PRINCE MAHIDOL AWARD CONFERENCE

World Health Organization

THE WORLD BANK

Japan International Cooperation Agency

Prince Mahidol Award Conference 2012

Report on Prince Mahidol Award Conference 2012:

MOVING TOWARDS UNIVERSAL HEALTH COVERAGE

HEALTH FINANCING MATTERS

January 24-28, 2012

Centara Grand & Bangkok Convention Centre
at Central World, Bangkok, Thailand

PRINCE MAHIDOL AWARD CONFERENCE

World Health Organization

JICA

Prince Mahidol Award Conference 2012

Report on Prince Mahidol Award Conference 2012:

MOVING TOWARDS UNIVERSAL HEALTH COVERAGE

HEALTH FINANCING MATTERS

January 24-28, 2012

Centara Grand & Bangkok Convention Centre
at Central World, Bangkok, Thailand

Table of Contents

Background of the 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 resources 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 in 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 international awards upon individuals or institutions that have made outstanding and exemplary contributions to the advancement of medical and public health services for humanity throughout 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 awardees 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 anyone 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."

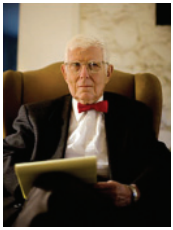
The Prince Mahidol Award ceremony will be held in Bangkok in January each year and presided over by His Majesty the King of Thailand.

Prince Mahidol Award

Her Royal Highness Princess Maha Chakri Sirindhorn, as the Representative of His Majesty the King, conferred the Prince Mahidol Award 2011 to the Laureates on Wednesday, 25th January 2012 at 17.30 hours at the Chakri Throne Hall.
On behalf of His Majesty the King, Her Royal Highness Princess Maha Chakri Sirindhorn hosted a banquet in honour of the Prince Mahidol Laureates 2011 on the same day at Boromrajasathitmaholarn Throne Hall at 20.00 hours.

On 11 November 2011, the meeting of Board of Trustees of the Prince Mahidol Award Foundation, chaired by Her Royal Highness Princess Maha Chakri Sirindhorn, decided to confer the Prince Mahidol Award 2011, to the following laureates out of 76 candidates from 45 countries.

Prince Mahidol Award Laureates for the Year 2011 Awards in Medicine



Professor Aaron T. Beck (USA), Professor Emeritus of Psychiatry, University of Pennsylvania, and Honorary President of the Aaron T. Beck Psychopathology Research Centre, Pennsylvania, for his outstanding contribution in the development of cognitive behavioural theory.

Professor Aaron T. Beck is the first person who has worked on the method of cognitive behavioral therapy (CBT) to use on patients suffering from depression. He developed CBT in the early 1960s when he was a psychiatrist at the University of Pennsylvania. He researched, developed and tested the efficiency of the method used on patients. This method focuses on how thinking affects the way a person feels and acts, and helps to change their thinking, behavior, and emotional responses to become more rational. Later studies show that CBT is the best method for major depression. CBT has been widely used by psychiatrists and psychotherapists for the treatment of depression. This therapy has helped more than 120 million people suffering from major depression and reduced the rate of suicide among more than 1 million people worldwide every year. Professor Beck has become known as the Father of Cognitive Behavioral Therapy.

Dr. David T. Wong (USA), Adjunctive Professor, Neurobiology, Department of Psychiatry, Indiana University School of Medicine, for his outstanding contribution in the discovery of fluoxetin.

Dr. David T. Wong started his study and research in the 1970s and later found fluoxetine, which was the first selective serotonin reuptake inhibitor (SSRI). It then took about 15 years before the US Food and Drug Administration (US FDA) approved fluoxetine for marketing as an antidepressant drug under the trade name “Prozac” in January 1988. In 1990, fluoxetine or Prozac gained its most prescribed antidepressant because of its sustained effectiveness, low side-effect profile, overdose safety and once-a-day dosing. It has been widely used to help more than 100 million depressed patients around the world. Moreover, fluoxetine has become the basic model in developing many antidepressants.

Both cognitive behavior therapy and fluoxetine play a major impact on the treatment of major depression, but the combination of the two gives a more effective and satisfactory result.

Prince Mahidol Award Laureate for the Year 2011 Award in Public Health

Dr. Ruth F. Bishop (Australia), Professorial Fellow, Department of Paediatrics, University of Melbourne, and Senior Principal Professorial Fellow, Murdoch Children's Research Institute, Australia, for her outstanding work on Rotavirus and vaccine against Rotavirus diarrhea.

Dr. Ruth F. Bishop is the first person who discovered that diarrhea in children, which occurs in those younger than 6 years old around the world, is caused by Rotavirus. The virus claims about half a million children's lives every year, especially in low and lower middle income countries in Africa and Asia. In 1973, Dr. Bishop and her team at Royal Children's Hospital examined cells from the intestines of children with gastroenteritis under the electron microscope and found that the virus has a round and wheel-like shape, so they named it as "Rotavirus". Furthermore, she also discovered the demonstration of protective immunity against severe disease by natural neonatal rotavirus infection. This laid groundwork for vaccine development against Rotavirus. Since 2007, it was mandated that every Australian child must receive the vaccine against Rotavirus diarrhea. At present, the vaccine has been widely accepted and used in more than 60 countries including Thailand, saving lives and providing health care to millions of children worldwide.

For more information see:
http://www.princemahidolaward.org/index.en.php

Message from Chairs of the International Organizing Committee




Vicharn Panich Carissa Etienne Cristian Baeza Kiyoshi Kodera

In recent years, the goal of Universal Health Coverage has become an increasingly important issue - featuring more and more prominently on global, regional and national agendas. This is a most welcome development. It is our task to make a difference to the 150 million people in the world who currently suffer severe financial hardship each year because they fall ill, use health services, and need to pay for them at the point of delivery. It is our job to make a difference to the 1 billion people who cannot use the health services they need - partly because they cannot afford to do so.

Universal Health Coverage has various social meanings not only on health status itself of individuals. Universal Health Coverage facilitates economic development. If people do not have to pay financially crippling health bills and if they can remain healthy for longer, they keep working, keep producing, and keep earning. Universal Health Coverage fosters social cohesion - binding people together into what is effectively a mutual support system.

Universal Health Coverage depends on strong and well-designed health financing systems that assure sufficient financial resources for health. They guarantee that people do not have to pay catastrophic out-of-pocket payments for health services, and that funds are used as efficiently and equitably as possible.

But Universal Health Coverage requires more than this. Health financing is not the only component. Universal Health Coverage means ensuring that people can easily access the services they need, and that these services are of good quality. It means having enough health workers close by and ensuring that they are well trained and motivated. It means ensuring that the medicines and equipment they need are available, affordable and distributed appropriately.

Country after country has shown the world that Universal Health Coverage is achievable. But it never appears overnight. Moving towards Universal Health Coverage requires concerted efforts from within and outside the health sector - strong links between efforts to promote health, social development and economic growth. And even when it has been achieved, it is essential to assure systematic monitoring and evaluation - not just of the health financing system, but of the health systems themselves and the impact on the population's health.

As Chairs of the International Organizing Committee, we, the Prince Mahidol Award Conference, the World Health Organization, the World Bank and the Japan International Cooperation Agency are very pleased to welcome you to the Prince Mahidol Award Conference on "Moving towards Universal Health Coverage: Health Financing Matters", in Bangkok, Thailand, where you join more than eight hundred fellow champions of Universal Health Coverage from around the world.

Over the next few days, we will share presentations from a number of countries, at different stages of economic development and with different types of health systems, which have taken innovative steps in health financing to move closer towards Universal Health Coverage. The main conference programme features five plenary and eighteen parallel sessions. These explore the wide range of health systems financing options, partly from a policy perspective, and partly from the practical perspective of implementation. Some sessions focus on measuring the impact of Universal Health Coverage.

We urge you to take advantage of the varied range of toolkits and side meetings. You are also invited to take part in one of the site visits, which will offer you a taste of Thailand's own efforts to achieve Universal Health Coverage - and to maintain it over the last decade. An independent assessment of the Thai scheme has recently been completed and we hope to share this with you.

With this unique opportunity, we hope that you will be able to strengthen your networks and build new alliances and, above all, strengthen your determination to undertake new actions to deliver on our joint vision.

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 the international partners, the Prince Mahidol Award Foundation, Ministry of Public Health, Ministry of Foreign Affairs and Mahidol University. Last but not least, we would like to extend our thanks to all speakers, moderators, discussants and participants whose wealth of experience, knowledge and skills will benefit us all this week - and help us achieve our common objective - Universal Health Coverage.

This conference provides us a chance for all stakeholders to work together to effectively translate ambitious policy intentions into concrete actions that can make Universal Health Coverage a reality for all people, everywhere, ensuring better health for everyone - whoever they are, wherever they live.

Dr. Vicharn Panich

Chair
Prince Mahidol Award Conference

Dr. Carissa Etienne

Co-Chair
World Health Organization

Dr. Cristian Baeza

Co-Chair
The World Bank

Mr. Kiyoshi Kodera

Co-Chair
Japan International Cooperation Agency


WARD CONFERENCE 2012

Summary in Brief

Program

Monday 23 – Saturday 29 January 2012
23 side meetings and toolkit sessions. List of side meetings and toolkit sessions is shown in ANNEX III

Wednesday, 25 January 2012
8 optional field visits

- Connecting and managing all health insurance schemes through ICT system
- Central design with flexible decentralized UC management system at Saraburi Province
- Managing referral system for better access to excellent centres of Universal Coverage Scheme beneficiaries
- Beyond medical education: roles of university hospitals in Universal Coverage Scheme
- Engaging community organizations in the management of Universal Coverage Scheme
- Integrated healthcare system: a pre-requisite for universal coverage system
- Private healthcare providers: involvement is better than exclusion?
- Can private clinics provide comprehensive care for beneficiaries of the Universal Coverage Scheme?

Thursday 26 - Saturday 28 January 2012

- Keynote address
- 5 plenary sessions
- 18 parallel sessions

Participants

816 participants from 68 countries
Afghanistan, Albania, Australia, Bangladesh, Belgium, Benin, Brazil, Burkina Faso, Cambodia, Cameroon, Canada, Chad, Chile, China, Colombia, Costa Rica, Egypt, Ethiopia, France, Gabon, Georgia, Germany, Ghana, India, Indonesia, Iran, Italy, Japan, Kenya, South Korea, Kyrgyzstan, Lao People's Democracy Republic, Malaysia, Maldives, Mali, Moldova, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nepal, Netherlands, Nigeria, Norway, Pakistan, Papua New Guinea, Peru, Philippines, Rwanda, Senegal, Singapore, Solomon Islands, South Africa, Sri Lanka, Switzerland, Taiwan, Tanzania, Thailand, Timor Leste, Togo, Turkey, Uganda, United Arab Emirates, United Kingdom, United States, Vietnam, Zimbabwe


will be so proud
me your hands


INTERNET CAFÉ


Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH


SIRIRAJ HOSPITAL


UHC: an achievable goal by countries at all income level - experience from Thailand
1. UHC reduces poverty in addition to improve health. (MDG 1)
2. UHC can be started and achieved without having to wait until high income.
3. How to mobilize additional resources for health?
4. Better Value for Money

Conference Program in Brief

Tuesday 24 January 2012

08:30-17:30	Side Meetings and Toolkit Sessions

Wednesday 25 January 2012

07:00-18:00	Field visits

Thursday 26 January 2012

09:00-10:30	**Opening Session by HRH Princess Maha Chakri Sirindhorn & Keynote Address**	
11:00-12:30	**Plenary Session 1:** Universal Health Coverage: Utopia or Mirage to Human Development?	
14:00-15:00	**Plenary Session 2:** The Complex Nexus: Political Will, Civil Society and Evidence in Achieving UHC	
15:30-17:30	**2.1** Raising More Domestic Resources for Health	**2.2** Role of Development Assistance in Universal Coverage
18:00-20:30	Welcome Dinner	

Friday 27 January 2012

09:00-10:00	**Plenary Session 3:** Pathways to UHC: Debates on Critical Policy Choices	
10:30-12:30	**3.1** Defining, Measuring and Monitoring Universal Health Coverage	**3.2** Voluntary Insurance Schemes: What Lessons for Low- and Middle-Income Countries
14:00-15:00	**Plenary Session 4:** Achieving Universal Coverage: a Key Role of Health Systems	
15:30-17:30	**4.1** Measuring the Impact and Outcome of Universal Coverage	**4.2** Resource Scarcity, Efficiency and Coverage with Health Services

Saturday 28 January 2012

09:00-10:00	**Synthesis: Summary, Conclusion & Recommendations**
10.30-12.00	**Plenary Session 5:** Ministerial Round Table: Advancing UHC Agenda
12.30-13.00	**Closing Session**

2.3 Macroeconomics and Universal Health Coverage	**2.4** Governance Structure and Institutional Capacities in Advancing UHC	**2.5** Voice of the People	**2.6** The Role of the Private Sector in Universal Health Coverage: a Blessing or a Curse?
3.3 Beyond Bismarck and Beveridge: Lessons from Hybrid Financing to Cover a Billion People	**3.4** Reaching and Protecting the Poor in Low Income Countries: What Challenges?	**3.5** Portability of Financial Risk Protection Across Schemes, Across Borders	**3.6** Universal Health for the Working Poor: Barriers to Access
4.3 Provider Payment: Aligning Proper Incentives and Efficiency	**4.4** Using Financing as a Platform for Quality Improvement	**4.5** Ageing Populations: What Challenges for Health Financing?	**4.6** Giants Racing Towards UHC: Health Financing Reforms in China and India

Rationale

Health financing is one of the six building blocks of the WHO health systems framework, i.e., service delivery; health workforce; information system; medical products & technologies; financing; and leadership & governance. The Framework provides clear functions and poses major challenges of each building block, in particular healthcare financing faced by the developing countries. It is clear that health system strengthening requires integrated responses of all six building blocks.

It is well recognized that functional health system requires equitable, efficient and sustainable health financing which ensures access and utilization of essential health services without financial barrier and people are protected from financial catastrophe or impoverishment due to illnesses. This is the goal of health financing system aiming at universal health coverage (UHC).

The World Health Assembly resolution, WHA 58.33 in 2005 on "sustainable health financing, universal coverage and social health insurance" urges member states to ensure that the health financing systems include prepayment method with a view of risk sharing and solidarity. WHO and partners convened the first global symposium on health system research with the theme of "science to accelerate universal health coverage" in Montreux in November 2010. About 1,200 registered participants who are researchers, policy-makers, funders, academia and other stakeholders representing diverse constituencies gathered to share evidences and experiences and identify knowledge gaps and need of research in low and middle income countries to foster the momentum of universal coverage movement. The latest World Health Report in 2010 on "health system financing: the path to universal coverage" was launched in Berlin, Germany in 22-23 November 2010 and subsequently in Beijing, China on 29 November 2010. The report reaffirms all countries can improve the health financing system and strongly persuades faster moving towards universal health coverage goals.

There are also other concerted movements to improve the health financing systems and to move towards universal health coverage. The 2009 G8 summit in Toyako committed on health system strengthening which focused on three interrelated components: health information systems, human resources for health and health care financing. There are also movements at global, regional and country levels to support technical collaboration e.g., the High Level Task Force on UHC, the Joint Learning Network supported by Rockefeller Foundation as well as South-South collaboration.

Given the rich context on UHC, and a number of countries striding towards UHC, time has come to share the country experiences and challenges on financing reforms and to push this momentum forward in order to effectively translate good policy intention into concrete actions in accelerating towards UHC.

The Prince Mahidol Award Conference is an annual international conference co-hosted by the Royal Thai Government, the Prince Mahidol Award Foundation, and other relevant International Organizations, Foundations and Civil Society Organizations. The Conference serves as an international forum for sharing evidences for health related policies and strengthens social commitments for health development. This conference is linked to the annual Prince Mahidol Award for public health and medicines, one of the most prestigious international health awards.

The 2012 Prince Mahidol Award Conference is dedicated to deliberation on experiences on health financing reform, support global dialogue and foster global, regional and national movements towards universal health coverage.

Resilient and responsive health system is a foundation and pre-requisite to successful UHC achievement; it requires functioning healthcare delivery system particularly at PHC level where the majority poor can access and use service when needed, adequate number and skill-mix of health workforce who are responsive to the population health needs, adequate, equitable and efficient health financing, health information systems which guide evidence based policy decision, availability of medicines and medical products and governance of the system. This Conference focuses on the contribution of health financing in advancing towards UHC; however other enabling environments would be addressed.

Objectives

1. To position the universal health coverage in the global and national development agendas.
2. To identify enabling factors contributing to success of health financing reforms e.g. political, economic, societal support, health services infrastructure especially primary health care, human resources for health, acceptability and expectation of people.
3. To review and share experiences among low, middle and high-income countries at different stages of achieving universal health coverage, on different dimensions of universal coverage such as financing sources, risk pooling, strategic purchasing, governance and outcome of different designs of universal coverage

Structure of the Conference Program

The theme of Prince Mahidol Award Conference 2012--Moving Towards Universal Health Coverage: Health Financing Matters / Prince Mahidol Award Conference 2012 was convened during the week of 24-28 January 2012 and hosted activities, including:

- Side meetings,
- Capacity building workshops,
- Field visits,
- Marketplace,
- Main conference program.

The main conference program consisted of the Plenary and Parallel Sessions, in addition to the opening, closing and official dinner sessions.

Conference Partners

The conference is co-hosted by the Prince Mahidol Award Conference, the World Health Organization, the World Bank, and the Japan International Cooperation Agency.
Other partners include:

- China Medical Board
- Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
- International Development Research Centre
- National Institute for Health and Clinical Excellence
- Results for Development Institute
- Thai Health Promotion Foundation
- The International Labour Organization
- The Rockefeller Foundation
- World Health Organization Regional Office for South-East Asia

Keynote Session

Ruth Bishop
Professorial Fellow, Murdoch Children's Research Institute, Australia

Good morning. Her Excellency, Ladies and Gentlemen.
I'm very honored to have received this award and to be given the opportunity to address you this morning.

I really will describe to you vaccines that are poised to cause great saving of lives in children throughout the developing world and need now your support in financial negotiations and distribution negotiations to get them to every child who is eligible and in need.

The work began with a clinical problem that was very common at the Royal Children's Hospital Melbourne in the early 1970's. This was a child who was admitted, approximately 10% dehydration, and she was eventually rehydrated over 48 hours and showed the fat happy personality that she really was.

In many cases worldwide, even in Australia, children died of the associated dehydration but there was absolutely no explanation. The disease was infectious and caused often ongoing malnutrition. I worked in a pediatric gastrology department in the hospital which had an interest in malabsorbtion and we began a study to try and explain why whether or not the damage to the gut could explain this malabsorption. Biopsies that were examined in light microscopy showed considerable damage to the upper small intestine, destruction of villi, loss of epithelial cells that are responsible for digestion and absorption, and considerable invasion of the inflammatory cells. However, it proved impossible to culture either known viruses or bacteria or any other intestinal pathogens from these children.

Realizing that we had discovered the lesion associated with acute gastroenteritis, we turned to use of electron microscope to examine the same tissue. The first section from the first child we examined showed the existence of a new virus. It was budding through the endoplasmic reticulum of an intestinal epithelial cell, collected in sac cells and eventually destroying the cell.

The technique of intestinal biopsy was clearly not suitable for large-scale epidemiological studies so we so we turned to the technique of examining and extracting these viruses from diarrhoea feces.

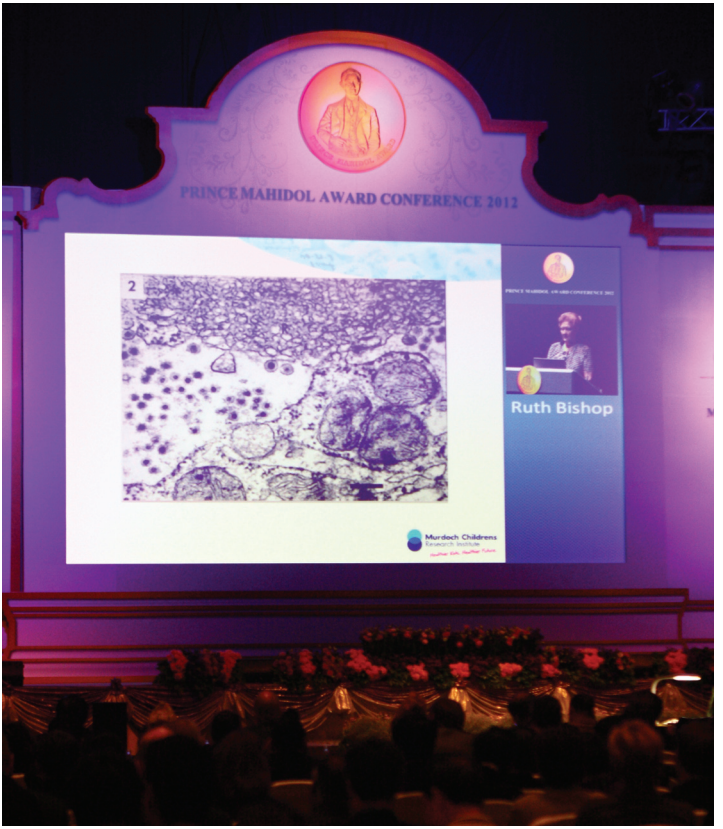
This medium sized virus with very distinctive morphology was found in many of these children. The name given to this was rotavirus based on the spoke-like appearance of the outer shell, looking like a wheel, and rota was Latin for wheel, so this was the name given and adopted worldwide.

Many epidemiological studies in Australia and elsewhere reported rotavirus very quickly after our discovery was published. Epidemiological studies were required to determine the importance of the disease locally and worldwide. We found that it was responsible for more than 50% of rotavirus infection occurred in more than 50% of young children with acute gastroenteritis and many reports worldwide agreed with our results and showed the importance of 50-60% usually in epidemiological studies. It was clearly of major importance worldwide in the causation of acute severe gastroenteritis.

The burden of disease was mostly carried by children under 2 years of age. It infected and caused severe dehydration which was treatable, provided the child was admitted early enough to a treatment facility.

The conclusions of many epidemiological studies are given in this table. It turned out to be the single most importance cause of severe diarrhoea in infants and young children worldwide. It was labeled as a democratic disease in that it infected children regardless of socioeconomic status. It infected early in life, as early as the neonatal period in many children, and it was transmitted from person to person contact so the prevalence was not likely to be reduced by improved sanitation. Strategy for prevention then focused on development of vaccine.

CDC did many epidemiological studies worldwide and this is one of their conclusions that worldwide in developing countries 70 children died per hour of severe diarrhoea compared with 50 children who died per year in USA with severe diarrhoea. So it was clearly of major importance in terms of mortality in developing countries. This again is an illustration of CDC's results showing where the burden of mortality is. Even today it largely falls upon children in sub-Saharan Africa and throughout South East Asia. The requirement for vaccine development when you first faced with this as major problem was to work



out the natural history of the disease. Does the disease result in immunity? If it doesn't, then vaccination is a very difficult thing to achieve. If it does show a development of immunity then you have a good chance of getting a successful vaccine. Does infection confer immunity? We did a longitudinal study in children in Melbourne Australia that were recruited a birth. They had neonatal infections or they escaped neonatal infections and we followed up children who had a neonatal rotavirus infection comparing them with a control group who had escaped neonatal infection. We found that neonatal infection did not protect from reinfection. This was regular, frequent, often annually or more often than annually, so the neonatal rotavirus infection did not prevent reinfection but it did give clinical protection against severe disease on reinfection.

The conclusion from this is that if you could get a vaccine, give it early in life, then the child on its second, third reinfections which

were frequent would no longer have such a severe damage that it resulted in acute life-threatening gastroenteritis. This study was initially done in Melbourne but it was followed by a very detailed study in Mexican children so the same conclusion could be made from longitudinal studies there that it was clinical protection against severe rotavirus diarrhoea after 2 rotavirus infections and that symptom-free rotavirus infections could also result in protective immunity.

The next question to settle was what vaccine strategy should be chosen. It was decided upon development of live attenuated rotaviruses to be given orally in the first few months of life, very similar fashion to the oral polio vaccine. What rotaviruses to use? Animal strains had been cultured. Human strains had been cultured with great difficulty.

Another strategy that was turned to was to use reassortant animal and human rotaviruses. These had the advantage of being easy to culture because of this animal source. But to carry antigenic determinants that were appropriate for human rotaviruses. These eventually evolved into 2 current rotavirus vaccines. Rotarix developed by GSK and RotaTeq developed by Merck. They were both tested in large numbers of children. They were effective in preventing severe rotavirus diarrhoea in similar numbers of children, 85% Rotarix, 95% RotaTeq. The difference there is probably not important. Prevented hospital admission for any diarrhoea, not just severe rotavirus diarrhea, and were effective against the major rotavirus serotype G1s. These results were published in the New England Journal of Medicine simultaneously in the year 2006 and this is a comment which The Lancet made the same year saying that the efficacies of these 2 vaccines were impressive and will one day likely to stand alongside smallpox, measles, poliomyelitis vaccines in their global public health benefit.

They are now widely used in developed countries in particular and they have resulted in 80-90% reduction in the need to admit children with severe diarrhoea to a hospital. They are beginning to be used in developing countries. One of the major barriers to their use has been the price. They function against the full range of serotypes so that they can cover at the moment the serotypes that are common in the community. But we need further epidemiological studies to show whether they continue to maintain protection if the serotypes in the communities change. We are attempting to develop a vaccine that can be giving in the neonatal period for 2 particular reasons. One is that even in developed countries children can be infected early in the neonatal period or after discharge to home. But particularly in developing countries the initial rotavirus infection is often at a very young age and it is a good strategy to develop neonatal infection, particularly as this is an age when most young children encounter health care services.

As I alluded to, the major difficulty now facing all people involved in this area is to adjust the price so that they are affordable in developing countries.

Keynote Session

Vashaben Thakor
Board Member, National Insurance VimoSEWA Cooperative Ltd., India

Namaste! I am Varshaben Thakore. I come from Gujarat, India. I am an agricultural worker and have been working in the Self Employed Women's Association (SEWA) as a community health worker for the past 11 years. SEWA is a trade union of 1.4 million working poor women across 9 states of India. SEWA provides an integrated set of services to its members through a cadre of 4000 trained village leaders like myself. In terms of health, SEWA provides preventive health education, links members to the existing services, provides insurance services, runs low-cost drug shops.

As a SEWA community health worker I work in 5 villages helping other village women by:-

- Conducting health education sessions.
- Providing referral services.
- Linking with & strengthening the government health services (National Health Insurance Scheme, Primary Health System).
- Linking with SEWA's insurance services.
- Providing SEWA manufactured traditional medicines.

As a SEWA community health worker I also represent village women on –

- Village Health and Sanitation Committee (under the National Rural Health Mission)
- SEWA Insurance Cooperative- India's first all women insurance Cooperative

Since becoming a SEWA community health worker my life has changed in so many ways:-

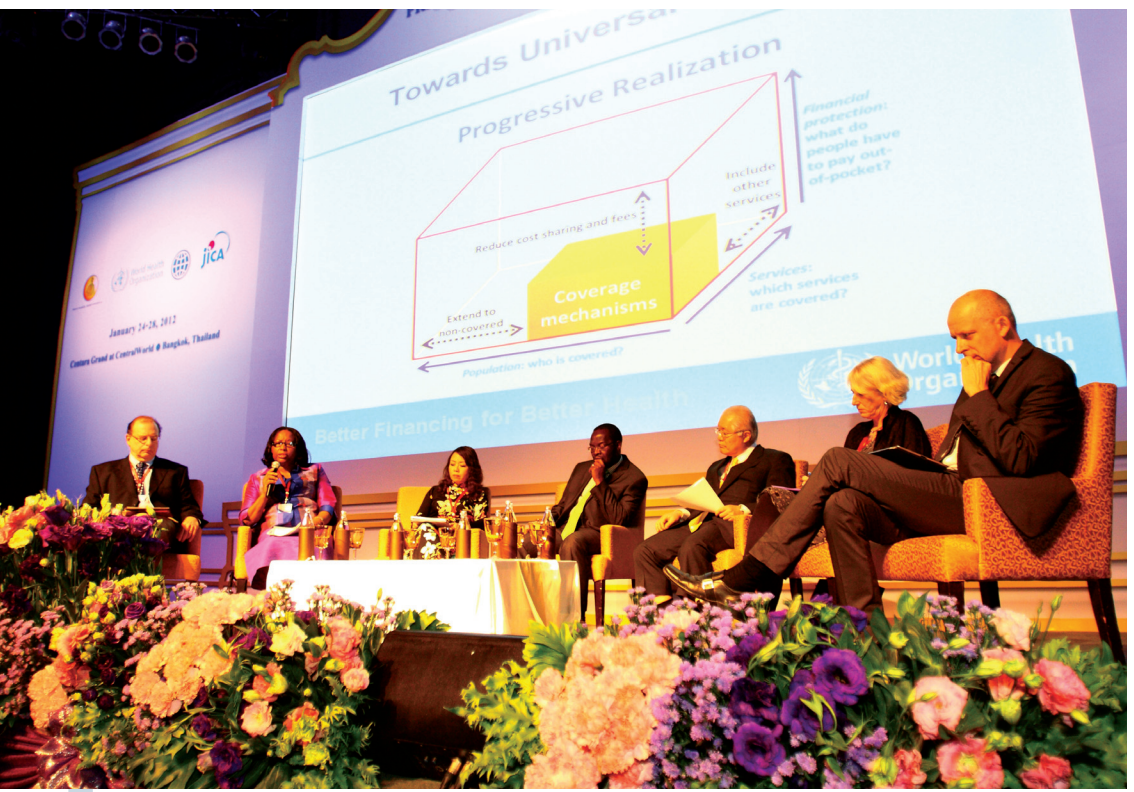
- Had no confidence to travel alone in the village even and today I am travelling overseas. I am the first person in my Village and in my entire Thakore community to travel overseas. I thank you for this honour and opportunity.
- Regular confidence building has helped me in solving the issues of the village. I can talk to the medical officers on my own.

Based on my experience I feel it is important that the Government of India should:-

- Provide free primary health care
- Provide free medicines for all.
- Increase the cadre of community health workers.

I believe that if Government and organizations like SEWA, join hands we can make the dream of Universal health a reality. Thank You!

What is Universal Health Coverage? Is It Realistic?



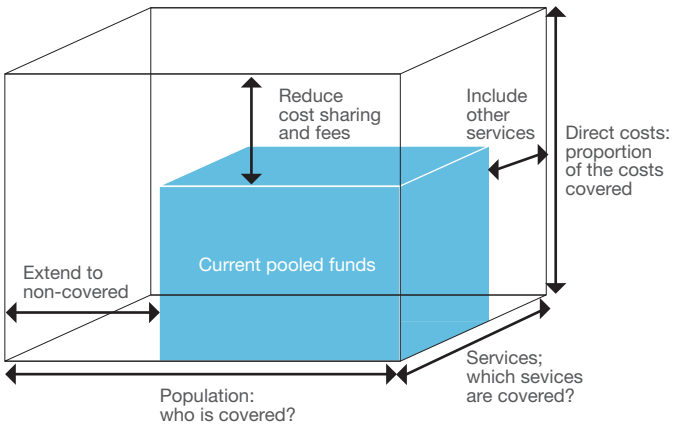


Figure 1 **UHC Cube**

Is UHC a goal or a means to an end? The Conference felt that UHC can be a health goal countries needed to reach. The societal goals of an improved level and distribution of health of the population and better access to needed health care by all people with minimum financial barriers can be achieved through UHC.

With the explicit meaning of universality, UHC is in itself a political and societal intolerance of inequities in health; with this goal in mind, every country, no matter what level of income, can do something in expanding coverage to the population. There are many options for expanding coverage depending on country socio-economic, political and health systems context and progress over time can be measured by the UHC Cube (see Figure 1) in three dimensions; the population coverage on the X axis, the level of financial protection on the Y axis, and the comprehensiveness of the benefit covered on the Z axis.

Not only mobilizing more resources and population coverage expansion, but the way services are purchased from healthcare providers determines cost control and the level of financial risk protection for the population. Cost containment facilitates the long term financial sustainability of efforts to increase coverage with health services and with improved financial risk protection, regardless of whether the country uses public funding and public provision of services, insurance mechanisms, or a mix.

In view of the increasing challenge of non-communicable diseases and increasing size of aging populations, increased spending on primary prevention of chronic non-communicable diseases and stimulating healthy ageing are major milestones for low and middle income countries.

Building Consensus for Universal Health Coverage

Building consensus for UHC requires political and financial commitment, not a rhetoric political statement; the fostering of a sense of solidarity, and a multi-sectoral holistic approach engaging Ministries of Health, Finance, Labour, Social Welfare, National Planning, and civil society organizations (CSO) from grass root to national level. At times movement towards UHC is led by the health of the state. Moments of crisis or political and social change are often windows of opportunity for UHC; for example, UHC is one of the political campaigns in some of the low and middle income countries.

Intersectoral action and CSOs through “Voice of the People” can play a major role, and good examples were shown in various sessions of the Conference.

Thailand achieved universal coverage in 2002 when twelve civil society organizations proposed a draft Bill on National Health Security with the support of more than 50,000 citizens’ signatures. This achievement came from various enabling contextual factors, starting from increasing evidence and intolerance of inequities. Additionally, UHC was built on a strong foundation consisting of (1) right to access health care by all Thais according to the 1997 constitution (2) extensive coverage of health care facilities and systems at district level (3) institutional capacity to mange transition towards UHC by the Ministry of Public Health (4) evidence and intelligence which came from strong health system research capacity and a computerized civil registration

system. Importantly, there were three pillars that drove change; (1) political commitment (2) civil society mobilization (3) technical know-how. In Thailand, the “people’s voice” is institutionalized in the health system via representatives in governing boards of the National Health Security Office at the local, provincial, regional and national levels. Various channels for civil society participation include annual public hearings regarding the implementation of UHC; a call center for members to voice their problems and concerns; an independent complaints center which is run by civil society organizations with cooperation of the NHSO; “Friendship Support Centers” of volunteer patient groups; “No Fault Compensation Fund” providing assistance to patients and providers negatively affected by the health services.

The Pan African Health Congress was held in Ghana in November in 2011 to which representatives of over 20 African countries participated. The Congress was an attempt to hear the voices of different stakeholders on universal health coverage, to share their experiences, exchange ideas and opinions, and discuss different schemes and policy processes related to UHC. The conference led to creating a Movement for Universal Coverage in Health (MUCH) in Africa, a platform that will advocate African countries to actively move towards UHC and monitor progress.

Similarly in the Philippines, an autonomous, well structured governing body with a legal framework supporting universal

coverage and political commitment has been crucial for the success of PhilHealth, which focuses on four institutional components: organizational strengthening, enrolment and collection, accreditation, and contracting and benefits development.

Roles of women's organizations and trade unions were particularly highlighted during this conference. CSO also has a particular role in strengthening the voice and agency of poor people and contributing to pro-poor and health equity policies. Development oriented CSOs have many different sources of resources that they can access or generate. However there is no single "best practice" method by which CSOs to use or develop their resource mobilization strategies.

The People's Health Movement, India and its "Right to Health Care" campaign was launched in 2003, and emerged from a combination of deterioration in government health services and declining public health budgets and a sharp rise in costs of unregulated private medical care and growing resistance to the negative effects of privatization in care. Elements of the campaign include regional public hearings that have culminated in a national public hearing involving health officials from the central and state governments. Community-based monitoring (CBM) and planning of health services has been key to the success of the movement. From the perspective of health rights, community members and local activists form committees to identify gaps, issues and priorities for change. The committees then challenge hierarchies of power for change. The initiative was launched as a pilot project in 2007 in Maharashtra State and has gradually expanded. So far, over 170 public hearings have been organized at Primary Health Care, block and district levels. Media have actively been engaged to publish on CBM. In villages and districts with CBM, health services are improving and utilization of health services is i ncreasing.

Key Messages for Building Consensus for UHC

- Foster a sense of solidarity
- Need multi-sectoral holistic approach and engaging various Ministers
- Fiscal risks need be assessed and managed
- Not only political but financial commitment by increased health budget
- Build evidence through monitoring and evaluation – impact on population and health system
- Moments of crisis or political and social change are a window for setting UHC agenda

Key Recommendations

- Universal coverage should be "Constitutionalised" in order to secure political commitment and political advocacy to support health care financing
- When implementing the universal coverage, the country should prioritise and contextualize the benefit package based on the country's needs and situation
- The issue of equity should be of high concern. The poor should not be ignored and the government needs to ensure equitable geographical distribution of service coverage
- A roadmap for the reform should be developed based on country context
- As financial resource can be a major constraint, the country should ensure cost containment and financial sustainability by design of provider payment that sends appropriate signals towards efficient use of scarce resources
- Make the case for UHC as a development objective and national priority agenda
- Inclusive of all sectors and civil society and continuing dialogue in advancing UHC agenda
- Virtuous cycle of civil society pressuring political commitment which demands technocrat analysis, proposed policy options, effective implementation and monitoring and evaluation which generate new evidence to fine tuning policies

Major Problems and Issues Confronting the Move to UHC

- In low and middle income countries, there is limited institutional capacity in generating evidence and proposing options which inform civil society and political debates in advancing UHC agenda
- How to better engage ministries of Finance, Labour, and Social Welfare in UHC agenda setting?
- Differing views on balance between rights-based and economic efficiency arguments
- Financial sustainability depends on the macro-economic situation, available fiscal space, and governments' political commitments

Design and Governance of UHC

The experiences presented at the Conference highlighted a number of factors ensuring good governance and institutional arrangements for these schemes to successfully move to universal coverage.

To date, Community Based Health Insurance (CBHI) in Rwanda has reached 96% of the population. The success factors for the CBHI to have reached such high coverage include 1) a conducive environment for universal coverage with existence of a legal framework for universal and mandatory health insurance coverage and strong political commitment and leadership 2) a sound and decentralized national management system, good coordination between different levels and schemes and sources of funds 3) evidence-based, participatory and incremental policy development starting with pilots and then scaling-up, and reforms and 4) strong local support for insurance coverage, especially in management, marketing and identification of the poor for subsidies and 5) mandatory enrolment.

In China, there are three financial health risk protection schemes: the new rural cooperative medical scheme (RCMS) for rural residents, urban employee-based basic medical insurance (UEBMI), and urban resident-based basic medical insurance (URBMI). China plans to merge these schemes and integrate them into one single purchaser national health insurance scheme by 2020 to reduce administrative complexity and improve efficiency and equity. Nowadays, 95% of the population is

covered by one of the schemes though with a shallow benefit package and still high level of out of pocket payment, though decreasing. A universal national health insurance scheme requires a legislative framework, an effective single administrative authority, a workable plan, and the recognition that a universal health insurance can improve equity in health between urban and rural areas.

Similarly the success factors for free health care in Sierra Leone include clear vision, high-level leadership, stakeholder alignment, supply-side preparations, participation of civil society, and mutual accountability.

Along with their success factors, UHC implementers face a number of challenges in governance and institutional arrangement of their schemes. These include 1) ensuring institutional and financial sustainability in the context that the benefit package should be enlarged to provide sufficient protection 2) the need to subsidize the poor to promote equity 3) coordination and consolidation among the different fragmented schemes 4) improving quality of care and 5) appropriately contract with providers and their payments –moving away from fees for services.

Another challenge is how to balance the power between different stakeholders in the governing body of the insurance fund, including effective engagement of civil society, to ensure accountability and to represent the views of the beneficiaries. Absence, inadequate, contradictory and weak rule enforcement, weak capacity for implementation, and non-conductive inter-organizational relationships are also constraints to the success of the schemes. For large pooled schemes like in China and the Philippines, developing an accurate and effective database and information (IT) system is a major challenge.

The ideological debate on the merits of Bismarck and Beveridge models appears to be outdated. Both have their own strengths and weaknesses which generate some good and bad examples of these two models. According to recent studies comparing the performance of countries implementing the two models, there is no clear indication that one model systematically outperforms another. Countries performing well can be found in all types of institutional arrangement, as well as countries doing poorly. However, the performance of the countries depends on country specific context, social and economic factors, policy, implementation strategies and governance structures, which matter much more than the model itself in order to expand the coverage and

improve health outcomes. Thus, there is a need to initiate new debate on how to best achieve good performance for three health financing functions (revenues mobilization, risk pooling, and purchasing), equity, and health goals. Instead of choosing one of the two models, more and more countries adopt the hybrid system, which combine some features of the Bismarck model and some of the Beveridge model to finance and manage health insurance. For example, the traditionally Beveridge-ian countries like Spain and Denmark have already adjusted their purchasing strategies to be more like that of the Bismarck model.

Some suggestions and recommendations were made to overcome the above-mentioned challenges and issues. These included the introduction of new rules, rule-redesign, rule-alignment, strengthening enforcement which is important to achieve the design goals. Consolidation and harmonization of different schemes can reduce the administrative complexity and increase efficiency and equity. Instead of merging them where politically not feasible, creation of a national body to coordinate them overall is being considered by various countries. Investment of the reserve funds can help generate some extra revenue and in the case of PhilHealth, re-investment of the large reserved funds in enlargement of the benefit package with proven cost effectiveness, and/or reduction of premium rates should be considered.

Key Messages for Design and Governance of UHC

- No blueprint of best model – countries need to adapt ideas to their own country context -- history matters and there is a strong path dependence to UHC
- Importance of institutional design, governance and arrangements which hold all partners accountable and responsive
- Creating a legislative framework is essential to ensure long term sustainability of UHC
- Consolidation and harmonization across different fragmented schemes over time to reduce inequities is required
- UHC is not just financing reform – governments need to address health delivery systems to be able to provide services to the whole population

Resource Mobilization

With universal health coverage moving up the global agenda (The World Health Report 2010, World Health Assembly resolutions 2005 and 2011), the demand of countries for technical and financial assistance to their transition towards UHC increases. However raising more domestic resources for health is not a recent topic. The Macroeconomic Commission for Health contributed to the debate in 2001. The increasing burden of non-communicable diseases has been challenging the financial sustainability of UHC in developed countries for many years.

The World Health Report 2010 addressed the three pillars of health financing for UC: raising more resources, developing financial protection against health related risks and improving efficiency (more value for money) through appropriate design of purchasing functions.

Given the current low level of public spending in health in low and middle income countries, achieving UHC requires increased spending by their governments and reduced the out of pocket spending. Without political and financial commitment, UHC is a rhetorical statement.

Constant advocacy for UHC to get more political commitment is crucial, however the involvement of the whole population and other sectors than health is also is necessary. Despite what has been done in the past in many countries (e.g. Burkina Faso,

Gabon, Laos, Korea, and Indonesia) in raising more resources for health, there is always need for additional and alternative sources of funding and growth in health spending faster than the GDP is always a concern.

In addition to general tax, there are other potential sources of health financing, such as payroll tax from public and private formal sector employees and employers, sin tax from health hazardous products such as tobacco and alcohol, and external donor resources. Each source has its potential and limitations, and countries should make best use of these sources based on their socioeconomic and political context.

The main drivers of health spending are population aging (roughly a quarter of the increase in spending-to-GDP ratios), and excess cost growth (ECG), i.e. the difference between real health expenditure growth and real GDP growth, explains the rest; more specifically, this is technology, health policies and other factors.

For advanced economies, the projected increases in public health spending are large. The projected increases vary by country, with the United States facing the largest increase. For emerging economies, projected increases in public health spending are moderate. Spending pressures in emerging Asia are lower than those emerging in Europe and Latin America. For countries that face large fiscal pressures from public health spending, the challenge is to improve efficiencies and contain spending growth. For countries with available fiscal space, the challenge is to expand coverage in a long-term fiscally sustainable manner. It is important to learn from past experiences and avoid the inefficiencies and resulting cost escalation. It is essential to restrict benefit packages to the most essential services and proven cost effective interventions, until there are higher fiscal capacities.

Currently, Development Assistance for Health (DAH) currently faces more challenges than known solutions. Some of these challenges are the need to ensure sustainability for ODA, given the context of priority and macroeconomics. Low and middle income countries, especially in South Asia and Sub-Sahara Africa, are dependent on DAH and the unpredictability and shifting donor priorities make it even more difficult to address sustainability. It is therefore critical for national governments to have ownership and drive their health agendas and have national priorities which guide partnerships with donors.

“ODA is not only about the money, but also about the technical assistance and knowledge sharing,” as stated by The World Bank. Developing capacity is the major key success factor in achieving UHC that was echoed by the three countries represented by Nepal, Solomon Islands and Cambodia. Thus, moving away from the concept of ODA as “assistance” towards “collaborative learning” is necessary. Although focusing on the monetary aspect of ODA is rather narrow, its importance cannot be ignored since keeping donor’s commitment on funding would actually double funds for health.

Although being one of the major topics on the global agenda, UHC does not seem to have specific budgets allocated to its support. Looking at the contributions made it is currently not possible to quantify those specifically related to strengthening

UHC systems in countries. This poses difficulties for monitoring and evaluation demands. The lack of information poses also further questions related to the equity, effectiveness and efficiency issues regarding the use of funds.

Whether a country adopts Bismarck-ian, Beveridge-ian or a hybrid model, there are a number of problems and challenges that the country needs to tackle in implementing universal coverage. In the Bismarck model, the key weakness is the reliance on payroll taxes from formal sector workers. In many developing countries, the size of the informal sector economy remains large (the proportion of informal sector workers representing 50-70% of the total workforce) for the past decades. Despite rapid economic growth in these countries, the proportion of formal sector workers has only grown slightly over the years. Moreover, a number of developing countries are facing a demographic transition, with a sharp increase of the aging population and a reducing size of the economic productive population. This ultimately leads to a decline in wage-based revenues for UHC. Furthermore, the country also needs to tackle how to mobilize budget to subsidize premiums for the poor, especially for low-income countries where domestic resources are scarce and DAH could hamper long term sustainability. Including the non-poor informal sector into the coverage is also a substantial challenge, as some of them are well-off but enjoying taking advantage of subsidized premiums, which is the case highlighted in Taiwan.

A country that follows the Beveridge-ian model, on the other hand, is likely to face a rising expenditure while expanding health coverage, which will lead to the need to increase general revenues and taxes reform. It may also discourage the formalization of workers and firms. Countries that adopt a hybrid model also face a unique problem, as formal sector workers continue to pay payroll taxes for the social health insurance and other personal income taxes, through the general taxation, to fund the health insurance of informal sector workers and the poor and vulnerable. Formal sector workers in several countries start to doubt the fairness of their countries' health insurance system, as they need to pay double health taxes - one for themselves and the other for other members of the society. This puts the sustainability of the hybrid model into question. Such theoretical debates should in the future supported by empirical evidence on health equity in financing health care.

Regardless of the models, a number of countries also encounter other challenges, including the cost escalation due to increasing

prevalence of chronic diseases and adoption of high-tech medical equipment, fiscal sustainability, fragmentation of schemes with multiple payers, public-private interface in health service
provision. Countries like Thailand also face the issue of self-selection, as beneficiaries with higher income level tend to opt not to receive universal coverage services due to long waiting time at public hospitals, although this is not considered as a negative factor for the sustainability of the universal health coverage.

There is no magic model that will help a country achieve universal health coverage. Nevertheless, there are three groups of factors that have been noted in countries that have successfully expanded coverage while managing to improve health outcomes and keeping costs under control: (i) institutional and societal factors; (ii) policy factors; (iii) implementation factors. The institutional and societal factors include strong and sustained economic growth, long-term political stability and sustained political commitment, strong institutional and policy environment, and high levels of education of the general population. Political commitment is key to the achievement of universal health coverage in both Taiwan and Thailand.

Key Issues of Resource Mobilisation for UHC

- UHC usually needs additional revenue, and as recommended by the 2010 World Health Report, efforts should be given to ensure value of money (efficiency) for such growth in health spending, equitable access and utilization of services
- Countries are taking a pragmatic approach based on context – there is no blueprint model. Usually, countries adopted a hybrid of general revenue, contributory schemes while at the same time also exploiting other innovative sources of revenue
- Continued concern about high level of out-of-pocket in financing healthcare in most low and middle income countries which result in limited access to care by those who cannot afford to pay, or catastrophic health spending and health impoverishment
- Countries should stride towards reducing fragmentation and problems in sustainability of development assistance for health
- Whatever sources of health financing, countries need to generate evidence on equity implications of these sources

Pooling and Purchasing

The session on “Giants Racing Towards UHC: Health Financing Reforms in China and India” is interesting. Both India and China are rapidly reforming their health systems including major financial reforms to achieve to UHC.

China has already achieved 97% population coverage and has done this at a very rapid pace over only a few years due to strong political and financial commitment. China has a high level of OOP as a percentage of household expenditure even with health insurance schemes so there is a need to expand benefit package coverage and minimize the level of copayment.

India’s path to UHC is a “rights-based” plan to gradually achieve universal coverage by 2020; while China is pursuing demand-side financial reform mechanisms, India plans to take on a supply-side financing approach. Since reforms are only just being implemented it is yet to be determined whether they will succeed. India has the largest unregulated private health sector in the world: How to regulate this rapidly expanding sector?

India has to overcome significant inter-state differences. China has 300 million urban migrant workers with no health insurance portability from the RCMS: how will China provide coverage for this large and highly mobile population group is challenging. China is improving its financial risk protection by expanding coverage to outpatient services, and has yet to minimize the great geographical variances of services utilization and across three insurance schemes.

India: The government is considering the 8 recommendations proposed by the High-Level Commission on UHC notably, increasing public expenditure on health, using general taxation, avoiding user fees, and providing access to free essential drugs.

China: To continue proceeding with 3 health insurance schemes: urban employees, urban residents, and new rural cooperative medical scheme. Their aim is to expand coverage for OPD and primary care, and to introduce various pre-payment mechanisms. The government is aware of and makes efforts in reducing fragmentation and gaps in the benefits package across the three schemes, and harnesses the power of Health Informatics to strengthen UHC coverage and monitoring. Both countries include monitoring and evaluation as they implement their UHC reforms. Evaluation will have to include evaluation of quality of care.

Provider payment methods (PPM) mainly relate to getting the incentives right to guide health provider behaviour to attain the objectives of efficient uses of scarce resources. However, there is also a requirement to consider the intensity of the financial incentives, their level, as well as other non-financial incentives. The underlying fundamental problem with setting the incentives relates to information asymmetry between healthcare providers and patients, whereby different PPMs send different signals and either deliver too many or too few services. The way hospitals and clinicians are paid is a major determinant of their behaviour and total costs associated with health care provision. However changing PPM is a major task that faces enormous resistance, in particular when the benefits of doctors and hospitals are challenged.

All types of PPM have potential perverse incentives that can trigger unwanted behaviour by healthcare providers. A mixture of different methods is often adopted. For example fee for services should not be applied for ambulatory care, as it stimulates unnecessary items of diagnostics, treatment and medicines, and thereby cost increases. However it can be useful to apply for preventive services such as cervical cancer screening.

The development and employment of sound monitoring and evaluation systems are required to guide the process of PPM changes and service purchasers and providers need to understand the cost implications of different provider payment methods and actively engage in the negotiation process. This should ensure that reforms are locally/country and evidence based driven and are accompanied by the required level of political support.

Key Messages of Pooling and Purchasing

- In the context of multiple insurance schemes, there is need to consolidate this fragmentation in order to minimize inequity across schemes, and allow portability of insurance coverage across schemes to ensure continued risk protection among members
- Active purchasing is an important determinant of efficiency and ensuring quality through purchasing power and contractual agreement between purchasers and healthcare providers
- There is a great opportunity to align provider payment with system objectives of assured quality, appropriate cost control, access to care and utilization of health services
- Information systems have a critical role in providing evidence for purchasers to play an active role in purchasing services
- The Conference highlights the needs for improved measurement and monitoring of quality of care

Service Provision

Significant discussion was given to the role of the private sector in UHC and whether it was in fact a blessing or a curse. In discussing the role of the private sector, a clear distinction was made between financing and provision roles. There was a general consensus from participants that the public sector should play the lead role in financing, due to problems associated with high OOP payments such as catastrophic health expenditure and impoverishment or barriers for the poor and vulnerable; and the weakness of private health insurance not covering the older people while higher health risk members are liable to more expensive premiums and lack of solidarity across the population group. But private health insurance could play a supplementary role to services not covered by the statutory schemes.

For provision, it was recognized that the private sector could play a potentially important role, depending on the country context and particularly the regulatory capacity of governments. It was noted that there is no clear evidence that the private provision performs better or worse than public provision.

Major Problems and Issues

A major problem identified in the service provision of UHC was weak primary care systems and referral systems and some discussion was devoted as to how strengthen them. Defining role of private providers in UHC and strengthening regulation of the private sector is deemed essential. The role of autonomy, decentralization of public services, developing quality standards, measurement, Continued Quality Improvement

(CQI), accreditation and improving the quantity, quality, and distribution of Human Resources for Health (HRH) were all seen to be essential aspects of service provision. Availability of functional health delivery systems are essential platforms for implementing UHC. The question of how to define the benefit package and extend coverage for better health financial risk protection over time with the application of Health Technology Assessment (HTA) needs consideration.

Key Messages for Service Provision

- In enabling a successful UHC implementation, it is critical to strengthen primary care and effective referral backups
- Better access and quality of health services determine success of UHC implementation
- Address health system strengthening in parallel with financing reforms in particular ensuring an adequate number and appropriate skill mix of health workforce, distribution of medicines, medical supplies and medical devices, as well as effective Health Information Systems
- Improved system efficiency will free resource and increase fiscal space for UHC
- A successful UHC implementation requires accountability and responsiveness of service providers to the local population, a major good governance indicator by purchasing organizations

The UHC Cube: Coverage of Costs, Population Groups and Benefits

UHC means that all people have access to needed health services with financial risk protection. The WHO defines Universal Health Coverage as “access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access. The principle of financial-risk protection ensures that the cost of care does not put people at risk of financial catastrophe” (World Health Assembly resolution 58.33, 2005). UHC can be conceptualized along three main dimensions (see the UHC cube): the level of population coverage, coverage of costs, and health service coverage. Each country must decide what their priorities are – whether it is to increase the proportion of the population that is covered, to enhance the level of financial protection, or to expand the coverage of health services, in order to best allocate the funds. The concept of UHC and these three main dimensions of UHC are further clarified in the World Health Report 2010.

The overall definition and understanding of universal coverage is generally shared. As a result, there is no need to reinvent the wheel and redefine the definition, which would cause confusion. The discussion, however, needs to focus on the appropriate level of emphasis that should be placed on these three aforementioned dimensions.

Coverage is often measured only in terms of the first dimension, based on existence of legislation, which fails to reflect whether quality health services are in fact accessible in terms of availability and affordability. For example, evidence from China, Vietnam and Rwanda show that an increase in population coverage does not always lead to better financial protection or better service provision. Population coverage in Rwanda increased from very low levels to 90% between the years 2000 and 2009, while the percentage of OOP expenditures decreased only from 61% to 59% during the same period. This reflects the small size of benefit packages covered or high level of copayment by members, or both. Therefore, an increase in population coverage does not always lead to financial protection and does not always guarantee needed health services. It is understandable of shallow coverage of benefit package to a large population size due to fiscal constraints. When there is larger fiscal space these countries are considering improving their financial health risk protection.

There are circumstances that leave people with no health insurance coverage, including travel, in-country and across country migration and change in employment status (self-employment, formal employment and unemployment). Three case studies were presented from China, South Korea and the Philippines.

Portability of financial risk protection problem occurs when people travel, migrate or change their employment status. For example, in China, 19.4% migrate within the country but 52% do not have health insurance coverage though they are fully covered by RCMS despite higher exposure to health risk environment. On the other hand, in South Korea, portability in terms of premium contribution (self-employed pay higher premium than the employed people) remains a problem as well as various ways that foreigners and Korean-Americans abuse the national health insurance system. For the Philippines, despite having established a health insurance program for Filipinos working abroad, portability in terms of premium payment and health benefits remain to be addressed.

There are many issues raised on the financial risk protection, health benefit packages, and the reimbursement process. The main question that needs to be addressed is how to design a portable health insurance that will provide financial risk protection regardless of one's employment status, residence or citizenship, especially when travelling or working abroad temporarily. Firstly, there is a need to reduce inequity in premium contribution

in terms employment status. For instance, in South Korea the employed sector pay less than the self-employed while the overseas Filipino workers contribute less than the poor families. Secondly, the health coverage for migrants, foreigners and stateless people has not been set up properly. As a result, they do not have regular access to health care. Thirdly, when different health insurance schemes are merged into one single fund, what is the best way to deal with the losers in this process? Lastly, what is the best way to standardize the benefits for migrants and non-migrants?

The informal economy is a very large economic system within which workers are not taxed or monitored by the government. Informal workers suffer different exposures to health risks and receive less income than formal workers. There are two main categories of informal workers. 1. Self employed workers in informal enterprises 2. Wage workers in informal jobs.

In order to ensure financial risk protection among migrants / employed/self-employed/overseas workers, the health insurance scheme should be set up with flexibility for enrollment, paying premiums, and reimbursement in order to provide seamless coverage to all beneficiaries whenever they move to another place within or outside the country or change their employment status.

Major Problems and Issues

- In view of methodological inadequacy, ineffectiveness and difficulties in identifying the poor or exempting the poor from user charges, universal enrollment of everyone eliminates these difficulties; however, the poor may not benefit initially from UHC due to various socio-cultural determinants
- When countries apply a targeting approach, they run the risk of creating a multi-tiered system for which the elites have good coverage, or vice versa, the poor get poorer services. The elites are a major resistance in moving towards UHC for fear of losing their privilege
- It is difficult to strike a balance between ensuring good protection (comprehensive benefit package) and equity, and maintaining financial sustainability
- Often there are inadequate regulatory capacities among purchasers. This is reflected by providers prescribing unnecessary care, resulting in rising cost for the scheme and hence increased insurance premium; the final risk is then transferred to beneficiaries
- Poor quality of care discourages enrollment and availing of the schemes
- UHC is a holistic approach. Providing financial risk coverage alone is not adequate, The supply side of health care

(health workforce, medicines, infrastructure etc.) need to be upgraded and expanded in order to facilitate successful implementation of UHC

Key Messages for Coverage of Costs, Population Groups and Benefits

- Several challenges were identified, for example, how to cover the sheer size of informal sector, as they don't have regular income for assessment of premium contribution, collecting premium from this group is costly, administratively difficult, and enforcement is difficult.
- How to identify and cover the poorest is a classic problem and evidence shows no effective instrument; universal enrolment is the answer, but constrained by fiscal capacity.
- The issues of portability require seamless coordination, information technology of membership across insurance schemes, and exchange of membership to ensure portability of coverage.
- There is a hard choice on the path to UHC, and the dilemmas were raised such as deepening risk protection versus the expansion of supply side capacities especially Primary Health Care, and the dilemma of targeted coverage versus universality. Country pragmatic decisions need to be based on socio-economic, political and cultural contexts
- Due to the inherit weakness, voluntary insurance is unlikely to reach high levels of population coverage, unless 'quasi-compulsory' such as the case of the Rwandan scheme
- Empowering beneficiaries – information on rights and benefits, and complaint handling put consumers on a level field with the healthcare providers
- Community Health Workers can be "agents for change"

Measurement and Learning

Many countries have set universal coverage through national policy or requirement by law and are moving towards UHC goals. Evidence-based policies that aim at achieving UHC call for the measurement of progress as compared to the baseline status. However, currently neither a globally agreed definition (unlike Millennium Development Goals (MDG) clear targets and goals, and measurement) of universal coverage and access to health services exists, nor conformity on methodologies for measuring and monitoring related developments.

Clearly, universal coverage is not a binary concept, i.e. whether or not the individual is covered, as everyone already has some kind of coverage. Therefore, the focus should not be only on expanding population coverage, but rather on narrowing the gaps in the benefit package between the poorer population and the formal sector employee. In the conference discussion, it was mentioned that universal coverage relates to other goals such as better health of the citizens, financial protection of individuals, protecting from poverty due to health payment, increasing equity, better health service quality and the efficient use of resources, among others. All of these goals can gradually be achieved as countries move towards UHC. With a clear set of goals in mind, the issue of how to measure and monitor UHC can become more evident. Furthermore, measuring and monitoring UHC ensures accountability and transparency and promotes learning by doing; “do and correct” at the same time. In this respect, UHC monitoring helps revise and fine-tune reform measures.

Challenges to Measurement and Learning

Each country must be able to assess where it currently stands relative to its goals, and must be able to measure and monitor whether it is moving in the desirable direction in order to assess the impacts of universal health coverage reforms. The challenge of each country is to find its balance of the three main dimensions of UHC, given its socio-economic and political context. Examples of such context include the national levels of poverty and the extent of the informal economy. These socio-economic backgrounds of a country are key determinants of UHC progress given their impact on the availability of funds from domestic resources, which are generated through taxes and contributions, and the technical feasibility to reach out to the excluded, in particular the sheer size of the informal sector.

One of the major challenges that each individual country faces in measuring and monitoring UHC is how to set a target for the volume of the "universal coverage box." This "box" reflects how the volume of pooled funds is spent among the three dimensions of universal coverage. Population coverage, as previously mentioned, can only be determined by connecting it to the other two dimensions. Therefore single indicator measures for each dimension may not capture the full picture. This raises a number of methodological questions, such as whether to aim for a single index or to propose a set of multiple indicators. If one aims for a single index, how should one combine different indices and how to weight the different components? Furthermore, apart from the technical methodological issues, the availability of data (or lack thereof) is another challenge in most low income countries.

Of the three dimensions in universal coverage, measuring the extent of health service coverage proves to be the most difficult. Coverage of health services should not only take into account the number of services covered, as the amount does not indicate the importance of the services. Coverage of health services must be set in relation to the actual needs of the population, which is more difficult to measure. There are thus a number of measurement challenges, particularly as to measuring need for specific health services (the denominator) against which to compare effective coverage for these services (enumerator).

There are equally questions around measuring financial protection. Indicators of affordability and financial protection may include OOP payments as a share of total health expenditure or the incidence of households experiencing catastrophic health expenditure. The share of non-poor households being impoverished due to health payment is

also an important indicator. In fact, falling into impoverishment may not be a result of only high OOP payments and catastrophic health expenditures, but may result from the lack of earning while absent from work due to illness. Related thereto, another indicator of financial protection that could be included is the existence of some form of income support when sick.

In conclusion, the conference discussion showed that the overall definition and understanding of universal coverage is generally shared, though there might be different emphasis on the different dimensions. Yet, the discussion pointed to the need to urgently come to a conceptual consensus on the measurement, not the least to effectively contribute to the discussion around the post-MDG agenda. There was not much focus on equity during the presentations, and it was proposed to put a stronger focus on indicators for equity in the UHC measurement, as universal coverage has an explicit notion of health equity.

While there is a need to harmonize measurement concepts, there is clearly no single road to achieve UHC. Ultimately, countries need to decide on their own set of indicators, particularly on their own indicator targets based on their socio-economic context and other constraints. These targets must reflect country-level characteristics. Finally, it was emphasized that there is no need for countries to wait for an international consensus to undertake their own UHC measurement over time. Ultimately, countries need to invest and develop in their monitoring systems and set up sound data collection mechanisms.

Key Messages for Measurement and Learning

- Good measurement is essential to make case for UHC, for its design, and to adapt it over time
- It is important to harmonize definitions, and measure progress against the baseline
- Further work is needed on defining and measuring various sets of indicators of UHC
- Countries need institutions and capacity for ICT, monitoring and evaluation
- Need to strengthen links between research and policymaking communities
- Need to strengthen learning within and across countries. A joint learning platform across countries is a useful forum for sharing and learning

Conclusions

- All countries can move closer to UHC no matter the level of economic development; a country may give priority to provide financial risk protection for the poor and vulnerable
- Keep building and sustaining commitment, generate evidence and keep the momentum for UHC
- It is a legitimate and the key priority to protect the poor and the vulnerable
- In this Conference, we have learned a lot, but also there is a need to keep learning and sharing across countries


PRINCE MAHIDOL AWARD CONFERENCE 2012
PRINCE MAHIDOL AWARD CONFERENCE 2012
JICA

Bangkok Statement on Universal Health Coverage

28 January 2012

We, Ministers of Health and the participants of the Prince Mahidol Award Conference 2012, "Moving Towards Universal Health Coverage: Health Financing Matters", gathered in Bangkok, Thailand on 24-28 January 2012, learned and shared experiences among governments, academia, civil society, private sector and development partners;

1. Concerning one billion people worldwide do not have access to healthcare, 150 million people face catastrophic healthcare costs each year because of direct payments for healthcare, while 100 million are driven below the poverty line; thereby contributing to avoidable morbidity and premature mortality, aggravating inequity and impeding sustainable social and economic development;

2. Recalling global evidence of and advocacy for universal health coverage, in particular the 2010 World Health Report and the World Health Assembly Resolution 64.9 in May 2011 on Sustainable Health Financing Structures and Universal Health Coverage;

3. Recognizing that universal health coverage with progressive and sustainable funding sources, comprehensive benefit package, primary health care approach, where all people can use the health services they need without fear of being impoverished because of payments, is a fundamental instrument in realizing the right to health, enhancing health and societal equity, promoting social cohesion and sustainable human and economic development;

4. Underlining the valuable contribution of universal health coverage towards achieving health-related Millennium Development Goal 1, to eradicate extreme poverty and hunger; Goal 4, to reduce child mortality; Goal 5, to improve maternal health; Goal 6, to combat HIV/AIDS, malaria, TB and other diseases and Goal 8, to develop a global partnership for development; and the achievement of wider social policy objectives as set out by the Joint UN Social Protection Floor Initiative;


PRINCE MAHIDOL AWARD CONFERENCE


INDIA
AUSTRALIA

5. Recognizing the essential contributions of resilient and responsive health systems with extensive geographical coverage of good quality primary health care services, adequate number and skill of health workforce, to the effective implementation of universal health coverage;

6. Recognizing the needs for strengthening institutional capacity of health policy and systems research in generating robust evidence to inform policy and systems design, routinely monitoring, periodically evaluating and continuously fine-tuning policies, and the ability to adapt to changing circumstances over time; sharing country experiences and facilitating North-South and South-South collaborations;

7. Recognizing that each country can start providing financial risk protection to several target populations, taking into account harmonization across different schemes and gradually accelerate progress towards universal health coverage is possible even at a low level of socio-economic development, provided that there are strong, continued and sustained political and financial commitments by successive governments as well as support from civil society, communities and international development partners;

8. Recognizing that predictable long term support from development partners, in line with the principles of the Paris Declaration and Accra Agenda for Action is important to facilitate universal health coverage in particular in resource poor countries;

9. AGREE to work together and with others across sectors and disciplines in translating policy intentions, guided by evidence, into concrete actions that make universal health coverage a reality and to ensure better health for all;

10. COMMIT ourselves to raise universal health coverage on the national, regional and global agendas, and to advocate the importance of integrating it into forthcoming United Nations and other high-level meetings related to health or social development, including the United Nations General Assembly, and promoting its inclusion as a priority in the global development agenda.







ANNEX I International Organizing Committee Members

No.	Name	Position / Organization	Role
1.	Dr. Vicharn Panich	Chairman, Mahidol University Council	Chair
2.	Dr. Carissa F. Etienne	Assistant Director-General, World Health Organization	Co-chair
3.	Dr. Cristian Baeza	Director, Health, Nutrition & Population, Human Development Network, The World Bank	Co-chair
4.	Mr. Kiyoshi Kodera	Vice President, Japan International Cooperation Agency	Co-chair
5.	Dr. Lincoln Chen	President, China Medical Board	Member
6.	Dr. Ariel Pablos-Mendez	Managing Director, The Rockefeller Foundation	Member
7.	Dr. David de Ferranti	President, Results for Development Institute	Member
8.	Dr. Keizo Takemi	Research Fellow, Japan Center for International Exchange	Member
9.	Dr. Xenia Scheil-Adlung	Health Policy Coordinator, The International Labor Organization	Member
10.	Dr. Athula Kahandaliyanage	Director of Health Systems Development, World Health Organization Regional Office for South-East Asia	Member
11.	Dr. Matthias Rompel	Head of Section, Social Protection, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH	Member
12.	Dr. Kalipso Chalkidou	Director, National Institute for Health and Clinical Excellence	Member
13.	Ms. Bridget Lloyd	Coordinator, People's Health Movement	Member
14.	Dr. Paijit Warachit	Permanent Secretary, Ministry of Public Health, Thailand	Member
15.	Mr. Theerakun Niyom	Permanent Secretary, Ministry of Foreign Affairs, Thailand	Member
16.	Dr. Supat Vanichakarn	Secretary-General, Prince Mahidol Award Foundation	Member
17.	Dr. Winai Sawasdivorn	Secretary-General, National Health Security Office, Thailand	Member
18.	Dr. Piyasakol Sakolsatayadorn	President, Mahidol University, Thailand	Member
19.	Dr. Teerawat Kulthanan	Dean, Faculty of Medicine Siriraj Hospital, Mahidol University,Thailand	Member
20.	Dr. Suwit Wibulpolprasert	Senior Advisor on Disease Control, Ministry of Public Health, Thailand	Member
21.	Dr. Viroj Tangcharoensathien	Senior Public Health Expert (Health Economics), Ministry of Public Health, Thailand	Member
22.	Dr. Pongpisut Jongudomsuk	Director, Health Systems Research Institute, Thailand	Member
23.	Dr. Sopida Chavanichkul	Director, International Health Bureau, Ministry of Public Health, Thailand	Member
24.	Dr. David Evans	Director, Health Systems Financing, World Health Organization	Member & Secretary
25.	Dr. Churnrurtai Kanchanachitra	Vice President for Collaboration and Networking, Mahidol University, Thailand	Member & Secretary
26.	Dr. Toomas Palu	Lead Health Specialist, The World Bank, Vietnam	Member & Secretary
27.	Dr. Achra Sumboonnanonda	Deputy Dean for Academic Affairs, Faculty of Medicine Siriraj Hospital, Mahidol University, Thailand	Member & Secretary
28.	Mr. Yojiro Ishii	Deputy Director General, Human Development Department, Japan International Cooperation Agency	Member & Secretary


Jiuping Sheng
Juan Pablo Uribe


Dalipada


PRINCE MAHIDOL AWARD CONFERENCE


PRINCE MAHIDOL AWARD CONFERENCE

ANNEX II Conference Speakers / Panelists, Chairs / Moderators and Rapporteurs

Speaker / Panelist	Chair / Moderator	Rapporteur
Keynote Session		
Ruth Bishop		Seye Abimbola
Vashaben Thakor		Rungsun Munkong
		Sirinya Pulkerd
Plenary Session 1: Universal Health Coverage: Utopia or Mirage to Human Development?		
Peter Anyang' Nyong'O	Toomas Palu	Raoul Bermejo III
Fran Baum		Lara Brearley
Daniel Cotlear		Passawee Tapasanan
Carissa Etienne		
Tien Nguyen Thi Kim		
Keizo Takemi		
Plenary Session 2: The Complex Nexus: Political Will, Civil Society and Evidence in Achieving UHC		
Timothy Grant Evans	Michael Cichon	Gina Lagomarsino
Heather Grady		Areekul Puangsuwan
David Legge		Amal Shafik
Bheki Ntshalintshali		Jenpicha Cheva-Isarakul
Jon Ungpakorn		
Parallel Session 2.1: Raising More Domestic Resources for Health		
Seng Eun Choi	Poonam Singh	Jittinan Aukayanagul
Jean Pierre Mbeng Mendou	Joseph Kutzin	Claude Meyer
Anne Mills		Chanwit Tribuddharat
P.A. Nitiema		
Kotsaythoune Phimmasone		
Hasbullah Thabrany		
Parallel Session 2.2: Role of Development Assistance in Universal Coverage		
Rifat Atun	Robert Emrey	Michael Adelhardt
Stephen Kido Dalipada		Maki Ozawa
Lal Shanker Ghimire		Natalie Phaholyothin
Eva Jarawan		
Veasna Kiry Lo		
Ingvar Theo Olsen		
Wim de Ceukelaire		
Parallel Session 2.3: Macroeconomics and Universal Health Coverage		
Walaiporn Patcharanarumol	Adam Wagstaff	Akhnif El Houcine
Baoping Shang		Robert Marten
Juan Pablo Uribe		Tanavij Pannoi
Parallel Session 2.4: Governance Structure and Institutional Capacities in Advancing UHC		
Eduardo P. Banzon	Mushtaque Chowdhury	Por Ir
Valeria de Oliveira Cruz		Kanang Kantamaturapoj
Andrew Makaka		Kanokwaroon Watananirun
Qingyue Meng		
Ikuo Takizawa		
Wim Van Damme		
Lara Brearley		

ANNEX II Conference Speakers / Panelists, Chairs / Moderators and Rapporteurs

Speaker / Panelist	Chair / Moderator	Rapporteur
Parallel Session 2.5: Voice of the People		
Sam Adjei	David Sanders	Iyarit Thaipisuttikul
Matthew Anderson		Luc Van Leemput
Orajitt Bumrungskulswat		
Douglas Munoreveyi Gwatidzo		
Abhay Shukla		
Parallel Session 2.6: The Role of the Private Sector in Universal Health Coverage: a Blessing or a Curse?		
Jane Dohert	Ravindra Rannan-Eliya	Christopher James
Gustavo Nigenda-Lopez	Marie-Gloriose Ingabire	Manasigan Kanchanachitra
Sakthivel Selvaraj		Rapeepong Supanchaimatr
Robert Yates		
Plenary Session 3: Pathways to UHC: Debates on Critical Policy Choices		
Peter Berman	David de Ferranti	Baktygul Akkazieva
Naoki Ikegami		Cha-aim Pachanee
Pongpisut Jongudomsuk		Inthira Yamabhai
Nathaniel Otoo		Thidaporn Jirawattanapisal
Kanuru Sujatha Rao		
Parallel Session 3.1: Defining, Measuring and Monitoring Universal Health Coverage		
Tan-Torres Edejer	Ariel Pablos-Mendez	Trassanee Chatmethakul
Ainura Ibraimova	Apiradee Treerutkuarkul	Manasigan Kanchanachitra
Xenia Scheil-Adlung		Inke Mathauer
Adam Wagstaff		
Parallel Session 3.2: Voluntary Insurance Schemes: What Lessons for Low- and Middle-Income Countries Seeking to Cover the Informal Sector?		
Solène Favre	Marty Makinen	Jean-Marc Thome
Yogesh Rajkotia		Vuthiphan Vongmongkol
Yemale Tiawara		Orn-anong Waleekhachonlert
Fadhili Chacha Marwa		
Matar Camara		
Parallel Session 3.3: Beyond Bismarck and Beveridge: Lessons from Hybrid Financing to Cover a Billion People		
John Langenbrunner	Toomas Palu	Juthaporn Assawachananont
Jui-fen Rachel Lu		Por Ir
Ammar Siamwalla		Sutayut Osornprasop
Parallel Session 3.4: Reaching and Protecting the Poor in Low Income Countries: What Challenges?		
Mursaleena Islam	Daniel Cotlear	Bart Jacobs
Chansaly Phommavong		Parunyou Julayanont
Fredrick Ssengooba		Taro Kikuchi
Parallel Session 3.5: Portability of Financial Risk Protection Across Schemes, Across Borders		
David B. Evans	Richard Smith	Leizel Lagrada
Qingyue Meng		Tanapat Laowatutanon
Alexander De Las Alas Padilla		Aungsumalee Pholpark
Bong-Min Yang		
Parallel Session 3.6: Universal Health for the Working Poor: Barriers to Access		
Laura Alfers	Francie Lund	Luc Van Leemput
Chris Atim		Jirawat Panpiemras
Mirai Chatterjee		Jutamas Saoraya
Kalpana Jain		Isidore Sieleunou
Boonsom Namsomboon		

Speaker / Panelist	Chair / Moderator	Rapporteur
Plenary Session 4: Achieving Universal Coverage: a Key Role of Health Systems		
Evelyn Korkor Ansah Narayanan Devadasan Samrit Srithamrongsawat Andrei Usatii	Carissa Etienne	David Hercot Rapeepun Jommaroeng Mariyam Suzana
Parallel Session 4.1: Measuring the Impact and Outcome of Universal Coverage		
Peter Annear Supon Limwattananon Yogesh Rajkotia Peter C. Smith Van Tien Tran	Masato Mugitani David B. Evans	An Appelmans Chalermpol Chamchan Moe Ko Oo
Parallel Session 4.2: Resource Scarcity, Efficiency and Coverage with Health Services		
Kara Hanson Rozita Halina Tun Hussein Naoki Ikegami Manuel Inostroza Palma Winai Sawasdivorn	Tan-Torres Edejer	Sarbani Chkraborty Pennapa Kaweewongprasert Thinakorn Noree
Parallel Session 4.3: Provider Payment: Aligning Proper Incentives and Efficiency		
Irene Agyepong Martin Edgar Braun Ainura Ibraimova Christopher D. James Joseph Kutzin Qingyue Meng	Cheryl Cashin	Charamporn Holumyong Bart Jacobs Noppakun Thammathach-aree
Parallel Session 4.4: Using Financing as a Platform for Quality Improvement		
Pierre Barker Gerard La Forgia Mei-Shu Lai Yogan Pillay Anuwat Supachutikul	Kalipso Chalkidou	Sawarai Boonyamanond Kari Hurt
Parallel Session 4.5: Ageing Populations: What Challenges for Health Financing?		
Hideki Hashimoto Ajay Mahal Christian Peters	Daniel Cotlear	Valeria de Oliveira Cruz Zurnila Marli Kanjana Tisayaticom
Parallel Session 4.6: Giants Racing Towards UHC: Health Financing Reforms in China and India		
Mirai Chatterjee Wen Chen Srinath Reddy Kolli John Langenbrunner Anne Mills	Robert Hecht	Joanne McManus Natalie Phaholyothin Thananan Ratnachotpanich
Plenary Session 5: Ministerial Round Table: Advancing UHC Agenda		
Peter Anyang' Nyong'O Surawit Konsomboon Aaron Motsoaledi Ali Ghufron Mukti Enrique T. Ona Andrei Usatii	Lincoln Chen	Wilfred Gurupira Joanne McManus Yuttapong Wongswadiwat

Lead Rapporteur Team	Rapporteur Coordinator
David Evans Jeff Johns Timothy Johnston Anne Mills Viroj Tangcharoensathien	Walaiporn Patcharanarumol

ANNEX III List of Side Meetings and Toolkit Sessions

Monday 23 January 2012

08:30 – 17:00	Universal Health for the Working Poor: Barriers to Access by WIEGO and HomeNet Thailand (Continue on 24 Jan)
08:30 – 17:30	Leveraging Universal Health Initiatives to Achieve High Quality Care by The Institute for Healthcare Improvement, partnering with NICE International (Continue on 24 Jan)
09:00 – 17:00	Providing for Health (P4H) - Moving together towards universal coverage and social health protection WHO in collaboration with ILO, World Bank, France, Germany, Spain and Switzerland

Tuesday 24 January 2012

08:30 – 16:30	Results-Based Financing: good results or just a lot of hype? A critical review of what we know so far by The World Bank
09:00 – 12:00	Asia Pacific Observatory on Health Systems and Policies by WHO/WPRO on behalf of the APO
09:00 – 12:30	Ten Years Assessment of the Thai Universal Coverage Scheme by Health Systems Research Institute (HSRI)
09:00 – 12:30	Shaping health financing institutional design for universal coverage by World Health Organization
09:00 – 12:30	Health expenditure tracking: what is new? By World Health Organization, USAID/HS2020
09:30 – 12:30	Mobilising for Health: Challenging Power Relations by People's Health Movement
09:00 – 15:00	Harmonizing health insurance information system standards – sharing tools and strategies by PATH and Pharm Access
09:00 – 16:30	Evidence-informed resource allocation, health technology assessment (HTA) and basic package of care: the missing link by Health Intervention and Technology Assessment Program (HITAP) Thailand, Center for Global Development (CGD) USA, NICE International, UK
09:00 – 17:00	Measuring and monitoring health equity: application of ADePT by The World Bank, International Health Policy Program (Thailand)
09:00 – 17:00	Universal Health for the Working Poor: Barriers to Access by WIEGO and HomeNet Thailand (Continue from 23 Jan)
09:00 – 17:00	Leveraging Universal Health Initiatives to Achieve High Quality Care by The Institute for Healthcare Improvement (IHI), partnering with NICE International (Continue from 23 Jan)
13:30 – 17:00	Capitation and DRG: how to session by National Health Security Office (Thailand)
13:30 – 17:30	Launch Seminar of the Japan–World Bank Partnership Program: Challenges and Opportunities for Achieving Universal Health Coverage by Japan Center for International Exchange (JCIE), Japan International Cooperation Agency (JICA) and The World Bank

13:30 – 17:30	OneHealth tool for strategic planning and costing in health by World Health Organization
14:00 – 17:00	Emerging Voices for Global Health about health systems research mapping in low and middle income countries: Health Systems Research, Knowledge Management and Capacity Building by The Institute of Tropical Medicine, Belgium (ITM)
16:30 – 19:30	'Good health at low cost' 25 years on – what makes an effective health system? By International Health Policy Program (IHPP), Ministry of Public Health, Thailand and London School of Hygiene & Tropical Medicine (LSHTM)
18:00 onwards	Regional Asian Network for Health Professional Education in 21st Century by 5 Countries for HRH Education Network

Thursday 26 January 2012

17:30 – 19:00	AAAH Steering Committee Meeting by AAAH Secretariat

Friday 27 January 2012

07:00 – 09:00	UHC Global Advocacy Working Group by World Health Organization
07:30 – 09:00	Global HRH Movement and the Way Forward by International Health Policy Program Thailand
18:00 onwards	Expert-level meeting of the Foreign Policy and Global Health Initiative by Ministry of Public Health, Thailand

Saturday, 28 January 2012

7:30 – 9:00	Prince Mahidol Award Conference 2014 by PMAC Secretariat

Printed by :

The Graphico Systems Co., Ltd.

119/138 Moo 11, The Terrace, Soi Tiwanon 3, Tiwanon Rd., Talad Kwuan, Muang Nonthaburi, Nonthaburi 11000, Thailand.

Tel : +66 2525 1121, +66 2525 4669-70 Fax : +66 2525 1272 E-mail : graphico_sys@yahoo.com

For further information, please contact

PRINCE MAHIDOL AWARD CONFERENCE SECRETARIAT OFFICE

INSTITUTE FOR POPULATION AND SOCIAL RESEARCH MAHIDOL UNIVERSITY

Salaya, Nakhon Pathom, 73170, Thailand
tel: (66) 2441-0203 ext 627 or 628
fax: (66) 2441-9333
e-mail: pmaconference@mahidol.ac.th
website: www.pmaconference.mahidol.ac.th