layperson could be more influential and less threatening in changing students’ and teachers’ practices.

This option raises implications for resourcing. With schools increasingly employing nurses, social workers, and school counsellors, is there potential to employ youth workers, health promoters, or cultural support workers to enhance school wellbeing? Could these non-teaching staff lose their ability to challenge the status quo in schools if they become internal employees with teachers as their managers? Careful negotiation of these roles and management will be needed to ensure the legitimacy of their roles as part of the school environment while maintaining their independence and ability to challenge.

Third, there are several aspects that require further development and evaluation. For example, can the programme be enhanced to improve areas that were relatively resistant to change—eg, aggressive behaviours and perpetration of bullying in the INCLUSIVE trial? What might explain the different effects by gender in these trials, and to what extent might intervention effects vary by age, ethnicity, religion, or other differences?

Finally, some school health promotion messages can appear incongruous, and be less effective, in the context of wider societal norms. About 720 million school-aged children live in countries where corporal punishment at school is not fully prohibited. Although they found favourable effects on drinking, the investigators of the INCLUSIVE trial suggest that the lack of effect on sexual health could be due to these behaviours typically occurring outside school. The difficulties in improving sexual health might lie in social taboos and cultural norms that prevent open and honest discussions with adolescents about relationships, consent, and safer sexual behaviour without resorting to shaming or use of scare tactics.

Notwithstanding issues that require further attention, both trials provide compelling evidence to target investments and resources to enhance school environments as a social determinant of health amenable to modification.

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A global accountability mechanism for access to essential medicines

Access to affordable, quality-assured essential medicines is a prerequisite for effective universal health coverage. Efforts to ensure comprehensive access to essential medicines have been hindered by a dearth of information. Most monitoring efforts have focused on measurement of a prespecified list of essential medicines in health facilities. Measures of affordability in private and public health facilities have relied on periodic surveys, usually by non-governmental organisations (NGOs) or academia. The quality of medicine products
and of prescribing practice, as well as patients’ use of essential medicines, have been assessed even less often. Pharmaceutical expenditure in the public and private sector is not prioritised in national systems, and is rarely reported. Without systematic data reporting on national pharmaceutical expenditure, there is a lack of attention to access to essential medicines in major reports such as the World Health Statistics. The 2015 Millennium Development Goals Task Force report concluded that tracking progress on access to essential medicines was impossible, given the absence of country-level data.

When target measurements are used to improve access, a robust monitoring and accountability system is needed—eg, the three-step framework recommended by Paul Hunt, former UN Special Rapporteur on the Right to Health, that involves appropriate collection of data, independent review, and the necessary corrective action. The Lancet Commission on Essential Medicines Policies made an initial proposal for such a framework. Independent review and corrective action are important components of an accountability mechanism, as shown by UNAIDS’ HIV progress reports and work in reproductive, maternal, newborn, child, and adolescent health.

Members of the Lancet Commission on Essential Medicines Policies and WHO have discussed options for such a framework. A global accountability mechanism for monitoring access to essential medicines must take account of major global trends—eg, strengthening patient-centred primary health care; efficient country-led horizontal health systems, including prevention and treatment of non-communicable diseases; systems of risk-sharing, pre-payment, and social health insurance; and greater attention to the quality of care, the quality of health products, the skills and attitudes of health workers, and cost-effective treatment. Civil society is also demanding better data collection, transparency, and systems of accountability to promote equity and good governance.

The focus of accountability should move away from measuring only availability of medicines towards the effectiveness, quality, and efficiency of patient-centred comprehensive primary care services, which encompasses equitable access to essential medicines. To advance this agenda, indicators are therefore needed that are sensitive to differences in access on the basis of gender, ethnicity, education, residential location, and wealth quintile. WHO has already provided resources to assist national programmes in applying an equity lens. Under the aegis of WHO, medicine access indicators should now be developed in close collaboration with member states, academia, and civil society, consisting of a small set of screening indicators supported by more detailed diagnostic and progress indicators.

Further high-level discussions between WHO, the Lancet Commission, other UN agencies, and NGOs have led to the identification of four priorities to ensure the development of a global Accountability Mechanism for Access to Essential Medicines (abbreviated as 2A2M). First, high-level political support is needed through the definition of the accountability structure and operating mechanisms, taking into consideration the roles and responsibilities of national governments, academic partners, and civil society. Second, the strategic generation, analysis, and use of prioritised data for decision making is vital, with a strong focus on national capacity building and leveraging existing technical support programmes. Third, technological advances in data collection must be adopted, building on the principles of the Health Data Collaborative and existing data platforms and recognising variability in national digital maturity. Finally, global advocacy is needed to ensure the engagement of all relevant technical and financial contributors at national and international levels.
A global accountability mechanism for access to essential medicines that is nationally applicable and feasible will take several years to achieve. However, experiences in HIV and reproductive, maternal, newborn, child, and adolescent health have shown that it can be done, provided a clear political mandate and the necessary financial and technical resources are ensured, together with country leadership and the engagement of civil society and academic institutions.


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Harnessing the value of NHS patient data

In April, 2018, the House of Lords Select Committee on artificial intelligence released AI in the UK: Ready, Willing and Able?, a report about the opportunities and benefits of embracing artificial intelligence in the UK.1 The report describes patient data in the UK’s National Health Service (NHS) as a “unique source of value for the nation”.1 But who controls these data and how best to harness the commercial value of patient data are controversial topics for politicians and health-care providers. Survey-based and focus group research suggests patients are uncomfortable with their data being used by industry but are comfortable if anonymised health data can be used to improve the health system or for public benefit.2 Patients are also concerned about the potential for their data to be used by insurance companies or in situations where it might result in data-driven discrimination.2

The potential for digital technology to transform health care is well documented, but as companies race to develop the next algorithm, much of their success rests on their ability to access patient data. Use of NHS patient data in the UK is a complex issue. There are different uses to which data might result in data-driven discrimination.2


For the NHS Data Protection and Security Toolkit see https://www.dpptoolkit.nhs.uk/K1(Q3cmjyicn6qmwmxb))/AspxAutoDetectCookieSupport=1

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