REPORT

ON THE 2016 CONFERENCE ON

PRIORITY SETTING

FOR UNIVERSAL HEALTH COVERAGE

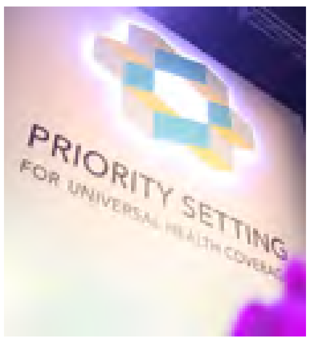
26-31 JAN 2016

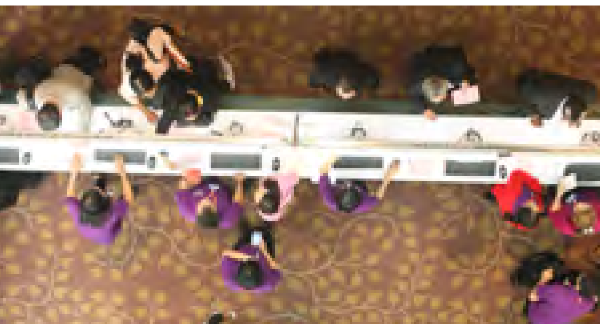
CENTARA GRAND & BANGKOK CONVENTION CENTRE
AT CENTRALWORLD, BANGKOK, THAILAND

True Success is not in the learning
but in its application to the benefit of mankind

His Royal Highness Prince Mahidol of Songkla

The beloved Prince in our memory





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Prince Mahidol Award

The Prince Mahidol Award was established in 1992 to commemorate the 100th birthday anniversary of Prince Mahidol of Songkla, who is recognized by the Thais as 'The Father of Modern Medicine and Public Health of Thailand'.

His Royal Highness Prince Mahidol of Songkla was born on January 1, 1892, a royal son of Their Majesties King Rama V and Queen Savang Vadhana of Siam. He received his education in England and Germany and earned a commission as a lieutenant in the Imperial German Navy in 1912. In that same year, His Majesty King Rama VI also commissioned him as a lieutenant in the Royal Thai Navy.

Prince Mahidol of Songkla had noted, while serving in the Royal Thai Navy, the serious need for improvement in the standards of medical practitioners and public health in Thailand. In undertaking such mission, he decided to study public health at M.I.T. and medicine at Harvard University, U.S.A. Prince Mahidol set in motion a whole range of

activities in accordance with his conviction that human resource development at the national level was of utmost importance and his belief that improvement of public health constituted an essential factor in national development. During the first period of his residence at Harvard, Prince Mahidol negotiated and concluded, on behalf of the Royal Thai Government, an agreement with the Rockefeller Foundation on assistance for medical and nursing education in Thailand. One of his primary tasks was to lay a solid foundation for teaching basic sciences which Prince Mahidol pursued through all necessary measures. These included the provision of a considerable sum of his own money as scholarships for talented students to study abroad.

After he returned home with his well-earned M.D. and C.P.H. in 1928, Prince Mahidol taught preventive and social medicine to final year medical students at Siriraj Medical School. He also worked as a resident doctor at McCormick Hospital in Chiang Mai and performed operations alongside Dr. E.C. Cord, Director of the hospital. As ever, Prince Mahidol did much more than was required in attending his patients, taking care of needy patients at all hours of the day and night, and even, according to records, donating his own blood for them.

Prince Mahidol's initiatives and efforts produced a most remarkable and lasting impact on the advancement of modern medicine and public health in Thailand such that he was subsequently honoured with the title of "Father of Modern Medicine and Public Health of Thailand".

In commemoration of the Centenary of the Birthday of His Royal Highness Prince Mahidol of Songkla on January 1, 1992, the Prince Mahidol Award Foundation was established under the Royal Patronage of His Majesty King Bhumibol Adulyadej to bestow an international award - the Prince Mahidol Award, upon individuals or institutions that have made outstanding and exemplary contributions to the advancement of medical, and public health and human services in the world.

The Prince Mahidol Award will be conferred on an annual basis with prizes worth a total of approximately USD 100,000. A Committee, consisting of world-renowned scientists and public health experts, will recommend selection of laureates whose nominations should be submitted to the Secretary-General of the Foundation before May 31st of each year. The committee will also decide on the number of prizes to be awarded annually, which shall not exceed two in any one year. The prizes will be given to outstanding performance and/or research in the field of medicine for the benefit of mankind and for outstanding contribution in the field of health for the sake of the well-being of the people. These two categories were established in commemoration of His Royal Highness Prince Mahidol's graduation with Doctor of Medicine (Cum Laude) and Certificate of Public Health and in respect to his speech that:

"True success is not in the learning,
but in its application to the benefit of mankind."

Professor Harald Zur Hausen
Prince Mahidol Award in the field of Medicine in 2005

Nobel Prize in Physiology or Medicine 2008

Professor Dr. Satoshi Omura
Prince Mahidol Award in the field of Medicine in 1997

Nobel Prize in Physiology or Medicine 2015

Professor Barry J. Marshall
Prince Mahidol Award in the field of Public Health in 2001

Nobel Prize in Physiology or Medicine 2005

Professor Tu YouYou
A member of The China Cooperative Research Group on Qinghaosu and its Derivatives as Antimalarials

Prince Mahidol Award in the field of Medicine in 2005

Nobel Prize in Physiology or Medicine 2015

Dr. Margaret F.C. Chan, M.D.
Prince Mahidol Award in the field of Public Health in 1998

Director General of the World Health Organizatiion

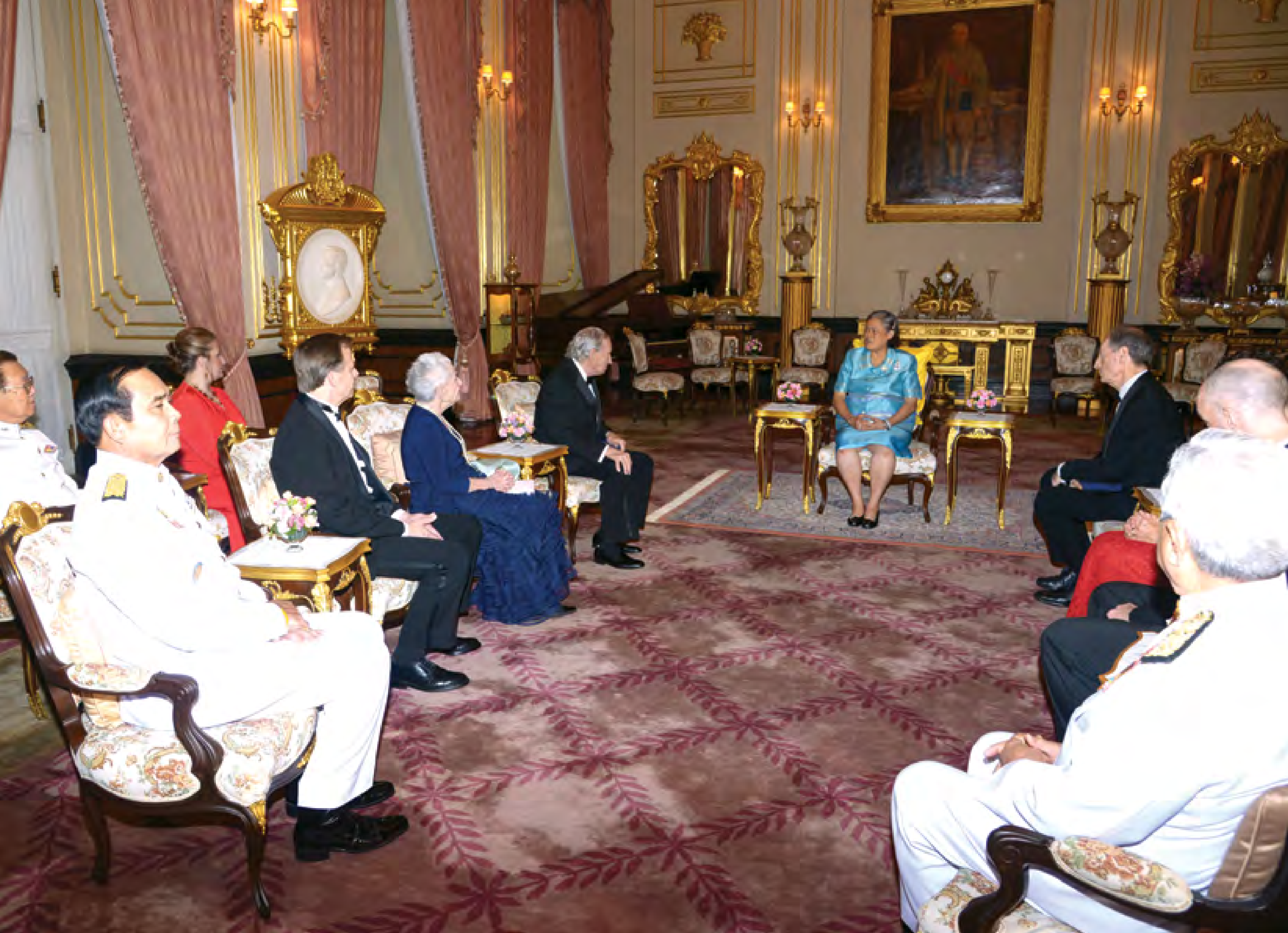
Dr. Jim Yong Kim, M.D., Ph.D.
Prince Mahidol Award in the field of Public Health in 2013

President of the World Bank Group

The Prince Mahidol Award ceremony will be held in Bangkok in January each year and presided over by His Majesty the King of Thailand.

In the past 24 years, 70 individuals, groups of individuals, and institutions had received the Prince Mahidol Award. Among them, 4 subsequently received the Nobel Prize. More importantly, 2 of the most the recent Nobel Prize (2015) laureates in physiology or medicine were conferred the Prince Mahidol Award prior to their continual prestigious recognition.

The Prince Mahidol Award Foundation of which H.R.H. Princess Maha Chakri Sirindhorn is the President, decided to confer the Prince Mahidol Award 2015 in the field of medicine to Professor Morton M Mower. In the field of public health, the Prince Mahidol Award was conferred to Sir Michael Gideon Marmot.



Prince Mahidol Award Laureate 2015
In the Field of Medicine

Professor Morton M Mower

Professor of Medicine
Johns Hopkins University School of Medicine
Baltimore, USA

Professor of Physiology and Biophysics
Howard University College of Medicine
Washington DC, USA

Professor Morton Mower has been awarded the 2015 Prince Mahidol Award for his outstanding achievements in the field of medicine. He is the co-inventor of the Automatic Implantable Cardioverter Defibrillator (AICD) and the main inventor of the Cardiac Resynchronization Therapy (CRT) device. The AICD is a battery powered implantable device that can perform cardioversion, defibrillation and pacing of the heart, without the requirement of an external defibrillator. By constantly monitoring the heart's rhythm and rate, it can deliver electrical current when the heart rate when abnormal heart rhythm is detected preventing sudden cardiac death. Work began on the AICD with Israeli physician Dr. Michel Mirowski, while he was researching cardiovascular drugs at Sinai Hospital in Baltimore, USA.

The AICD device conceptualization began in1969, then in 1980, the first patient was implanted. In 1984 it was approved by the US FDA, and has gone on to dramatically reduce mortality of patients with cardiac arrhythmia, when compared against medical therapy only. Every year, around 200,000 patients are implanted with this device, and a total of 2-3 million people worldwide are using it currently. As well as saving lives, the AICD device is helping to improve their quality of life.

In 1955, Professor Mower undertook pre-medical studies at the Krieger School of Arts and Sciences at the Johns Hopkins University and went on to graduate in 1959 from the School of Medicine at the University of Maryland. He served his residency and fellowship in cardiology at Sinai Hospital, Baltimore (Maryland, USA).

Prince Mahidol Award Laureate 2015
In the Field of Public Health

Sir Michael Gideon Marmot

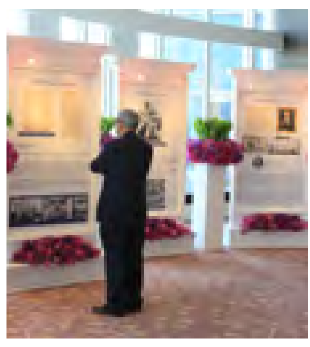
Director, UCL Institute of Health Equity

Professor of Epidemiology and Public Health
University College London,
United Kingdom

President of the World Medical Association

Sir Michael Marmot was made laureate of the Prince Mahidol Award in public health for his evidence-based evaluation of the role of Social Determinants of Health i.e. the conditions affecting health, disease prevention and long-term capability development of people from birth through old age, which include socio-economic levels, schooling, fair employment, standards of living and access to healthy environments. The British government and World Health Organisation (WHO) adopted this concept for public policy planning and appointed the Commission on Social Determinants of Health in March in 2005 to eliminate health inequities.

For more than 35 years, Sir Michael Gideon Marmot has been a pioneer of social epidemiology. His research has focused on inequalities and the effects of socioeconomic status, lifestyle, race, and the environment on the health, and the resultant life expectancy and risks for diseases both locally and globally. Sir Marmot graduated in 1968 with a Bachelor of Medicine, Bachelor of Surgery (MBBS) degree from the University of Sydney earned a Master of Public Health in 1972. He gained his PhD from the University of California, Berkeley (USA) in 1975.



Message from the Chairs

of the International Organizing Committee

It is important to get decisions on public and donor spending on health right because they affect who receives what, when, and at what cost. These difficult decisions are about setting priorities. Given that demand for healthcare is infinite and resources are limited, all countries, health systems, health service payers and global funders must set priorities. Investing in one health care intervention inevitably means investing less or not investing at all somewhere else that might improve population health, financial protection or equity. Ad hoc or passive priority setting approaches disproportionately impact the poorest and most vulnerable, and distort a national health system's ability to progress towards Universal Health Coverage (UHC).

Priority setting is not just about deciding on whether to cover an expensive cancer drug or introducing the latest vaccine into a national immunisation programme. Trade-offs apply to all dimensions of UHC, not just what products

and services to cover with public monies, but also how completely to cover, for whom, and under what circumstances. Thus Priority Setting is also about how to allocate public resources between primary care centres and training family doctors, and building hospitals and training specialists; deciding which population groups ought to receive subsidised care; as well as defining a cost-effective package of services for a disease or condition, through locally developed clinical guidelines and quality standards.

Better priority setting means that the decision makers and the process are made explicit and transparent, and priority-setting is conducted in a deliberative manner, involving relevant stakeholders, and in consideration of best available evidence about clinical and cost-effectiveness and social values. Nonetheless, there is no one-size-fits-all approach to carrying out explicit priority setting for UHC. The demography and epidemiology, and the choices made and the funds available, together with the local costs of healthcare interventions are different for every country. Each country will find its own solution that will necessarily evolve over time, and design its essential drugs lists, health benefits plans and clinical guidelines based on its own values, ambitions and political economy.

With the success of incorporating UHC into the Sustainable Development Goals (Target 3.8), the arduous task of attaining UHC is now left for national governments and the global health community to achieve. In the global context of development assistance, the race towards fulfilling SDG commitments requires a massive shift from "billions to trillions" where resources will have to be earmarked across 17 Sustainable Development Goals and over 100 Targets. Accountability becomes a critical factor in ensuring that focus and support remain unwavering with regards to SDG 3.8. Hence, Priority Setting is akin to the compass of accountability in decision making that national policy makers can use to steer effective and wise "investments" towards UHC.

This year, the Prince Mahidol Award Conference joins forces with international partners including the World Health Organization, the World Bank, the Global Fund for AIDS, TB and Malaria, Japan International Cooperation Agency, U.S. Agency for International Development, China Medical Board, the Rockefeller Foundation, the UK National Institute for Health and Care Excellence, Bill & Melinda Gates Foundation, the National Evidence-based Healthcare Collaborating Agency with support from other key related partners, to host a Conference placing Priority Setting for Universal Health Coverage firmly on the global and national development agendas.

Making better decisions about priorities in the context of UHC, regardless of how rich or poor a country may be, or how much progress it has made in its UHC journey, is the focus of our Conference. It will serve as a trigger for a longer-term, collaborative international effort to articulate priority setting as a necessary (if not sufficient) condition for attaining and sustaining UHC.

As Chairs of the International Organizing Committee, we are delighted to welcome you to Bangkok, Thailand, to join more than 800 fellow health leaders, practitioners and reformers from around the world. We encourage your active participation in the plenary and parallel sessions to share experiences, challenges and ideas, and develop practical ways for supporting the journey to UHC through explicit Priority Setting processes. We hope you will take advantage of the varied range of side meetings organized by our partners, and that you are able to join the field trips that demonstrate Thailand's efforts in setting priorities for UHC.

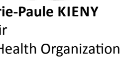
We would like to thank the many committed individuals and organizations that have worked together to prepare and execute the plan for this conference, in particular our international partners, the Prince Mahidol Award Foundation, and the Royal Thai Government. We would also like to express our thanks to all speakers, moderators, discussants, and participants whose wealth of experience and knowledge will benefit us all this week.

By defining, explicitly, the "why", the "who" and the "what" of UHC, an obligation is placed on governments, citizens and global funders to hold health systems for greater levels of accountability and impact, and to address growing inequalities in many countries committed to UHC.

We look forward to welcoming you in Bangkok!

Dr. Vicharn PANICH
Chair
Prince Mahidol
Award Conference

Dr. Marie-Paule KIENY
Co-Chair
World Health Organization



Dr. Timothy EVANS
Co-Chair
The World Bank

Dr. Mark Dybul
Co-Chair
The Global Fund to Fight AIDS, Tuberculosis and Malaria

Dr. Ariel PABLOS-MENDEZ
Co-Chair
U.S. Agency for
International Development

Ms. Kae YANAGISAWA
Co-Chair
Japan International
Cooperation Agency

Mr. Michael MYERS
Co-Chair
The Rockefeller Foundation

Dr. Lincoln C. CHEN
Co-Chair
China Medical Board

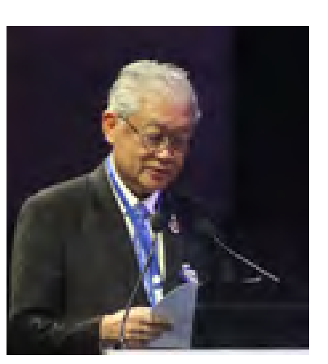
Sir Andrew DILLON
Co-Chair
National Institute for
Health and Care Excellence

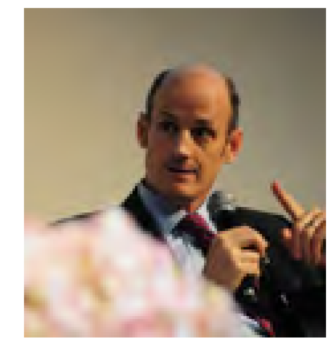
Dr. Trevor MUNDEL
Co-Chair
Bill & Melinda Gates
Foundation

Dr. Tae-Hwan LIM
Co-Chair
National Evidence-Based
Healthcare Collaborating Agency

Conference Co-hosts and Contributors

The Royal Thai Government
Prince Mahidol Award Foundation under the Royal Patronage
Ministry of Public Health, Thailand
Mahidol University, Thailand
World Health Organization
The World Bank
United Nations Development Programme
The Global Fund to Fight AIDS, Tuberculosis and Malaria
U.S. Agency for International Development
Japan International Cooperation Agency
The Rockefeller Foundation
China Medical Board
Chatham House
National Institute for Health and Care Excellence, United Kingdom
Bill & Melinda Gates Foundation
National Evidence-based Healthcare Collaborating Agency, South Korea
Technical Experts





PRIORITY SETTING

FOR UNIVERSAL HEALTH COVERAGE

Programs

PMAC 2016

PRIORITY SETTING

FOR UNIVERSAL HEALTH COVERAGE

Pre-conference

Tuesday 26 - Wednesday 27 January 2016

There were 48 side meetings and workshops convened by partners.

A list of side meetings and workshops is shown in ANNEX IV

Site Visits: Thursday 28 January 2016

There were 6 optional field visit sites.

A list of sites is shown in ANNEX VII

Main Conference

Friday 29 – Sunday 31 January 2016

- 4 Keynote addresses
- 5 plenary sessions
- 15 parallel sessions
- 8 Launches: books, website, program
- Conference synthesis

Total registered participants

63 countries; 854 participants
(female 46%, male 52%, not known 2%)

Background

The Prince Mahidol Award Conference (PMAC) is an annual international conference focusing on policy-related health issues of global significance. The conference is hosted by the Prince Mahidol Award Foundation, the Thai Ministry of Public Health, Mahidol University and other global partners where their institutional mandates are relevant to the Conference theme.

It is an international policy forum that Global Health Partners, public, private and civil society organizations, can co-own and use for driving global health agenda. The Conference in 2016 is co-hosted by the Prince Mahidol Award Foundation, the World Health Organization, the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Japan International Cooperation Agency, the U.S. Agency for International Development, the China Medical Board, the Rockefeller Foundation, NICE International, the Bill & Melinda Gates Foundation, and the National Evidence-based Healthcare Collaborating Agency, South Korea with the support from other key related partners. The Conference is held in Bangkok, Thailand, from 26 -31 January 2016.

Rationale

Universal health coverage (UHC) is high on the global agenda as a means to ensure population access to health services and financial risk protection. UHC is endorsed as one of the health related Sustainable development Goals. In most countries where current access to essential health care is limited, introducing UHC prompts serious concerns among government leaders on the growing expenditures and demands for public resources. As such, priority setting is indispensable and has been applied at various levels, to ensure that finite health resources are used in the most cost-effective ways, to provide a high quality and appropriate package of healthcare for the population. At the macro level, priority setting can be used to set limits of the health budget and how much should be spent on health insurance; at the meso level, how much should be spent on infrastructure development and human resources; at the micro level, how much should be spent on particular drugs, technologies, intervention, and policies within a health problem.

Priority setting in the PMAC theme encourages the use of evidence, transparency, and participation in making decision on resource use. Although priority setting cannot avoid politics, evidence should come first and politics makes decision based on these informed evidence. It is noteworthy that since health-related decisions are driven by the Health in All Policy notion, priority setting is undertaken not only by policy makers in the Ministry of Health and Health Insurance Office, but also by stakeholders in non-health sectors such as the Ministry of Finance, development partners, and civil society organizations.

The role of health intervention and technology assessment (HITA), not only as a technical exercise but also as a deliberative process, is increasingly recognized as a tool for explicit priority setting, including in the development of the health benefits package, which is an integral part of UHC – what kind of services to provide and to whom. The concept of HITA and its contribution to UHC were endorsed in the resolutions of the WHO Regional Committees for the Americas in 2012 and Southeast Asia in 2013, the Executive Board in January 2014, and the World Health Assembly (WHA) resolution in May 2014. All these resolutions call for capacity building for and introduction of HITA in all countries, especially in those resource-finite settings. It is anticipated that HITA movements will increase awareness and demand for HITA studies in the health sector. The WHA resolution also requests the WHO Director-General to report back to the WHA in May 2016. Thus the PMAC in January 2016 would be most timely to track the progresses and recommend further actions.

Objectives

- To advocate and build momentum on evidence-informed priority setting and decisions to achieve UHC goals;
- To advocate global movement and collaborations to strengthen the priority setting for health interventions and technology in the long-term;
- To share knowledge, experience, and viewpoints on health-related priority setting among organizations and countries; and
- To build capacity of policymakers and respective stakeholders for development introduction of contextually-relevant priority setting mechanisms in support of UHC

Audiences

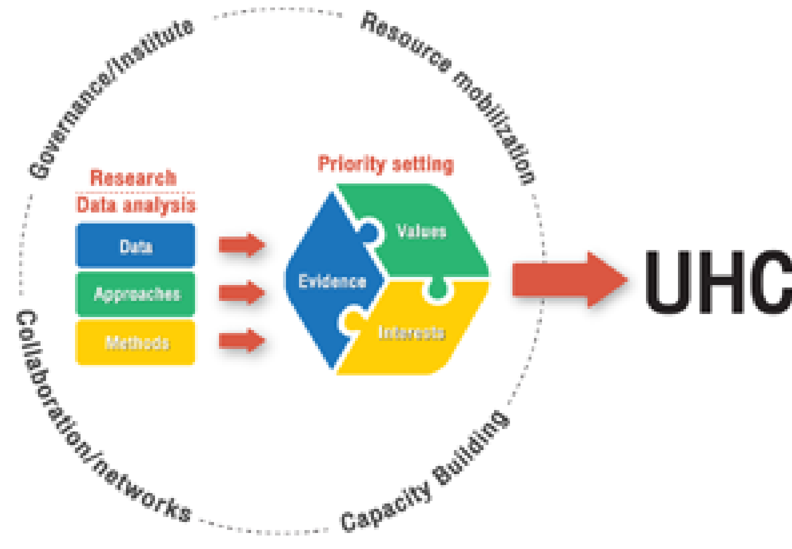
The target audience includes policymakers, senior officers, and staff of national bodies that are responsible for the decisions of resource allocation in UHC, including the Ministry of Finance, Ministry of Health and other relevant agencies, HTA agencies, civil society organizations, international organizations and development partners, academic institutes, and industry.

Conceptual Framework

The PMAC 2016 sessions were developed on the conceptual framework illustrating essential elements of health priority setting that addresses the need for evidence-informed decision making in support of universal health coverage (UHC), see figure. In this sense, priority setting of health problems and solutions involves evidence generation (Sub-theme 1), use of evidence in resource allocation, program management and quality assurance in health delivery (Sub-theme 2). Sub-theme 3 depicts how priority setting was implemented in real life from different country context. Priority setting in particular health systems is implicated by a wide range of political, economic and sociocultural factors, through the following building blocks:

- Governing structure and functions of different institutes who are responsible for generating evidence or use of evidence for decision making;
- Resource availability and mobilization to support priority setting activities as well as supporting institutional capacity to generate evidence for setting priorities;
- Capacity building of individuals and institutes and approaches to sustain these capacities to generate evidence for priority setting in the long term;
- Collaboration and networks of local, international and global organizations on HITA which is one part of priority setting. These collaboration can contribute to capacity building and learning and sharing of HITA findings.

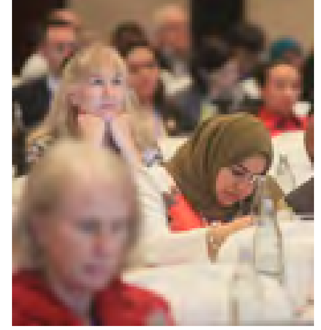
Figure:

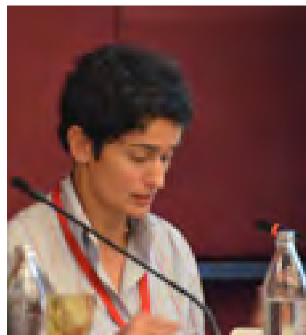


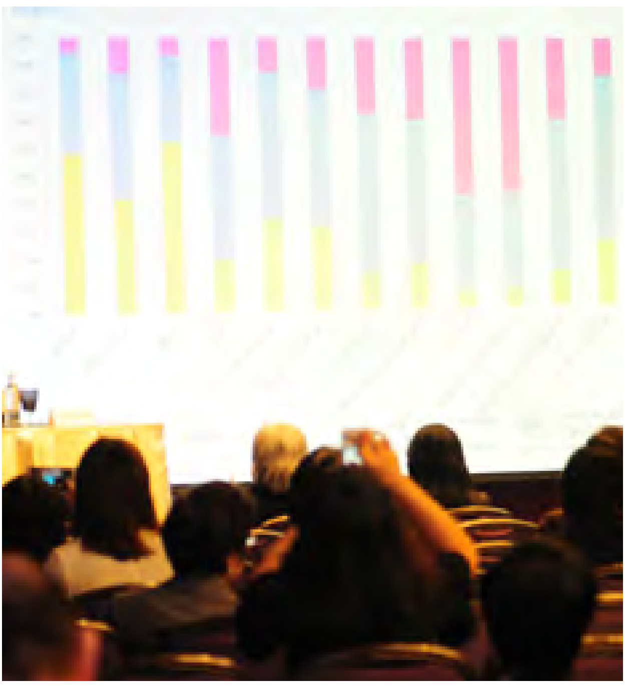
Key areas
1. Evidence
2. Using evidence in making UHC decision
3. Priority setting in action

Evidence generation, either from research studies or from relatively simpler analysis of information, requires not only capable human resources, but also reliable and up-to-date data/information, rigorous methods and practical approaches. Health intervention and technology assessment has been recognized as a useful tool for priority setting of biomedical interventions and public health measures. Other approaches for determining priority health interventions also exist, such as the profile of burden of diseases indicates what diseases/conditions that policy should focus on. Meanwhile, connection between evidence, priority setting processes and policy decisions is politically-oriented, as it is shaped by social values (such as efficiency, equity, morality, and solidarity) and variety of interests, all of which are usually competing with each other.

In practice, health priority setting (Sub-theme 3) in most low- and middle-income countries is imperfect, owing to constraints in the four building blocks. Importantly, the absence of good governance can result in inadequate resources, system capacity and support from different organizations. These allow powerful interests, with certain values, to dominate both the technical and political aspects of priority setting, and subsequently undermine quality of evidence as well as political commitment to using evidence to inform coverage decisions, disinvestment, program designs and guidelines formulation in the UHC context.







Sub-themes

Topics to be discussed fall under three main sub-themes, with a focus on organizing priority setting, using priority setting in UHC decisions, and practical experiences of priority setting. The three sub-themes are interrelated and may somewhat overlap, thus, the issues in each sub-theme may be similar, but with different perspectives depending on the sub-theme.

Sub-theme 1
Organizing priority setting: what evidence is needed?

Various tools are available to support priority setting; some are well established and widely used, others are emerging and under development. Moreover, some analytical methods, such as economic evaluation, comprise different approaches, e.g. generalized cost-effectiveness analysis, extended cost-effectiveness analysis, etc. Notably, there is not a single tool that addresses all priority setting concerns among decision makers and stakeholders. The effectiveness of a tool depends on the objective and context of use. This sub-theme provides not only basic information to participants who are not familiar with priority setting and its technical terms, but also, in some sessions, offers in-depth dialogues on current challenges in order to call for collaborations in order to address these challenges in the future.

Objectives

- To overview techniques and approaches available for priority setting including their advantages and disadvantages
- To discuss what evidence is required in priority setting for the whole range of interventions from single technologies to complex interventions, health systems arrangements, and disinvestment of existing interventions/technologies
- To discuss the governance of priority setting

Sub-theme 2
Using priority setting evidence in making UHC decisions

The main objective of this sub-theme is to demonstrate political economy and options to link evidence to UHC policy. This sub-theme also addresses current challenges in this area, including the lack of integration of evidence in policy development, such as the revision of the benefits package, national formularies, standard practice guidelines, and designs of public health programs.

Objectives

- To discuss political economy of priority setting for UHC, including why decision makers do or do not use evidence in decision making
- To address how evidence is applied, transcendent across geographical boundaries, and communicated in UHC decisions in different country contexts

Sub-theme 3
Priority setting in action: learning and sharing country experiences

This sub-theme covers real world experiences by development partners and countries where priority setting mechanisms exist or HITA studies have been conducted, as well as countries without formal mechanisms. The sub-theme offers an opportunity for learning and sharing country experiences with different levels of development towards UHC and priority setting capacities, and the role of development partners in these countries. It will also discuss missed opportunities of countries without explicit health priority setting. The sub-theme will lead to policy and practical recommendations for the establishment or maintenance of priority setting mechanisms for the sustainability of UHC.

Objectives

- To learn and share experiences on priority setting for UHC in different country contexts
- To develop policy recommendations for establishing or maintaining priority setting mechanisms for UHC

OPENING SESSION

BY HER ROYAL HIGHNESS
PRINCESS MAHA CHAKRI
SIRINDHORN

KEYNOTE ADDRESSES

Morton M. Mower

Prince Mahidol Award Laureate 2015
Professor of Medicine
Johns Hopkins University School of Medicine (Baltimore)
Professor of Physiology and Biophysics
Howard University College of Medicine (Washington, D.C.), USA

IMPLANTABLE DEFIBRILLATOR AND OTHER ELECTRICAL TREATMENTS AND THEIR APPLICABILITY TO PRIORITY HEALTH INITIATIVES

I am very much indebted to the Prince Mahidol Foundation for the high honor of this award, and for this opportunity to address you today. I am perhaps best known in my field for my work with Dr. Michel Mirowski on the Implantable Cardioverter Defibrillator, and for the development of Cardiac Resynchronization Therapy for Congestive Heart Failure.

But, in addition to both of these therapies which have had great acceptance by the medical profession and have saved and improved many lives over the past three decades, my lab has now stumbled onto a previously unrecognized electrical control system for Non-Cardiac tissues, which also promises to have great applicability for novel treatments of numerous disease states. Like many things in life, one has to be at the right place at the right time and be influenced by the right people.

My career has been a mixture of Research and Private Care Medical Practice. I grew up in a small rural town, had Polio as a child and as a result wasn't any good at sports. I learned to be self-reliant and to trust my own judgements. I couldn't wait to return to a big city which happened when I went to college.

My research started at the Undergraduate Campus of Johns Hopkins University. I worked under the geneticist Professor Bentley Glass. He gave me a project to map the location of two specific genes in the fruit-fly. Unfortunately these two genes were lethal in combination, so I worked for a very long time unsuccessfully to get the colonies to grow. It's a wonder that I ever continued in Research at all.

I trained at Sinai Hospital of Baltimore in the 1960's, which was when we were recruiting Dr. Mirowski to be Chief of our Coronary Care Unit, which was just being built, and which was one of the first ones on the Eastern Seaboard in the United States. He brought the intriguing idea of miniaturizing a cardiac defibrillator and endowing it with a little intelligence as a partial help for the problem of sudden cardiac death. Of course this wasn't a popular idea at the time and it took a lot of time and effort to bring it into fruition. We were also subject to a great deal of criticism in the medical literature.

During this time, we also became aware of an Unexpected Sudden Death Syndrome (SUDS) here in Thailand and ran a study called DEBUT (Defibrillator Versus Beta Blockers for Unexplained Death in Thailand), which was highly successful and showed complete protection against sudden death by the defibrillator.

I then realized that the Implantable Defibrillator, even as good as it was, was an "incomplete" therapy. It treated potential sudden death quite well but did nothing for heart failure, or more broadly left ventricular dysfunction. By pacing more than a single site on the ventricles and forcing the myocardium to beat synchronously, I discovered the efficiency could be improved and this has now become the standard of care for class 3-4 heat failure.

I then realized that adding anodal currents to the standard cathodal pacing waveform improved the speed of conduction and increased contractility in animal models. There ensued a slowdown with approvals at our Animal Care Committee and Institutional Review Board at the hospital, and for want of anything better to do, we started pacing cell cultures, for which we needed no approvals.

Lo and behold, we found that current containing anodal components had new and novel unexpected results on cellular functions: resting membrane potential was increased, this effect persisted even after pacing was stopped, the cells produced more ATP which is the energy molecule of the body, and that ATP could be used for the work of the cell, whatever the work of that cell happened to be.

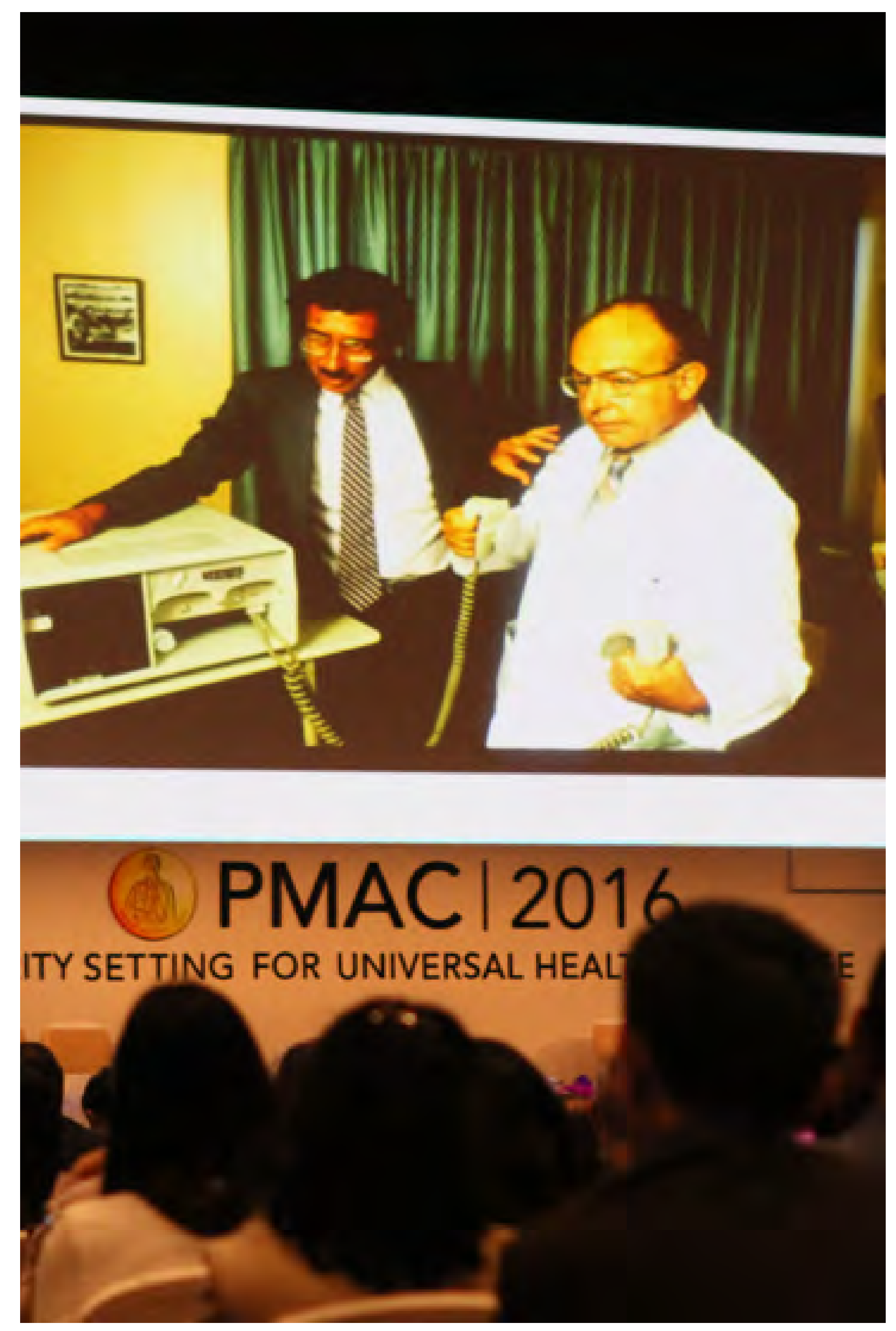
For example, we found that we could command the Islet cells of the pancreas to make Insulin in the absence of the usual stimuli (i.e. Glucose) to do so. It is not yet completely clear how this and effects on other cells of the body will play out, but it is an opportunity in a previously unexplored area.

Why am I telling you all this. Actually for two reasons, firstly because this has the possibility of further increasing longevity and well-being of patients in the future, and secondly because there still exist areas in research which have the potential to improve quality of care and access to care for future populations which is a goal of this conference.

Among the interests of the Prince Mahidol Foundation are the promotion of collaboration of the Thai medical and health community with international institutions. There are intriguing opportunities to do this. I would submit that Ben Gurion University of the Negev, in Israel is one such suitable institution. My wife Toby Mower has an Honorary Doctorate from there for innovation in the field of drug and alcohol addiction, and they have instituted a Curriculum for the Prevention and Treatment of Addiction, which has much to offer for professional and personal development of Thai young people in the fields of medicine, nursing, public health and human services. A cooperation between faculty members and students of Siriraj Hospital, and other Thai institutions of higher education with Ben Gurion University would be extremely desirable.

Development of ties with more hospitals in the United States would be highly desirable. In specific, I would point to the possibilities of collaborative relationships with places such as the University of Colorado in Denver, and Johns Hopkins Hospital, with which I have my associations.

In addition, the American Heart Association is taking bold steps to accelerate the future of medicine with a new development called precision cardiovascular medicine — a rapidly evolving approach towards disease treatment and prevention that takes into account an individual's genes, environment, and lifestyle, and with programs to drive innovations and advance them in a multicultural manner.



The American Heart Association is an organization devoted to saving people from heart disease and stroke. It teams with millions of volunteers to fund innovative research, fight for stronger public health policies, providing lifesaving tools and information to prevent and treat these diseases.

The concept of precision medicine (also known as personalized and individualized medicine) was first touted nearly a decade ago and hopes ran high when the human genome was mapped in 2003. Since that scientific achievement, the promise of precision medicine has seen some successes in areas such as cystic fibrosis and some forms of cancer. In January 2015, a national initiative was launched by the White House and the National Institutes of Health to apply precision medicine concepts on an all-encompassing level to deliver evidence-based, appropriate, and timely treatment to the patients who most urgently need them. This has not yet been focused on cardiovascular disease which remains the number one cause of death in America (611,105 deaths, or 1 in every 4 deaths, in 2013 alone).

This past November, the AHA and the life sciences team at Google each contributed 25 million dollars to launch an Institute for Precision Cardiovascular Medicine. The project will involve a massive data base including genetic and environmental information from volunteers which can be queried by individual physicians.

Because we don't know why some people who do "all the wrong things" live to a ripe old age, or why different people with the "same" genetic makeup have widely varying outcomes, it will be highly desirable for this massive database to have healthy volunteers as well, and to include as many international populations as well.

Thus this final discovery portal, accessible to all physicians will be a treasure trove of actionable intelligence able to tailor treatments to individuals in a very specific, detailed, and most efficient manner. This is indeed an International opportunity for an important collaboration.

In conclusion, let me say that I am very indebted to my family, especially my wife Dr. Toby Mower, and my children for their support and forebearances during those times of long hours and frequent absences from home during the last fifty years. For this, and for this Foundation's great honor, I will be eternally grateful. Thank you so very much.

Sir Michael Gideon Marmot

Prince Mahidol Award Laureate 2015
Director, UCL Institute of Health Equity
Professor of Epidemiology and Public Health, University College London
United Kingdom

A recent report from Oxfam showed that just 62 billionaires have the same wealth as the poorest half of the global population. With a bit of a squeeze all 62 could fit into one London double-decker bus. Not so the other 3.6 billion people. Within most countries, too, inequalities of income and wealth have been growing. Should we care?

We should for three reasons. First, as Sir Tony Atkinson highlights in his recent book, Inequality, surveys find that the population in the US and Europe identify inequality as the number one problem in the world. People feel it that is just plain wrong, unfair, unjust.

Second, too much inequality threatens democratic legitimacy. If life's chances are sequestered at the top, the rest of the population, rightly, feels that the governance of countries does not serves their needs. Similarly, if the global economic and political order serves the elite in some countries at the expense of the rest of the world, it is major challenge to our existing arrangements.

Third, highly unequal societies are associated with social evils such as ill-health and crime. Some place emphasis on the gini coefficient and argue that inequality damages the health of everybody. In my book, The Health Gap, I emphasize that the ill-health effect of inequality increases with increasing degrees of social disadvantage—the poor suffer the most.

Central to the ill-health effect of inequality is both poverty and relative disadvantage. Absolute poverty means disempowerment in an extreme way: having insufficient money to meet basic needs. Relative disadvantage is related to the social gradient in health. Relative disadvantage, too, is disempowering. Following Amartya Sen I argue that relative inequality deprives people of the freedom to lead a life they have reason to value.

One welcome response to such inequality in health is universal health coverage – the theme of this conference. It is appropriate that it should be held in Thailand, given the great strides that Thailand has made in implementing universal health coverage. It is much needed. I have just come from a meeting in Kolkata where colleagues point to the fact that India's health care system not only is failing to meet people's health needs, but out of pocket expenditures is emiserating people. A simple contrast between India and Thailand is instructive. In India, according to WHO figures, of all expenditure on health care private expenditure makes up 73%; of which 87% is out of pocket. That means 63% of all health care expenditure is out of pocket. In Thailand, by contrast, only 20% of health care expenditure is private of which 57% is out of pocket i.e 11% is out of pocket. Out of pocket is 63% in India and 11% in Thailand…and the pockets are shallower in India.

Something else is needed, too. When we began the WHO Commission on Social Determinants of Health we asked rhetorically: why treat people and send them back to the conditions that made them sick? It is the first line of my book, The Health Gap. We need action on the conditions in which people are born, grow, live, work, and age; and on inequities in power, money and resources that give rise to inequities in these conditions of daily life. We need action, in other words, on the social determinants of health. And when people get sick, they need access to health care free at the point of use.

It is an absolute pleasure to be the 2015 Prince Mahidol Award laureate for Public Health. A pleasure for me, personally, of course. But that is of little interest. The pleasure is that this prestigious award recognizes the importance of social determinants of health. It validates the hardy band of brothers and sisters who have toiled in this field.

As many of you will know Prince Mahidol was selected by his father the King for a career in the Navy. The Prince thought he could serve his people better by studying medicine, than pursuing a career in the military. At Harvard Prince Mahidol diverted from medicine to public health and only later finished his medical degree. It is appropriate that there are awards in both Medicine and Public Health. In the Prince Mahidol museum in Siriraj Hospital here in Bangkok is a quote attributed to Prince Mahidol:

"The primary function of men of health science including physicians is not to assume the office of salvagers of wrecks but rather of pilots preventing them".

There should be no conflict between wishing to prevent the wrecks and dealing with the problems when they occur. I argue strongly with ministers of education, environment, occupation, social security and finance that what they do in their day job influences health. So powerful is the influence of societal action on health, that health equity is a good measure of how we are doing as a society.

Conversely, I seek to get the doctors involved. Somewhat surprisingly I find myself President of the World Medical Association. In that role I am engaging actively with medical societies in all regions of the world to explore what they and other health practitioners can do to address the social determinants of health. I am hugely encouraged.

I say to them that Universal health coverage is vital but it will not abolish inequalities in health. In The Health Gap, I write about Baltimore and London. In both cities we see twenty year gaps in male life expectancy. Twenty years! But there is a crucial difference. In the UK we have universal health coverage, free at the point of use. Further, all round the world, we see difference in health not just between rich and poor, but there is a social gradient: the more years of education, for example, the better the health.

I emphasize disempowerment. If we want to see disempowerment in action, look at the recent paper by Anne Case and Angus Deaton showing a rise in mortality in the US among non-Hispanic whites aged 45-54. And the conditions that carry people off? Poisonings due to drugs and alcohol, suicide, alcoholic liver diseases, and external causes of death. Disempowerment from the social determinants of health rather than lack of health insurance.

Looking more positively, empowerment of women through education has clearly made a major contribution to the reduction in infant and child mortality globally. But the revolution in child survival shows the importance of treatment.

I referred to my recent book, The Health Gap. I wanted to call the book The Organisation of Misery. As one or two of you may know, I have been quoting Pablo Neruda and inviting colleagues to:

Rise up with me…

Against the organisation of misery, The publisher said I could not give a book such a title. No one would read it. I proffered The Organisation of Hope. Better, said the publisher, but a bit obtuse.

I compromised. I called the first chapter, The Organisation of Misery, and documented the dramatic inequalities in health within and between countries. I then bring together the evidence on what we can do through the life course to reduce avoidable inequalities in health – health inequities – starting with equity in early child development, education, working conditions and better conditions for older people. I call the last chapter The Organisation of Hope because I document examples from round the world that show we can make a difference.

When in Thailand for the National Health Assembly in December 2009 our Thai colleagues taught me about the triangle that moves the mountain. The three sides of the triangle are government, knowledge including academia, and the people. Get the three sides of the triangle aligned and we can move mountains.

Michel Sidibé

Executive Director
The Joint United Nations Programme on HIV/AIDS
Switzerland

Universal Health Coverage—Leaving no one behind

Your Royal Highness, Your Excellencies, ladies and gentlemen: It is an honor and privilege to be here today. The Prince Mahidol Award Conference has been for many years a place for important discussion and debate at the cutting edge of global health. This meeting is a fantastic platform for bringing together renowned global health policy experts and implementers.

Princess Maha Chakri, I want to thank you personally for your commitment. Thailand has become a model country for shining a light on Universal Health Coverage (UHC) as an integral part of the Sustainable Development Goals (SDGs). UHC is about the health of everyone, including the poorest people and those forgotten by society. It is about leaving no one behind.

It is timely and topical that we are here in Bangkok, at the dawn of a new era in development, for these important discussions of priority setting. Thailand

should be applauded for the transformations it has achieved for the health of its people. You have demonstrated that countries can reach universal access to HIV services, and that we can dream of the day when we will end AIDS as a public health threat. HIV treatment has been fully integrated into the country's UHC system with spectacular results: In just seven years, the number of people accessing treatment has grown from 40,000 to more than a quarter of a million.

Thailand has also shown great coverage in leveraging TRIPS flexibilities to make lifesaving drugs available to people for free. Thailand gives undocumented migrants equal access to HIV treatment. This is exactly what we mean by leaving no one behind. It is about changing the paradigm for scaling up to UHC.

Critical linkages

UHC is much more than "making a package of services available." The ultimate measure of our success must be whether the poorest, the most marginalized and the most vulnerable people enjoy health and well-being. This requires going upstream and assessing and addressing—in specific contexts, and for specific populations—the causes of exclusion and ill-health. It is time to address the critical linkages between health, injustice, inequality, poverty and conflict.

UHC puts the focus on people, not diseases. This approach has been transformative for the AIDS response over the past 30 years. Thanks to the engagement of empowered communities, we broke the conspiracy of silence. We brought people out of the shadows—sex workers, men who have sex with men, people who use drugs and LGBTI people—who had no access to health services because they had to hide themselves and exist "underground."

The AIDS response demonstrates the power of activism and political will. Leveraging this experience and knowledge will be critical to making UHC a reality. It will happen because we know how to use community engagement to create demand for services.

We also know how to use innovations in science and technology to bring medicines and services to the greatest number of people. We were able to reduce the cost of HIV treatment from US$ 15,000 per person per year to just $80. We reduced dosages from 18 pills a day to just 1, and soon to just a single injection every four months. UHC will require the same effort to democratize access to affordable services, drugs and diagnostics and to exploit the full range of tools already available, including TRIPs flexibilities. We must be able to quickly apply new science, not wait 10 years before we move from research to implementation. This is what makes universal access possible.

Balancing equity and efficiency

Priority setting must keep human rights at its heart by ensuring careful arbitration between equity and efficiency. Equity means that quality health services reach all those in need; efficiency means that limited public resources are used for health interventions that provide maximum returns on investment. Managing this trade-off will be critical, and it won't be easy.

We must also take into account social determinants of health, addressing the root causes of fragile and neglected communities, dismantling structural barriers and reforming laws, policies and practices that restrict access. We must also focus strongly on services at the community level, summoning the courage to move from the comfortable but unsustainable disease approach to the primacy of the health of the individual.

There can be no global health security without proper management of individual health risks. We saw this with Ebola, and we are already seeing it with the Zika virus. If we are unable to transfer competencies, if we cannot reach people efficiently with knowledge and information, we will not be able to manage global health risks in the future.

For UHC, let us think not in terms of "health systems," but rather, "systems for health," with people at the centre. This means completely changing our service delivery approach to reinforce the interface between providers of health services and the community, tapping into non-conventional capacities whenever we can. For example, Ethiopia's Health Extension Programme, funded by HIV investments, has recruited, trained and supported more than 35,000 rural community health workers who now provide sustainable, comprehensive primary care in some of the hardest-to-reach areas. They are addressing the root causes of fragile communities.

We need to reduce health inequities between countries. When Ebola struck, there was 1 doctor for every 45,000 people in Sierra Leone and fewer than 2 doctors for every 100,000 people in Liberia. But in the United States, there is 1 doctor for every 400 people. It is very difficult to sustain the dream of UHC with these dramatic differences.

Our current global health architecture is unsustainable. We will need to build a new governance system for UHC that will reduce duplication and push governments to build systems that reach all people. We are no longer trying to reach millions of people who are sick; we must now reach billions of people with services to stay healthy, because UHC is also about nutrition, education and lifestyle choices. This requires a global health architecture that supports equitable, inclusive and resilient systems for health while also responding to crises and emergencies.

Civil society will be key to accountability and transparency for UHC. We must support communities to play their role effectively as agents of change, ensuring space and support for civil society both as partners in the design and delivery of UHC and as advocates, watchdogs and whistle-blowers.

Investing beyond ODA

Building architecture that supports UHC means going beyond ODA financing. We need shared responsibility, and that means more domestic financing. Countries must increase their budgets and per capita spending targets on health. This need not represent a costly burden: UHC can deliver benefits 10 times greater than investments.

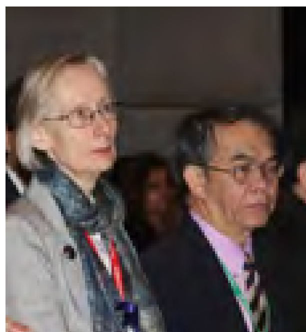
Low-income countries still need support, especially in the interim period, so it will be essential for wealthy countries to meet their pledge to provide 0.7% of GNI in ODA and to ensure that the SDG agenda is fully financed.

Shared responsibility has made all the difference in the AIDS response over the past five or six years. African countries have increased their domestic spending on AIDS by 150%. South Africa is spending US$ 2 billion from their own budget for AIDS programmes, compared to almost nothing a few years ago. We see the results in millions more people on treatment and millions fewer new infections.

UHC is not a charitable enterprise. It is good governance. It is an essential thread among the rights that are woven into the very fabric of modern society. If you are accused of a crime, you are entitled to a lawyer. You have a right to a fair trial. If you are sick, you are entitled to a health provider. You have the right to health.

The time to act is now. Together, we will make UHC a matter of rights. Together, we can achieve the single most critical objective of the entire SDG agenda—to leave no one behind.

Thank you.



Mirai Chatterjee

Chairperson
National Insurance VimoSEWA Insurance Cooperative
Director, SEWA Social Security
India

Understanding the context is essential for priority-setting whether for microinsurance or universal health care. In India, where the majority of the working poor – 93 per cent – are engaged in the informal economy, priority-setting must take this reality into account. Most informal workers have no fixed employer-employee relationship, and many are purely self-employed like street vendors, artisans and other small producers. Agriculture is still the largest source of livelihood for most Indians, and the majority are self-employed, small and marginal farmers.

Informal workers are characterized by little or no work and income security. They also do not have even basic levels of social security like health care, child care, shelter with basic amenities, insurance and pension. Further, food security is still an issue for many of these workers.

Women are a significant segment of poor, informal workers in the India. They most often get the most hazardous work like growing and processing tobacco, and are the least paid. There is an overlap between informality, poverty and gender which is also the case in many other countries.

The Self-Employed Women's Association, SEWA, a national union of informal women workers to which I belong, was founded over four decades ago by Ela Bhatt, a lawyer and labour organiser. She was moved to act after seeing how informal women workers struggled to make two ends meet, despite being economically very active. From a handful of street vendors, SEWA has grown to a fairly large organisation with almost 2 million members. It also has developed into an international movement, helping to promote organisations across Africa and Asia. Homenet Thailand, an organisation dedicated to the well-being of home-based workers, is one such sister organisation.

SEWA is inspired by the leader of India's freedom struggle, Mahatma Gandhi. SEWA is committed to continuing the struggle for the Second Freedom, as Gandhi called it – freedom from hunger and poverty – which he said all Indians should work towards after obtaining our First Freedom, our independence. Over the years, we have learned that the Second Freedom can only be obtained when the poor organise, build their solidarity and develop their own membership-based organisations, where they are the users, managers and owners. It is through these collective organisations that the poor find the strength to resist the many injustices and the exploitation that they face every day. This is even more so for women workers, who also have to face gender discrimination at every step—in their homes, in their communities and in society at large.

We have learned that poor women, like our SEWA sisters, can only emerge from poverty and move toward self-reliance through full employment at the household level. Full employment includes work and income security, food security and social security. The latter must include at least the basic services and facilities mentioned earlier – health care, child care, shelter with a tap and toilet in every home, insurance and pension. All of this is only possible when women come together in their own organisations and find creative solutions to their own issues. More than 5000 small, medium and large membership-based organisations have been set up by SEWA. Women are democratically elected to their boards, and they set their own priorities, and in an inclusive and equitable way.

Mahatma Gandhi understood that in a country with a large number of poor people, priorities need to be set according to the needs of the poorest and most vulnerable in society. He said:

'Recall the face of the poorest and weakest man whom you may have seen, and ask yourself, if the step you contemplate is going to be of any use to him. Will he gain anything by it? Will it restore him to a control over his own life and destiny?'

At SEWA, we have tried to follow the direction laid out by Gandhi, focusing on the poorest in Indian society – women workers of the informal economy. One of the priorities and needs of our SEWA sisters has been financial services. From the very early days, women explained that they could not emerge from poverty if they were bound to money-lenders and others who advanced them credit at usurious rates. They also needed a safe haven for their savings and then affordable credit services. Once these basic services were provided by their own cooperative bank, SEWA Bank, they expressed their need for insurance. As Ayesha, a garment worker and leader of the union explained:

‘We work hard and save. But one illness or death of a family member means that our savings are wiped out, and we are forced to borrow from money-lenders or pawn our jewelry, and go into debt. So how can we ever stand on our own two feet?’

Her colleague, Nanuben, an old clothes vendor has taken a loan 27 times from SEWA Bank to build up her business. She says:’ Women like me need credit and we get this at affordable rates from our own bank. When my husband passed away, I used up all my savings for his funeral rites. I could not pay back my loan for several months. Women like me need insurance.’

Thousands of other women like Ayesha and Nanuben also pressed SEWA for insurance. We approached the insurance companies, all nationalised in the late 1970s.Earlier banks had turned women away, saying they were ‘not bankable’, now they were told that they were ‘bad risk’ and hence could not be insured by the insurance companies. In 1992, when SEWA’s membership reached 50,000, the insurance companies were ready to discuss insuring women.

The companies had never sat face-to-face with informal women workers before, and slowly began to understand their needs, how much they could afford and how the services needed to be organised. Women said that they needed both life and non-life insurance—health, accident and asset insurance. And thus in 1992, the long journey towards some basic insurance, actually microinsurance, began. By 2009, women had enough microinsurance experience to set up their own cooperative, and thus, the National VimoSEWA Insurance Cooperative was formally registered with 12,000 share-holders, all informal women workers, and from five states of India. Some of their organisations like SEWA Bank and SEWA’s health cooperative also invested in this new cooperative, along with eleven other such membership-based organisations. It was the first of its kind, with women and their organisations as share-holders. Further, only women were insurance policy-holders, and through them, their families could also be insured. Today VimoSEWA offers 10 insurance products to over 100,000 insured women. These products include health insurance, life and accident insurance and insurance for loss of income due to hospitalization.

VimoSEWA also offers multiple services including developing microinsurance products, educating women on the concept of insurance, linking with large insurance companies to provide suitable products, selling these products, processing claims and maintaining a data base to facilitate prompt services. It also links women with other services provided by SEWA – banking by SEWA Bank and primary health care through Lok Swasthya health cooperative, for example.

The road to providing microinsurance for informal women workers was an unchartered one. But as usual, women showed the way. The first step was consultation with our members in different settings – urban and rural. We spoke with women young and old, and tried to learn about their priorities and needs. They were enthusiastic about obtaining insurance services and were ready to pay premium. Then we undertook surveys in both rural and urban areas to deepen our understanding about their needs, what kind of products were their top priorities and how much they could afford to pay by way of premium. The survey findings were then shared widely within the organisation, and in small and large meetings of women and other fora, to test ideas on possible insurance products and ways to reach these to the poorest of our members.

Next we organised small workshops with women and actuaries from insurance companies to actually develop microinsurance products. We also conducted training sessions on the concept of insurance, till then quite unknown to our SEWA sisters. We had to patiently explain to them when they asked: 'What happens if I don't get sick? Will I get my money back?' The concept of a risk pool to which all contribute but only some obtain benefits by way of claims was an idea that took time for women to digest. In fact the first five years of VimoSEWA were a period of much investment in insurance education and capacity-building to run the services.

This process of consultation, interaction with members and discussion on various products and their pricing continues till today. Once VimoSEWA was formally registered as a cooperative, it had a board elected for a period of five years with representation from all the five states from which its members were drawn. Now all policies are decided by the board, and major ones in the annual general meeting. This process of continuous consultation, feedback from members in board meetings and other fora, ensure that priority-setting is led by women themselves, with professionals providing the back-up support required, like actuarial calculations. It is board members who negotiate with insurance companies during annual pricing meetings. And it is they who now are demanding that with years of experience, VimoSEWA should no longer be an intermediary between them and the insurance companies, but convert itself into a full-fledged insurer.

This process of priority-setting has often led to creative out-of –the-box thinking, and always to the developing of appropriate products and processes, tailor-made to their needs and budgets. Health insurance has always topped the priority list, given that hospitalization, in particular, leads to heavy expenditures. Women asked for coverage for their whole families, and we developed affordable family floater products. Then they said that they did not have the money needed when a family member was hospitalized, and had to borrow from others like money-lenders. They came up with the idea of informing VimoSEWA when they or a family member were hospitalized, and getting the cooperative to then pay out cash on the hospital bed itself, thus preventing borrowing at high interest rates.

Next they asked VimoSEWA to come up with a product to cover their income losses due to hospitalization. We jointly came up with a product that pays them a flat amount. This has proved to be a popular add-on product to some of the government's health insurance programmes that were developed a few years ago. In fact, when developing nation-wide health insurance for Below Poverty Line (BPL) families, the policy-makers consulted with VimoSEWA and our members, adopting many of the processes and procedures that we had developed over the years.

Other products that women developed with VimoSEWA's insurance professionals included low priced life insurance and savings-linked products which encouraged asset-building in women's name with a risk cover. Finally, our sisters developed the idea of 'bundled products'—life, health, accident and asset insurance combined with one consolidated premium, and all at an affordable price. From a group that had no knowledge of insurance as a concept, our SEWA sisters sharpened their knowledge and skills to not only priority-setting, but also product development and implementation!

The impact of needs-based microinsurance services with priority-setting by women is evident in the last three years' performance, where VimoSEWA has become financially viable, and is now registering an average growth of 10 per cent per annum. Today our share-holders are obtaining dividends. But it took us twenty years of experimentation and struggle to develop the balance between financial and social goals. It has been a long journey but one that has

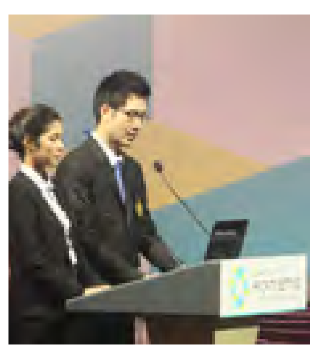
resulted in growing outreach with insured members now in seven states and with partner organisations beyond those in the SEWA movement. Slowly we are bringing microinsurance services to several parts of the country, tweaking and tailoring our products to suit local women's needs in different areas.

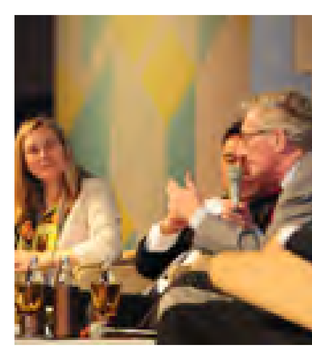
Importantly, concrete economic support in times of risk has reached women and their families. In the last ten years, Rs 159 million or US $ 2.38 million went directly into informal women workers' hands by way of claims. As mentioned earlier, several of VimoSEWA's learnings have been incorporated into the national health insurance called RSBY. In addition, the Indian Parliament's insurance committee has recognised the importance of microinsurance as a risk mitigation tool and an anti-poverty measure. It invited VimoSEWA cooperative to depose before a multi-party committee of Members of Parliament. Our board member and garment worker, Hamida, took the floor and explained how microinsurance, developed according to the needs and priorities of women like her, had been a life-saver. The Chairman of the Insurance Committee declared VimoSEWA's deposition to be 'an eye-opener and a breath of fresh air'. The Committee unanimously has recommended that such microinsurance initiatives be encouraged across the country, and that they be run preferably by community-based organisations like cooperatives.

As I mentioned earlier, it has been a journey full of challenges and of balancing both financial and social objectives. Achieving financial sustainability was a slow process of many ups and downs. We strove to increase our outreach, keeping an eye on acquisition costs, knowing that our revenues from premium paid by women were modest, at best. Products and processes had to be according to women's priorities with all terms and conditions explained clearly and in a simple manner. While managing costs, we had to make sure our services were of quality and timely too. Finally, we continue to face the challenge of lack of an enabling environment for microinsurance in India, the vast numbers of our working poor and their need for risk mitigation notwithstanding. VimoSEWA continues to serve as an intermediary with small margins rather than a full-fledged insurer due to the high capital requirement of one billion Rupees or about US $ 20 million that is required for a licence. VimoSEWA's board has worked out its business plan and shown that low income households can be served in a financially viable manner with about 30 million Rupees or US $ 7 million, as our products are of modest size and the risks are low, especially when women run their own insurance services.

VimoSEWA's main lesson which may be of relevance to our conference today is that whether for universal health care or microinsurance, or any other development programme, people must be at the centre of all our efforts, as Gandhi reminded us so many years ago. In Thailand, the national health assemblies that are now a regular institution have been a source of inspiration to us in India, as we slowly move towards universal health care. At all times, we have learned it is people, especially the poorest and most vulnerable like the women of our countries, who must steer the process and take the lead, setting priorities that will benefit all in our society. Starting with their priorities, we will not go astray, as their's is an inclusive and equitable vision which not only takes care of the social determinants of health, but also the well-being of all.

CONFERENCE SESSIONS

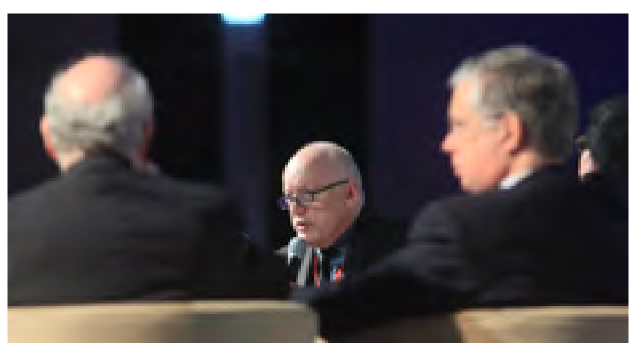




Opening Session & Keynote Address

Opening Plenary

The Primacy of Priority Setting: Global Advocates and Country Realities



Plenary 1

Using Priority Setting Evidence in Making UHC Decisions

Parallel Session 1.1
Evidence for Health Benefits Package Choices: Is Cost-Effectiveness Analysis the Answer?

Parallel Session 1.2
Accountability, Fairness and Good Governance in Priority-Setting for UHC

Parallel Session 1.3
Strengthening Capacity to Produce and Appraise HTA Evidence

Parallel Session 1.4
Human Rights - Entitlement to Health: What Does It Mean in Practice and How Can It Affect Priority Setting for UHC?

Parallel Session 1.5
Priority Setting and Public Health Security: Leveraging UHC Reform for Disease Surveillance Systems in a Globalized World

Plenary 2

Is the Current Evidence Fit-for-Purpose? What Evidence Do Decision Makers Need to Set Priorities in the Future?

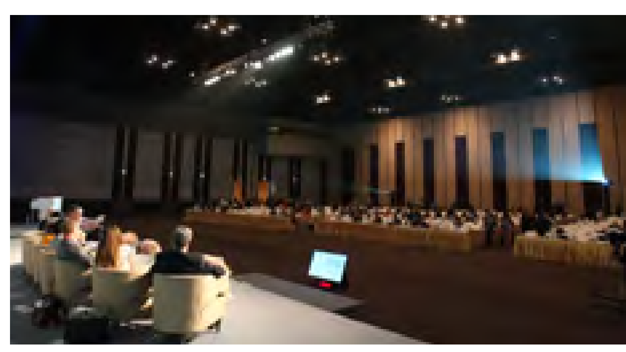
Parallel Session 2.1
Demonstrating the Relevance of Economic Evaluation to Multiple Objectives of UHC: What Are the Key Challenges?

Parallel Session 2.2
Missed Opportunities and Opportunity Costs: Reprioritizing UHC Decisions in Light of Emergence of New Technologies, Continued Budget Constraints, and Incentives for Innovation

Parallel Session 2.3
Can You Handle the Truth? Accounting for Politics and Ethics in UHC Is Very Challenging

Parallel Session 2.4
Stakeholder Dynamics in UHC Priority Setting

Parallel Session 2.5
Enabling Better Decisions for Better Health: Embedding Fair and Systematic Processes into Priority-Setting for UHC



Plenary 3

Action Express Priorities: Progressing towards Sustainable UHC / Bangkok Statement

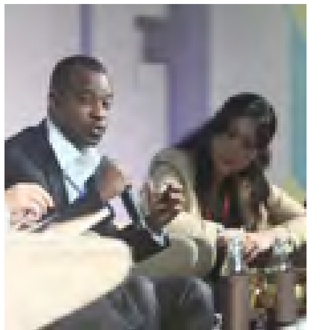
Parallel Session 3.1
Defining the "What", "How" and "for Whom"
of UHC: Country Experiences of Developing and Implementing Benefits Plans
and Other Tools for Priority-Setting

Parallel Session 3.2
Prioritising Research to Deliver Evidence for UHC: How Can Policy Makers Shape the Research Agenda to What They and Their Populations Need

Parallel Session 3.3
Aligning Local and Global Priorities for Health: The Roles of Governments, CSOs and Development Partners in Setting and Funding for The Priorities

Parallel Session 3.4
Coping with Budget Reductions & Economic Austerity: Implications for UHC Priority Setting

Parallel Session 3.5
Translating Priorities into Action

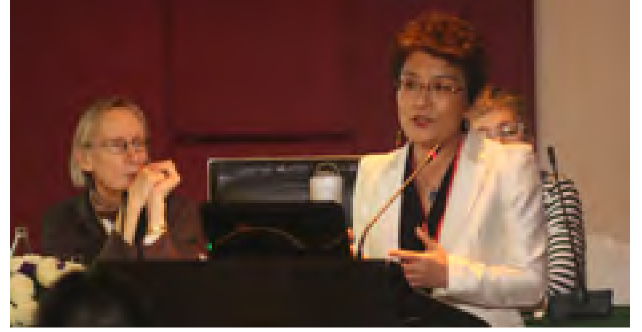


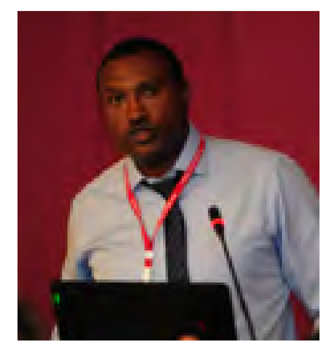
Plenary 4

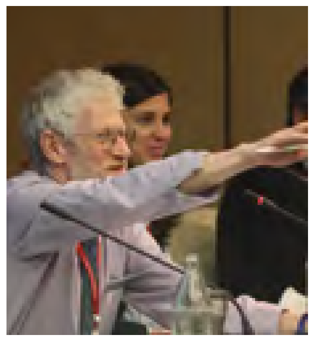
Better Decisions for Better Health: from Rhetoric to Reality

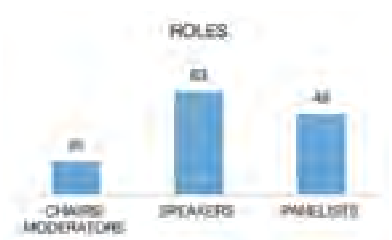
Synthesis: Summary, Conclusion & Recommendations

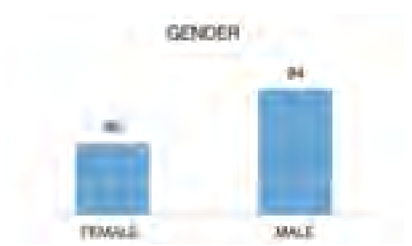
Profile of chairs, moderators, speakers and panelists

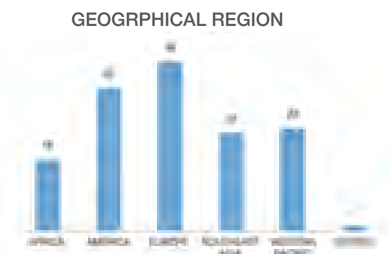


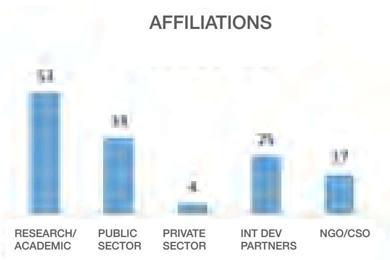












CONFERENCE SYNTHESIS

Global Context

Priority setting comes into play, especially in the context of Universal Health Coverage (UHC).

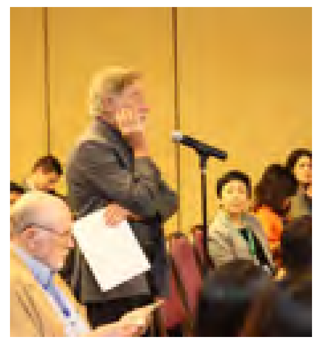
The global commitment to UHC was endorsed by UN Member States through the adoption of UNGA Resolution A/70/L.1 "Transforming our world: the 2030 Agenda for Sustainable Development" in October 2015. UHC is one of the health related Sustainable Development Goal (SDG) 3.8.

Commitments to Health Intervention and Technology Assessment (HITA) have been embodied in the WHO AMR/PAHO resolution, CSP28.R9 "Health Technology Assessment and Incorporation into Health Systems" September 2012, the WHO SEA Regional Committee Resolution SEA/RC66/R4 "HITA in support of UHC" September 2013, and the World Health Assembly Resolution WHA67.23 "HITA in support of UHC", May 2014. This involves, inter alia, a call for strengthening of national capacities, and regional and international networking.

Implementing UHC requires significant investment by the government either through tax financed scheme or social health insurance contributions; in this context, there is a need for priority setting such as what cost effective interventions should be covered in the benefit packages; what priority policies is needed?

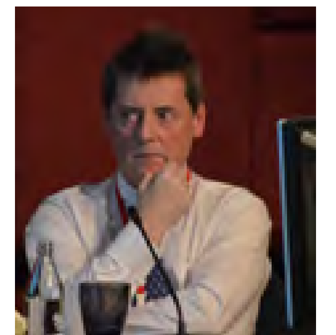
Matching Resources and Demand for Health

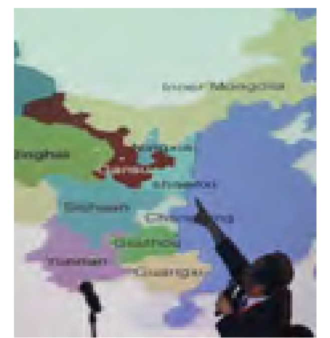
Health resources are always finite while demand is always infinite; in light of demographics, epidemiological transitions, technology advancement and increased expectations of patients and providers. Therefore governments must be accountable to their people to make best use of limited public resources. HITA is thus essential to inform resource allocation, and is the goal of PMAC 2016 i.e. learning and sharing to drive Priority Setting for UHC.

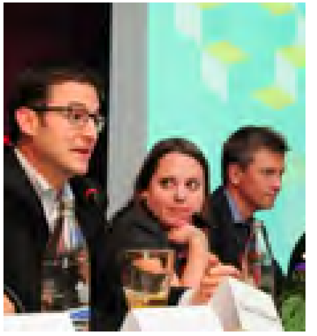


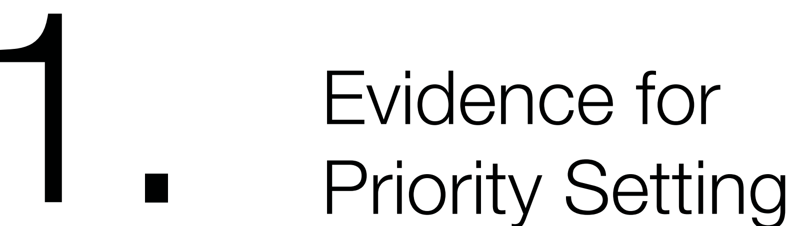
Key Areas

1. Evidence for Priority Setting
2. Using Priority-Setting Evidence in Making UHC Decision
3. Priority Setting in Action: Learning and Sharing Experiences







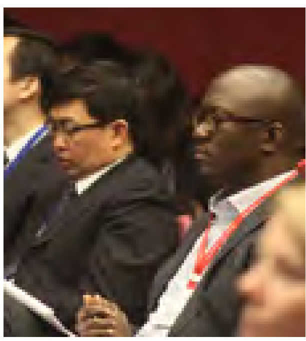


1. Evidence for Priority Setting

Evidence – Overview

Priority setting takes place at many different levels, from global, national, and sectoral, to local and individual. Therefore Ministries of Finance must consider a range of factors when choosing how much to allocate to health, particularly the impact on productivity/growth and its cost-effectiveness, using evidence that resources are used efficiently and making comparisons across sectors. The latter is often hampered by the absence of appropriate metrics for evaluation of effectiveness and benefits across sectors. Countries are increasingly seeking to use evidence of cost-effectiveness in establishing benefit packages, but lack of country level data on costs and effectiveness leads to reliance on global sources (e.g. WHO-CHOICE tool or evidence from the analysis in the Disease Control Priority DCP). A range of initiatives to strengthen collection of national cost data is needed, with appropriate tools to bridge between theory and practical guidance.

Evidence: Extending Perspectives

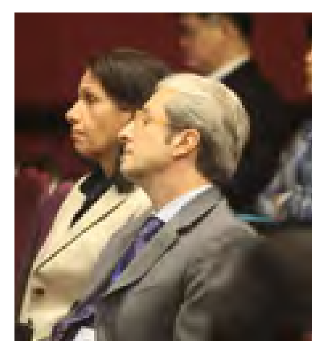


Methods need to take account of health system constraints, and to connect priority setting with the existing health system architecture. This includes the available human resources and capital, the costs of implementing changes (transition costs), system inter-dependencies (e.g. economies of scope) as well as governance and decision making processes. Such adaptation would aid the process of generalisability of evidence across settings, and improve the effectiveness of priority setting generally. The scope for wider application of methods that explicitly incorporate multiple criteria in decision making, however, given their uncertainties, their value may lie in the deliberative process they encourage. It is important that evidence covers a range of preventive and promotive interventions not only biomedical and curative services.

Economic evaluation of health system interventions is rare and also difficult to assess (e.g. pay-for-performance and strategic purchasing). The evidence available on some social determinants and non-health interventions, although challenging, should not be ignored. Currently there is considerable debate about appropriate thresholds for decision making, as these thresholds must reflect opportunity costs as well as affordability (budget constraints/impact) in the particular setting. The issue of thresholds should not be confused with ensuring incentives for innovation. Thresholds have important implications for both health system sustainability and accountability. Ultimately, financial risk protection is also an objective of UHC and interventions may prevent households from falling into poverty, which can be captured through extended cost-effectiveness analysis (CEA) or other methods.

Generating evidence is a dynamic process and the system needs to keep up to date. Countries must be prepared to revise priorities as new evidence becomes available, such as the examples that were shown from Thailand, New Zealand and South Korea. Horizon scanning and early assessments of new technologies are also part of the HITA continuum. It is important to remember "frugal innovations" as well as those innovations that improve outcomes but at considerable additional cost. A particular challenge is that of de-listing or addressing the "trailing edge" of technologies, for example removing older therapies from national essential drug lists.

2. Using Priority-Setting Evidence in Making UHC decision



Understanding Priority-Setting

Though evidence is an essential starting point in priority setting, but values and interests also come into play to protect human rights. Different and opposing interests can skew or better shape priority-setting. Often different values can be in conflict, and the question is then how to reconcile evidence, values and interests in a rational and ethical way. Regardless, the principles for priority setting are that they (1) should be impartial, (2) treat equal as equal, (3) should aim at a fair distribution and health maximization and (4) should satisfy with conditions of fair process. It must not be overlooked that priority-setting has a dynamic nature because values and interests also change over time. As evidence changes, new interventions and new methods can become feasible. The final and important part of the priority-setting process is monitoring and evaluation, with the goal of determining whether the outcome of the priority-setting process played out as anticipated, with the desired results.

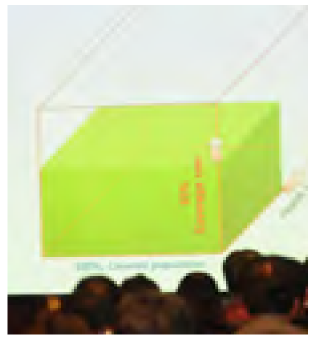
Participation in Priority-Setting Processes

Countries should strive to create transparency and engagement of stakeholders in their priority-setting process. The process must be transparent, inclusive, impartial and engage with all stakeholders; which will gradually bring trust and trustworthiness of HTA processes and outcomes.

They need to ACTIVELY ENABLE participation and facilitate dialogue across groups. As not all stakeholders are equal in power e.g. differences due to gender issues, marginalized groups, language, information gaps etc., there is a need to level the playing field in which the priority-setting game is played, and how this can be achieved still remains a question. Mechanisms are required to strengthen individual and institutional capacity; overcome gender barriers to participation, and facilitate inclusion of marginalized groups. Engagement should be EARLY and OFTEN. We need to ensure that participation is not only inclusive, but MEANINGFUL in that it allows the views of participants to be reflected in the ultimate decisions.

Donors also Influence Priority-Setting

Donors also have priorities, which reflect evidence, values and interests and their institutional mandates, which may be in conflict with other stakeholders in the priority-setting process. They also bring important resources to support both the generation of evidence and the development of HITA capacity. However, donors should play a supporting, not a dominant role. It is worthwhile to consider whether a systematic, participatory and transparent process of priority-setting at the country level can help to persuade donors to prioritize differently, in line with country plans, needs and capacities.



3. Priority Setting in Action: Learning and Sharing Experiences

Generation of evidence can be achieved through a variety of strategies including

- Local training and team building
- Utilising expertise from universities, research institutes, and reverse brain drain (such as the case of the Republic of Korea)
- Develop and use of the National guidelines, endorsement for legitimacy and application by all institutes which conduct HTA
- HITA units as agencies established with or without legal entity but need a strong link with policy decision
- Supply (evidence) induced demand (users)

Evidence is useful for coverage decisions where the enabling factor is the demand for evidence by purchaser organizations. Large population coverage by purchaser organizations is critical for success. Potential platforms for coverage decision include National Essential Drug List committees as one of the main users of evidence. An example is the benefit package committee in countries such as the Philippines, Malawi, China, and Thailand.

The use of HITA to inform coverage decisions is mandatory in a few countries. Institutionalizing and sustaining capacities of HITA is critical, however different trajectories are context specific. Some HITA agencies have been established without legislative endorsement (e.g. HITAP-Thailand), while some HITA agencies were established, followed by legislative endorsement (NECA Republic of Korea). In same cases there was legislative endorsement upfront, then HITA agency was formed e.g. UK NICE.

Regional networks

Networks are important for strengthening capacity and can provide support for economic evaluation through regional collaborations. Such collaboration can be in several forms, such as capacity building, training and fellowship, internship; joint research, sharing of HTA findings, sharing cost information and outcome evidences.

Regional HTA networks exist in Europe, America, Africa, Eastern Mediterranean, Asia Pacific and Latin America, and have successfully built on existing capacities, promoted knowledge sharing and helped to expand existing research networks. The question that arises is how to ensure a financial base for such networks that protects their impartiality and independence?

Challenges of HITA Agency at Country Level

Countries with limited capacities

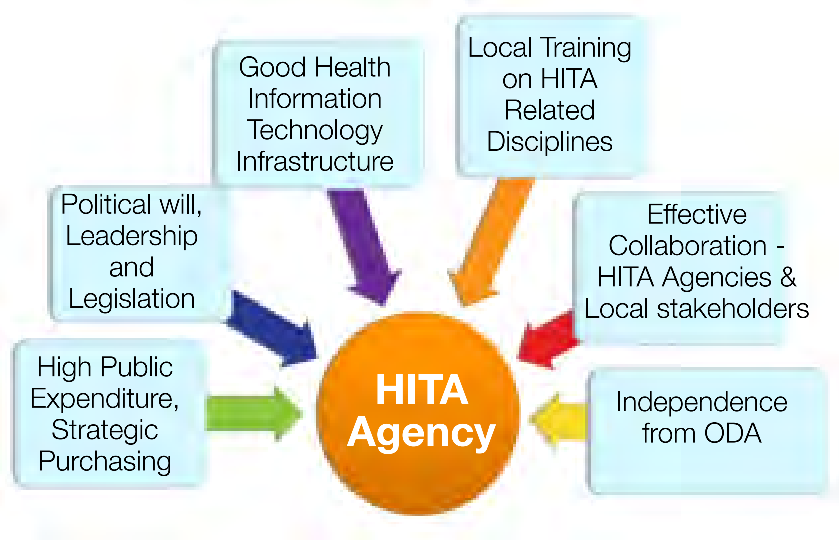
- Limited capacities: human and financial resources to generate evidence and use for coverage decisions
- Existing global evidence may not fit well or applicable to LIC context

Countries having some capacities

- Seven case studies in Asia Pacific: Silo-based decision making, poor decision-making criteria, strict controls on research, undue influence of "expert opinion"
- Inadequate process of priority setting: transparency, engagement by stakeholders
- Know-do gaps: assessment—appraisal--coverage decisions

Characteristics of HITA Capacity Development:

Experiences of 7 High and Middle Income Settings



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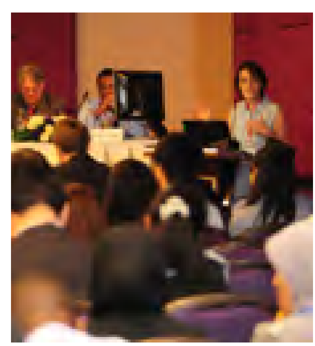
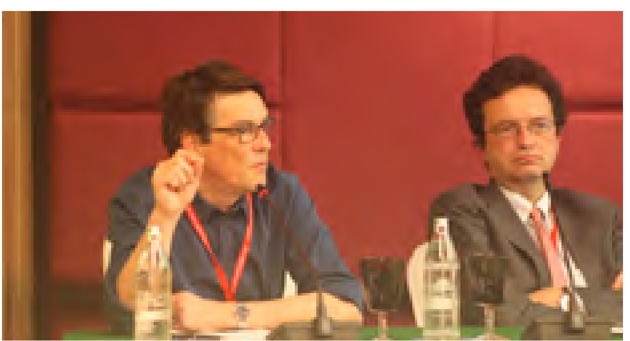
Priority-implementation gaps: health systems capacities to deliver the prioritized benefit packages





Lessons Learnt from Country Experiences

Country capacity is essential to generate evidence, ensure due process of engaging stakeholders, to establish and implement appraisal criteria e.g. cost-effectiveness, budget impact, equity, financial risk protection, social values, and transparency. Countries need to develop and implement national HITA guidelines including thresholds, and National Clinical Practice Guidelines. However there is no single pathway; the trajectory is highly dependent on local context, as seen from the variety of experiences of countries to date.

Conclusions

Priority setting is accepted as an essential enabling process in making coverage and policy decision on investment in the health sector, which contribute to sustainable UHC, and priority setting processes allow decisions about rationing to be explicit, and based on evidence, values and interests. The process of assessment and appraisal of the evidence is as important as the evidence itself. To deliver these priorities we need strong health systems, but priority setting can contribute to this strengthening. Achieving UHC will require the health system to deliver on priorities; it requires capacity, system design and supporting interventions.

ACTIONS FOR DRIVING PRIORITY SETTING FOR UHC

Assure a Fair Process of Priority Setting: Transparent, Accountable, and Participative

Maximize Use of Global Public Goods: WHO-CHOICE, DCP, Cochrane Library, NCD Guidelines

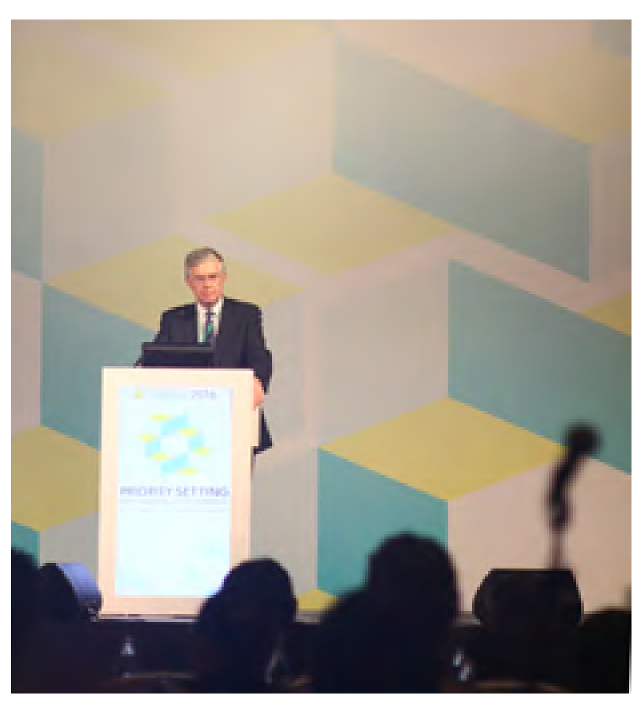
Promote Networking, Learning and Sharing, Contributing to Global Public Goods

Build, Strengthen, and Sustain Institutional Capacities in Assessment, Appraisal and Decision Making

Apply the Bangkok Statement in Line with National Context

BANGKOK STATEMENT

ON PRIORITY-SETTING FOR UNIVERSAL HEALTH COVERAGE



We, Ministers of Health and participants of the Prince Mahidol Award Conference 2016, gathered in Bangkok on 29-31 January 2016 to learn and share experiences, namely:

1. Recalling global evidence of the need for priority-setting set out in the 2010 World Health Report, the 2012 UN General Assembly Resolution on Universal Health Coverage (UHC), World Health Assembly 2014 Resolution "Multisectoral action for a life course approach to healthy aging" (A67/23), and the 2015 Global Goals for Sustainable Development.i

2. Recognizing that UHC will require difficult trade-offs between expanding priority services, including more people, and reducing out-of-pocket payments, and the fact that demand for health services may be infinite while resources are limited and donor contributions are declining in some settings.

3. Recognizing that all health systems must set priorities over time, no matter their wealth.

4. Noting that ad hoc rationing is ubiquitous, with the possible effect of undermining national goals for ensuring equitable access and managing spending and costs, such that many of the most cost-effective interventions, particularly those that favor the poor, continue to be under-provided, while less cost-effective interventions consume public subsidy.

5. Recognizing the need for more explicit priority-setting considering fairness and equity, and based on cost-effectiveness with respect to health outcomes, while also incorporating due consideration of financial protection, ethical principles, social values, political feasibility, and public health security.

6. Noting that priority-setting is best seen as a continuous process, where priorities will change as populations age, financial resources grow, and healthcare technologies and prices evolve.
7. Recalling that priorities are only meaningful if they are translated into action by regulation, budget allocations, purchasing and procurement, supervision, medical curriculum , and similar.
8. Noting the legitimate desire of interest groups and other stakeholders to influence priority-setting processes, and the need to establish a fair, transparent, inclusive and just process for their participation.
9. Recognizing that progressive realization of the right to health requires national and global health stakeholders to work synergistically to support priority-setting processes that ensure alignment, participation, transparency, empowerment, nondiscrimination, and accountability.
10. Recognizing that better priority-setting processes can help to forecast real demand for cost-effective innovations, and to establish rules of the game and predictability that can benefit public payers and encourage innovation.
11. **AGREE** to work together to develop fair, transparent, systematic and evidence-based priority-setting processes that will support UHC goals, in particular to:

National governments (with support from global donors, if appropriate)

a. Embed and design evidence-informed and accountable priority-setting processes into UHC decisions taken by public agencies.
b. Mobilize university and research centre support for governments' priority-setting efforts and the translation of evidence into better policy decisions.
c. Ensure that patients, civil society, and the general public have avenues to meaningfully participate in and inform priority-setting processes.
d. Monitor de facto implementation of the normative priorities that emerge from the abovementioned processes.

Development partners (including bilaterals, regional and multilateral banks, foundations, and other international organizations)

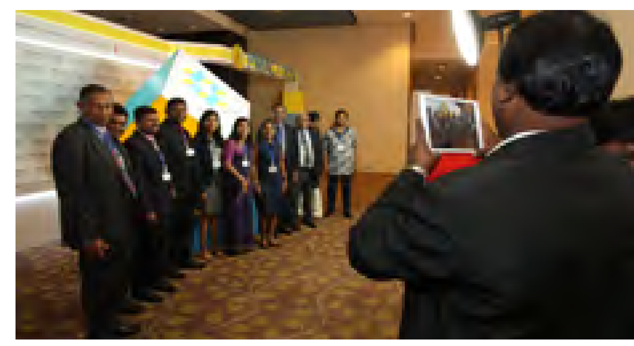
e. Offer financial or technical support for strengthening of national systems and technical capacity for priority-setting for health, with particular attention to countries undergoing transitions from aid.
f. Enhance their own processes for evidence-informed priority-setting.
g. Align with country priorities to support priority-setting for UHC.

All stakeholders (including industry, academia, professional organizations, and patient groups)

h. Create an enabling environment for priority-setting processes by informing, creating and abiding by fair rules of the game that can be respected by all stakeholders in the system.

All stakeholders

i. To collaborate, mutually support, and share learning and experiences in priority-setting as a data and knowledge-based global public good.



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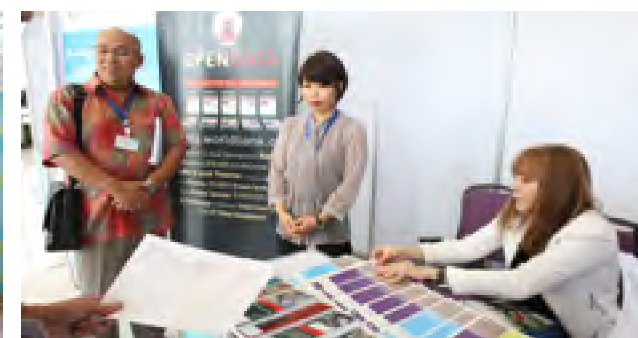
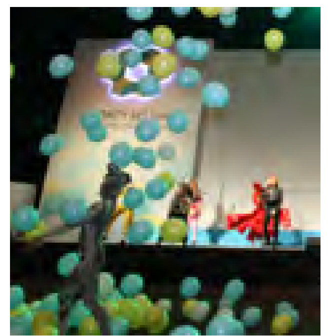
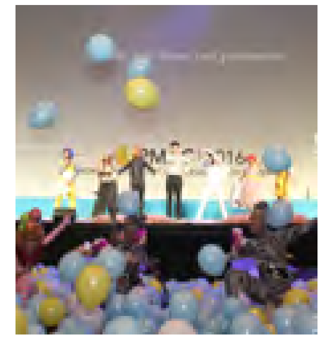





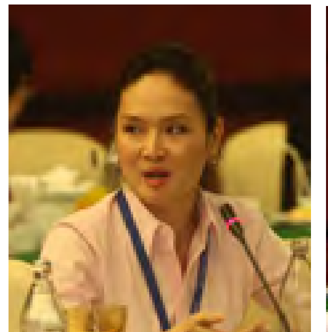
PRIORITY SETTING
You've got a job and you wanna do
the very best job you can.

ANNEX

ANNEX I

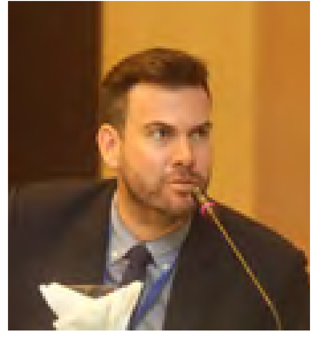
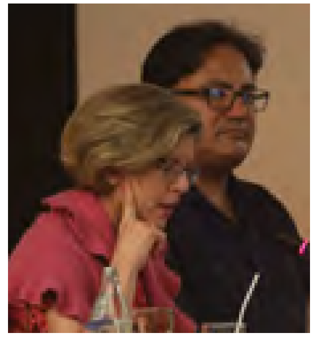
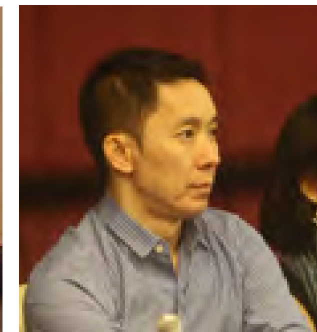
International Organizing Committee Members

Name - Surname	Position	Organization	Role
Dr. Vicharn Panich	Chair, International Award Committee and Scientific Advisory Committee	Prince Mahidol Award Foundation / Mahidol University, Thailand	Chair
Dr. Marie-Paule Kieny	Assistant Director-General for Health Systems and Innovation	World Health Organization, Switzerland	Co-Chair
Dr. Timothy Evans	Senior Director for Health, Nutrition and Population (HNP)	The World Bank, USA	Co-Chair
Dr. Mark Dybul	Executive Director	The Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland	Co-Chair
Ms. Kae Yanagisawa	Vice President	Japan International Cooperation Agency, Japan	Co-Chair
Dr. Ariel Pablos-Mendez	Assistant Administrator, Bureau for Global Health	United States Agency for International Development, USA	Co-Chair
Dr. Lincoln C. Chen	President	China Medical Board, USA	Co-Chair



Name - Surname	Position	Organization	Role
Mr. Michael Myers	Managing Director	The Rockefeller Foundation, USA	Co-Chair
Sir Andrew Dillon	Chief Executive	National Institute for Health and Care Excellence, United Kingdom	Co-Chair
Dr. Trevor Mundel	President of the Global Health Division	Bill & Melinda Gates Foundation, USA	Co-Chair
Dr. Tae-Hwan Lim	President	National Evidence-based Healthcare Collaborating Agency, South Korea	Co-Chair
Prof. Anne Mills	Deputy Director and Provost	London School of Hygiene & Tropical Medicine, United Kingdom	Member
Dr. Douglas Webb	Cluster Leader, Mainstreaming, Gender and MDGs, HIV, Health and Development Group	United Nation Development Programme, USA	Member
Dr. Geoff Adlide	Director of Advocacy and Public Policy	GAVI Alliance, Switzerland	Member
Prof. David Harper	Senior Consulting Fellow	Chatham House, United Kingdom	Member

Name - Surname	Position	Organization	Role
Prof. Kara Hanson	Professor of Health System Economics	London School of Hygiene and Tropical Medicine, United Kingdom	Member
Dr. Amanda Glassman	Director of Global Health Policy	Center for Global Development, USA	Member
Dr. Jasmine Pwu	Senior Investigator, Health Data Research Center	National Taiwan University, Taiwan	Member
Prof. Karen Hofman	Associate Professor, School of Public Health	University of Witwatersrand, South Africa	Member
Dr. Kamran Abbasi	International and Digital Editor	British Medical Journal, United Kingdom	Member
Ms. Bridget Lloyd	Global Coordinator	People's Health Movement, South Africa	Member
Mr. Apichart Chinwanno	Permanent Secretary	Ministry of Foreign Affairs, Thailand	Member
Dr. Sopon Mekthon	Permanent Secretary	Ministry of Public Health, Thailand	Member
Dr. Supat Vanichakarn	Secretary General	Prince Mahidol Award Foundation, Thailand	Member
Secretary General	Secretary General	National Health Security Office, Thailand	Member

Name - Surname	Position	Organization	Role
Dr. Udom Kachintorn	President	Mahidol University, Thailand	Member
Prof. Prasit Watanapa	Dean, Faculty of Medicine Siriraj Hospital	Mahidol University, Thailand	Member
Prof. Piyamitr Sritara	Dean, Faculty of Medicine Ramathibodi Hospital	Mahidol University, Thailand	Member
Dr. Suwit Wibulpolprasert	Vice Chair	International Health Policy Program Foundation, Thailand	Member
Dr. Viroj Tangcharoensathien	Senior Advisor	International Health Policy Program, Thailand	Member
Dr. Yot Teerawattananon	Director	Health Intervention and Technology Assessment Program, Thailand	Member
Dr. Phusit Prakongsai	Director, International Health Bureau	Ministry of Public Health, Thailand	Member
Mr. James Pfitzer	Technical Officer (Legal), Health Systems and Innovation, Office of the Assistant Director-General	World Health Organization, Switzerland	Member & Joint Secretary
Dr. Toomas Palu	Sector Manager for Health, Nutrition and Population East Asia and Pacific Region	The World Bank, Thailand	Member & Joint Secretary

Name - Surname	Position	Organization	Role
Dr. Osamu Kunii	Head, Strategy, Investment and Impact Division (SIID)	The Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland	Member & Joint Secretary
Mr. Ikuo Takizawa	Deputy Director General	Japan International Cooperation Agency, Japan	Member & Joint Secretary
Mr. Anthony Boni	Health Management Analyst, Bureau for Global Health	United States Agency for International Development, USA	Member & Joint Secretary
Dr. Piya Hanvoravongchai	Southeast Asian Regional Coordinator	China Medical Board, Thailand	Member & Joint Secretary
Ms. Natalie Phaholyothin	Associate Director	The Rockefeller Foundation, Thailand	Member & Joint Secretary
Dr. Kalipso Chalkidou	Director	National Institute for Health and Care Excellence, United Kingdom	Member & Joint Secretary
Dr. Damian Walker	Senior Program Officer, Integrated Delivery	Bill & Melinda Gates Foundation, USA	Member & Joint Secretary
Dr. Jeonghoon Ahn	Senior Director	National Evidence-based Healthcare Collaborating Agency, South Korea	Member & Joint Secretary
Dr. Pongpisut Jongudomsuk	Senior Expert	National Health Security Office, Thailand	Member & Joint Secretary
Dr. Sripen Tantivess	Senior researcher	Health Intervention and Technology Assessment Program, Thailand	Member & Joint Secretary
Dr. Churnrurtai Kanchanachitra	Director	Mahidol University Global Health, Thailand	Member & Joint Secretary

ANNEX II

List of Scientific Committee Members

Name - Surname	Position / Organization	Role
Dr. Tangcharoensathien, Viroj	Senior Advisor, International Health Policy Program, Thailand	Chair
Dr. Panich, Vicharn	Chairman, Mahidol University Council, Thailand	Member
Prof. Cairns, John	Professor of Health Economics, London School of Hygiene and Tropical Medicine, United Kingdom	Member
Dr. Chuenkongkaew, Wanicha	Professor in Ophthalmology, Department of Ophthalmology, Siriraj Hospital, Mahidol University, Thailand	Member
Dr. Fukuda, Takashi	Department Director, Department of Health and Welfare Service, National Institute of Public Health, Japan	Member
Prof. Hofman, Karen	Associate Professor, School of Public Health, University of Witwatersrand, South Africa	Member
Dr. Hutubessy, Raymond	Senior Health Economist, Immunization, Vaccines and Biologicals (IVB) Department, World Health Organization	Member
Dr. Li, Ryan	Adviser, NICE International, United Kingdom	Member

Name - Surname	Position / Organization	Role
Prof. Nugent, Rachel	Clinical Associate Professor, Global Health, University of Washington, USA	Member
Ms. Ombam, Regina	Head-strategy development, National Aids Control Council, Kenya	Member
Ms. Phaholyothin, Natalie	Associate Director, The Rockefeller Foundation, Thailand	Member
Dr. Palu, Toomas	Sector Manager for Health, Nutrition and Population, East Asia and Pacific Region, The World Bank, Thailand	Member
Dr. Patcharanarumol, Walaiporn	Senior Researcher, International Health Policy Program, Thailand	Member
Mr. Pfitzer, James	Technical Officer, Health Systems and Innovation, Office of the Assistant Director-General, World Health Organization, Switzerland	Member
Dr. Pwu, Jasmine	Director, Center for Drug Evaluation, Taiwan	Member
Prof. Sewankambo, Nelson	Principal, Makerere University, Uganda	Member

Name - Surname	Position / Organization	Role
Dr. Sugishita, Tomohiko	Senior Advisor on Health, Human Development Department, Japan International Cooperation Agency, Japan	Member
Dr. Summerskill, William	Senior Executive Editor, The Lancet, United Kingdom	Member
Dr. Talungchit, Pattarawalai	Director of Siriraj Health Policy Unit, Faculty of Medicine, Siriraj Hospital, Thailand	Member
Dr. Tantivess, Sripen	Senior researcher, Health Intervention and Technology Assessment Program (HITAP), Thailand	Member
Dr. Teerawattananon, Yot	Director, Health Intervention and Technology Assessment Program (HITAP), Thailand	Member
Dr. Tribuddharat, Chanwit	President, Executive Medical Staff Organization Committee, Faculty of Medicine Siriraj Hospital, Mahidol University, Thailand	Member
Dr. Watanapa, Prasit	Dean, Faculty of Medicine Siriraj Hospital, Mahidol University, Thailand	Member
Dr. Yamabhai, Inthira	Researcher, Health Intervention and Technology Assessment Program (HITAP), Thailand	Member

ANNEX III

Conference Speakers/Panelists, Chairs/Moderators and Rapporteurs

Speaker/Panelist	Chair/Moderator	Rapporteur
Opening Session		
Mirai Chatterjee		Songhee Cho
Michael Gideon Marmot		Sutayut Osornprasop
Morton M. Mower		Sangay Wangmo
Michel Sidibé		
Opening Plenary The Primacy of Priority Setting: Global Advocates and Country Realities		
Lincoln C. Chen	Amanda Glassman	Xiaohui Hou
Timothy Evans		Jintana Jankhotkaew
Soonman Kwon		Waraporn Suwanwela
Michael Rawlins		
Untung Sutarjo		
Plenary 1 Using Priority Setting Evidence in Making UHC Decisions		
Sebastian Garcia-Saiso	Daniel Miller	Thunyarat Anothaisintawee
David Haslam		Pandu Harimurti
Robinah Kaitiritimba		Tanita Thaweethamcharoen
Alex Ross		
Brendan Shaw		
Karla Soares-Weiser		

Speaker/Panelist	Chair/Moderator	Rapporteur
Parallel session 1.1 Evidence for Health Benefits Package Choices: Is Cost-Effectiveness Analysis the Answer?		
Cheryl Cashin	John Cairns	Pitipa Chongwatpol
Karl Claxton		Juntana Pattanaphesaj
Rabson Kachala		Ali Subandoro
Li Lingui		
Peter Smith		
Ranjeeta Thomas		
John Wong		
Parallel session 1.2 Accountability, Fairness and Good Governance in Priority-Setting for UHC		
Marianela Castillo-Riquelme	Peter Neumann	Orana Chandrasiri
Supamit Chunsuttiwat		Thierry Defechreux
Katharina Kieslich		Jun Moriyama
Ole Norheim		Pattarawalai Talungchit
Thomas Wilkinson		
Parallel session 1.3 Strengthening Capacity to Produce and Appraise HTA Evidence		
Emily Carnahan	Richard Cookson	Carol Levin
Karen Hofman		Prapaporn Noparatayaporn
Andres Pichon-Riviere		Songyot Pilasant
Catherine Pitt		Thananan Rattanachotphanit
Jasmine Pwu		
Sripen Tantivess		
Madeleine Valera		

Speaker/Panelist	Chair/Moderator	Rapporteur
Parallel session 1.4 Human Rights - Entitlement to Health: What Does It Mean in Practice and How Can It Affect Priority Setting for UHC?		
Leonardo Cubillos-Turriago	Siri Gloppen	Mari Honda
Lawrence Gostin		Pochamana Phisalprapa
Anand Grover		Suteenoot Tangsathitkulchai
Carleigh Krubiner		Aviva Tugendhaft
Mulumba Moses		
Parallel session 1.5 Priority Setting and Public Health Security: Leveraging UHC Reform for Disease Surveillance Systems in a Globalized World		
Kalipso Chalkidou	Patricio Marquez	Kanlaya Teerawattananon
John MacArthur	Ariel Pablos-Mendez	Yothin Thanormwat
Xiaopeng Qi		
Shams Syed		
Abdulsalami Y Nasidi		
Yasuhide Yamada		
Plenary session 2 Is the Current Evidence Fit-for-Purpose? What Evidence Do Decision Makers Need to Set Priorities in the Future?		
Mark Blecher	Kara Hanson	Catherine Pitt
Somsak Chunharas		Suladda Pongutta
Jeanette Vega Morales		Jomkwan Yothasamut
Parallel session 2.1 Demonstrating the Relevance of Economic Evaluation to Multiple Objectives of UHC: What Are the Key Challenges?		
Melanie Bertram	Rachel Nugent	Phumtham Limwattananon
Manuel Espinoza		Chieko Matsubara

Speaker/Panelist	Chair/Moderator	Rapporteur
Elliot Marseille		Marc Voelker
Solomon Memirie		Tommy Wilkinson
Anna Vassall		
Stephane Verguet		
Parallel session 2.2 Missed Opportunities and Opportunity Costs: Reprioritizing UHC Decisions in Light of Emergence of New Technologies, Continued Budget Constraints, and Incentives for Innovation		
Alexandre Barna	Amanda Glassman	Udomsak Saengow
Amie Batson		Yuna Sakuma
Karl Claxton		Kittiphong Thiboonboon
Rachel Melrose		
Sang Moo Lee		
Andreas Seiter		
Kun Zhao		
Parallel session 2.3 Can You Handle the Truth? Accounting for Politics and Ethics in UHC Is Very Challenging		
Angela Chang	Jesse Bump	Saudamini Dabak
Yling Chi		Jintana Jankhotkaew
Karen Grepin		Gloria Nenita V. Velasco
Jan Liliemark		
Hiiti Sillo		
Parallel session 2.4 Stakeholder Dynamics in UHC Priority Setting		
Amanda Howe	Daniel Miller	Prasinee Mahattanatawee
Sheila Sabune		Vasinee Singsa
Brendan Shaw		Lester Tan
Lawrence Sherman		
Tessa Tan-Torres Edejer		

Speaker/Panelist	Chair/Moderator	Rapporteur
Parallel session 2.5 Enabling Better Decisions for Better Health: Embedding Fair and Systematic Processes into Priority-Setting for UHC		
Abou Bakarr Kamara	Jaime Sepulveda	Ully Adhie Mulyani
Somsak Chunharas	Nick Timmins	Manasigan Kanchanachitra
Anindita Gabriella		Vuong Lan Mai
Dale Huntington		Kobayashi Seisi
Raman Kataria		
Michael Rawlins		
Kawaldip Sehmi		
Rakesh Srivastava		
Ioana Vlad		
Parallel session 3.1 Defining the “What”, “How” and “for Whom” of UHC: Country Experiences of Developing and Implementing Benefits Plans and Other Tools for Priority-Setting		
Manuel Espinoza	Amanda Glassman	Suchunya Aungkulanon
Ali Ghufron Mukti		Chalermpol Chamchan
Ruben John Basa		Anit N. Mukherjee
Somil Nagpal		Masaaki Uechi
Samrit Srithamrongsawat		
Parallel session 3.2 : Prioritising Research to Deliver Evidence for UHC: How Can Policy Makers Shape the Research Agenda to What They and Their Populations Need		
Siddhi Aryal	Suzanne Hills	Minjoo Kang
Jittrakul Leartsakulpanitch		Abha Mehndiratta
Kanchan Mukherjee		Pien Ploenbannakit
Mai Oanh Tran		Kanokwaroon Watananirun
Nelson Sewankambo		
Hasbullah Thabrany		
Goran Tomson		
Thomas Walley		
Beibei Yuan		
Parallel session 3.3 Aligning Local and Global Priorities for Health: The Roles of Governments, CSOs and Development Partners in Setting and Funding for The Priorities		
Omar Ahmed Omar Mohamed	Walaiporn Patcharanarumol	Karolyne Carloss
Ebenezer Appiah-Denkyira	Takao Toda	Sandra Khoury
Ashadul Islam		Suvimol Niyomnaitham
Osamu Kunii		Thitiporn Sukaew
Toomas Palu		
Amit Sengupta		
Ikuo Takizawa		
Damian Walker		
Parallel session 3.4 Coping with Budget Reductions & Economic Austerity: Implications for UHC Priority Setting		
Pinnegowda Boregowda	Christoph Kurowski	Wanrudee Isaranuwatchai
Triin Habicht	Ajay Tandon	Robert Liu
Yongjun Lee		Rapeepong Suphanchaimat
Elva Lionel		Titiporn Tuangratananon
Untung Sutarjo		
Parallel session 3.5 Translating Priorities into Action		
John Appleby	Kara Hanson	Sarocha Chootipongchatvat
Damien De Walque	Anne Mills	Marrten Jansen
Tamar Gabunia		Jeehyun Hwang
Boshoff Steenkamp		Yumiko Miyashita
Kun Zhao		

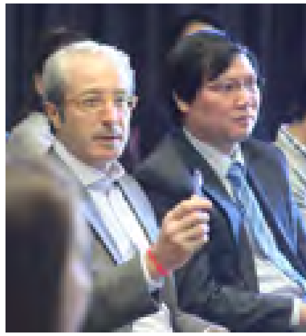
Speaker/Panelist	Chair/Moderator	Rapporteur
Plenary session 3 Action Express Priorities: Progressing towards Sustainable UHC / Bangkok Statement		
Sinead Andersen	Keizo Takemi	Dewi Indriani
David Haslam	Nick Timmins	Pritaporn Kingkaew
Amy Khor		Nattadhanai Rajatanavin
Untung Sutarjo		Saya Uchiyama
Soumya Swaminathan		
Damian Walker		
Kae Yanagisawa		
Plenary session 4 Better Decisions for Better Health: from Rhetoric to Reality		
Ala Alwan	Amanda Glassman	Ryan Li
Paulin Basinga		Arimi Mitsunaga
Maria Guevara		Sangay Wangmo
Dean Jamison		Sitaporn Youngkong
Piyasakol Sakolsatayadorn		
Lead Rapporteur Team		
Caryn Bredenkamp		
Kara Hanson		
Jeff John		
Viroj Tangcharoensathien		
Rapporteur Coordinator		
Warisa Panichkriangkrai		
Walaiporn Patcharanarumol		
Inthira Yamabhai		

Dinner Debate
This House Believes that Cost-Effectiveness is More Important than Human Rights for Setting Health Priorities in Real Life Situations

ANNEX IV

List of Side Meetings and Workshops

TITLE	ORGANIZATION
Prince Mahidol Award Youth Program	Prince Mahidol Award Youth Program
Taking the UHC agenda forward in Bangladesh: current scenario and road map for the future "	The Rockefeller Foundation, Centre of Excellence for UHC (icddr,b and JPGSPH/ BRAC University)
China Medical Board (CMB) Meeting	China Medical Board
Integrating Donor-Financed Health Programs While Building Sustainable Health Financing Systems	The World Bank
Building Financial Risk Protection into Essential Health Benefits Packages for Fair Universal Health Coverage (UHC)	Disease Control Priorities (DCP3)
DCP3 ACE meeting (Advisory Committee to the DCP3 Editors)	Disease Control Priorities (DCP3)
HTA trends and future in HTAsiaLink	National Evidence-based healthcare Collaborating Agency (NECA)
HTA Evidence on Medical Devices	National Evidence-based healthcare Collaborating Agency (NECA)
Health Intervention and Technology Assessment (HITA): A Path to Universal Health Coverage (UHC)	World Health Organization (WHO), Southeast Asia Regional Office (SEARO), Health Intervention and Technology Assessment Program (HITAP)

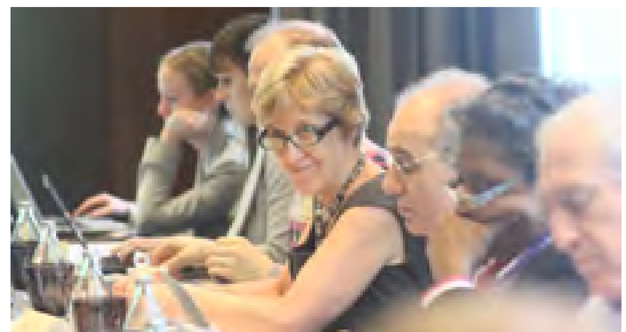


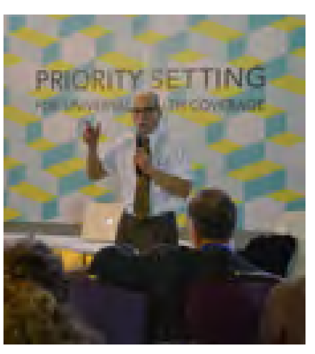
TITLE	ORGANIZATION
Introduction to Health Intervention and Technology Assessment: HITA 101	Health Intervention and Technology Assessment Program (HITAP)
Advanced Workshop in Methods for HTA	University of York, UK
People's Health Movement Steering Council: Challenges of growing a health movement – volunteerism and commitment	People's Health Movement (PHM)
The evidence for a unified public funded health system to advance UHC	People's Health Movement (PHM)
The 2016 G7 Summit in Japan: Toward Resilient and Sustainable Universal Health Coverage (UHC)	Japan Center for International Exchange (JCIE), The Global Health Working Group for the 2016 G7 Summit (GHWG), University of Tokyo
Universal Health Coverage & Quality: Ensuring quality care for all! Part 2	World Health Organization (WHO) Service Delivery and Safety department, Health Systems & Innovation Cluster, The Healthcare Accreditation Institute (HAI Thailand)
Intersectoral governance and financing to strengthen UHC	United Nations Development Programme (UNDP)
Access and Delivery Partnership (ADP) Stakeholders' meeting: South-South exchange to support implementation	United Nations Development Programme (UNDP)
Global Symposium on Financial Accountability and Sustainability	Organisation for Economic Co-operation and Development (OECD), Paris
Asia Alliance on Global Health (AAGH)	Mahidol University Global Health (MUGH)

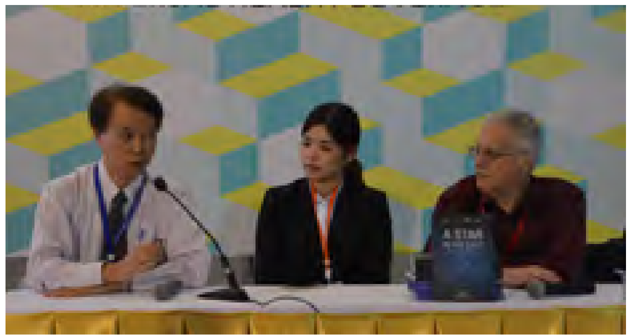
TITLE	ORGANIZATION
Making decision makers accountable: Better journalism – better chances of getting to Universal Health Coverage	NICE International, The Guardian, UK; HITAP, Thailand; The King's Fund, UK
Proposed African Priority-Setting In Healthcare Network	PRICELESS SA
What services should health systems provide? Health benefits plans in low- and middle-income countries	Center for Global Development, NICE International
iDSI Board meeting (NI)	NICE International
Priority setting and public health security: leveraging UHC reform for disease surveillance systems in a globalized world	World Health Organization (WHO), The World Bank
Projecting Implementation Priorities to advance Universal Health Coverage in the post-2015 agenda – Lessons Learned from the Go4Health Project	The Rockefeller Foundation, Go4Health
SEA Constituency – the way forward in 2016	Ministry of Public Health, Thailand, Country Coordination Mechanism (CCM)
Implications of the Trans Pacific Partnership (TPP) and Regional Comprehensive Economic Partnership (RCEP) on Universal Health Coverage	Knowledge Ecology International (KEI)
Prioritizing for UHC: Urban HEART as key tool for decision making and ensuring health equity	World Health Organization (WHO)
From cost-effectiveness to fairness: Guidance and tools on the path to Universal Health Coverage	World Health Organization (WHO), Health Systems Governance and Financing

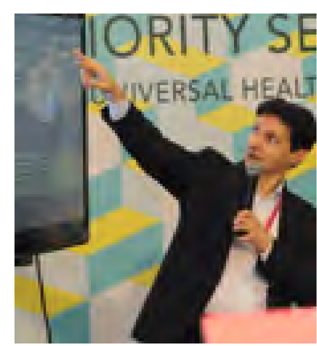
TITLE	ORGANIZATION
Achieving Universal Health Coverage (UHC) - The relevance of economic burden, cost and cost-effectiveness analysis to support policy makers in prioritizing vaccines	World Health Organization (WHO), Southeast Asia Regional Office (SEARO), Health Intervention and Technology Assessment Program (HITAP)
International Advisory Committees Meeting on Health Policy and Technology Assessment (HePTA) Program	Mahidol University , Faculty of Pharmacy
After the commission report and WHA resolution: What happened and what's next on Transformative Health Workforce Education and Training to support UHC?	Health Professional Education Foundation in Thailand
Harnessing and Aligning the Private Sector for Universal Health Coverage	Asian Development Bank (ADB)
Community Health Workers (CHWs) for Achieving UHC: Experience in using evidence to guide decision-making for CHW programs	U.S. agency for international development (USAID), Health Systems Global Technical Working Group, WHO/GHWA, Community Health Workers in Health System Development
AAAH Intersession Activity " Emerging Challenges and solutions on faculty development in Asia and Pacific Region"	Asia_pacific Action Alliance on Human Resources for Health(AAAH)
Innovative Financing for Health Promotion: Country and community practices that complement effectiveness of UHC	Thai Health Promotion Foundation
Role of WHO- Global Evaluation Tool (GET) in transforming health worker education	World Health Organization (WHO), Department of Health Workforce

TITLE	ORGANIZATION
Launch of the APO / OECD Comparative Country Study on Case Based Payments for Hospital Funding in Asia: An Investigation into Current Status and Future Directions	Asia Pacific Observatory on Health Systems and Policies (APO)
Addressing Antimicrobial Usage in Asia's Food Animal Production Sector: Toward a Unified, One Health Approach to Preventing and Controlling Resistance	U.S. agency for international development (USAID), FAO, OIE, WHO
National One Health Challenges: Prepare and Response for Emerging disease/Pandemic and Sustainable Development	One Health Coordination Unit, (OHCU), Thailand
Evidence-based priority setting in India's Quest for Universal Health Coverage	The World Bank
Domestic Resource Mobilization for UHC: Approaches for Sustainably Financing Priority Health Programs "	U.S. agency for international development (USAID),
Consultation on options to strengthen accountability for Universal Health Coverage	Management Sciences for Health, World Health Organization (WHO), USAID, The Rockefeller Foundation , Save the Children
Best Buy!! Mother and Child Health Handbook for Improving Continuum of Care through Women's Empowerment	Japan International Cooperation Agency (JICA)
Equity Initiative Research Planning Consultation	China Medical Board (CMB)
PMAC World Art Contest	Prince Mahidol Award Conference
The World Bank Private Meeting	The World Bank




PRIORITY SETTING





HePTA
Full

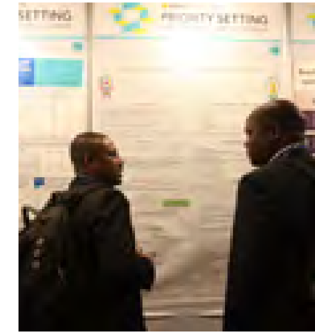
ANNEX V

List of Posters

ID	Poster Title	Author
P1	Cambodia's health systems performance and the need for systems thinking approach	Erlyn Rachelle Macarayan
P2	Collaborative Public-Private Partnership in the efficient provisioning of health care insurance coverage to the informal sector	Maika Ros Bagunu
P3	Rural/urban access deficits: Evidence for extending coverage to vulnerable populations	Xenia Scheil-Adlung
P4	Health service utilization in Northern Ghana: Is the National Health Insurance scheme making any difference?	Philip Ayizem Dalinjong
P5	Functional measures: Are they appropriate to assist in prioritizing health care?	Meri Goehring
P6	Evaluation of the Tuberculosis Surveillance System in Magelang District — Indonesia, 2011	Lalu Hendi Hutomo
P7	Principal approaches to improve immunisation coverage: Strategies of CORE Group Polio Project (CGPP), India in addressing barriers to routine immunisation	Manojkumar Choudhary
P8	Immunization card holder boost immunization coverage in Uttar Pradesh, India	Rina Dey
P9	Prioritization of health promotion programs for consensus development between stake holders such as local government, NGOs and residents -health promotion planning in Nakai town, Kanagawa Prefecture, JAPAN	Yoshihisa Watanabe

ID	Poster Title	Author
P10	Introducing the concepts of health technology assessment to Sri Lanka: A cost utility evaluation of Beclomethasone metered dose inhaler	Sathira Perera
P11	Priority setting beyond health to fund universal health coverage	Natalie Sharples
P12	Stakeholder perspectives and Geographical Information Systems (GIS) for priority setting in achieving location efficiency in specialist care in North Western Province (NWP) of Sri Lanka	Dilantha Dharmagunawardene
P13	Reaching the community - how strength in primary care systems can help with priority setting and inclusivity	Amanda Howe
P14	Cost- effectiveness of computer-assisted Clinical Decision Support System (CDSS) in improving maternal health services in Ghana	Maxwell Dalaba
P15	Analyzing the effect of government subsidies for rural health insurance on equity of benefits	Min Hu
P16	Prioritizing Investment for HIV response: Experiences of improving allocative efficiency in HIV programmes	Emiko Masaki
P17	The extent of health insurance coverage, health expenditure and health service utilization prior to national health insurance enforcement in Indonesia	Ade Suzana
P18	Rotavirus vaccines contribute towards universal health coverage: An extended cost-effectiveness analysis	Tharani Loganathan
P19	Quality health service delivery is the priority for realizing universal health coverage: Reducing neonatal mortality at a hospital by quality improvement interventions	Mohammad Islam
P20	Priority setting using Hanlon Method in Yogyakarta Province, Indonesia in 2014 - The double burden of health problems	Nur Aini Kusmayanti

ID	Poster Title	Author
P21	Health for all: Implementing UHC in Bangladesh	Tasfiyah Jalil
P22	A reform on medicine procurement system under universal health coverage in Indonesia	Yusi Anggriani
P23	Prioritising aboriginal people groups in the context of an advanced economy to achieve universal health coverage	Emily H. B. Brown
P24	Trends on pharmaceutical spending under JKN 2014	Yusi Anggriani
P25	Pitfall of health seeking: Catastrophic health expenditure and it's determinants in Bangladesh	Md Zabir Hasan
P26	Sustaining universal coverage: The contribution of NCDs to public health expenditures in Mongolia	Otgontuya Dugee
P27	Does the health system provides universal coverage? - the story of Republic of Macedonia	Stefan Vasilevski
P28	Coverage when resource constrained: Targeting benefits of Myanmar's hospital equity fund	Soe Htet
P29	Spending on cancer drugs in Kosovo: A formulary review to inform priority setting	Kate Mandeville
P30	A randomized controlled trial on Rehabilitation through Caregiver-Delivered Nurse-Organized Service Programs for Disabled Stroke Patients in Rural China (The RECOVER Trial): Design and rationale	Shu Chen
P31	Reducing the financial burden of healthcare for TB patients in China	Weixi Jiang
P32	Developing the evidence base for priority setting for universal health coverage in fragile and conflict affected contexts	Sarah Ssali



ID	Poster Title	Author
P33	What role for district-led quality improvement approaches in priority setting for Universal Health Coverage: Learning from Bangladesh, Ethiopia, Indonesia, Kenya, Malawi, Mozambique	Lilian Otiso
P34	The role of capacity building in gender and ethics in health system priority setting: Making universal health coverage truly universal	Rosemary Morgan
P35	Priority setting with absence of evidences: experiences from Chagas disease control in Nicaragua	Kota Yoshioka
P36	Using evidence to design health benefit plans for stronger health systems: Lessons from 25 countries	Naz Todini
P37	Are health care resources allocated fairly according to health needs in Malaysia?	Saw Chien Gan
P38	Evaluation of dimensions of universal health coverage among patients undergoing cataract surgeries in Wijaya Kumaratunga Memorial Hospital (WKMH) – Sri Lanka	Dilantha Dharmagunawardene
P39	Factors affecting essential newborn care practices in Bangladesh: Evidence from a national survey	Mohammad Rifat Haider
P40	Using of generic medicines and independence of generic medicines in national health insurance (JKN) era in Indonesia	Raharni Raharni
P41	Impact of maternal and neonatal health initiatives on access to care: Evidence from Bangladesh	Mohammad Rifat Haider
P42	Evaluation of non-communicable disease risk factor identification in the integrated program for health in ageing, Gianyar District, Bali Indonesia 2014	I Nyoman Purnawan

ID	Poster Title	Author
P43	Policy choices for universal health coverage through assessing economic burden and economic evaluation of seasonal influenza infection in Nepal	Shiva Raj Adhikari
P44	Main health problems in Semarang District, Central Java Province, Indonesia -2014	Yudi Pradipta
P45	Modelling financial equilibrium: A pragmatic tool for governance of resource allocation policies	Genevieve David
P46	Combining national health accounts and social accounting matrices for a better decision making to achieve universal health coverage	Diafuka Saila-Ngita
P47	The importance of local analyses in a priority-setting exercise for maternal and child health in South Africa	Aviva Tugendhaft
P48	Leveraging effects of priority setting in the field by knowledge management: A case of the neglected tropical disease, Chagas disease, in Central America	Ken Hashimoto
P49	Priorization of health problems In Yogyakarta, Indonesia, 2013	Defryana Rakebsa
P50	Dominant approaches to priority setting for uhc undermine the global policy of primary health care	David M Sanders
P51	Understanding client preferences for maternal and child health at NHSDP clinics: A discrete choice experiment	Nadia Alamgir
P52	Designing programme implementation plan for universal health coverage: Experiences from Odisha, India	Srinivas Nallala

ID	Poster Title	Author
P53	Development of a Global Health Cost-Effectiveness Analysis (GHCEA) Registry	Peter Neumann
P54	Medicines in health systems: advancing access, affordability and appropriate use. flagship report of the alliance for health policy and systems research	Goran Tomson
P55	The political drivers of priority setting: How can we achieve progressive universalism?	Olivia Tulloch
P56	An evaluation study on WHO PEN implementation in rural place Western China	Jane Huang
P57	The role of universal insurance in achieving universal health coverage: the case of China 2003-2013	Zhang Yan
P58	A comparative study of equal access to rural essential health care between China and Thailand	Yang zhe
P59	The impact of China's national essential medicine system on improving rational drug use in primary health care facilities: an empirical study in four provinces	Zhang Shihua
P60	Effects of the national essential medicine system in reducing drug prices: an empirical study in four Chinese provinces	Xiu-Ping Gao
P61	Getting to the most difficult to reach with universal health coverage: A novel approach to national priority setting on Neglected Tropical Diseases	Louis-Albert Tchuem Tchuenté
P62	Country case study on enhancing universal health coverage by ensuring migrant friendly health policies and programs	Kolitha Wickramage

ID	Poster Title	Author
P63	Using participatory governance Approaches in setting a citizen-driven agenda forUHC	Jessica Gergen
P64	How the political economy and UHC priority setting is influencing scale-up of the performance-based financing pilot in Mozambique	Yogesh Rajkotia
P65	Development of health benefits packages for effective and sustained national HC	Theodor Mihai Trif
P66	Strengthening the availability and use of improved unit cost data to improve efficiency and resource allocation of HIV/AIDS, TB and Immunization programs	Carol Levin
P67	What evidence do we need to set priorities in complex health system for chronic patients in LMICs?	Wenxi Tang
P68	Evaluation of clinical practice guidelines using the AGREE instrument in Japan	Kanako Seto
P69	Supporting community VOICES? Implementation research on strengthening community participation through village health committees in India	Kabir Sheikh
P70	Strategic use of social and community prescription in universal health coverage in Japan	Toshiro Kumakawa
P71	Applying the Urban Health Equity Assessment and Response Tool (Urban HEART) to prioritize action on addressing health inequities in service coverage	Alex Ross
P72	Priority setting in the context of universal health care reforms in South Africa	Fillip Meheus

ANNEX VI

PMAC 2016 World Art Contest

Since 2013 a unique activity called the "Art Contest" was introduced to the Prince Mahidol Award Conference (PMAC) which not only crossed over two different sides of knowledge, art and science, but also brought the public audience, the community, closer to the PMAC concept.

The Art Contest project was initiated as an instrument to communicate the idea of the conference theme to the public audience. The contest was open to students aged under 9 to 25, with the aim of raising the awareness of the young generation in how their health is connected to their little families and through the entire world. Vice versa, the various new perspectives of a successful world where all people live better, happy, healthy and equitably from the young generation have been presented to our prestigious participants.

This year, the Prince Mahidol Award Conference invited students and all people to take part in the PMAC 2016 World Art Contest under the topic "How to Choose ... for Better Health" through Drawings & Paintings; Photos; and Comic & Cartoon Art.

The project has received positive response nationally and internationally from young people, parents and schools. 376 entries from 5 countries were sent in and 97 young artists won the prizes. The winners were invited to receive the award during PMAC 2016 on 28 January 2016, at the Centara Grand at CentralWorld. The award ceremony event was a fulfilling and enjoyable experience for the winners and participants, as most of the winners came from very difficult and remote areas of Thailand for example, schools located in the mountainous Northern provinces, schools from three Southern border provinces, schools from disadvantaged North-Eastern provinces.

All the winning artworks were displayed during the conference. The display art pieces amazed most PMAC participants by their high quality artistic skill and creativity. In addition, we recognized the difficulties of many schools which support our program. Consequently, we introduced the "art contribution". The purpose was to provide financial contribution from our prestigious PMAC participants to schools which supported the art program for their students. The "art contribution" of winning art pieces from PMAC 2016 has raised Baht 46,861.

Drawings & Paintings Category

Group: Under 9 years old

World First Prize

Thitirat Laosakun, Phanchita Thongchan, Siwaya Wongsiri

World Second Prize

Tunyamon Laopongpitch

World Third Prize

Kunsinee Chottaechakit, Poramet Choemue, Eakkachai bainglee,
Pornkanokwan khamnoi

World Honorary Mention

Chanyanut Anan,Thankun Pongsakun,Thepphanom Chummat, Natcha Kansophon, Natthaphum Prachantha, Nattha Kaeokamkong, Kanokrat Ruangrat, Krittiyanee Sirikong

World Young Artist Recognition

Suvachara Mitrayoon, Supidsara Phasanpod, Chaiyasit Khuntong, Nuttasith Sirisupavich, Phatsara Naranunn, Piyabhat Ruangnorrabhat, Athibodi Ratchata, Natthanicha Huakho, Thanakorn Santhaweesuk, Siripagorn Laosrirak, Natkrita Tiaparit

Group: 9-13 years old

World First Prize

Thatchaphon Kaeokamkong, Pramot Prachkratok,
Kaeoladda Khamsaman

World Second Prize

Kacha Kamdam

World Third Prize

Nannanin Ruengyoungmee

World Honorary Mention

Phirapob Labkrum, Chompupischaya Saiboonyadis,
Thisawan Suwan, Jutahamanee Kamdam

World Young Artist Recognition

Natkanda Chuenaiam, Chanunchida Wongsirasawat,
Anatthaya Buame, Pitchakorn Salangsing, Toungthip Mala,
Nantayos Poonsawat, Petcharat Maliphan,
Nattakamol Laksana, Nitiphon Thoblong, Somchit Pangleelas,
Uthaithip Lordkaeo, Jantagan Hanpichanan

Group: 14-17 years old

World First Prize

Paveenuch Sratongrad, Paveena Sratongrad,
Kamonwan Saikasoon

World Second Prize

Boonyakorn Udompol

World Third Prize

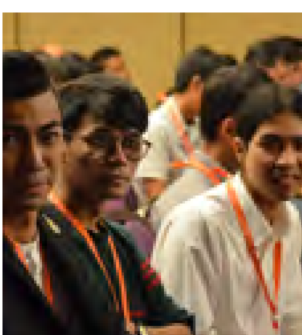
Porndanai Wattanapraditchai

World Honorary Mention

Pruksa Songsawatchai, Maneerat Rattanasupa,
Airada Kerdsiri, Chanakon chachamroey, Phraewa Sae-lim

World Young Artist Recognition

Thunyamai Siengwong, Natthawut Pimtee, Mathuros Srilailaphet, Natcharin Srisai, Yuka Sato,
Wigavee Rattamanee, Tanakon Khananpak,
Chuthamat Rattanaphibunkun,
Chanthakan Chantaragomol, Anant Wongsin,
Tiwtus Kanama



Group: 18-25 years old

World First Prize

Kittachaphol watcharachaisakul

World Second Prize

Jaran Boonpraderm

World Third Prize

Terdtanwa Kanama

World Honorary Mention

Anuwat Ainphu Khachen Playbun Pasutee Weerachai

World Young Artist Recognition

Natthanya Rojjanakhamthorn, Chaichana Luetrakun,
Waraluck Junta,Jakkapond Tapkao

Photos Category

World Honorary Mention

Keereekhan Chaiyaporn, Petch-um-pai Aukkalayot,
Narongkorn Kwandee, Phasut Waraphisit,
Thanawin Kongmaharpunk, Samut Satawichairut

World Young Artist Recognition

Siripong Patumaukkarin, Kittipol Thongkaolaikanok,
Banhan Prangtad, Samatcha Srijunta

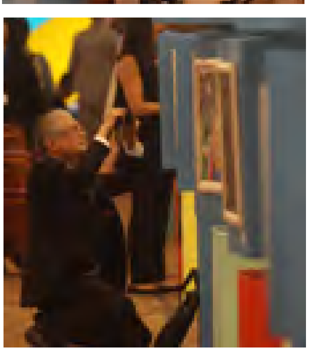
Comic & Cartoon Art Category

World Honorary Mention

Kasempong Deecharoenpaiboon,
Praewpan Kangwanchiratada, Jamille Bianca Aguilar,
Tiwtus Kanama

World Young Artist Recognition

Boonyanutch Janpetch, Samran Jarukulvanich,
Achira Apirakaramwong, Nattha Patcharawathin



ANNEX VII

Field Trip Program

The Prince Mahidol Award Conference (PMAC) 2016 is devoted to strengthening health priority setting in support of resource allocation and other policy development in the realm of universal health coverage (UHC). Every year a field trip program is arranged as a one-day visit to different sites, offering participants the opportunity to directly observe practice and activities of not only health personnel but also staff of local public agencies, civil society organizations, and lay people involved in service provision and supporting mechanisms. By interacting with persons in charge of policy decisions and implementation in real life, the participants will get an insight into Thailand's health systems including care delivery, financing and management. For the PMAC 2016 field trips, evidence generation and its roles in policy decisions regarding the adoption and use of health interventions and technology in the context of UHC will be highlighted. The descriptions of 6 site visits are as follows:

Site 1 Saving our children's sight: Effective eye screening by school teachers
Location: Samut Prakan Province

Site 2 Management of high-cost, essential medicines in the UHC context
Location: Faculty of Medicine Ramathibodi Hospital, Mahidol University

Site 3 Universal access to high cost medicine: Off-label use of bevacizumab
Location: Mettapracharak (Wat Rai Khing) Hospital, Nakhon Pathom Province

Site 4 Priority setting in university hospital toward Universal Health Coverage
Location: Faculty of Medicine Siriraj Hospital, Mahidol University

Site 5 Increasing access to essential renal dialysis through "PD First" policy
Location: Ban Phaeo Hospital, Samut Sakhon Province

Site 6 Priority setting for health promotion by community
Location: Suan Luang Municipality, Kratumban District, Samut Sakhon Province

PRIORITY SETTING
FOR UNIVERSAL HEALTH COVERAGE
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NICE International

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