PMAC | PRINCE MAHIDOL AWARD CONFERENCE 2020

REPORT ON THE

PMAC 2020
UHC Forum 2020

ACCELERATING PROGRESS TOWARDS UHC

28 JAN - 2 FEB 2020 I BANGKOK, THAILAND

True Success is not in the learning
but in its application to the benefit of mankind

HIS ROYAL HIGHNESS PRINCE MAHIDOL OF SONGKLA


Two Hearts
for the Benefit
of Mankind

TABLE OF CONTENTS

08 PRINCE MAHIDOL AWARD
16 Prince Mahidol Award 2019
18 Prince Mahidol Award Laureate 2019 in the Field of Medicine
22 Prince Mahidol Award Laureate 2019 in the Field of Public Health

28 PRINCE MAHIDOL AWARD CONFERENCE
31 PRINCE MAHIDOL AWARD CONFERENCE 2020
34 Message from Chairs of the International Organizing Committee
41 Conference Co-hosts and Supporting Organizations

44 CONFERENCE PROGRAM STRUCTURE
46 Profile of Speakers, Panelists, Chairs, Moderators and Rapporteurs
48 Profile of Participants

50 CONFERENCE OVERVIEW
57 Objectives
58 Sub-themes

76 SUMMARY OF THE OPENING SESSION & KEYNOTE ADDRESSES
76 Opening Session
80 Keynote Addresses

118 CONFERENCE SESSIONS AT A GLANCE

138 CONFERENCE SYNTHESIS
140 1. UHC achievements
144 2. A mixed picture on progress to UHC
146 3. The solution
162 4. UHC: challenged by global megatrends
166 Healthy Meeting

168 FIELD TRIP

184 ANNEXES
188 Annex I International Organizing Committee Members
194 Annex II List of Scientific Committee Members
200 Annex III List of Speakers/Panelists, Chairs/Moderators and Rapporteurs
206 Annex IV List of Poster Presentations
212 Annex V List of Side Meetings and Special Events
224 Annex VI World Art Contest


PRINCE MAHIDOL AWARD

PRINCE MAHIDOL AWARD

The Prince Mahidol Award was established in 1992 to commemorate the 100th birthday anniversary of Prince Mahidol of Songkla, who is recognized by the Thais as 'The Father of Modern Medicine and Public Health of Thailand'.

His Royal Highness Prince Mahidol of Songkla was born on January 1, 1892, a royal son of Their Majesties King Rama V and Queen Savang Vadhana of Siam. He received his education in England and Germany and earned a commission as a lieutenant in the Imperial German Navy in 1912. In that same year, His Majesty King Rama VI also commissioned him as a lieutenant in the Royal Thai Navy.

Prince Mahidol of Songkla had noted, while serving in the Royal Thai Navy, the serious need for improvement in the standards of medical practitioners and public health in Thailand. In undertaking such mission, he decided to study public health at M.I.T. and medicine at Harvard University, U.S.A. Prince Mahidol set in motion a whole range of activities in accordance with his conviction that human resource development at the national level was of utmost importance and his belief that improvement of public health constituted an essential factor in national development. During the first period of his residence at Harvard, Prince Mahidol negotiated and concluded, on behalf of the Royal Thai Government, an agreement with the Rockefeller Foundation on assistance for medical and nursing education in Thailand.

One of his primary tasks was to lay a solid foundation for teaching basic sciences which Prince Mahidol pursued through all necessary measures. These included the provision of a considerable sum of his own money as scholarships for talented students to study abroad.

After he returned home with his well-earned M.D. and C.P.H. in 1928, Prince Mahidol taught preventive and social medicine to final year medical students at Siriraj Medical School. He also worked as a resident doctor at McCormick Hospital in Chiang Mai and performed operations alongside Dr. E.C. Cord, Director of the hospital. As ever, Prince Mahidol did much more than was required in attending his patients, taking care of needy patients at all hours of the day and night, and even, according to records, donating his own blood for them.

Prince Mahidol's initiatives and efforts produced a most remarkable and lasting impact on the advancement of modern medicine and public health in Thailand such that he was subsequently honoured with the title of "Father of Modern Medicine and Public Health of Thailand".

In commemoration of the Centenary of the Birthday of His Royal Highness Prince Mahidol of Songkla on January 1, 1992, the Prince Mahidol Award Foundation was established under the Royal Patronage of His Majesty King Bhumibol Adulyadej to bestow an international award - the Prince Mahidol Award, upon individuals or institutions that have made outstanding and exemplary contributions to the advancement of medical, and public health and human services in the world.

The Prince Mahidol Award will be conferred on an annual basis with prizes worth a total of approximately USD 100,000. A Committee, consisting of world-renowned scientists and public health experts, will recommend selection of laureates whose nominations should be submitted to the Secretary-General of the Foundation before May 31st of each year. The committee will also decide on the number of prizes to be awarded annually, which shall not exceed two in any one year. The prizes will be given to outstanding performance and/or research in the field of medicine for the benefit of mankind and for outstanding contribution in the field of health for the sake of the well-being of the people.

These two categories were established in commemoration of His Royal Highness Prince Mahidol's graduation with Doctor of Medicine (Cum Laude) and Certificate of Public Health and in respect to his speech that:

TRUE SUCCESS
IS NOT IN THE LEARNING,
BUT IN ITS APPLICATION
TO THE BENEFIT
OF MANKIND

In the past 27 years, the Prince Mahidol Award has been conferred to 83 individuals, groups of individuals, and institutions. Among them, 4 were Award recipients of Thai nationality, namely (1) Professor Dr. Prasong Tuchinda (2) Dr. Suchitra Nimmannitya who received the Prince Mahidol Award in the field of Medicine in 1996, and (3) Dr. Wiwat Rojanapithayakorn and (4) Mr. Mechai Viravaidya who received the Prince Mahidol Award in the field of Public Health in 2009.

Among the Awardees of the Prince Mahidol Award, 5 subsequently received the Nobel Prize:

(1) PROFESSOR BARRY J. MARSHALL

from Australia was conferred the Prince Mahidol Award in the field of Public Health in 2001 for the discovery of the new bacterium identified as Helicobacter pylori that caused severe gastritis and its sensitivity to particular antibacterial drugs. He received the Nobel Prize in the field of Medicine in 2005 for the same discovery.

(2) PROFESSOR HARALD ZUR HAUSEN

from Germany was conferred the Prince Mahidol Award in the field of Medicine in 2005 for the discovery of the human papilloma virus HPV16 and HPV18 from the cancer tissue and elucidated how the viruses turn normal cells into cancer cells. He received the Nobel Prize in the field of Medicine in 2008 for the same discovery.

(3) PROFESSOR DR. SATOSHI OMURA

was conferred the Prince Mahidol Award in the field of Medicine in 1997. He is known for the discovery and development of various pharmaceuticals originally occurring in microorganisms. His research group isolated a strain of Streptomyces Avermitilis that produce the anti-parasitical compound avermectin which contributed to the development of the drug ivermectin that is currently used against river blindness, lymphatic filariasis, and other parasitic infections. He received the Nobel Prize in the field of Medicine in 2015 for the same discovery.

(4) PROFESSOR TU YOU YOU

a member of the China Cooperative Research Group on Qinghaosu and its Derivatives as Antimalarials, was conferred the Prince Mahidol Award in the field of Medicine in 2003 in an organisational category for the discovery of Qinghaosu as a new drug for treatment of the P.falciparum malaria. She received the Nobel Prize in the field of Medicine in 2015 for the same discovery.

(5) SIR GREGORY PAUL WINTER

was conferred the Prince Mahidol Award in the field of Medicine in 2016. He was a pioneer in the field of antibody engineering and modification technology. He invented techniques to humanise antibodies for therapeutic uses, which later led to the creation of cutting-edge therapeutic drugs. He received the Nobel Prize in the field of Chemistry in 2018 for the same discovery.

The Prince Mahidol Award ceremony will be held in Bangkok in January each year and presided over by His Majesty the King of Thailand. The Prince Mahidol Award Foundation under the Royal Patronage was established in commemoration of the centenary of the birth of His Royal Highness Prince Mahidol of Songkla, on 1 January 1992. The Foundation is under the Royal Patronage, with Her Royal Highness Princess Maha Chakri Sirindhorn as President. The Foundation annually confers two Prince Mahidol Awards upon individual(s) or institution(s), which have demonstrated outstanding and exemplary contributions to the advancement of the world's medical and public health services. Each Award consists of a medal, a certificate and a sum of US $100,000.

www.princemahidolaward.org

PRINCE MAHIDOL AWARD

The Prince Mahidol Award Foundation of
which H.R.H. Princess Maha Chakri Sirindhorn
is the President, has decided to confer
the Prince Mahidol Award 2019

In the field of Medicine to
Professor Dr. Ralf F.W. Bartenschlager

In the field of Public Health to
Professor David Mabey

Her Royal Highness
Princess Maha Chakri Sirindhorn,
as the Representative of His Majesty the King,
Presiding Over the Presentation
Ceremony of the Prince Mahidol Award 2019
at the Chakri Throne Hall as well as a Dinner Party
in Honour of the Prince Mahidol Award Laureates 2019
at the Boromarajasathitmaholarn Hall
on Thursday, 30th January, B.E. 2563 (A.D. 2020)

PRINCE MAHIDOL AWARD

IN THE FIELD OF MEDICINE

PROFESSOR DR. RALF F.W. BARTENSCHLAGER

HEAD
THE DEPARTMENT FOR INFECTIOUS DISEASES
MOLECULAR VIROLOGY
UNIVERSITY OF HEIDELBERG

HEAD
THE DIVISION OF VIRUS-ASSOCIATED CARCINOGENESIS
GERMAN CANCER RESEARCH CENTER

GERMANY

Professor Dr. Ralf F.W. Bartenschlager received his Ph.D. in Molecular Biology from the University of Heidelberg in 1990. He was appointed as Professor of Molecular Virology at the Institute for Virology, University of Mainz, in 2000, and moved to University of Heidelberg in 2002. He is currently Head of the Department of Infectious Diseases Molecular Virology at University of Heidelberg and Head of the Division of Virus-Associated Carcinogenesis at the German Cancer Research Center, Germany.

Professor Bartenschlager's most prominent work is on the life cycle of hepatitis C virus (HCV) that provides basis for the development of effective and safe specific antivirals. At present, over 71 million people worldwide suffer from chronic HCV infection and approximately 400,000 people die each year. HCV infection also leads to liver cirrhosis and hepatocellular carcinoma.

For a decade after the discovery of HCV in 1989, scientists had failed to replicate it in cell culture. Professor Bartenschlager and his colleague identified a method to replicate HCV in cell culture and make "replicons" (fragments of the virus's RNA). This made possible the rapid screen for thousands of candidates of antivirals. He also identified the viral nonstructural protein 3 (NS3) as viral protease that is now a central target structure for antivirals. His studies resulted in the invention of the new generation of anti-HCV drugs called the DAA (Direct Acting Antiviral) with a 95% success rate in curing HCV infection with minimal side effects.

However, the concern is the high expense of full treatment. With the prospect of ending HCV epidemics, supports have been offered for low-income countries resulting in the increasing number of patients who receive DAA-based treatment for HCV from 1 million to 1.5 million between 2015 and 2016. In Thailand, the National Health Security Office has bargained the drug price down over 70% and put it into the National Drug List so all Thais can access to the drug.

Professor Bartenschlager has published his research of more than 300 articles in renowned journals. He was a recipient of many awards including Robert Koch Award (2015), Lasker-DeBakey Award (2016), and Hector Prize (2017) and his tireless effort has led to the discovery of a cure for hepatitis C, and saved millions of lives worldwide.

PRINCE MAHIDOL AWARD

IN THE FIELD OF PUBLIC HEALTH

PROFESSOR DAVID MABEY

PROFESSOR
COMMUNICABLE DISEASES CLINICAL RESEARCH DEPARTMENT
LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE

UNITED KINGDOM

Professor David Mabey received his Bachelor and Doctorate of Medicine degrees from Oxford University, United Kingdom. In 1994, he was appointed Professor of Communicable Diseases at the London School of Hygiene & Tropical Medicine. He is currently Professor of Communicable Diseases, Clinical Research Department at the London School of Hygiene & Tropical Medicine, United Kingdom.

Professor Mabey has studied trachoma, the most common eye infection leading to blindness worldwide for more than 30 years. Trachoma is caused by the bacterium Chlamydia trachomatis. It is responsible for the blindness or visual impairment of about 1.9 million people globally annually. Infection

spreads through personal contact and by flies that have been in contact with discharge from the eyes or nose of an infected person, particularly in developing countries with inadequate hygiene, crowded households, and inadequate access to water and sanitation.

Since early 1980s, Professor Mabey and his colleagues conducted a field work in Gambia and Tanzania and discovered that trachoma blindness is caused by the host immune response to the bacterial infection. In 1993, it was discovered that a single dose of azithromycin was effective for treatment of trachoma. He later set up a multicentre study to demonstrate that annual treatments given to whole communities was effective in reducing transmission of trachoma, and the elimination of disease can be achieved by a mass treatment of azithromycin in endemic communities.

The research of Professor Mabey prompted the World Health Organization (WHO) to establish a global eradication program using SAFE strategy - (S) control through surgery, (A) mass treatment with antibiotic, (F) face washing, and (E) environmental and sanitation improvements. More than 700 million doses of azithromycin were provided to people in 40 countries between 1999 - 2017. Until now, 13 countries have reportedly achieved the goals of eradicating trachoma. The WHO projections suggest that trachoma will be eradicated as a public health problem and cause of blindness in all countries by 2025.

Professor Mabey has published his research of more than 200 articles in renowned journals. He was a recipient of many awards in the area of tropical health and was appointed the Commander of the British Empire (CBE) in 2014 by Her Majesty Queen Elizabeth II for services to health development in Asia and Africa. His continuing endeavour to control and eradicate trachoma blindness has improved the livelihood of millions of people throughout the world.


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PRINCE MAHIDOL AWARD CONFERENCE

The Prince Mahidol Award Conference was first organized in 1998 to celebrate the 5th anniversary of the Prince Mahidol Award, then again in 2002 to celebrate the 10th anniversary of the award. To celebrate the 15th anniversary of the award and the 115th Birthday Anniversary of His Royal Highness Prince Mahidol of Songkla, Her Royal Highness Princess Maha Chakri Sirindhorn, President of the Prince Mahidol Award Foundation under the Royal Patronage, requested the conference to be organized annually since 2007.

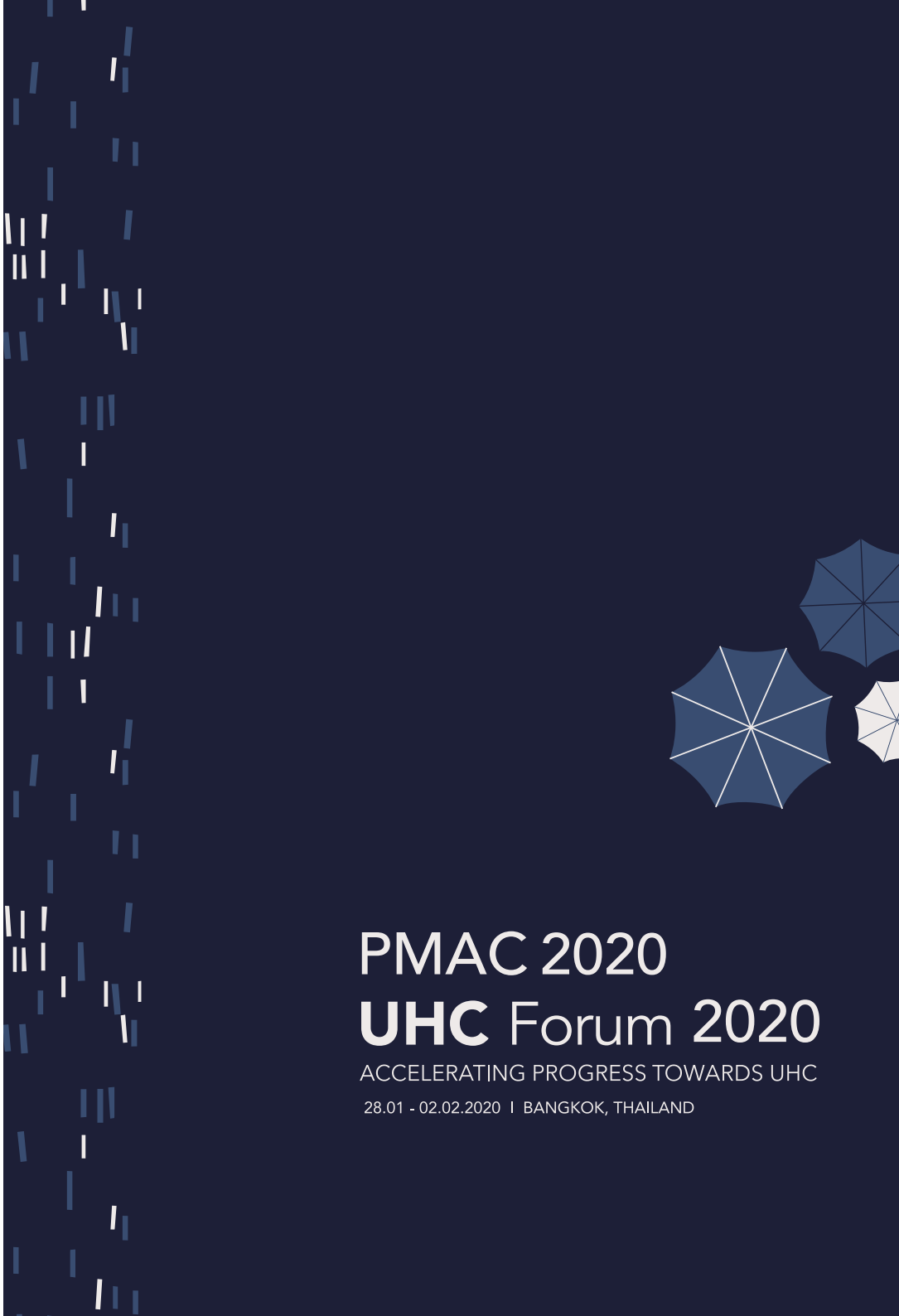
Since 2007, the Prince Mahidol Award Conference has been organized as an annual international conference focusing on policy-related public health issues of global significance. The conference is hosted by the Prince Mahidol Award Foundation, the Royal Thai Government and other global partners, for example the World Health Organization (WHO), the World Bank, the United States Agency for International Development (USAID), the Japan International Cooperation Agency (JICA), the Rockefeller Foundation, the China Medical Board (CMB), and other related UN agencies.

The general objective of the annual Prince Mahidol Award Conference is to bring together leading public health leaders and stakeholders from around the world to discuss high priority global health issues, summarize findings and propose concrete solutions and recommendations. It aims at being an international forum that global health institutes, both public and private, can co-own and use for the advocacy and the seeking of international advices on important global health issues. Specific objectives of each year's conference will be discussed among key stakeholders and co-hosts of the conference.

The conference participants include ministers, senior government officials, intergovernmental organizations, international development partners, global health initiatives, health policy and health systems researchers and advocators, civil society organizations, and high-level stakeholders from developing and developed countries.

THE PAST AND UPCOMING CONFERENCES INCLUDE:

1997 : The International Conference Science and Health
2002 : Medicine and Public Health in the Post-Genomic Era
2007 : Improving Access to Essential Health Technologies: Focusing on Neglected Diseases, Reaching Neglected Populations
2008 : Three Decades of Primary Health Care: Reviewing the Past and Defining the Future
2009 : Mainstreaming Health into Public Policies
2010 : Global Health Information Forum
2011 : 2nd Global Forum on Human Resources for Health
2012 : Moving towards Universal Health Coverage: Health Financing Matters
2013 : A World United against Infectious Diseases: Cross-Sectoral Solutions
2014 : Transformative Learning for Health Equity
2015 : Global Health Post 2015: Accelerating Equity
2016 : Priority Setting for Universal Health Coverage
2017 : Addressing the Health of Vulnerable Populations for an Inclusive Society
2018 : Making the World Safe from the Threats of Emerging Infectious Diseases
2019 : The Political Economy of NCDs: A Whole of Society Approach
2020 : PMAC2020 / UHC Forum 2020 : Accelerating Progress Towards UHC
2021 : COVID-19 : Advancing Towards an Equitable and Healthy World



MESSAGE

FROM THE CHAIRS OF THE INTERNATIONAL ORGANIZING COMMITTEE

HEALTH IS A HUMAN RIGHT

NO ONE SHOULD SUFFER OR DIE BECAUSE OF LACK OF ACCESS TO AFFORDABLE, QUALITY, EFFECTIVE HEALTH CARE.

Health is a human right. No one should suffer or die because of lack of access to affordable, quality, effective health care. Universal health coverage (UHC) is critical to fulfilling the right to health and is also a key pathway for investing in health and human capital; and, in the wealth of nations.

The reality today is very different. **Progress has been slow and uneven** for achieving the Sustainable Development Goal SDG 3.8 target on UHC for all by 2030. More than half the world's population does not enjoy access to quality and affordable health care as documented in the WHO 2019 Global

Monitoring Report . Every year, more than 800 million people incur catastrophic health expenses, and 100 million people are pushed into extreme poverty by out-of-pocket payments. More than 50 countries lack the infrastructure they require to provide universal health coverage. They are short of skilled health workers, quality medicines and medical products, and basic amenities such as water, sanitation and electricity. Unless we change course, up to 5 billion people will still lack access to essential health services in 2030. Stigma, discrimination and violence continue to impede access to health services. Not only is the human toll of this injustice appalling, but the lack of access to affordable, quality health care is also a brake on economic growth and sustainable development. It deepens inequalities and keeps people bogged down in poverty, sapping productivity and draining hope.

To address these challenges, global momentum on UHC has been strengthened in recent years with several high-level political meetings including G7, G20, AU Summit and UHC Forum in 2017. We are currently witnessing an **unprecedented political commitment for health** at the level of Heads of States and of Governments: during the United Nations General Assembly, at the High-level Meeting on Universal Health Coverage on 23 September 2019, all 193 UN Member States approved the Political Declaration on UHC, the most comprehensive international health agreement in history, after a year-long preparatory process that strongly involved civil society. But unless the political declaration is funded and implemented, it is just empty rhetoric.

As global health leaders, practitioners and reformers, we must address the **UHC implementation challenges** not only linked to health systems but also to changing disease epidemiology and population demography, climate change, and the profound influence of economic, environmental, commercial, social and legal determinants on individual and population health and well-being. Here are a few sound and bold solutions:

Primary health care (PHC) provides the programmatic engine for UHC, health and well-being. It reflects the right priorities and is a critical milestone along the road to achieving UHC as highlighted in the Declaration of Astana . Emphasizing community empowerment and social accountability, PHC provides a platform for integrating previously separate services for communicable diseases with those for women and children's health and noncommunicable diseases, for addressing both the demographic and epidemiological challenges facing most countries, for public health and preventative interventions, many of them dealing with determinants of health and well-being such as environmental pollution, adequate food supply and appropriate nutrition intake, sanitation and hygiene, and for innovations such as digital health and public-private partnerships. And it remains the most cost-effective way to address comprehensive health needs close to people's homes and communities. More than 80% of all health needs can be addressed with quality, people-centred, primary health care and disease control services, including with consolidated action to develop diverse and a sustainable health workforce.

Robust and high-quality health financing system is essential for sustainable UHC and PHC. Governments in most countries have increased investments into health over the last two decades, but not sufficiently to enable universal access to health services and reverse the trend of increasing catastrophic and impoverishing out-of-pocket payments for essential health care. Significant funding gap remains with what is needed to reach the goals by 2030, in particular in low and lower-middle income countries. Countries face multiple challenges in structuring their health financing system: mobilizing more funding for health domestically; spending the resources better to maximize heath for the money; coordinating

[1] Primary Health Care on the Road to Universal Health Coverage, 2019 Global Monitoring Report. Geneva: World Health Organization; 2019.

[2] Declaration of Astana, Kazakhstan, Global Conference on Primary Health Care, 25.26 October 2019.

[3] As documented in footnote 1 reference.

fragmented development assistance; and taking on inefficiencies and inequities in health system. WHO is issuing **an urgent call to action for governments to increase their investment in quality primary health care by at least 1% of GDP** – either by increasing or reallocating health spending – or both. Not to add a burden on the poorest countries, humanitarian and development assistance for health, as well as long-term technical assistance, must increasingly be focused on low income countries, developing, evaluating and expanding new and innovative models of service delivery and system strengthening, especially in the context of major global trends such as the climate crisis and migration. These investments could save about 60 million lives every year and extend global life expectancy by 3.7 years by 2030.

Successful health system builds on the **whole-of-government (multisectoral), whole-of-society (multi stakeholder) and health-in-all-policies approaches.** In Thailand there is an approach for reform applying the "Triangle that moves the mountains", the vertices of the triangle representing government technocrats, policy-makers and politicians (referred to often as the 'government sector'); civil society, communities, and the population ('people's sector'); and academia, think tanks, and research institutions ('knowledge sector'). The core principle of the National Health Assembly of Thailand is to bring together the three groups represented by the triangle corners to combine top–down and bottom–up approaches to achieve progress and reform.

In the context of the "Fourth Industrial Revolution", **digital technologies and communications** create opportunities for rapid changes in health governance, financing, policies and access.

Gender norms and power relations also influence access to health services. The path to success starts with a solid commitment to focus on women and girls and others who are left behind.

The goal of universal health coverage is ambitious. But it is doable and achievable, first and foremost through publicly-financed primary health care, under a good governance and strong political leadership.

Prince Mahidol Award Conference 2020/Universal Health Coverage Forum 2020

The Conference this year will be held jointly with the Universal Health Coverage Forum, which aims to strengthen momentum on UHC in international fora and accelerate global efforts for achieving UHC, and will provide a platform to all stakeholders, including governments, the United Nations System, academic institutions, civil society organizations, professional associations, non-governmental and faith-based organizations, philanthropic foundations, young professionals and the private sector to come together to debate and discuss the most innovative and bold ideas, to propose solutions and forge partnerships to concretely explore how the progress towards Universal Health Coverage can be accelerated.

As the Co-chairs of this crucial global Conference, we are delighted to welcome you to Bangkok, Thailand, to join more than a thousand fellow health leaders, practitioners and reformers around the world, and to take full advantage of all the opportunities that PMAC 2020/UHC Forum 2020 has to offer: more than 50 side meetings organized by the Conference partners, engaging and educational field trips, the fascinating world art contest and abstract presentations, in addition to the insightful Conference programme that includes several plenary discussions with renowned speakers and parallel sessions for examining issues in more detail. All these activities will ensure that Conference attendees are given a chance to actively participate through exchanging experiences, learning from each other and meeting new colleagues and partners.

Appreciation

We would like to acknowledge the valuable contribution of the co-sponsoring organizations, whose tireless efforts helped bring the Conference to fruition. We especially thank the Prince Mahidol Award Foundation and the Royal Thai Government for their remarkable support and outstanding leadership, as well as the PMAC Secretariat for providing their overall guidance, day-to-day support and an incredible team spirit.

We look forward to welcoming you to Bangkok!

Dr. Vicharn PANICH
Chair
Prince Mahidol
Award Conference

Dr. Naoko YAMAMOTO
Co-Chair
World Health Organization

Dr. Muhammad Ali PATE
Co-Chair
The World Bank

Mr. Haoliang XU
Co-Chair
United Nations Development
Programme

Ms. Henrietta H. FORE
Co-Chair
United Nations
Children's Fund

Ms. Gunilla CARLSSON
Co-Chair
Joint United Nations
Programme on HIV/AIDS

Dr. Osamu KUNII
Co-Chair
The Global Fund to Fight AIDS,
Tuberculosis and Malaria

Ms. Irene KOEK
Co-Chair
U.S. Agency for
International Development

Dr. Roger GLASS
Co-Chair
National Institutes
of Health

Dr. Yasuyuki SAHARA
Co-Chair
Ministry of Health,
Labour and Welfare, Japan

Dr. Takao TODA
Co-Chair
Japan International
Cooperation Agency

Dr. Naveen RAO
Co-Chair
The Rockefeller Foundation

Dr. Lincoln C. CHEN
Co-Chair
China Medical Board

Dr. David HARPER
Co-Chair
Chatham House

CONFERENCE CO-HOSTS AND SUPPORTING ORGANIZATIONS

A full list of the PMAC 2020
International Organizing Committee
Members is given in ANNEX I,
and Scientific Committee Members in ANNEX II.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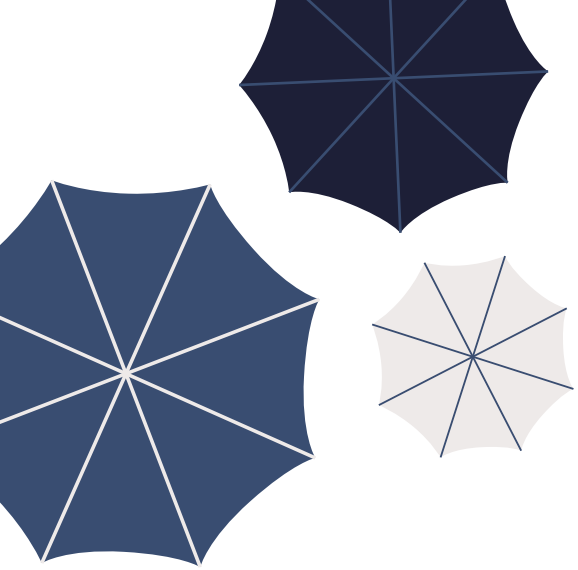


CONFERENCE PROGRAM STRUCTURE

PRE-CONFERENCE PROGRAM

28-30 January 2020

55 SIDE MEETINGS

7 FIELD TRIPS

MAIN CONFERENCE PROGRAM

31 January-2 February 2020

4 KEYNOTE ADDRESSES

5 PLENARY SESSIONS

15 PARALLEL SESSIONS

6 SPECIAL EVENTS

42 E-POSTER PRESENTATIONS

SUBMISSIONS OF WORLD ART CONTEST

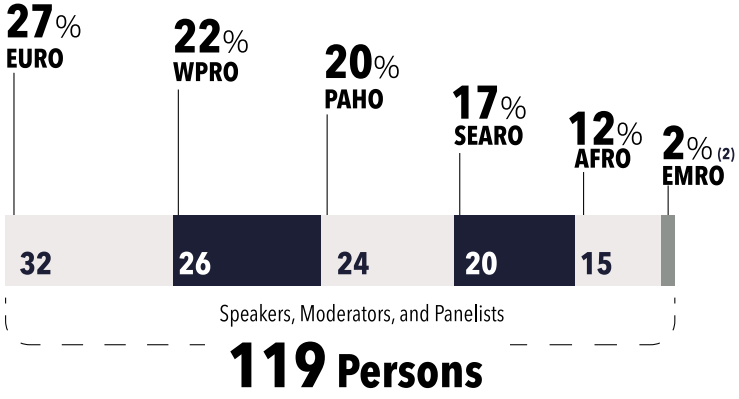
696

SPEAKERS, MODERATORS AND PANELISTS

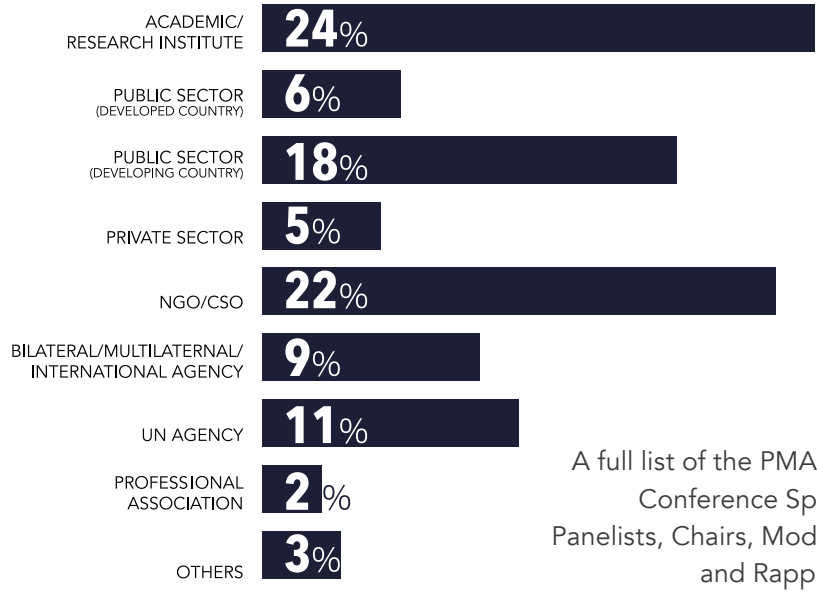
Speakers, moderators and panelists:
There were a total 119 speakers, moderators, and panelists altogether (Female 46%, Male 54%) in all 20 plenary and parallel sessions of the PMAC 2020.

46% Female | **54%** Male

Country of origin of moderators, speakers and panelists by six WHO regions



Orgnization of moderators, speakers and panelists



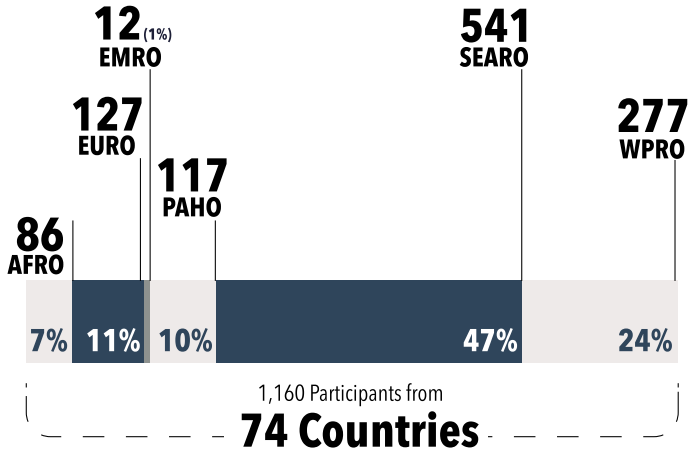
A full list of the PMAC 2020 Conference Speakers, Panelists, Chairs, Moderators and Rapporteurs is shown in ANNEX III

PARTICIPANTS

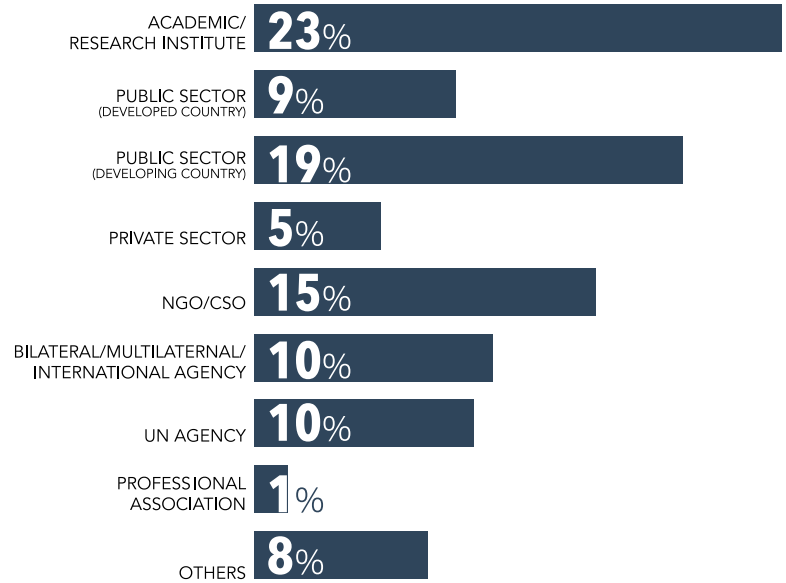
Total registered participants:
There were a total of 1,160 participants
from 74 countries
(Female 47%, Male 53%).

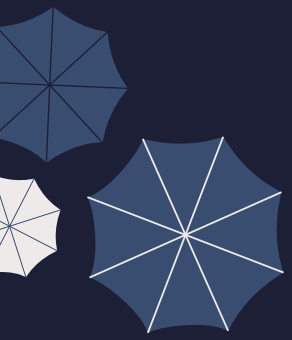
47% Female | **53%** Male

Country of origin
of participants
by six WHO regions

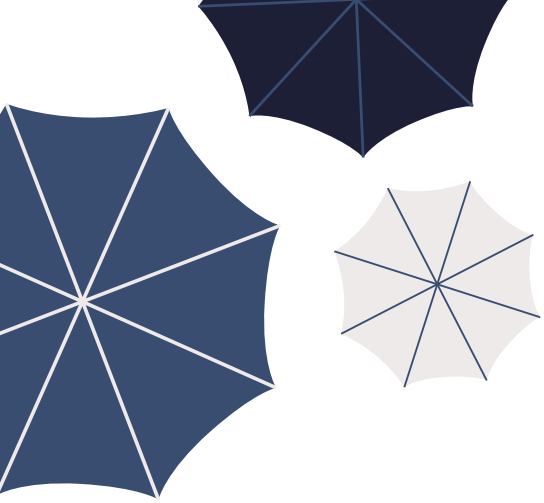


Organization of
participants





CONFERENCE
OVERVIEW



RATIONALE

The Prince Mahidol Award Conference (PMAC) is an annual international conference focusing on policy-related health issues. The PMAC 2020 is co-hosted by the Prince Mahidol Award Foundation, the Thai Ministry of Public Health, Mahidol University, the World Health Organization, The World Bank, United Nations Development Programme, United Nations Children's Fund, Joint United Nations Programme on HIV/AIDS, The Global Fund to Fight AIDS, Tuberculosis and Malaria, United States Agency for International Development, National Institutes of Health, Ministry of Health, Labour and Welfare, Japan, Japan International Cooperation Agency, China Medical Board, The Rockefeller Foundation, Chatham House, with support from other key related partners. The Conference will be held in Bangkok, Thailand, from 28 January – 2 February 2020. The theme of the conference is "Accelerating Progress Towards Universal Health Coverage".

In 2015, the world united around the 2030 Agenda for Sustainable Development, pledging that no one will be left behind and that every human being will have the opportunity to fulfil their potential in dignity and equality. UHC is the aspiration that all people at all ages can obtain the health services they need, of good quality, without suffering financial hardship. Health services cover promotion, prevention, treatment, rehabilitation and palliative care, and all types of services across the life course. However, recent monitoring indicates though that progress is off-track for achieving stated UHC goals by 2030. Large coverage gaps remain in many parts of the world, in particular for the poor and marginalized segments of the population, as well as in fragile and conflict-affected states. Even for the countries that have seen expansion in the access to health services and coverage of key interventions over the last decades, sustaining these achievements is challenged by the rise in burden of NCDs and aging of population occurring on a compressed timeline. In middle- and lower-income countries this increase in burden of disease is observed without corresponding rapid increases in economic and societal prosperity, as well as in fiscal capacity.

Hence, UHC needs to be seen within the context of megatrends, including other issues beyond the health sector, that shape global health. Societies are facing the changing nature of the challenges that impact on health systems. These include systemic shocks such as disease outbreaks, natural disasters, conflicts and mass migration, economic crises, as well as longer-term processes, such as population growth or decline, epidemiological and demographic transitions, urbanization, food insecurity, climate change and widening economic disparities. These changes and shocks can affect the three core objectives of UHC: the gap between service needs, availability and use; quality of services, and financial protection. Health systems need to continuously adapt to provide appropriate and needed health services, and more generally, to ensure equitable progress along the related dimensions of population, service and cost coverage.

These megatrends, in the context of the alarming growth of NCDs, require the development of systems that are integrated and sustainable, not just the sum of their parts. Hence, forty years after Alma Ata, the world is making a new commitment to primary health care, but in ways that reflect vast changes that have occurred in medicine, economics and society since the late 1970s. The key to dealing with today's public health challenges and changing landscape is not to change strategic direction but to enable a shift from health systems designed around diseases and health institutions towards systems designed for people, with people is required. This entails developing a competent health workforce, building capacity of local and sub-national health authorities to lead change at their communities, and engaging patients and relatives in co-creation of health.

The way forward for financing UHC will require strong political commitment as sine qua non underlying principle that is implemented via action on two fronts. On the one hand, countries can get additional mileage from adapting and accelerating core principles for progress derived from proven strategies for sustainable and equitable resource mobilization, pooling and purchasing for UHC, drawing on lessons from countries that have seen rapid UHC progress in the past. At the same time, we are living in times of a "second machine age," the "fourth industrial revolution" driven by very rapid advances in digital technologies and communications. Digitalization of health financing systems, analysis of Big Data accumulating in real time from multiple sources has opened new avenues to stop leakages, detect fraud, facilitate payments, and better understand behaviors of people and institutions. At the same time, health financing systems need to be ready to embrace and support service delivery innovations that can improve access, efficiency and quality.

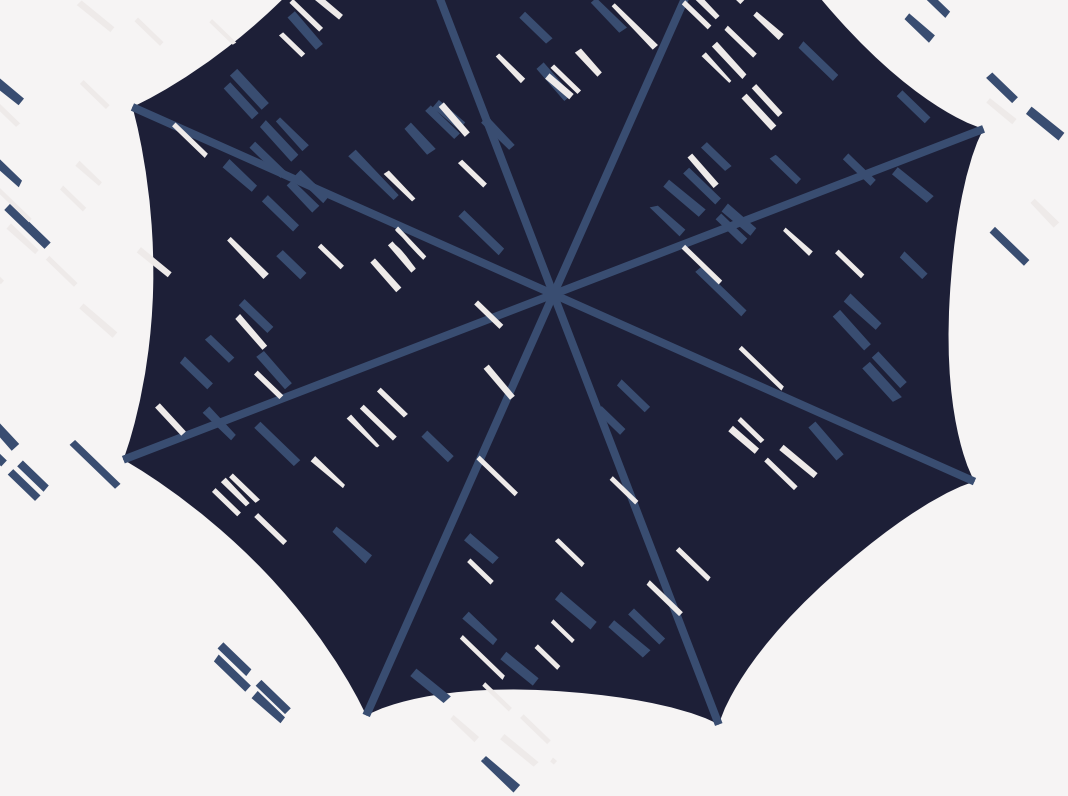
Countries would need strong and informed governance to harness innovations that can potentially address some of our most pressing health-care problems by transforming lives, preventing disease, restoring people to full health and making the health-care delivery system more effective and efficient. Such innovations should be guided by clear public policies oriented to equitable pathways towards UHC. Realizing these opportunities will also depend on sufficient and appropriate investment in R&D, figuring out common interests, accountability and partnerships with industry, ensuring that benefits of innovations are accessible to those who most need it irrespective of the wealth, mechanisms and processes encourage socially desirable innovation and promote equity driven innovation.

To seize the above-mentioned opportunities and challenges and transform it into the actual progress towards UHC and SDGs, we need strong leadership that can foster solidarity across different sectors at all levels. The role of local authorities and engagement of communities in concretely moving from commitment to action should not be understated. Good governance, and transparent, effective and accountable institutions are enablers for UHC. Giving the civil society a voice and an active role in advocating for and supporting progress to UHC is critical. In this context, health systems should become adaptive, learning systems that are able to adjust over time by analyzing past implementation and anticipating future challenges.

An adequate health system accessible to all members of society can contribute to societies that value security, solidarity, and inclusiveness. Particularly in fragile and conflict settings, health can be a bridge for peace. PMAC 2020 will be good timing to review the progress made over the first five years on this pathway towards 2030 goals and to strategize for the final decade.

THIS CONFERENCE WILL PRESENT EVIDENCE AND ADVANCE DISCUSSION ON:

- Progress on UHC goals and challenges for the next decade in the context of global megatrends and other SDGs.
- Developing PHC-based health systems to efficiently and effectively meet the needs of people over the life course, including consolidated actions to develop diverse and sustainable health workforce.
- Transforming service delivery models and implementing quality improvement strategies to achieve people centered and integrate care
- What does it take to implement and scale up the core principles and strategies of health financing for UHC.
- Harnessing socially responsible and equity enhancing innovations in medical technologies, digital health, service delivery and health financing that help to accelerate progress towards UHC goals.
- Strengthening leadership and accountability to accelerate progress towards UHC and SDGs and the role of local authorities and civil society in moving from commitment to action.



SUB-THEME

1

IMPLEMENTATION CHALLENGES AND INNOVATIVE SOLUTIONS FOR UHC 2030

INTRODUCTION: PROGRESS AND CHALLENGES

Underlying the achievement of most SDG3 targets is universal access to and uptake of quality, affordable health services (SDG target 3.8), the large majority delivered close to where people live and work (i.e. primary care). Most parts of the world have seen expansion in the access to health services and coverage of key interventions over the last two decades. There have also been notable improvements in financial protection. Yet, in many countries, large coverage gaps remain, in particular for the poor and marginalized segments of the population, as well as in fragile and conflict-affected states. It is estimated that still 3.5 billion people lack access to essential health services worldwide. Even when essential services are accessible, they are often fragmented, of poor quality and safety, and do not always address the upstream determinants of health and equity in health. At the same time, the burden of noncommunicable diseases, accidents and mental health problems is growing. Ageing populations are causing people to live longer, but often with multiple diseases and conditions that require complex care over time.

With the growth of social media and digital communication, healthcare users and their families are much more informed (or mis-informed) and are demanding more say in how health services take care of them. As Antonio Guterres, Secretary-General of the United Nations, said the world is suffering from a bad case of "trust deficit disorder". This is also particularly notable in the health sector with for instance the rise in medical consumerism, malpractice litigation, and lack of trust in

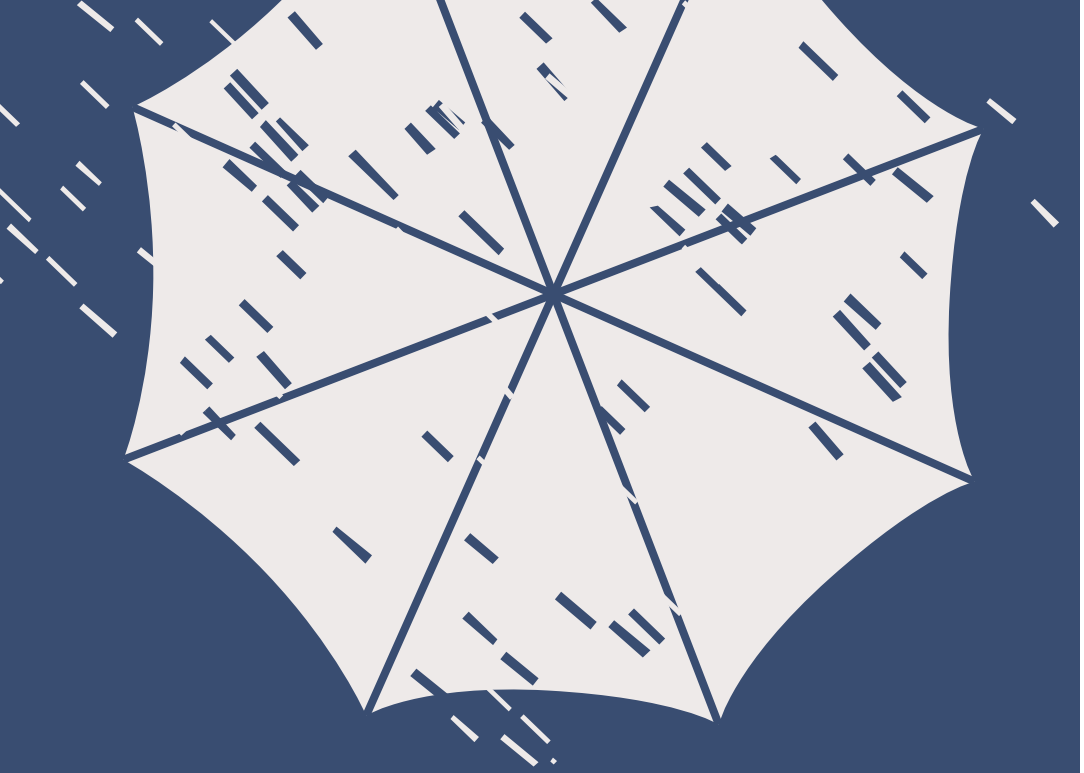
vaccination campaigns in more mature health systems. While in more fragile health systems, lack of confidence in health services explains reluctance of population to seek care and has proven to threaten early identification and threatens response and recovery in pandemics. Such as during the Ebola outbreak in Western African countries. This shows that communities are the anchor of nations' resilience-building efforts. In this context, increased accountability (including social accountability to local communities) and broader stakeholder participation is needed.

The key to dealing with today's public health challenges and changing landscape is not to change strategic direction – primary health care is still the path towards UHC – but to transform the way health and social services are organized, funded and delivered. For health care and coverage to be truly universal, it calls a shift from health systems designed around diseases and health institutions towards systems designed for people, with people. This is required to meet the evolving needs of the population, ensure population trust in services and subsequently their effective use, and to curb inefficiencies related to duplication and waste. In the wider context of Sustainable Development Goals, healthcare providers are also expected to demonstrate their social responsibility: protecting the general public's well-being and meeting social expectations, while also aiming to reduce the impact on the environment of their activities.

OBJECTIVES AND METHODS

Political commitment to achieving UHC is strongly affirmed at the global level as the world convened in Astana in 2018 to reiterate their commitment to PHC; and the 2019 United Nations General Assembly United Nations prepares to hold a High-Level Meeting on "Universal Health Coverage: Moving Together to Build a Healthier World".

In this context, this sub-theme aims at building on the global commitments and experiences learned from pioneering countries to go one step further and identify innovative solutions to make significant progress in implementation for local communities, ensuring no one is left behind. This sub-theme adopts whole-of-system approach to achieving UHC and considers both the supply and demand side interventions. It is complemented by sub-theme 2 that covers health financing policies to achieve UHC and by sub-theme 3 that set the broader picture and identifies major trends that will influence the service delivery model and capacity to deliver (availability of resources). Hence, interventions to increase population coverage or expand health benefits package or digitalization of health and innovation will be addressed in these sub-themes.



SUB-THEME

2

SUSTAINABLE FINANCING FOR EXPANDING & DEEPENING UNIVERSAL HEALTH COVERAGE

BACKGROUND

Universal Health Coverage (UHC) – a policy and political commitment that is part of the United Nation's Sustainable Development Goals (SDGs) for 2030 – is about ensuring that all people can use the promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective, while also ensuring the use of these services does not expose the user to financial hardship. Increasing the level and efficient use of public and other compulsory prepaid/pooled sources of financing – targeted in ways that improve effective service coverage and financial protection, especially for the poor and vulnerable – is necessary for countries to make sustained progress towards UHC.

Since 2000, the world has advanced towards UHC, but not fast enough. At present rates, the 2030 global UHC targets under the SDGs will not be met. Despite progress in recent years, World Health Organization (WHO)-World Bank (WB) estimates indicate that more than half the world's population still does not have access to a basic package of health services, and more than 100 million individuals annually are impoverished due to high out-of-pocket (OOP) spending at the time and place of seeking care. Where gains in service coverage have been more evident, examples of corresponding improvements in financial protection have been far fewer and less notable across developing countries. Urgent action is needed to speed up gains in the two dimensions of UHC, health service coverage and financial protection, and to ensure that no one is left behind.

To accelerate progress, more funding will invariably be necessary: there are insufficient funds to ensure that all people obtain the health services they need with financial protection to reach the ambitious SDG targets in many low and lower-middle income countries. An important first step for mobilizing sufficient resources is political commitment by Governments. Increasing number of countries have made UHC as an explicit policy objective in national strategies and plans, and health has been used as a winning argument to raise more pro-health and pro-poor revenues. It is important that these examples also catalyze political action by other governments and grassroot actions.

However, more financing on its own will not be enough as countries cannot spend their way to UHC if resources are not utilized effectively: the challenges of sustainable financing are not only to raise more resources in and for countries that need them in equitable and efficient way, but also to ensure that the funds are pooled and used equitably and efficiently as well. This requires consolidating and expanding existing strategies that we know work, implement these strategies more effectively and aggressively, while at the same time continuing and encouraging some degree of focus and attention towards new approaches to raise and use funds for UHC.

The health financing policy landscape – beyond the critical recognition that both financial protection and effective service coverage are co-equal dimensions of UHC – is diverse. Over the past 15 years, a growing number of countries in all parts of the world have moved away from approaches relying on individual, de facto voluntary contributions towards more effective use of general budget revenues derived from broad-based taxes. They often target funds to the poor and channel them to an agency such as a national health insurance fund that purchases services from both government and private providers in a dynamic, data driven approach, while bolstering traditional supply-side public financing to government providers. There remain though significant gaps in the application and adaptation of good practices, and the challenging fiscal context has made progress difficult in most LMICs.

At a decisive time for the global UHC movement in 2020, the proposed series of sessions address policy makers in countries that are striving to sustainably finance accelerated progress toward UHC, along with their national and global partners. The subtheme underscores the argument that the way forward for financing UHC will require strong political commitment as sine qua non underlying principle that is implemented via

action on two fronts. On the one hand, countries can get additional mileage from adapting and accelerating core principles for progress derived from proven strategies, drawing on lessons from countries that have seen rapid UHC progress in the past. At the same time, we are living in times of a "second machine age," the "fourth industrial revolution" driven by very rapid advances in digital technologies and communications. Digitalization of health financing systems, analysis of Big Data accumulating in real time from multiple sources has opened new avenues to stop leakages, detect fraud, facilitate payments, and better understand behaviors of people and institutions. At the same time, health financing systems need to be ready to embrace and support service delivery innovations that can improve access, efficiency and quality. Opportunities may exist for countries to surpass previous achievements by embracing a culture of adaptive learning based on a virtuous cycle of implementation, data generation, analysis, and policy/implementation adjustment. Shared domestic and cross-country learning, as well as courageous leadership willing to make change happen, are key success factors.

The PMAC 2020 and 2nd UHC Forum will take place after the High Level Forum on UHC at UNGA 2019, where Global Health Organizations will present and commit to coordinated action to support accelerators for achieving SDG3+. These key steps toward a global agenda for UHC financing will build upon and take further the discussions at the 1st UHC Forum in December 2017, UHC Financing Forums in 2016, 2017 and 2018, Health Finance, Public Finance and UHC Symposia in 2014, 2016, and 2017, and the UHC financing discussions at the G20.

OBJECTIVES

This sub-theme will address the issue of sustainable financing for expanding and deepening UHC – consolidating the lessons and guiding principles for action emerging from global experience with health financing reforms -- while taking stock of why, in many countries, there remains inadequate progress. Within the bounds of these principles, adaptations of "traditional" modalities related to the financing functions of revenue raising, pooling, and purchasing will be explored. Attention will be given to the transition from policy to action (implementation), ensuring that a sense of urgency (given that there are only 10 years remaining for attainment of the SDG UHC target) does not deteriorate into desperation leading to a search for solutions that have been proven to fail (i.e. "keep calm and carry on"). This sub-theme will also scan the horizon of "non-traditional, innovative" modalities in health financing, including those spurred by digital technology advancement, to stimulate discussion and highlight potential opportunities.

MORE SPECIFICALLY, THE OBJECTIVES WILL BE TO:

Review the global health financing landscape, identify key remaining health financing challenges in the context of UHC, and reflect on what technical and political actions can help overcome obstacles to moving forward much more rapidly. For global landscaping, data will be pulled from the UHC Global Monitoring Report, while other synthesis studies including commissioned work will be used to identify the obstacles and potential solutions.

Discuss political context of health financing, including ramifications of UHC as social contract and civil society role, demand generation for UHC financing from human rights and economic case arguments, introduction of pro-health and pro-poor fiscal policies.

Consolidate and broaden consensus regarding core health financing principles that should guide health financing policy-making for UHC in any context.

Explore and synthesize key lessons from country experience with the implementation of health financing reforms, including deeper dives into specific aspects of health financing reforms (revenue raising, pooling, benefit design, and purchasing, including related actions such as the alignment with public financial management and policy towards private finance and provision.) and draw out the implications of these lessons for accelerated action.

Discuss and identify how technological advances can be (or have been) harnessed to enhance the effectiveness of health financing policies (particularly strategic purchasing) to drive progress towards UHC.

Understand how technical support in health financing, including cross-country learning, might be adapted to better support countries to build their own capacity and institutions.

It is important to note that part of the discussion will be very much on "how": lessons on how countries have achieved political commitment to UHC and transformed core principles into practice, critical implementation steps and sequencing, and also experience of those countries that have not been able to address adequately the obstacles to progress; and, the "what", in particular to distill from country experience the core guiding principles that should drive actions in revenue raising, pooling, purchasing and benefit design.

SUB-THEME

3

ADAPTING TO THE CHANGING GLOBAL LANDSCAPE: FOSTERING UHC-BASED SOLIDARITY TO DRIVE TOWARDS SDGs

BACKGROUND

The environment for health systems has been changing and certainly continues to change globally and nationally. Societies are facing the changing nature of the challenges that impact on health systems. These include systemic shocks such as disease outbreaks, natural disasters, conflicts and mass migration, as well as longer-term processes, such as population growth or shrink, epidemiological and demographic transitions, urbanization, food insecurity, climate change and widening economic disparities. These changes and shocks can affect three core dimensions of UHC: population coverage, health services coverage and financial coverage. Health systems need to continuously adapt to provide appropriate and needed health services. To achieve and sustain UHC through health system strengthening, each country needs to forecast the likely impact of these megatrends on their health systems and adapt them accordingly.

Health and other Sustainable Development Goals are mutually reinforcing. Addressing other SDGs can promote UHC, whereas achieving UHC can benefit other sector goals. Poverty, for example, can prevent people from seeking health services if health expenses are not affordable, as 100 million people are being pushed into poverty each year because they have to pay for health care out of their pockets. Poverty reduction can lead to improved access to health services, and financial protection, as a part of UHC, would prevent poverty. Climate change threatens our health in various ways including increase of extreme whether events or


changing patterns of vector-, food- and water-borne diseases. Countries with weak health systems will be least able to prepare and respond to these changes. Thus, health systems need to be resilient enough to anticipate, respond to, cope with, recover from and adapt to climate-related shocks and stress.

Sustainable industry, another focus of SDGs, is critical to continue to boost research and development, and to produce new technologies. The new technologies including medical products could facilitate the progress towards UHC and SDGs in many ways. For example, in the health sector, potent vaccine for HIV, Malaria or Tuberculosis would drastically change the landscape of the disease burden, which could accelerate the progress towards UHC. To this end, as a whole society, sufficient and appropriate investment is needed to promote R&D.

On the other hand, given the growing health expenditure strongly associated with new technologies all over the world, nations and the world need to ensure financial sustainability of health systems. One of the biggest challenges is to expand access to and use of medical products while the provision and its expansion are continuously financed. Mechanisms of properly financing health services as well as technologies (investing in R&D) need to be well designed. How to form a great partnership with the medical product industry with a proper mechanism to tackle this challenge, and eventually to achieve sustainable industry and sustainable health systems is key to promoting the solidarity with common goals of UHC and SDGs.

Innovation has great potential to accelerate human progress and many of SDG agenda including UHC. At the same time, innovation has to lead to societal positive impacts by steering the innovation process. Further, the benefits of innovations need to be accessible to those who most need it irrespective of the wealth. Innovation can address some of our most pressing health-care problems by transforming lives, preventing disease, restoring people to full health and making the health-care delivery system more effective and efficient: point-of-care diagnostics, digital health, artificial intelligence, and internet-of-things based solutions, to name a few. However, "side effects" of innovation also have been seen within and beyond the health sector, including negative impacts on health and environments, ethical issues and economic burden. For example, DDT, a pesticide, used for malaria control has potential negative effects on health and environment; a longtime project on the electronic patient record system was abandoned due to unresolved privacy issues after substantial investment. Moreover, technological innovation could widen disparities across social groups, socio-economic groups, and geographic locations. Given both positive and negative effects of innovation, questions are what mechanisms and processes encourage socially desirable innovation and promote equity driven innovation.

Good governance, and transparent, effective and accountable institutions at all levels themselves are common enablers for SDGs as well as important conduits for peaceful and inclusive societies of SDG 16. These enablers also apply to UHC. Intersectoral collaboration, concerted efforts of stakeholders, good decision-making process, proper financial allocation, enabling legal environments – all these factors that are necessary for UHC result from good governance and effective institutions. Without these as

well as peaceful and inclusive societies, UHC is harder to achieve. In turn, good governance and institutions can promote peaceful and inclusive societies with UHC as a means. An adequate health system accessible to all members of society can contribute to societies that value security, solidarity, and inclusiveness. Particularly in fragile and conflict settings, health can be a bridge for peace. Delivery of health services or health workers can be a neutral meeting point to bring conflicting parties.

To seize the above-mentioned opportunities and challenges and transform it into the actual progress towards UHC and SDGs, we need strong leadership that can foster solidarity across different sectors at all levels. In some political context, UHC reform may be resisted by particular interest groups as it would entail redistributing resources across the society. In divided societies such as ethnically, religiously or economically, the drivers of redistribution may be weaker, and the reform would be opposed, for instance, by right-wing populists or ruling elites who wants to distribute patronage favours to supporters. The leaders who have a vision and a broad supporter base could close the divide, and build up the momentum to move things forward. Such a movement can be underpinned and strengthened by evidence on the ground. In fact, often times, there were champions who propelled the movement. The questions are how to produce such champions in societies or countries where such a movement has not been seen yet, and how the global society can help to foster such an environment where they may appear.

This sub-theme will look at megatrends and global issues affecting UHC to find a way to adapt or respond to them, and identify synergistical opportunities and to overcome challenges that the society can synergistically address. With this recognition, it aims at fostering social solidarity toward SDGs by committing to UHC.

OBJECTIVES

- Considering megatrends affecting the achievement of Universal Health Coverage
- Seizing opportunities and addressing threats towards UHC and SDGs
- Building partnerships within and beyond the health sector, and fostering social solidarity by committing to UHC to drive toward SDGs

[1]Von Schomberg, Rene (2013). "A vision of responsible innovation". In: R. Owen, M. Heintz and J Bessant (eds.) Responsible Innovation. London: John Wiley and Sons Ltd, pp. 51-74

[2]Weiss, Daniel et al. "Innovative technologies and social inequalities in health: A scoping review of the literature" PloS one vol. 13,4 e0195447. 3 Apr. 2018, doi: 10.1371/journal.pone.0195447

OPENING SESSION

HER ROYAL HIGHNESS
PRINCESS MAHA CHAKRI
SIRINDHORN

HER ROYAL HIGHNESS PRINCESS MAHA CHAKRI SIRINDHORN

CHAIRMAN, BOARD OF TRUSTEES AND PRESIDENT,
PRINCE MAHIDOL AWARD FOUNDATION

It is a great honor for me to join you today at the Prince Mahidol Award Conference 2020 / UHC Forum 2020 on the theme "Accelerating Progress Towards Universal Health Coverage".

With only a decade left to achieve the UHC goals by 2030, this year's conference presents an important international stage to review progress on UHC goals and challenges to be overcome in the context of global megatrends and other SDGs. This conference also aims at building on the global commitment affirmed at the UHC Forum 2017 and the United Nations High-Level Meeting on "Universal Health Coverage: Moving Together to Build a Healthier World" in September 2019. We recognize that a whole-of-system approach is essential to achieve UHC. Resilient health systems designed for people, with people; strong political commitment from government; strategic leadership; sufficient and sustainable financing; innovation; intersectoral collaboration; and enabling legal and regulatory environments – all these factors are vital for expanding and deepening UHC. Through global solidarity and collective effort, we can accelerate progress towards achievement of universal health coverage for the attainment of healthy lives and well-being for all.

I would like to sincerely thank our co-hosts and partners – the World Health Organization, the World Bank, the United Nations Development Programme, the United Nations Children's Fund, the Joint United Nations Programme on HIV/AIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the U.S. Agency for International Development, the National Institutes of Health, the Government of Japan, the Japan International Cooperation Agency, The Rockefeller Foundation, the China Medical Board, the Chatham House, the United Nations Population Fund, the Swedish Ministry of Foreign Affairs, the Bill & Melinda Gates Foundation, the National University of Singapore, NCD Alliance, the People's Health Movement, the British Medical Journal, and FHI 360 – for their continuous support to the Conference. With their dedicated contributions, the Conference has come to fruition.

I wish you a very productive meeting and I now declare the Prince Mahidol Award Conference 2020 / UHC Forum 2020 open.

KEYNOTE ADDRESS

PROFESSOR DR. RALF F.W. BARTENSCHLAGER

HEAD
THE DEPARTMENT FOR INFECTIOUS DISEASES, MOLECULAR VIROLOGY,
UNIVERSITY OF HEIDELBERG

HEAD
THE DIVISION OF VIRUS-ASSOCIATED CARCINOGENESIS
GERMAN CANCER RESEARCH CENTER

GERMANY

Your Royal Highness Princess Maha Chakri Sirindhorn, Your Royal Highness Princess Dina Mired, Excellences, Distinguished Guests, Ladies and Gentlemen,

I am deeply grateful and extremely honored to receive the Prince Mahidol Award in Medicine 2019. It is an extremely high recognition of my work and although it is given to me, I accept this prize on behalf of all my colleagues and friends, who contributed tremendously throughout my academic life to HCV research in my laboratory. For sure, without their commitment and efforts I would not be here.

One of the biggest privileges I enjoyed as a scientist is to follow the individual passion. In my case, it was biology, more precisely virology and even more precisely the study of viruses infecting the human liver. My fascination in biology started already at school, when I met a teacher who raised my interest in botany and zoology. After finishing High School and a 3-years training and work as police officer, I began to study biology at Heidelberg University. During this time, it was in the early 1980s, I became very interested in plant sciences, but it turned out, in those days, molecular studies of plants were not established at Heidelberg University. Therefore, I resorted to a topic of equal interest, which was Infectious Diseases. Fortunately, there was one laboratory in Heidelberg, headed by Prof. Heinz Schaller, who worked on hepatitis B virus, a topic I found most fascinating. I got the opportunity to join his lab and did my PhD thesis that was dedicated to studies of molecular aspects of the hepatitis B virus replication cycle. During this time, I received an excellent training in molecular biology and how to molecularly clone and engineer viral genomes, a skill that became very important for my future research. In 1990, I moved to a big pharmaceutical company to establish a research program on an agent that was originally called non-A, non-B hepatitis, but after its discovery by Michael Houghton and his team just one year before my move, was renamed as hepatitis C virus (In the following, I will abbreviate as HCV). This discovery set the stage to establish diagnostic tests for screening blood products and it opened the arena for molecular studies of this virus. One of the first tasks was to delineate the genome organization of HCV and to identify the viral enzymes that could serve as targets for antiviral therapy. Initially, I focused on one enzyme, called the viral NS3 protease and characterized the molecular determinants of this protein. After returning back to academia at the University of Mainz in Germany, where I started my own independent research group, we continued these studies and included a second viral enzyme called the NS5B polymerase. This enzyme was most likely responsible for the amplification of the HCV genome and therefore an obvious drug target.

BEING A BASIC SCIENTIST, THERE ARE ONLY A FEW "EUREKA" MOMENTS, AT LEAST IN MY CASE

Although these in vitro studies progressed quite rapidly, the whole HCV research community and drug development activities got stuck very soon, because of the lack of a cell culture system for HCV. Viruses are obligate intracellular parasites and thus, can only replicate themselves inside living cells. But how can you study the replication cycle of a virus and how can you develop and test antiviral drugs when you cannot grow the virus in cultured cells? For that reason, many labs in the world aimed at the establishment of an HCV cell culture system and we were no exception to that. It turned out to be a long and windy road to come up with a solution, but after more than 5 years of intense trial and error, mainly driven by Volker Lohmann in my research team, we came up with a solution. It was a genetically engineered HCV mini-genome, also called replicon that could be propagated in easy to culture human liver cells. Being a basic scientist, there are only a few "Eureka" moments, at least in my case, but on the day when Volker showed me the Northern blot indicating HCV replication in cells, I just got goose bumps and had a hard time to believe that we had solved this problem.

ALL THESE PROBLEMS DISAPPEARED WITH THE DEVELOPMENT OF DAAs. THEY ACHIEVE HCV ELIMINATION IN MORE THAN 95% OF PATIENTS WITHIN A ROUTINE 12-WEEKS TREATMENT

This achievement opened many doors for research and development and within a short period of time, our replicon system became the gold standard in research laboratories in academia and industry. Given the simplicity of the system and its robust nature, antiviral drugs could be easily tested. In this way, NS3 inhibitors like Simeprevir and NS5B polymerase inhibitors like Sofosbuvir were developed on the basis of clever rational drug design and validation in our replicon system. It is interesting to note though, that an additional class of inhibitors was identified by mass screening of millions of chemicals using the replicon system. These drugs target a viral protein, originally thought to be nondruggable, because it has no enzymatic activity, the HCV NS5A protein. However, this assumption was proven wrong because NS5A inhibitors such as daclatasvir are by far the most potent antiviral drugs ever made. For that reason, NS5A inhibitors became a cornerstone of HCV-targeting therapy, and an indispensable element of all DAA-based combination therapies.

The development of these DAAs was a game changer in the clinic. Before their availability, patients were treated with a combination therapy of interferon and ribavirin. However, this therapy has numerous drawbacks. First, there was no guarantee for therapy success and only around 40% of treated patients sustainably eliminated the virus. Second, this success rate very much depended on the HCV genotype. Therefore, cost- and labor intensive diagnostic tests were required to predict success chances of an individual patient. The third drawback was that interferon/ribavirin therapy has many contraindications and therefore, many people with chronic hepatitis C cannot be treated with these drugs. On top, this therapy has enormous side effects including pronounced flulike symptoms, hematologic abnormalities such as anemia and severe depression up to the risk of suicide. For these reasons, patients could only be treated by very experienced physicians, who had to monitor closely the patients, provide compensatory medication such as erythropoietin or anti-depressives, and very often therapy had to be discontinued. Another major drawback was, the therapy had to be given for one year. It is difficult to image to suffer from all these side effects for such a long time, while having no guarantee that HCV will have disappeared after the end of therapy.

All these problems disappeared with the development of DAAs. They achieve HCV elimination in more than 95% of patients within a routine 12-weeks treatment. Therefore, for the first time it became possible to cure a chronic viral infection. HCV-targeting DAAs are also extremely well tolerated, have very minimal contraindications, can even be given to patients with advanced liver diseases and are active against most or even all HCV genotypes. For all these reasons, there is no medically justified

argument to use interferon-based therapy any longer. Moreover, since treatment of chronic hepatitis C changed from a complicated therapy with many side effects to a simple therapeutic scheme, it can now be provided by physicians outside specialized centers. This is most important for people living in more remote rural areas, where medical care is less available.

For these reasons, DAAs and the therapy of chronic hepatitis C has become a unique opportunity to control or even eradicate a virus on a global scale. WHO has declared its aim to reduce the number of new HCV infections by more than 90% by the year 2030. Unfortunately, thus far only few countries are on track to reach this goal and many obstacles have to be overcome. One of the most challenging problems is to make DAAs available to all countries and patients. In this regards, a major limiting factor has been, and still is, the high price of these drugs. I remember the time, it was in 2014, when Sofosbuvir was introduced in Germany for the price of 80,000 Euro per treatment, which ignited extensive discussions about pricing of medications, our health care system and how to tame excessive costs. Luckily, with the development of equipotent drugs by other pharmaceutical companies, prices went down and have reached around 30,000 Euro in Germany per routine therapy. Nevertheless, for most countries, many of them having a high prevalence, such prices are unaffordable. As a result of extensive discussions and negotiations at several levels, companies started to grant licenses to produce generic HCV drugs e.g. in India, which enabled the introduction of generic DAAs e.g. in Egypt and India at prices in the range of 25 to 80 USD per treatment. While this is great achievement, there is hope that prices go further down, although the magnitude of reduction will for sure be smaller than what we have seen in the past.

Apart from pricing, the establishment of proper medical infrastructure to diagnose HCV infection is necessary. This is a very important task because current estimates suggest that up to now only around 20% of all chronic HCV infections have been diagnosed. Unfortunately, most infections are asymptomatic and therefore people are not aware of their infection. Yet, they have a high risk to develop end-stage liver disease, but because of the long asymptomatic incubation time, they consult the physician in most cases only when liver disease is advanced, but often this is too late. In fact, people with advanced liver disease have a high risk to develop liver cancer even when HCV has been eliminated, whereas those treated before cirrhosis has developed have no such risk. Therefore, diagnosis and treatment have to be provided early, which requires both an adequate medical infrastructure, but also the financial resources to establish and sustain such programs.

DIAGNOSIS AND TREATMENT HAVE TO BE PROVIDED EARLY, WHICH REQUIRES BOTH AN ADEQUATE MEDICAL INFRASTRUCTURE, BUT ALSO THE FINANCIAL RESOURCES

TO ESTABLISH AND SUSTAIN SUCH PROGRAMS

In that respect, the implementation of a universal health care system is a very important step towards this goal, with the antiviral therapy of chronic hepatitis C providing a great opportunity to demonstrate the benefit of this system. For sure, there is a high number of HCV infected individuals and all of them should get the health care they need; and this has to come along without the risk of being driven into poverty because of high out-of-pocket health spendings. Therefore, further increase of universal access to affordable, which means generic DAAs and intensified screening to identify those who are infected, is warranted. Only then we will be able to reach global control of chronic hepatitis C, at the national and international level, in line with the declared goal of WHO. In this respect, the topic of this Prince Mahidol Award Conference is a perfect fit and I want to congratulate the organizers for having put together such an exciting meeting on this most important topic.

As a basic scientist I had the privilege to follow the history of hepatitis C, from the discovery of the virus in 1989 until the implementation of all-oral interferon free, DAA-based antiviral therapy. Although it is often perceived that DAAs are equal to the end of HCV, this is certainly not true. Following a quote of Winston Churchill: "(DAAs are) not the end. They are not even the beginning of the end. But they are, perhaps, the end of the beginning."

Important work lies ahead of us, and increasing universal access to DAAs is certainly one major task. Another one that needs to be considered, relates to the question whether we will ever be able to eliminate HCV on a global scale by sole antiviral therapy? I think we do not know and there is no precedence for that. Thus far global eradication of viruses, poxvirus and hopefully very soon also poliovirus, has only been possible by vaccination. Therefore, we should at least consider the development of a vaccine to prevent chronic HCV infection. This is a scientifically challenging task and given the non-existing interest of pharmaceutical industry, a topic that needs to be addressed by scientists working in academia. Without such a vaccine, global eradication of HCV is questionable and therefore, we should get prepared.

In closing, I would like to thank again the Prince Mahidol Award Foundation for their recognition of my work and for honoring me with this prestigious prize.

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PROFESSOR DAVID MABEY

PROFESSOR
COMMUNICABLE DISEASES CLINICAL RESEARCH DEPARTMENT
LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE

UNITED KINGDOM

Your Royal Highness Princess Maha Chakri Sirindhorn, Your Royal Highness Princess Dina Mired, Your Excellences, Distinguished Guests, Ladies and Gentlemen,

It is a very great honor to receive the Prince Mahidol Award in the field of public health which I am accepting on behalf of my many wonderful colleagues in London, Gambia and Tanzania, without whose contributions I would not be standing here.

I went to work in The Gambia, in West Africa, as a clinician, at the Medical Research Council Laboratories in 1978. I soon realised that sexually transmitted infections were a big problem there, but discovered that there was not a single publication at that time on genital chlamydial infection

THESE RESULTS WERE VERY ENCOURAGING, BUT AZITHROMYCIN WAS STILL UNDER PATENT AND WAS VERY EXPENSIVE.

in Africa, so did not know if I should be treating my patients for that infection. I discussed this with my mentor, Hilton Whittle, who had recently arrived in The Gambia to set up a virology research programme, and he said "You had better find out." So I learned how to culture Chlamydia trachomatis, as this was the only way to diagnose the infection in those days, and set up a diagnostic facility in his lab. There was an old notice on the door saying that this used to be the MRC trachoma unit. I knew nothing about trachoma at the time, but soon discovered that it is the leading infectious cause of blindness, and is also caused by C. trachomatis, transmitted from eye to eye among neglected people living in poverty with little access to water and sanitation. 100 years ago it had been common in Europe, but had disappeared during the 20th century as living standards improved. It causes a follicular conjunctivitis, affecting particularly the inside of the upper eyelid, as you see here. Repeated episodes of infection cause scarring and, as the scars contract, they cause the lashes to turn inwards and rub against the cornea. This is known as trachomatous trichiasis (TT). As you can imagine, this is extremely painful and, in many cases, results in blindness due to corneal damage. I discovered that the MRC trachoma unit, led by Prof Leslie Collier, had completed 3 trachoma vaccine trials in The Gambia in the 1970s. Unfortunately the vaccine was not protective, and it was even suggested that it might make the disease worse.

So, under Hilton Whittle's supervision, I started to do some research on the immune response to ocular C. trachomatis infection, with a view to developing a better vaccine. At that time it was very hard to get funding for research on Neglected Tropical Diseases (NTDs), and very little research was being done on trachoma, but I was lucky enough to get research funding from a charitable organisation in New York called the Edna McConnell Clark Foundation, led by an inspirational American Tropical Diseases doctor called Joe Cook. Not long after I started working on trachoma, an English medical student called Robin Bailey came out to work with me for 6 months. At that time the treatment for trachoma recommended by WHO was tetracycline ointment, applied to both eyes twice daily for 6 weeks. Robin pointed out that a new antibiotic called azithromycin had recently come on the

TRACHOMA IS A DISEASE OF POOR, NEGLECTED COMMUNITIES, AND IN THOSE DAYS THERE WAS LITTLE OR NO FUNDING AVAILABLE FOR NTDS.

market, a single dose of which seemed to be an effective treatment for genital C. trachomatis infection. We did a randomised controlled trial in 2 Gambian villages, comparing the impact of a single oral dose of azithromycin with that of twice daily, supervised tetracycline ointment, delivered to both eyes for 6 weeks. We showed that the treatments were equivalent but that, when only individual cases were treated, reinfection was common. In collaboration with American colleagues, we then persuaded Joe Cook to fund a study in three African countries in which we compared the two treatments given as mass drug administration to entire communities. This slide shows the results in 4 pairs of Gambian villages, and you can see that reinfection was less common in those that were treated with azithromycin.

IN THE PAST 20 YEARS
MORE THAN 850 MILLION DOSES OF
AZITHROMYCIN HAVE BEEN DONATED;
THE NUMBER OF PEOPLE
AT RISK OF TRACHOMA
HAS BEEN REDUCED
BY 91%

These results were very encouraging, but azithromycin was still under patent and was very expensive. Trachoma is a disease of poor, neglected communities, and in those days there was little or no funding available for NTDs. Fortunately Joe Cook's office in New York was just down the road from the headquarters of Pfizer, the pharmaceutical company which makes azithromycin, and he was able to persuade them to donate it to trachoma control programmes. As a result of this, in 1998 the World Health Assembly passed a resolution calling for the global elimination of trachoma as a public health problem by 2020, using the SAFE strategy: Surgery for trichiasis, Antibiotic (azithromycin) mass treatment, and the promotion of Face washing and Environmental improvement to reduce transmission. These were the elimination targets set by WHO: prevalence of TT <0.2% in ≥15-year-olds; prevalence of trachomatous inflammation-follicular <5% in 1–9-year-olds; and the ability to identify and manage new cases of trichiasis.

Soon after this we were awarded a research grant by the Wellcome Trust to evaluate the impact of SAFE in The Gambia and Tanzania. We recruited a wonderful research team, in collaboration with our American partners, and were especially lucky to recruit 3 outstanding PhD students: Matthew Burton, an ophthalmologist, whose research in Ethiopia has for the first time definitively identified the best operation for trichiasis; Paul Emerson, an entomologist who studied the impact of fly control on trachoma in The Gambia, and is now Director of the International Trachoma initiative which oversees the azithromycin donation programme; and Anthony Solomon, an infectious diseases trainee who showed it was possible to eliminate trachoma from a community in Tanzania with a single round of mass treatment, and now leads the trachoma elimination programme at WHO.

In the past 20 years more than 850 million doses of azithromycin have been donated; the number of people at risk of trachoma has been reduced by 91% (from 1.5 billion to 142 million), and the number of people needing surgery for trichiasis has been reduced by 68% (from 7.6 million to 2.5 million). Pfizer has committed to donating azithromycin for as long as it is needed, and almost all endemic countries are committed to elimination. So far 9 countries have been validated as meeting WHO elimination targets (China 2019, Ghana 2018, Cambodia 2017, Iran 2018, Laos 2017, Mexico 2017, Morocco 2016, Nepal 2018, Oman 2012), and 4 other countries report meeting the targets (Gambia, Togo, Iraq, Myanmar). We will not achieve our goal of global elimination of trachoma as a public health problem by 2020 but, at the current rate of progress, we should achieve it well before 2030.

During our first trial of azithromycin mass treatment in The Gambia we showed that it had additional benefits, reducing the prevalence of malaria and the incidence of fever, diarrhoea and vomiting. Our American colleagues noticed that, in Ethiopia, it seemed to reduce overall mortality in children under 5 years. Last year we published the results of a randomised controlled trial conducted in 3 African countries in collaboration with our American colleagues, showing that twice yearly azithromycin mass treatment reduced under 5 all-cause mortality by 13%, and mortality in infants between the ages of 1 and 6 months by 25%. I am delighted that the increase in funding for the control and elimination of Neglected Tropical Diseases over the past 10 years, and MDA programmes such as this, in which community volunteers give out the treatment, has had a significant impact on the health of the most neglected populations in the world, and has already accelerated progress towards universal health coverage. Long may it continue!

LONG MAY IT CONTINUE!

MR. BAN KI-MOON

DEPUTY CHAIR
THE ELDERS

REPUBLIC OF KOREA

Your Royal Highness Princess Maha Chakri Sirindhorn, Your Royal Highness Princess Dina Mired, Respected Prince Mahidol Award Laureates, Dr. Bartenschlager and Dr. Mabey, Excellencies, Ladies and Gentlemen,

I am honoured to speak to you today at the opening ceremony of the Prince Mahidol Award Conference, which has become one of the most important events on the global health calender. This conference has had a profound impact in shaping the global health agenda - most notably through initiating and spearheading the campaign for Universal Health Coverage. Leading health activists and policy makers have been championing UHC at PMAC for almost a decade now and your collective efforts helped ensure that UHC was incorporated into the Sustainable Development Goals. I congratulate you all for this tremendous achievement.

This year, PMAC is taking place at a time of acute public concern about global health risks posed by corona virus in China, which has already spread to other countries and continents. As with SARS and avian flu, this

epidemic highlights the principle importance of achieving UHC through resilient health systems that can protect all citizens regardless of income or background. The WHO has just declared corona virus a global health emergency. The way to overcome the corona virus is through countries working together in a spirit of solidarity and coordination. This is the same spirit that informs the United Nations SDGs of which UHC forms an integral element.

Today I am speaking to you as the Deputy Chair of The Elders, the organisation of independent global leaders working together for peace, justice and human rights that was founded by Nelson Mandela in 2007. The Elders believe that the best way to achieve the health SDG is though UHC, where everybody receives the quality health services they need, without suffering financial hardship.

Three times over the last decade, all countries have committed themselves to achieving UHC at the United Nations –most recently at the High Level Meeting on UHC in September 2019. At this, dozens of heads of state said that they would ensure that their countries reach UHC by 2030 and made bold announcements about the health reforms they will implement to achieve this goal.

WITH THE CLOCK TICKING TO THE SDG DEADLINE IN 2030

TO ACHIEVE THIS TARGET, MANY COUNTRIES WILL REQUIRE MASSIVE INVESTMENTS IN THEIR HEALTH SYSTEMS AND RADICAL CHANGES IN POLICIES TO IMPROVE ACCESS TO CARE FOR THE POOR AND VULNERABLE.

But if we are being honest, we have to acknowledge that since the signing of the SDGs, progress towards UHC has not been adequate. The latest WHO and World Bank UHC Monitoring Report shows that although health service coverage has been improving, levels of out-of-pocket health spending have been rising, meaning that more people are being impoverished because of health costs. This shows that governments are not meeting their obligations to finance UHC properly – too much of the burden is falling on households. This not only undermines achieving UHC, it is also a threat to global health security, because out-of-pocket-spending on medicines is one of the main drivers of anti-microbial resistance. High private health spending also inhibits progress towards other SDGs including eliminating poverty, reducing inequality and achieving gender equality. Women and their children often suffer most when health services are underfunded, as they have higher healthcare needs but often lower access to financial resources to pay for services themselves. This is why, when implementing UHC reforms, countries must prioritise delivering the health services women and children need most and provide them free at the point of delivery.

With the clock ticking to the SDG deadline in 2030, it is therefore appropriate that the theme of this year's PMAC is "Accelerating Progress Towards UHC". To achieve this target, many countries will require massive investments in their health systems and radical changes in policies to improve access to care for the poor and vulnerable.

So how are we going to hold our political leaders to account in delivering the commitments they have made so publicly to UHC and the SDGs?

The good news is that, by learning from UHC success stories from around the world, including Thailand, we know what works and what doesn't. Take for example the tricky issue of how to finance UHC.

As my fellow Elder, Gro Harlem Brundtland, highlighted at the United Nations High Level Meeting in September: there was a time when some development agencies and Western governments used to discourage higher government spending on health and instead promoted private voluntary financing like user fees and private insurance. These policies were driven by ideology rather than evidence and resulted in hundreds of millions of poor people being denied effective health care.

But thankfully across the world political leaders, and the heads of international financial institutions and lenders, have now listened to the needs of their people. They have rejected these failed policies and instead switched to a health financing system dominated by public financing – either through general taxation or compulsory social health insurance. This is the only way to ensure that healthy, wealthy members of society subsidise services for the sick and the poor, so that nobody gets left behind. As Dr Brundtland said in New York: "If there is one lesson the world has learned, it is that you can only reach UHC through PUBLIC financing."

Therefore one of the simplest ways we can hold political leaders to account in reaching UHC is tracking how much public financing they allocate and disburse to their health systems.

Transitioning from a health system dominated by private out-of-pocket financing to one mostly financed by public financing has become one of the defining steps in achieving UHC. It's a transition my own country, the Republic of Korea, made in 1977 and was also seen as the key step to bringing UHC to the United Kingdom in 1948 and Japan in 1961.

And of course one of the most celebrated and impressive transitions to publicly financed UHC happened right here in Thailand in 2002, with the launch of the Universal Coverage scheme. It's worth remembering that this was implemented in the immediate aftermath of the Asian Financial Crisis, when the World Bank advice was that Thailand couldn't afford to increase public health spending to cover everyone. But as my friend and former World Bank President, Jim Kim, said at the World Health Assembly in 2013, the Thai Government wisely ignored this advice and in one year injected around a half a percent of GDP in tax financing into its health system. In the process the country swiftly moved from around 70% coverage to almost full population coverage – a shining example of how to accelerate progress towards UHC.

What this required, and is the pre-requisite for successful UHC reforms everywhere, was genuine and sustained political commitment from the head of state. This is needed both to secure the necessary public financing and oversee the required health reforms. Successful UHC reforms can't just be left to the Ministry of Health - they require leadership from the head of state and the active engagement of the whole of government.

What Thailand, the Republic of Korea, Japan, the UK and many other countries have also shown is that UHC reforms are so effective and so popular, they can become part of a nation's identity and prove resilient in the face of changes of government. Once a country switches to a universal publicly financed health system, almost all mainstream political parties recognise how important it is to the people to retain and improve such a system – it's rare that coverage dimishishes.

HEALTH CANNOT BE A QUESTION OF INCOME; IT IS A FUNDAMENTAL HUMAN RIGHT

NELSON MANDELA

So what are the implications for the theme of this year's PMAC: accelerating progress towards UHC? On a global level, we need to prioritise helping countries that are still to make the transition to a universal publicly financed health system. Here our focus should be on countries with low levels of public health spending, often less than 1% of GDP, where up to three quarters of health spending is in the form of user fees. These countries need to double or triple their public spending on health over the next decade and prioritise funding a universal package of services, focussing on primary care services provided free at the point of delivery.

These low-spending countries tend to be in Sub-Saharan Africa and South Asia but there are already shining examples of countries in these regions using public financing to extend health coverage - for example Sri Lanka in South Asia and Rwanda in Africa. Also it is perfectly feasible to increase public spending on health this quickly, if there is political will, as shown by Thailand and China. This reinforces the point made by the WHO Director General Dr Tedros that UHC is a political choice.

The focus of our UHC programme at The Elders is to encourage political leaders to make this choice, by helping them appreciate the health, economic, societal and political benefits of achieving UHC. Some of my fellow Elders have spearheaded successful UHC reforms themselves, like former President Ricardo Lagos of Chile and former President Ernesto Zedillo of Mexico – so we are speaking from experience.

In doing this we are very keen to work with you, the UHC community, to identify opportunities to promote UHC reforms at the highest level of government. We have already engaged with political leaders in Indonesia, India, South Africa, Tanzania and the United States to promote UHC and are always on the lookout for windows of opportunity to champion UHC to the next generation of global leaders. So if you feel political commitment to UHC is lacking in your country and we can be of assistance, do please let us know, as we want to play our part in acclerating UHC as a means to deliver the SDGs.

UHC makes medical, economic, political and social sense. But as the founder of The Elders, Nelson Mandela, so powerfully stated: "Health cannot be a question of income; it is a fundamental human right."

At the start of a new decade which also marks the 30th anniversary of Mandela's freedom from prison, let us commit to work together to realise his vision and make UHC a reality for all.

HRH PRINCESS DINA MIRED

PRESIDENT
THE UNION FOR INTERNATIONAL CANCER CONTROL

SENIOR ADVISER-
VITAL STRATEGIES

JORDAN

Your Royal Highness Princess Maha Chakri Sirindhorn, Prince Mahidol Award Laureates, Prof. David Mabey and Prof. Ralf F.W. Barte nschlager, Your Excellency Ban Ki-moon, Distinguished Guests, Ladies and Gentlemen,

Dear Friends and Colleagues,

I am beyond honored to have been invited to speak at the Prince Mahidol Award Conference. Hosting this conference on Universal Health Coverage (UHC) in Thailand, could not have been a better choice given Thailand's leading and admirable achievements in implementing UHC.

We are all here today, making the effort and taking the time to keep on advocating and urging all governments all over the world to embark on the journey of Universal Health Coverage.

We are also here today, because we reject the status quo, that 70% of our children, brothers and sisters especially from low-middle- income countries perish needlessly from NCDs including cancer diseases that can be cured, for the simple fact that they either live in the wrong place, the wrong time, be in a conflict zone or have a bank account that is not immunized against catastrophic expenses.

According to UHC's Global Monitoring Report 2019, as we speak nearly half of the earth's population is still unable to access basic healthcare services, and 100 million people fall into poverty each year due to heavy burden of medical expenses. And if current trends continue, up to 5 billion people will still be unable to access health care in 2030.

...THE MAGIC POTION THAT WILL SAVE YOUR LIFE IS HERE, BUT NOT FOR YOU...

THIS IS WHAT LACK OF UHC AND ACCESS TO TREATMENT IS ALL ABOUT

Our health care systems have long been geared to treat communicable diseases only and certainly not to prevent disease, making some to call ministries of health as far as "Ministries of disease". This has resulted in our current systems no longer being able to deal with the multitude of systemic shocks of today's epidemiological and current landscape. These shocks include the double burden of communicable and non-communicable diseases as well as natural disasters, conflicts, mass migration, urbanization and other so called "megatrends" that impact the health system. That is why our health systems that we have all inherited are literally bursting at the seams and have become fragmented inefficient and therefore are defaulting on delivering lifesaving treatments to their citizens.

To really understand the value of Universal Health Coverage (UHC), is to imagine its absence, to imagine for one second what it looks and feels like, if you or a loved one, who is struck with cancer for example , is not covered for treatment nor protected by UHC. It's like looking at someone and saying, "The magic potion that will save your life is here, but not for YOU." This is what lack of UHC and access to treatment is all about, we can sugar coat it all we want, but it is about the harsh and tragic reality of depriving someone from lifesaving treatment.

The hopeful news, is that we now have a new drive from the UN General Assembly through the Political Declaration on Universal Health Coverage (UHC), urging countries to implement UHC, so that all persons whoever and wherever they are, and whatever their income level, are guaranteed an essential package of quality health services without having to incur catastrophic expenses. UHC is about not leaving anyone behind.

UHC promises a lot. At first glance, one would be forgiven if one dismissed it as perhaps yet another idealistic rhetoric. It could sound like an impossible utopian dream to many countries.

However, I assure you that the UHC ambition is absolutely not a dream. I have attended the 2019 UNHLM in New York and became more hopeful as I heard many leaders from Rwanda, Turkey, Thailand, Philippine, Uruguay, Zambia, Senegal and others, who have embarked on implementing UHC.

We all know the benefits of implementing a universal UHC that truly leaves no one behind. A lot of the emphasis was on that but not on the how to do that. There are main important prerequisites and contextual drivers that have to underpin the approach prior to embarking on UHC.

All equally important. Rifat Atun article on Turkey's Health transformation in the lancet highlighted many of the below.

Firstly, without question, you need political will from Heads of government and across the whole cabinet. Dr Tedros, Director General of WHO, said in his opening speech, "Health is a political choice and he was glad that many leaders have made that responsible choice".

That is why those who have implemented UHC in their own countries, made sure that the decision was a whole cabinet responsibility and a long-term goal. This ensured that the cabinet was committed not just to the concept of "health for all" but rather "all for health".

Secondly, the overall thinking has to be one of comprehensiveness and of transformation. The usual transient band-aid solutions no longer work and have become extremely wasteful and inefficient. Therefore, countries have to take a new fresh look at their health and health financing systems to re-transform and re-organize to meet the epidemiological needs of today on a life-course approach. Making sure to strengthen their primary health care system as a cornerstone of their efforts. Thailand is a great example of its primary health care strengthening work since 1970's that laid the strong foundation upon which they were able to expand their UHC.

The third prerequisite, there has be a decision as to the managerial structure and engine that will drive the process forward in a terrain that is long-term and fraught with many obstacles along the way.

The countries that are delivering UHC understand the limitations of their current capacities at their health ministries which do not typically include a team of long-term strategic planners. Health Ministries' roles in many countries end up being more operational rather than being able to focus on the long-term strategic and policy changes needed to improve health

MAKING SURE THAT ALL UNDERSTAND THAT IT IS A "RIGHT" AND NOT A "GIFT"

nationally. Once a minister is appointed, he/she enters the "treadmill cycle" of barely managing his/her schedules. So, those who have a long-term vision for UHC, have established a "transformation team" like the model in Turkey, or "policy entrepreneur team" in Thailand or the "planning commission team" in India.

Strong governance mechanisms such as those are crucial as the planning and implementation stage and can take from 2 to 5 years and above, certainly exceeding any political cycle of any Minister. The transformation team is the only way to make sure that the cabinet commitment is sustained for the duration of the journey to achieving UHC- and beyond, to its monitoring and evaluation.

Fourthly but certainly not lastly, the people! UHC is about giving health care access to the people they intend to serve. Persons healthy or unwell have to be at the center of it all. In many countries, people have long

lost trust in their public health system. Gaining the trust of the people is crucial and they have to be part and parcel of the UHC plan from the beginning.

Starting from enshrining and delineating their health rights in the laws, making sure that all understand that it is a "right" and not a "gift" that can be given or taken at will. Delineating those rights into what to expect from a health system, in terms of respect, quality, delivering an essential package of services, procedures and transparent channels for public complaints, will offer you a large powerful constituency that adds to a country's monitoring and evaluation function of those services. By so doing empowering patient rights to a whole new level and transforming health care systems from one that are designed around diseases to ones that are designed for people.

And the fifth item, the usual elephant in the room, "who will foot the bill"? UHC is not a one size fits all. But many countries will tell you that significant money came from simply reducing existing inefficiencies, some from an increase in actual investment as a percentage of GDP and of course some from co-contributions from the public.

Others, utilized innovative financing, including earmarking what I call "the good taxes" to finance some of the services, such as taxes on tobacco, alcohol, sugar and salt; as the drivers of many

THE USUAL ELEPHANT IN THE ROOM, "WHO WILL FOOT THE BILL"?

THE MONEY CAN BE FOUND IF THE WILL IS THERE.

NCDs. These provide triple wins, one reduces the avalanche of new NCD and cancer cases, saves future treatment costs and at the same time provides new revenues for the budget for health and wellbeing.

Starting with fighting tobacco, that alone can reduce a third of all cancers and other NCDs. Countries who have understood the power of taxation on harmful products benefited. A great example is the Philippines who placed a so called "cancer tax" on alcohol and tobacco. The revenue generated from that is now, in part, being used to pay for universal health coverage for the citizens of the Philippines and for new health programs.

Other powerful examples include vaccinating girls and boys with the cervical vaccine, the hepatitis vaccine and others to literally stop those diseases and save lives and save money.

Other innovative financing includes a new study by Vital Strategies' global Organization that urges governments to reconsider giving subsidies to unhealthy commodities that harm us and cause NCDs, such as fossil fuels and redirecting those subsidies towards health provision or other social benefits instead. Again, another win-win situation.

The opportunity for further efficiency savings can also be addressed by the proper governance and use of the latest digital innovation, such as point of care diagnostics, digital health, artificial intelligence to name a few.

So, the money can be found if the will is there.

Footing the bill for the current disease burden is one thing, but to keep on footing the bill for recurrent preventable and early detectable diseases is downright irresponsible and wasteful both in human and money terms.

The global health community has already proven that by investing in 1.7 dollars per person per year on prevention and early detection on NCD's, saves countries in treatment costs 350 billion dollars cumulatively by 2030…350 billion dollars…We have also known for a long time what to do to curb those NCDs at the instance-by implementing effective regulation, legislation and taxation on commercial determinants of health.

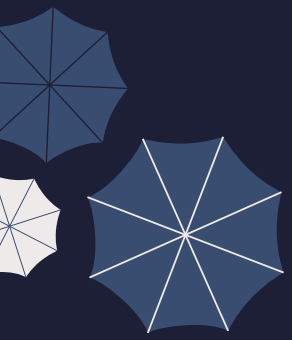
And yet, many UHC packages to date, still shy away from including coverage for prevention and early detection for those very diseases, such as Cancer and other NCDs, that inflict the highest long-term burden on health systems financially and administratively! Mind boggling.

Leaders and countries who have really succeeded in implementing meaningful UHC, understood that Cancer represented the ultimate litmus test for Universal Health Coverage. They understood that by excluding cancer in their UHC plans, the plan would be rendered as hollow, meaningless and so porous that it would leak out all the economic investment put in beforehand.

A great example of this is cervical cancer. Global donors such as the global fund who supported LMICs burdened with AIDS with millions of dollars to help beat the disease. Whilst we are thankful for that, we also know that HIV patients are more likely to have cervical cancer as well as other co-morbidities. So, if UHC plans do not include cancer, then all this investment in saving lives, collapses and dies with the very patients themselves afflicted with cervical cancer.

So UHC is not just about investing more but investing better! I strongly urge all countries to start the UHC journey because as aptly coined Hon. Prof. Piyasakol Sakolsatayadorn, former Minister of Health, Thailand Minister of Health, Thailand "The decision to embark on the UHC journey is not because you are a rich country, but precisely because you are a poor country".

UHC IS NOT JUST ABOUT INVESTING MORE BUT INVESTING BETTER



CONFERENCE
SESSIONS
AT A GLANCE

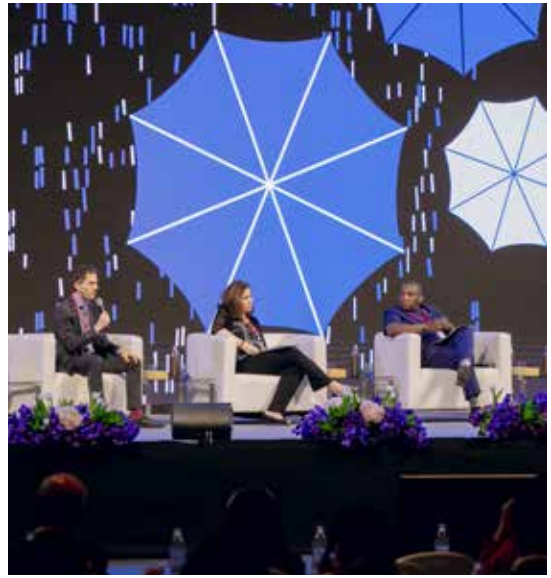
PLENARY SESSION 0

ACCELERATING PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE

Anutin CHARNVIRAKUL
Gaku HASHIMOTO
Naoko YAMAMOTO
Daniel DULITZKY
Anders NORDSTROM
Evalin KARIJO
Khuat THI HAI OANH
Ariel PABLOS-MENDEZ
Ashley MCKIMM

PLENARY SESSION 1

IMPLEMENTATION CHALLENGES AND INNOVATIVE SOLUTIONS FOR UHC 2030



Koku AWONOOR
Erica DI RUGGIERO
Beverly HO
Justin KOONINS
Takao TODA
Naoko YAMAMOTO

PARALLEL SESSION 1.2

INVESTING IN THE HEALTH WORKFORCE FOR THE 21ST CENTURY

PARALLEL SESSION 1.1

REVITALIZING PHC – ASTANA AND BEYOND

PARALLEL SESSION 1.3

ACHIEVING UHC THROUGH STRONG LOCAL HEALTH SYSTEMS

PARALLEL SESSION 1.4

ADDRESSING THE POLITICAL ECONOMY OF UHC

PARALLEL SESSION 1.5

ENSURING HEALTH PROMOTION AND DISEASE PREVENTION IN UHC

PLENARY SESSION 2

MAKING HEALTH FINANCING FOR UHC SAFE

Lydia DSANE-SELBY
Holger MICHIEL VAN EDEN
K. Srinath REDDY
Yasuhisa SHIOZAKI
Agnès SOUCAT
Kara HANSON

PARALLE SESSION 2.1

MAKING AND USING (FISCAL) SPACE FOR UHC

PARALLEL SESSION 2.3

LEVERAGING STRATEGIC PURCHASING FOR UHC THROUGH STRENGTHENED GOVERNANCE

PARALLEL SESSION 2.2

SMART HEALTH FINANCING – SEIZING DIGITAL OPPORTUNITIES

PARALLEL SESSION 2.4

HEALTH FINANCING TRANSITIONS: THE ROLE OF DEVELOPMENT ASSISTANCE ON THE ROAD TO SUSTAINABILITY

PARALLEL SESSION 2.5

ASSESSING HEALTH INTERVENTIONS FOR A FAIR, EFFICIENT, AND SUSTAINABLE UHC

PLENARY SESSION 3

UHC AND THE CHANGING GLOBAL LANDSCAPE

Parry AFTAB
Carlos CORREA
Henna DHAWAN
Montira PONGSIRI
Aquina THULARE
Robert YATES

PARALLEL SESSION 3.1

TACKLING CLIMATE CHANGE WHILE MAXIMIZING HEALTH IMPACT

PARALLEL SESSION 3.2

ARTIFICIAL INTELLIGENCE AND DIGITAL HEALTH: OPPORTUNITIES AND RISKS

PARALLEL SESSION 3.3

MAKING HEALTH SERVICES ACCOUNTABLE TO THE PEOPLE – A GLOBAL TREND?

PARALLEL SESSION 3.4

SOLIDARITY & UHC – LEADERSHIP FOR CHANGE

PARALLEL SESSION 3.5

MAKING GLOBAL TRADE POLICIES WORK FOR UHC

SYNTHESIS
SUMMARY, CONCLUSION & RECOMMENDATIONS

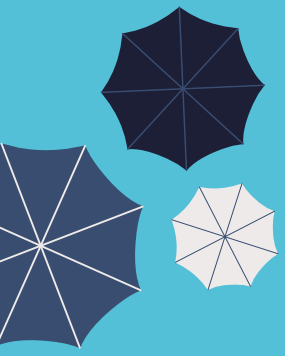
Anne MILLS
Walaiporn PATCHARANARUMOL
Viroj TANGCHAROENSATHIEN
Aquina THULARE
Teo YIK YING

PLENARY SESSION 4

FROM POLITICAL DECLARATION TO REAL ACTIONS

Mark BLECHER
Chieko IKEDA
Kaha IMNADZE
Vitavas SRIVIHOK
Phyllida TRAVIS

CLOSING SESSION



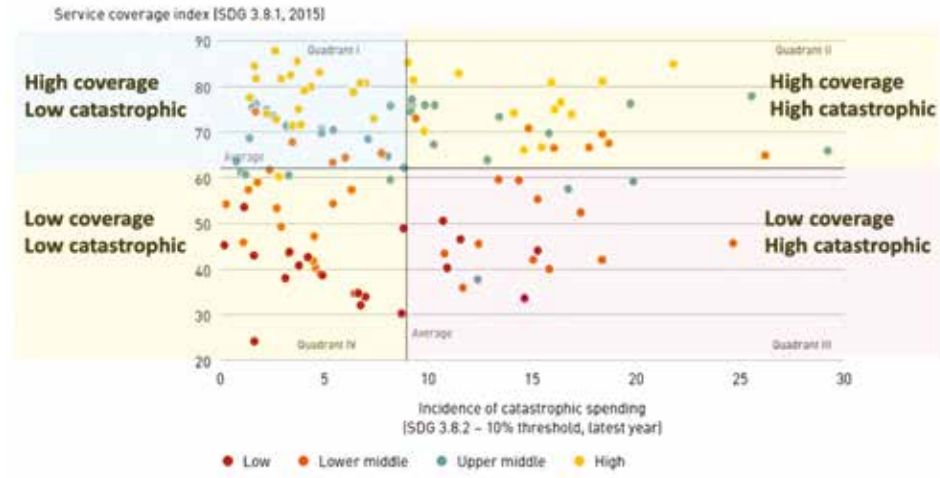
CONFERENCE
SYNTHESIS

1

UHC
ACHIEVEMENTS

The 2019 global monitoring reports reveal good and bad news. The good news is the UHC service coverage index improved from 45 (of 100) in 2000 to 66 in 2017 with an increasing annual average of 2.3%. The bad news is the increase in the incidence of catastrophic health spending (out-of-pocket more than 10% of household budget); it increased from 9.4% to 12.7% during the same period. However, there are large regional and country variations. Countries are at different stages in service coverage and financial protection.

WHO MEMBER STATS DISTRIBUTION BY LEVEL OF FINANCIAL RISK PROTECTION AND SERVICE COVERAGE



Source: Adapted from the Primary Health Care on the Road to Universal Health Coverage 2019
Global Monitoring Report, World Health Organization, 2019.

The scatter plot in Figure 4 of the two indicators (service coverage index and incidence of catastrophic health spending), when countries are located in four quadrants by global averages, categorizes four groups of countries which need different policy choices.

FIRST, countries belonging to the quadrant of high coverage index and low incidence of catastrophic spending are good performers. Monitoring should focus on the sub-national level and on socio-economic stratification and inequalities.

SECOND, countries having high coverage but also high incidence of catastrophic spending need to improve their financial risk protection through policies such as a more comprehensive benefit package, inclusion of medicines and other cost-effective interventions as guided by Health Technology Assessment evidence, and increased cost subsidies and not allowing balanced billing.

THIRD, countries having low coverage and high incidence of catastrophic spending need to boost service provision capacity, as well as expand financial protection through e.g. investing in essential infrastructure and, given fiscal constraints, prioritizing the poor and vulnerable populations. Policy decisions should prioritize equity given that difficult policy choices may arise between improving service capacity and expanding population coverage.

FINALLY, countries having low coverage and low incidence of catastrophic spending are the worst performers. Poor households who cannot afford to pay for health services may forego required care and instead choose to die at home. The magnitude and profiles of unmet healthcare need should be assessed. Countries in this quadrant, often in complex emergency situations, need to accelerate progress on supply-side capacity and financial risk protection targeting the poorest and most vulnerable groups.

It should be noted that low income countries belong to low coverage and high incidence of catastrophic spending as well as low coverage and low incidence of catastrophic expenditure.

2

A MIXED PICTURE ON PROGRESS TO UHC

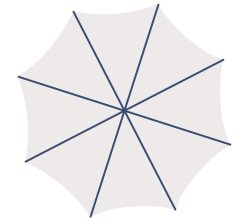
As countries are not at "a clean slate" on their journey towards UHC; low- and middle-income countries (LMICs) have certain financial risk protection systems, but they are often fragmented. This creates multiple health insurance schemes with different benefit packages, provider payment methods, expenditure, efficiency and performance. Many current health systems are fragmented, with a tendency for low services coverage among the uninsured population and high out of pocket or inability to access to services due high out of pocket payment.

3

THE SOLUTION

FOUR POLICY ACTIONS NEEDED

for progressive realization of UHC include: 1) making quality health care services available and accessible for all populations, 2) extending financial risk protection and reducing unmet need focusing on the poor and vulnerable population if the government fiscal spaces do not allow coverage to the whole population, 3) improving governance and accountability, and 4) enhancing capacity to monitor and evaluate.

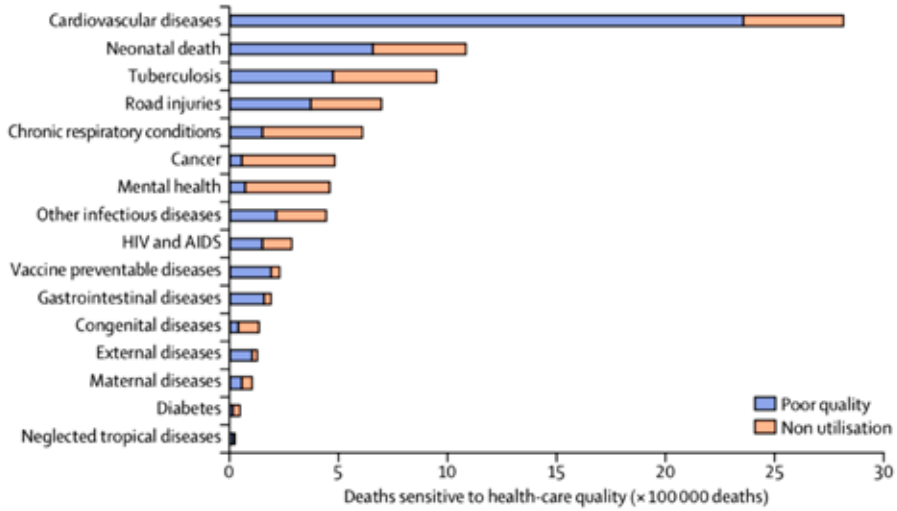


3.1

MAKING QUALITY SERVICE AVAILABLE AND ACCESSIBLE

Countries have been facing the problems of both access and quality of health care services. The mortality rate in a variety of conditions sensitive to health care quality is one of the key measures of the quality of care. The data from 137 low- and middle-income countries has shown the deaths sensitive due to poor quality health services is far greater than non-utilization. This indicates clearly access to poor quality of care is more harmful than not access to services.

The other element is to ensure the availability and affordability of essential medicines and vaccines (SDG3.b.3). This requires effective mechanisms such as the monopsonistic purchasing power of public procurers and price control policies. For example, in Ukraine, international procurement has resulted in substantial price reduction and more patients accessing treatment.



MORTALITY SENSITIVE TO HEALTH-CARE QUALITY AND NON-ACCESS TO SERVICES, 137 LOW- AND MIDDLE-INCOME COUNTRIES.

Source: Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al., English M. High-quality health systems in the Sustainable Development Goals era: time for a revolution. The Lancet Global Health. 2018 Nov 1;6(11):e1196-252

It is important to use the TRIPS flexibility provisions, and promoting the use of generic medicines and biosimilars, which create opportunities to improve access to medicines. It is also important to have an effective supply chain management system which address the fundamental causes of stock out medicines.

The necessary action is to create demand for a better access to health services from individuals and community to align multi-actions for health, particularly to address NCD epidemic and rapidly aging populations. The possibilities of public-private partnerships are to improve access, public private partnership requires strong government regulatory capacity, clear contractual agreements, the correct incentives, accountability and good governance. Lastly, investing in health promotion and disease prevention through the life-course approach is essential to sustain UHC.

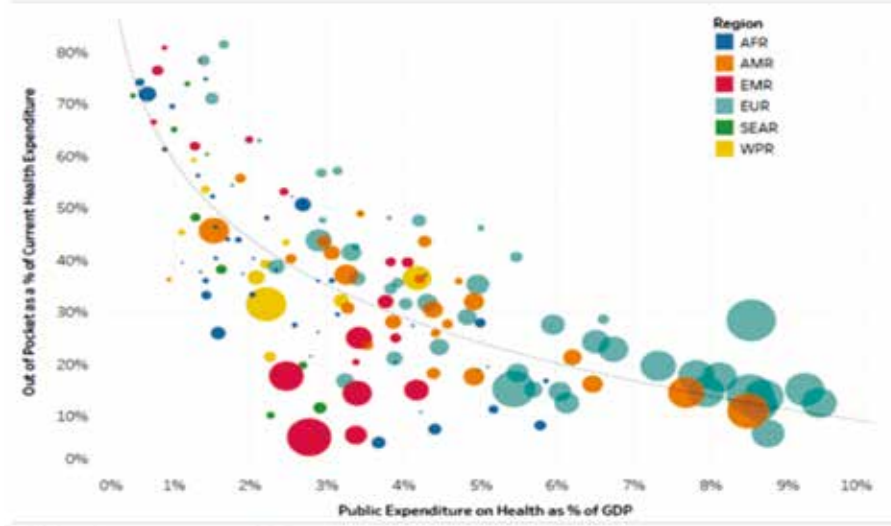
THE NECESSARY ACTION IS
TO CREATE DEMAND FOR A BETTER ACCESS TO HEALTH SERVICES
FROM INDIVIDUALS AND COMMUNITY TO ALIGN MULTI-ACTIONS FOR HEALTH

3.2

EXTENDING FINANCIAL PROTECTION AND REDUCING UNMET NEED

There is inadequate and inefficient spending on health. There have been specific discussions on challenges facing countries transitioning from donor support moving from low- income countries to lower middle-income, emphasizing the need to increase domestic financing in order to ensure financial sustainability of the health system, sustain and accelerate progress of programs which were previously funded by donors. There has been an emphasis on the need to expand population coverage and financial protection through a rights-based approach and social solidarity. There is a need to increase public health spending. The figure shows that countries with the highest share of out-of-pocket pocket payments in health expenditure have a low share of public spending as a percentage of GDP. Government in member states in WHO European Region, having high level of GDP per capita, spent more on health of the population while the citizens spent lower out of pocket payment on health services.

Countries with high share of OOP in health expenditure have low share of public spending as a % of GDP



Bubble size represents GDP per capita

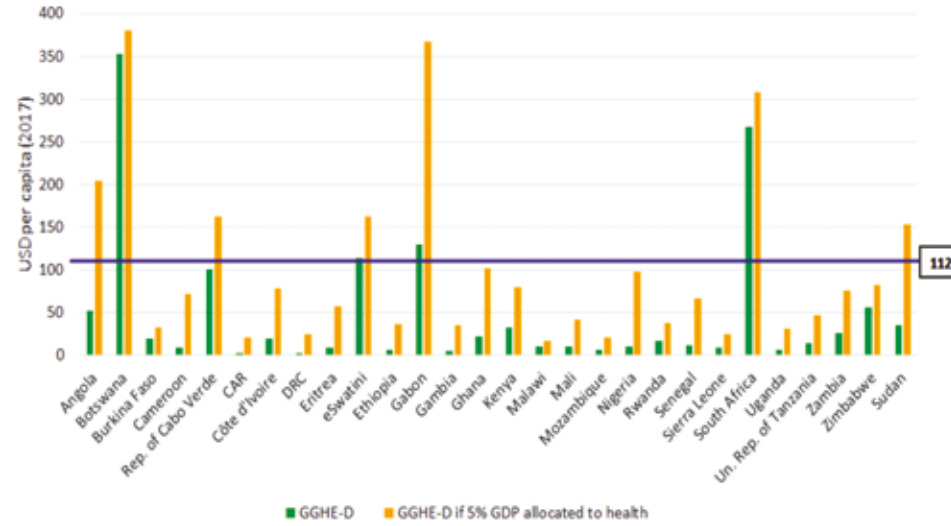
PUBLIC EXPENDITURE ON HEALTH AS % GDP AND OUT OF POCKET PAYMENT AS % OF CURRENT HEALTH SPENDING

Source: Kutzin J. Why public finance matters for UHC. Prince Mahidol Award Conference, Parallel session 2.1; 31 Jan - 2 Feb 2020; Bangkok, Thailand: 2020.

One critical action is to mobilize domestic finance as the most progressive and sustainable source for UHC. The increasing fiscal space defined as tax or government revenue as a proportion of GDP can be achieved through tax reform, improve tax collection efficiency, expand the tax base, and stimulate economic growth. Within fiscal space, health should be prioritized through a political commitment to accelerate the growth of general government health expenditure to reach 5% of GDP and 1% of GDP to primary health care as committed in the UN General Assembly High Level Political Declaration on UHC in 2019.

It is clear in Figure 7, the current General Government Expenditure on Health (in green bar) is far too little in most countries in Africa (except Botswana, Gabon and South Africa) comparing with the benchmark of US$ 112 per capita to achieve UHC. Even when assuming the governments allocate 5% of its GDP to health services (in yellow bar); the per capita spending on health cannot reach the benchmark of US$ 112 in most countries except a few (Angola, Cave Verde, Eswatini and Sudan)

Innovative sources of health financing is another critical entry point for raising funds for UHC. For example, the sin tax is a triple win; it prevents NCDs, it saves future NCD treatment costs, and it increases revenue for health.



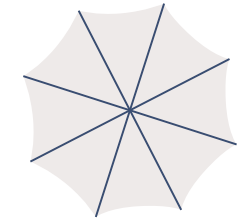
PER CAPITA DOMESTIC GENERAL GOVERNMENT HEALTH EXPENDITURE: STATUS QUO AND ASSUMING IF 5% OF GDP IS ALLOCATED TO GGHE, AGAINST A BENCHMARK OF US$ 112 PER CAPITA, SELECTED COUNTRIES IN WHO AFRICAN REGION

*112 USD per capita was a model projection. Source: Lancet Global Health 2017: e875-87

Source: Bemelmans M. Making the case for more fiscal space for health: a civil society perspective. Prince Mahidol Award Conference, Parallel session 2.1; 31 Jan - 2 Feb 2020; Bangkok, Thailand: 2020.

It is important to prioritize a comprehensive benefits package to minimize out-of-pocket payments for non-covered services. There is a need to design an appropriate co-payment policy such as a fixed rate with exemptions for the poor, or annual cap is preferable than the percentage of medical bills. There is also a need to reform public financial management to facilitate effective budget execution by healthcare facilities. The countries with the burden of debt servicing should seek the way to maximize the discretionary portion in the budget and recognize the burden; as debt servicing is a "discretionary budget".

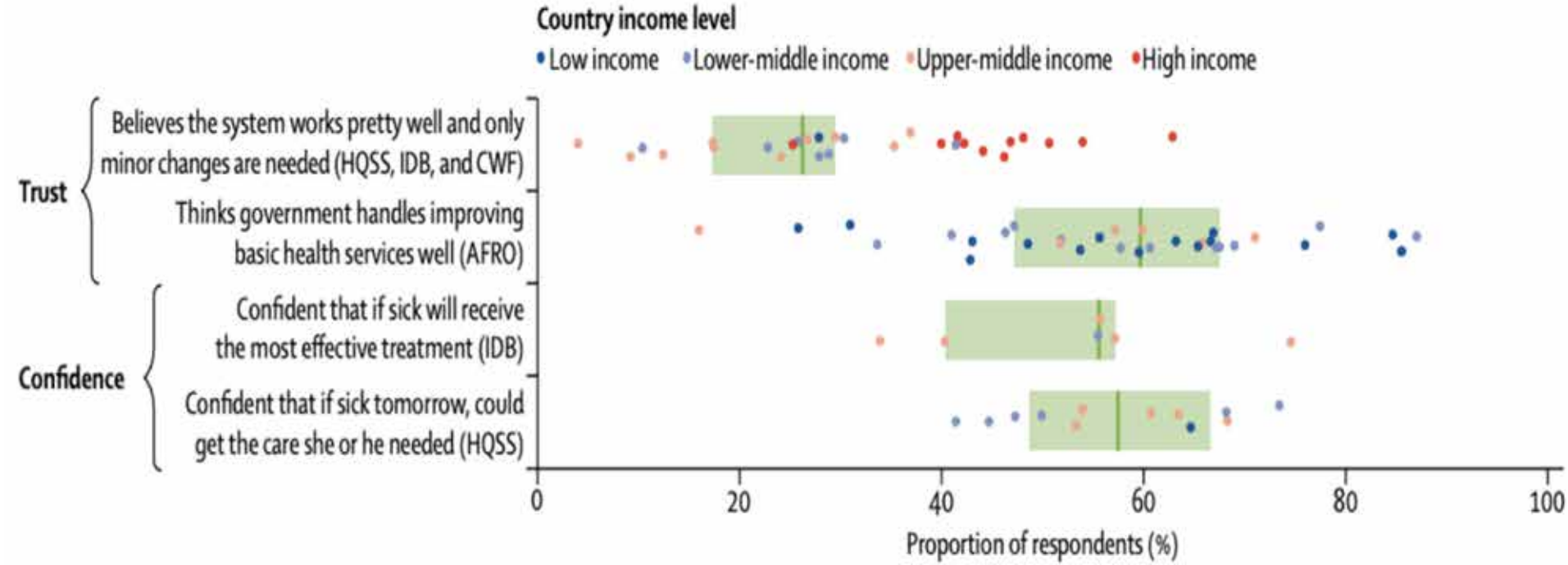
THERE IS A NEED TO DESIGN AN
APPROPRIATE
CO-PAYMENT POLICY
SUCH AS A FIXED RATE WITH EXEMPTIONS FOR THE POOR, OR ANNUAL CAP IS PREFERABLE THAN THE PERCENTAGE OF MEDICAL BILLS.



3.3

IMPROVING GOVERNANCE AND ACCOUNTABILITY

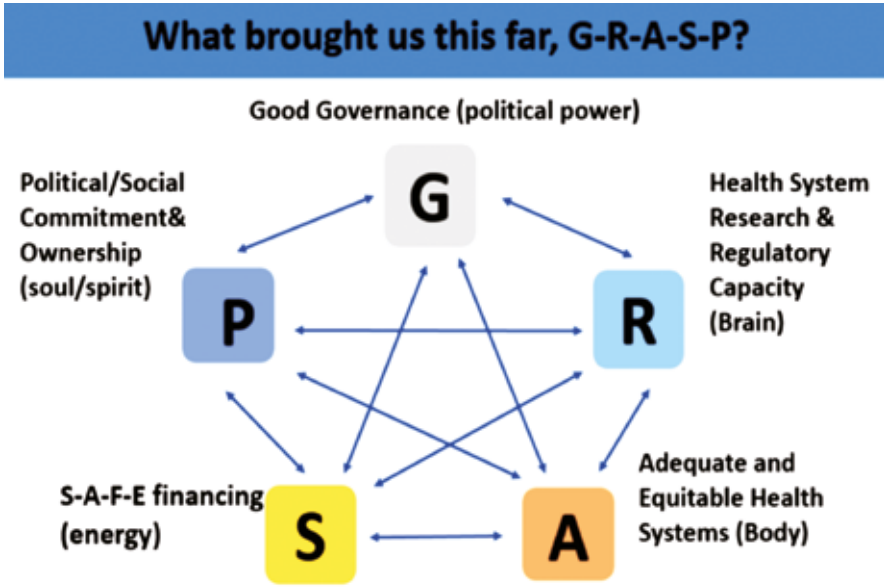
The political economy of UHC reform needs to balance power and ensure the alignment of goals between governments and donors with trust-based key stakeholder governance to enhance mutual accountability. The donors and countries should be accountable for their actions. It is clear that UHC has to be country-driven, and it has to be the country that sets the strategic direction and ensures accountability for the use of public resources and good performance at all levels. The legislation has a value to enhance good governance. This is not just the legislation, but it is very critical to strengthening implementation capacities in order to translate legislative provision into action and good outcomes.



LEVEL OF TRUST AND CONFIDENCE IN HEALTH SYSTEMS ACROSS LOW, LOWER- AND UPPER- AND HIGH INCOME COUNTRIES

Source: Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al., English M. High-quality health systems in the Sustainable Development Goals era: time for a revolution. The Lancet Global Health. 2018 Nov 1;6(11):e1196-252.

It is critical to embed citizen participation, engagement, and empowerment in the UHC governance. For example, the seats for citizens on the governing body, in the committee which designs the benefits package, feedback channels so that citizen voices are heard and actions are taken, annual public hearings, mandatory consultation processes, and etc. There is a need to establish mechanisms to counter corruption, prevent fraud and regulatory capture, and enhance transparency. Transparency is one of the essential elements in the good governance. Fundamental of trust relies on information sharing and effective communication across partners. It is significant issues across countries at different levels in the degree of trust and confidence that citizens have in the health systems and need addressing. An example of Thailand with 'GRASP' diagram shows the important success factors to achieve and sustain UHC.



G-R-A-S-P DIAGRAM: THE KEY SUCCESS FACTORS TO ACHIEVE AND SUSTAIN UHC

Source: Charnvirakul A. Accelerating Progress towards Universal Health Coverage (UHC). Prince Mahidol Award Conference, Plenary 0; 31 Jan - 2 Feb 2020; Bangkok, Thailand: 2020.

Note: In SAFE financing, S stands for sustainable, A for adequate, F for fair and E equity

MONITORING UHC MUST FOCUS NOT JUST ON THE 'LEVEL' BUT ALSO 'DISTRIBUTION' AS A KEY PRIORITY IN CLOSING THE GAPS BETWEEN ECONOMIC GROUPS AND ACROSS SUB-NATIONAL LEVELS

Enhancing the capacity to monitor and evaluate is very important. Monitoring UHC must focus not just on the 'level' but also 'distribution' as a key priority in closing the gaps between economic groups and across sub-national levels. Countries need geospatial information to facilitate health infrastructure investment and disease surveillance to work out where best to invest, which of the most underserved areas. Effective coverage has to be monitored, not just coverage but effective coverage to enhance health gain. The key challenges of UHC monitoring and evaluation are (a) current difficulties of estimating primary health care and total pharmaceutical expenditure, (b) unknown unmet health care needs, and (c) the need to obtain epidemiological and clinical data to monitor effective coverage.

3.4

ENHANCING CAPACITY TO MONITOR AND EVALUATE

Monitoring UHC must focus not only on 'level' but also 'distribution' as key priority in closing the gaps between economic groups and across sub-national levels. As the UNGA resolution on SDG has deliberate intention to leave no one behind. It said;

"Sustainable Development Goal indicators should be disaggregated, where relevant, by income, sex, age, race, ethnicity, migratory status, disability and geographic location, or other characteristics, in accordance with the Fundamental Principles of Official Statistics."

The use of geo-spatial information identifies gaps of infrastructure distribution and facilitates government investment to fill the gaps and leave no one behind. Further it supports disease surveillance and enhanced the International Health Regulation core capacity.

To ensure value for money, it is essential that Ministry of Health and partners focus also on assessment of "effective coverage" of priority health interventions to enhance health gain. For example, the percent of population having high blood pressure, and high blood glucose are screening and recruited for treatment and the percentage of those enrolled in treatment that their blood pressure was well control under 140/90 mmHg; and the HbA1C under the benchmark of 7%.

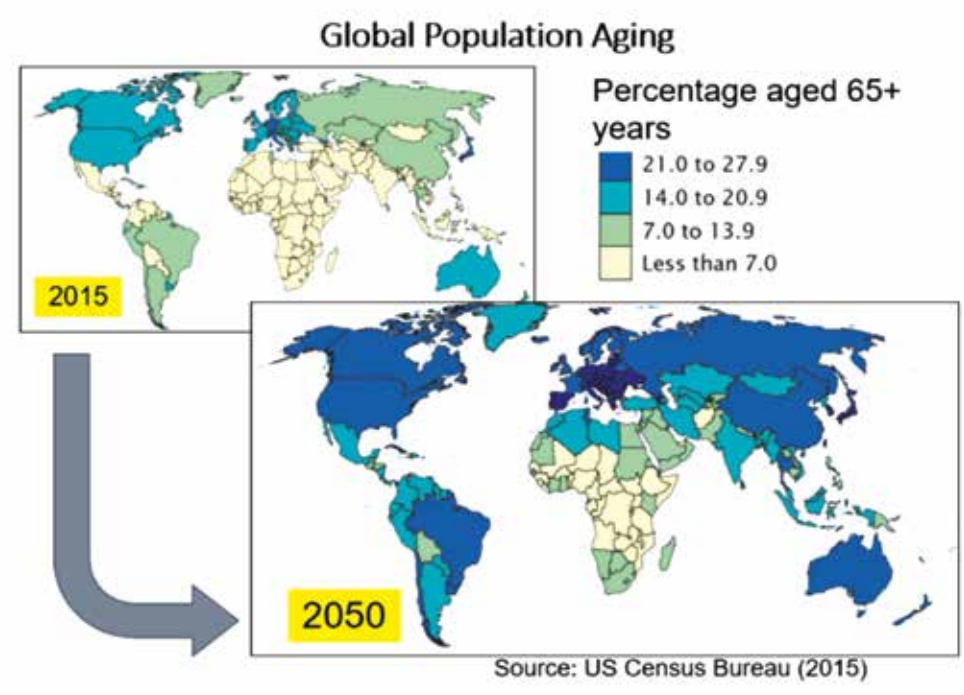
KEY CHALLENGES ON MONITORING ARE IDENTIFIED.

For example, it is yet to understand the total spending on PHC, and total pharmaceutical expenditure for which the current OECD Systems of Health Account (2011) does not provide guideline for data capturing for routine monitoring.

4

UHC CHALLENGED BY GLOBAL MEGATRENDS

PMAC 2020 also discusses some global megatrends: (1) climate change threatens humanity and hampers achievement of the SDGs. It requires health systems to adapt and mitigate impacts. Climate change will have massive effects on population habitats and survival. (2) geopolitics and political conflicts. It is already resulting in a massive migration of refugees and displaced populations. The shift of multilateralism towards bilateral agreement hampers international collective efforts



TREND OF AGEING POPULATION, BETWEEN 2015 AND 2050

Source: Yamamoto N. Ensuring Health Promoting and Disease Prevention in UHC. Prince Mahidol Award Conference, Parallel session 1.5; 31 Jan - 2 Feb 2020; Bangkok, Thailand: 2020.

CLIMATE CHANGE

CHANGING POPULATION DEMOGRAPHY

GEOPOLITICS AND POLITICAL CONFLICTS

DIGITAL AND ARTIFICIAL INTELLIGENCE (AI)

to protect health. (3) changing population demography, an aging society poses a double threat to health systems through higher health care demand and shrinking labor force. The rapid urbanization is not accompanied by significant and sufficient investment in health infrastructure, especially for the urban poor. (4) digital and artificial intelligence (AI) creates both opportunities and risks. It may help to replace low quality health care mainly used by the poor, improve quality of the service, and therefore reduce inequality. It may outperform the human capacity for visual identification in 5-10 years. It will reduce cost, time, burden on personnel, and increase productivity. But the main challenge is the high cost and unaffordable by the government and the poor. At present, the governance and capacity to regulate are still limited. There are big problems of privacy, regulation, and use of data.

HEALTHY MEETING

CONFERENCE POLICY

PMAC 2020 is strongly committed towards a healthy meeting, continuing from last year's initiative in setting global and national norms and standards of a healthy and active meeting. The conference provides an opportunity to all participants to choose healthier diets and engage in physical activity. Nutrition information and a warning label for food containing high sugar, sodium, and fat have been placed in every food corner. Furthermore, PMAC 2020 is an alcohol-free conference. More physical activity space has been set up and welcomes all participants throughout the meeting. Standing tables for conference participants are made available in the plenary venues though not in the side meeting venue. Everywhere in the conference venue is free of smoking.

FIELD TRIP

SITE 1

UNIVERSAL HEALTH COVERAGE FOR HIGH COST TREATMENTS: INTERDISCIPLINARY CARE FOR KIDNEY DISEASE

Location : HRH Princess Maha Chakri Sirindhorn Medical Center, Nakhonnayok and Buengyitho Medical and Rehabilitation Center, Pathumthani

Kidney disease, resulting in a high fatality rate, is one of the most important health issues in Thailand. Furthermore, financial barriers due to high cost of treatment and after-care as well as a limitation of suitable service facilities have affected patient care need. The National Health Security Office (NHSO), therefore, has taken initiatives to address this issue not only through its healthcare packages, but also by supporting related healthcare system developments. One of them is the cooperation with the Faculty of Medicine, Srinakharinwirot University to set up Regional Renal Replacement Therapy Technology and Training Center (RRRT-TTC) to provide model of care to slow progression of worsening kidney function in patients with chronic kidney disease (CKD). The continuous ambulatory peritoneal dialysis (CAPD), kidney transplantation (KT) and vascular access clinics have been set up to help patients with end stage renal disease (ESRD) to access renal replacement therapy (RRT) in accordance with PD First Policy. RRRT-TTC has also supported other hospitals to build up networks including academic activities to improve clinical outcomes. The success of its operation has been achieved through interdisciplinary collaboration of such personnel as specialists, nurses, pharmacists, social workers, etc. from a super-tertiary hospital, primary care facilities and community in NHSO Region 4 Saraburi, and members of the Thai Kidney Club.

The policy initiated by NHSO will help patients with CKD and/or ESRD access the health services they desperately need. With the PD First Policy, a lot of CKD and/or ESRD patients, together with their families, can be saved from going bankrupt due to the especially high cost of treatments and, as a consequence, their quality of life would be greatly improved.

Upon the site visit, participants will learn how NHSO' benefit packages for such high-cost treatments are deployed to be implemented and achieved and how system management based on holistic and interdisciplinary care for patients with kidney disease is highlighted.

SITE 2

QUALITY OF LIFE OF PRISONERS: SAMUTPRAKAN CENTRAL PRISON

Location : Samutprakan Central Prison, Samutprakan

According to the prisons survey, it was found that there are very few prisoners who could access to healthcare services due to many reasons such as various obstacles to access, personal security of the prisoners, and not enough health workforce. Therefore, an MOU in January 2019 set up Samutprakan Central Prison as a contracting unit in the NHSO system. The aim is to assure the international community that Thailand takes care of prisoners in line with human right principles. A primary care unit in prison is supported by Bangbo hospital as a contracting unit for primary care (CUP). The primary care unit in Samutprakan Central Prison is undertaking registrations and links with Bangbo hospital as referral hospital for further healthcare services including early screening for TB, prevention and promotion activities, etc.

This site visit will present how it is implementing to support developing access to healthcare services, healthy environment, and social assistance in prisons. The participants will experience the real life of prisoners, and see how multi-sectors both government and non-government organizations working together to improve quality of life of prisoners.

SITE 3

PRIMARY CARE CLUSTER TO PROMOTE UNIVERSAL HEALTH COVERAGE

Location : Pakchong District Health System, Nakhon Ratchasima

In 2016, the Ministry of Public Health launched the 12th National Health Development Plan 2017-2021 to establish primary care clusters, the primary care system with an adequate number of family doctors and multidisciplinary teams. The primary care policy aims to improve primary care services to ensure a proactive health system that provides comprehensive health care to achieve a goal of quality of life for all age groups, and effective disease and risk prevention. It also aims to strengthen networks and partner collaboration in communities and change the way that health and social services are organized, funded, and delivered. In order to sustain the progress of UHC, the National Health Security Office (NHSO) has launched the on top payment for Primary Care Cluster in 2018 to accelerate coverage of family doctors and multidisciplinary teams, and primary health care services.

The Pakchong-city primary care cluster was established in October 2016. It comprises of three primary care units with three family doctors and multidisciplinary teams, covering a population of around 30,000. It collaborates with networks and partners to provide comprehensive health care for all age groups, chronic disease patients, disabilities, dependent patients, palliative care patients, etc.

This site visit will show an insightful story of Pakchong-city primary care cluster and how they move forward the primary care clusters policy to accelerate coverage of primary health care services to sustain the progress of Universal Health Coverage (UHC).

SITE 4

MATCHING FUNDS FOR BETTER REHABILITATION AND INTERMEDIATE CARE

Location : Saraburi Provincial Administrative Organization and Saohai Hospital

Saraburi Provincial Rehabilitation Funds are matching funds set to be contributed in equal amount from the National Health Security Office and Saraburi Provincial Administrative Organization. The funds were launched in accordance with Section 47 of the National Health Security Act and aimed to serve health care needs of the local community by including the local community in decision making and co-funding of health-related programs. The funds were set up to provide health access for disabled, elderly, dependent or palliative care patients; which include intermediate care, rehabilitation services, medical products, assistive devices, to develop their quality of life.

The funds have strengthened the abilities to respond to various needs of intermediate care and dependent patients. As the growing number of patients who have suffered from stroke, traumatic brain injury and spinal cord injury; many patients are not fully recovered or ready to care for themselves, and become care burden for

their families and communities. They struggle in managing their conditions resulting from adverse events due to inappropriate care. The intermediate care system and rehabilitation services have been established by the support of these available matching funds. Patients receive necessary health care services by the multidisciplinary care team during a golden period of recovery such as health care services in an intermediate ward, outpatient rehabilitation services, home visits and home modifications. By receiving these services, the abilities to care for themselves of patients and their families increased and various complications decreased.

The study visits will present how they provide and support activities of intermediate care and rehabilitation services to disabled patients, and the activities of related local community networks.

SITE 5

PRIMARY CARE TRUSTS, E-REFERRAL, AND MOBILE HEALTH APPLICATION IN CAPITAL CITY FOSTERING UNIVERSAL HEALTH COVERAGE-BASED SOLIDARITY TO DRIVE TOWARDS SDGS

Location : Bhumibol Adulyadej Hospital

A collaboration of big public hospitals with private clinics to primary care services close to home before referring to the hospital has been initiated to solve over-crowding problems in public hospitals. The primary care units and the hospitals have been strengthened by the system called "Primary Care Trust" (PCT). This trust means believability between public and private medical centers in the standard medical treatment with the quality and continuous healthcare for the referral patients. The National Health Security Office-Bangkok Branch (NHSO-BB) has been providing the capacity and developing the e-Referral system to share patients' medical records to physicians in hospitals and clinics. This electronic medical data transferring system ensures that patients will get the same standard treatment from different level of healthcare providers.

In Bhumibol Adulyadej Hospital, the e-Referral system has been developed by the cooperation of the hospital with NHSO-BB, network partners, and the National Electronics and Computer Technology Center (NECTEC), bringing information and communication technology to forward patient care data to community clinics and the hospital network. Recently, Bhumibol Adulyadej hospital has developed a new patient care system called BHA connect, the application that enables the patients to know their basic health information such as history of illness, treatment data, appointment date, etc. This application will be developed as a part of home health care system in the near future.

This site visit will show the strong and close collaboration between government units, private organizations, and NGOs to promote access to health care service and prevention promotion activities to their catchment population such as birth registration, immunization of children, child health, as well as, the use of electronic medical data system to support access to health care service.

SITE 6

UNIVERSAL HEALTH COVERAGE FOR INNOVATIVE COST-EFFECTIVE SERVICE: ONE DAY SURGERY

Location : Pahonpolpayuhasena Hospital, Kanchanaburi

The Ministry of Public Health has been setting the 5-year-goal for One Day Surgery (ODS) to cover at least one health unit in each regional health area within 2021. Because of no admission, the One Day Surgery system possibly reduces the national expenditure by around 1,267.50 million Baht by supporting patients with self-preparation before going to the hospital and after receiving surgery, then going back home without admission within 24 hours. This system does not only reduce the rate of total admission and lower the budget, but also saves money for patients, shortens waiting-list of surgery and softens over-crowding problems in hospitals.

The Universal Health Coverage (UHC) also play a major role in increasing an accessibility of clients to ODS service by directly supported budget to the hospital based on the number of ODS clients. As a result, all people in Kanchanaburi who require this service can access to this ODS service without any condition.

Phaholpolpayuhasaena Hospital in Kanchanaburi has been providing One Day Surgery for hernia surgery for more than 10 years since 1999. Since 2017, it has been developing to be a One Day Surgery center, which is being planned to be a training center in the future.

This site visit will show the roles of UHC for the innovation of service such as ODS to solve the problems of long waiting-list of surgery and over-crowding in hospitals and this innovation will be developed to be covered in the national benefit package. After the site visit, sightseeing at the River Kwai Bridge, the historical place during the World War II, will be provided.

SITE 7

UNIVERSAL HEALTH COVERAGE INVESTMENT AND MANAGEMENT TO ACCESS ORPHAN ANTIDOTES

Location : Ramathibodi Poison Center, Faculty of Medicine Ramathibodi Hospital, Mahidol University

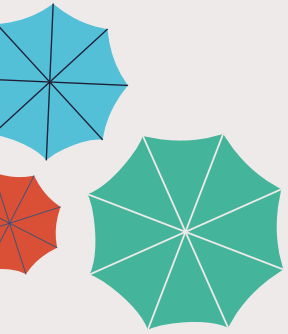
UHC scheme of Thailand has paid attention to the orphan drugs since this scheme was initiated in 2002. More than 10 years of implementation, concrete solutions have been used to save many patients' lives. Queen Saovabha Memorial Institute and Ramathibodi Poison Center are the examples of very good cooperation to solve this problem.

Queen Saovabha Memorial Institute has produced 4 orphan antidotes and all anti-venoms used in Thailand as well as exported these products to save lives of patients who are bit by venomous snakes in other countries under coordination with WHO.

Ramathibodi Poison Center provides accurately up-to-date information and counsel from professionals or hospitals for diagnosis 24 hours by hotline-1367. Ramathibodi Poison Center is a center of antidote database for the treatment of poisonings and can provide fast treatment for people who are poisoned. It also has a laboratory to check the poison level.

In January 2018, Ramathibodi Poison Center was able to save 2 Nigerians from Botulism by providing Botulinum Antitoxin from Thailand to the Federal Republic of Nigeria in a short period of time after receiving a request from Nigeria WHO Country Office, with coordination among Ramathibodi Poison Center, the National Health Security Office (NHSO, the Government Pharmaceutical Organization (GPO), and WHO Thailand Office. Since October 2018, Ramathibodi Poison Center has been a WHO Collaborative Center for the Prevention and Control of Poisoning.

This site visit will show how strong collaborative network among governmental organizations to secure orphan antidote access under Universal Health Coverage (UHC), a simulation case of poisoning management, and anti-venom/antidote production. You will also be excited by venomous snake handling and diverse poisonous animals in Thailand.



ANNEXES

Annex I International Organizing Committee Members
Annex II List of Scientific Committee Members
Annex III List of Speakers/Panelists, Chairs/Moderators and Rapporteurs
Annex IV List of Poster Presentation
Annex V List of Side Meetings and Special Events
Annex VI World Art Contest


FIRE EXIT

ANNEX I

PRINCE MAHIDOL AWARD CONFERENCE 2020

INTERNATIONAL ORGANIZING COMMITTEE MEMBERS

NAME – SURNAME	POSITION	ORGANIZATION	ROLE
Dr. Vicharn Panich	Chair, International Award Committee	Prince Mahidol Award Foundation, Thailand	Chair
Dr. Naoko Yamamoto	Assistant Director-General for Universal Health Coverage and Health Systems Cluster	World Health Organization, Switzerland	Co-Chair
Dr. Muhammad Ali Pate	Global Director for Health, Nutrition and Population	The World Bank, USA	Co-Chair
Mr. Abdoulaye Mar Dieye	Assistant Secretary General, Bureau for Policy and Programme Support	United Nations Development Programme, USA	Co-Chair
Ms. Henrietta H. Fore	Executive Director	United Nations Children's Fund (UNICEF), USA	Co-Chair
Ms. Winnie Byanyima	Executive Director	Joint United Nations Programme on HIV/ AIDS, Switzerland	Co-Chair
Dr. Osamu Kunii	Head, Strategy, Investment and Impact Division	The Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland	Co-Chair
Ms. Irene Koek	Acting Assistant Administrator, Bureau for Global Health	United States Agency for International Development, USA	Co-Chair
Dr. Roger Glass	Director, Fogarty International Center Associate Director for International Research	National Institutes of Health, USA	Co-Chair
Dr. Yasuyuki Sahara	Senior Assistant Minister for Global Health, Minister's Secretariat	Ministry of Health, Labour and Welfare, Japan	Co-Chair
Dr. Takao Toda	Vice President for Human Security and Global Health	Japan International Cooperation Agency, Japan	Co-Chair
Dr. Lincoln C. Chen	President	China Medical Board, USA	Co-Chair
Dr. Naveen Rao	Managing Director	The Rockefeller Foundation, USA	Co-Chair
Dr. David Harper	Senior Consulting Fellow, Centre on Global Health Security	Chatham House, United Kingdom	Co-Chair
Dr. Rintaro Mori	Regional Adviser (Population Ageing and Sustainable Development)	United Nations Population Fund, Thailand	Member
Mr. Anders Nordström	Ambassador for Global Health, UN Policy Department	Ministry for Foreign Affairs, Sweden	Member

NAME - SURNAME	POSITION	ORGANIZATION	ROLE
Dr. Damian Walker	Deputy Director, Data & Analytics, Global Development	Bill & Melinda Gates Foundation, USA	Member
Dr. Teo Yik Ying	Dean, Saw Swee Hock School of Public Health	National University of Singapore, Singapore	Member
Ms. Katie Dain	Chief Executive Officer	NCD Alliance, United Kingdom	Member
Dr. David Sanders	Chair	People's Health Movement, South Africa	Member
Dr. Kamran Abbasi	International and Digital Editor	British Medical Journal, United Kingdom	Member
Dr. Tim Mastro	Chief Science Officer	FHI 360, USA	Member
Mrs. Busaya Mathelin	Permanent Secretary	Ministry of Foreign Affairs, Thailand	Member
Dr. Sukhum Kanjanaphimai	Permanent Secretary	Ministry of Public Health, Thailand	Member
Dr. Supat Vanichakarn	Secretary General	Prince Mahidol Award Foundation, Thailand	Member

NAME - SURNAME	POSITION	ORGANIZATION	ROLE
Dr. Sakchai Kanjanawatana	Secretary General	National Health Security Office, Thailand	Member
Dr. Nopporn Cheanklin	Director	Health Systems Research Institute, Thailand	Member
Dr. Supreda Adulyanon	Chief Executive Officer	Thai Health Promotion Foundation, Thailand	Member
Dr. Banchong Mahaisavariya	Acting President	Mahidol University, Thailand	Member
Dr. Prasit Watanapa	Dean, Faculty of Medicine Siriraj Hospital	Mahidol University, Thailand	Member
Dr. Piyamitr Sritara	Dean, Faculty of Medicine Ramathibodi Hospital	Mahidol University, Thailand	Member
Dr. Suwit Wibulpolprasert	Vice Chair	International Health Policy Program Foundation, Thailand	Member
Dr. Viroj Tangcharoensathien	Senior Advisor	International Health Policy Program, Thailand	Member
Dr. Walaiporn Patcharanarumol	Acting Director, Global Health Division	Ministry of Public Health, Thailand	Member

NAME - SURNAME	POSITION	ORGANIZATION	ROLE
Dr. Tadayuki Tanimura	Technical Officer, Office of the Assistant Director-General, Universal Health Coverage and Health Systems	World Health Organization, Switzerland	Member & Joint Secretary
Dr. Toomas Palu	Advisor in Global Health	The World Bank, Switzerland	Member & Joint Secretary
Mr. Hakan Bjorkman	Regional Health Advisor/ Team Leader a.i. for Asia and the Pacific	United Nations Development Programme, Thailand	Member & Joint Secretary
Ms. Karin Hulshof	Regional Director, East Asia and the Pacific Regional Office	United Nations Children's Fund (UNICEF), Thailand	Member & Joint Secretary
Dr. Eamonn Murphy	Director, UNAIDS Asia Pacific Regional Support Team	Joint United Nations Programme on HIV/ AIDS, Thailand	Member & Joint Secretary
Dr. Aye Aye Thwin	Special Advisor, Office of the Assistant Administrator, Bureau for Global Health	United States Agency for International Development, USA	Member & Joint Secretary
Mr. Daisuke Oura	Special Officer for Global Health Development Policy Division International Bureau	Ministry of Finance, Japan	Member & Joint Secretary
Mr. Tsunenori Aoki	Senior Deputy Director, Human Development Department	Japan International Cooperation Agency, Japan	Member & Joint Secretary
Dr. Le Nhan Phuong	CMB SE Asia Regional Representative	China Medical Board, Thailand	Member & Joint Secretary

NAME - SURNAME	POSITION	ORGANIZATION	ROLE
Dr. Charlanne Burke	Associate Director	The Rockefeller Foundation, USA	Member & Joint Secretary
Dr. Jadej Thammatach-aree	Deputy Secretary General	National Health Security Office, Thailand	Member & Joint Secretary
Dr. Manee Rattanachaiyanont	Deputy Dean for Academic Affairs	Faculty of Medicine Siriraj Hospital, Mahidol University, Thailand	Member & Joint Secretary
Dr. Churnrurtai Kanchanachitra	Professor Emeritus	Institute for Population and Social Research, Mahidol University, Thailand	Member & Joint Secretary

ANNEX II

PRINCE MAHIDOL AWARD CONFERENCE 2020

SCIENTIFIC COMMITTEE MEMBERS

NAME – SURNAME	POSITION & ORGANIZATION	ROLE
Dr. Tangcharoensathien, Viroj	Senior Advisor, International Health Policy Program, Thailand	SC Chair
Mr. Aoki, Tsunenori	Director, Human Development Department, Japan International Cooperation Agency, Japan	SC Member
Mr. Baker, Peter	Senior Public Health Adviser International Decision Support Initiative (iDSI), Thailand	SC Member
Ms. Bhatia, Reeta	Senior Policy Adviser, Joint United Nations Programme on HIV/AIDS, Thailand	SC Member
Mr. Bjorkman, Hakan	Regional Health Advisor/Team Leader a.i. for Asia and the Pacific, United Nations Development Programme, Thailand	SC Member
Ms. Bornemisza, Olga	The Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland	SC Member
Dr. Bump, Jess	Lecturer on Global Health Policy, Executive Director of the Takemi Program International Health, Harvard T.H. Chan School of Public Health, USA	SC Member
Dr. Chunjongkonkul, Pisut	Internist, Office of Disease Prevention and Control 8, Nakhonsawan Province, Department of Disease Control, Ministry of Public Health, Thailand	SC Member
Dr. Collins, Tea	Advisor, World Health Organization, Switzerland	SC Member
Prof. Friberg, Peter	Co-founder and director, SIGHT, Sweden	SC Member
Dr. Guisset, Ann-lise J. M.	Coordinator a.i., World Health Organization, Switzerland	SC Member
Prof. Harper, David	Senior Consulting Fellow, Centre on Global Health Security, Chatham House, United Kingdom	SC Member
Dr. Hirabayashi, Kunihiko Chris	Regional Advisor, Health, Regional Chief of Health and HIV, UNICEF East Asia Pacific Regional Office, Thailand	SC Member
Dr. Isaranuwatchai, Wanrudee	Senior Researcher, Health Intervention and Technology Assessment Program (HITAP), Thailand	SC Member

NAME – SURNAME	POSITION & ORGANIZATION	ROLE
Dr. Kosiyaporn, Hathairat	Research fellow, International Health Policy Program, Thailand	SC Member
Dr. Kutzin, Joseph Douglas	Coordinator, Health Financing, World Health Organization, Switzerland	SC Member
Dr. Limwattanayingyong, Attaya	Director, Global Health Division, Ministry of Public Health, Thailand	SC Member
Dr. Mayurasakorn, Korapat	Family Physician, Researcher, Division of Molecular Medicine, Department of Research and Development, Siriraj Medical Research Center, Mahidol University, Thailand	SC Member
Mr. Mori, Rintaro	United Nations Population Fund, Asia Pacific Regional Office, Thailand	SC Member
Dr. Norizuki, Masataro	Deputy Director, Minister's Secretariat, International Affairs Division, Ministry of Health, Labour and Welfare, Japan	SC Member
Dr. Palu, Toomas	Advisor in Global Health, The World Bank, Switzerland	SC Member
Dr. Patcharanarumol, Walaiporn	Director, International Health Policy Program, Thailand	SC Member
Dr. Phuong, Le Nhan	CMB SE Asia Regional Representative, China Medical Board	SC Member
Ms. Renshaw, Nina	Policy and Advocacy Director	SC Member
Prof. Sanders, David	Chair, People's Health Movement, South Africa	SC Member
Dr. Saonuam, Pairoj	Director, Promotion of Healthy Lifestyle Section, Thai Health Promotion Foundation, Thailand	SC Member
Dr. Srinonprasert, Varalak	Head of Division of Geriatric Medicine, Siriraj Medical Research Center, Mahidol University, Thailand	SC Member
Dr. Tanimura, Tadayuki	Office of the Assistant Director-General, Universal Health Coverage and Health Systems, World Health Organization, Switzerland	SC Member
Dr. Thwin, Aye Aye	Special Advisor, Office of the Assistant Administrator, Bureau for Global Health, United States Agency for International Development, USA	SC Member
Dr. Vathesatogkit, Prin	Doctor, Lecturer, Faculty of Medicine Ramathibodi Hospital, Mahidol University, Thailand	SC Member
Prof. Yik Ying, Teo	Dean, Saw Swee Hock School of Public Health, National University of Singapore, Singapore	SC Member

WELCOME DINNER
& UHC CONCERT

ANNEX III

LIST OF SPEAKERS, PANELISTS, CHAIRS, MODERATORS, AND RAPPORTEURS

SPEAKER/PANELIST	CHAIR/MODERATOR	RAPPORTEUR
OPENING SESSION & KEYNOTE SPEECH		
Ralf F.W. Bartenschlager Ban Ki-moon David Mabey Dina Mired		Jaruayporn Srisasalux Benyapa Tancharoen Titiporn Tuangratananon
PLENARY SESSION 0 ACCELERATING PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE		
Anutin Charnvirakul Daniel Dulitzky Gaku Hashimoto Evalin Karijo Takashi Miyachi Anders Nordstrom Khuat Thi Hai Oanh Ariel Pablos-Mendez Naoko Yamamoto	Ashley McKimm	Worawit Boonyatistan Lyndah Kemunto Manoti Milin Sakornsin
PLENARY SESSION 1 IMPLEMENTATION CHALLENGES AND INNOVATIVE SOLUTIONS FOR UHC 2030		
Koku Awonoor Erica Di Ruggiero Beverly Ho Justin Koonins Takao Toda	Naoko Yamamoto	Jintana Jankhotkaew Sarayuth Khuntha Natnicha Manaboriboon Fonthip Watcharaporn

SPEAKER/PANELIST	CHAIR/MODERATOR	RAPPORTEUR
PARALLEL SESSION 1.1 REVITALIZING PHC – ASTANA AND BEYOND		
David Hipgrave Edward Kelley Tares Krassanairawiwong Belinda Nimako Rajeev Sadanandan	Beth Tritter	Christian Kraef Chompoonut Topothai Wit Wichaidit
PARALLEL SESSION 1.2 INVESTING IN THE HEALTH WORKFORCE FOR THE 21ST CENTURY		
Ayat Abuagla Donnela Besada James Buchan Sunil De Alwis Ann Keeling Tomas Zapata	Kumanan Rasanathan	Natthawut Adulyanukosol Audrey Fontaine Pritaporn Kingkaew Pyae Phyoe Kyaw
PARALLEL SESSION 1.3 ACHIEVING UHC THROUGH STRONG LOCAL HEALTH SYSTEMS		
Rudolf Abugnaba-Abanga Donna Capili Karin Hulshof Hajime Inoue Aye Aye Sein	Jennifer Requejo	Somtanuek Chotchoungchatchai Joe Tsurumi Sininard Wangdee
PARALLEL SESSION 1.4 ADDRESSING THE POLITICAL ECONOMY OF UHC		
Jesse Bump Beverly Ho Chalermsak Kittitrakul Jacqueline Kitulu	Gabriel Leung	Alex Ergo Karunpong Kitthanadol Sharon Low Kanyarat Vejjajiva

SPEAKER/PANELIST	CHAIR/MODERATOR	RAPPORTEUR
PARALLEL SESSION 1.5 ENSURING HEALTH PROMOTION AND DISEASE PREVENTION IN UHC		
Supreda Adulyanon	K. Srinath Reddy	Miwa Kanda
Edwine Barasa		Sirinard Nipaphorn
Manuel M Dayrit		Christopher Painter
Amirhossein Takian		Chanyapron Pengnorapat
Naoko Yamamoto		
Teo Yik Ying		
PLENARY SESSION 2 MAKING HEALTH FINANCING FOR UHC SAFE		
Lydia Dsane-Selby	Kara Hanson	Mayumi Okada
Holger Michiel van Eden		Patinya Srisai
K. Srinath Reddy		Waraporn Suwanwela
Yasuhisa Shiozaki		Aunyawan Thavinkaew
Agnès Soucat		
PARALLEL SESSION 2.1 MAKING AND USING (FISCAL) SPACE FOR UHC		
Marielle Bemelmans	Sheena Chhabra	Ayako Honda
Thant Sin Htoo	Ajay Tandon	Bawi Mang Lian
Joseph Kutzin		Vuthiphan Vongmongkol
Nathaniel Otoo		
PARALLEL SESSION 2.2 SMART HEALTH FINANCING – SEIZING DIGITAL OPPORTUNITIES		
Fahdi Dkhimi	Christoph Kurowski	Salin Amponnavarat
Monique Dolfing-Vogelenzang	Aye Aye Thwin	Elisabeth Listyani

SPEAKER/PANELIST	CHAIR/MODERATOR	RAPPORTEUR
Oliver Groene		Rungsan Munkong
Boonchai Kijsanayotin		
Alok Kumar		
Sonia Ancellin Panzani		
Marvin Ploetz		
PARALLEL SESSION 2.3 LEVERAGING STRATEGIC PURCHASING FOR UHC THROUGH STRENGTHENED GOVERNANCE		
Lydia Dsane-Selby	Caryn Bredenkamp	Han Win Htat
Loraine Hawkins	Grace Kabaniha	Apipat Wiriya
Jack Langenbrunner		Woranan Witthayapipopsakul
Jadej Thammatacharee		
Jin Xu		
PARALLEL SESSION 2.4 HEALTH FINANCING TRANSITIONS: THE ROLE OF DEVELOPMENT ASSISTANCE ON THE ROAD TO SUSTAINABILITY		
Midori De Habich	Sara Bennett	Katherine Bond
Bhavesh Jain		Emiko Ishikawa
Irma Khonelidze		Thura Koko
Justice Nonvignon		Bharadee Lalitkittikul
Toomas Palu		
Susan Sparkes		
Raminta Stuikyte		
PARALLEL SESSION 2.5 ASSESSING HEALTH INTERVENTIONS FOR A FAIR, EFFICIENT, AND SUSTAINABLE UHC		
Chhorvann Chhea	Teo Yik Ying	Nima Asgari-Jirhandeh
Stephanie Anne Lim Co		Abelardo Apollo, Jr. David
Erica Di Ruggiero		Sorawat Thananupappaisal
Walaiporn Patcharanarumol		
Kenji Shibuya		

SPEAKER/PANELIST	CHAIR/MODERATOR	RAPPORTEUR
PLENARY SESSION 3 UHC AND THE CHANGING GLOBAL LANDSCAPE		
Parry Aftab	Robert Yates	Aparna Ananthakrishnan
Carlos Correa		Cynthia Sin Nga Lam
Henna Dhawan		Aniqa Marshall
Montira Pongsiri		
Aquina Thulare		
PARALLEL SESSION 3.1 TACKLING CLIMATE CHANGE WHILE MAXIMIZING HEALTH IMPACT		
Betty Barkha	Anders Nordstrom	Omnia El Omrani
Diarmid Campbell-Lendrum		Piyawan Kanan
Ramon Lorenzo Luis		Thitiporn Sukaew
Rosa Guinto		
Andy Haines		
Maria Nilsson		
Sandhya Singh		
PARALLEL SESSION 3.2 ARTIFICIAL INTELLIGENCE AND DIGITAL HEALTH: OPPORTUNITIES AND RISKS		
Parry Aftab	Ashish Jha	Pornnapat Manum
John Wong		Akiko Nakagawa
		Nattadhanai Rajatanavin
		Jin Xu
PARALLEL SESSION 3.3 MAKING HEALTH SERVICES ACCOUNTABLE TO THE PEOPLE – A GLOBAL TREND?		
Rachel Cooper	Hakan Bjorkman	Mathudara Phaiyarom
Lorena Di Giano		Noppawan Piaseu
Edgardo Ulysses Dorotheo		Honey Win
Mariecar C. Mangosong		
Olga Stefanyshyna		

SPEAKER/PANELIST	CHAIR/MODERATOR	RAPPORTEUR
PARALLEL SESSION 3.4 SOLIDARITY & UHC – LEADERSHIP FOR CHANGE		
Ann Keeling	Justin Koonins	
Tomas Reinoso Medrano		Sigit Arifwidodo
Tracey Naledi		Seng Moon Aung
Sabrina Rasheed		Thitikorn Topothai
Ana Santos		
PARALLEL SESSION 3.5 MAKING GLOBAL TRADE POLICIES WORK FOR UHC		
Kalipso Chalkidou	Tenu Avafia	
Carlos Correa		Supapat Kirivan
Chalermsak Kittitrakul		Jiayun Koh
Ruth Lopert		Nicola Pocock
Rachel Silverman		
PLENARY SESSION 4 FROM POLITICAL DECLARATION TO REAL ACTIONS		
Mark Blecher	Phyllida Travis	Sunicha Chanvatik
Chieko Ikeda		Aya Ishizuka
Kaha Imnadze		Kasemsak Jandee
Vitavas Srivihok		Wan-ibtisam Masamae
LEAD RAPPORTEUR TEAM		
Anne Mills		
Walaiporn Patcharanarumol		
Viroj Tangcharoensathien		
Aquina Thulare		
Teo Yik Ying		
Rapporteur Coordinator		
Orana Chandrasiri		
Warisa Panichkriangkrai		
Payao Phonsuk		

ANNEX IV

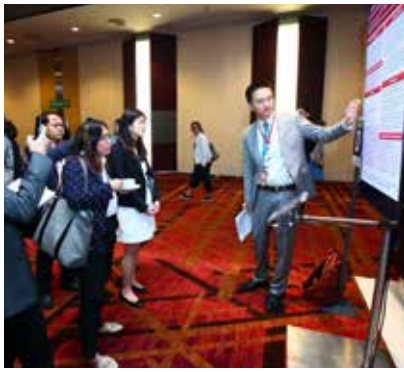
LIST OF POSTER PRESENTATIONS

ID	POSTER TITLE	AUTHOR
A01	Human Resource for Health Planning in Tribal Populated districts for Comprehensive Primary Health Care	*Narayan Tripathi*
A02	Health Systems Convergence and Universal Health Coverage: Role of Health Information Systems and lessons learned from conflict-affected areas in Myanmar	*Zaw Toe Myint*
A04	Access to Essential Medicines for UHC: Results of a study on availability of medicines in public health facilities in Central India	*Narayan Tripathi*
A05	Utilization of Maternal Health Services in Humanitarian Crisis: Findings from a study on Rohingya Refugees in Cox's Bazar, Bangladesh	*Nadia Farnaz*
A06	Including all migrants in Universal Health Coverage in Thailand: the Migrant Fund (M-FUND), a private low-cost, not-for-profit health insurance	*Nyunt Thein*
A07	Achieving universal health coverage for marginalized communities: lessons learnt from indigenous communities in south India.	*Mathew Sunil George*
B01	Challenges of anti-corruption research in LMICs: innovative approaches to research in Bangladesh	*Nahitun Naher*
B02	Demand and supply-side barriers and challenges in providing sexual and reproductive health services to Rohingya refugee women and adolescent girls in Bangladesh	*Nadia Farnaz*
B03	Community Engagement and Capacity Development of Stakeholders in Enabling Access to PHC Services by Rural Community People in Sudan	*Kei Yoshidome*
B04	Lessons from the field: Recasting Primary Health Care (PHC) – A Primary Health Care framework and roadmap design to strengthen local health systems to achieve Universal Health Care (UHC) in Northern Samar, the Philippines	*Marie T. Benner*
B06	Dual work and job satisfaction of primary healthcare providers in rural China: a cross-sectional mixed methods study	*Yinzi Jin*
B07	Assessment of Policy Initiatives on Rural Health Practitioner Cadre for Primary Health Care in Chhattisgarh state of India	*Narayan Tripathi*
B08	Affordable Essential Diagnostic Services to Achieve Universal Health Coverage: Should Governments Outsource them or Strengthen In-house Provisioning?	*Narayan Tripathi*
C01	Friends, not foes: public-private co-design in Senegal in pursuit of UHC	*Isseu Toure*
C02	Do rising administration costs threaten future shifts to private health insurance risk-pooling in Hong Kong?	*Jianchao Quan*

ID	POSTER TITLE	AUTHOR
C03	Using HBM and TRA model to predict intention to buy Social Health Insurance and to prevent boycott from Independent Workers in Depok City, Indonesia	*Dwi Oktiana Irawati*
C04	Who is using PhilHealth? Using segmentation to track social health insurance resources to broad patient populations	*Celina Ysabel Gacias*
C05	What attitudes and beliefs do ministries of finance have towards taxing tobacco to help fund universal healthcare?	*Jean-Luc Eisel*
C06	Exploring Opportunities for Tobacco Tax Reform for Sustaining National Health Insurance of Indonesia	*Ryan Rachmad Nugraha*
C07	Better understanding the issues around out-of-pocket spending in medicines: an analysis of medicines sales data in four South East Asian countries	*Lluis Vinals Torres*
C08	Sustainable health systems and sustainable markets: Assuring the quality of medicine in pursuit of UHC	*Steven Harsono*
D01	10 years of China's comprehensive health reform: a systems perspective towards universal health coverage	*Jin Xu*
D02	Impact of Free Annual Health Assessment to Improve Health Outcomes, Health-Related Quality of Life and Fill Preventive Care Service Gap of Working Poor in Hong Kong	*Caitlin Hon Ning Yeung*
D05	Access to Emergency Maternal Care Services in Backward regions – Potential of 'Strategic Purchasing' from Non-profit Providers to fill the gap	*Narayan Tripathi*

ID	POSTER TITLE	AUTHOR
D06	Facility-Based Intervention Costing for the 48 Highest Burden Diseases in the Guaranteed Health Benefits Package of the Philippine Department of Health and the Philippine Health Insurance Corporation	*Stephanie Anne Lim Co*
D07	UHC package expansion in Senegal: producing the cost evidence for a better planning	*Sophie Faye*
D08	Intervention Scoping Addressing the Top 48 Philippine Disease Burden	*Abigail Tan*
E01	National Health Insurance in Lao PDR: accelerating progress toward Universal Health Coverage	*Dasavanh Manivong*
E02	Expanding Social Health Protection in Cambodia: an assessment of the current coverage potential and gaps, and social equity considerations	*Robert Kolesar*
E03	The Limitation of the NHI system towards UHC and SDG: The case of contributions arrears in South Korea	*Sun Kim*
E04	The National Health Insurance Fund of Sudan: Sustainable Financing for Expanding & Deepening UHC	*Basit Yousif Ibrahim Salih*
E06	When publicly-funded health insurance schemes fail to provide financial protection: An indepth study of patients' experiences from urban slums of Chhattisgarh, India	*Sulakshana Nandi*
E07	Achieving the mortality reduction targets for SDG3: intervention financing and coverage requirements	*Rachel Nugent*

ID	POSTER TITLE	AUTHOR
E08	Questing for Sustainable Fiscal Space of Universal Health Scheme	*Theepakorn Jithitikulchai*
F01	Rethinking and re-measuring what causes health inequities and how to act: now and in the future	*Jessica Shearer*
F02	Strengthening health systems and preparing for pandemics in Ukraine through clinical decision support and online learning.	*Lalitha Bhagavatheeswaran*
F03	Broadening UHC beyond national boundary: a prerequisite to addressing the challenge of Tuberculosis and Migration.	*Wirun Limsawart*
F04	Using research for action towards achieving UHC and SDGs equitably: A case study among the Baiga Particularly Vulnerable Tribal Group in India	*Sulakshana Nandi*
F05	Deriving Lessons on Legislating Universal Health Care in the Philippines: a historical perspective	*Manuel Dayrit*
F06	Transforming health service delivery models in the Philippines supporting UHC through better hospital and health facility regulation: the role of regulatory impact assessment	*Katherine Ann Reyes*
F07	A Study on Factors Influencing Drug Prices Among National Public Hospitals	*Cheyenne Ariana Modina*
F08	Setting performance-based financing in the health sector agenda: a case study in Cameroon.	*Isidore Sieleunou*



ANNEX IV

LIST OF SIDE MEETINGS AND SPECIAL EVENTS

TITLE	ORGANIZATION
Ensuring effective access to essential medicines in Thai UHC	Health Systems Research Institute (HSRI); Thailand Ministry of Public health; Food and Drug Administration, Pharmacy Council; Thai Industrial Pharmacist Association and Thai Drug Watch
The EGAT study: impact of social disparity on health and ways to minimise it	Faculty of Medicine Ramathibodi Hospital, Mahidol University
People Purpose and Passion: The Pathway to success for RDU Country	Food and Drug Administration, Thailand; Faculty of Medicine Siriraj Hospital, Mahidol University; Health Systems Research Institute (HSRI), Thailand ; International Health Policy Program (IHPP), Thailand; International Society to Improve the Use of Medicine (ISIUM); Drug System Moni
People's Health Movement Steering Council – Primary Health Care and / or Universal Health Coverage: sustaining the vision	People's Health Movement (PHM)
3rd Experts Meeting on Collaboration for DRG Development and Reform in South-East Asia (SEA-DRG)	The World Bank; National Health Security Office (NHSO), Thailand
UHC X EndTB strategy: working together to End TB	Health Systems Research Institute (HSRI), Thailand; World Health Organization,Department of Medical Sciences, Ministry of Public Health,Department of Disease Control, Ministry of Public Health,
Making health financing work for UHC	World Health Organization (WHO) ; The World Bank; The Global Fund; The Gavi Alliance; The Global Financing Facility
Prince Mahidol Award Youth Program Conference 2020: Opening ceremony and PMAY Scholars Presentation	Prince Mahidol Award Youth Program; Faculty of Medicine Siriraj Hospital, Mahidol University; Faculty of Medicine, Chiang Mai University; Faculty of Medicine, Chulalongkorn University
Translation of Health Technology Assessment Research into Evidence-Based Policies and Actions towards Achieving Universal Health Coverage: Lessons Learned from Low and Middle Income Countries	Mahidol University: Faculty of Medicine Ramathibodi Hospital; Faculty of Medicine Siriraj Hospital; Faculty of Pharmacy; Faculty of Public Health; Faculty of Social Sciences and Humanities; Institute for Population and Social Research; Faculty of Graduate Studies
Investing in the Health Workforce towards UHC and SDGs: A Community-based Approach	Mahidol University GLO+UHC project under JICA and MOPH MOU ; WHO to Thailand; Better Health Project under the Prosperity Fund,UK ; ASEAN Institute for Health Development, Mahidol University; The International Federal Medical Students Association (IFMSA).

TITLE	ORGANIZATION
No UHC without Migrant Health Coverage: Leaving No Migrant Behind	International Organization of Migration (IOM); United Nations; University International Institute for Global Health; Asia Pacific Observatory for Health Systems and Policies; Asian Development Bank; International Health Policy Program; Joint UN Initiative on Migration and Health in Asia (JUNIMA)
Working together for better health internationally: the UK's Global Better Health Programme	British Medical Journal UK Foreign and Commonwealth Office
Two Giants Go Universal: India and Indonesia on the Path to UHC	The World Bank; National Health Authority (India); HSTP India
Private sector funds for private sector health – a feasible strategy to increase access to health care?	United States Agency for International Development (USAID); Sustaining Health Outcomes through the Private Sector (SHOPS) Plus (USAID-funded project)
Helping decision makers access (and use) the evidence: the role of regional health observatories in sharing tools for UHC	Asia Pacific Observatory on Health Systems and Policies European Observatory on Health Systems and Policies; African Observatory on Health Systems and Policies
Retaining rural health workers: lessons from the field	World Health Organization (WHO); IHPP Thailand
A Bottom-Up Approach to Advancing UHC: Voices, Stories, Opportunities	CMB Foundation Equity Initiative

TITLE	ORGANIZATION
Accelerating progress to UHC in diverse contexts: Learning from levers of policy recognition and investment in family and child health and wellbeing	United Nations Population Fund (UNFPA); Training and Research Support Centre (TARSC)
In Memory of Dr. Sanguan Nittayaramphong: No one left behind in practices: Accelerating Progress of Universal Health Coverage (UHC)	National Health Security Office (NHSO); Thailand Heart to Heart Foundation; The Partnership Project for Global Health and Universal Health Coverage: JICA GLO-UHC Project
Attain & Sustain Health Gains: Incorporating Value-For-Money in the Universal Health Coverage (UHC) Dialogue	Health Intervention and Technology Assessment Program (HITAP), Thailand
Public Healthcare Delivery Models and Universal Health Care: Lessons from Country Experiences	People's Health Movement (PHM)
Stronger collaboration with private sector for better UHC	Japan International Cooperation Agency (JICA); National Health Security Office, Thailand; Ministry of Public Health, Thailand; International Health Policy Program,GLO+UHC project
Working with the Private Sector to Improve Service Delivery	United States Agency for International Development (USAID) Support for International Family Planning and Health Organizations 2 (SIFPO2) (USAID-funded project)
Leaving no woman, no child, no adolescent behind in efforts towards universal health coverage: the evidence	Countdown to 2030 for Women's, Children's and Adolescents' Health Partnership for Maternal, Newborn and Child Health





SIDE MEETINGS

TITLE	ORGANIZATION
Learning through partnerships to build stronger health systems to deliver UHC and respond to NCDs - Experience from Mexico, South Africa, Malaysia, Philippines and Thailand	Public Health England UK Foreign and Commonwealth Office
Reaching those furthest behind in the post-UN High-Level Meeting on UHC	The World Bank International Health Partnership for UHC 2030 (UHC2030); World Health Organization (WHO); Civil Society Engagement Mechanism for UHC2030 (CSEM)
For the Win-Win! Harnessing the Private Sector for UHC through Smart Policy	United States Agency for International Development (USAID); Health Policy Plus Project (USAID Funded Project)
Power of Social participation: a key contributor towards UHC and Sustainability	National Health Commission Office; World Health Organization; National Health Security Office; UHC2030,Social Participation Technical Network
Transforming health service quality for UHC: a focus on basic water, sanitation and hygiene (WASH) in health care facilities	World Health Organization (WHO); WaterAid; National Institute of Public Health, Cambodia
Dermatology and UHC: Thailand's Experience and Contribution to the World	Japan International Cooperation Agency (JICA); Institute of Dermatology, Thailand (IOD)
The Role of Digital Health in Achieving Universal Health Coverage	ACCESS Health International FHI 360
The role of the private sector in accelerating progress towards UHC	World Health Organization (WHO); National Center for Global Health and Medicine, Japan (NCGM)

TITLE	ORGANIZATION
Ageing and elderly care: experiences of countries in Asia and Latin America	Japan International Cooperation Agency (JICA)
Stakeholder Consultation: Reformulating Japan's Global Health ODA to Meet Changing Global Needs	Japan International Cooperation Agency (JICA); Japan Center for International Exchange (JCIE)
Leaving No One Behind in Achieving UHC : Challenges and Solutions to Reaching Vulnerable Populations (tentative)	Japan International Cooperation Agency (JICA); Johns Hopkins University/Health Systems Program; Institute for Global Health Policy Research (iGHP); National Center for Global Health & Medicine (NCGM); Waseda University
Human Resource Development for Health toward establishing UHC	National Center for Global Health and Medicine
Pathways to Sustainable Health Financing towards Achieving UHC -Practical experiences from Cambodia, Kenya, Sudan and Thailand	Japan International Cooperation Agency (JICA); Participating Countries: Cambodia, Kenya, Sudan, Thailand, etc
From commitment to action: private sector engagement for UHC	UHC2030 World Bank; World Economic Forum
Primary Health Care Measurement and Improvement to Accelerate Progress toward UHC: Examples of Country Leadership	The World Bank; UNICEF; Primary Health Care Performance Initiative (PHCPI)
Towards a diverse, sustained health workforce for all: Approaches, evidence, and best practices	United States Agency for International Development (USAID); Chemonics International,Human Resources for Health in 2030 Program (HRH2030); Frontline Health Workers Coalition

TITLE	ORGANIZATION
P4H – the global Network for health financing and Social Health Protection	P4H network - coordination Desk WB WHO
UHC and Vertical Health Programmes: HIV, TB and Malaria: Entry points in the face of fragile primary health care & absence of an UHC roadmap	Joint United Nations Programme on HIV/AIDS (UNAIDS); JICA; Stop TB; Global Malaria Program; ADB
Leveraging and Sustaining Gains on HIV to Support UHC	United States Agency for International Development (USAID)
From capital to clinic to community: learning from each other to identify solutions to improve the implementation of UHC and PHC policies	Bill & Melinda Gates Foundation; PATH
What the public wants: Quality at the forefront in Cambodia's journey to UHC by 2030	FHI360
Empowering UHC through population-based health promotion	Thai Health Promotion Foundation; Thailand International Network of Health Promotion Foundations (INHPF)
Digital Innovations for Health Supply Chain Management at Scale - The Success Story of India	United Nations Development Programme (UNDP)
Accelerating progress towards UHC by promoting South-South partnerships on Social Health Protection	International Labour Organization (ILO) ASEAN Institute for Health Development (AIHD)
Towards the Universal Health Coverage in Southeast Asia: What Can We learn from Key Areas of Health Systems Reforms in Indonesia, Malaysia, the Philippines, Thailand, and Vietnam?	Faculty of Medicine Ramathibodi Hospital, Mahidol University; Harvard T. H. Chan School of Public Health; Harvard University's Asia Center

TITLE	ORGANIZATION
Supporting migrant mothers and children in the anthropocene through UHC	Ministry for Foreign Affairs, Sweden; SIGHT; WHO's Alliance for Health Policy and Systems Research; UNICEF; Public Health Agency of Sweden
From UHC Political Commitments to Reality Ensuring Accountability for Progress, Ensuring Accountability for Equity	The Global Fund to Fight AIDS, Tuberculosis and Malaria; Expertise France / Initiative 5 % ; APCASO
When you can't have it all: How to prioritize health financing for UHC in Africa	International Decision Support Initiative (iDSI)
Prince Mahidol Award Youth Program Conference 2020: Cognitive Assessment for Dementia From Detection to Care: Thailand and USA Experience	Prince Mahidol Award Youth Program; Faculty of Medicine Siriraj Hospital, Mahidol University; The Dementia Association of Thailand; Thai Society of Gerontology and Geriatric Medicine; Department of Medical service, Ministry of Public Health
Prince Mahidol Award Youth Program Conference 2020: Strengthening UHC through health literacy programs	Prince Mahidol Award Youth Program; Faculty of Medicine,Chiang Mai University; Royal College of Family Physicians of Thailand; The General practitioner/Family physician association of Thailand
Prince Mahidol Award Youth Program Conference 2020: Evidence-Based Microbiome and Probiotics for Metabolic diseases	Prince Mahidol Award Youth Program; Faculty of Medicine, Chulalongkorn University
PMAC 2020 World Art Contest Award Ceremony	Prince Mahidol Award Conference

LIST OF SPECIAL EVENTS

Launch of Bulletin of the WHO,
Editorial Accelerating universal health coverage
Organized by
Prince Mahidol Award Conference,
World Health Organization

Joint launch of two new publications by the World Bank and WHO on implementing case-based (DRG) payments for health
Organized by
The World Bank, World Health Organization

Noncommunicable Disease Prevention:
Best Buys, Wasted Buys and Contestable Buys
Organized by
Health Intervention and Technology Assessment Program

Launch of a BMJ Collection
Reaching all women, children and adolescents with essential health interventions by 2030
Organized by
British Medical Journal,Partnership for Maternal, Newborn and Child Health (PMNCH) and Countdown to 2030: Women, Children and Adolescents

David Sanders
Celebrating His Contribution to Global Public Health
Organized by People's Health Movement

ANNEX VI

PMAC 2020
WORLD ART CONTEST

Bridging culture awareness and health awareness is the most important aspiration for the PMAC World Art Contest. For more than 8 years, a unique activity called the "Art Contest" was introduced to the Prince Mahidol Award Conference (PMAC). We believe that art is a universal language. The aesthetic expressions are magically able to illustrate complex "Health" concepts to easy understanding that connect us to a common goal.

The contest was open to everyone, with the aim of raising the awareness of the young generation in how their health is connected to their little families and through the entire World. Vice versa, the various new perspectives of a successful world where all people live better, happy, healthy and equitably from the young generation have been presented to our prestigious participants.

This year, the Prince Mahidol Award Conference invited students and all people to take part in the PMAC 2020 World Art Contest under the topic "Universal Health Coverage" through Drawings & Paintings and Community Art Project.

The project has received positive response nationally and internationally from young people, parents and schools. Out of 11 nationalities that participated, 697 entries were sent in, 135 young artists won the prizes (52 prizes worth over 436,500 Baht). The winners were invited to receive the award during PMAC 2020 on 30 January 2020, at

the Centara Grand at CentralWorld. The award ceremony event was a fulfilling and enjoyable experience for the winners and participants.

All the winning artworks were displayed during the conference. The display art pieces amazed most PMAC participants by their high quality artistic skill and creativity. We recognized the difficulties of many schools which support our program as well. Consequently, we introduced the "art contribution". The purpose was to provide financial contribution from our prestigious PMAC participants to schools which supported the art program for their students. The art contribution of winning art pieces from PMAC 2019 has raised 51,841.20 Baht and 11 schools were invited to receive 4,700 Baht each from PMAC 2019 art contribution.

The PMAC 2020 Art Contribution and Story Telling Exhibition project have raised 47,169.00 Baht (as of February 2020). Since the COVID-19 pandemic has had severe and widespread impacts on our world, this year the art contribution was donated back to the health workforce: Siriraj Foundation and Ramathibodi Foundation 20,000 Baht each, to provide assistance to this drastic global health situation.

DRAWINGS & PAINTINGS CATEGORY

UNDER 9 YEARS OLD

WORLD FIRST PRIZE
Kannaphat PREECHACHAN
Atidtaya PREECHACHAN

WORLD SECOND PRIZE
Patcharachanok JAKKABUT

WORLD THIRD PRIZE
Napatsadol UBOLKAEW
Natthanont SAKSIRIWUTTHO
Sipang SRIHIRUN
Prin SEPTHAM

WORLD HONORABLE MENTION PRIZE
Deeyada KARNJANA, Chonlanant NAMJANDEE,
Nanthida LAKSANASRI, Panatchanan KERDSRI,
Thanit CHANGWONG, Adithep KATHANEPA,
Chonlanat NAMCHANDEE, Praewa TATHADUANG,
Kittikarn WONGSIRI, Reangyot YOMMANEE

WORLD YOUNG ARTIST RECOGNITION
Aimmika BOONSAWAT, Pornpisut CHAROENPITTAYA,
Pakinpong SIRIJAROENPANITCH,
Rangbandanjai SATJAWIWATNGAM,Reev Al SIRE,
Nusaira JAHAN HAQUE,Zabreen SIDDIQUE,
Nahatai LAOPRASOPWATTANA,
Pitchaya LAOPRASOPWATTANA,
Thananchanok SUKMA, Kunanya WETJARUS,
Dujyada KOTHISEN, Korranun TATTINAPANIT,
Veerathon TENGSIRIKUL, Chidchanok INTHARAT,
Pichamon KATBORROM

9-13 YEARS OLD

WORLD FIRST PRIZE
Siriwimul PRANGPHET
Sudatip KANJANAWIWIN

WORLD SECOND PRIZE
Prawpitcha KETKRATHOK
Chanida BOURMADUN
Napasrapee TANGKRATHOK

WORLD THIRD PRIZE
Sirirach RATTAMANEE

HONORABLE MENTION PRIZE
Chanita THIRATRAM
Chanida THIRATRAM
Sadanan THIANKATHOK
Thanawat JOEMWATTHANA
Nichapa SONGPHASUK
Sarinthip VONGWAIRAT
Watchara THONGSONGKHRAM
Wichaya SAENGNON
Khunnaphat CHOUYKEOT

YOUNG ARTIST RECOGNITION PRIZE
Zarin SUBAH
Nunnalin NUNDUN
Nunthida SOMNUEK
Ketsuda KIANGSRI
Supidsara PASANPOT
Thanva LUEAKLANG
Surasri JURBRUM
Natthaphong TOMKRATHOK

14-17 YEARS OLD

WORLD FIRST PRIZE
Kittitouch PALAKLANG
Sorrawich SAKULPEEB

WORLD SECOND PRIZE
Thanabadee LAMUNPAND

WORLD THIRD PRIZE
Natthanan DETMONGKOLWATTHANA
Kritsada THONGRAKSA
Geatsuda TANTHAKITWATTHANA
Thinnakorn THINKRATHOK
Panukron DOURGKRATHOK
Ketvarin TANKRATHOK

HONORABLE MENTION PRIZE
Woranan CHURJAI
Papitchaya SANGNAK
Anchana THAMMAKHANTHA
Nattanan JITAREE
Pannapach KEEREEDEJ
Papitchaya PAKAWAN
Chantakan HANPICHANAN

YOUNG ARTIST RECOGNITION PRIZE
Nicha LUKANAPACHUENGUL
Adeena HASAN
Nannapat KUIKLANG
Nannanin RUEANGYOUNGMEE

18-25 YEARS OLD

WORLD FIRST PRIZE
Wigavee RATTAMANEE

WORLD SECOND PRIZE
Jongruk SOMBOON

WORLD THIRD PRIZE
Porndanai WATTANAPRADITCHAI
Unchalika KEAWJAN

HONORABLE MENTION PRIZE
Sariti PARNMONGKOL
Ploychompoo JUABRERKYEN
Katanyu WATTANAPRADITCHAI
Maneerat RATTANASUPHA

YOUNG ARTIST RECOGNITION PRIZE
Suphakorn PHANWONG
Tiwtus KANAMA

COMMUNITY ART CATEGORY

WORLD FIRST PRIZE

BELIEVE2 = BEAUTIFUL HEALTH
Connecting Cultural Beliefs and Modern Medicine
though DIY Stethoscope and Litmus Paper
Location: Mountainous Makhampom Village, Akha minority community, Chiang rai

TEAM
Takoeplabpla Pittaya School, Chiangrai
Wimwipha YAWIRAI, Ekphawit PANYANA, Nuan KHOMAOI,
Tanwaa MAYH, Poramet CHOEMUE, Apisara BIANGLAE,
Soraya CHIMSEANG, Siraphatsorn DONCHAI,
Siriyagon DONCHAI, Kessara CHOEMUE, Duangnapa LUNGTANG

SUPERVISOR
Chawengsak BOONKANIT, Piyaluk BOONKANIT,
Wanpen DONSRI

WORLD SECOND PRIZE

COLOR OF LIFE
Revitalizing the Public Space from Young Local Creatives to Community
Location: Nong Prajak public Park, Udonthani

TEAM
Bansillapa School, Udonthani
Sirayakorn SONGPHASUK, Atikan SANGSANANANT,
Chalita KONGSUWAN, Mingkaew SUBIN, Khunjira KHOTABUD,
Thapana SAPPHAKITKAMCHORN, Kanyapat CHAIMANETED,
Greenrat WATCHARAPHONGCHARAT, Chaimongkol TREEWATANASUWAN,
Chanidpreeya TIEWSIRISUP, Sutinan RAMJABOG,
Kueaphon CHEEWARUNGRUANGKUL

SUPERVISOR
Narunart JOEMWATTHANA, Sataporn SOMASRI

HONORABLE MENTION PRIZE

ART IN SPACE
Building Art Sculpture through Sharing Health Experiences
Location: Thai-Japan Bangkok Youth Center, Bangkok

TEAM

School of Architecture and Design (SoA+D) KMUT
Nahathai BOONTAE, Nannapas KATEWONGVEERACHART
Tantika SINGKAEW, Pongpat POLSORN,
KIttapong CHONGTRAKUL

SUPERVISOR
Teerayut MONGKONAUTASAN

YOUNG ARTIST RECOGNITION PRIZE

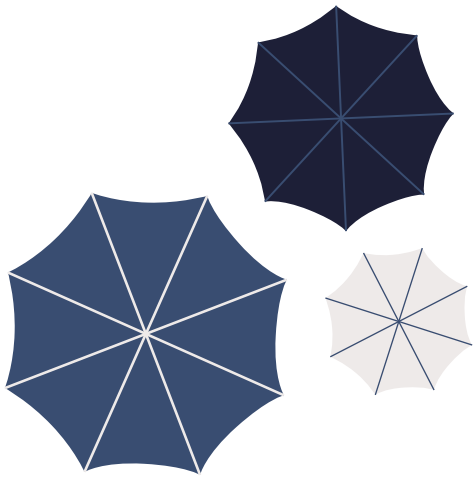
WANDERLUST
Creating relaxing activity for Wanderlusts T-Shirt Painting Workshop
Location: Bang Sue Railway Station, Bangkok

TEAM

Fine Arts Department,
King Mongkut's Institute of Technology Ladkrabang
Watcharin DEDDAUNG, Agarat CHUKAEW
Tanat PALAKUL, Chonticha SEASIM, Witchada LAKSAMAN,
Rachen SEMSOMBUN, Prapan PINMORA, Titikan YUSAMRUN,
Satanan WETCHAPRAMN, Agarat CHUKAEW,

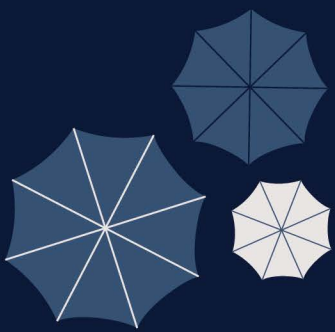
SUPERVISOR
Komsan NOOKIEW


PMAC 2020 | UHC Forum 2020
ACCELERATING PROGRESS TOWARDS UHC
28 JAN - 2 FEB 2020 I BANGKOK, THAILAND



PMAC 2020
UHC Forum 2020

ACCELERATING PROGRESS TOWARDS UHC



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