Proceedings of the Universal Health Coverage: Considerations in Designing Medicines Benefits Policies and Programs Workshop

September 28-30, 2014
Cape Town, South Africa

Welcome

September 29, 8:30 – 9:00 am
Speaker: **Douglas Keene, Vice President, Center for Pharmaceutical Management, MSH**
Opening remarks from host country and partner organizations:

- **Precious Matsoso, Director General, National Department of Health, South Africa**
- **Dr. Delanyo Dovlo, Director, Health Systems and Services Cluster, Regional Office for Africa, WHO**
- **Anthony Boni, Pharmaceutical Management Specialist, Office of Health Systems, USAID**
- **Anita Wagner, Department of Population Medicine, Harvard Medical School and Pilgrim Care Institute**

Douglas Keene opened the conference with a brief overview of the rationale behind the workshop and an introduction of the convening partners. He noted that Universal Health Coverage (UHC) is a key component of MSH's 5-year Strategic Roadmap. The previous meeting hosted by MSH and its partners was held in Washington, DC in June 2013. *Medicines as Part of Universal Health Coverage: Starting a Dialogue* brought together stakeholders from 11 countries from around the world. At the conference, unanimous agreement was reached on the need for regional technical meetings on medicines management as part of UHC strategies.

Dr. Keene highlighted that this year's conference, *Universal Health Coverage: Considerations in Designing Medicines Benefits Policies and Programs*, has four primary meeting objectives:

- Share experiences about how countries are incorporating or planning to incorporate medicines coverage into their UHC strategies.
- Develop a shared understanding of how sound medicines benefits design and management can contribute to cost containment and improved care.
- Build a case for evidence-based decision-making in medicines benefit design and management.
- Share MSH's thinking and plans for a medicines management guidance manual and options analysis tool.

As an interactive workshop, Dr. Keene stressed that the workshop will serve as a place for people to share and discuss ideas. With the workshop's regional focus, country representatives and partners can focus on shared concerns and regional experiences related to medicines benefits, while building networks for continuous idea exchange. After Dr. Keene's remarks, South Africa's Director General of the National Department of Health, Precious Matsoso, made her remarks. Subsequently, collaborating organizations, WHO, USAID, and Harvard University, gave introductory remarks.

The Director General of South Africa's National Department of Health, **Precious Matsoso**, emphasized that health systems should be able to deal with new epidemics, such as Ebola. There is an increasing demand for new medicines not yet approved by regulators. The Director General indicated that South Africa will be discussing the implementation of its UHC policy next week. She brought up a number of challenges faced by UHC in

implementation, such as addressing financial burden through risk pooling and risk-sharing mechanisms, combating fraud, and strengthening regulatory governance. She stressed the need for countries to adapt UHC according to the functionality of their health systems (upper middle-income countries (UMIC), post-conflict countries, etc.). Out-of-pocket (OOP) expenditure is often high for households in low and middle-income countries and often leads to impoverishment due to extremely high personal expenditures on health. The Director General said that access to medicines is a wider concept involving physical, therapeutic, financial, and service access, and referenced MSH's conceptual framework on access.

Dr. Delanyo Dovlo from the WHO Regional Office-Africa noted that the World Health Organization is committed to improving access to essential medicines, which is still a large unmet need. Health systems should be able to respond to emerging health threats. He stated that UHC strategies should aim at minimizing catastrophic health expenditures and that efforts should be made to eliminate substandard, falsified, and counterfeit medicines.

Anthony Boni from the Office of Health Systems, USAID-Washington, began his remarks by stating that access to medicines is crucial in avoiding financial hardships and catastrophic health expenditures in already impoverished households. UHC should guarantee access to medicines for women, children, the poor, and the most vulnerable. Equity and sustainability are important in designing UHC and medicines benefits programs and policies. He stressed that there is a need for better allocation and utilization of existing resources, while providing mechanisms for transparency and accountability within the system. He stated that rational use of medicines and infection control strategies could reduce pharmaceutical wastage. He added that access to medicines is often a blind spot in UHC discussions, which usually tend to be heavily financial in focus. There is no Medicines Benefits Management (MBM) guidance document at USAID. He urged for the development of UHC performance metrics.

Anita Wagner from Harvard University emphasized the need for research on medicines access to inform pharmaceutical policies.

Plenary session, UHC and Medicines

September 29, 9:00 - 11:15 am
Facilitator: **Aggrey Ambali, Director, African Science, Technology, and Innovation, NEPAD**
Rapporteur: **Evans Sagwa, MSH/Namibia**
Speakers: **Kees de Joncheere, World Health Organization**; and **Kwesi Eghan, MSH**.
Panelists: **Banda Ngaujake and Etienne Coetzee, UHC Committee/Social Security Commission** (Namibia); **Mpuma Kamanga, Ministry of Health, National Social Health Insurance Coordinator** (Zambia); and **Ropah Hove, Director of Pharmacy Services, MOHCC** (Zimbabwe).

Kees de Joncheere from the World Health Organization spoke on the "Importance of medicines in the health system and UHC; stakeholders and their roles and responsibilities." He began by explaining that countries' current health systems are a product of epidemiology, culture, and politics. de Joncheere also explained that UHC is a direction and not a destination. Every country could tackle any of the UHC range of choices at any stage of a country's development, but choices remain between population coverage, package of services, and financial protection. While health insurance is a condition of labor, UHC is a condition of citizenship. The challenge is to overcome the fragmentation of health schemes and resources in the public and private sectors. In most low and lower middle-income countries, up to 80-90% of medicines are purchased by out-of-pocket expenditure instead

of by insurance. Key stakeholders, such as professional associations, patients, citizens, industry, and civil society, must be included in the medicines benefits discussion. Key issues to be included in such discussions include access to essential medicines, the Millennium Development Goals, non-communicable diseases, medicines pricing, appropriate medicine use, and innovation for new products and affordable pricing.

Following Kees de Joncheere's presentation, a panel discussion on the "Perspectives from three Southern Africa countries in relation to medicines benefits and efforts toward UHC" was held. Namibia was represented by **Banda Ngaujake** and **Etienne Coetzee** from the UHC Committee/Social Security Commission. **Mpuma Kamanga**, the National Social Health Insurance Coordinator in Zambia, presented the challenges as experienced from his position in Zambia's Ministry of Health. **Ropah Hove**, Director of Pharmacy Services at the MOHCC, highlighted the perspectives of UHC and medicines coverage in Zimbabwe.

Country	Perspectives on UHC and Medicines Coverage	Challenges
Namibia	• Social Security Commission (SSC) coordinates UHC initiative • ~15% of Namibians have health insurance • Focus is on expanding coverage and building efficient systems • Good use of IT systems	• How to ensure equitable access, especially for vulnerable groups • Physical access (huge, sparsely populated country) • High unemployment • Low generic utilization rates
Zambia	• There is political will for UHC • The country's health budget been increased threefold • All primary health care is free • User fees are at tertiary level • Pro-poor strategies (e.g. social cash transfers) being explored	• Health is still underfunded • Low insurance coverage (1% of population covered) • Inequities between SEC quintiles • High dependence on donor funding • Need to strengthen coordination between Government Ministries and Departments • Paper-based systems
Zimbabwe	• All medicines have to be registered • There is a generic policy in place • There are programs for promoting appropriate use of medicines • Medicines are made available for primary health care	• Insufficient HR is leading to staff burnout • Limited funding sources • Paper-based systems

After the panel discussion, **Kwesi Eghan** from MSH presented on "Medicines benefits management policies and programs: an update." He emphasized that the focus on medicines exists because they are a key component of preventive, curative, and rehabilitative health interventions and responsible for a large proportion of total health care expenditures in low and middle-income countries. There are complex inter-linkages between pharmaceutical and insurance systems that need to be explored and understood. To help countries better understand how they can efficiently manage medicines benefits programs, MSH, in collaboration with

Accenture Development Partners, created a manual and assessment guide on medicines benefits management policies and programs in low and middle-income countries, which is currently in draft form. The assessment guide is modular with the following sections: Stakeholder Analysis; Laws and Regulations; Health care Programs; Manufacturer/Distributor; and Information Technology and Operations; and Performance Monitoring. Eghan discussed the results of an assessment of medicines benefits programs in Namibia. There is a large uninsured population in Namibia that has limited access to services. Approaches need to be introduced to address specific diseases, strengthen governance, and monitor use of medicines. He stressed that the Government of Namibia needs to play a leading role in adapting existing technology within medical aid plans into the public sector and creating a standardized national coding system. An assessment using a methodology similar to the study in Namibia has been conducted in South Africa on medicines benefits management in collaboration with the National Department of Health. A draft report is undergoing final review before it is shared with key stakeholders. An assessment is also planned in Ghana to start in December 2014/January 2015.

Plenary session, Medicines Benefits Design & Management

September 29, 11:15 am – 12:30 pm
Facilitator: **Pamela Kauseni, Ministry of Finance, Planning & Budgeting, Zambia**
Rapporteur: **Bada Pharasi, MSH/South Africa**
Speakers: **Anita Wagner, Harvard University**; **Anban Pillay, National Department of Health** (South Africa); and **Roger Wiseman, Liberty Health** (South Africa).

Anita Wagner from Harvard University presented on the topic "Designing & managing medicines benefits – goals, policy options, ethical considerations." She focused on the following four objectives of UHC: ensure availability of quality products, improve equitable access, encourage appropriate use, and keep costs affordable. With equity being a goal of UHC, ethical considerations include providing equal access to available care, addressing equal needs, ensuring equal utilization for the equal need, and equal quality of care for all. There is a fundamental choice to be made between the ethical ideal of paying for all "medically necessary" treatment and the economic choice to create a budget and determine who will be covered for what medical conditions. Her discussion highlighted that medicines benefits policies and programs need to balance multiple competing objectives. To manage competing objectives, policies and programs need to target populations, settings, and medicine selection; be continually adapted; and undergo routine monitoring and periodic evaluation. This requires efficient data systems and human capacity to generate and analyze information.

After describing the South African epidemiological context, **Anban Pillay** from South Africa's National Department of Health presented on the topic of "Designing and managing medicines benefits – estimating costs; operational and governance considerations." Pillay explained that South Africa is experiencing four colliding epicenters of increased health care demand: maternal, newborn and child health; non-communicable diseases; HIV/AIDS and TB; and violence and injury. The disparities between the public and private sectors are great in relation to human resources. South Africa is developing a plan for implementation of National Health Insurance (NHI), in which funding will flow from the National Treasury to both public and private accredited hospitals and primary health care facilities. NHI uses a defined set of medical conditions that are covered, standard treatment guidelines, a medicines formulary, and clear eligibility criteria for access to restricted medicines. He proposed that the selection of medicines be determined by the burden of disease, effectiveness, safety, quality, and appropriateness. In designing and managing medicines benefits, Pillay urged participants to

consider procurement design, how dispensers can be reasonably reimbursed, the structure for copayments, and the importance of using market intelligence to inform decisions.

Roger Wiseman from Liberty Health in South Africa led workshop participants through a discussion on "Designing and managing medicines benefits - experiences and partnerships with the private sector." In South Africa, the private sector provides health insurance to 8.7 million people, covering approximately 16% of the entire population. Total private health care expenditure is about approximately R 125 billion with R 18 billion for medicines expenses. Wiseman presented a model for Information Technology and Software Support that had five phases: Medicine Selection and Clinical Governance, Pre-authorization, Provider Engagement, Disease Management Programs, and Monitoring and Evaluation. He emphasized that the private and public sectors share the belief in generics. The private sector replaces the tender process with the application of generic reference pricing. In this model, a threshold price is set and the market adjusts in accordance with the desire to meet this threshold. In his concluding remarks, he stated that there was a need to apply an open mind to private sector offerings and focus on promoting access and improving quality rather than purely implementing crude cost reduction strategies. There is potential for collaboration between the private and public sectors.

Facilitated Group Discussions – Part I

September 29, 1:30 – 4:45pm

B1) **How to determine medicines benefits policy and program needs?**
Facilitator: **Jane Robertson, WHO**
Rapporteur: **Ziyonda Ngoma, MSH/South Africa**

1. What are the objectives of medicines benefit policies and programs on the path toward UHC?
2. How do we set priorities for selection of medicines for coverage of populations with different needs, given the competing objectives of availability of quality generic and innovator products, equitable access, appropriate use, and affordable costs?
3. What are potential unintended impacts of medicines benefits policies and programs?

Response to Question 1:
Participants identified the objectives of medicines benefit policies and programs on the path toward UHC as medicine affordability and cost effectiveness, equitable access to service, rational use of medicines, quality of service, and achieving clinical outcomes. It is important to note that equitable access means different things to different people. Equitable access can refer to the quality of care, geographic, economic and physical availability of medicines, meeting community needs, or the adoption of new approaches to address service gaps. Key components of a country's plan towards UHC adoption include strengthening health systems, engaging political support, building the public's trust, managing the public and private sector interface, ensuring sustainability, emphasizing M&E, and recognizing the country's disease profile.

Response to Question 2:
Setting priorities for the selection of medicines for benefit programs is important to address the needs of different populations. Tools that can be used to prioritize the selection of medicines to be covered include cost-effectiveness determination using pharmacoeconomic approaches, standard treatment guidelines (STGs) and protocols, essential medicines lists, intellectual property rights, epidemiological country profiles, and investment on the "health balance sheet" (prevention measures). Traditional medicines should be included to some extent

to address the needs of populations. The selection of medicines also falls upon the budget impact, local industry capabilities, risk sharing, incentives that can be offered, and stakeholder expectations.

Response to Question 3:
Medicines benefits policies and programs can result in unintended impacts that we should be aware of and anticipate. Possible financial unintended impacts may include abuse of policies, changing market forces, outsourcing to the private sector, and the waste of resources. Other unintended consequences of medicines benefits policies include political interference, limited patient choice, poor alignment with goals, focus on incentives, collusion, influx of sub-standard products, and the loss of provider and manufacture interest due to lack of subsidies.

B2) **How can medicines benefits be sustainably and equitably financed?**
Facilitator: **Tienie Stander, Hexor, South Africa**
Rapporteur: **Percy Daames, MSH/South Africa**

1. What information is needed to estimate costs of medicines benefits programs?
2. What medicines policy and program approaches are needed to efficiently cover medicines for both acute and chronic disease management?
3. What strategies exist to address the economic, logistic, ethical and other challenges of covering new specialty medicines equitably and sustainably?

Response to Question 1:
There is a need to estimate the total economic cost of setting up medicines benefits programs. The framework surrounding an estimation of costs involves identifying stakeholders and understanding the environment and needs; identifying IT resources, human resources, financial resources, and the impact of the disease burden; developing a monitoring and evaluation plan; and identifying the costs of distribution and implementation of the program. The costs of medicines benefits programs are extensive stakeholder mapping, stakeholder engagement activities, implementation, and M&E. Implementation refers to the cost of products, cost of professional services, cost management programs, and the provision of economic incentives to providers. M&E requires the purchase of software programs for dispensing and prescribing medicines, while having staff to monitor appropriate use.

Response to Question 2:
Medicines policy and program approaches need to cover medicines for both acute and chronic disease management. Recommendations were made during this group session for a progressive funding mechanism, inclusion of local knowledge, identification of gaps between the private and public sectors, creation of risk-sharing agreements to improve access to expensive programs, and the development of clear protocols on entry, diagnosis, and treatment criteria. Government regulations must align to each other. The prioritization of donor funds and public sector investments in health needs to be balanced to meet both chronic and non-chronic disease financial needs. Preventive efforts may result in the reduction of medicines utilization, thereby reducing costs to the system.

Response to Question 3:
Participants mentioned a number of different strategies to enable the coverage for new specialty medicines in an equitable and sustainable manner. A proportion of the budget for a medicines benefit program should be

allocated to specialty medicines. Specialty medicines should be used in controlled environments, such as specialty centers in agreement with providers. Guidelines on access to specialty medicines should be developed to ensure equity. Regional pooled procurement and price negotiation can be explored to lower costs of specialized medicines.

B3) **What are key aspects of managing a medicines benefits program?**
Facilitator: **David Lee, MSH**
Rapporteur: **Catherine Vialle-Valentin, Harvard University**

1. What functions (e.g., updating formularies according to changing needs; price negotiation; purchasing; contracting with providers and suppliers; claims processing; payment; and others) are required to manage a medicines benefits program?
2. What human and technical (including information technology) resources are needed to execute these functions?
3. What governance and administrative structures are needed to manage a medicines benefits program?

Response to Question 1:
Enhancing access and achieving UHC is not necessarily a public sector prerogative. It is important to frame issues in a way that includes both the public and private sectors. Governments have to play a stewardship role in overseeing the availability of medicines. In designing an essential medicines package, functions have to be defined according to what needs to be achieved. First, governments must decide what conditions to cover and which exceptions to allow. Public and private sectors should work together on the selection of medicines. A current medicines list must be maintained for the conditions covered. The first stage of the formulary should be at the active pharmaceutical ingredient level and not brand specific. To ensure that the list is credible, regulations must be developed to avoid any conflicts of interest. Products will have to be used appropriately according to STGs, even in the private sector. There is a need for clinical and regulatory leadership, and pharmacoeconomic expertise. A medicines benefits program requires M&E, a database for decision making, and proper information systems. There is also a need for quantifying the needs for whatever medicines are covered, improve the administrative structure to carry on management functions, and negotiating contracts and services fees to recreate a relationship with clinical services and suppliers.

Response to Question 2:
Various human resource functions are required to fully execute a dynamic medicines benefits program. Economists and planners are needed to anticipate future trends and conduct macroeconomic analyses to understand the consequences of contracts with suppliers. Market intelligence gathering should be used to understand the prices and costs of suppliers, prescribers, and dispensers. Regional collaboration and sharing of pricing information across countries and tracking price indexes is beneficial in ensuring low medicine costs. Knowledgeable software developers and managers with access to financial data are required to run robust management platforms to manage inventory from the beginning of procurement to local distribution. In South Africa, the MSH dashboard gives real time access to information about facilities stocks through RxSolution. The adoption of a medicines benefit program also requires M&E specialists to monitor the claims and pricing, and make sure they are in line with guidelines. Resources such as claims processing specialists are needed to track payments and suspected cases of fraud. Additionally, specialists need to design and monitor performance-based incentive programs. Communication specialists can liaise with providers and patients, and determine if drug utilization is appropriate. The support of clinical specialists to develop a specialist formulary beyond the basic

formulary is also critical. Overall, a strong regulation and policy framework must be developed that interfaces between policy and planning. Regulation about pricing does not often exist, although it is in the best interest of countries to have it. Sometimes pricing is not uniform, even within a country, and it becomes a nightmare to manage programs.

Response to Question 3:
Administrative and governance structures are needed to guide the management of medicines benefits programs. The aim should be to move towards a uniform language between all stakeholders that also codifies and standardizes terms used for products. Administratively, capacity is needed to do economic analyses, manage system and individual behavior changes, and influence provider and consumer behaviors. Teams must be cross-sectional and closely work together. Providers must be supervised and undergo M&E and utilization reviews. After adopting standards for quality care facilities should be assessed and accredited, thereby creating a culture of positive performance evaluation and quality assurance in human resources. Disputes between patients and providers must be managed properly as well. The question remains of how to address non-citizens' claims for benefits. Brazil currently has a temporary insurance framework with a voucher system to address non-citizens entering the health care system. In the area of governance, a multi-perspective and multi-stakeholder approach must be taken. Committees should have specific objectives. Legal policies need to be strong and accompanied with a strong public relations wing. Actuaries can draw important connections between money and benefits. Governance must also address the guidelines for appropriate referrals and role of pharmaceutical and therapeutic committees. An unanswered question remains on how the system can empower the patient to know what services and/or medicines for which to ask.

Plenary session, Information for decision-making
September 29, 4:45 – 5:45 pm
Facilitator: **Kofi Aboagye-Nyame, MSH**
Rapporteur: **Stephanie Berrada, MSH/South Africa**
Speakers: **Dennis Ross-Degnan, Harvard University**; and **Christo Rademan, Mediscor** (South Africa)

To ensure wise use of limited resources, emerging and expanding insurance schemes must monitor what they spend money on, and how much money they are spending. Medicines are key for achieving the goals of UHC, and at the same time the main reasons for inefficiency in spending. It is therefore crucial to monitor key indicators of medicines in health systems using the existing data and to strive toward information technology that facilitates the processes.

Dennis Ross-Degnan from Harvard University led a session titled "Working towards generating information routinely for medicines benefits management – A system framework." He covered both the data sources available in the pharmaceutical system and how routine and ad hoc data can be used to assess policy performance. Ross-Degnan identified six domains for assessing medicines policy performance: availability, cost and affordability, equitable access, appropriate use, improved outcomes, and provider and patient satisfaction. To assess policies using routine data, analysts can use member/patient data (age, gender, employment status, and insurance), clinical and utilization data (inpatient and outpatient statistics, medication dispensing data, and prevention services), and cost data (medicines, hospital, physician services, procedures, and lab costs). He highlighted that administrative data relies on characteristics of payments, while clinical data is generated at the point of care. Clinical data can be more difficult to collect and standardize, although can be found increasingly through electronic medical records. Routine pharmaceutical monitoring relies on key performance measures,

such as cost, utilization, quality of care and adherence, levels of aggregation, and frequency of data collection. He stressed that among the challenges to routine data being used to inform policy decisions is the abundance of providers and different treatments, shifting populations, and data ownership, quality, confidentiality and integration. Types of ad hoc data that can be used to assess system performance includes pre-and post-visit surveys, direct observations of service provision, population surveys, and focus groups. In his concluding remarks, Ross-Degnan stressed that policies have many objectives and that while there are many sources for medicines data, evidence is crucial to inform good decision-making. Routine data can be used to assess performance in relation to objectives, while ad hoc data is needed for key population-based measures.

Mediscor's Managing Director **Christo Rademan** led a session exploring the critical role of evolving information systems and the need for standardized coding, using Mediscor as an example. He began by highlighting that both the public and private sectors need the ability to manage the cost and dispensing of medicines and that international research has shown that use of a pharmaceutical benefits management (PBM) company can be successful in achieving that objective. A PBM is a company that manages the dispensing of medicine by providing national, real-time electronic solutions for claims processing with a set of rules, providing a claims payment, and issuing management reports. A PBM requires a regulatory environment, use of computers, and a telecoms presence. In a PBM, management of medicines occurs at the point of sale, which reduces fraud and creates cost savings. Income for Mediscor PBM is 90% from funders and 10% from pharmacies. There is interoperability with the systems used in pharmacies with, in some cases, accreditation of the operating systems. If PBM models are used in rural settings, web-based systems and cell phones can overcome geographical challenges.

Panel Session, Multiple-stakeholder partnerships for medicines benefits in moving towards UHC

September 30, 8:30 – 9:30 am
Facilitator: **David Lee, MSH**
Rapporteur: **Jafary Liana, MSH/Tanzania**
Panelists: **Margareth Ndomondo-Sigonda, NEPAD**; **Timothy Johnston, World Bank**; **Constance Matabiswana, MRI Botswana**; **Clinton Van Zitters, Aspen Pharmacare**; and **Karen Cavanaugh, USAID Office of Health Systems**.

Margareth Ndomondo-Sigonda from NEPAD's Planning and Coordinating Agency noted that significant progress has been made on the Abuja Declarations and its commitments, although the progress remains partial and uneven. Some of the many successes include national governments taking ownership of Africa's health challenges, strategic plans developed by the African Union (AU) Commission, and the adoption of a historic Roadmap by AU member states in 2012. Ndomondo-Sigonda explained the African Medicine Regulatory Harmonization (AMRH) initiative and its focus to accelerate access to products by improving product registration in Africa. Working with a number of partners, the initiative will develop common requirements, guidelines and format for product registration and promote work sharing among countries. For the implementation of medicines benefits programs, she indicated that the following steps can be taken: the establishment of a partnership framework for medicines benefits programs at various levels, a mapping exercise on the status of health insurance schemes throughout the region, adoption of standard regional tools and advocacy strategies, and monitor countries' progress towards program implementation. Ndomondo-Sigonda stressed the need for regional action and support to develop medicines benefits programs.

Timothy Johnston from The World Bank brought to the group's attention the need to have defined rules and implementation tools that are ready to go as UHC becomes a reality. He pointed out that drug budget overruns

are the norm. Medicines benefits programs involve more than just paying for drugs. They also include patient education, financial incentives, and addressing fraud and collusion, among other critical aspects of implementation. In order for programs to run effectively, rules and tools must be designed up-front. They must exhibit restrictive and enforceable qualities. If you limit benefits at the on-set of a program, you can always add more benefits later. All management tools must be in place before benefits are implemented. Data is critical to be able to appropriately adjust rules and inform negotiations. In designing medicines benefits programs and policies, structures must be in place for assessment and decision-making on inclusion of new technologies, case management for high-cost patients, and negotiation strategies for dealing with the pharmaceutical industry.

Constance Matabiswana from MRI Botswana discussed the role of the private sector in health care in Botswana. Twenty-one percent of the population in Botswana is involved in the private sector. It is critical to focus on the actual value of money spent in the private sector and the relation to health outcomes. She noted that the private sector in Botswana is mature enough to contribute effectively to requests by the government and public sector for guidance. In Botswana, the government has Public-Private Partnerships, and has outsourced to the private sector. An example of this outsourcing includes the disease management of HIV/AIDS. Seventeen thousand patients were handed over to a private company, which put a process together where drugs were provided by the Central Medical Stores and supply chain management was done at the point of distribution. A centralized call center was able to manage the program. She emphasized the importance of technology and that technology is where the private sector can play a major role in health care. As funders of schemes, she noted that many are worried about the increasing cost of care and the possibility of not being able to manage it. It is important to determine what can be included in a health care scheme.

Clinton Van Zitters from Aspen Pharmacare highlighted that UHC is a way to reduce health care costs, reduce financial burden, and potentially improve health. Aspen Pharmacare is the 5th biggest generic medicine company in the world. In South Africa, almost 1 in 4 medicines dispensed is an Aspen Pharmacare product. Van Zitters indicated that UHC policies should encompass primary care, communicable and non-communicable diseases, and preventive care. Policies will need to be responsive and resolve conflicts involving substandard or counterfeit medicines and cognizant of how to reduce out-of-pocket expenditures.

Karen Cavanaugh from USAID's Office of Health Systems stated that the role of medicines is seen as an important component of health system strengthening. Funding available from ministries of health is consistently low, and priorities may sometimes be different from the priorities of the funding sources. For example, women give birth with no professional assistance, but the ministry of health may be seeking assistance to procure cancer drugs. It is in the donor's interest to provide resources to the population that needs them most. In UHC, medicines benefits packages should focus on the drugs that save more lives. Patient education is critical. We need to work with consumers to improve their awareness of drug quality. There is a need to shift to a situation where drug delivery requires less human resources. Sharing experiences on medicines benefits across countries is essential to creating effective medicines benefits policies. USAID's approach on medicines includes the following elements: quality assurance to meet standards; strengthening systems to monitor pharmacovigilance; governance; human resources to manage pharmaceuticals; and the containment of antimicrobial resistance (AMR).

David Lee concluded the panel session, emphasizing that there are many challenges for stakeholders to overcome in working together to achieve UHC, but we have seen the willingness of stakeholders to achieve the desired goals. Partnerships and new initiatives are highly needed to achieve more success on the path toward

UHC. He thanked all panelists who devoted their time to be part of the conference and to share their experiences.

Facilitated Group Discussions – Part II

September 30, 9:30 am – 12:00 pm

C1) **What information is needed to inform medicines benefits decisions?**
Facilitator/presenter: **Anita Wagner, Harvard University**
Rapporteur: **Stephanie Berrada, MSH/South Africa**

1. What are key performance indicators of medicines benefits from different stakeholders' perspectives?
2. How can indicators be created using existing data in countries and systems?
3. What are successes and challenges in using existing data to inform medicines benefit design, implementation, and adaptation?

Response to Question 1:
For patients, the key performance indicator of medicines benefits is client satisfaction with actual care. Data from patients can be collected through surveys. Providers are interested in the percent of claim compliance with STGs/protocols and the percent of patients with intended outcomes. For medicine schemes/payers, they are primarily interested in the value of money put into benefit packages. Among other indicators, medicine schemes/payers are interested in the percent of the insured population actually receiving medicines coverage, the percent of the population with certain diseases who are funded by the scheme, the percent of allocated funds towards therapeutic categories, the ratio of the budget compared to spending, the percent of reported non-adherence to treatment, and the percentage of reported fraud. Payers are also concerned with the relevance of the package compared to the disease burden. Suppliers are another interested stakeholder in the system.

Response to Question 2:
Indicators can be created using system and country-level data. The goal is to have a clear picture of the value for money. Examples of existing indicators include the HIV/AIDS outcome measure versus the money spent, the number of transmissions averted, changes in life expectancy, overall quality of life, the number of HIV/AIDS-related hospitalizations, mortality related to chronic and non-chronic diseases, and the number of new infections each year. There remains a moral obligation for HIV/AIDS medicines, and the focus should still be on value for money. A question remained concerning the appropriate threshold used to determine the cost-effectiveness ratio.

Response to Question 3:
There are limitations to using existing data to inform medicines benefits design, implementation, and adaptation. In some countries, it is difficult to quantify how money is spent. In South Africa, conditional grants are used.

C2) **What characteristics of systems are needed to generate information for medicines benefits policy and program decisions?**
Facilitator/presenter: **Ricardo Kettledas, National Department of Health, South Africa**
Rapporteur: **Katelyn Payne, MSH**

1. Which elements are crucial to capture in evolving care delivery and financing information systems for managing medicines benefits?
2. How do current or proposed information systems facilitate generating information for medicines benefit decisions?
3. What technical and human resources as well as governance approaches are needed to facilitate use of information from systems to inform medicines benefits?

Response to Question 1:
There needs to be a link between health care systems and financing systems. Donors need to coordinate with public sector, private sector, and other funders. Financing within the health care system requires information on the budget, studies of utilization within the system, and out-of-pocket patient expenditures. The information that is needed must have the proper coding and include unique patient identifier and diagnosis, type of facility and services, drug utilization, adherence to treatment, adverse events/reactions, household data, treatment outcomes, and demographic data on patients.

Response to Question 2:
The existing information systems include manual registers, case management, and various types of information systems. In Zambia, HMI, case management, Smartcare (CDC), and IFMIS are used for information management. In Malawi, IFMIS, logistics (supply chain) management, and DHIS are used for information management. In South Africa, proposed systems for information management include biometric systems and national ID systems. Systems are needed to improve availability and use of information related to the access to social assistance and welfare programs, coordination between systems as patients move, and cell phone use for data reporting. There is a huge need for decision support systems. There is also a big gap in most countries in up-to-date vital statistics. New systems should be open-source, allowing for greater information sharing, use and application, but we must ensure that the right people have access. There is a human resources gap in information technology. The public sector stands to learn a lot from the application of systems within the private sector.

Response to Question 3:
The technical resources required for information systems include interoperability between systems, network capacity, innovative data collection method, such as mobile phone technology, and the movement to web-based system connectivity from paper or single computer methods. Within the arena of human resources, there is a need to track the movement of skilled workers, build knowledgeable IT support and database managers, and build staff capacity. Governance must address and formalize data protection policies, ethics, access to information on the primary level, tools to implement policies, know who has access to critical data, risk management plans, and business continuity and disaster recovery plans. These three aspects must all link to each other.

Closing and Farewell

September 30, 12:00 – 1:00 pm
Facilitator: **Gilles Forte, WHO**
Rapporteur: **Catherine Vialle-Valentin, Harvard University**
Speaker: **Douglas Keene, MSH**

Country response: Representatives of each of the seven southern African countries participating in the meeting will share their thoughts on the most important points learned at the meeting and what would be needed to achieve the objectives of medicines benefits policies on the path to UHC in their countries.

Representatives from ***Swaziland*** noted that although the public sector is the predominant source of health services for the country's population, public-private partnerships exist for specific conditions, including renal dialysis, ART, and TB. Private sector TB medicines are paid for by medicine schemes that get medicines from the public sector. Swaziland is involved in the SADC pooled procurement initiative to use economies of scale to lower medicines prices and other regulatory harmonization activities. The country needs to accelerate UHC implementation to expand access to medicines and prioritize governance stewardship, inclusiveness, financing policies, and multi-stakeholder involvement in designing UHC. Going forward, Swaziland needs to create an agenda, and a program to manage medicines benefits. The country is the initial stage of UHC adoption. The National Health Sector strategic planning committee recently met and created a goal set on UHC. Decision-makers need to progress from there with stakeholder workshops, development of regulatory framework, financing, and NHI discussions with the Ministry of Health.

Malawi has achieved the provision of free health care services at all public health facilities. The country has an essential health package, Health Sector Strategic Plan 2011 -2015, its National Medicines policies in its final draft stage, and its Essential Medicines List and Standard Treatment Guidelines in its final stage of revision. Representatives from Malawi stated that UHC requires a multi-stakeholder approach that goes beyond the Ministry of Health and includes HMIS and LMIS data for decision-making to appropriately design medicines benefits policies and programs. UHC is a holistic approach to increase efficiency in the health sector. Moving forward, representatives resolve to share their learning with MoH senior management and colleagues, align existing health programs with UHC and medicines benefits concept, and stimulate discussions and partnerships for UHC and medicines benefits programs.

In ***Lesotho***, unimaginable stress was placed on the health care system beginning in the 1980's by HIV/AIDS, in addition to the constant challenge of providing services in a country where 70% of the population is rural. The public sector works in partnership with the private sector and churches. Primary health care is free in Lesotho with specialty care being accessible for an additional fee. The Government of Lesotho contracts services out to private hospital and clinics. Medicines are provided to patients at no cost from the government, and the private sector also has access to government warehoused medications. There is active community participation through the involvement of community health workers. SIAPS/Lesotho is focusing on forecasting timely delivery of medications and working with CHAI. In Lesotho, there is a small tax base, but the government is still exploring a contributory pension scheme for public servants. As Lesotho moves forward in discussions on UHC, particular interest should be paid towards governance and taking advantage of the increasing pool of civil servants to finance social protection. An essential health benefits package exists in Lesotho, but it should be standardized for public and private clinics. The country needs support with selection, quantification, and distribution through information management systems. There is a strong need to update the STGs and EML, while developing patient education programs.

Representatives from ***Zimbabwe*** expressed their belief that UHC will be reached slowly if interested parties stay on course. Multi-stakeholder involvement is required for a coordinated effort in trying to increase coverage and quality. The addition of a steering committee on UHC would be beneficial. UHC policies should be built upon Zimbabwe's national strategy and national medicines policy. Hospitals are equipped with MIS to capture key

data points critical to UHC implementation. There is an effort to put UHC at the core of health policies and develop an M&E assessment.

Most of the groundwork has already been laid for UHC in ***Namibia***. A committee has been established to advise the Ministry of Health on UHC. Representatives from Namibia emphasized that medicines need to be an essential component of the whole UHC package. Infrastructure and logistics management are needed in Namibia. The acute shortage of pharmacists, especially in the public sector, has begun to be addressed by a newly implemented pharmacist-training program that provides generous scholarships. Currently, most pharmacists come from abroad, mainly Ethiopia. The Essential Medicines List has been in place since 2008, but has been challenging to update. Going forward, UHC in Namibia must include partners and provide strict attention to the improvement of IT systems.

In ***Zambia***, UHC is one of the stated goals in the country's revised 6th National Government Plan. With a growing economy and 40% of the population under the age of 30, cost-effective medicines access and human resources are essential. The government has tripled the amount it allocates to the public health sector. More than 95% of the population is dependent on the public sector for health services. Primary health care is free in Zambia with minimal user fees for higher levels of care. The government proposed a pro-poor health insurance scheme with a contributory component for formal workers and non-contributory (cash transfers) component. The country also has a National Supply Chain strategy and an electronic management system to track medicines. There is opportunity to harness the comparative advantages of the private sector through private-public partnerships. A multi-stakeholder meeting should be held to share lessons learned.

Within ***South Africa's*** 10-Point Strategic Plan to Improve the Health System, the seventh point is to improve access to medicines. There is a green paper on National Health Insurance with a white paper soon to be published. In South Africa, UHC is not an "if" but a "when." To increase access with the available resources, governance and collaboration across public and private sectors is key. The country requires a legislative framework that enables the implementation of UHC, a clarification of funding sources, and information on patient use of medicines. The country must adopt new models of service delivery, educate the public, and capacitate the workforce to meet new service expectations. The implementation of UHC goes beyond the health care system, and requires the participation of demand planners, forecasting analysts, lawyers, and logistics specialists.

Closing Remarks:
Douglas Keene closed the conference by thanking both speakers and participants for their valuable and active contributions during the discussions and encouraged them to continue the dialogue within their respective countries when they return home. He also encouraged participants to network between countries to take advantage of the wealth of experiences and ideas available in the region.

MSH will continue to champion the cause of medicines availability, access and appropriate use as critical components of Universal Health Coverage. Work will continue on the medicines management guidance manual and options analysis tool introduced at this meeting with external review starting before the end of 2014. In early 2015, both the guide and the tool will be available in their final forms.

We are already planning for the third UHC and medicines workshop, which will be scheduled for the second half of 2015. Continuing the precedent of this regional meeting, the 2015 event will likely be in East or West Africa.