GLOBAL HEALTH 2035

A World Converging within a Generation

POLICY REPORT

Implementing Pro-Poor Universal Health Coverage

Lessons from country experience

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CONTENTS

ABBREVIATIONS

CEA   cost-effectiveness analysis

DAH   development assistance for health

ECEA   extended cost-effectiveness analysis

FP   financial protection

GDP   gross domestic product

HBPs   health benefit plans

HICs   high-income countries

HSS   health systems strengthening

JLN   Joint Learning Network

LICs   low-income countries

LMICs   lower-middle-income countries

M&E   monitoring and evaluation

MICs   middle-income countries

NCDs   non-communicable diseases

NGO   non-governmental organization

OOP   out-of-pocket

NHAs   national health accounts

P4P   pay for performance

RBF   results-based-financing

SDGs   Sustainable Development Goals

UHC   universal health coverage

UMICs   upper-middle-income countries

USAID   United States Agency for International Development

WHO   World Health Organization

EXECUTIVE SUMMARY

Background

Universal health coverage (UHC)—ensuring that everyone has access to quality, affordable health services when needed—can be a vehicle for improved equity, health, financial well-being, and economic development. In its 2013 report, *Global Health 2035*, the Commission on Investing in Health (CIH) made the case that progressive ("pro-poor") pathways towards UHC, which target the poor from the outset, are the most efficient way to achieve both improved health outcomes and increased financial protection (FP). Countries worldwide are now embarking on health system changes to move closer to achieving UHC, often with a clear pro-poor intent. While they can draw on guidance related to the technical aspects of UHC (the "what" of UHC), such as on service package design, there is less information on the "how" of UHC—that is, on how to maximize the chances of successful implementation.

Motivated by a shared interest in helping to close this information gap, a diverse international group of 21 practitioners and academics, including ministry of health officials and representatives of global health agencies and foundations, convened at The Rockefeller Foundation's Bellagio Center for a three-day workshop from July 7–9, 2015. The participants shared their experiences of implementing UHC and discussed the limited evidence on how to implement UHC, focusing on a set of **seven key "how" questions** from across five domains of UHC (Figure 1).

Key lessons

Generating and sustaining political will for pro-poor UHC requires acting when a window of opportunity opens. Examples of such policy windows include *crises* (e.g. the economic crisis in Argentina in 2001–2002 and the 2002–2003 SARS crisis in China were important factors in building political will for UHC); (2) the *widespread realization of the harms of existing health policy* (e.g. the harms of user fees); or (3) a country's *poor performance* in an international ranking exercise on health outcomes. Pushes to drive UHC up the political agenda during election years can be particularly effective. Other factors that can promote political will include using ethical and legal arguments to frame the need; enlisting support of the ministry of finance (especially by using the argument that UHC promotes social and fiscal stabilization); preventing the process from being captured by one political party over another; and actively managing and countering the opposition.

Engaging civil society in supporting UHC begins with a strong commitment to accountability and to open, two-way communication. Citizens want access to health care that is available, affordable, and of high quality, and are increasingly vocal about their demands; as such, for advocates of UHC within and outside government, citizens are the "ultimate resource." There needs to be a strong high level voice in government (e.g. head of state, cabinet, parliamentary committee) who can respond to public demands. UHC

Figure 1. Implementing UHC: 7 "how" questions

Political and public engagement	Generating and using evidence	Expanding UHC	Promoting quality and efficiency	Fostering international collective action
Q1. How can political will for UHC be generated and sustained? **Q2**. How can civil society be engaged in supporting UHC and pushing for more rapid progress?	**Q3**. How can information be generated/used to support implementation of UHC? **Q4**. How can coverage with financial protection (FP) & needed health services be measured, monitored, and maintained especially among the poor?	**Q5**. How best can countries manage the evolution and growth of service coverage and forms of FP?	**Q6**. How can countries use incentives to improve the quality & efficiency of health services, whether provided directly or purchased externally?	**Q7**. How can international collective action best support country efforts towards UHC?

advocates should not assume that all non-governmental organizations (NGOs) are supportive—NGOs that provide or advocate for specific types of services, for example, may be opposed if they fear that broader UHC reforms might reduce their funding or exclude them from service provision.

Generating and using information to guide UHC must include a commitment to publish and disseminate existing information, such as on health benefit plans (HBPs, defined as pre-determined, publicly managed lists of guaranteed health services). The lack of documentation and information sharing is a barrier to country progress, and to cross-country learning. However, even when there is little evidence to guide UHC implementation, countries should move forward, monitoring progress and adjusting their approach in light of these data. Citizens' values and preferences should be elicited as a crucial component in generating information.

Measuring, monitoring, and maintaining FP and high levels of effective coverage of needed health services has been the focus of recent joint work between the World Bank and WHO in preparation for the post-2015 development agenda that includes UHC as one of the health targets. The FP component has also been the subject of recent economic research, which has led to the development of new assessment tools. For example, extended cost effectiveness analysis (ECEA) can help health planners to compare the health and FP impacts of different health interventions. FP monitoring is best achieved by conducting reliable household expenditure surveys every 2 to 5 years. National Health Accounts (NHAs), which track public and private expenditure flows in the health sector, can be a valuable tool in monitoring FP—particularly time series NHAs. But NHAs are under-used in many low-income countries (LICs) and middle-income countries (MICs). The recent rise in interest in UHC worldwide could be a window of opportunity to make the case for increased investment in NHAs.

The evolution and growth of service coverage and FP can be greatly aided by the use of national health technology assessment (HTA), which is based on an explicit decision-making process. This process can help to identify and engage with key stakeholders and outline rules for reaching a decision, which in turn can support the government in its evidence-based decision-making and in managing political pressures. HTA agencies or experts can also help in translating global agendas into national agenda-setting and in showing the value of specific health investments, making the case for these investments to the ministry of finance. Assessing the levels and degree of service fragmentation is an important component in managing UHC

growth. All countries should be able to achieve a greater degree of harmonization, pooling, and cross-subsidization (from rich to poor and from healthy to sick) even if fully merging all schemes is not feasible. Strong leadership is crucial in this process, particularly when it comes to trying to align different institutions and resources and especially in federal states such as Ethiopia.

To incentivize provider quality and efficiency, including the quality and efficiency of health insurance where it is being implemented, paying for performance can have a moderate effect on clinical quality measures, though direct incentives have not been found in studies to improve efficiency. There are four important lessons related to payment systems: (i) ensure that public health purchasers have the mandate and accountability to purchase quality services for the population with FP; (ii) strengthen integrated service delivery networks to align incentives across different levels of care; (iii) create the right balance of autonomy and accountability for providers to respond to incentives and serve the public interest; and (iv) use information to understand, motivate and improve provider performance.

International collective action can best support pro-poor UHC efforts by adopting a much stronger "country lens" and supporting domestic agendas, such as through provision of technical assistance; capacity building (including building in-country analytic capacity); knowledge generation and sharing; information management; and support for measurement. There is also an important role for international networks of cross-learning and for communities of practice. One crucial way in which international collective action can support pro-poor UHC is for development assistance for health (DAH) to be increasingly shifted towards the "global functions" of global health, such as providing global public goods (e.g. research and development, knowledge generation and sharing) and fostering leadership and stewardship of the global health system.

Conclusions and future directions

Four major cross-cutting themes emerged from the workshop that can help guide future work on the "how" of UHC:

- Implementing pro-poor UHC is an inherently political process at all stages. A better understanding of this process could form the basis of a "political economy toolkit" to help reformers take advantage of policy windows and to negotiate with diverse constituents, including opponents. National HTA, based on an explicit decision-making process, can help with stakeholder engagement and with managing political pressures.

- Citizens are increasingly vocal in their demands for UHC, and yet their support has not been fully tapped by health reformers. One strong theme emerging from the Bellagio meeting is the importance of engaging citizens at multiple points, including in decisions about HBPs.

- Insufficient documentation and sharing of information on UHC reforms currently hinders implementation. One tool that could be helpful is an online "living" guide on the "how" questions, one that is regularly updated and adjusted over time as new country experiences (both positive and negative) are shared. International networks of cross-learning and communities of practice will become increasingly important in tackling the "how" questions.

- A new kind of international collective action will be needed to support countries to achieve UHC, with the focus shifting away from donors and towards ministries of health and finance and their domestic agendas. In the post-2015 era, it will become increasingly important for donors to fund the neglected "global functions" of global health, particularly research and development (including policy and implementation research on pro-poor UHC). One of the most important ways that the international community can support countries is to assist with building capacity in information management and measurement, for example creating health information systems that can reliably monitor progress in maintaining FP and high levels of effective coverage.

1. BACKGROUND

Poised to be a central component of the global health framework in the Sustainable Development Goals (SDGs) era, universal health coverage (UHC) can be a vehicle for improving equity, health, and the financial well-being of households. It can also help to foster human and economic development. Margaret Chan, Director General of the World Health Organization (WHO), has called UHC the "single most powerful concept that public health has to offer."[i] Ariel Pablos-Méndez, Assistant Administrator for Global Health at the US Agency for International Development (USAID), has said that "UHC is a testimonial to the power of ideas to change the world."[ii]

Questions central to UHC—such as which health services to guarantee, how to pay for them, and how to most effectively deliver them—have faced governments since the earliest days of national health reforms. More recently, attention has also focused on how UHC can ensure financial protection (FP). Each year 150 million people suffer health-related financial catastrophe,[iii] and 100 million people are pushed into poverty as a result of out-of-pocket health expenditures (Xu et al, 2007). The 2015 joint World Bank/WHO report *Tracking Universal Coverage* estimated that in 2013 at least 400 million people lacked access to health services. The report also found that in the same year, 6% of people in LICs and MICs were "tipped or pushed further into extreme poverty ($1.25/day) because they had to pay for health services out of pocket." The poor are the most at risk of the adverse financial consequences of health expenditures and disproportionally suffer from inadequate access to high quality health services (Kruk et al, 2009). Health economists have long been concerned about FP, while public health professionals have long been concerned with access to needed services—UHC has brought these two concerns together and heightened their interdependence.

Gwatkin and Ergo (2011) coined the term "progressive universalism" to describe the pursuit of steps towards UHC that seek to protect the poor from the outset. As they describe it, progressive universalism has at its center "a determination to ensure that people who are poor gain at least as much as those who are better off at every step of the way toward universal coverage, rather than having to wait and catch up as that goal is eventually approached." Examples of steps to protect the poor from the outset include ensuring that coverage packages target diseases that disproportionately affect the poor, prohibiting the exclusion of the poor (and those in poor health) from insurance plans, and exempting the poor from paying user fees[iv], insurance premiums, or copayments.

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Box 1: Two progressive pathways proposed by the CIH that countries can take towards UHC

In the first pathway, public funds from general taxation, payroll taxes, or both, cover an initially narrow set of essential health interventions. An example would be interventions to achieve "a grand convergence" in maternal, child, and infectious conditions and a basic package of best-buy interventions to tackle non-communicable diseases (NCDs). This pathway directly benefits the poor, as they are disproportionately affected by these health conditions. The second pathway specifies a larger benefit package from day one, funded through a wider range of financing mechanisms, such as mandatory premiums and co-payments, with poor people exempted from these payments. The poor are covered through public funds (e.g. they do not pay any contributions to the "insurance").

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The *Lancet* Commission on Investing in Health (CIH)[v] in its 2013 report, *Global Health 2035: A World Converging within a Generation* (GH2035),[vi] endorsed the call for progressive

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i   See http://www.who.int/dg/speeches/2013/universal_health_coverage/en.
ii Opening session, Bellagio Workshop on Pro-Poor UHC, July 7, 2015.
iii Where "financial catastrophe" was defined as devoting over 40% of non-food spending to out-of-pocket health expenses (Xu et al. 2007).

iv User fees can be defined as "fee-for-service charges at the point of care without the benefit of insurance" (Jamison et al, 2013).
v   Chaired by Lawrence H. Summers and co-chaired by Dean T. Jamison. The list of 25 CIH Commissioners is at www.globalhealth2035.org.
vi See www.globalhealth2035.org for links to the report, accompanying appendices, editorials, and background working papers.

universalism, making the case that progressive ("pro-poor") pathways[vii] towards UHC, which target the poor from the outset, are the most efficient way to achieve both improved health outcomes and increased FP. GH2035 proposed two progressive pathways towards UHC (Box 1). In both, coverage is universal: everyone, not only the poor, is assured that they will have access, if needed, to the same set of guaranteed services.

Countries around the world are now embarking upon health system changes that move them closer to achieving UHC, following the path that high-income countries took some decades ago. In many cases, they are doing so with a clear intent to be pro-poor. There is increasing agreement that a universal—rather than targeted—approach to UHC is the best way forward in most settings (Nicholson et al, 2015).

There is a growing empirical literature on technical aspects of UHC. This literature addresses what we call "the what" of UHC, meaning *what* steps countries have taken or are currently taking, and what steps technical experts have recommended, with regards to five core UHC action areas: (1) setting and expanding guaranteed services; (2) developing health financing systems to fund guaranteed services and ensure FP; (3) ensuring quality service availability and delivery; (4) improving governance and management of the health sector; and (5) strengthening other aspects of health systems to advance toward UHC. Less well understood, however, are the best strategies to address some of the most difficult and sensitive challenges to achieve UHC.[viii] There is a lack of information on what can be called

the "how" questions, i.e. those related to how to maximize the chances of implementation success. For example, how have some countries managed to push UHC to the top of the political agenda? How did they build and sustain political commitment for UHC over time?

This lack of information on the "how" of UHC is due in part to the heterogeneity of country institutions and experiences, and in part to the non-linear process through which countries implement health system reforms. There are often stops and starts that are influenced by politics, administrative and technical challenges, and resource constraints—as well as the ever-evolving fiscal and political environments in which UHC decisions are made (Stefan Nachuk, personal communication).

The arguments for pursuing UHC have been well documented—see, for example, WHO (2010), Maeda et al (2014), WHO (2014), World Bank and WHO (2014), Nicholson et al (2015). These arguments were not the focus of the Bellagio workshop. There was agreement among the participants that (i) taking a pro-poor approach towards UHC is *technically feasible*, and (ii) the anticipated economic growth of LICs and MICs, documented in GH2035,[ix] will mean that it will be *financially feasible* for many countries to fund UHC mostly from domestic sources. The obstacles, and opportunities, are more likely to be political and institutional, an "interplay of institutions, ideas, and interests" (John, 1998)—it is these obstacles and opportunities that were the focus of the Bellagio workshop.

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vii   We have opted not to use the term "pathway" in this paper, as it implies that there are normative unidirectional ways towards UHC. Yet each country starts from its own circumstances—historical circumstances within and outside of the health sector, political commitment, fiscal depth, analytical capacity, and system discipline to respond to decisions that are made at the top. Thus we have instead chosen to use terminology that recognizes the unique nature of each country-specific setting, e.g., "steps towards UHC" or "interventions that strengthen UHC that proactively benefit/protect the poor."

viii Nicholson and colleagues (2015) recently called for "more attention and research...(to) be devoted to the practical issues of UHC implementation."

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ix   The CIH estimates that LICs are on course to add about $0.9 trillion to their annual GDP by 2035, and lower MICs are on course to add around $9 trillion by the same year. These estimates are based on projections that forecast real GDP growth per year of 4.5% for LICs and 4.3% for lower MICs from 2011 to 2035. Additional sources of domestic revenue that could help to fund UHC include taxation of tobacco and alcohol and redirecting fossil fuel subsidies to the health sector.

2. THE BELLAGIO WORKSHOP: HELPING TO ADDRESS THE INFORMATION GAP

Motivated by a shared interest in addressing the information gap on the "how" of implementing UHC, a diverse international group of 21 practitioners and academics (Annexes 1 and 2) convened at The Rockefeller Foundation's Bellagio Center for a three-day workshop. The group comprised representatives from government, foundations, donor agencies, universities, health technology assessment (HTA) agencies, and think tanks from eleven different countries.

Participants noted that to date there has been very little empirical research on the "how" of successful implementation of UHC. But a diverse set of LICs and MICs, some of which were represented at the Bellagio meeting (Argentina, China, Ethiopia, Ghana, Mexico, Myanmar, Sri Lanka, and Thailand), has rich experience in initiating and implementing reforms for UHC and has learned valuable lessons along the way. Countries are moving forward even without perfect information on the best approach. These experiences formed the basis of the workshop, and of the key lessons that were proposed, summarized in Section 3 below. Wherever possible, the lessons from the country-based experiences were complemented with findings of empirical research. This report distils the key messages from the workshop that can help guide implementation; it does not represent all country contexts or the opinions of every individual who attended.

Financing UHC will be largely a domestic agenda, rather than an aid agenda, though there will be an important role for international collective action, as described below, and some LICs will continue to need development assistance for health (DAH) for years to come. And just as the concept of "trickle-down economics" has been widely challenged, the pro-poor approach to UHC is an antidote to the notion of "trickle down health care"—the idea that providing high quality coverage for formal sector workers will somehow lead to downstream health benefits for the poor. The workshop proposed that universalism and inclusion of the poor

from day one must be the markers of progress towards UHC, and that as the economies of LICs and MICs grow, governments must increase their social sector spending (if they do not, the public will "vote with its feet" and pay more and more for care, setting off an explosion in out-of-pocket [OOP] expenses).

The participants shared their experiences in, and discussed the limited amount of empirical evidence on, tackling a set of key "how" questions across five domains (Figure 1, page 2). These questions had emerged ahead of the workshop from conducting a review of the literature and a series of key informant interviews with country implementers and academic experts.[x] In Section 3, we use Figure 1 as a guide/structure to addressing these 7 crucial implementation questions.

One "cross-cutting" theme that emerged at the meeting, which applies to multiple domains in Figure 1, is the importance of adopting FP, progressivity, and universalism as overarching guiding principles in implementation. As Sri Lanka's experience has shown, early adoption of FP, progressivity in revenue raising, and universalism in using pooled funds as guiding principles for health financing can be a valuable approach to protecting the poor while advancing toward UHC. A pro-poor approach in Sri Lanka, as endorsed by the CIH, began with a focus on ensuring universal access to a publicly financed health benefit plan (HBP) of adequate quality, which was then expanded over time in its depth and quality. In Sri Lanka's case, provision of this HBP was in the public sector. Citizens paid OOP to obtain services excluded from the HBP and to access private providers. A politically driven set of policies was used to ensure pro-poor public provision (Ravindra Rannan-Eliya, personal communication): minimal user fees, good physical access to public services, an emphasis on FP in allocation of resources, strong management and efficiency in delivery, and a strong health-care provider culture of "doing more with less."

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x   The background paper that was prepared ahead of the workshop is available at http://www.globalhealth2035.org/our-work/domestic-health-investments/universal-health-coverage-uhc-implementation

3. LESSONS FROM COUNTRY EXPERIENCE

POLITICAL AND PUBLIC ENGAGEMENT

Political and public engagement	Generating and using evidence	Expanding UHC	Promoting quality and efficiency	Fostering international collective action
Q1. How can political will for UHC be generated and sustained? **Q2**. How can civil society be engaged in supporting UHC and pushing for more rapid progress?	**Q3**. How can information be generated/used to support implementation of UHC? **Q4**. How can coverage with financial protection (FP) & needed health services be measured, monitored, and maintained especially among the poor?	**Q5**. How best can countries manage the evolution and growth of service coverage and forms of FP?	**Q6**. How can countries use incentives to improve the quality & efficiency of health services, whether provided directly or purchased externally?	**Q7**. How can international collective action best support country efforts towards UHC?

3.1. How can political will for UHC be generated and sustained?

"Above all else, the push toward universal health coverage is a political process," noted Nellie Bristol (2014) from the Center for Strategic and International Studies in a recent report on the global movement toward UHC. UHC requires policy-makers to develop and implement new policies and regulations that facilitate the movement towards UHC and to raise significant funds that will enable it to happen. Implementation of these policies often requires establishing new health systems actors (e.g. insurers) and introducing significant changes to the relationships between actors. As such, UHC can be a very political process, and achieving UHC goals will require political commitment from the highest levels. The Bellagio workshop examined ways in which leaders in the ministry of health and other UHC reformers and advocates could generate and sustain government political will for, and financial commitment to, pro-poor UHC. It also explored how countries can successfully address political challenges and effectively manage opposition to different aspects of UHC policy or strategy implementation.

Key lessons on political will

UHC advocates have successfully used policy windows to push UHC to the top of the agenda

One important lesson on pushing UHC to the top of the political agenda is that advocates should be ready to act when a policy window opens. Kingdon (1995) described policy windows as moments in time when a problem, a policy solution, and the political will needed to enact the solution all come together. Participants described examples of three moments when this happens.

- **Crises**: The 2001–2002 economic crisis in Argentina, which worsened health outcomes for poor women and children, opened a policy window that was used by reformers to launch Plan Nacer, a public health insurance plan for pregnant women and children that uses results-based financing (RBF) (World Bank, 2013). This plan was later expanded, as Programa SUMAR, to further extend coverage. In China, the SARS crisis in 2002–2003 provoked interest in expanding health insurance coverage (Guo et al, 2010; Yip et al, 2012).

- **Realization of the harms of existing health policy**: Mounting opposition to an existing health policy, such as the use of OOP expenses to pay for medical care, can open a window of opportunity for health reform—especially if all political parties recognize the harms of the existing policy. In Ghana, for example, growing realization of the impoverishing effects of the country's "cash and carry" (user fee) scheme instituted in the 1990s opened a policy window that eventually led to Ghana's National Health Insurance Plan (Blanchet et al, 2012).

- **International rankings or comparisons**. A third window is when a country's poor performance in health is highlighted by an international ranking—spurring the country to try and "catch up" with others. For example, the World Health Report 2000 (WHO, 2000), which compared national health systems performance, found that Mexico did poorly on a measure called "fair financing" (Frenk et al, 2009). The WHO defines fair financing as meaning "that every member of society should pay the same share of their disposable income to cover their health costs."[xi] The report spurred Mexico's ministry of health to conduct its own national research that showed high rates of catastrophic medical expenses among poor, uninsured households—which in turn was an important factor in the launch of the public health insurance scheme *Seguro Popular*. China's push towards UHC was in part motivated by closing the "East-West gap" in health performance (Guo Yan, personal communication).

Pushes to drive UHC up the political agenda during election years can be particularly effective. In all cases, being able to reach national political figures with decision-making power is important. One major gap in the literature is on how best to reach these figures and, more broadly, how best to make use of policy windows. In Kingdon's model of agenda setting, he described the importance of "policy entrepreneurs," policy actors who are poised and ready to act to promote a specific policy solution at key moments in time (Kingdon, 1995). There is emerging evidence showing that the presence of policy windows and policy entrepreneurs, particularly those who are persistent in their efforts, is linked with successful policy change. For example, a 2009 study of nine child health policies that had been successfully implemented found that "all conditions required to open a policy window were reported to be present in eight of the nine case studies, as was the most important resource of a policy entrepreneur, sheer persistence" (Guldbrandsson & Fossum, 2009).

Participants at the Bellagio workshop suggested that it would be valuable to develop a "political economy toolkit" to help UHC advocates manage these key moments of opportunity—for example, to (a) identify key stakeholders, (b) understand what types of arguments or information motivate each of them, recognizing that different individuals are influenced by different types of messages, and (c) understand and manage opposition to, and encourage supporters of, UHC.

Framing the case for UHC using ethical and legal arguments can help to persuade stakeholders

There is good evidence from the policy literature that the way that a health issue is framed is a key factor in whether that issue receives political priority (e.g. see Shiffman, 2004; Shiffman, 2007; Shiffman & Smith, 2007; Hafner & Shiffman, 2013; Smith, et al, 2014). One way to frame UHC that can resonate with some key stakeholders is through an ethics and rights-based lens. Many countries, especially those in Latin America, already have a constitutional right to health, which provides a valuable foundation on which to make the case for UHC. If they do not, UHC advocates could draw upon international agreements or treaties, such as the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights, both of which recognize a right to health. Framing pro-poor UHC in terms of social solidarity can also have resonance with some stakeholders. In their study of how UHC requires an intersection between social, political, and economic sustainability, Borgonovi and Compagni (2013) argue that "UHC coverage implies a sense of solidarity and interconnectedness within a society as members agree to pool resources to guarantee at least an acceptable level of response to those in need."

Securing the support of the ministry of finance is important in getting UHC on the political agenda and moving subsequently towards UHC

In most LICs and MICs, many other ministries have more political power than the ministry of health—the ministry of finance, planning ministries/departments, and offices of the head of state. One way to elevate pro-poor UHC on the political agenda is to convince key staff in the key departments, particularly the ministry of finance, of the value of supporting UHC.

Participants at the Bellagio workshop shared their experiences of "what works" in outreach to the finance minister and ministry. Arguing that health spending improves economic performance, as shown, for example, by the Commission on Macroeconomics and Health[xii] and the

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xi WHO glossary: http://www.who.int/trade/glossary/story047/en.

xii http://www.who.int/macrohealth/en

CIH, may help to frame the argument. However, investments in other sectors—such as infrastructure, water, and education—can also boost economic growth, so making the economic case for increased health investment may not always be persuasive. Participants have had more success using arguments that center on the stabilizing effects of UHC—how it can help to prevent a cost explosion and to promote efficiency, value for money, social stability (Borgonovi and Compagni, 2013), and "fiscal sustainability" (Kutzin et al, 2010).

Realistic cost estimates can help to persuade the finance ministry of the feasibility of moving towards UHC. While the costs of individual programs (e.g. HIV, child health, TB) can be helpful to the health ministry, the finance ministry needs a consolidated view of what a UHC program will cost. The consolidated cost estimate must be affordable and feasible, allowing the finance ministry to support the cost of scaling up all key programs together. The finance ministry needs to know the financial implications for reforming the overall health system (e.g. health workers, buildings, and equipment) as well as for extending financial protection in order to assess the affordability and feasibility of UHC.

If the process is captured by one political party, the chances of successful reform may be lower

The chances of attaining UHC are likely to be improved if the reforms have buy-in across the political spectrum. In Ghana, for example, multiple political parties acknowledged the harms of user fees and were supportive of a national health insurance scheme. Putting UHC on the agenda and sustaining and expanding coverage will occur over extended periods of time and may span changes in the governing party and leadership.

There will be multiple sources of opposition to UHC, but these can be anticipated and countered

Opposition to UHC can come from several different sources, including the finance ministry, trade unions, private health providers, and certain political parties (Table 1). Opposition could also come from existing beneficiaries and from businesses if they are required to contribute (e.g. through a payroll tax or value added tax increase).

In Mexico, for example, one argument that was used to oppose *Seguro Popular*—a scheme aimed at covering the unemployed, self-employed, and those working outside the formal labor force—was that it would encourage individuals to leave the formal workforce to avoid paying payroll taxes (Bosch et al, 2012). Another argument was that *Seguro Popular* was being used for political motives.

Managing such opposition, and also managing the inevitable waning of political support for UHC over time, is based on marshalling evidence-based arguments as well as understanding the political process. Election watchdogs, for example, can be helpful in preventing health schemes from being used for political purposes. Public sector controls can be used to reassure opponents that health services can be efficiently delivered in the public sector.

Table 1. Sources of opposition to implementing pro-poor UHC

Source	Rationale for opposition
Finance ministry	Concerns about the budgetary implications of implementing UHC.
Trade unions	Fears of erosion of the existing health insurance benefits for their members if the scheme is expanded to include the poor and the informal sector. Unions representing health providers might be concerned that their incomes will be eroded or their work times increased.
Private health providers	May argue that public provision is inefficient or inadequate.
Political parties	May feel that UHC is being used for political gain by one party over another.
Businesses, and existing beneficiaries	Businesses may be opposed if they are required to contribute (e.g. through a payroll tax or value added tax increase), particularly if they provide health insurance or health services to their employees. Private health insurance companies selling voluntary insurance might fear the loss of business with a more universal system of financial protection.

There are potentially some valuable lessons for LICs and MICs from the US government's experience in managing opposition to the 2010 Affordable Care Act, which took effect in 2014 and which expanded insurance coverage to an additional 16.9 million people between September 2013 and February 2015 (Carman et al, 2015). The Act withstood intense and highly vocal opposition, including multiple legal challenges. Two factors that may have helped to manage the opposition were (i) the poor performance of the US health care system compared with those of neighboring countries, particularly Canada and Cuba; and (ii) in fashioning the Act, expensive compromises were made to ward off opposition from several powerful actors, particularly insurance and pharmaceutical companies. The Bellagio participants noted that an important success factor is to neutralize any opposition from powerful health-care providers, particularly physicians.

3.2. How can civil society be engaged in supporting UHC and pushing for more rapid progress?

Designing UHC schemes that are responsive to the needs of the population requires mechanisms through which the public can engage in decision-making and hold policy-makers and implementers accountable. Given the diversity of stakeholders and interests in UHC implementation, governments also require strategies to mediate these interests and negotiate conflicts, while maintaining a pro-poor focus. The Bellagio workshop examined how best civil society can be engaged.

Key lessons on civil society engagement

The public can best be engaged through accountability and open, two-way communication

Citizens want access to quality health care that is available and affordable (Box 2). In their case studies of UHC, Rosenquist and colleagues (2013) documented how civil society movements in Ghana, Thailand, and Uganda have shaped national UHC programs. A "Civil Society Call to Action on Universal Health Coverage" has been signed by civil society organizations worldwide.[xiii] For advocates of UHC, both within and outside government, citizens are the "ultimate resource" (Jesse Bump, personal communication), provided that they can be engaged, that their demand for health care can be leveraged, and that there is a strong high level voice in government (e.g. head of state, cabinet, parliamentary committee) who can respond to public demands. One important means of engagement is for health reformers to regularly share with the public their reform plans and the intended impacts of these reforms. Another is to open a variety of channels of public communication, such as using community stakeholder forums, engaging the media, and encouraging public critiques and debates of the reform plan. Meeting citizens "where they are," for example through village outreach, understanding their needs and preferences, and giving them adequate time to reflect on reform plans before giving their feedback can all help to foster meaningful public engagement.

Some non-governmental organizations (NGOs) may be opposed

While many health NGOs are supporters of, and advocates for, pro-poor UHC, it should not be taken for granted that all NGOs are supportive. Creating a stakeholder map (Brugha & Varvasovszky, 2000) can be valuable in showing

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xiii The call for action is at http://www.actionforglobalhealth.eu/file-admin/AfGH_Intranet/AFGH/Publications/UHC/UHC_Call_to_Ac-tion_eng2.pdf. The list of signatories is at http://www.actionforglobal-health.eu/our-work/universal-health-coverage/cso-call-to-action.html

> **Box 2: Citizen demand for UHC**
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> As Tim Evans, director of Health, Nutrition, and Population at the World Bank, has argued: "The demand for universal health coverage is not coming from advocates or from experts just saying this is a good idea. This is being driven by citizens at the country level, a phenomenon politicians ignore at their peril" (Paulson, 2013). African non-governmental organizations (NGOs), for example, have created the African Platform for UHC (africaforuhc.org/who-we-are) to "demand a set of measures to our governments in order to move towards Universal Health Coverage." The 2013 street protests in Brazil were in part provoked by public anger at weaknesses in the public health system and public demands for more affordable and better quality care (Bristol, 2014). The protests played a role in prompting the government to pass a law that reserves 25% of oil royalties for health care.

which NGOs are supportive, which are neutral, and which are opposed. Some NGOs focus only on advocacy for a particular disease—if the HBP includes interventions for that disease, they are likely to be supportive, but they could be opposed if the initial plan excludes these interventions. Some NGOs are service providers (e.g., providing cataract or cancer services); they may be displaced or disadvantaged financially by UHC schemes. In Mexico, the government asked such NGOs to shift over to providing social support services, such as transportation.

Marketing and advertising techniques, used by the consumer goods and technology sectors, can be helpful in UHC advocacy

While "marketing" UHC is not the same as marketing most other products or services to consumers, nevertheless UHC advocates could potentially learn lessons on messaging and advocacy from the consumer goods and technology sectors. This industry has expertise in, among other things, identifying and reaching its target audience, refining its messaging to each type of audience through consumer input, and using multiple communication channels (billboards, radio, TV, etc.). These techniques have been successfully adopted in social marketing campaigns with public health goals (Cohen & McGray, 2010).

National advocacy coalitions can help to raise the political profile of UHC

Advocacy coalitions are groups of individuals—from within and outside government, including civil society—who share common values and goals and who regularly interact with the aim of shaping policy (Sabatier, 1998). Such coalitions have a long history of effectiveness in global public health, in a wide range of policy arenas, including HIV/AIDS and tobacco control (Weishaar et al, 2015). An international UHC advocacy coalition (universalhealthcoverageday.org/coalition) was recently launched to "urge governments to accelerate universal health coverage so that everyone, everywhere, can access quality health services without financial hardship." National advocacy coalitions could play a similar role in forging partnerships between government, academia, and civil society to champion pro-poor UHC.

GENERATING AND USING EVIDENCE

Political and public engagement	Generating and using evidence	Expanding UHC	Promoting quality and efficiency	Fostering international collective action
Q1. How can political will for UHC be generated and sustained? **Q2**. How can civil society be engaged in supporting UHC and pushing for more rapid progress?	**Q3**. How can information be generated/used to support implementation of UHC? **Q4**. How can coverage with financial protection (FP) & needed health services be measured, monitored, and maintained especially among the poor?	**Q5**. How best can countries manage the evolution and growth of service coverage and forms of FP?	**Q6**. How can countries use incentives to improve the quality & efficiency of health services, whether provided directly or purchased externally?	**Q7**. How can international collective action best support country efforts towards UHC?

3.3. How can information be generated and used to support implementation of UHC?

Adequate information on use of services and the population's health status is critical for effective and efficient priority setting. Information about health systems performance is also essential for identifying weaknesses in the health system and developing appropriate responses to them. A number of questions remain about the type of information required to guide UHC implementation. One important question concerns strategies for efficiently, effectively, and fairly selecting services to guarantee, and for ensuring the capacity to use data required in the process.

Key lessons on generating and using information to guide pro-poor UHC

The evidence on, and processes used to determine, health benefit plans offered to citizens needs to be published and disseminated

USAID's Health Finance and Governance Project (HFG) recently conducted a study across 25 countries that examined the types of evidence used to design and update HBPs, which the study defines as "pre-determined, publicly managed lists of guaranteed health services" (Nakhimovsky et al., 2015). Such plans can help to make guaranteed services explicit to citizens, but should be developed with an evidence-based priority setting process free of undue political capture. In addition, citizens' rights to access HBPs must be enforceable to maximize the impact of these plans. HFG found that governments have generated and used evidence to (i) advance UHC objectives of equity, efficiency, and FP (Table 2), and (ii) promote the sustainability of HBPs (Table 3). However, the authors found that in the countries included in their sample there had been limited documentation of HBP design and update processes. This lack of documentation is a barrier to institutionalizing good governance of HBP design and updates. It also limits establishing transparent communication with the public and sharing of experience that supports cross-country learning. The authors urge governments to document and disseminate more information about their priority setting processes, arguing that such transparency has benefited

government advocates for the HBP as well as the public and other health system stakeholders.

Table 2. The use of evidence in achieving UHC objectives

UHC goal	Types of evidence	Examples
Equity	Data on: disease burden, utilization, monitoring and evaluation (M&E), cost-effectiveness	AUGE Plan (Chile) Seguro Popular (Mexico)
Efficiency	Cost-effectiveness data (and related global guidance) Unit costs of services by facility Disease burden	PhilHealth (Philippines) HBP for non-communicable diseases (Zhuhai Municipality, China)
FP	Household out-of-pocket spending Data on willingness to pay	RSBY (India) Seguro Popular (Mexico) PIAS (Uruguay)

(Nakhimovsky et al., 2015)

Table 3. The use of evidence in promoting HBP sustainability

UHC goal	Types of evidence	Examples
Financial sustainability	Budgets, projected over time Unit costs	UNMHCP (Uganda)
Program adaptation	Results from piloting Data from M&E Health technology assessments	Plan Nacer (Argentina) UCS (Thailand)
Political sustainability	Population preference surveys Focus groups	NHI (S Korea) PhilHealth (Philippines)

(Nakhimovsky et al., 2015)

Even if there is little evidence, countries can move forward on UHC while learning lessons along the way

Participants at the workshop agreed that countries should not "let perfect be the enemy of good"; steps can be taken towards UHC even if the available evidence is imperfect. While moving forward, reformers should document, monitor, and assess progress along the way, incorporating research into implementation. In the face of resource, capacity, and time constraints, LICs and MICs may want to pilot test the rollout of guaranteed services. For example, Ethiopia has rolled out community-based health insurance through a pilot in 13 districts (Haile et al, 2014; Ethiopian Health Insurance Agency, 2015). Thailand uses a pragmatic approach to service expansion in which the decision to add a service or intervention is based on a series of factors, such as cost-effectiveness, budgetary impact, ethical and equity considerations, and whether the necessity to pay out-of-pocket for the intervention causes catastrophic expenditures (Viroj Tangcharoensathien, personal communication).

Eliciting citizen values and preferences is an important step in generating information

Eliciting the values and preferences of citizens is an important component of the UHC information agenda (Box 3). Citizens' priorities may be surprising or may differ from those of the ministry of health, and are important to elicit as a way to boost public confidence in how priorities are set and in fostering accountability. For example, the Yeshasvini health insurance scheme for rural farmers in India began by eliciting the view of farmers themselves, who wanted the scheme to prioritize surgical procedures and outpatient care (Aggarwal, 2010).

Box 3: Public involvement in HBP decision-making in South Korea

A few countries actively engage their populations, both through informing and educating them about health care financing and service provision trade-offs, and through proactively soliciting their inputs into decision-making. For example, South Korea relies on "Citizen Committees" to collect population preference data about potential new services to include in the health benefit package. These committees have influenced decision-making: recently 9 of 13 additional services included in South Korea's HBP were added based on Committee recommendations (Oh et al. 2014). Importantly, the South Korean experience has shown that populations do not demand an infinite number of services; instead, once the realities of limited financing and the need for prioritization are understood, populations "may be willing to increase premium contribution to expand some, but not all, benefits when a deliberative decision-making process exists with access to information" (Nakhimovsky et al, 2015).

UHC is a form of social collective action, and as such it is crucial to document views across society. In some cases, such as in Sri Lanka and Japan in the 1930s, there was public pressure to focus on building a health system with FP, even though doctors did not prioritize FP early on (Rannan-Eliya, 2010).

There is a clear need for national capacity in data collection and stewardship

A dominant theme of the workshop was the need for capacity building in collecting information and in analyzing and using it for health systems improvement. The Ebola crisis in West Africa exposed weaknesses in national health information systems, and has created a window of opportunity to renew efforts in strengthening these systems. This information is required by technocrats and policy-makers to develop plans, assess progress, and modify strategies as necessary. It also needs to be translated into a language that the public can understand so that public advocacy for rapid progress towards UHC can be effective.

Utilization and administrative data, and data from insurance companies (if feasible to access), could all help in designing or refining HBPs

Other sources of data that could be helpful in designing or refining an HBP, include (i) administrative data (e.g. administrative costs or operating manuals), and (ii) data from insurance companies (e.g., data on medical inflation, trends in service utilization, or care management guide-lines). While the insurance industry may be reluctant to share data because of proprietary concerns, it has a wealth of data and experience that could be immensely valuable to UHC reformers. Data on provider behavior is also critical to identify outliers, e.g. providers that provide unnecessary care or populations that obtain insufficient access to services.

3.4. How can FP and coverage of needed health services be measured, monitored, and maintained especially among the poor?

FP is an essential goal of UHC. Countries must raise funds to finance health so that the poor can benefit from the resulting services without financial hardship. Being "pro-poor" means that countries should (i) consider progressive approaches to raising funds (e.g. progressive tax or insur-ance contributions), (ii) guarantee eligibility of the poor to access benefits financed from pooled funds, and (iii) ensure that these funds purchase services that are rele-vant to the poor. One important question that the workshop examined that underpins all of these aspects of pro-poor UHC is how FP can be measured and monitored as steps are taken to achieve UHC. Other key questions addressed were how FP can be prioritized, and how program costs can be contained while simultaneously expanding coverage of services and maintaining or improving FP.

Key lessons on measuring, monitoring, and maintaining coverage with FP and needed health services

National household surveys that assess OOP expenditure and access to services are important for monitoring FP

As Saksena and colleagues (2014) have argued, "Robust monitoring of financial risk protection requires reliable household expenditure surveys ideally conducted every 2 to 5 years" (although some countries, including Thailand, do them annually). Participants at the workshop argued that these should ideally be nationally owned and conducted.

While measuring the extent of OOP payments is important, this measurement alone fails to capture information on those who never seek care due to the high costs or other constraints. Thus it is also important to assess access barriers and non-use of services. WHO and the World Bank have recently provided some guidance to countries on how to do this, by tracking coverage of key health services and FP (or its absence) (World Bank/WHO 2014; Boerma et al. 2014). They have also published the first global monitoring report of UHC illustrating what can be done with data that are currently available (WHO/World Bank 2015).

Measuring and monitoring the proportion of total health expenditures that are paid for OOP, i.e. as a direct house-hold outlay, is marginally more straightforward than measuring catastrophic expenditures (or other indicators of the lack of FP, such as the proportion of the population impoverished due to OOP expenditure). However, relying on the proportion of OOP expenditures in total health expendi-tures as an indicator of FP needs to be considered care-fully as it can be difficult to interpret. For example, if the proportion rises it is important to understand the reasons for the rise (e.g. perhaps richer citizens are spending more to obtain care from the private sector).

The "UHC moment" can be used to champion and support National Health Accounts (NHAs)

NHAs, which track public and private expenditure flows in the health sector, can be a valuable tool in reporting changes in OOP expenditure, which strongly correlate with changes in FP. Even so, NHAs—particularly time series NHAs (Xu et al, 2010)—continue to be under-used in many LICs and MICs. The recent rise in interest in UHC world-wide relating to tracking expenditures on specific diseases, conditions, or population groups could be a window of opportunity to make the case for increased investment in NHAs.

Managing costs and improving efficiency can ensure that more can be achieved with the available funds (hence UHC goals, including FP, can be reached more quickly)

The three major domains that contribute to excessive costs are (i) *unnecessary services* (e.g. through defensive medicine or using higher cost branded drugs instead of equal quality generic versions); (ii) *inefficiently or ineffectively delivered services* (e.g. service duplication, preventable complications); and (iii) *administrative inefficiency*.

Avoiding unproductive cost escalation, using approaches such as strategic purchasing, gatekeeping arrangements, prescribing of generic medicines (Box 4), and a strong culture of audit and transparency, are important components in achieving and maintaining FP and health service coverage goals. In their study of Thailand's approach to pro-poor UHC, Tangcharoensathien and colleagues (2014) highlight in particular the crucial role of provider payment reform (e.g. based on capitation and diagnostic related groups) in achieving efficiency and FP. Provider payment, say the authors, is the most critical factor contributing to FP and technical efficiency; fee-for-service payment, they argue, results in cost escalation, inefficiency, excessive use of services, and increased medical impoverishment.

Such reforms, however, may be politically difficult to achieve. In a push for efficiency, it is likely that at least one stakeholder group may lose out (e.g. physicians if their payments are reduced, or drug companies and private pharmacies if there is a switch to generic medicines). Such stakeholders may therefore oppose reform; it is important to predict and plan for such opposition. Two important themes emerged from discussions at the Bellagio workshop. First, one way to achieve broad buy-in for efficiency reforms is to make sure that some of the efficiency gains are returned to the providers; for example, in Ghana, initial physician concerns about payment caps gave way to support when physicians realized that they would get to keep some of the efficiency gains (Schieber et al, 2012). Second, attempting to control costs by restricting coverage is highly inefficient. As the CIH noted, "Under provision of health care is not cost containment—it is output reduction. Policy makers should spend more (not less) on effective interventions that are presently underprovided" (Jamison et al, 2013).

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Box 4: Selected strategies for avoiding unproductive cost escalation.

Adapted from Jamison et al, 2013

Single payer approaches: these can reduce administrative costs, such as through using integrated information technology platforms.

Controlling health care supply: for example, promoting use of generic medicines and negotiating drug prices with companies can lower costs for public payers.
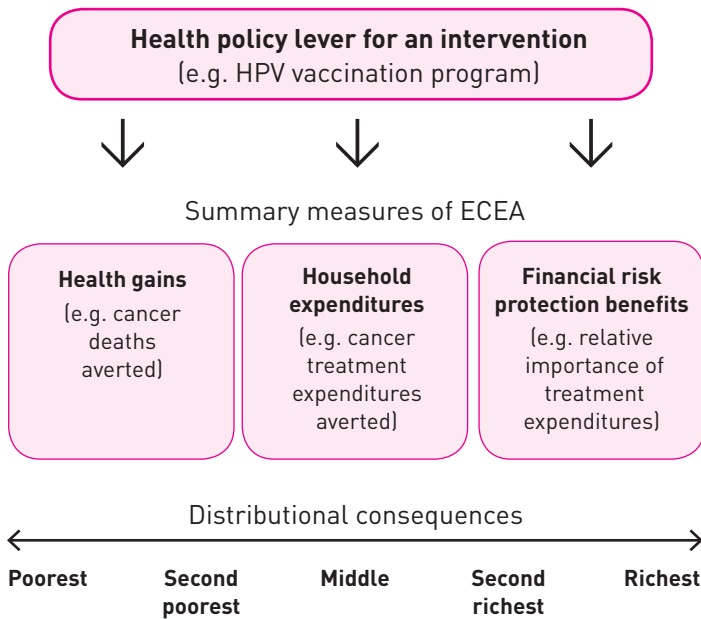
Strategic purchasing: the World Health Report 2000 recommended strategic purchasing—that is, making strategic decisions on which services should be purchased from whom—as a way to improve efficiency (WHO, 2000). An example is contracts between the government as a payer and any competent public or private provider.

Gatekeeping arrangements: costs can be contained when patients must first see a primary care provider before seeing a specialist.

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A new tool, extended cost effectiveness analysis (ECEA), can help health planners with priority setting

ECEA is a new tool that can be used to compare the health and FP impacts of different health interventions. An ECEA is "extended" beyond a traditional CEA "in the sense that it not only assesses how much health is gained per million dollars spent but also how much financial protection is purchased" (Jamison et al, 2013). Another benefit of ECEAs is that they examine the distributional consequences of the intervention, i.e. they can assess whether an intervention is pro-poor (Figure 2).

Figure 2. Benefits of ECEA: measurement of health gains, distributional consequences, and FP

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┌─────────────────────────────────────────┐
│   Health policy lever for an intervention │
│      (e.g. HPV vaccination program)       │
└─────────────────────────────────────────┘
         ↓           ↓           ↓
           Summary measures of ECEA
```

Health gains (e.g. cancer deaths averted)	Household expenditures (e.g. cancer treatment expenditures averted)	Financial risk protection benefits (e.g. relative importance of treatment expenditures)

Distributional consequences

←──────────────────────────────────────→

Poorest   Second poorest   Middle   Second richest   Richest

For example, Verguet and colleagues (2015) used ECEA to evaluate the health and FP benefits of 9 different interventions (three vaccines, one surgical operation, and five acute medical treatments) that could be publicly financed by the Ethiopian government. They found that, per dollar spent, the interventions that avert the most deaths are measles vaccination, pneumococcal conjugate vaccination, and caesarean section. The interventions that avert the most cases of poverty are caesarean section, TB treatment, and hypertension treatment. By showing the trade-offs in achieving two key UHC objectives—improved health and FP—ECEA can help planners design service packages, particularly in ensuring that these are pro-poor. Ethiopia is moving forward with ECEA, training economists in the ministry of health to use this tool (Addis Tamire Woldemariam, personal communication). Nevertheless, ECEA is still a relatively new tool and it is clearly not the only tool for priority setting. The results should be considered along with other ethical, social, political, and economic considerations, such as benefit to cost ratios and the strength of the health delivery system (Verguet et al, 2015).

EXPANDING UHC

Political and public engagement	Generating and using evidence	Expanding UHC	Promoting quality and efficiency	Fostering international collective action
Q1. How can political will for UHC be generated and sustained? **Q2**. How can civil society be engaged in supporting UHC and pushing for more rapid progress?	**Q3**. How can information be generated/used to support implementation of UHC? **Q4**. How can coverage with financial protection (FP) & needed health services be measured, monitored, and maintained especially among the poor?	**Q5**. How best can countries manage the evolution and growth of service coverage and forms of FP?	**Q6**. How can countries use incentives to improve the quality & efficiency of health services, whether provided directly or purchased externally?	**Q7**. How can international collective action best support country efforts towards UHC?

3.5. How best can countries manage the evolution and growth of health-care service coverage and FP?

Countries face many challenges in initially determining and later expanding both the population and the services to be covered by UHC programs, and in managing the evolution of different forms of FP. Countries have taken different approaches—e.g., targeting the poor for early participation, or adding the poor into existing schemes for formal sector workers—each with its own challenges in ensuring coverage, maintaining quality, providing FP, and reducing fragmentation. How to effectively increase coverage is a central question for all countries that are pursuing UHC, as is the question of how best to build institutional capacity to manage this evolution.

Key lessons on managing the evolution and growth of service coverage and FP

Health technology assessment can help manage evolution and growth

Health technology assessment (HTA) is defined by the International Network of Agencies for HTA (inahta.org) as: "the systematic evaluation of the properties and effects of a health technology, addressing the direct and intended effects of this technology, as well as its indirect and unintended consequences, and aimed mainly at informing decision making regarding health technologies." By using an explicit process, HTA can support more informed decision-making that can guide service expansion—not just for decisions about drugs, but for a wider set of interventions including public policies (e.g. on tobacco control) or service delivery models (Kalipso Chalkidou, personal communication). Even decisions "at the margin" can have major budgetary implications—for example, pressure to add an expensive drug to an HBP can have a very large impact.

While HTA agencies have their limitations, and many countries will not yet have the capacity to develop stand-alone agencies, the process of *explicitly setting priorities* can help to manage the process to achieve UHC in three important ways:

a. An explicit decision-making process, as used by HTA agencies, can be a valuable mechanism to identify and engage with key stakeholders and to outline rules for reaching a decision. As such, this process can help the government to strengthen its evidence-based decision-making and to manage political pressures. Similarly, this explicit process can help to sustain coverage that is pro-poor, insulating decisions from politics. Building a strong relationship with the media, as seen in the UK with the National Institute for Health and Care Excellence, can support an HTA agency in explaining decision-making processes—which in turn can help to shield the agency from politics.

b. Dedicated staff and explicit processes such as those in HTA agencies can help in translating global agenda setting (e.g. the global recommendations of the *Global Health 2035* report) into national agenda setting, by helping to contextualize decisions at the national level.

c. HTA can help to show the value of specific health investments, making the case for these investments to the ministry of finance and other stakeholders. More broadly, formal priority setting such as the process used by HTA agencies can demonstrate that there is an explicit mechanism in place for achieving value for money and efficiency.

Nevertheless, in many countries there is only limited capacity to conduct HTA. If it is not feasible to build a national agency, other solutions may be to use university capacity or to draw on regional initiatives. The key, in all cases, is to understand how and where decisions are currently made, and then to ensure that an explicit decision making process is put in place. A Center for Global Development Report (2012) on HTA made two major recommendations. First, a "global health technology assessment facility should be created to provide sustained technical and consultative support to global funding agencies and low- and middle-income country governments." Second, LICs and MICs should receive direct technical support to establish their own HTA agencies. Given the fragility of donor funding, such agencies or other organizational arrangements for priority setting are more likely to be sustained long term if they are funded domestically. For example, a comparative case study of six health policy analysis institutes—three in Asia and three in Africa— found that out of three institutes that received external donor support, two collapsed when funding was withdrawn (Bennett et al, 2012).

Program fragmentation can be a barrier to expansion

Examples of program fragmentation include separate fund pools used to finance HBPs for different population groups (and on the supply side, using separate delivery channels for difference diseases and supply chains for different medicines). Fragmentation is a problem that many countries face in their efforts to reach UHC, since they are often starting off with multiple "inherited" schemes (and "vertical programs" with their own delivery points and supply chains). Such fragmentation can create inequity and inefficiency. It can also be a major barrier to further expanding coverage as the groups that have the most generous HBP are unwilling to risk diluting their "package" by being incorporated into a universal system (Nicholson et al, 2015).

The Bellagio workshop participants suggested that "diagnosis" should be the first step in addressing this challenge, i.e. identifying where in the system the fragmentation is occurring and how easy it would be to fix this problem. For example, in China there is fragmentation at multiple levels of the health system including: (i) fragmented *financing*: there are three major health insurance schemes in China, each with its own financing, reimbursement, and administrative mechanism; (ii) fragmented *service delivery*: across primary care, secondary care, and tertiary hospitals with no gatekeeping and no clear referral system; and (iii) fragmentation of *international technical assistance*: there are multiple external agencies who do not coordinate their activities and often give contradictory advice (Guo Yan, personal communication).

Steps to increase effective pooling can be taken, even when schemes cannot be fully merged

If a country was starting off today in pursuit of UHC, there are strong arguments in support of achieving full population coverage from the outset, initially with a relatively narrow set of guaranteed services, as recommended by *Global Health 2035*. As Nicholson and colleagues (2015) say, such universalism is preferable to "covering selected population groups with more generous packages of services and leaving some people relatively uncovered."

However, many countries are not at this starting point, but instead have different groups of people already covered by different funding mechanisms—they may contribute different amounts or nothing at all, and may be guaranteed a different HBP. This reality has not stopped such countries from progressing towards UHC, as seen in Mexico and Thailand. Some countries have a longer-term vision to reduce or eliminate fragmentation, and with it, inequality. Thailand, for example, has a goal of merging its three existing health insurance schemes: the social security scheme, the civil servants' medical benefit scheme, and the universal coverage scheme (Evans et al, 2012). However, to date, this has been politically challenging, and so the Thai government has created virtual pooling by modifying the extent to which it subsidizes the three schemes.

The Bellagio workshop participants agreed that countries should be able to achieve a greater degree of harmonization, even if fully merging all schemes is not feasible. Strong leadership is vital, particularly when it comes to aligning different institutions and resources and especially in federal states such as Ethiopia. HBPs and RBF can be valuable tools in such alignment (Martín Sabignoso, personal communication). Better pooling and cross-subsidization (from rich to poor and from healthy to sick) can be achieved even without a full merger by varying the size of government contributions to the various schemes.

Greater harmonization between ministries, and with international agencies, could also help to reduce fragmentation. For example, health stewardship may be fragmented by the ministries of finance, labor, and health having competing views and receiving technical assistance, guidance, and financing from different international organizations

(e.g. the International Monetary Fund assisting the finance ministry, the WHO assisting the health ministry, and the International Labour Organization assisting the labor ministry).

Government sponsored health insurance schemes can promote UHC

Government-mandated health insurance schemes (and national health systems, such as those in the UK, Malaysia and Sri Lanka) can help promote UHC by (i) being a "smart" strategic purchaser of services (or a smart purchaser of inputs); (ii) purchasing more cost-effective services (e.g. in some countries, providers substitute e-mail or phone calls for out-patient consultations on minor health issues); (iii) fostering integrated care; and (iv) using incentives and other tools to promote efficiencies.

There may be political opposition to expanded service coverage, which can be anticipated and managed

As discussed earlier, managing opposition to UHC—to its initial rollout or its expansion—requires marshalling compelling evidence-based arguments. Having baseline knowledge on who is being covered by which scheme can help ward off political conflicts during expansion. Protecting expansion decisions from undue influence or competing interests is important—HTA can be helpful in this process. Hiring or appointing ministers with longevity and continuity in mind can also reduce the vulnerability of the process to political influence.

Institutional capacity is needed to support UHC expansion

Expanding health service coverage and FP clearly requires institutional capacity, as well as strong links from the institution to key stakeholders in the UHC process. An important foundation of more rapid movement towards UHC is to embed the key concepts of solidarity, redistribution, progressivity, and responsiveness to citizens in all institutions and processes. Framing UHC from the beginning as key to sustainable development, and as a broad and long-term movement, can also help when it comes to expanding coverage. And, given the political power of health-care providers in many countries, gaining the support of professional societies as early as possible in the pursuit of UHC can help with later expansion.

Political and public engagement	Generating and using evidence	Expanding UHC	Promoting quality and efficiency	Fostering international collective action
Q1. How can political will for UHC be generated and sustained? **Q2**. How can civil society be engaged in supporting UHC and pushing for more rapid progress?	**Q3**. How can information be generated/used to support implementation of UHC? **Q4**. How can coverage with financial protection (FP) & needed health services be measured, monitored, and maintained especially among the poor?	**Q5**. How best can countries manage the evolution and growth of service coverage and forms of FP?	**Q6**. How can countries use incentives to improve the quality & efficiency of health services, whether provided directly or purchased externally?	**Q7**. How can international collective action best support country efforts towards UHC?

3.6. How can countries use incentives to improve the quality and efficiency of health-care services, whether provided directly or purchased externally?

Quality of care is sometimes considered to be the "fourth dimension" of UHC, i.e. in addition to coverage of the population with needed services and with FP (Kruk, 2013). Expanding health service coverage as part of the strategy to achieve UHC is of limited value if services are of poor quality. Expanding service coverage and quality improvement require inputs including human resources, infrastructure, medicines and other medical products, and effective regulations to incentivize and enforce proper service delivery. In many countries, these challenges are complicated by large and fragmented provider markets, including growing private sectors. The Bellagio workshop considered how provider incentives can best be used to drive quality, equity, and efficiency. As Wagstaff recently argued,[xiv] "tackling provider incentives may be just as—if not more—important in the UHC agenda as demand-side initiatives."

Key lessons on using incentives

Fee for service payment gives perverse incentives to providers

Such payment encourages over-servicing and cost overruns. Where it is unavoidable politically, it needs to be combined with effective controls on both price and volume, which requires effective information systems that allow provider behavior to be monitored. This has been the development in most high-income countries that pay providers using fee for service.

Paying providers based on performance achieves modest impacts on quality

A recent systematic review of the evidence on 11 pay for performance (P4P) programs found that the greatest impact of P4P was on coverage indicators (quantity of services), though studies did not control for underlying trends (Cashin et al, 2014). The review found no impact on outcomes, and only modest impacts on clinical quality measures. Direct incentives were found to have mixed results for equity and no impact on efficiency. The authors concluded that the overall role of financial incentives is unclear, particularly as they often do not reach front-line providers. As discussed further below, the incentives of the *underlying payment system*—the "foundational conditions"—may be more important than the financial incentive itself for promoting quality and achieving other UHC objectives.

Public health purchasers need to have the mandate and accountability to purchase high-quality services for the population with FP

Ghana's National Health Insurance Scheme (NHIS) accounts for 30% of public spending on health and 16% of total health spending (Schieber et al, 2012); it has the mandate to provide access to the services and medicines in the NHIS HBP and to be pro-poor. Accountability is increased by the annual National Health Insurance Authority's annual report to Parliament on equity (Cheryl Cashin, personal communication).

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xiv World Bank's Let's Talk Development Blog: http://blogs.worldbank.org/developmenttalk/we-just-learned-whole-lot-more-about-achieving-universal-health-coverage

Strengthening of integrated service delivery networks can help to align incentives across levels of care

Alignment across the continuum of care occurs when services and provider competencies are well defined at the different levels, when there are clear guidelines on when patients should be referred between levels, and when providers at one level have a stake in what happens at different levels.

The right balance of autonomy and accountability can help providers to respond to incentives and serve the public interest

Sri Lanka's strong tradition of "democratic accountability" and of physician support for achieving efficiency and doing "more with less" have been important factors in serving the public interest (Rannan-Eliya & Sikurajapathy, 2009).

Information can be used to understand, motivate, and improve provider performance

Argentina's Plan Nacer and Programa SUMAR use information on provider performance as a key tool for motivation. These plans, which are performance-based, have included improvements in the collection of data, clarification of the goals of providers, and measurement of provider activity and performance, and a more informed dialogue between purchasers and providers (Martín Sabignoso, personal communication).

FOSTERING INTERNATIONAL COLLECTIVE ACTION

Political and public engagement	Generating and using evidence	Expanding UHC	Promoting quality and efficiency	Fostering international collective action
Q1. How can political will for UHC be generated and sustained? **Q2**. How can civil society be engaged in supporting UHC and pushing for more rapid progress?	**Q3**. How can information be generated/used to support implementation of UHC? **Q4**. How can coverage with financial protection (FP) & needed health services be measured, monitored, and maintained especially among the poor?	**Q5**. How best can countries manage the evolution and growth of service coverage and forms of FP?	**Q6**. How can countries use incentives to improve the quality & efficiency of health services, whether provided directly or purchased externally?	**Q7**. How can international collective action best support country efforts towards UHC?

3.7. How can international collective action best support pro-poor UHC efforts?

External partners, particularly international donors, multilateral agencies, and development banks, often support countries' UHC implementation and reform processes. Partnerships with such organizations can provide access to essential support and resources, while also raising challenges for countries—as discussed previously—such as how to ensure alignment across partners and with local priorities. As countries tackle the many complex and political questions of UHC implementation, there are also opportunities for learning across countries based on their experiences navigating such challenges.

Key lessons on international collective action in support of UHC

The international community needs to adopt a stronger "country lens" and support domestic agendas

UHC is a domestic agenda, deeply tied to national politics, requiring redistribution, national commitment, and solidarity. For the international community, supporting UHC will require a transformation—a shift in the locus of power from donors to countries, a shift in decision-making from external agencies to national governments, and a greater focus on process over individual projects (Robert Marten, personal communication). International collective action can support national UHC processes through provision of

technical assistance, capacity building (including building in-country analytic capacity), knowledge generation and sharing, information management, and support for measurement. It can also align much more closely with national health plans and strategies, adopting the so-called "seven behaviors" of good development cooperation as agreed in the International Health Partnership.[xv] This is even more important now the Sustainable Development Goals (SDG) have been adopted by the United Nations. UHC is included as one of the health targets, but the SDG document argues that *each government would set their own targets* "guided by the global level of ambition."[xvi] Each country will focus on its own priorities and will need the international community to buy into plans that are feasible and desirable for the country rather than plans wanted by particular parts of the international community.

Networks of cross-learning and communities of practice can support UHC

The Joint Learning Network, the USAID-supported Health Financing and Governance Project, the International Decision Support Initiative (idsihealth.org), and the P4H Leadership for UHC Programme (p4h-network.net/global/cpd/) have shown the value of international network activities in supporting UHC. Regional efforts, such as the "ASEAN Plus Three UHC Network" (aseanplus3uhc.net), can contribute to cross-country experience sharing. ASEAN Plus Three "serves as a platform to support and accelerate progress towards well-functioning and sustainable UHC in developing countries and advancing the regional and global UHC agenda." Other examples of how networks can contribute are the provision of rapid response support to countries that face a window of opportunity for reform and the generation of comparative international analytics and

performance rankings. These networks supplement the routine work of agencies such as WHO and the World Bank in supporting countries in their move towards UHC and in sharing information across countries.

Development assistance for health (DAH) will need to shift over time towards core "global functions"

One important way in which international collective action can support pro-poor UHC is for DAH to adequately fund the "global functions" of global health, such as providing global public goods (e.g. research and development, knowledge generation and sharing) and fostering leadership and stewardship of the global health system (Schäfer-hoff et al, 2015).

For example, the CIH report, *Global Health 2035*, recommended that donors should help to fund population, policy, and implementation research to help elucidate the most effective ways to implement UHC and the impacts of these reforms. The report argued that evaluation of such reforms has been a neglected global public good. Such evaluation should be "an integral part of good practice in health system strengthening efforts to guide planning, policy development, monitoring, and evaluation" (Berman & Bitran, 2011).

There is also a role for continued DAH and technical assistance in initiating efforts to reach UHC, particularly in the low-income countries with restricted domestic sources of finance. For example, the Global Fund and other development partners finance about a quarter of the premium contributions of the poorest of the population in Rwanda's community based health insurance (Farmer et al, 2013). These partners also provide technical assistance.

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xv   The "seven behaviours" are at http://www.internationalhealthpartnership.net/en/about-ihp/seven-behaviours/

xvi Transforming Our World: the 2030 Agenda for Sustainable Development. Finalized text for adoption, 1st August 2015. Paragraph 55. At https://sustainabledevelopment.un.org/post2015/transformingourworld

CONCLUSIONS AND FUTURE DIRECTIONS

Much of the global attention to achieving UHC is focused on providing technical support to countries in tackling challenges such as designing HBPs and developing health financing systems. This work will continue to be crucial, and there is an important opportunity for learning-by-doing along the way. But other important aspects of achieving pro-poor UHC have garnered less attention to date—particularly questions related to the "how" of UHC. The Bellagio Workshop on Implementing Pro-Poor UHC examined some of these questions, with a particular focus on learning from country experiences with successes and obstacles. Four major cross-cutting themes emerged that can help guide future work on the "how" of UHC.

First, **implementing pro-poor UHC is an inherently political process**, during the early stages of getting UHC onto the agenda and designing the initial guaranteed services and in later stages of service coverage expansion. A better understanding of this process would be very valuable, and could form the basis of a "political economy toolkit" to help reformers act when a window of opportunity opens and negotiate with diverse constituents, including opponents. When it comes to service coverage expansion, national HTA, based on an explicit decision-making process, can help with stakeholder engagement and managing political pressures.

Second, **citizens are increasingly vocal in their demands for UHC**, and yet their support has not been fully tapped by health reformers. One strong theme emerging from the Bellagio meeting is that implementing pro-poor UHC benefits greatly from engaging citizens at multiple points, including in decisions about HBPs.

Third, **there is an unfinished measurement and information agenda**—that is, there is insufficient documentation and sharing of information on UHC reforms, which hinders implementation. Despite this challenge, countries worldwide are moving towards UHC, and they should monitor progress and adjust their approach in light of these data. One tool that could be helpful is an online "living guide" on the "how" questions, one that is regularly updated and adjusted over time as new country experiences (both positive and negative) are shared. International networks of cross-cross learning and communities of practice will become increasingly important in tackling the "how" questions. One of the most important ways that the international community can support countries is to assist with building capacity in information management and measurement, for example creating health information systems that can reliably monitor progress in maintaining FP and high levels of effective coverage.

Fourth, **a new kind of international collective action will be needed** to support countries to achieve UHC, with the focus shifting away from donors and towards ministries of health and finance and their domestic agendas. In the SDGs era, it will become increasingly important for donors to fund the neglected "global functions" of global health, particularly research and development (including population, policy and implementation research on pro-poor UHC).

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ANNEX 1. PARTICIPANTS AT THE BELLAGIO WORKSHOP

*Commissioner, Lancet Commission on Investing in Health (GlobalHealth2035.org)

1. **Jesse Bump**: Executive Director, Takemi Program in International Health, Harvard T.H. Chan School of Public Health, USA

2. **Cheryl Cashin**: Senior Program Director, Results for Development Institute & Joint Learning Network, USA

3. **Kalipso Chalkidou**: Founding Director, NICE International, UK

4. **David Evans**: Bellagio meeting chair, and Scientific Project Leader, Swiss Tropical and Public Health Institute, Switzerland*

5. **Eduardo Gonzalez-Pier**: Deputy Minister of Health, Mexico

6. **Yan Guo**: Professor, Peking University School of Public Health, China*

7. **Jeanna Holtz**: Principal Associate, Health Finance and Governance Project, Abt Associates, USA

8. **Daw Thein Thein Htay**: Deputy Minister of Health, Myanmar

9. **Carol Levin**: Senior Health Economist, Disease Control Priorities Network, USA

10. **Robert Marten**: Senior Program Associate, The Rockefeller Foundation, USA

11. **Sylvester Mensah**: Former Chief Executive of NHIA; currently in charge of Special Duties, Office of the President, Ghana

12. **Ariel Pablos-Méndez**: Assistant Administrator for Global Health, USAID*

13. **Ravindra Rannan-Eliva**: Executive Director, Institute for Health Policy, Sri Lanka

14. **Martín Sabignoso**: National Coordinator, Plan Nacer & Programa SUMAR, Argentina

15. **Helen Saxenian**: Independent Consultant, USA*

16. **Neelam Sekhri Feachem**: Associate Professor, Epidemiology & Biostatistics, University of California, San Francisco, USA

17. **Agnes Soucat**: Director, Department of Health Systems Governance and Financing, Cluster on Health Systems and Services, World Health Organization*

18. **Viroj Tangcharoensathien**: Senior Expert, Health Economics, Ministry of Public Health, Thailand

19. **Hong Wang**: Senior Program Officer, Bill & Melinda Gates Foundation, USA

20. **Addis Tamire Woldemariam**: Director General (Chief of Staff), Office of the Minister, Ministry of Health, Ethiopia

21. **Gavin Yamey**: Professor of the Practice of Global Health and Public Policy, Duke University, USA*

ANNEX 2. PARTICIPANT BIOGRAPHIES

Jesse Bump
Executive Director, Takemi Program in International Health, Harvard T.H. Chan School of Public Health

As of 1 July 2015 Jesse Bump became Executive Director of the Takemi Program in International Health with a Faculty Lecturer appointment at the Harvard T.H. Chan School of Public Health. He holds a PhD in History of Science, Medicine & Technology from Johns Hopkins and an MPH in Global Health from Harvard University. Previously he was Assistant Professor in the Department of International Health, Georgetown University. His research focuses on the political economy of current and historical public health problems in developing countries, community-directed programs, health system design, and health reform. His projects examine the influence of competition in international aid, agenda setting and universal health coverage, the political economy of health reform, the politics of defining objectives in global health policymaking, and the methodological and theoretical tools required for analyzing the policy significance of historical evidence.

Cheryl Cashin
Senior Program Director, Results for Development Institute & Joint Learning Network

Cheryl Cashin is a health economist specializing in the design, implementation and evaluation of health financing policy in low- and middle-income countries, with a particular focus on health purchasing and provider payment for universal health coverage. She has worked in more than 20 countries on health financing policy development and implementation. Cheryl is currently a Senior Program Director at Results for Development Institute (R4D) where as part of her portfolio she leads the Provider Payment Mechanisms technical initiative of the Joint Learning Network for Universal Health Coverage (JLN). Cheryl has served as a health financing adviser and consultant for the World Bank, WHO, USAID-funded projects, OECD and other international technical partners. She has held academic positions at Boston University's School of Public Health and University of California, Berkeley's Nicholas C. Petris Center on Health Care Markets and Consumer Welfare.

Kalipso Chalkidou
Founding Director, NICE International

Kalipso Chalkidou is the founding director of NICE's international programme, helping governments build technical and institutional capacity for using evidence to inform health policy. She has been involved in the Chinese rural health reform and also in national health reform projects in Colombia, Turkey and the Middle East, working with the World Bank, PAHO, DFID and the Inter-American Development Bank as well as national governments. She holds a doctorate on the molecular biology of prostate cancer from the University of Newcastle, an MD (Hons) from the University of Athens and is a visiting Professor at King's College London, a senior advisor on international policy at the Center for Medical Technology Policy and visiting faculty at the Johns Hopkins Berman Institute for Bioethics.

David B. Evans
Scientific Project Leader, Swiss Tropical and Public Health Institute

David Evans, who holds a PhD in economics from the Australian National University, previously served as the Director of the Department of Health Systems Governance and Financing and the Director of WHO's Global Program on Evidence for Health Policy at the World Health Organization. An expert in the economics of household decision-making, cost-effectiveness analysis and health financing in developing countries, Evans joined WHO in 1990 to help develop research into the social and economic factors relating to tropical diseases. He joined the Department of Epidemiology and Public Health at the Swiss Tropical and Public Health Institute in March 2015.

Eduardo González-Pier
Deputy Minister of Health, Mexico

Dr. González-Pier currently serves as the Vice-Minister for Integration and Development of the Health Sector in the Ministry of Health in Mexico. He previously served as Executive Chairman of Funsalud. He was the Chief Financial Officer of the Mexican Institute of Social Security (IMSS). Prior to this, Dr. González-Pier served as Chief Economist and as General Coordinator of Strategic Planning at Mexico's Ministry of Health, where he was responsible for drafting the National Health Program 2001–2006 and participating in the formulation

and implementation of health financing reform initiatives, including the introduction of the System of Social Protection in Health (Seguro Popular de Salud). Dr. González-Pier holds a PhD in Economics from the University of Chicago.

Yan Guo
Professor, Peking University School of Public Health

Yan Guo is a Professor of Public Health at Peking University School of Public Health, Vice Director of the China Academy of Health Policy and Board Member of the Community Health Branch of the Chinese Hospital Management Association. She is a former Vice President of the Peking University Health Science Center. Yan has served as a consultant for a range of internationally sponsored projects carried out in China such as DFID's China Urban Health and Poverty Project, the World Bank-sponsored Final Assessment of TB Control project, and the UNICEF-funded Comprehensive Primary Health Care Project.

Jeanna Holtz
Principal Associate, Health Finance and Governance Project, Abt Associates, USA

Jeanna Holtz is a health financing specialist with more than 25 years of experience. Since joining Abt Associates in July 2014, Ms. Holtz has provided technical assistance on private sector, health finance and health systems strengthening projects, with emphasis on insurance and universal health coverage, public private partnerships and contracting approaches. Previously, Ms. Holtz served as Chief Project Manager of the International Labour Organization's Impact Insurance Facility. In that position she launched an innovation program that awarded grants of more than $15 million to 60 implementing partners to test approaches to make quality insurance products accessible to poor households in developing countries. She oversaw project initiatives in knowledge management, capacity building, and research. Earlier in her career, Ms. Holtz held positions with global financial services provider Allianz, and worked for more than a decade for the US health insurer Aetna.

Daw Thein Thein Htay
Deputy Minister of Health, Myanmar

Dr. Thein Thein Htay is Deputy Minister for Health and currently is responsible for medical education as well as health services delivery in Myanmar. Dr. Thein is also an adjunct faculty member, as well as an honorary Professor, to the University of Public Health in Myanmar. She obtained her Masters of Health Science in population development and reproductive health from the Hopkins Bloomberg University of Public Health and her Masters of

Public Health from the University of Medicine (1), Yangon. She also holds a medical degree from the University of Medicine (2), Yangon. Dr. Thein leads the public health division of the Department of Health, with a main thrust on meeting MDGs 4 & 5. She also served as a member of the Gender Advisory Panel, WHO-HQ from 1999 to 2004, and as a regional steering committee member for the *Lancet* series on South East Asia Region's health issues and also a country lead for the *Lancet* Myanmar Series 2014. Currently, she is a member of International Steering Committee of 8th Asia Pacific Conference on Sexual & Reproductive Health and Rights.

Carol Levin
Senior Health Economist, Disease Control Priorities Network

Carol Levin is an expert in conducting economic evaluations of health technologies and clinical/programmatic interventions for public health programs in developing countries. Prior to joining the Disease Control Priorities project (DCP3), Dr. Levin worked as a Senior Economist at PATH where she conducted economic evaluations including cost or cost-effectiveness analyses related to the introduction of new vaccines, supply chain logistics, reproductive health interventions, and diagnostic tests. Dr. Levin is a recognized technical expert in designing and implementing primary cost analyses, and has served as an advisor to the WHO, GAVI-the Vaccine Alliance, the World Bank, PAHO, CDC, CIDA, and DFID on economic evaluation. She holds a PhD in agricultural economics from Cornell University.

Robert Marten
Senior Program Associate, The Rockefeller Foundation

Robert Marten is a Senior Associate for the Transforming Health Systems Initiative, where he coordinates Foundation work with partners and leads research in support of the strategic development and execution of Foundation initiatives. He is also currently managing the Foundation's response to the Ebola crisis. Prior to joining the Foundation, Mr. Marten served as a consultant to the World Bank, WHO, and the German Technical Cooperation in Zambia and South Africa. He also worked at the Global Public Policy Institute in Germany and served as a UN Volunteer on HIV/AIDS in Vietnam. He is on the Board of Directors of the Global Health Council, and is a member of the Advisory Council of the Young Professionals Chronic Disease Network, and of the editorial board of Global Health Governance. Mr. Marten received a bachelor's degree from McGill University, a master's degree in public policy from the Hertie School of Governance, and a master's degree in public health from Johns Hopkins University. He is currently pursuing a doctoral degree from the London School of Hygiene and Tropical Medicine.

Sylvester Mensah

Former Chief Executive of the National Health Insurance Authority (NHIA); currently in charge of Special Duties, Office of the President, Ghana

Mr. Mensah has recently been appointed to be in charge of special duties in the Office of the President in Ghana. He previously served as the Chief Executive of the NHIA. In this capacity, he has initiated organizational restructuring, charting out a new strategic direction, and instituting re-form initiatives such as clinical auditing, which are driving cost-efficiency and other improvements in the National Health Insurance Scheme (NHIS). Under his leadership, the NHIS was awarded a UN award for Excellence, Leader-ship, and Innovation. He has over 25 years of experience working in various sectors including public services, banking, politics, and academia. Mr. Mensah served as a Member of Parliament for the Dadekotopon constituency in the Greater Accra Region between 1997 and 2001. He holds an MBA in Finance from the University of Leicester and a diploma in public health from the University of California.

Ariel Pablos-Méndez

Assistant Administrator for Global Health, USAID

Dr. Pablos-Méndez is the Assistant Administrator for Global Health at USAID, a position he assumed in 2011. Prior to serving in this role, Dr. Pablos-Méndez served as Professor of Clinical Medicine and Epidemiology at Columbia University, and as Managing Director at The Rockefeller Foundation where he led its global strategy on the transformation of health systems towards Universal Health Coverage and Public-Private Partnerships for technologies against diseases of poverty. He was previously Director of Knowledge Management at the World Health Organization. Dr. Pablos-Méndez received his MD from the University of Guadalajara's School of Medicine and his MPH from Columbia University.

Ravindra Rannan-Eliya

Executive Director, Institute for Health Policy, Sri Lanka

Dr. Rannan-Eliya is the Executive Director and Fellow of the Institute for Health Policy. He has expertise in a number of areas relating to health systems equity, health financing and policy, social protection and public expendi-ture analysis, with research, consulting and field experi-ence throughout Asia, Africa, Europe and Latin America. He is a leading international expert in health expenditure estimation and projection methods and health accounts systems, and has collaborated extensively with WHO, World Bank, OECD, and Eurostat. He is the coordinator of the Equitap health equity research network in Asia, and co-PI for the Global Network on Health Equity. He holds a doc-toral degree in health economics from Harvard University, and qualified as a physician from Cambridge University.

Martín Sabignoso

National Coordinator, Plan Nacer & Programa SUMAR, Argentina

Martín Sabignoso is a lawyer and the National Coordinator of Plan Nacer/Programa SUMAR, a federal policy of the National Ministry of Health of Argentina, that aims to gradually transform public health coverage into "effective coverage" for more than 14 million people through the implementation of an innovative results-based financing strategy. During his mandate, he led the design and implementation of a rigorous external evaluation of the program, receiving international recognition for being the first health insurance program in Latin America to demonstrate positive results through quantitative impact assessment. In 2014, Plan Nacer was awarded at the Geneva Forum for Health organized by McKinsey and Company as an innovative and transformative health policy. During 2014, he provided advisory services to the Health Ministry in Colombia (as an IADB consultant) and also to the Health Ministry in Perú (as an IPA consultant) on the design of health plans and results-based financing mech-anisms. He currently is a consultant for the Global Health Solutions Department of Washington University, Seattle.

Helen Saxenian

Independent Consultant

Dr. Saxenian works as an independent consultant to various organizations. She is a senior consultant to the Results for Development Institute. She led the Institute's support to GAVI-the Vaccine Alliance on the revision of several of its policies, including its eligibility policy, co-financing policy, and introduction grants and support to campaigns. Prior to this, Dr. Saxenian worked at the World Bank for 20 years in technical and managerial positions in the health area. Dr. Saxenian holds a PhD in applied economics from Stanford and a BA in economics from UC Berkeley.

Neelam Sekhri Feachem

Associate Professor, Epidemiology and Biostatistics, UCSF School of Medicine

Neelam Sekhri Feachem has over 30 years of experience in health policy, financing, and management of health care systems. She is course director for Comparative Health Systems and Health Financing in the MS in Global Health program at UCSF. She also teaches in other UCSF pro-grams, and serves as faculty for the UC Berkeley Global Health Leadership Forum. From 2003–2007, Ms. Sekhri Feachem served as health financing and policy advisor at the World Health Organization. More recently she was Senior Vice President for Global Access and Alliances at a San Francisco-based biotechnology firm. As founder and CEO of The Healthcare Redesign Group Inc. since 1994, Ms. Sekhri Feachem advises governments and international

organizations on health reform, financing, and policy. Previously, she spent fourteen years with Kaiser Permanente where she held executive positions in hospital and medical group management. She is an Associate Professor of Epidemiology and Biostatistics in the School of Medicine at UCSF.

Agnes Soucat
Director, Department of Health Systems Governance and Financing, Cluster on Health Systems and Services, World Health Organization

Before joining WHO, Dr. Soucat was the Global Lead: Health, Nutrition and Population for the World Bank. She previously held the position of Director for Human Development for the African Development Bank, where she was responsible for health, education, and social protection for 53 African countries. She previously worked for the World Bank in various capacities, including as Lead Economist and Advisor for Human Development for Africa; she additionally worked for UNAIDS, UNICEF and the European Commission. Soucat has many publications to her name, notably as co-author of the World Development Report 2004 'Making Services Work for Poor People.' A French national, Soucat holds an MD and Masters in Nutrition from the University of Nance, and a Master of Public Health and PhD in Health Economics from Johns Hopkins University.

Viroj Tangcharoensathien
Senior Expert, Health Economics, Ministry of Public Health, Thailand

Dr. Tangcharoensathien is a senior expert in health economics at the Ministry of Public Health, Thailand, and senior advisor to its International Health Policy Program, where he also heads the research hub for the Asia Pacific Observatory. In his role at the Ministry, Dr. Tangcharoensathien was involved in the design of the 1991 Social Health Insurance and 2002 Universal Health Coverage Scheme. Dr. Tangcharoensathien chaired the negotiations of the WHO Global Code of International Migration of Health Personnel, adopted by the Sixty-third World Health Assembly. He holds a medical degree from Mahidol University, and a PhD in health planning and finance from the London School of Hygiene and Tropical Medicine.

Hong Wang
Senior Program Officer, Bill & Melinda Gates Foundation

Dr. Hong Wang has over 29 years of experience in health policy globally, with a focus on health economics, financing and systems in developing countries. Currently a Senior Program Officer in the Integrated Delivery team at the Bill & Melinda Gates Foundation, Dr. Wang's responsibilities include leading formulation of the Foundation's position on critical issues in health economics, financing and systems, particularly related to primary healthcare (PHC) development. In addition he serves as an internal advisor and expert on the effects of health economics, financing, and systems on portfolio and program performance and on technical and data questions related to financing for health, health systems and PHC measurement. Dr Wang also manages a grant portfolio focused on improving primary healthcare globally. He received his MD from Beijing Medical University and PhD in Health Economics from University of Wisconsin at Madison. Dr. Wang is also an affiliate professor at the Department of Global Health, University of Washington.

Addis Tamire Woldemariam
Director General (Chief of Staff), Office of the Minister, Ministry of Health, Ethiopia

Dr. Addis Tamire Woldemariam is currently serving as the Director General of the Office of the Minister (Chief-of-Staff) in the Ministry of Health of Ethiopia. Before joining the Ministry he worked as a public health researcher for local and international organizations. For a good number of years after graduation Dr. Addis served as a physician in different public and private institutions. He has authored and co-authored a number of articles in prestigious journals including *The Lancet*. Dr. Addis is a medical doctor by profession with Masters Degree in Public Health from University of South Africa.

Gavin Yamey
Professor of the Practice of Global Health and Public Policy, Duke University

Gavin Yamey is a Professor of the Practice of Global Health at the Duke Global Health Institute (DGHI), Associate Director of Policy at DGHI, and a Professor of the Practice of Public Policy in the Duke Sanford School of Public Policy. He is also Director of Duke's Center for Policy Impact in Global Health. He was previously the Lead of the Evidence to Policy Initiative in the Global Health Group at the University of California, San Francisco. Dr. Yamey previously served as the Deputy Editor of the *Western Journal of Medicine*, Assistant Editor of the *BMJ*, and founding Senior Editor of *PLOS Medicine*. Awarded a Kaiser Mini-Media Fellowship in Global Health Reporting, Yamey developed a series on scaling up low cost health tools in Sudan, Uganda, and Kenya that was discussed in the UK Parliament. He has been external advisor to the WHO and to TDR, the Special Program for Research and Training in Tropical Diseases. Dr. Yamey holds a medical degree from Oxford University and University College London. He serves on two international commissions, The Commission on Investing in Health and The Commission on Global Surgery.

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