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The Drive for Universal Health Coverage: Health Care Delivery Science and the Right to High-Value Health Care

Thursday, December 12, 2013

Media content from this session

Throughout the session we've been producing newsletters, conducting interviews and taking photos.

You can access all of these materials online, should you want to share them further with your own network, or simply remember your time here at Schloss Leopoldskron and Salzburg Global Seminar.

Newsletters can be downloaded from the Session Page under 'Session Media': SalzburgGlobal.org/go/507.

Interviews with speakers and Fellows can be found here: SalzburgGlobal.org/go/OurFellows. Over next week, you will also be able hear our podcasts from these interviews on our SoundCloud stream: SoundCloud.com/SalzburgGlobal.

All the photos from the session are available to download from Flickr.com/SalzburgGlobal and to view and share on Facebook.com/SalzburgGlobal.

Blogs will also be posted on the WBI and Dartmouth Center websites so don't miss out!



Participants discussed different approaches to achieving universal health coverage and considered how these experiences could inform their work in their home countries

Sharing Ideas at the Knowledge Café

Quick fire discussions & multiple topics maximize learning opportunities

Emily Fletcher

Salzburg Global Seminar participants gathered yesterday for a knowledge café, in which six participants led small group discussions about their areas of expertise as they relate to the drive for universal health coverage.

The room buzzed as participants moved from discussion to discussion, sharing experiences and asking colleagues about health system successes and failures and how they might be applied in other country contexts.

The making of Morocco's National Action Plan

Sidi Abdellatif Idrissi Azzouzi, coordinator of Regional Directorates in the office of the Secretary General of the Ministry of Health in Morocco focused his discussion on health care financing reform in his country.

With a new national constitution in 2011, legal issues and political and social transition framed the conversation about how to involve the various stakeholders and actors and how to ensure accountability and responsibility in the system. Azzouzi said that the Regime d'Assistance Medicale (REMAD) covers about six million patients in Morocco.

The Brazilian team also shared their experiences implementing a similar program several years earlier.

Operationalizing the right to health in a low resource, post conflict setting

Salzburg Global Program Director Diasmer Bloer shared her experiences operationalizing the right to health in Liberia, a low-resource, post-conflict setting.

Participants discussed the difficulties and management of politics, change, conflict environments, resources, and the various actors who have a stake in the system. In many countries, a disconnect exists between those making the policy, the health care workforce and the people.

Bloer also explained and led discussion about the reason behind the push for a rights-based approach to health care in Liberia: a long conflict, the need to decentralize everything, and the importance of guaranteeing the rights to every state service.



Members of the Brazilian delegation also mentioned their program in which godmothers ensure pregnant women are appropriately using the system.

Seguro Popular: reaching 50 million Mexicans previously excluded from Insurance

As the former national commissioner for Seguro Popular, a national health insurance program in Mexico, David Garcia Junco Machado led his table's discussion on Mexico's insurance programs, with a particular focus on Seguro Popular, in the context of the drive for universal health coverage.

The national scheme provides insurance for citizens who are not covered under Mexico's other insurance plans, though Garcia described the difficulty of standardizing protocols across the various programs.

Participants were interested in how insurance can be used as a tool to expand health care access in different country contexts.

Leveraging partnership innovations for universal health coverage

Emmanuel Higenyi, head of capacity building at the Joint Medical Store in Kampala, Uganda, led a discussion about leveraging partnership innovations for universal health coverage in the country.

He focused on involving the important stakeholders in the health care system, which in Uganda is based on a strong legal framework and policy for public-

private partnerships. While these partnerships initially focused on the pharmaceutical supply chain, they were then broadened to include general health care delivery.

Participants were also interested in hearing about how communities can become involved in the health care system using technology, such as programs that allow health system users to provide feedback on the quality of care and any issues that arose via mobile phones. The Ugandan team has already tested new technology in getting user feedback through a partnership with UNICEF.

Learning how to create value from variation

On the other side of the room, director of the Dartmouth Center for Health Care Delivery Science, Al Mulley's table discussed how to create value out of lessons learned from variation in the health care system.

Mulley said that countries currently investing in health care capacity should base their investments on revealed patient preferences in order to avoid the waste and harm—which constitute up to 40 percent of health care costs today—which is apparent in many existing systems. By studying widespread variation in health care costs per capita and service utilization rates throughout the United States, Dartmouth researchers have found that more care and more expensive care does not lead to better outcomes.

No health care decisions at the individual or aggregate level should be made in the face of avoidable ignorance, Mulley said, and respect for patients and their preferences should be the cornerstone of health systems.

Realizing and sustaining universal health coverage in a limited resource setting

At Jean-Pierre Nyemazi's table, the head of planning, monitoring and evaluation at the Rwanda Biomedical Center led discussions focused on realizing and sustaining universal health coverage in a limited resource setting, with Rwanda as the central example.

The concentration in Rwanda, he said, was investing more in primary care, especially at the community level, to realize community involvement and ownership of the health care system and to reduce costs at the hospital level. Rwanda's community health worker (CHW) program relies on women who are elected by their communities and receive an initial month of training, with periodic refresher training. There is an average rate of one CHW per 100 people, and the women visit households to administer basic care, promote health, and identify patients for referral to other services, according to Nyemazi.

Participants were interested in how an incentive program that provides business capital to cooperatives of CHWs could be applied in other settings.