BMZ Federal Ministry for Economic Cooperation and Development

GIC Forum on Health and Social Protection conference on **Universal Health Coverage: From Promise to Practice**

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GIC Forum on Health and Social Protection **Universal Health Coverage: From Promise to Practice**

INTRODUCTION

The German International Co-operation (GIC) Forum on Health and Social Protection entitled **"Universal Health Coverage: From Promise to Practice"** was held in Germany on 26th and 27th August 2013. Two hundred and forty participants from five continents gathered at the Gustav-Stresemann Institute in Bonn, to discuss how to move from the promise of universal health coverage to its practical implementation.

What is Universal Health Coverage?

The goal of universal niversal health coverage (UHC) is to provide everyone with the quality health services they need, without exposing them to the risk of impoverishment as a result of having to pay for these services. For a health system to achieve UHC, the services covered must include an appropriate and quality-assured mix of prevention, promotion, treatment, rehabilitation and palliative care. To be able to finance these equitably and without the risk of financial hardship for patients, a prepayment and pooling mechanism must be put into place. For most countries, moving towards UHC happens in stages over a number of years. There are several areas in which progress can be made, such as quality management, medicine provision, health financing, health workers or infrastructure.

More than a billion people – one in seven of the world's population – do not currently have access to the health care they need – either because it is not available, or because they cannot afford it. Millions of poor people can only access health care through high out-of-pocket expenditure that pushes them further into poverty.

UHC is something to aspire to, but it is also a moving target. The appropriate mix of health services and the amount that a country can afford hinges on economic development, technological and medical advances, popular expectations as well as health challenges created by demographic, epidemiological and lifestyle changes.

Globally, political commitment to the concept of UHC has never been higher, but many countries are struggling with its practical implementation. How can they transform the promise of UHC into practice? How can universal health coverage be financed? How can policymakers determine health priorities within available resources, especially at times of economic crises and financial insecurity? How comprehensive can UHC be and how can service quality be assured?

Whilst the Millennium Development Goals were aimed at the developing world, the debate about the post-2015 agenda is now shifting towards global sustainable development. UHC offers the reassurance that health services are accessible, of good quality and affordable to all when they need them. These are issues of concern for everyone, whether they live in developing or industrialised countries, north or south, east or west.

"The day after a President makes a key speech committing to UHC feels a bit like the day after you get married. You wake up the next morning and ask 'Why did I do that…what comes next?' There's no set textbook on how to make it succeed." (Conference delegate Nathaniel Otoo, from NHIA, Ghana)

Why hold a GIC Forum on UHC?

The aim of the GIC Forum on Health and Social Protection was to move beyond theoretical discussions about what UHC is or should be, to its practical implementation. How can the rhetoric be made reality, with tangible, measurable results? How can UHC be implemented and financed?

The Forum was organised by Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) on behalf of the German Ministry for Economic Co-operation and Development (BMZ) and in collaboration with KfW. It provided a platform for policy-makers, practitioners and academics to discuss questions, challenges and controversial issues related to the three dimensions of UHC: universality, financial risk protection and delivering quality services. Experts from around the globe working in the private and public sectors as well as development agencies and the research community explored what UHC means for their work and discussed successful examples and innovative approaches for tackling practical challenges.

FORUM PROCEEDINGS: FROM RHETORIC TO REALITY

Opening plenary

The conference opened with a welcome address by **Dr Reinhard Tittel-Gronefeld**, Head of BMZ's Health and Population Policies Division, who said "the time is right" for UHC. "Health is a human right and we hope this event will contribute to moving the concept of UHC from promise to practice." To facilitate this process, he announced the launch of a new web portal called "Healthy Developments" (health.bmz.de) which would provide a forum for continuing the debate and sharing experiences about UHC.

In her opening remarks, **Karin Kortmann**, Deputy Director General of GIZ's Sectoral Department reminded delegates that although UHC is a hot topic at the moment, she hoped – along with the billion or more people who currently have no access to health care – that the conference would come up with concrete ways of achieving UHC and moving the process forward.

In his keynote speech, **Dr David Evans**, Director of the World Health Organization's Department of Health Systems Financing, said UHC is an intrinsic goal of development. "Healthy people earn an income. Healthy children learn. Financial protection prevents people being pushed into poverty," he said. UHC contributes to health and economic development as well as being a valued goal in its own right. UHC is important "because people want it. People demand it at the ballot box. People need the assurance that the health systems they need for their families are available, accessible and affordable, without ruining them financially in efforts to pay for it."

However, Dr Evans reminded delegates that "There's no one size fits all. Each country needs to find a way in accordance with its capacities and abilities." With six countries still spending less than $20 per person a year on health, they would not find it easy to fund UHC. But UHC wasn't just a question for developing countries – it was a global issue and every country had options. Although great progress had been made towards achieving UHC in the last three years, it had not been fast enough and there was still a long way to go. Many countries would need help, and it was vital to keep the momentum going.

He concluded that the post-2015 agenda would be very important, especially for the billion people without access to health, and it is "critical that health stays on the agenda. As the debate plays out in the coming months, it will be vital for the health sector to present a united front, rather than fight its individual corners".

In her keynote address, **Dr Speciosa Wandira-Kazibwe**, Uganda's Presidential Adviser on Health and Population at the Ministry of Health said that she approached UHC both as a medical doctor and politician. "Every politician wants people to be healthy because presiding over poverty is the worst thing," she said. "Politics is the key for UHC because that's where decisions are made about what gets spent where." She told delegates that UHC had been an election manifesto pledge in the last Ugandan elections, and that her country was committed to implementing it.

Panel discussion

A panel discussion moderated by **Conny Czymoch** followed the opening speeches.

Dr Hasbullah Thabrany, Professor of Health Policy and Insurance at Universitas Indonesia, stressed that UHC could not be implemented overnight, and talked about Indonesia's experience of building capacity in medical professionals and the insurance industry over the past 15 years. Demand from the population was important in making progress: "The more people understand UHC, the more we can move forward." He added that technology would also be crucial in achieving UHC for 240 million Indonesians scattered across many islands.

Dr Tim Evans, Director, Health, Nutrition and Population at the World Bank said that no country had yet got the "right" formula for UHC, but highlighted the need for new thinking to "get beyond Bismarck and Beveridge". Since few countries could afford to fund health care purely from taxation, and the informal sector was a major part of many economies, Dr Evans said they needed to be thinking beyond taxation to pluralistic pre-payment systems or home-grown solutions that would also be rational and accountable. However, new ways of financing would not of themselves be enough, he said: "We also need to invest in rethinking the role of the workforce. People lead systems."

Dr Walter Seidel, The European Commission's Head of Health Sector (EuropeAid), said that health expenditure was already an essential component of EU development aid. However, UHC was also a national policy issue and national politicians and institutions would need to develop models that they could pay for. To this end, he said the "UHC cube model" was useful since it showed the three dimensions of UHC – who was covered, what was covered and how well people were protected from the risk of financial impoverishment.

Frazer Goodwin, Save the Children's Senior Advocacy Adviser (EU Office) said: "My role as a member of civil society is to be persistently upset." This, he said, was not a criticism of the work being done, but just to highlight how much more still needed doing. "This issue is fundamentally a political issue at the highest level. Progress will come with political commitment," he said. "There will be differences in priorities, but we need to be doing more."

Dr David Evans agreed that civil society would have a really big impact on the UHC agenda in the next few years, but argued there was also a need for a multi-sectoral approach between ministries: "For example, we need to think about how educational institutions develop core competencies for UHC, and the public-private mix."

The panellists also debated whether countries should continue to be self-financing in moving towards UHC or whether "some sort of global contingency fund" would need to be established to cover issues such as financial crises or massive migration. However, Dr David Evans said that the idea of setting up yet another fund did not appear very promising to him. He stated that UHC was about much more than social protection. "Social protection provides a floor – but the floor is a floor. The aim of UHC is to move the ceiling upwards, so everyone gets what they need over time."

At the opening plenary session of the second day of the conference, Ben Bellows of the Population Council of Kenya gave a presentation entitled 'Can vouchers help achieve UHC?'. Drawing on Kenya's experiences, he argued that vouchers provided subsidies to the poorest and most vulnerable in society to ensure that they could access essential services. Voucher schemes could be expensive to run, but had been shown to be a cost-effective, short-term way of increasing use of services and increasing equality of access, until more sophisticated schemes could be established.

WORKSHOP PROCEEDINGS

Following the opening plenary session and panel discussion, participants were offered twelve workshops, organised according to the three themes of the conference:

Theme 1: Overcoming challenges and bottlenecks on the way to financial risk protection
Questions of health financing are central to UHC. The way countries pay for health varies enormously, but the fundamental questions affect developing and developed countries alike: Who pays, how much and how? How can equitable prepayment systems via insurance or taxes be designed and rolled out, and out-of-pocket expenditure at the point of use be decreased. What other sources of funding may be used? How can the most vulnerable be included in these systems, and thus be protected from the financial risks of poor health?
Theme 1 co-ordinator: Jean-Olivier Schmidt, GIZ

Theme 2: Aligning health systems to deliver UHC
Strengthening health systems is a crucial part of achieving UHC. The goal is to move beyond basic curative care towards integrated and comprehensive health systems that provide health promotion, prevention, treatment, rehabilitation and palliative care. Participants discussed the practical instruments that help achieve the necessary intervention coverage to improve health for all. Among them were health service delivery methods, quality management and accreditation, as well as training of health workers. Other sessions analysed broader issues, such as how marginalised and vulnerable people can have equal access to care or how health systems can integrate both public and private providers for the benefit of all.
Theme 2 co-ordinator: Ole Doetinchem, GIZ

Theme 3: Cross-cutting issues
Health financing and service provision cannot be treated in isolation from each other if UHC is to be achieved. Issues such as strategic purchasing of commodities and services, provider payment mechanisms etc. are related to both these areas. Demographic and epidemiological trends strongly impact health financing options, as well as health care needs. Research and exchange, including south-south cooperation, can help to identify new solutions to the many interrelated dimensions and challenges of UHC. This theme focused on these cross-cutting and interrelated issues.
Theme 3 co-ordinator: Klaus Peter Schnellbach, GIZ

The aims and outcomes of these themed workshop sessions are summarised below:

THEME 1:
Overcoming challenges and bottlenecks on the way to financial risk protection:

Which ways lead to UHC? Variety and patterns

This workshop session examined a range of different national health systems currently trying to implement UHC. Participants discussed the challenges that countries faced, and how the different starting points in different countries affected the implementation of UHC. They considered whether there were certain trends common to many of these systems, regardless of their past history. If so, what lessons could be derived from them? What modifications were needed to existing systems? Did countries need a health financing strategy, and was the choice always one between tax and contributory systems or were there alternative financing mechanisms?

Speakers:
Joseph Kutzin, WHO, Geneva
Dr Sok Kanha, Ministry of Health, Cambodia
Adelio Fernandez, GIZ, Cambodia
Dr Nishant Jain, GIZ, India
Professor Hasbullah Thabrany, Universitas Indonesia
Julia Fimpel, KfW Development Bank, Kenya
Atia Hossain, GIZ, Kenya
Dr Tirtha Raj Burlakoti, Ministry of health and population, Nepal
Franziska Fürst, GIZ, Nepal
Dr Michael Thiede, GIZ, South Africa

Session format: introductory keynote speech, country poster stations and presentations followed by panel discussion
Session organiser: Viktoria Rabovskaja, GIZ

Following presentations given by Joe Kutzin of WHO and country-specific presentations from Cambodia, India,

Indonesia, Kenya, Nepal and South Africa, participants concluded that UHC was a not an "end product" per se, but a means of moving towards goals of efficiency, equality and affordability in health. Although UHC was being enthusiastically embraced by many countries, there was no "one size fits all" solution to its implementation. Since no country started from a blank health system canvas, reforms had to be country-specific and "tailor made".
However, despite such variations between countries, they also had many things in common and there were lessons to be learned from each other – both from positive experiences and mistakes that had been made.

Summary of key messages:

- *UHC should be "home grown" but no country starts from scratch. Each country's historical starting point is different and it is important to understand the context.*
- *UHC cannot be based on voluntary payment systems.*
- *UHC is not about schemes for the formal sector – those would worsen inequalities.*
- *For UHC where informality is high, general revenues must play a stronger role in financing health care.*

Reaching the poorest:
What role can cash transfers play in attaining UHC?

The workshop considered the important contributions of cash transfers and other non-contributory types of social protection to UHC by exploring experiences from different regional and country contexts across Latin America, sub-Saharan Africa and Asia. It also explored how social protection mechanisms could contribute to improved access to and demand for health services in poor households.

The workshop focused specifically on maternal and child health services, as well as the needs of vulnerable groups. Participants discussed how demand- and supply-side interventions could be co-ordinated to improve access to health services, and how contributory social health protection schemes (such as community-based health insurance) could be linked to non-contributory approaches. Can cash transfers be targeted effectively so that the poorest are included in UHC? What is the role of development co-operation in strengthening the impact of basic social protection mechanisms?

Speakers:
Dr Ilcheong Yi, United Nations Research Institute for Social Development, Geneva
Andi Z.A. Dulung and **Emmy Widayanti**, Ministry of Social Affairs, Indonesia
Claudia Gonzales del Valle, GIZ, Peru
Dr Jessica Hagen-Zanker, Overseas Development Institute, UK

Session format: presentations, country examples and discussions
Session organisers: Martina Bergthaller and Cormac Ebken, GIZ

Participants at this session concluded that there was growing evidence that both conditional and unconditional cash transfers make health care affordable, by subsidising user fees, transportation and other costs that make it difficult for the poor to access services. However, they also concluded that cash transfers alone were not enough, and that UHC would also need more investment in services and better co-ordination between sectors.

Summary of key messages:

- *Cash transfers can improve access to health services for the poorest in society by addressing the demand-side of health services. Experience with cash transfers in some countries shows greater utilisation of health services (e.g. making user fees/ transportation affordable, supporting behaviour change through conditions and sensitisation measures), but there is less evidence in terms of actual health impacts.*
- *Unconditional and conditional cash transfers can only stimulate the demand for health services and cash transfers cannot solely achieve UHC. In many countries, the supply-side barriers are hindering people from accessing health. To achieve a positive health outcome, this demand must be met by ensuring that high-quality health services are available at affordable costs. This also requires investing in the supply and quality of services.*
- *This in turn requires better co-ordination between sectors. In some countries, we are already seeing synergies between access to cash transfers and other elements of access to health, e.g. cash transfers guaranteeing access to health insurance or investments in health institutions in areas covered by cash transfers.*

Under shock: UHC during financial crisis

This workshop discussed how countries that had either already achieved a high degree of health coverage, or aimed to increase coverage in the future, could keep their commitment to UHC in times of financial crisis. Participants considered what coping mechanisms could be adopted to keep UHC on course during such crises. Were there lessons for mitigation and prevention? Could crises be a catalyst for change?

Speakers:
Elena Andradas, Ministry of Health, Social Services and Equality, Spain
Dr Alvaro Salas Chaves, Costa Rica Social Security Fund
Dr Walaiporn Patcharanarumol, Ministry of Health, Thailand

Session format: introductory statements from participating countries followed by panel debate and open discussion
Session organiser: Kai Straehler-Pohl, GIZ

The participants discussed the effect of financial crises on implementation of UHC, and heard three presentations about the experiences of:

- **Thailand**, where health coverage was scaled up after the 1997 East Asian financial crisis.
- **Costa Rica**, where the 2007 global financial crisis triggered a funding crisis for the social security system, which provides free access at the point of care through contributory and non-contributory schemes.
- **Spain**, one of the European countries hardest hit by the global financial crisis.

Summary of key messages:

- *Crises have the potential to act as catalysts for reform. For example: benefit package reform using health technology assessments / cost effectiveness analysis.*
- *Health can be an area of anti-cyclical investment, but crises often lead to pressure to realise short-term savings: "rationalising" drug prescriptions and infrastructure investment stops – and it is too early to judge the longer-term effects on the potential of health systems to deliver results.*

THEME 2:
Aligning health systems to deliver UHC

Providing a continuum of care for all population groups

One of the many challenges is how to implement UHC and at the same time provide specific services for population groups with specific needs, such as persons with disabilities. Many persons with disabilities experience unequal or inadequate access to and treatment in health care services. In many cases, unmet health care needs increase marginalisation and exclusion from society.

This session discussed different practical approaches to attaining UHC, and the challenges faced during the implementation process, in particular as they affect persons with disabilities. Participants considered whether, given the huge differences in needs, UHC could be both universal and specific at the same time. What should governments and policymakers consider when designing strategies for UHC? How could people themselves be included in the design, implementation and delivery of UHC schemes? And what can international development co-operation contribute to the process?

Speakers:
Alexandre Cote, International Disability Alliance
Dr Michael Palmer, Nossal Institute for Global Health, Melbourne University

Session format: keynote presentations and group discussions
Session organiser: Constanze Schmoger, GIZ

The workshop session concluded that the guiding principles of Universal Health Coverage (UHC) are to provide a continuum of care that meets the diversity of all population groups without causing financial hardship. Attention to marginalised groups, who seem hard to reach and are easy to forget, should be inherent in any UHC policy design from the beginning – not considered complicated and treated as an unaffordable afterthought.

Governments should meet the diverse needs of all groups, including persons with disabilities, many of whom have specific care needs, but reduced ability to pay.

Under Article 25, those countries signatories to the international Convention on the Rights of Persons with Disabilities have a legal obligation to provide access to affordable health services for persons with disabilities. The debate should not be about the cost-benefit of doing this, but about finding the most cost-effective way of doing so.

Participants concluded that in order to include the needs of persons with disabilities and other marginalised groups in the design of UHC policies, governments need to follow a number of key messages.

Summary of key messages:

- *Consult with persons with disabilities and other specific population groups so that their needs are adequately taken into account at the UHC design stage.*
- *Collect data to ensure they are included.*
- *Train health care personnel on the rights and needs of persons with disabilities, respecting principles of dignity and free and informed consent.*
- *Adapt existing systems to meet these needs or design disability specific packages which complement each other. There is a need to improve eligibility determination processes.*
- *The resources required for the inclusion of persons with disabilities are not under the sole responsibility of the responsible sector ministry (health). Other ministries – such as transport, infrastructure, social affairs – have to take their share of responsibilities.*
- *Accessibility of existing services improves the utilisation of services by persons with disabilities.*

Ensuring effective coverage: The role of quality management and accreditation

Although most definitions of UHC mention adequate quality of services, strategies to attain this often focus predominantly on quantitative aspects and targets, and tend to neglect quality issues. However, quality management of health systems is an essential prerequisite for attaining effective coverage.

This session focused on the importance of quality management for ensuring effective and efficient health services, and for guiding purchaser-provider-relationships. Participants heard examples of how different countries have tried to manage the often conflicting aims of extending services and population coverage, whilst at the same time containing costs and ensuring quality. The issues considered included: Which aspects of quality management are most important and effective from a UHC perspective? What is the role of evidence-based guidelines in ensuring efficient provision of quality health care? What part can certification and accreditation play in improving quality and guiding resource allocation and ensuring safe and effective health service provision?

Speakers:
Dr Jamal Nasher, Ministry of Public Health, Yemen
Sylvia Sax, University of Heidelberg, Germany
Dr Christian Thomecsek, German Agency for Quality in Medicine, Berlin
Professor Stuart Whittaker, Council for Health Service Accreditation of Southern Africa

Session format: three short presentations and a panel discussion enriched by country examples
Session organisers: Dr Kai Stietenroth and Dr Klaus Peter Schnellbach, GIZ

The workshop heard country examples from Germany, South Africa and Yemen.

Summary of key messages:

- *Quality assurance and improvement are essential ingredients of health service multi-disciplinary management, ensuring the efficient and effective implementation of evidence-based medicine directed through the use of guidelines and clinical audits and the supportive technical and administrative environment essential for quality patient care and the safety of patients, staff and visitors.*
- *Accreditation, supported by quality improvement programmes, state-of-the-art information, monitoring and communication systems, can improve the quality and safety of health care organisations and contribute to the effectiveness and efficiency of measures introduced to achieve universal health coverage and improvements to the entire health system.*
- *In order to achieve an impact at a health systems level,*

accreditation and quality improvement interventions must be tailored to the specific context with the involvement of a wide range of stake holders and a focus on capacity building, knowledge exchange and the monitoring of the effectiveness of clinical services and managerial, administrative, technical and legal services.

UHC in the shadow of the human resource crisis: Who will actually deliver the services?

Health workers are the foundation of any health system, and a precondition for delivering essential health services and improving health outcomes. The shortage of health workers is a key constraint to the provision of UHC and remains a global challenge, in high-income as well as in low- and middle-income countries. Addressing the critical shortage of health workers should be a key priority on the international health agenda, now more than ever.

This session discussed effective health workforce approaches within UHC-strategies and the role of key actors, including policy makers, development practitioners, researchers, management and planning officers in education and health institutions. Participants debated how to address past and present health workforce gaps while at the same time planning for the future. Which interventions at community, country and international levels can improve both quantity and quality of health workers? How can the demands of the international health workforce market be managed? What are the implications for both national governments and the international community, and German development co-operation in particular?

Speakers:
Professor Barbara McPake, Queen Margaret University, UK
Birgit Wendling, Federal Ministry for Economic Co-operation and Development, Germany
Professor Yasmin Amarsi, School of Nursing & Midwifery, The Aga Khan University, Kenya
Bich Luu Nguyen, Vietnam Nurses Association
Heino Güllemann, terre des hommes, Germany
Moderator: Dougal Thomson, The Economist, Switzerland

Session format: presentation followed by panel discussion
Session organisers: Julia Warich and Natalia Melkoserov, GIZ

Summary of key messages:

- *The health workforce crisis is an international crisis, not a national crisis. Existing international agreements should be used to scale up action and develop and implement financing solutions, as well as to reduce the negative impact of migration.*
- *The human resource gap refers to all health professions, not just doctors, nurses and midwives.*
- *Uneven distribution of health workers between rural and urban areas is one of the biggest challenges in low- and middle-income countries as well as in high-income countries. Despite this health workforce shortage there are simultaneously unemployed health workers due to a lack of funding.*
- *The removal of user fees for health services needs to be well prepared in a political, structural and financial way. Decentralisation of human resources for health management and decentralisation of fund management could be a strategy to implement policies according to local needs.*

The private sector in health: Moving towards UHC in the midst of pluralistic health systems

The private sector is generally associated with service provision for richer populations when, in fact, in many instances it is the primary or only source for the poor and vulnerable groups. However, in many countries, the private sector is generally poorly integrated into national health systems. Mistrust and a lack of dialogue between the two spheres, limited capacities and a lack of effective policies and regulatory environment often prevent effective engagement of the private sector towards UHC.

This workshop considered the role of the private sector in the move towards UHC. Bearing in mind that the private sector includes a range of actors, from informal individual providers and drug sellers to (well-equipped) for-profit hospitals, and – depending on the definition – also non-health companies, the session drew on case studies from Bangladesh, Pakistan, Georgia, Tanzania and Ghana. Participants discussed the role of informal providers in health markets and how to make them work more effectively for the poor, and asked whether social franchising could improve access to quality health services. They also explored

different experiences of privatisation of health systems and discussed ways of improving public-private dialogue.

Speakers:
Dr Gerald Bloom, Institute of Development Studies, UK
Andrea Godon, KfW, Germany
Yaron Inbar, Archimedes Global Ltd, Israel
Dr Samwel Ogillo, Association of Private Health Facilities in Tanzania
Dr Holger Till, GIZ Ghana
Moderator: Professor Barbara McPake, Queen Margaret University, UK

Session format: presentations and Q&A
Session organiser: Beate Barth, GIZ

Summary of key messages:
- *The private sector can play an important role in UHC – but it is not a magic wand, and market failures have to be accounted for.*
- *The private sector does not only provide care for the better off. Sometimes it is an important source of care for the poor, and ignoring this means ignoring the less well off.*
- *There have to be appropriate regulatory frameworks, which must take into account the diversity and specific requirements of the different private sector actors. Engaging with private-for profit hospitals requires different approaches than regulating informal providers.*
- *Capacity development is needed for effective private sector management in moving towards UHC. Mistrust between the private and public sectors is common, so open dialogue is crucial.*

THEME 3:
Cross-cutting issues

The role of strategic purchasing and provider payment

Any move towards implementing UHC raises questions about how health care is paid for, at what point and by whom? Research shows that the way health care providers are paid has a significant impact on health expenditure as well as the quality of care. What is the relationship between how and when the provider is paid and the quality and range of services delivered? Can global health care systems get better value for their money through performance-based financing? This has been tried in high- and low-income countries alike, often with mixed results.

This session focused on the latest developments in provider-contracting and reimbursement world-wide. It drew on regional case studies to show how provider payment mechanisms can impact on the provision of medical care. It also examined how inefficiencies in the reimbursement system (especially fraud and informal payments) could be minimised.

Speakers:
Byambasaikhan Purevsuren, GIZ, Mongolia
Dr Christine Thayer, Health for Development Ltd, France
Dr Sören Eichhorst, KPMG, Germany

Session format: three presentations followed by a panel discussion with Q&A
Session organisers: Susanne Elisabeth Ziegler and Roland Panea, GIZ

The workshop session heard case studies from both developing and developed countries and shared experiences and problems.

Summary of key messages:
- *In order to improve quality of care through reimbursement systems, context-specific definitions – and ideally indicators – are paramount.*
- *Political and institutional good-will are key to catalysing as well as maintaining the successes achieved in paying providers for quality.*
- *Information technology may act as a catalyst for efficient provider reimbursement systems.*

South-South co-operation for UHC

There is a growing demand in the global south to learn from and share experiences of implementing UHC with other countries that face similar challenges or have used innovative approaches to overcome them.

This session considered the key challenges countries are

facing in the transition towards UHC and discussed the role of south-south collaboration in overcoming some of these. It also explored factors that have led to a successful collaboration between peer countries and obstacles that hinder such collaboration. Concrete examples were presented by policy-makers and academic institutions from Bangladesh, Ghana, Pakistan and the Philippines on how south-south collaboration is supporting changes in their national systems. Results from a recent study conducted in Asia on the challenges and opportunities of information technology for UHC and the role of networks were also presented.

Speakers:
Nathaniel Otoo, NHIA, Ghana
Kelvin Hui, GIZ, Bangladesh
Dr Arturo Alcantara, PhilHealth, Philippines
Dr Rumana Huque, University of Dhaka, Bangladesh
Dr Javaid Abbas, Benazir Income Support Programme, Pakistan
Dr Nishant Jain, GIZ, India

Session format: short presentations and panel discussion with country examples followed by an interactive format for knowledge exchange and mutual learning.
Session organiser: Jennifer Hennig and Susanne Lein, GIZ

Summary of key messages
- *One main issue for south-south cooperation is knowledge management. There is plenty of knowledge in all of the countries. The question is how to manage it well.*
- *What makes it possible for countries to easily cooperate with each other:*
- *Desire to co-create knowledge*
- *Importance of physical meetings*
- *Share failures equally as successes*
- *Role of DPs in supporting south-south co-operation: Act as brokers, enable access to their extensive networks and bring knowledge to the "doorstep".*
- *South-south co-operation is not a substitute for research or for traditional development assistance, even though it can complement the other elements.*

Paying for the pills: The role of pharmaceuticals in UHC
According to WHO, spending on medicine accounts for 20-30% of health expenditure globally, and up to 60% of health spending in lower- and middle-income countries, where the cost of medicines continues to be the biggest share of out-of-pocket expenses. Consequently, the way medicines are purchased, distributed, prescribed and used in a health care system are crucial issues in moving towards UHC.

This session discussed various approaches to pharmaceutical policies and the way they work in practice. Participants debated how to manage the costs of medicines whilst assuring their supply. They also discussed how pharmaceutical policies should be aligned within the UHC agenda. And what is the view of the pharmaceutical industry with regards to emerging and developing economies and their UHC plans?

Speakers:
Dr Anita Wagner, Harvard Medical School, USA
Fachriah Syamsuddin, Ministry of Health, Indonesia
Dr Wilhelm Volk, 1A Pharma, Germany
Dr François Bompart, Sanofi, France

Session format: four presentations with Q&A, followed by panel discussion
Session organisers: Roland Panea and Viktoria Rabovskaja, GIZ

A diverse panel of academics, medical experts and representatives of a multinational originator and a German generic drug manufacturer took part in the discussions and heard a case study from Indonesia.

Summary of key messages:
- *Information and data available is crucial for decision-makers when dealing with pharmaceutical costs, counterfeit drugs etc.*
- *Regulatory environments have to be established and strengthened in order to prepare the grounds for UHC.*
- *We can learn from other countries' experience of strategic purchasing.*

- *There are interesting models of co-operation between the public sector and industry which should be explored to create win-win partnerships.*
- *More discussions are needed on issues of price design and negotiations at country level.*
- *Capacity building is highly important, as many countries lack experience in this policy area.*

Responding to demographic and epidemiological change

Population dynamics have a critical influence on social, economic and environmental development. Population growth due to high fertility rates, large and rapidly growing youth populations combined with rapidly ageing populations, increasing urbanisation and changing epidemiological patterns all have an impact on health care needs. In particular, there has been a rapid shift from infectious diseases to an increase in non-communicable diseases, not only in more developed countries, but more recently also in developing countries where health systems are already struggling to cope.

This session examined how these demographic and epidemiological developments impact on the goal of UHC. Participants considered how health care systems react, change and adapt to these new demands. They heard a presentation about the specific example of Germany, where it took some 120 years to develop a health system that attends to most of the population but is still constantly evolving and adapting to new challenges. How can existing health services adapt to meet modern challenges? What role can health promotion and prevention play in rolling out UHC?

Speakers:
Dr Hermann Schulte-Sasse, Senator for Health, Bremen, Germany
Professor Rolf Horstmann, Bernhard Nocht Institute for Tropical Medicine, Hamburg

Session format: presentation followed by panel and group discussions
Session organisers: Barbara Kloss-Quiroga, Kristin Haefner, Sigrid Mehring and Simon Gottwalt, GIZ

The workshop heard presentations about how the German health system is responding to a growing elderly population, and how the increase in non-communicable diseases is impacting on health systems in Africa. The working groups came up with a very clear message about how health services should respond to such challenges by building societal consensus for adjustment. They concluded that the process needs to take into account specific contexts and encourage local ownership of the process, whilst remaining flexible and adaptable.

Summary of key messages:

- *There is a need to create awareness on the right to UHC, in order to build societal consensus on the need for adjustment to demographic change according to the specific context.*
- *In the context of the BRIDGE project which is responding to the epidemiological change by addressing non-communicable diseases in sub-Saharan Africa, make local staff at health facilities central to these efforts. Encourage them to take ownership by motivating them and taking their considerations into account.*

Health and health systems research for UHC

Universal Health Coverage is not just a technocratic strategy, but has profound policy implications. This workshop explored how research contributes to the global and national debate about UHC. What is the relationship between researchers and policymakers in the current drive towards UHC? Participants from a range of countries and backgrounds described how their UHC-related research helped to set the health agenda and address health care gaps and considered when research is most effective in shaping decisions about UHC, and whether policymakers make best use of it.

Speakers:
Manuela de Allegri, University of Heidelberg, Germany (facilitator)
Professor Wim van Damme, Institute for Tropical Medicine, Belgium
Dr Walaiporn Patcharanarumol, Ministry of Public Health, Thailand

Dr Beverly Ho, independent researcher, Philippines
Dr Isidore Sieleunou, CoP Financial Access to Health Services, Cameroon
Dr Nishant Jain, GIZ, India
Shafiu Mohammed, University Heidelberg, Germany
Gilbert Abiiro, University Heidelberg, Germany
Dr Raoul Bermejo, Institute for Tropical Medicine, Belgium

Session format: keynote speech, presentations and "fishbowl discussion"
Session organiser: Binod Mahanty, GIZ

This workshop was a dynamic session with presentations from the Philippines, Cameroon and Thailand, followed by a "fishbowl discussion". The main focus was on why research is important for UHC and how it should be approached and implemented.

Summary of key messages:

- *UHC is both a technical and a political concept. To move towards universal health coverage, technical expertise and research/evidence is needed to inform policy decisions. However, it is naive to think that research and evidence are the only considerations policy makers have when making political decisions. An important aspect of the context is about power and politics and how decisions are made in countries.*
- *Knowledge-brokering is important and participants acknowledged the diversity of actors in knowledge translation and UHC. Individuals, think tanks, communities of practice, social movements and the media act as knowledge brokers who bridge the gap between producers of knowledge and decision makers.*
- *Participants recognise the difficulties in matching research and policy time frames. Researchers need to understand policy dynamics as well as how and in what sequence decisions are made. They also need to find a balance between fast and reactive research and the slow pace of academic research.*

FORUM CLOSING PROCEEDINGS AND KEY CONCLUSIONS

Ole Doetinchem, GIZ's adviser on global health and health systems, began the final plenary session by saying "One of the questions I have frequently heard at this conference has been what's the difference between UHC and 'Health for All'? The answer is not that much! But that's good because it means we have been on the right track." He added that "UHC is not something that one does but something one aspires to, and only concrete actions on the ground will get you there."

To conclude the conference, a representative from each of the 12 workshops presented the rest of the delegates with a brief summary of the key conclusions they arrived at. Following these short presentations, delegates were invited to add their own key messages. Some of their responses were as follows:

- The question of governance has largely been missing from the debate about UHC.
- The biggest challenge is fragmentation of implementation and lack of co-ordination.
- There needs to be a lot more capacity building.
- Innovative thinking will be needed rather than "old wine in new bottles".
- We need to make better use of new technologies and consider how the internet/mobile networks can influence and facilitate UHC.
- There has been too little discussion of rationing of services or what the cut-off point of UHC might be – what NOT to provide under UHC.
- UHC is a paradigm shift and will need a change of attitudes. How will we achieve this?
- It would be useful to have an online exchange forum to share experiences.

Asked **what their personal take home message from the conference** was, responses from delegates included:

- There is a need to “think large”.
- There will be no perfect blueprint for UHC – context is everything.
- UHC is an umbrella process.
- It’s “all about money”.

“The answers are known and what is missing is the Big Push” Conference delegate

Dr Günther Taube, Director of GIZ's Health, Education and Social Protection Division, delivered the conference closing speech, in which he thanked the participants, contributors and conference organisers for their work. He underscored the importance of dialogue and discussions such as the Bonn Forum for UHC to move from promise to practice. “In a globalised world, UHC has universal relevance”, he said, adding that GIZ’s core mission is capacity building for technical development. “The quest for UHC is an ongoing quest for human rights and at the heart of the debate about the future we would like to see.”

Before returning to their five different continents, the 240 delegates were invited to indulge in some “blue sky thinking” and write down their hopes for UHC and its impact on one family or individual in ten years’ time. These wishes were then attached to colourful balloons and released into a cloudless sky above Bonn.

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