of financing, Morales raised the issues of market failure, the importance of reducing out-of-pocket on medicines, financial protection against catastrophic expenditure, and improving efficient use of resources. The group reported that the challenges were developing and refining formularies, the lack of transparency in reference prices, and the negative perception of generics. For solutions, the group noted the following areas as potential places for positive action:

- Blending incentives with regulation and advocacy
- Strengthening governance systems to prevent misuse of limited funds
- Focusing systems on demand in addition to supply
- Using either centralization and de-centralization where appropriate and beneficial

How to Ensure Quality of Care and the Public's Health
Discussion Lead: Madeleine Valera, Philippines

In her report out, Dr. Valera began her discussion with a quick list of the key descriptors of quality that were defined by the group, including performance against expectation, patient satisfaction and value for money, and safety and effectiveness. Through a variety of country-based examples and a discussion of the existing mechanisms to address quality of care in public health, the group developed three statements for participants to ponder—

- There are significant problems with the quality of medicines and health care.
- This is reflected in the perceptions of stakeholders, in unintentional harm to patients, and overuse of ineffective care (intentional or unintentional)
- Poor quality generates additional costs, yet current financing arrangements may actually impede improvements

Approaches to Cost Containment
Discussion Lead: Alan Lyles

Mr. Lyles opened his report out with an acknowledgment that the issue at hand is much larger than cost containment. The focus on UHC has caused many countries to make expansive commitments and as they unroll, it becomes clear that the costs, including those on medicines, need to be contained in order to be sustainable. Dr. Lyles asserted the containment strategies need to not only be evaluated based on value for money but also on quality of care. It is also imperative to evaluate particular strategies in the local context. For example, having a generics-only policy may actually balloon overall health care costs if the quality of the medicines prescribed is subpar and thus forces patients to see multiple care providers and multiple levels in the health system. This specific example highlighted the importance of regulation, testing and having quality information publically available. Finally, to keep the costs of mistakes low, countries should utilize small scale testing and piloting as a way to see if programs work in local settings.

The Role of the International Community Panel Discussion

June 4, 1:30 pm – 3:00 pm
Moderator: Jonathan Quick, MSH
Panelists: Ariel Pablo-Mendez (USAID), Andreas Seiter (World Bank), David Evans (WHO), Guy Stallworthy (Gates Foundation), Swarup Sarkar, UNITAID; Gina Lagomarsino (R4D)

In the panel discussion entitled "The Role of the International Community," Dr. Quick moderated a conversation among donor and implementer representatives that covered several key themes: UHC policy and politics, the way that donors and thinking about funding, medicines and benefits management, and UHC in the post-Millenium Development Goals agenda.

In the conversation, the panelists discussed the rising demand for UHC across many different countries. David Evans, WHO, discussed that the concept of UHC is a condition where everyone has the services

that they need without going broke—at the household and at the national level. WHO member states have indicated that this is a priority and over 80 countries have requested technical support in financing for UHC. Additionally, Ariel Pablos-Mendez, USAID, made a clear endorsement of UHC as a way to reduce global poverty and achieve health goals, thus acknowledging an economic rationale for the support of UHC. Dr. Pablos-Mendez agreed with Mr. Evans that financing is critical because people's demand for health is still costing them too much in out-of-pocket payments and is resulting in a huge explosion of an unregulated private sector.

The panelist had a back and forth discussion around the topic of reducing the price of medicines through collective bargaining power. Several panelists emphasized the importance of having predictable markets and demand to incentivize companies to reduce the prices of their medicines. If a country can say that they will need a certain amount of medicines over a period of several years, companies will see this as a steady stream of revenue. According to Dr. Pablos-Mendez, the role of donors should be to ensure that the money is there for those medicines and to buy out that risk so that countries can negotiate reduced rates.

Finally, there was a brief conversation around the importance of innovation and knowledge sharing to help countries progress towards UHC. Gina Lagomarsino, R4D, talked about the importance of South-to-South collaboration. As countries and policy makers have successes, they need to have a mechanism to share them. This is the primary role of the UHC Joint Learning Network.

Summary of Discussion and Shaping of Guided Principles

June 4, 3:30 pm – 4:30 pm

Meeting participants broke up into six "domains of action" groups and identified the four priority steps that need to be undertaken for each domain to effectively work towards UHC:

Domains for Action

Medicine Benefits Design for Cost and Quality

1. Need to undertake utilization reviews. Start with the paper-based system, but investing in IT-based systems actually saves money in the long run.
2. Need to develop basic tools to cost the benefits, with particular emphasis on the medicines component.
3. Create a space for documenting the processes and thoughts around decision making. What tools can be used to select medicines and services.
4. Look at how countries can do a step-wise approach to rolling out benefit packages.

Public-Private Design for Cost and Quality

1. Define what public-private partnership means to each country. Health contracting? Buying out government facilities? Managing government facilities?
2. Create an enabling environment, such as supportive regulations, and ensure partnership will blossom
3. Align incentives with clear health objectives
4. Identify success stories and promote these

Information for Decision Making Across Systems (all stakeholders)

1. Define indicators and feedback mechanisms that can help decision makers find out what's really happening in system
2. Define methodologies—standardize data and interoperability of data across systems. Systems should be able to share information across bodies so that they can together inform decision making.
3. Provide information to patients about different options
4. Keep track of money/pricing.

Governance

1. Develop outcome metrics to lead to accountability and transparency
2. Link payments to outcome metrics—you get what you pay for. If you want to achieve outcomes, you need to provide incentives.
3. Upgrade regulatory body capacity
4. Be inclusive and engage stakeholders at all levels— up and down the supply chain, and across providers/players

Advocacy and Civil Society

1. Develop core set of metrics and most compelling facts for media and communications so that the key points get reinforced.
2. Develop national standards of indicators that inform choices. Update targets on regular basis.
3. Develop actionable plans for agencies
4. Demonstrate that a program works so that it gets rolled into national health agenda.

The Politics of Medicine and UHC

1. Acquire political savvy
2. Bring stakeholders together to build a common understanding of UHC
3. Understand and address fragmentation and inequity at country health level.
4. Understand position of professional bodies and develop a common understanding.

Medicines in UHC schemes: Next Steps

June 4, 4:30 pm–5:00 pm

Douglas Keene, MSH

At the end of the two days, Douglas Keene outlined four key action items as next steps to help move the discussion forward

- Prepare and disseminate proceedings of meeting via www.UHC-medicines.org
- Develop a white paper that focuses on the importance of medicine coverage as it relates to UHC
- Explore the forum for continuing dialogue on medicines and UHC
- Create a repository of information on medicines and UHC that everyone can access