Conference synthesis:
Summary & Recommendations

Saturday 31 January 2015

09.00-10.00

Conference programme structure

- Monday 26 – Tuesday 27 January 2015
  - 28 side meetings
- Wednesday 28 January 2015
  - 6 field trips
- Thursday 29 - Saturday 31 January 2015
  - 3 Keynote addresses
  - 5 plenary sessions
  - 20 parallel sessions
- Total registered participants,
  - 614 participants from 58 countries

Rapporteuring

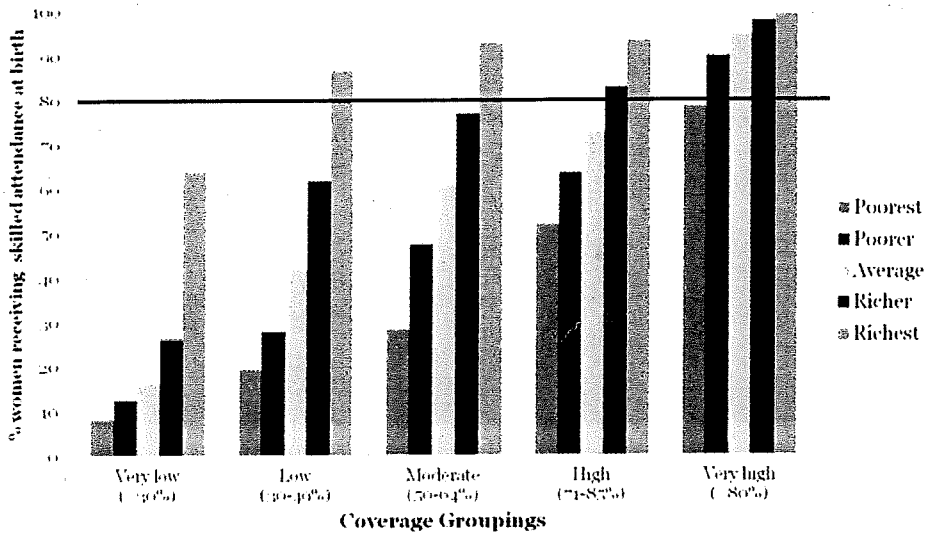
- Each session had three or four rapporteurs
- Pre-meeting for rapporteurs
- Templates for abstract and summary
- Abstracts used for this session
- Both abstracts and summaries will be used for the conference proceedings
- All presentations are uploaded on the web site : www.pmaconference.mahidol.ac.th
- Gratefully acknowledge the contributions of all 71 rapporteurs

SDG 2030

- Better health is a "precondition for, an outcome of, and an indicator of all three dimensions of sustainable development". Rio+20
- 17 goals, 169 targets:
  - Too many though comprehensive
  - Clear interlinks between health and sustainable development.
  - Thorough consultations, engagements by country, CSO, IDP
  - Ambitious targets, are they achievable?
  - Challenges: loads on country reporting, capacity to monitor equity
- Main bottleneck of achieving SDG:
  - Untouched political determinants of inequity and supranational influences in particular trade interests
- SDG should focus on UHC as a main goal, not sub-goal: universalism contributes to equity.

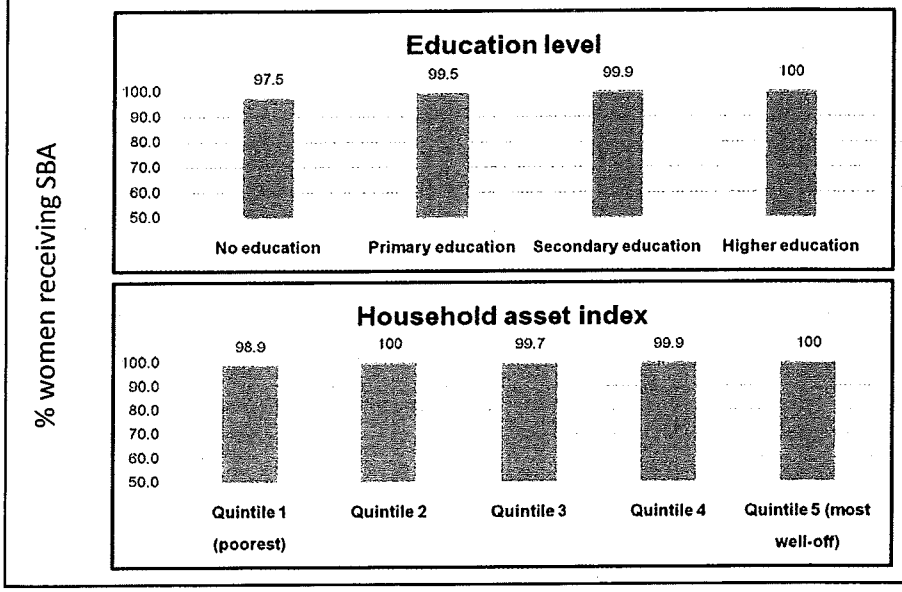
Universality contributes to equity:

The higher the SBA coverage, the smaller the rich-poor gaps
Channon et al 2015 analysis from 35 DHS (PMAC talk)



Universal SBA, Thailand 2009 RHS

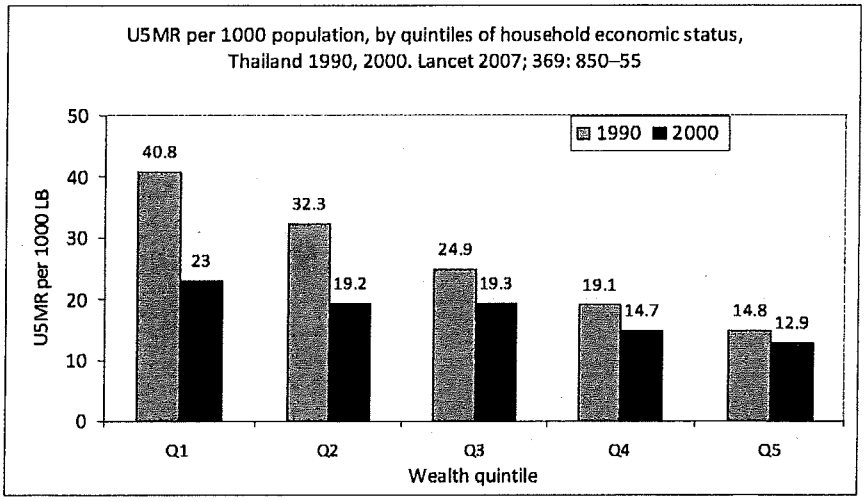
The higher the coverage, the smaller the rich-poor/education gaps
RHM2011;19(37):86–97



Universal coverage of MCH services:

minimizes rich-poor child mortality gap, Thailand 1990, 2000 census

***Lancet* 2007; 369: 850–55**



Diverse country experiences:

platforms for learning and sharing

- Rwanda and Ethiopia –significant health improvements
  - Clear government leadership,
  - Increased domestic resources, aligned donor support
- Challenges among MDG off-track countries:
  - Failing health delivery systems, lack of financial risk protection
  - Recent Ebola outbreak demonstrated weakness of health system capacities and lack of resilience.
- Japanese UHC experience:
  - improved access + improved income re-distribution (Gini) + inclusive economic growth + social stability.
  - Challenges to sustain UHC in view of ageing population and low economic growth
- Good learning platform for global community

Transition from donor dependence

- Transition from GAVI, GFATM:
  - Requires strong political commitment
  - Create fiscal space for health and programmatic and financial sustainability transition plan
- Access to commodities in post 2015
  - GAVI and GF efforts on market shaping:
    - Target to bring down vaccine prices to below 19USD per fully immunized child (DTP, Hb, Hib, Pneumo, Rota) by 2017, plan that MICs purchase at 20% above LICs
  - Challenges:
    - Oligopoly, monopoly market esp. ART, Vaccine, public disclosure of price
  - Solutions:
    - MIC to access pooled procurement for best possible price given assured quality, encourage market transparency: publish vaccine prices, share market and procurement knowledge

Governance and accountability

"We are challenged to develop a public health approach that responds to the globalised world. The present global health crisis is not primarily one of disease, but of governance..."

Ilona Kickbusch

- Accountability not only for health sector; call for same accountability by other sectors (trade, transport, urban planning, education) that impact health of population
  - Embed culture of accountability
  - Use Human Rights framework to move the SDG forwards
- Better data, information and improved use
  - For performance assessment and to hold healthcare providers accountable and responsive

Changing power relations: between elites and local health workers

- Strengthen the local health workforce:
  - Evidence shows better retention
    - Recruiting students from local communities, ethnic minorities for health workforce training and home town placement
    - Eg upgrading training of medical assistants in Vietnam
- Ensure accountability:
  - Names and mobile phone numbers of all health workers posted in all rural clinics in Rwanda
- Ensure transparency:
  - Ghost doctors are removed from payroll after electronic transfer of salaries in West Africa

Political origins of health inequity

Ottersen et al, Lancet 2014; 383: 630–67

- Unacceptable health inequities within and between countries cannot be addressed within the health sector, by technical measures, or at the national level alone - require global political solutions
- Norms, policies, and practices that arise from transnational interaction should be understood as political determinants of health that cause and maintain health inequities
- Power asymmetry and global social norms limit the range of choice and constrain action on health inequity; these limitations are reinforced by systemic global governance dysfunctions and require vigilance across all policy arenas

Political origins of health inequity

Ottersen et al, Lancet 2014; 383: 630–67

- There should be independent monitoring of progress made in redressing health inequities, and in countering the global political forces that are detrimental to health
- State and non-state stakeholders across global policy arenas must be better connected for transparent policy dialogue in decision-making processes that affect health
- Global governance for health must be rooted in commitments to global solidarity and shared responsibility; sustainable and healthy development for all requires a global economic and political system that serves a global community of healthy people on a healthy planet

Call to Action

Universal Health Coverage

- Amend the current Goal 3:
  - Ensure healthy lives and [promote well-being for all at all ages] achieve progressive universal health coverage
- Government commitment on progressive universalism
  - Expand supply side capacities to provide quality services, ensure financial risk protection through mix of financing sources, strategic purchasing to achieve pro-poor benefit incidence, reduce OOP, contain cost and improve efficiency
- Health workforce:
  - Rapid scaling up training of adequate number of competent, committed health workforce; also helps create economic opportunities for local communities and employment
  - Retain them in places where needed with adequate resources
  - Governments should abide by the Global Code of Practice on International Recruitment of Health Personnel, to mitigate negative impact of economic migration

Call to Action

Accountability

- Strengthen accountability framework, enforcement mechanisms and reporting in order to hold governments, private sectors, transnational corporations, supra-national agencies accountable to sustain or accelerate MDGs and implement the upcoming SDGs.
- Ensure effective local citizen/community engagement in health delivery systems, through local accountability mechanisms, e.g. public disclosure reporting;
- Strengthen information systems and institutional capacities for monitoring UHC achievement (effective coverage, financial risk protection) stratified by wealth index, vulnerability (mentally ill, migrants, people with disability, ethnic minorities, LGBT, etc)
  - Service Availability and Readiness Assessment (SARA) or Service Delivery Indicators are useful tools to assess effective coverage, hence enhancing accountability.

Call to Action

Increase Fiscal Space for health through

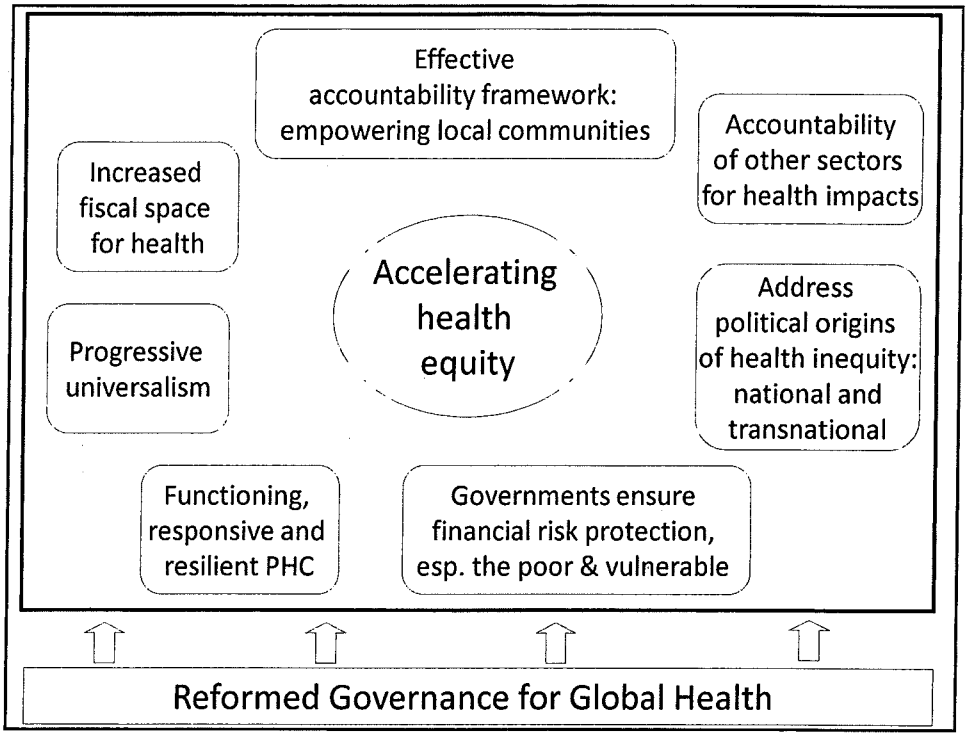
- Domestic action e.g. tax reform, earmarked tax for health, drive down cost of health products and commodities through pooled purchasing, mobilize innovative financing sources e.g. sin tax, reduce fuel subsidies
- International solidarity actions e.g. financial transaction tax, 21% of ODA for health (20% of 0.7% of GDP)

Health Systems

- Strengthen health systems preparedness to combat outbreaks and prevent epidemics by strengthening IHR core capacities.
  - "Underinvestment in public health kills people and derails economies!" [Tim Evans]

Global Health Governance

- WHO should reposition its role in global health and do first things first, namely at global level, pandemic preparedness and responses, normative functions, convening for public health actions; target country support where greatest needs.



Acknowledgements

- All PMAC 2015 supporting staff, secretariat for their able support and dedication
- All 71 session rapporteurs
- All co-hosts for their continued engagement and support

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Thank you for your attention