Advancing toward Universal Health Coverage through Smart Choices

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A Report of the CSIS Global Health Policy Center

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Advancing toward Universal Health Coverage through Smart Choices

Nellie Bristol[1]

As countries around the world advance toward universal health coverage, leaders are looking for ways to best use resources to improve health and promote long-term economic development and social stability. As part of the discussion, consensus is evolving over how to ensure decisions related to benefits packages are equitable, transparent, evidence based, and responsive to the needs of patients and local health systems. In Spring 2015, the Global Health Policy Center at the Center for Strategic and International Studies gathered global and country experts for a stimulating discussion of current models and approaches for moving the conversation forward.

CSIS Global Health Policy Center Director J. Stephen Morrison set the stage for the morning's discussion. Morrison noted that decisions about what services will be covered are a vitally important and complex dimension of universal health coverage. As countries expand health services, they must decide how to make quality choices on the best mix of benefits. "This may sound simple," Morrison said, "but it's not. It's not so simple to reach informed decisions amidst financial scarcity, competing demands, complex political realities, fluid market conditions, and multiple uncertainties…."

In an ideal world, Morrison said, people aspire to a common set of quality benefits and to reach informed decisions that are transparent, evidence based, linked to health outcomes, and financially sustainable. Coverage decisions must be defensible to multiple audiences including civil society groups, ministers of finance, and private-sector players, which have a large role in many health systems.

While the decisionmaking process is complicated, interested parties are in the midst of a lively and important debate on the methodology and philosophy for proceeding, Morrison said. In addition, there is a growing body of analytic evidence and country experiences as national leaders and the global health community work toward the best approaches.

Universal Health Coverage Defined, Chilean System Explored

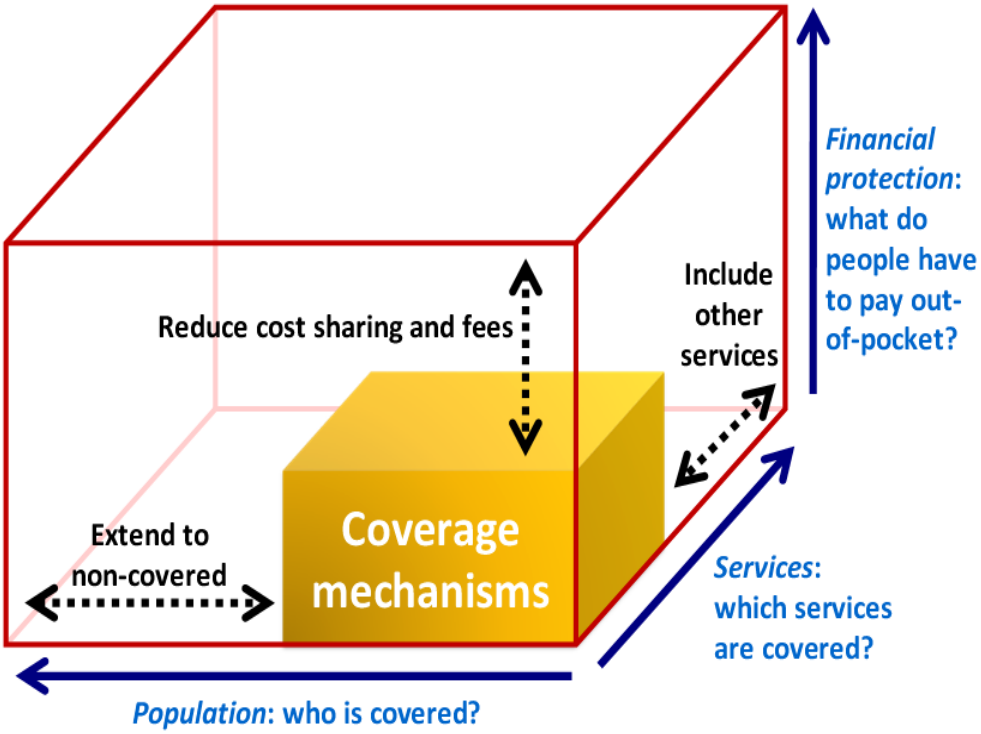
In an opening keynote address, Jeanette Vega, director of Chile's Fondo Nacional de Salud (FONASA), framed the day's conversation by setting out a definition of universal health coverage: "All people can access the health services they need without incurring

[1] Nellie Bristol is a senior fellow with the CSIS Global Health Policy Center in Washington, D.C.

financial hardship." She noted that universal health coverage is two interrelated concepts: access to needed quality health services and financial risk protection. Health services under universal coverage should be broadly defined to include prevention, health promotion, treatment, and rehabilitation. Progress toward the goals can be measured through proxy indicators such as utilization rates for different conditions and events, she added. The level of financial protection can be measured by the percentage of catastrophic payments and out-of-pocket expenditures.

But, Vega added, "Advancing toward universal health coverage is more than focusing on health financing. In fact, it's about focusing on the whole architecture of the system." She cited the importance of building up the various components of health services, including facilities, health workers, and governance structures, and analyzing patient outcomes.

Working toward universal health coverage requires policymakers to grapple with a complex set of tradeoffs. The World Health Organization (WHO) developed a policy box to help visualize strategic choices (see below). The box depicts the three dimensions of universal health coverage: Population—who is covered; services—which services are covered and at what level of quality; and financial protection—what do people have to pay out of pocket. In assessing who should be covered, policymakers need to make choices about what population will be covered by what services and make tradeoffs between these two dimensions, Vega said. "Deciding how to start on the journey toward universal health coverage is critical," she added.



Source: World Health Organization.

Countries usually pursue one of two broad strategies when developing their coverage systems, Vega noted:

1) Cover the whole population with a package of priority services;

2) Prioritize financial coverage to specific population groups, for example, those in the formal employment sector or the poor, offering them a broader package of services.

Vega said there has been a lot of discussion about which strategy to follow. In the last year, she said, a consensus is emerging that at least in developing countries it is better at the beginning to make the program universally available—covering the entire population, even if it is with fewer services. Countries can expand the number of services as the system advances.

If a country starts its coverage with a select population, prioritization occurs, Vega said. Latin America has a lot of experience with this phenomenon, she added. It can result in health coverage of the wealthiest groups through publicly subsidized or private health insurance schemes. In the meantime, attempts are made to cover the poor, usually with publicly financed and provided services. The latter systems usually are less generous and services are of poorer quality, she noted.

Between those two groups is the "missing middle," a large population of uncovered individuals generally working in the informal employment sector. They often pay for services out of pocket, putting them at constant risk of financial hardship. Coverage systems that remain fragmented in this way are ineffectual because so much of the population is uncovered, Vega noted. They also are inefficient because their coverage pools are separate, creating higher administrative costs. Further, they are inequitable because the richest households benefit disproportionately.

The 2013 Lancet Commission on Investing in Health, Vega said, made a strong case for compulsory publicly governed health financing. Other high-level organizations agree that mandatory financing mechanisms are required to achieve universal health coverage for the entire population with necessary services. The evidence, Vega said, points to the importance of publicly governed systems and minimizing fragmentation of financing pools.

Vega next turned to the topic of how to prioritize services under universal health coverage. Priority setting in health, she said, is "the task of determining the priority to be assigned to a service, a service development, or an individual patient at any given point in time." In viewing the concept as an opportunity cost, Vega said, the process determines who is to go without a specific health intervention in order that others have it—giving priority to one group of people takes it away from another group and prioritizing some services means deprioritizing others.

Priority setting is necessary, she said, because demands on health resources are always greater than the resources available. In the absence of well-designed priority setting, an ad hoc system develops that is inequitable and inefficient. Having a specific priority setting mechanism allows policymakers to achieve national objectives, allocate resources, and define the benefit package. It also allows them to assess new technologies. Priority-setting mechanisms increase the efficiency and equity of heath funding, she said.

Priority setting exists at all levels, Vega pointed out. At the broadest level, the government makes decisions, especially on issues that involve the whole country. On the other end of the spectrum, health care practitioners regularly make decisions regarding services for their patients. Those decisions, she said, can have the biggest impact in terms of cost. At the practitioner level, decisions usually are not evidence based. In most countries, practitioners are unregulated, meaning that most of the costs of the system cannot really be controlled. That is why it is important to introduce clinical guidelines in countries so that practitioners have a set of evidence-based criteria on which to build their treatment decisions, she added.

Using her country as a case study, Vega noted that Chile relies on mandatory social health insurance to provide universal coverage to its population. She said the system is segregated by public and private systems. FONASA, the single public insurer, covers 80 percent of the population. A separate system covers those involved in formal employment. To standardize its fragmented coverage system and make benefits more equitable, Chile in 2005 developed a system-wide benefit package, AUGE. Under the system, both public and private insurers must provide specified services. The system includes additional guarantees for 80 diseases that create the largest burden of disease and constitute the biggest financial burden. Health services have to be provided by properly registered and qualified providers according to standardized clinical guidelines and delivered within explicit deadlines. The health plans must cover 80 percent of the costs of the guaranteed package. While Chile had specific mechanisms for determining what would be covered, ultimately the process needs to be informed and participatory and cannot just be a technical exercise, Vega argued.

AUGE has been very successful with a high approval rating. Chilean officials are improving the system by creating one insurance pool instead of the current 15 private pools and one public pool, Vega said. The biggest downside of the program is that waiting lists are increasing for nonprioritized procedures. Since the AUGE system has explicit deadlines for treatment, physicians and patient groups are pushing for their conditions to be included. Officials also are instituting systems to make health care purchasing more efficient. The system's success has attracted the attention of the private insurers, who also want to participate, she added.

Key Messages

- In advancing toward universal health coverage, policymakers must define who should be covered, how services will be paid for, and what services should be covered first.
- The most successful systems cover the entire population with a basic set of health services to avoid system fragmentation and inequities.
- Priority setting is a complicated, political, and "muddy" process that must be participatory and not just technical.

Developing Coverage Priorities: The Global Perspective

The day's first panel represented groups that are working internationally in the priority-setting arena. Participants included Tessa Tan-Torres Edejer from the World Health Organization; Akiko Maeda of the World Bank; Kalipso Chalkidou from NICE (National Institute for Health and Care Excellence) International; and David Grainger of Eli Lilly and Company.

Tessa Tan-Torres Edejer—World Health Organization

Edejer began the conversation by referring again to universal health coverage as tradeoffs between who is covered by what services and how it should be financed. She cited the example of her home country, the Philippines, which, like Chile, also has the problem of the "missing middle." She said the set of services available is patchy and unusual, including, for example, kidney transplantation. She asked whether the country should simply expand on that set of benefits or offer benefits to those without coverage with fewer services. "Who answers those questions?" she asked. "Where do we get guidance?"

The global community, she noted, is advancing new development goals, which will be considered by the UN General Assembly in September. The Sustainable Development Goals (SDGs) in their current form contain targets related to health including reducing the burden of infectious diseases such as HIV and tuberculosis and reducing child and maternal mortality. One subgoal related to universal health coverage calls for access to essential services with 100 percent financial protection. "How will we select among the many interventions that are implied in order to reach these goals?" she asked. "We cannot afford all of them . . . they need to be prioritized."

Each country will decide its own approach to the universal health coverage goal, Edejer said. WHO offers cost-effectiveness analyses that look at the main interventions for various conditions using a standardized process. Ethicists, economists, and country representatives developed a second tool to take a broader look at benefits prioritization.

The resulting document, *Making Fair Choices on the Path to Universal Health Coverage*, calls for eliminating the missing middle and ensuring equity in the provision of health services, Edejer said.

While some aspects of priority setting could be done on a regional basis—for example, cost-effectiveness analysis of particular interventions—the actual choice of benefits to cover is very political and must be done on a local basis, Edejer emphasized. This is particularly the case because policymakers have to make hard decisions that will result in some patients receiving coverage for their treatment while others will not, a situation that will require policymakers to justify their decisions based on local circumstances.

Akiko Maeda—The World Bank Group

Akiko Maeda, lead health specialist for the World Bank, said that while analyzing the cost-effectiveness of health services is valuable, it is not enough to ensure provision of equitable health services. The process is missing critical elements, she argued, that will necessitate transformative thinking. Health systems have been viewed too much from a mechanical engineering approach, reviewing elements such as inputs, components, and evidence. But health systems are not mechanical systems, she noted, but instead are organic and involve complex relationships with stakeholders. Maeda argued that policymakers need to be more aggressive in evidence-based thinking in three areas:

1) Political economy should be explicit as a central piece of universal health coverage. Policymakers need to consider dynamics such as equity, redistribution, tradeoffs, and negotiation. Health technology assessment brings the process part of the way but there needs to be a clear governance of priority setting that combines ethics with evidence.

2) Behavior and psychological sciences need to be considered as part of the governance structure.

3) Big data and social media can be used as tools to gather evidence in a fair and transparent way.

Maeda cited Japan's system as an example of negotiated priority setting. Japan has a national fee schedule for reimbursement with mainly private health care providers. The fee schedule defines benefit packages and conditions for reimbursement and is updated every two years. Prices are decided through consideration of public policy, the market, and the "pure politics of interest groups fighting it out." The process is not easy, she added, but it is transparent and creates long-term relationships among stakeholders that make them responsible to the public.

As an example of stakeholder negotiations, Maeda cited the government's support for a larger role for public health nurses to coordinate care for the elderly. The move is facing

pushback from clinicians, pointing to the need for greater education of health workers and negotiation around how to move forward in the public's interest.

Kalipso Chalkidou—NICE International

Chalkidou is the founding director of NICE International, the international arm of the UK's well-regarded National Institute for Health and Care Excellence. Her group works with governments and others to develop evidence-based priority setting. Chalkidou said priority setting is important because countries are not using health interventions appropriately—those that are of high value are not being used frequently enough while those that are of low value are too prevalent. While explicitly choosing to cover some services over others "will anger people, will sadden people," the system developed by NICE helps ensure those decisions are evidence based and transparent while creating policies that are fair and equitable.

Priority setting, Chalkidou said, must be achieved locally and involve countries' own institutions and processes. It involves setting out ground rules for benefits considerations and increasing accountability. Countries should put money aside for quality improvement and develop a system to measure health systems strengthening. The process, she said, is not a technocratic exercise. It involves scientific rigor in assessing the efficacy and cost-effectiveness of health interventions, but also calls for inclusiveness in decisionmaking, consideration of social values, transparency, and independence.

The demand for help with priority setting is coming from middle-income countries, Chalkidou noted, where governments have more money to spend on the activity. Donors may need to take a bigger role in low-income countries where resources are not available for priority setting. For example, she said Gavi, the Vaccine Alliance, and the Global Fund to Fight AIDS, Tuberculosis and Malaria, both may have role in advocating for priority setting in countries where they operate.

David Grainger—Eli Lilly and Company

Grainger is senior director of global public policy for Eli Lilly and Company, a multinational pharmaceutical company. As universal health coverage spreads, he said, policymakers are sometimes making very ambitious political commitments to increase coverage often without the financial capacity to deliver. "Clearly, the consequence of that is that you've really got to have some form of evidence-based priority setting that's going to guide health systems particularly during that initial period of universal coverage." He said the pharmaceutical industry is not concerned about requirements to produce evidence for priority-setting reviews. Companies know how to generate evidence and think it is far better if systems relied on evidence for decisionmaking rather than having decisions made without a complete understanding of the merits and ramifications.

At the same time, Grainger said, industry officials are seeing international organizations and others advocate for health technology assessment (HTA) as one of the key tools for achieving evidence-based priority setting. The industry prefers a broader approach, what it refers to as “macro HTA.” Rather than looking at evaluating individual interventions, macro HTA takes a more holistic view of the health system needs. It examines a system’s capacity and analyzes what is achievable and what is feasible. It encourages the use of clinical pathways and guidelines to ensure appropriate care for various conditions. Decisionmaking should use a combination of approaches, Grainger said. He added that industry is “very keen to have some sort of seat at the table” while countries develop their processes and advocated for a more continuous, negotiated approach to decisionmaking

In concluding, Grainger said that while a lot of medical care can be provided with basic technologies and services, in some cases more involved interventions are needed to appropriately address patient needs. In addition to strictly looking at the cost of interventions, good health technology assessment also takes into account structural organization and cultural issues. “I think what industry is concerned about is in some situations where you’ve got these intense affordability issues because the financing capacity is not keeping pace with the universal coverage expansion, then HTA can become a cost containment mechanism that is there to sort of be a barrier to adoption of more costly things,” Grainger said. “Done well it obviously is not like that and it doesn’t have to be like that and it is trying to find this balance that does have a broader set of considerations but clearly with affordability as a key part of it.”

Key Messages

- The World Health Organization offers several important tools to help countries define benefits packages, but ultimately the decisions must be made locally.
- While health technology assessment is an important aspect of priority setting, policymakers must look at the issue more broadly to include concepts like political economy, behavior change, and the use of big data.
- Explicit and transparent priority setting involves tough choices that will not sit well with everyone, but it is the only way to ensure health funding is used fairly and equitably.
- The pharmaceutical industry advocates a broad health systems process for setting priorities and wants to be involved when countries develop their decisionmaking mechanisms.

The Country Perspective: Thailand, Mexico, China

As emphasized by the first panel, local policymakers must make universal health coverage benefits decisions. The second panel featured experts on several countries that have taken the lead on the issue.

Yot Teerawattananon—Thailand

Yot Teerawattananon is the founding leader for Thailand's Health Intervention and Technology Assessment Program. Thailand has been an innovator in universal health coverage among middle-income countries. When it started its system 12 years ago, Teerawattananon said government officials had difficulty developing rational, equitable benefit packages with many decisions made in court, by technicians, or politicians. Policymakers then developed a new process whereby well-informed stakeholders made benefits decisions. Local capacity for generating and using informed choices could make universal health coverage sustainable, he added.

Under the Thai system, groups of stakeholders, including health providers, civil society, industry, and the public, nominate which interventions should be included in the program. A working group prioritizes the choices based on: the magnitude and severity of the problem; effectiveness of interventions; variation in practice; financial impact on households; equity; and, ethical considerations. Researchers perform assessments of the chosen interventions based on cost effectiveness and budget impact, which are then passed on to a committee for benefit package development. Finally, a national health security board composed of politicians, patients, and technocrats (but not industry representatives) makes the final decision. Teerawattananon gave some examples of decisions made by the board. The board rejected coverage of adult diapers for urinary and fecal incontinence as too costly without sufficient benefit. On the other hand, renal dialysis, which is significantly more expensive, was approved since kidney disease had a greater impact on families and quality of life and because dialysis is a lifesaving intervention.

The Thai government uses its cost-effectiveness analysis to negotiate lower prices with industry. As a result, the efficiency gains from using health technology assessment is in itself good value for money, Teerawattananon concluded.

Sebastián García Saisó—Mexico

Sebastián García Saisó is director general for health quality and education with the Ministry of Health in Mexico. Mexico has been a leader in developing programs to provide coverage to the previously uninsured, greatly increasing health care access over the last decade. Universal health coverage in the country, García said, has been a success. But, he said, policymakers need to make the system more sophisticated. They need to

move from coverage to effective access to services, from priority setting "into actually making a difference in people's health."

In an overview of Mexico's progress toward universal health coverage, García noted that government expenditures on health care have more than tripled between 2001 and 2013 and the growth has been maintained. "We are very proud of this," he said. During that time, Mexico implemented *Seguro Popular*, which now covers more than 57 million low-income Mexicans. The program includes an explicit benefit package that spells out what services will be covered for whom. As a result, the government knows how much the package costs and can prioritize services, he said. With the additional funding available for health, the government has changed from basic coverage to a more comprehensive package of benefits. The package includes more than 280 interventions chosen by a commission, plus almost 60 interventions in a catastrophic care package. In addition, 181 interventions are available to all children under 18. With these advances, García notes the country has made enormous progress in who is covered, what they are covered for, and the percentage of costs that are covered.

But still, there are challenges, García said. While paying the same amount for procedures in different facilities, there is a huge difference in patient outcomes, including survival rates. The "next frontier," he said, is ensuring quality of care is uniform across all health care providers. "If we are paying for universal coverage as a society, then we need to guarantee similar results regardless of where we are accessing this treatment," he said. To address the problem, Mexico has instituted a health care quality program that looks at the risks patients face in the process of consuming health services and is working to improve quality of care in substandard facilities.

Yanzhong Huang—China

Yanzhong Huang is a senior fellow at the Council on Foreign Relations. He focuses on universal health coverage and is an expert on the Chinese health system. He said that while China also has increased health coverage throughout the country, challenges remain in ensuring access to timely care and limiting out-of-pocket expenses.

Health insurance coverage in the country has increased from 30 percent in 2003 to 95 percent today. Out-of-pocket expenditures have decreased by 36 percent. All told, the government has spent billions of dollars on health reform. While all of this is good, Huang said, still people are not happy with the system. "Everybody seems to be complaining," he said. Government leaders are now admitting they need to do more to address access and affordability. Part of the problem, Huang said, is the fragmentation of the system. There are different coverage schemes and several thousand insurance pools in the country. They all have different levels of benefits and reimbursement. Government schemes prioritize inpatient care and coverage of catastrophic illness, but this emphasis means that many people do not seek care when conditions still may be relatively minor. Instead, they wait until they are eligible for hospital admission when

diseases are farther along and more costly to treat. In addition, Huang said, coverage is wide and shallow, only 30 percent of outpatient services are covered, with no coverage of dental care, checkups, or some life-saving drugs.

In summary, Huang said, while there has been progress in improving health coverage in China, the benefit level remains low and the system is highly fragmented. To improve coverage, the government needs to increase reimbursements for both inpatient and outpatient care, reduce deductibles and copayments, and integrate the different schemes into a common pool. The government is attempting to integrate its insurance schemes in terms of management, but not in funding or benefits packages, Huang said.

Key Messages

- Effective priority setting entails involvement of well-informed stakeholders acting at the local level.
- While coverage may be widespread in some countries, policymakers need to address quality of care to ensure it is adequate and uniform across health care providers.
- Fragmentation of coverage can result in high variation in access to and costs of health services. Governments should ensure uniformity of benefits and reimbursement levels across the entire system.

Universal Health Coverage and the U.S. Government

Ambassador Jimmy Kolker, assistant secretary for global affairs at the U.S. Department of Health and Human Services, wrapped up the conference with an overview of U.S. involvement with universal health coverage. He noted that on the domestic front, universal health coverage is one of the highest priorities of the Obama administration. This is a change in U.S. policy from the previous administration, a period when the United States resisted conversations about universal health coverage in international fora. It currently endorses international measures related to universal coverage because it is now consistent with U.S. domestic policy. Despite the change, the U.S. diplomats advocate caution with language on health services coverage, noting the health financing and systems building lies with national governments. The United States also continues to resist language calling for a "right to health," a commitment that has been made by many other governments. A right-to-health framework, Kolker says, allows citizens to sue for medical treatment, even if it is prohibitively expensive or experimental. "We are still opposed to this judicable right to health," he said.

Kolker noted that the United States has made strides toward universal health coverage for its own population, but progress is slow. Nonetheless health officials in other countries often ask U.S. health officials for advice on improving financing and delivery

of care. He noted that in addition to making coverage available, emphasis needs to be put on quality of care, efficiency, and costs.

The United States supports including universal health coverage as a dedicated goal in post-2015 development goals, Kolker said. “Many people have questioned whether universal health coverage is the right fit for development goals, but we think it is,” he said. Expanding health coverage is important, he said, because there now are so many poor in middle-income countries, which are subject to reductions in development assistance as their economies grow. In addition, he said, the proposed Sustainable Development Goals call for increases in longevity and addressing the precipitous rise in noncommunicable disease, targets that cannot be met without promotion of universal health coverage worldwide. The new goals will be broader than the current set, the Millennium Development Goals (MDGs), and will be less focused on development assistance, but rather urge increases in domestic resources for development advances. Countries are now looking more for technical rather than financial partners, an area that is “a sweet spot for us,” Kolker said. The Centers for Disease Control and Prevention, the National Institutes of Health, the Food and Drug Administration, and other U.S. agencies have a comparative advantage in providing technical assistance globally.

While the development framework likely will evolve to include all countries working to jointly solve universal challenges, focus still needs to continue on particular issues including sexual and reproductive health, noncommunicable diseases, infectious diseases, and improving water and sanitation, Kolker said. Promotion of universal health coverage will help countries prioritize and deliver on their own health goals rather than serving as an end in itself.

The United States is a clear example of the difficult path to universal health coverage, Kolker said. But even though there have been lots of obstacles, progress is possible. While the United States continues to have uneven access to health services, especially preventive services and wellness programs, the Patient Protection and Affordable Care Act still was a major step toward universal health coverage—an additional 11 million people in the United States now have health coverage, he noted.

Turning to the topic of the conference, Kolker said progress has been made on developing mechanisms to ensure the most appropriate care is provided to patients “but clearly not enough.” Health care providers, policymakers, patients, and governments need to have the ability to look at available technologies and “decide what’s appropriate for whom.” Countries also need to take on the issue of health governance to determine who makes coverage decisions that potentially can be life and death decisions for patients.

In the multinational context, Kolker said there are definitional questions around universal health coverage that need to be resolved. For example surgical care and anesthetics should be covered as part of primary care, but are not in all systems. Further,

the global community has not addressed mental health, dementia, and Alzheimer's disease. Guidelines also are needed in the area of palliative care including proper end-of-life care and appropriate drugs. "How do we make that process of dealing with chronic conditions one that's . . . humane, medically sound and financially put in the proper perspective," he said.

In conclusion, Kolker said, universal health coverage does not just involve governments and third-party payers in financing care, but is a goal that should be progressively achieved, is unique to every society, and should result in more equitable health outcomes. "It's both a technical agenda and a social justice agenda, and one that we as the United States are ready to embrace," he concluded.

Key Messages

- The United States was a late supporter of universal health coverage but now endorses it worldwide as a way to generate more equitable health outcomes.
- Evidence-based decisionmaking is essential in determining health services coverage.
- Definitional challenges need to be determined at the international level including those related to primary care services, mental health, and end-of-life care.

Smart Choices Critical to Universal Health Coverage Success

The Global Health Policy Center forum on evidence-based decisionmaking brought together global and country experts in the field to discuss the current state of this important debate. They highlighted the need for evidence of effectiveness and cost of health interventions as a key piece of coverage decisionmaking, but also stressed the social and political dimensions of the process. Making smart choices in benefits coverage is a critical element to ensuring universal health coverage achieves its ultimate goal of providing equitable health care that meets the needs of the entire population.

Appendix: Conference Program

Advancing Universal Health Coverage through Smart Choices
CSIS, Wednesday, March 11, 2015

Welcome

J. Stephen Morrison
Senior Vice President and Director, Global Health Policy Center, CSIS

Opening Keynote

Jeanette Vega
Director, Fondo Nacional de Salud, Chile

Panel 1: Global Approaches to Coverage Decision Making

Kalipso Chalkidou
Founding Director, NICE International

Tessa Tan-Torres Edejer
Coordinator, Unit on Costs, Effectiveness, Expenditure and Priority Setting, Department of Health Systems Governance and Financing, World Health Organization

David Grainger
Director, Global Public Policy, Eli Lilly and Company

Akiko Maeda
Lead Health Specialist, World Bank

Moderator
Nellie Bristol
Senior Fellow, CSIS Global Health Policy Center

Panel 2: Country Perspectives

Yot Teerawattananon
Founding Leader, Health Intervention and Technology Assessment Program, Thailand

Sebastián García Saisó
Director General, Calidad y Educación en Salud, Mexico

Yanzhong Huang
Senior Fellow for Global Health, Council on Foreign Relations

Moderator
Robert Hecht
Managing Director, Results for Development Institute

Luncheon Speaker

Jimmy Kolker
Assistant Secretary for Global Affairs, U.S. Department of Health and Human Services

For more information, see http://csis.org/event/advancing-universal-health-coverage-through-smart-choices.

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