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Report on the

Regional meeting on accelerating progress towards universal health coverage: experiences and lessons for the Eastern Mediterranean Region

Dubai, United Arab Emirates
5–7 December 2013

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1. INTRODUCTION

Universal health coverage, as a health system development goal, was articulated in the Constitution of the World Health Organization (WHO) in 1948 and was integral to the Alma-Ata Declaration of 1978. Nevertheless, it has never been higher on the international health and development agenda than now.

The World Health Report 2010, *Health systems financing: the path to universal coverage*, refers to universal health coverage as providing all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) that are of sufficient quality, while ensuring that the use of these services does not expose the user to financial hardship. The Report highlights the importance of reshaping national health systems to facilitate moves towards universal health coverage. It calls for reforming health financing systems to collect more money for health, enhance financial protection and generate "more health for the money". However, universal health coverage goes beyond health financing and requires addressing other essential elements of the health system, such as the health workforce, health information systems, and essential technologies and medicines.

In the WHO Eastern Mediterranean Region, several socioeconomic and health system challenges continue to hinder the progress towards universal health coverage. These include the need for sustained commitment, clear vision and a well laid out roadmap, the lack of financial risk protection arrangements for large population groups, inadequate provision of needed health services, a shortage in good quality human resources for health and weak health information systems.

Health system strengthening has been identified as one of five strategic priorities for the work of the WHO Regional Office for the Eastern Mediterranean with its Member States over the next five years. A paper presented to the Fifty-ninth Session of the Regional Committee, in October 2012, identified health system challenges for countries in their progress towards achieving universal health coverage in the Region. The paper devised options for policy-makers to consider in their endeavours to reform national health systems. A follow-up resolution (EM/RC59/R.3) called on the Regional Director to provide Member States with a review of international experiences in moving towards universal health coverage, demonstrating the lessons learnt.

In this context, a regional meeting on accelerating progress towards universal health coverage: global experiences and lessons for the Eastern Mediterranean Region was held by the WHO Regional Office from 5 to 7 December 2013 in Dubai, United Arab Emirates. The purpose of this meeting was to share international experiences with regional policy- and decision-makers to assist them in devising a clear vision for health system reform to achieve the goal of universal health coverage. The meeting's programme is included as Annex 1.

The specific objectives of the meeting were to:

- share evidence and exchange experience of countries from within and outside the Region about what has worked and what has not in addressing challenges related to the collection, pooling and purchasing functions of health financing;
- document and discuss countries' experiences in addressing challenges related to other health system components, in particular the health workforce, service provision and health technologies;
- support countries, at their various levels of socioeconomic development, to formulate a vision and a roadmap to address health system challenges to move towards universal health coverage;
- promote multisectoral collaboration and foster partnerships between national and international stakeholders to support countries of the Region to move towards universal health coverage and sustain prior achievements.

The meeting was attended by several ministers of health as well as policy- and decision-makers and health system experts from ministries of health, finance, economy, planning and development, in addition to academics, civil society organizations and representatives of the World Bank, UNICEF, the United Nations Population Fund and the United Nations Development Programme, as well as donor agencies active in supporting health system strengthening in the Region: Canadian International Development Agency, Japan International Cooperation Agency, UK Department for International Development and United States Agency for International Development. A list of participants is included as Annex 2.

The meeting's agenda was arranged around the three dimensions of universal health coverage: financial protection, provision of needed services and expanding coverage to the poor and vulnerable. An expected output of the meeting was the development of a roadmap to accelerate progress towards universal health coverage in the Region (see Annex 3).

2. SUMMARY OF PRESENTATIONS AND DISCUSSIONS

2.1 Opening session

In his opening address, Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean, observed that every year, millions of people globally are deprived of needed health care and millions of others experience financial hardship because of the way health services are arranged, delivered and financed. Universal coverage means that all people have access to needed and quality care, without facing the risk of financial ruin, he said.

Dr Alwan referred to the multiple challenges facing countries of the Region in their pursuit of universal health coverage, and emphasized WHO's commitment, as entrenched in its Constitution and follow-up declarations, to support its Members States to achieve the goal of universal health coverage. He noted the importance of research and the need to have a clear framework for action to guide countries in their pursuit of universal health coverage. He observed that the challenges were known and that it was time to develop country-specific

solutions to address them, building on the experiences of others. Finally, the Regional Director emphasized the importance of measuring and monitoring progress towards universal health coverage.

In his welcoming remarks on behalf of H.E. the Minister of Health of United Arab Emirates, Dr Nasser Khalifa Al-Bedour, Assistant Undersecretary at the Ministry of Health and Director of the Minister of Health's Office, emphasized the importance that the Ministry attributed to health system strengthening to promote universal health coverage. He described how the Ministry was working closely with its partners to achieve the highest standards in health care delivery.

Dr Enis Baris, of the World Bank, presented the new World Bank strategy for health in the Middle East and North Africa region and its links to the goal of universal health coverage. The new strategy rests on the values of fairness and accountability, taking into account the economic reality in countries. The World Bank is committed to eliminating poverty and enhancing prosperity, and while universal health coverage is important, maintaining achievements in this area is equally important. The World Bank will support countries to pursue the goal of universal health coverage, through increasing analytical work in support of health system strengthening, focusing on achieving the Millennium Development Goals (MDGs) 4 and 5, working with WHO and other partners to clarify measurement issues related to universal health coverage, deepening work on the delivery dimension of universal health coverage, especially by improving services for the poor, and improving health through action in all sectors.

Dr David Evans, Director of the Department of Health Systems Financing at WHO headquarters, addressed developments since the publication of the World Health Report 2010. In terms of progress towards universal health coverage, 1300 million people are still without access to affordable and effective health care, while 150 million and 100 million are facing financial catastrophe and impoverishment, respectively, due to out-of-pocket payments. While more funding for health is needed in many countries, reducing direct out-of-pocket payments by increasing compulsory prepayment and pooling (with consideration for the poor and vulnerable) and enhancing efficiency are of equal importance. It is also important to note that universal health coverage is not only about health financing and does not only concern treatment, but is a concern for all priority health programmes. It also does not entail abandoning the health MDGs. WHO provides support to countries for analysis, policy dialogue and developing national strategies for universal health coverage. The World Health Report 2013 focused on research for universal health coverage and WHO is undertaking research on the role and contribution of health system components and social determinants in advancing universal health coverage. There remains a need for continued advocacy for universal health coverage, given the many competing demands and the ongoing discussions related to the post-2015 development agenda.

The situation in Eastern Mediterranean Region was presented by Dr Sameen Siddiqi, Director of the Department of Health Systems Development at the WHO Regional Office for the Eastern Mediterranean. The share of out-of-pocket payments from total health spending

has been stable in the Region over the last decade, but different groups of countries in the Eastern Mediterranean Region have demonstrated different trends. In group 1 countries, the share of out-of-pocket payments decreased from 21% to 17% during the last decade; in group 2 countries, it fluctuated around 50%; and in group 3 countries, it increased from 59% to 69%. Regarding service coverage, there is variation in geographical access and discrepancy in the depth of coverage across the three groups, in particular in relation to noncommunicable diseases.

Despite the challenges, opportunities do exist for progress towards universal health coverage, as outlined in the strategies and roadmap of actions that were proposed to Member States during the last Regional Committee to accelerate progress towards universal health coverage. The strategies include developing a vision and strategy for advancing progress towards universal health coverage, establishing a multisectoral national taskforce to steer the agenda, advocating for political commitment and updating of legislation, strengthening the unit in ministries of health responsible for coordinating universal health coverage, generating local evidence and sharing international experiences, monitoring progress, and establishing a regional taskforce including representatives from development partners and countries. Universal health coverage is integral to the Twelfth General Programme of Work and the five priority work areas of the Regional Office. A framework for monitoring progress towards universal health coverage is currently being developed. It is important to include population coverage in any monitoring framework, and distinguishing between who is eligible, entitled and actually covered by various prepayment arrangements would be useful. The strengthening of all elements of the health system is important and this can be only done through effective partnerships.

2.2 Political commitment and universal health coverage

Dr Mihaly Kokeny, former Minister of Health of Hungary and Adviser to the WHO Regional Director for Europe, presented on how the European Region has used the robust generation of evidence to inform Europe-wide health policies and held high-level conferences on universal health coverage. This has resulted in the Region's evidence-based Health 2020 policy framework, adopted in 2012, which aims to reduce identified inequities in health through more horizontal and participatory governance for health. In addition, in 2013, three high level Europe-wide conferences were held to address issues related to universal health coverage. The April 2013 Oslo conference tackled the impact on health systems of fiscal policies brought about to respond to the economic crisis in Europe, with the adverse impact of decreased funding for health on health system performance being discussed.

The combination of good evidence and the Region-wide conferences contributed to the adoption of universal health coverage-related policy lessons at the Sixty-third Regional Committee for the Europe. Among these lessons were that social safety nets and labour market policies are part of intersectoral action that can mitigate the negative health effects of the financial and economic crisis and that fiscal policy should avoid prolonged and excessive cuts in health budgets. In particular, there is need for a systematic and reliable information and monitoring system to safeguard access to services.

Dr Suwit Wibulpolprasert, Senior Adviser on Disease Control, Ministry of Public Health, Thailand, enumerated six lessons from the country's experience in pursuing universal health coverage. The first lesson is that universal health coverage reduces poverty and can be started and eventually achieved despite a low level of national income. A second lesson is the need to ensure universal availability of quality comprehensive essential health services and committed health workers. The extensive expansion of rural health facilities and health professionals in early 1980s laid the foundation for the eventual push for universal health coverage in 2002.

The third lesson is that universal health coverage requires continuing efforts to get more money for health and more health for the money. The proportion of health to the total national budget increased from 3.4% in 1972 to 8.1% in 2004, and further increased to 14% in 2013. As the share of health to national budget increased, the share of out-of-pocket payment to total health spending was reduced from 75% to less than 30%. In addition, local authorities were persuaded to contribute to health spending through the Community Health Development Fund and an additional 2% was added, collected as tobacco and alcohol excise taxes earmarked for health. The use of a capitation-based budget with mixed payment mechanisms with primary care providers acting as gate-keepers, helped generate more health for the money. Central bargaining and purchasing of drugs also generated more health for the money.

The fourth lesson is that economic growth and peace ensure sustainability of universal health coverage. The estimated 30% fiscal space created between the mid-1980s to mid-1990s from internal peace and export-led economic growth facilitated more funding for universal health coverage. The fifth lesson is that the informal sector can be gradually covered, starting with the poor, near poor, children and elderly, and later on extended to everyone else. The final lesson is the need for adequate capacity to generate evidence on universal health coverage. Several institutions have been built up in Thailand to provide evidence on universal health coverage including the Health Systems Research Institute and the Health Intervention and Technology Assessment Programme.

Professor Meng Qingyue, Dean of the School of Public Health and Executive Director of the China Centre for Health Development Studies, Peking University, Beijing, China, described how the Chinese Communist Party Congress (CCPC) and the State Council provided the political commitment for implementing universal health coverage reforms in China. In 2002, the CCPC and State Council called for deepening rural health care development, leading to the roll out of the New Rural Medical Cooperative Scheme in 2003. In 2006, the State Council ordered the creation of a financial protection mechanism for urban residents leading to the establishment of the urban resident-based Basic Health Insurance Scheme in 2007. In 2009, the CCPC and State Council decided to reform both rural and urban health systems through comprehensive health system reform.

The 2009 health system reform called for extending population coverage and a benefits package of social health insurance schemes, while strengthening the capacity of the primary care system. Full government financial support was provided to cover 45 public health (primary care) programmes and interventions. Access to curative care was to be financed

through the New Rural Medical Cooperative Scheme, urban resident insurance schemes mainly funded by government and urban employee health insurance funded by employer and employee contributions.

CPCC approval meant that the political leadership for universal health coverage reforms was beyond and above ministries. It led to defined performance indicators for central ministries and local government. Indeed, the achievement of health reform became an important component for assessing performance of local government. By 2011, population coverage by the three health insurance schemes had gone up to 88% from less than 60% in 2007, while the percentage of out-of-pocket payment to total health expenditure went down from 60% in 2001 to 35% in 2011.

Lessons learnt

Generating political commitment for universal health coverage requires moving beyond the health system and engaging politicians, given that the pursuit of universal health coverage requires policy decisions and actions that are outside the health sector and that it is affected by decisions made outside the health sector. This engagement requires robust evidence and clear messages that will be understood by politicians. International organizations should also harmonize and clarify their messages. There is a need for continuous engagement, including the convening of meetings to sustain political support. Political commitment can be sustained by good performance and results, thus re-emphasizing the need for robust evidence, data and analysis. The economic crisis should be seen as an opportunity to scale up efforts towards universal health coverage. Finally, community tools can be used to ensure that the informal sector also contributes.

2.3 Expanding financial protection

Professor Recep Akdağ, former Minister of Health of Turkey, described how wide-ranging Turkish health system reforms had not only brought down out-of-pocket payments to 15% of total health expenditure in 2012 but had also decreased the rate of households impoverished due to health expenditure from 0.43 in 2002 to 0.07 in 2012, increased life expectancy to 75 years in 2009, and brought down the infant mortality rate to 9.15 and the maternal mortality rate to 14.5.

Prior to the reforms, Turkey had five different health insurance schemes that were considered inequitable with members getting limited access to health care services due to limited resources, the “dual practice” of health care professionals and extensive red tape. In response, Turkey designed a single government health insurance system that expanded the benefits for members (curative, pharmaceutical and other services) in coordination with Ministry of Health-funded primary care and emergency transport services.

The single payer system helped increase government spending for health care services, while controlling public pharmaceutical and other expenditure. Public expenditure for health increased from US$ 9 billion in 2002 to US$ 34.3 billion in 2012, while government

pharmaceutical spending in 2012 was maintained at its 2002 level of around 14.5 billion Turkish lira despite the increase in the number of pill boxes from 699 million in 2002 to 1.77 billion in 2012.

Dr Jamal Abu-Saif, Director of Technical Affairs, Studies and Research, High Health Council, Jordan, outlined how Jordan reduced the share of out-of-pocket payment to total health expenditure from 35.8% in 2007 to 22.6% in 2011. The decrease in out-of-pocket payment can be attributed to various factors including decreased pharmaceutical spending and an increasing share of social health insurance in total health expenditure.

With regards to pharmaceutical spending, its share of gross domestic product decreased from 3.1% in 2007 to 2.09% in 2011. This has been attributed to regular review of drug prices, the strengthening of the role of the Joint Procurement Department to purchase drugs for all public sector health institutions, and an improved computerized pharmaceutical supply system.

As to the increased spending on social health insurance, this was partly brought about by the decision to cover all children under the age of six years and senior citizens aged 60 years and above with the Ministry of Health's Civil Insurance Fund. This Fund and the Royal Medical Services' Military Insurance Fund are the two government health insurers in Jordan that cover 68% of the population. Their coverage, together with the population covered by the Jordan University and King Abdullah University Hospitals, private health insurers and UNRWA, brings the population covered by health insurance to more than 80% of the population. In addition, uninsured Jordanians can get full access to health care if they are granted an exemption by the Royal Court for being designated an "unable to pay" Jordanian national.

Dr Hailom Banteyerga, Professor in Behavioural Studies and Lead Researcher, Miz-Hasab Research Centre, Ethiopia, presented country reports for Bangladesh, Ethiopia, Kyrgyzstan and Thailand, and a report on the state of Tamil Nadu in India, from the Good Health at Low Cost study on universal health coverage. All four countries and state reported improved life expectancy and lowered total fertility, infant mortality, under-5 mortality and maternal mortality rates.

In Bangladesh, among the interventions that helped improve health system performance were a well-implemented generic pharmaceuticals policy and investment in the health workforce. Among interventions in Ethiopia was the health extension programme that led to more trained health professionals, new medical schools and scaled-up training of nurses and health officers. Funds were also made available throughout the health system utilizing different mechanisms including revenue retention and the opening up of private wings in public facilities.

A functioning health insurance system in Kyrgyzstan, which covered both hospital care and primary care, complemented by a state-guaranteed benefits package for vulnerable populations and an additional drugs package subsidizing essential medicines, drove the improvement in the health system performance. The health insurance system facilitated new

provider payment mechanisms and led to an expansion of community health centres and investment in the health workforce. Among other interventions, Tamil Nadu state used village health workers and a network of 24-hour primary health care facilities, built up with innovative approaches to funding and the construction of new health facilities, as well as investment in public health managers at district level, to bring about and sustain improved health system performance.

Thailand strengthened district hospitals with infrastructure investment and increased staffing, brought about by a bonding system whereby newly qualified doctors were required to spend three years in rural areas. In addition, many of the director-generals of the Ministry of Public Health and other senior staff received training overseas. Reform advocates worked closely with media, nongovernmental organisations and professional bodies. In particular, the Rose Garden group, an informal group closely linked to the Rural Doctors Society of Thailand, provided a forum for policy discussions and played a key role in the reforms.

In these countries and state, there were skilled and frequently inspirational individuals, supported by strong institutions ensuring capacity and continuity. They also seized windows of opportunity and ensured that programmes were adapted to the circumstances of the country rather than simply being copied from somewhere else.

Dr Eduardo Banzon, Regional Adviser, Health Economics and Health Care Financing, WHO Regional Office for the Eastern Mediterranean, presented the experience of Philippines where a social health insurance scheme was started in the early 1970s, partly in response to the perception of “better” services from private providers and the desire to access these private providers, and the subsequent need to address increasing out-of-pocket payment in private hospitals (and in private rooms/wards of government hospitals). The social health insurance scheme, called Medicare, mandated compulsory membership for formal sector employees, and then the rest of the population, with premium payments shared by formal sector employers and employees. Membership was a family membership with mostly hospitalization benefits. There was an independent Medicare commission as a policy-making body and two separate social health insurance funds managed by two separate government-managed pension funds; namely, the fund for private sector employees (Social Security System) and the fund for public sector employees (Government Service Insurance System). Unfortunately, unregulated co-payments or balance billing was allowed.

In the years that followed, there was deterioration in government hospital services marked by poor quality of care and lack of health goods and services. Patients were given prescriptions, and orders for diagnostics and other services, that required them to buy these medicines and services from outside the hospitals. Dual practice was not prohibited, resulting in increasing private practice and private rooms within government hospitals. With regards to private health care providers, unregulated co-payments and the fee-for-service Medicare payments did not substantially decrease out-of-pocket payment in private hospitals. Outpatient benefits were never implemented and very few informal sector Filipinos were enrolled in health insurance coverage, which stuck at 30% of the population.

In response, the government enacted a national health insurance law and established the Philippine Health Insurance Corporation (PHIC) in 1995. The PHIC is an autonomous government-owned and controlled corporation that focuses on health insurance and is attached to the Ministry of Health with its own governing board. It manages a single nationwide health insurance fund covering the formal, non-poor informal, and poor informal population. Government fully subsidizes the premiums of the poor who are identified by a nationally-run income proxy means test. The decision to set up the PHIC has led to increased funding for health, including recently approved tobacco and alcoholic taxes earmarked for health. The funding is protected and flexible and is not tied to the annual budget cycle. The PHIC has changed the relationship of the provider and the patient (covered member) by empowering the patient. It has facilitated strategic purchasing, including access to private providers and space for private sector involvement/partnerships. It has additionally forced government hospitals to improve management capacity and provided fertile ground for local governments to innovate.

Lessons learnt

The setting up of a single payer system has significantly contributed to expanding financial protection, coupled with government subsidizing of the health insurance premiums of the poor and other vulnerable populations. It has required overcoming resistance and opposition from stakeholders who believe that they will be adversely affected by the single payer system and government subsidies. This opposition is best addressed by politically by government.

Another intervention that has reduced household out-of-pocket payments is policy action to improve access to medicines including subsidies for drugs and leveraging government purchasing power through procurement or health insurance benefits. In both Jordan and Turkey, government action has contributed to reducing the prices of medicines and subsequently the share of out-of-pocket payments to total household expenditure on medicines.

Government should closely engage with the private sector in order to ensure that they support efforts to improve financial protection and do not oppose it. Universal health coverage objectives can be reached quickly if political commitment is coupled with intensive implementation.

2.4 Monitoring progress towards universal health coverage

Dr David Evans, Director, Health Systems Governance and Financing, WHO headquarters, presented the ongoing discussions on how to measure universal health coverage and how the subsequent measurements should be shown and communicated. The discussions include determining which health services to include when measuring service coverage and the criteria for inclusion as service (intervention) coverage indicators. Currently, the planned criteria include: being a priority health concern based on the burden of disease addressed by the intervention; the cost-effectiveness of the intervention; that the indicator includes a measure of quality (sometimes referred to as “effective coverage”); and the presence of

credible measurement methods that can be done on a regular basis. Other criteria are the possibility to do equity disaggregation by household wealth/income, gender, residence and other key stratifiers, and measurement comparability across countries.

Based on the criteria, tracer indicators of service coverage being considered include vaccination coverage, maternal health indicators and treatment of pneumonia in children. Other possible tracers are hypertension treatment coverage (with success), human papillomavirus (HPV) or hepatitis B vaccination, and measures on non-smoking, physical exercise, non-obesity and salt intake. Treatment indicators may include people with angina receiving ambulatory treatment, people with diabetes receiving effective treatment and those treated with coronary angioplasty/bypass surgery. With all these possible interventions that may be considered for monitoring, countries will have to make choices according to their own priorities and capacity to monitor. However, it is best that these choices include both MDG and chronic conditions, and be selected using a standard criteria that ensures technical soundness as well as resonance with policy-makers and the general public.

The financial risk protection indicators being considered are the incidence of catastrophic health expenditure due to out-of-pocket payments and catastrophic overshoot, and the incidence of impoverishment due to out-of-pocket payments and the deepening of poverty due to health care costs. The population measures include equity dimensions with a focus on the population at the bottom 40% income levels.

Finally, there is a need to bring together global and country perspectives. Globally, there will be one monitoring framework and one common small set of targets and indicators (or index) with regular standardized reporting and review of progress using the common indicators. At the country-level, universal health coverage monitoring will be based on an adapted set of tracer indicators with the monitoring aligned with country systems. Based on current discussions, the possible universal health coverage goal and targets post-2015 would be as follows.

Goal: Achieve universal health coverage: i.e. all people should obtain the quality health services they need without financial hardship.

Targets

- Coverage with needed health services should be at least 80% in the bottom 40% of the population by income.
- No one should be pushed into poverty because they need to use health services and have to pay out-of-pocket for them.

Possible indicators

- Health intervention coverage: a core set should include, for example, skilled birth attendance, full immunization coverage, family planning coverage, antiretroviral therapy coverage, tuberculosis treatment coverage, insecticide-treated net coverage for malaria (if relevant), non-use of tobacco, coverage of hypertension treatment, diabetes treatment and vision correction. More indicators can be added if good indicators become available (MDG/chronic condition and injury indexes).
- Financial risk protection: proportion of the population impoverished due to out-of-pocket health payments.

Professor David Peters, Chair of the Department of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, USA, described the importance of implementation research in achieving universal health coverage. Implementation research is the scientific inquiry into questions concerning any aspect of implementation, and uses various tools including management improvement, operational research, policy implementation, participatory action research, and dissemination and implementation of evidence-based medicine. Its research methods use a mix of quantitative and qualitative methods that require continuous adaptation. Implementation research seeks to understand how, why and what is implemented and the effects. It looks into "interventions" at several levels: policies, programmes and individual practices. It tests implementation strategies designed to improve the delivery of technical interventions.

Implementation research hopes to help practitioners, policy-makers, consumers, researchers, funders and others understand the context and inform them of how to improve coverage, quality, efficiency and effectiveness of health interventions. It helps assess performance, inform implementation, build ownership and accountability, strengthen health systems, support scale-up and integration of interventions, and develop and strengthen problem-solving capacity and learning capabilities.

Professor Jean-Paul Moatti, Director of the Institue Thematique Multi-Organismes de Sante Publique and Director of the University of the Mediterranean, Marseilles, France, presented the measures of efficiency and equity used in efforts to expand and achieve universal health coverage in France. The country has a compulsory government health insurance system with everyone paying according to their ability to pay and receiving benefits according to their need. It allows supplemental private health insurance as optional, with benefits and premiums mainly dependent on the quality of the insurance and partly on age. However, it provides free supplemental universal health insurance coverage for vulnerable populations.

With this set-up, there is vertical equity in health care financing (unequal treatment of unequals) with people needing different treatment receiving appropriately different treatment, irrespective of their other characteristics. Everyone pays nearly the same average amount of premium for the government health insurance, with the government subsidizing the poor. As to supplemental health insurance, the rich pay more for it, with the highest income decile paying more than ten times the lowest income decile.

There is horizontal equity in access to care (equal treatment of equals) as people in the same need of treatment receive similar treatment, irrespective of their other characteristics (such as income). Studies have shown that there are no significant differences in the lag time between primary diagnosis of breast cancer and treatment initiation between the rich and the poor. Furthermore, the utilization of health services by the rich is not significantly different to the poor.

Lessons learnt

The challenge is to determine global measures for universal health coverage and although much progress had been made on this, the discussions continue. However, whatever decisions are made globally, country-level monitoring should take into account the capacity and capability of countries to measure selected indicators. Countries should focus on getting implementation right and integrating data into decision-making. However aspirational they decide to be in the universal health coverage indicators they select, the indicators should always take equity and efficiency parameters into account.

2.5 Increasing service coverage for universal health coverage

Professor Salman Rawaf, Professor of Public Health, Imperial College London, United Kingdom (UK), presented the story of the UK's National Health Service (NHS) which was established to secure equal access to comprehensive health and health care for every individual across the country regardless of their ability to pay. The NHS is funded by taxes with resources allocated based on population structure, standardized mortality rates, deprivation, market forces and local health needs assessment. There is central government standard setting and planning with local level management. There are no military or university hospitals, and a very small complementary private health care sector. Management costs are low at 7% of the total NHS budget. In 2013–2014 (financial year), 18% of the government budget went to health care, with the NHS getting around £120 billion. In 2013, the NHS employed 1.7 million people with 146 000 medical and dental staff including 40 000 general practitioners (GPs) providing high quality health care.

Dr Hans V. Hogerzeil, Professor of Global Health and the Right to Health, Groningen University, Netherlands, talked about access to essential medicines as part of the "right to health". The rights-based approach asserts that the right to health is a human right enshrined in the WHO Constitution, United Nations declarations and Covenant, and supported by 135 national constitutions. Access to medicines is part of the right to health as this is included (as goods) in how this human right has been defined. The argument for the right to health (and medicines) had led to successful legal and court challenges in many countries, with the success often linked to constitutional provisions supported by human rights treaties, and legal, financial and advocacy support by public interest nongovernmental organizations. Court decisions have ordered reimbursement payment for essential drugs including antiretroviral medicine.

Analysis of legal texts in support of access to essential medicines as part of the right to health in the Eastern Mediterranean Region found that eight countries had a duty statement, five had a programmatic statement, five had specified entitlements, 12 had a national

medicines policy, and four had a draft national medicines policy. Given the analysis, countries should use ongoing political opportunities presented by the updating of constitutions to consider key human rights principles, and specifically the right to health and equitable access to essential medical goods and services. Examples of clear constitutional text identified by WHO, may serve as a model for activists, policy-makers and legislators when the political opportunity arises.

Dr Barbra Stilwell, Senior Director, Health Workforce Solutions, IntraHealth International, presented on the human resources for health dimension of universal health coverage. The health workforce is central to attain, sustain and accelerate progress on universal health coverage. Common issues for all countries include shortages of some categories of health worker, with more forecast, and an ageing health workforce presenting the challenge of replacement. Skills-mix imbalances persist and there is still insufficient utilization of advanced practitioners, midwives, nurses and auxiliaries in many settings. There are wide and persistent variations in availability and accessibility within countries because of attraction and retention difficulties. The need to adapt the contents and strategies of education is a major challenge everywhere and there is a need to keep health workers motivated in an enabling environment. Performance assessment and quality of care are afforded insufficient priority and there is varying country capacity to estimate future health workforce needs and design longer-term policies. Finally, human resource information data and systems to meet the needs of decision-makers require strengthening and investment.

Dr Hernan Julio Montenegro Von Mühlenbrock, Health System Adviser, Health Policy, Development and Services, WHO headquarters, talked about family practice in lower- and upper-middle income countries focusing on the experiences of Brazil, China and Thailand. In Brazil, after decades of a selective primary health care approach, municipality-based experiments with comprehensive, population-based approaches were started in the 1980s. By the mid-1990s, national programmes, such as the community health agent programme and the family health programme, had been built upon the success of these municipality-based experiments. By 2006, a national primary health care policy, the family health strategy (FHS), had been institutionalized.

The FHS uses multidisciplinary teams composed of a GP, nurse, medical auxiliary/nursing technician, community health agent (CHA) and oral health professional, responsible for around 3000 to 4000 people, with 1 CHA per 750 people. The team provides comprehensive services at a health centre supplemented by outreach activities and complemented by specialized support units. It is paid through per-capita funding plus incentives. The FHS has contributed to improved health outcomes, increased coverage and utilization of primary care services, and reduced inequities in utilization with 33 420 family health teams covering 55% of the population and 256 847 CHAs covering 65% of the population. There are also 20 113 oral health teams and 1250 specialized support units. There has been improved efficiency, such as a reduction in hospital admission rates for conditions treatable at primary care, and increased user satisfaction.

In China, from the 1960s to 1980s, there existed the village-township-county three-tiered care network and cooperative medical care system, providing coverage for 90% of rural residents. The economic reforms of the 1980s, including de-collectivization and hospital expansion, weakened the primary care system as much of the population bypassed primary care and went directly to hospital outpatient clinics and emergency rooms. In response, a national strategy to reform the health care system, including the strengthening of primary care, was started in 1997. This strategy included the construction of community health centres and the recruitment and training of GPs.

By 2011, the GP system has been formalized as an objective with a 2020 goal of 2/3 GPs per 10 000 people. Similarly to Brazil, the GP system has interdisciplinary teams providing comprehensive services at a centre plus outreach activities. They are gatekeepers with referral systems to the rest of health care network. After a couple of years, the results are showing increased coverage and utilization of primary care services and reduced inequities in utilization of primary care services

In Thailand, in the 1990s, the demonstration diffusion strategy, using a family/community medicine approach, was piloted in a number of provinces. In the late 1990s, family medicine as a specialty was expanded. In 2002, the introduction of universal coverage led to the strengthening of the primary care unit with a doctor, pharmacist and dentist present for 75% of the time. The universal coverage system defines the population that have to register with the contracted universal coverage who will then provide the registered population with comprehensive and integrated services plus outreach. This has led to improved health outcomes, particularly in maternal and child health, as well as increased coverage and utilization of primary care services, reduced inequities in utilization, improved efficiency, including a reduction in the bypassing of primary care services and in over-investigation/testing, and increased user satisfaction.

In all three countries, the family practice reforms required strong political commitment and consistency of policies linked to the expansion of public health care expenditures and comprehensive service delivery reform (shifting services from hospitals to primary care). Family medicine/GPs were defined as the preferred model of interdisciplinary primary care service teams and funded by improved resource allocation to primary care services including financial incentives.

Dr Sameen Siddiqi, Director, Department of Health System Development, WHO Regional Office for the Eastern Mediterranean, presented a study of the role of the private sector in Eastern Mediterranean Region. The study included 12 country studies on the private health sector and a review of published reports, ministry of health records and grey literature.

In the Region, the private sector accounts for 5% to 92% of primary care facilities in countries. The private sector share of pharmacies and diagnostic facilities is also high, reaching more than 80% in a number of countries. However, the private sector has a lower share of hospital beds in Gulf Cooperation Council (GCC) countries, with the highest share at 26%, in contrast to a private sector share reaching up to 83% in middle-income countries in

the Region. With regards to the health workforce, dual practice is increasingly being addressed in the Region with the practice not permitted in Jordan and GCC countries, and the Islamic Republic of Iran recently restricting it until after five years from graduation. The private health workforce is concentrated in urban areas and is marked by unregulated expansion. Unfortunately, there is limited data on workforce distribution, salary structure and multiple job holding, with inadequate coordination between ministries on planning for the public and private sectors.

There have been huge investments in high-tech imaging technology, sometimes motivated by medical tourism, with irrational use of biomedical devices and technologies leading to high out-of-pocket payment and associated medical errors. This is compounded by a weak medicine regulatory system, poor enforcement, limited control on medicine promotion/advertisement, and insufficient patient education. Indeed, non-prescription sale of antibiotics in private pharmacies is a major concern as it contributes significantly to increased antimicrobial resistance. Existing policies for engagement between public and private sectors are evolving in most countries but they need updating as informal health care is largely unregulated, there is inadequate regulatory control for quality, and limited ministry of health capacity to formulate policies and fulfil regulatory responsibility.

Dr Salim Al Saqri, Director of the Department of Primary Health Care, Ministry of Health, Oman, presented on the situation of health system strengthening for universal health coverage in Oman in line with the ongoing work to develop the Oman health system through Health Vision 2050 and the related strategy. The Ministry of Health is the primary provider of health services covering 90% of the population. The rest are covered through the Armed Forces, Royal Court, Sultan Qaboos University and the private sector. There are five tertiary, seven secondary and 230 primary health care facilities in Oman. The current focus is on strengthening primary health care by integrating preventive and curative services at the peripheral level, as well as decentralization of decision-making to district level. A focus will be given to the management of noncommunicable diseases, with more attention to early detection of diseases, identifying the needs of specific target groups and developing specific health strategies for these target groups such as adolescents and the elderly. To support the strengthening of primary health care, there are ongoing efforts to build GP capacity by getting the programme accredited by the UK’s Royal College of General Practitioners. Oman will continue to build new health centres and will redesign the current structure of the centres to match both service and training needs.

Lessons learnt

Expanding service delivery requires continuous funding as shown by the experience of the NHS where funding has been sustained and increased through the years. However, the increasing move to social health insurance systems and the new money they are mobilizing requires parallel reforms in service delivery as the new money would be wasted if it ends up funding a fragmented system. A service delivery reform that had been shown to work is the family medicine/primary care approach and parallel health insurance/family medicine reforms would expand service delivery. Service delivery expansion also needs reforms in

human resources for health, including increasing investment in producing family medicine/primary care health professionals. Another approach that has expanded access to health services and goods, particularly drugs and medicines, is the use of the right to health as a basis to assert legislatively and judicially the need for improved access to drugs and medicines. Finally, there is a need to coordinate and engage with the private sector in order to ensure that they support expansion of service delivery and so as to not fragment service delivery.

2.6 Population coverage: reaching out to all

Dr Nishant Jain, Deputy Programme Director, Indo-German Social Security Programme, German Development Cooperation (GTZ), New Delhi, India, presented on the Rashtriya Swasthya Bima Yojana (RSBY) health insurance scheme in India, which covers approximately 136 million people in 28 states and union territories. For the covered population, approximately 37.5 million RSBY cards have been issued by 17 private health insurance companies with around 6.3 million receiving RSBY-covered hospital services from around 11 000 enrolled hospitals. The state governments work with private insurance companies who are selected through an open tendering process and are then given a list of potential beneficiaries. The insurance companies then go into the field and enrol beneficiaries in villages. The premium for RSBY coverage is shared by the central and state government with the covered family paying 30 Rupees (US$ 0.5) per year upon enrolment. The enrolment process includes taking a fingerprint and photograph, and the printing and giving of a smart card on the spot, with a government representative authenticating the smart card and fingerprint. The smart card allows data to flow every day from each hospital to the insurer and the government, and facilitates paperless claim settlement processing for the enrolled hospitals.

The competition between public and private hospitals, with incentives flowing to the staff of public hospitals from RSBY payments, has led to an increase in the number and capacity of private hospitals including the setting up of private hospitals in remote areas and improved quality of services in both public and private hospitals. In a 2012 evaluation, 90% of the enrolled and hospitalized RSBY respondents had spent no money at the hospital for the last policy period in comparison to non-RSBY patients who spend on an average 17 000 Rupees (USD 320) per year from their own pocket. User satisfaction is high, with 90% of beneficiaries satisfied with the scheme and more than 94% of beneficiaries saying they would enrol the next year, even if they did not use hospitalization services.

Dr Abdullah Al Sharif, Secretary General, Council of Cooperative Health Insurance, Saudi Arabia, discussed the need to extend coverage to the expatriate population in GCC countries. In 2010, the expatriate population accounted for 86.5% of the total population in Qatar, 70% in the United Arab Emirates and 68.8% in Kuwait. In Bahrain, they account for 39% of the population. Both Oman and Saudi Arabia have the lowest rates with the expatriate population accounting for 28% of the total population. The GCC countries have taken steps to cover the expatriate population but have used different laws and arrangements, with varying levels of implementation and success. As a result, there are varying levels of population

coverage. Article 95 of Bahrain's 2008 labour law mandates that an establishment employing more than 50 workers should provide for the basic care of their health in accordance with orders to be made by the Ministry for Health in agreement with the Minister for Labour and Social Affairs. Article 1 of Kuwait's 1999 law on alien health insurance and the imposition of fees against medical services, states that health/medical services should be provided to aliens residing in the country under the health insurance and medical security systems in accordance with the provisions of the law, provided that it is not contradictory to Islamic law.

In Oman, Article 33 of Royal Decree 35/2003, issuing the labour law, provides that if a worker is treated in a government or private hospital, the employer shall incur the cost of treatment, medicine and in-patient care at the hospital in accordance with the regulations and financial rules applicable in such hospitals without prejudice to the provisions of the social insurance law. Article 144 of the Saudi labour law, Royal Decree M/51 September 2005 (23 Sha'ban 1426/27), requires an employer to provide their workers with preventive and therapeutic health care in accordance with the standards set forth by the Minister taking into consideration whatever is provided for by the cooperative health insurance law. In Qatar and the United Arab Emirates, mandatory health insurance schemes have been ordered for all national and non-national residents. Abu Dhabi has implemented the mandatory scheme for the last four years, while Dubai began implementing last year. Qatar is expected to fully implement the mandatory scheme by 2015.

Dr Arash Rashidian, Associate Professor of Health Policy and Management, School of Public Health, Tehran University of Medical Sciences (TUMS), presented on establishing urban primary health care in the Islamic Republic of Iran. In 2005, family medicine pilots in four provinces undertaken in 2002–2003 were scaled-up nationally leading to rural family physicians and rural health insurance in all villages and towns with populations of less than 20 000. In 2008, the first attempt was made to establish urban family medicine. The Ministry of Health and Medical Education started to establish urban family medicine pilot projects in three provinces with the expectation that the funds for implementation would be transferred from government insurance organizations to the Ministry. However, due to opposition from government health insurance organizations, the pilot projects proved a failure.

In the fifth 2011–2015 development plan, the policy on healthy people and comprehensive health included the following strategies: a) a universal and comprehensive health care system based on primary health care, family physicians and a referral system; b) a single-payer social health insurance and strategic purchasing; c) eliminating public-private dual practice; and d) increasing financial resources for health care, targeting governmental subsidies and earmarked taxes. This has led to the Ministry planning for urban primary health care in all cities nationally, with insurers expected to contract family physicians and oversight provided by the Ministry. It is expected that there will be no co-payment for a visit by a family physician and medicines. However, the lack of increased funding and opposition from the private sector and the Medical Council of Islamic Republic of Iran, along with weak support from insurers, has delayed implementation.

Dr Sania Nishtar, Founder and President, Heartfile, Pakistan, described the mixed health system of Pakistan. There are various ways in which resources are or can be mobilized for health care in the country. This includes adopting the universal service fund approach of the telecommunications industry and infrastructure financing through public-private partnerships. Other approaches are through philanthropy, by publicly mandating corporate profits for health, through *Zakat* and *Bait ul Mal*, and debt swaps.

Examples of innovations in pooling include the employees social security institutions which are a publicly mandated private means of pooling covering 4.30% of the population and contributing 0.99% of total health expenditure. Other approaches are piggy-backing health coverage on micro-insurance schemes and the *Takaful* Islamic insurance approach. The *Takaful* approach involves collectively guaranteeing against loss through the *Mudharabah* and *Wakala* models. However, there are regulatory weaknesses with this approach and a lack of awareness of it. Health loans, insurance built on the Bhutto income support programme and health equity funds (essentially non-contributory health insurance for the poor) are other pooling schemes available in Pakistan.

Lessons learnt

There is an increasing trend to look at population coverage as the population who are insured by health insurance schemes. The poor of India are covered by the RSBY government-revenue scheme, the rural population of the Islamic Republic of Iran are covered by a rural health insurance scheme and the expatriate population in GCC countries is increasingly mandated to have insurance coverage. However, being insured means being both covered and protected, and therefore must be accompanied by being covered by the needed health services and protected from financial hardship. The experience of trying to expand family medicine services from the rural to the urban population in the Islamic Republic of Iran underlines the need for health insurance to pay for needed health services.

2.7 Beyond the three dimensions of universal health coverage

Dr Jeanette Vega, Managing Director, Rockefeller Foundation, USA, presented on the role of the social determinants of health in advancing towards universal health coverage. Universal health coverage does not only involve health financing, but needs to include the social determinants of health in its monitoring framework. This entails defining the socioeconomic dimensions and identifying targets to stratify the core set of health outcomes and health-coverage measurements by equity-relevant markers such as income, education, sex and geographical distribution. Key indicators of social determinants of health need to be defined for inclusion in the framework that directly impact on health and are amenable to action from other sectors. Specifically, there should be equity targets in the global monitoring of universal health coverage, such as monitoring the reductions of absolute difference in health services coverage between urban and rural areas, and between the poorest 20% and the richest 20%, by half between 2015 and 2030.

Professor Ilona Kickbusch, Director, Global Health Programme, Graduate Institute of International and Development Studies, Switzerland, presented on the features of multisectoral mechanisms that enhance the move towards universal health coverage. These include good communication, adequate time, shared and innovative accountability arrangements, clarity regarding different responsibilities and tasks, a common understanding of objectives, and a valid theory of cause and effect. There should also be political commitment to rights, equity and empowerment as this can result in the reform of discriminatory laws, policies and practices that impede equitable progress towards universal health coverage. In fragile states, universal health coverage may be used to build a social covenant and create a common good that inspires people to work together and build horizontal social cohesion. High-level political support is needed to ensure that multisectoral mechanisms for universal health coverage can be sustained; this can be provided through interministerial committees, national strategic plans and interdisciplinary transformation leadership teams. There must also be particular efforts to strengthen the capacities of the ministries of health and finance to oversee improvement of quality and ensure that any promises of benefits are realistic, although all other actors need to be considered as well.

Dr Abdul Ghaffar, Executive Director, Alliance for Health Policy and System Research, presented a 2012 study in eight countries (Bangladesh, Chile, Ghana, Pakistan, United Republic of Tanzania, Thailand, Turkey and Viet Nam) to understand differences in perceptions of universal health coverage across stakeholders, highlight different approaches to universal health coverage across countries and identify factors contributing to progress or hindrance in universal health coverage from a stakeholder perspective. Several stakeholders indicated that the universal health coverage goal suffers from being too broad, and if stakeholders within each country do not have a harmonized vision of what achieving universal health coverage means, then efforts working towards it become disparate and ineffective. Another finding was that focusing solely on the financing mechanism is insufficient; rather, it is health systems financing in combination with health system reforms that is crucial in influencing the progress towards universal health coverage.

Policy drivers that were shown to facilitate change include political will, champions within and outside ministries of health, public participation in discussion and debate, and involvement of the media in making a case for the achievement of universal health coverage. Other policy drivers that were shown to contribute to the progress towards universal health coverage in low- and middle-income countries were constitutional rights to health, research capacity to undertake policy-relevant work, collaborations with sectors outside health, and effective and efficient health systems. The main challenges, in addition to health care financing, were the quality of health services, poor health information systems, health workforce shortages and a high turnover of policy/decision-makers.

Lessons learnt

As countries pursue universal health coverage, they should take into account the social determinants of health, the need for multisectoral efforts and the much-repeated message that universal health coverage is more than just health financing and more than just a health sector effort.

2.8 Developing a roadmap for universal health coverage in Eastern Mediterranean Region countries

Participants were divided into four working groups to discuss and finalize a proposed framework for action to accelerate universal health coverage in the Eastern Mediterranean Region and input comments from various representatives to a draft document. The groups discussed the appropriateness of the three universal health coverage dimensions and the applicability of universal health coverage in the Region. This was followed by a review of the draft framework of action. The four groups proposed several inputs which were then incorporated into the framework.

2.9 Closing session

The concluding session included a presentation of the finalized framework for action on advancing universal health coverage in Eastern Mediterranean Region as well as the main conclusions of the meeting. The latter were then shared for comment and finalized. Dr Siddiqi thanked all participants on behalf of Dr Alwan for their commitment and interest in universal health coverage. He described how the lessons from various countries worldwide applied to the different groups of countries in Eastern Mediterranean Region, but equally how lessons from within the Region could be useful both within the Region and beyond. He reiterated the readiness of WHO to provide the support needed to countries in their quest for universal health coverage. He thanked the United Arab Emirates for hosting the meeting and acknowledged the paradigm shift within GCC member countries in including their expatriate populations in the universal health coverage agenda. He also emphasized the need for in-country meetings and consultations to devise context-specific visions, strategies and roadmaps for universal health coverage.

3. CONCLUSIONS

The main conclusions from the meeting were as follows.

- Moving towards universal health coverage is a realization of the right to health and the Alma-Ata Declaration's aspiration of Health for All. In this regard, countries need to develop a specific vision, strategy and roadmap for universal health coverage, with a clear framework of action.
- Challenges are common and countries can learn from each other's experiences. Documenting and sharing country experiences can contribute to facilitating moves towards universal health coverage by learning about what works and what does not.
- Moving towards universal health coverage requires strong political commitment and buy-in from all stakeholders, including the private sector. It also calls for effective partnership and aligned support, as well as continuous capacity-building and constant consultation to evolve the universal health coverage agenda.
- Moving towards universal health coverage may entail a comprehensive reorganization of the entire health system.

- Moving towards universal health coverage requires: a) more funding for health, which is protected and flexible; b) increasing compulsory prepayment and pooling, while avoiding fragmentation; and c) addressing sources of inefficiency.
- Moving towards universal health coverage requires constant attention to be given to the poor and vulnerable and those in the informal sector. This calls for shifting from supply-driven to demand-driven approaches. The informal sector can be gradually covered starting with the poor, near poor, children and the elderly.

4. RECOMMENDATIONS

To Member States

1. Develop country specific-roadmaps for moving towards universal health coverage, based on the regional framework for action on advancing universal health coverage and building on lessons from countries both within the Region and beyond (see Annex 3).

To WHO

2. Support implementation of the framework for action on advancing universal health coverage in the Region by integrating relevant activities into the work plans of departments and technical units within the Regional Office and country offices.

3. Support countries of the Eastern Mediterranean Region to develop country specific-roadmaps for moving towards universal health coverage, based on the regional roadmap and building on lessons from countries both within the Region and beyond.

4. Facilitate effective policy dialogue with all stakeholders at national level to enhance the implementation of the devised roadmaps.

5. Foster collaboration with relevant sister-UN organizations and development partners to mobilize the needed technical and financial support to countries to expedite their move towards universal health coverage by implementing the agreed-upon roadmaps.

6. Build the capacity of regional academic institutions for generating the needed evidence to inform the move towards universal health coverage in the countries of the Region.

7. Collaborate with regional and national civil society organizations to generate momentum and facilitate the necessary political support to enhance the universal health care agenda in the Region.

Annex 1

PROGRAMME

Thursday, 5 December 2013

Opening session

08:00–08:30	Registration	
08:30–08:35	Address by H.E. Mr Abdul Rahman bin Mohamad Al-Owais Minister of Health, United Arab Emirates	
08:35–08:45	Address by Dr Ala Alwan, Regional Director, WHO/EMRO	
08:45–09:05	The road to universal health coverage: World Health Report 2010 and beyond	*Dr David Evans*
09:05–09:15	World Bank: helping countries move towards universal health coverage	*Dr Enis Baris*
09:15–09:30	Universal health coverage: challenges and opportunities for Eastern Mediterranean Region countries	*Dr Sameen Siddiqi*
09:30–10:25	Panel discussion	
10:25–11:00	Objectives of the meeting and agenda	*Dr Awad Mataria*

Session 1. Political commitment and universal health coverage

11:00–11:15	Universal health coverage in the European Region: how do we get there?	*Dr Mihály Kökeny*
11:15–11:30	Translating political commitment into actionable programme: reaching out to the informal sector in Thailand	*Dr Suwit Wibulpolprasert*
11:30–11:45	Towards universal health coverage: progress and achievements of health reform in China	*Professor Meng Qingyue*
11:45–14:00	Panel discussion	

Session 2. Expanding financial protection for universal health coverage

14:00–14:15	Transforming the Turkish health care system to move towards universal health coverage – health sector reform put in perspective	*Professor Recep Akdağ*
14:15–14:30	Good health at low cost – how did other low-income countries do it?	*Dr Hailom Banteyerga*
14:30–14:45	The role of social health insurance in promoting universal health coverage – the experience of Philippines	*Dr Eduardo Banzon*
14:45–15:00	The Jordanian experience: keeping out-of-pocket spending under control	*Dr Jamal Abu-Saif*
15:00–15:30	Panel discussion	
16:00–17:30	Panel discussion: reducing waste and improving efficiency	*Dr Henk Bekedam, Dr Faleh Ali, Dr Enis Baris, Dr Belgacem Sabri* *Moderated by Dr Awad Mataria*

Side meeting

17:30–19:00	Role of academia and civil society in promoting universal health coverage	

Friday, 6 December 2013

Session 3. Monitoring progress towards universal health coverage and developing a research agenda

08:30–09:15	Recap of Day 1	
09:15–09:30	Framework for monitoring progress towards universal health coverage	*Dr David Evans*
08:50–09:30	Discussion on framework for monitoring universal health coverage	
09:30–09:45	The importance of implementation research for achieving universal health coverage	*Professor David Peters*
09:45–10:00	The French experience in promoting and maintaining universal health coverage – the efficiency/equity trade off in expanding coverage to all?	*Professor Jean-Paul Moatti*
10:00–10:45	Panel discussion	

Session 4. Increasing service coverage for universal health coverage

10:45–11:00	The National Health Service (UK) and the quality of health care	*Professor Salman Rawaf*
11:00–11:15	Access to essential medicine and health technology in the context of universal health coverage	*Dr Hans V. Hogerzeil*
11:15–11:30	Moving towards universal health coverage in countries with a health workforce crisis: the way forward	*Dr Barbra Stilwell*
11:30–11:45	Family practice in lower- and upper-middle income countries – summary of the experience of Brazil, China and Thailand	*Dr Hernan Julio Montenegro Von Mühlenbrock*
11:45–13:30	The role and regulation of the private health sector in countries of the Eastern Mediterranean Region	*Dr Sameen Siddiqi*
13:30–14:00	Panel discussion	

Session 5. Population coverage: reaching out to all

14:00–14:15	Rashtriya Swasthya Bima Yojana (RSBY) experience from India: moving towards universal health coverage	*Dr Nishant Jain*
14:15–14:30	Establishing urban primary health care: experience from the Islamic Republic of Iran	*Dr Arash Rashidian*
14:30–14:45	Extending coverage to the expatriate population in GCC countries	*Dr Abdullah Al Sharif*
14:45–15:00	Oman's effort towards universal health coverage	*Dr Salim Suleiman Al Saqri*
15:00–15:30	Panel discussion	

Session 6. Developing a roadmap for universal health coverage in Eastern Mediterranean Region countries

15:30–16:15	Introduction followed by group work: developing a roadmap for universal health coverage in the Eastern Mediterranean Region	*Dr Eduardo Banzon*
16:15–18:00	Group Work: developing a roadmap for universal health coverage in the Eastern Mediterranean Region	

Saturday, 7 December 2013

Session 7. Beyond the three dimensions of universal health coverage

08:30–08:45	Beyond Bismarck and Beveridge: innovations in health financing to achieve universal health coverage	*Dr Sania Nishtar*
08:45–09:00	The role of social determinants of health in advancing universal health coverage	*Dr Jeanette Vega*
09:00–09:15	Multisectoral mechanisms to enhance the move towards universal health coverage	*Professor Ilona Kickbusch*
09:15–09:30	Perceptions and policy drivers of universal health coverage	*Dr Abdul Ghaffar*
09:30–11:00	Panel discussion	

Session 8. The role of development partners in universal health coverage

11:00–12:00	Round table: development partners' views and commitment towards universal health coverage in the Eastern Mediterranean Region	*Moderated by Sir George Alleyne*
12:00–14:00	Panel discussion: expediting the move towards universal health coverage in the Eastern Mediterranean Region – the way forward	

Concluding session

14:00–14:30	Presentation on road map for universal health coverage in the Eastern Mediterranean Region	*Dr Awad Mataria*
14:30–15:00	Discussion	
15:00–15:15	Closing remarks	

Annex 2

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Annex 3

FRAMEWORK FOR ACTION ON ADVANCING UNIVERSAL HEALTH COVERAGE (UHC) IN THE EASTERN MEDITERRANEAN REGION

Framework for action on advancing universal health coverage (UHC) in the Eastern Mediterranean Region

Commitments	Actions for countries	WHO support
Developing a vision and strategy for UHC	Undertake a health system review including: the current status of coverage by financial risk protection, needed health services and population; the institutional, political and security constraints; the extent of private sector/donor financing and provision; and role of health actors inside and outside the Ministry of Health Develop a national roadmap for moving towards UHC Establish a multisectoral mechanism that would include civil society, academia, private sector and community organizations to steer UHC Institute country-specific institutional arrangements accountable for coordinating UHC interventions Develop a communication strategy that would increase awareness and understanding of the general public, government health sector staff, other government ministries, social security organizations, international organizations and associations, private sector and other stakeholders Promote and sponsor applied research on UHC by academia, researchers and civil societies	Generate evidence and share international experiences in what works and does not work in advancing UHC Facilitate national policy dialogues to develop evidence-based UHC strategies Provide technical support for establishment of multisectoral mechanisms to enhance the move towards UHC Organize capacity-development courses on components of health system strengthening for moving towards UHC Facilitate exchange of experiences across countries Fund and support UHC-related research
Addressing coverage of financial risk protection	Review and update coverage under different pre-payment arrangements by conducting national health accounts analysis and undertaking the organizational assessment for improving and strengthening health financing (OASIS) Explore and advocate innovative approaches in health financing functions including the review of cash transfers, income support schemes and social security systems in order to develop synergies that would support UHC Consider the consolidation of different health insurance arrangements to reduce fragmentation and the establishment and/or strengthening independent or quasi-independent purchasing bodies in order to separate health financing from health care provision Track the incidence of catastrophic health expenditures and impoverishment, as well as the share of out-of-pocket payment in total health expenditures	Provide technical support for building up national capacities to conduct national health accounts, OASIS and economic evaluation Develop and organize training courses on health financing for universal health coverage Support the development of health care financing strategies for UHC including the introduction of pre-payment arrangements Provide technical support for the conduct of surveys and data analysis to assess financial risk protection

Framework for action on advancing universal health coverage (UHC) in the Eastern Mediterranean Region

Commitments	Actions for countries	WHO support
Expanding the coverage of needed health services	Provide the needed personal- and population-level, promotive, preventive, curative, rehabilitative and palliative health services based on the principles of primary health care	Develop a regional roadmap for accelerating integrated people-centered health services
	Improve the quality, safety and continuity of care by ensuring patient-centered and integrated health services; enhance access to and affordability of health services, essential medicines, diagnostic facilities, and other technologies; and increase availability of health workforce with appropriate skills mix to provide the needed health services	Develop and disseminate regional guidance and reviews on family practice, the private health sector, quality and safety in health care, and community health workers and outreach teams
	Strengthen the engagement of the private sector in service provision, particularly primary health care to support UHC	Support countries in their effort to establish effective and replicable family practice programmes including private sector family practice programmes
Ensuring population coverage	Progressively expand coverage by pre-payment arrangements for the entire population (particularly the poor, those in the informal sector, the unemployed and migrants or expatriate workers) to enhance coverage with needed services and financial risk protection	Provide technical guidance on mechanisms to cover the poor and vulnerable populations
	Collect data disaggregated by income, region, locality, gender and other categories to allow monitoring of equity and progress towards population coverage and include these UHC indicators in national health information systems	Develop a framework for monitoring population coverage and UHC

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