Technical consultation on the selection of health products

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Written by Sian Lewis.

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Acronyms and abbreviations

- **APL**  Priority Assistive Products List
- **EML**  WHO Model List of Essential Medicines
- **EDL**  WHO Model List of Essential In Vitro Diagnostics
- **LMICs** Low- and middle-income countries
- **PMD**  Priority Medical Devices List
- **NCD**  Noncommunicable disease
- **SDG**  Sustainable Development Goal
- **SOP**  Standard operating procedure
- **UHC**  Universal health coverage
- **WHO**  World Health Organization
Executive summary

Having national lists of essential health products helps countries use funds efficiently and focus their procurement, production and delivery efforts on the safest and most effective products to meet the most important needs in their health systems.

But how do countries decide what products should go on their lists? To support them in selection, WHO maintains four model lists:

- List of Essential Medicines;
- List of Essential Diagnostics;
- Lists of Priority Medical Devices; and
- Priority Assistive Products List.

In January 2019, WHO consulted stakeholders on how these lists are used and how they might be improved. Through an online survey and expert meeting, stakeholders reviewed each list, identified strengths and weaknesses, and suggested improvements.

They identified several benefits of using the lists, including more trust in national selection processes among stakeholders, stronger budget allocation, and more streamlined policies and processes. But they also pointed to several practical challenges, such as diversity of context across countries, limited local data on clinical value and cost-effectiveness of list items, lack of resources for developing or implementing a national list, and poor accessibility of the WHO lists.

One of the biggest barriers to use, particularly among the newer lists of diagnostics, medical devices and assistive products, is a lack of awareness, both at an operational level as well as at a ministerial level, within and beyond the health sector. A lack of integration across the lists—in nomenclature, timing, communications and information exchange—was also cited as a major barrier to use.

Through the survey and in-person meeting, stakeholders discussed priorities for improvement. From their deliberations emerged ten broad suggestions (each with a sub-set of suggested actions). These are summarized in Table 1 opposite and listed in full in Part III below.

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Part I. Background

About the selection tools

WHO maintains several ‘selection tools’ to support Member States to increase access to safe and affordable health products. These include:

- the WHO Model List of Essential Medicines (EML);
- the WHO Model List of Essential In vitro Diagnostics (EDL);
- the WHO Lists of Priority Medical Devices (PMD); and
- the WHO Priority Assistive Products List (APL).

These lists are designed to help promote policies and technical capacities that can guide health systems to expand access to health products, while delivering these safely and cost-effectively. Countries can use these ‘model’ lists to develop their own national lists, considering local contexts and cultures, and guide product development, production, service delivery, market shaping, procurement, and reimbursement policies (including insurance coverage).

Each list aims to help countries use funds more efficiently by getting them to focus on those products needed to diagnose, treat or manage the most common health conditions as well as the top global priority diseases. While the lists may be useful for all countries, they are particularly aimed at supporting decision making in the resource-constrained settings most commonly found in low- and middle-income countries (LMICs).

A technical consultation

In January 2019, to find out whether the selection tools are fit for purpose, WHO consulted Member States on how they use the model lists and how these might be improved. The consultation focused on finding ways to strengthen the lists’ practical use and to harmonize strategies and approaches across them. It comprised of two components:

1. an open online survey of Member States to collect data on country and stakeholder awareness and use of the lists; and
2. a meeting of participants with broad ranging expertise, held in Geneva, to identify ways of improving each list and shaping alignment across them.

The objectives of the combined consultation were to:

- Understand how the different selection tools are used by Member States; and what the main barriers to use are.
- Improve processes by which products are considered for investment and disinvestment.
- Promote collaboration, information and knowledge exchange to support country decision making processes on coverage of essential health products.

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List of Essential Medicines

- Launched in 1977; updated every two years.
- Comprises 433 medicines, targeting conditions such as malaria, HIV, tuberculosis, cancer, diabetes and hepatitis C.

List of Essential In vitro Diagnostics

- Launched in 2018; updated every year.
- Comprises 62 test categories.
- Includes 35 tests for common conditions; and 27 tests for ‘priority’ diseases.

Lists of Priority Medical Devices

- Concept launched in 2010, first lists in 2015.
- Multiple lists cover different populations and conditions. Includes 1500+ devices in different categories.
- The 2017 Global Atlas gives global status on national lists.

Priority Assistive Products List

- Launched in 2016; updated every 4 years.
- Comprises of 50 products, covering 6 domains: vision, hearing, mobility, self-care, communication, and cognition.
Part II. WHO lists in practice

About national lists

We know that many countries have their own national lists of essential health products, in some form or other. For example, the WHO repository of national EMLs includes lists from 140 countries around the world. And the 2017 Global Atlas of Medical Devices shows that nearly 100 countries also have national lists of medical devices for different types of healthcare facilities (with a few more holding lists for specific procedures, and a few less holding lists for procurement). The content of both types of lists can vary significantly from country to country, as can their implementation.

National or other lists of laboratory consumables and in vitro diagnostics are also common and tend to vary in scope and use. On the other hand, few countries have a policy or programme on national assistive technology, and only a handful use a national APL.

The online survey findings echoed the emphasis on medicines and medical devices compared to assistive products (see Figure 1). This disparity is to be expected: the EML has had more than four decades to embed itself into country selection processes, while the other lists have only been around for a few years. The APL, for example, is barely two years old, while the EDL is less than a year old.

Figure 1. Survey findings to the question 'Does your country have a national list?' (114 total survey respondents)

How countries use WHO lists

Almost half the survey respondents did not know whether their country used WHO model lists to inform the development of their own national lists. But many different country participants at the Geneva meeting did know; and they shared their experience of using the WHO model lists with participants. Country experience fell into three main categories:

1. Countries using the WHO lists as a starting point
The WHO model lists are intended to serve as a broad guide for developing national lists, and many countries use them in this way, taking the model lists as a starting point and adapting them to their own contexts. Some countries have established their own parallel structures for reviewing evidence and budgetary impacts of WHO decisions and updating their lists accordingly. Others leverage WHO support to analyse their healthcare sector, develop recommendations and update their lists through a transparent process.
In all cases, both the process and result of developing a national list can be highly variable. In Africa, for example, 93% countries have a national EML: all used the WHO model list to build them, but they have used different criteria for selection and their final content varies.

2. **Countries using the WHO lists as they come**

Many countries do not have the capacity to do their own evidence reviews or even to gather the local data needed to contextualize the model lists and so they use the lists exactly as they come. But most countries cannot afford everything on the list so are faced with significant budgetary issues as they decide what to leave in and what to leave out. For WHO, this highlights the need for further messaging on whether the lists represent a floor or an aspiration, and due consideration to the idea of categorizing or prioritization items on the lists into “need to have” versus “nice to have”.

3. **Countries not using the WHO lists**

Some countries develop their own national lists of essential health products with no regard for the WHO model lists at all. This is particularly true for the more recently established EDL, APL and lists of priority medical devices.

There are many different reasons why countries do or do not use the WHO model lists. The consultation sought to understand these by identifying the strengths and weaknesses of the different lists and sharing experience of the benefits and challenges of using each.

**Strengths and benefits**

Respondents to the online survey assessed key aspects of use by agreeing or disagreeing with seven pre-defined statements about the four WHO lists (see Annex 1). Results were relatively consistent across different lists (see Figure 2). The most commonly agreed with statement was that the lists are easily accessible on the website. Other strengths identified through the survey were the lists’ recommendations—which most respondents agreed were both clear and useful for decision processes—and their ability to address populations’ needs.

*Figure 2. Strengths of the different model lists identified through the online survey (Based on largest proportions of respondents agreeing with statement, excluding those who did not answer).*
The discussion at the Geneva meeting, which was not restricted to assessing pre-defined characteristics, pointed to a different set of strengths and benefits. Meeting participants highlighted five key ways in which they have found WHO model lists to be useful, as outlined below.

1. **The WHO brand lends authenticity and validation.** Several participants spoke about the value of using a list that has the WHO brand behind it as a way of ensuring that selection has a defined methodology and is objective, and of increasing trust among stakeholders (particularly within the media and private sector) in the national process. This is particularly true for the EML, which has been validated over four decades, and as such, has established its own sub-brand that engenders trust.

2. **The process of selection builds trust.** Across all four lists, the process of selection itself, which is both transparent and evidence-based, was cited as a major benefit and a key builder of trust among national stakeholders.

3. **Model lists help streamline existing tools.** This is particularly true of the newer WHO model lists, such as EDL. Many countries already have different policies, plans and guidelines in place to guide and facilitate laboratory work, including lists of in vitro diagnostics. But these vary significantly and have variable impact on access. Several speakers spoke about their expectation that the EDL will help streamline and build on existing tools to improve accessibility.

4. **Having a model list influences allocation of budget.** In some countries, use of the newer model WHO lists (particularly the APL) has enabled stakeholders to argue for, and secure, part of the health budget and so improve the provision of products.

5. **Other stakeholders use the lists for advocacy and action.** Civil society and nongovernment organizations have a major role in supporting access to health products, for example by pushing for lower prices. And several participants highlighted how these groups rely on the WHO model lists to inform and direct their efforts to ensure essential health products can be included on national lists.

While individual speakers tended to focus on their experience with one list, it was clear from the discussion that most of the benefits identified could apply across all four lists.

**Key challenges to use**

While participants at the Geneva meeting broadly acknowledged that using the WHO model lists are beneficial in theory, many also argued that in practice, using the lists can be a major challenge.

Perhaps the greatest barrier to use, particularly among the newer lists, is a **lack of awareness**, both at an operational level as well as a ministerial level, within and beyond the health sector. In some countries, the responsibility for providing medical devices or assistive products lies with other departments, such as social services, whose staff are unfamiliar with the model lists and so do not use them. In others, even though the responsibility for providing these products lies within the health division, the products themselves are consumables and so are not procured consistently.
The survey results support the concerns about lack of awareness of the newer lists. Asked directly about the four lists, only 37% of respondents said they were familiar with the APL, compared with 80% awareness of the EML (see Figure 3).

This lack of familiarity about the newer lists was further emphasized by the large number of respondents (approximately one-third) who did not answer specific questions about those lists, though this could also be explained by sampling and selection bias.

A lack of integration across the lists was also cited as a major barrier to countries’ use of the lists. So too was the disconnect with broader health priorities, including Sustainable Development Goal 3 (Healthy lives and well-being for all) and the push for universal health coverage (UHC), which significantly limits the lists’ appeal to high-level policymakers. Other practical challenges include diversity of context, limited resources and expertise and a lack of evidence on multiple fronts (see Table 1 overleaf).

While the list of challenges broadly applies to all the WHO model lists, speakers also drew on their experience of using individual lists to point to some of the specific challenges associated with each (see Figure 4).

“Only if we combine all four areas together can we support SDG 3.”
Table 1. Challenges and considerations identified by participants through discussion

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<th>Notes</th>
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<td><strong>Proof of impact</strong></td>
<td>At all levels, there is a lack of concrete evidence to show that using a national list increases access on the ground. Without more proof of impact, policymakers will remain unconvinced of the benefit of using WHO model lists.</td>
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<td><strong>Disconnect</strong></td>
<td>The WHO lists as a set suffer from a disconnect on two levels: First, is the disconnect across the different lists: they are promoted individually, follow individual processes and timing and use individually-defined terms and concepts. Second, is the disconnect between what the lists provide (four separate lists) and what policymakers want and need (a single comprehensive package for financing health). This will be addressed in the UHC menu and the health products for primary health care guidance.</td>
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<td><strong>Diversity of context</strong></td>
<td>The diversity of context across countries poses a broad range of individual challenges to adapting WHO lists, from coping with fragmented health systems in Latin America to tackling the environmental factors of small island developing states in the Western Pacific. Even within individual countries, the context for putting national lists into practice can vary significantly.</td>
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<td><strong>Implementation</strong></td>
<td>Even if countries know about the WHO lists, or have a national equivalent, they don’t always know how to put it into practice. Many participants emphasized the lack of guidelines available for operationalizing the lists.</td>
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<td><strong>Resources</strong></td>
<td>In practice, to effectively use the WHO lists, countries need resources—first for adapting the lists, then for implementing and maintaining them—which are not always available.</td>
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<td><strong>Broader infrastructure</strong></td>
<td>Practical utility of a national list to improve access ultimately relies on a country's broader health infrastructure, which countries may not yet have in place.</td>
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<td><strong>Local data</strong></td>
<td>Many countries have limited local data on clinical value and cost-effectiveness to draw on when deciding what medicines from the EML to include in their own national lists. There is even less local evidence available for other health products.</td>
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<td><strong>High-cost products</strong></td>
<td>High-cost health products on the lists pose a challenge to procurement, even if it is pooled. And for many countries, a small set of high-cost medicines that appear on a national list can end up dominating the budget even if they are not meeting a large public health need (for example, in the case of drugs for orphan diseases).</td>
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<td><strong>Length</strong></td>
<td>In the face of limited budgets, many countries argued that the lists are too long—both individually and as a group. Without a clear set of principles or guidelines to help prioritize the lists into a manageable set, the lists are of limited practical use.</td>
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<td><strong>Terminology</strong></td>
<td>The lack of consistent terminology both across lists and within individual sectors makes using the lists difficult. For example, the difference between ‘priority’ vs ‘essential’ is not well understood and can lead to a disregard for the former. Clear nomenclature could help listing and electronic management of the lists.</td>
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<td><strong>Accessibility</strong></td>
<td>Despite most survey respondents agreeing that the lists are easily accessible online, many meeting participants cited access as a challenge. The EML, published as a series of large pdf files, is often difficult to access and navigate; reviewing multiple different documents to understand past decisions is especially burdensome and impractical. Meanwhile, the other lists can be difficult to find.</td>
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THE MEDICINES PATENT POOL (MPP)

About the MPP
Established in 2010, the MPP is a UN-backed public health organization working to increase access to new patented medicines in LMICs. It operates by negotiating voluntary licences with the patent holder to allow other manufacturers to develop generics or new formulations that can make the medicines affordable and accessible. Building on its broad success with HIV medicines, the MPP has since expanded to work on Hepatitis C and TB. Now the organization is looking to expand even further and is considering other patented essential medicines that might benefit from the MPP model.

Participants at the Geneva meeting were asked for their views on how the MPP could play a role in making single source essential medicines more affordable, and their perspectives on the opportunities and challenges ahead. Meeting participants broadly welcomed the expansion of MPP’s scope and its alignment with the WHO EMLs.

Key messages from discussion:

High price is an issue for selection. Most participants agreed that the high price of some patented medicines—for example, cancer, diabetes and orphan drugs—is an important aspect when reviewing national EMLs. Countries shared that when high-cost medicines are included on national lists because there is no alternative available this may have a huge impact on the budget. They called for caution with respect to orphan drugs as costs can be very high, while serving only a small proportion of the population.

Beware small clinical benefits. Several participants warned to be wary of considering drugs with marginal benefits or drugs that are only slight improvements on older, patent-free, alternatives for inclusion on national EMLs. The impact on the budget can be disruptive with only marginal benefits for the population.

MPP to focus on essential medicines. Participants urged MPP not to stray outside the scope of the EML, although they acknowledged the need for horizon scanning and to sometimes act in advance—to ensure an affordable supply of likely candidates once they get on the list. They argued for a careful balance between targeting present EML drugs and predicting future ones. Horizon scanning could be done jointly between WHO and the MPP.

Look beyond medicines. Many participants pointed out the need to tackle monopoly and oligopolies and other access barriers in medical devices and assistive products too. They called on MPP to consider broadening their scope further to include other health products.

Keep our options open. The speakers stressed that while MPP is a good tool, it is not a panacea for selection. Participants agreed that voluntary licensing cannot always be used, so other options—including, for example, compulsory licensing and negotiations—must be kept open.

“We [MPP] need to align with WHO priorities and ensure we focus on key products to make a difference.”

Approximate number of medicines on EML with some patent protection in LMICs
Part III. Improving the lists

Survey findings

Respondents to the online survey were asked to identify priorities for improvement from a list of eight pre-defined activities (see Annex I). Their answers were broadly similar across the four lists. More than half of those that responded to the question felt that all the activities, across all the lists, qualified as ‘high priority’ activities. The one exception to this was translating the lists into WHO official languages (although 40–45% of respondents still said this was a high priority).

A closer look at the ‘high priority’ results suggest that two activities should be prioritized by WHO across all four lists; both focus on providing stronger support to countries (see Figure 5).

Participant suggestions

A large part of the agenda at the Geneva meeting was given to exploring ways of improving the WHO lists to increase their relevance and reach among countries.

The top two priorities identified in the survey came up time and time again, with many participants calling on WHO to step up its efforts to support countries adapt the lists to their own context and implement them on the ground. The shape of these efforts was the subject of much discussion, and fell broadly into two categories:

- **Change the lists themselves.** Many suggestions were about changing how the model lists are collated or presented. For example, by adding fields of information to the lists, expanding their scope, or categorising them by different criteria, such as resource setting or level of care.
- **Boost ancillary activities.** Other suggestions were about increasing the number and level of supplementary activities around the lists that support their implementation. For example, developing new guidance and tools, strengthening communications and dissemination, or establishing stronger links to other relevant products and processes.

Some of the activities suggested by participants are already under development. For example, WHO is already working on a ‘how to’ guide for national implementation of the EML, PMD and EDL that will offer further guidance on how to update national lists based on the global process. Similarly, WHO does already have some publications to support selection that are integrated across health products, for example its Disease Commodity Packages, Interagency Emergency Health Kit, Health Products for Primary Health Care and Universal Health coverage menu. Other suggestions require new deliberate and concerted action from WHO.
Participants were asked to consider the specific actions WHO and partners could do to improve the lists and support countries in their decision making and implementation efforts. A broad range of suggestions emerged from their deliberations. These are listed below, grouped by broad category but presented in no particular order.

1. **Integrate the four lists**
   - **Present the four lists as one.** This includes developing a comprehensive package for policymakers that integrates all four lists as well as ensuring the lists are linked, both online and in practice, when dealing with countries. “Together we are a great package; in isolation we are incomplete.”
   - **Establish common terminology.** This applies at all levels, across all lists. That means, for example, ensuring consistent use of the terms ‘priority’ and ‘essential’ and mutual understanding of terms such as ‘affordability’ and ‘sustainability’. Naming of the products with specific nomenclature and classification.
   - **Ensure representation across expert committees.** This includes ensuring a small set of cross-sector representatives that can cross-pollinate across the various expert committees and groups serving the different WHO lists.
   - **Align timing of the lists.** This may be impractical, but there were some suggestions for more alignment in the timing of processes for maintaining, updating and distributing the four WHO lists.
   - **Eliminate duplication across the lists.** This may be particularly relevant for the new EDL and existing lists of priority medical devices.
   - **Integrate information exchange about the lists.** This applies at multiple levels: information about the WHO lists between HQ and the regions is often shared on a list-by-list basis; similarly, information that is shared with countries and other stakeholders is also often limited to a single list. In both cases, information exchange should include all the lists. “We all need to do more to make sure we are thinking about the lists in an integrated way.”

2. **Improve communications**
   - **Develop and implement comprehensive communications strategies.** Every list and ancillary tool should have a strong communications strategy and plan in place to ensure it is mobilized to maximum effect. “We need to mobilize what we develop.”
   - **Integrate communications.** Ensure all messaging about selection covers all four lists and is communicated to countries in a way they can understand in terms of coordination. More than one participant encouraged WHO to reframe its messaging about the lists to present them as a package.
   - **Ensure communications reach the grassroots.** This requires efforts to ensure that the flow of top-down communications does not stop at regional offices but filters through countries to decision makers and practitioners on the ground. It also means finding mechanisms to disseminate lists at an operative level and increase understanding of how to use them (for example, by developing guides for health professionals). “Most of these lists go to the regional WHO office then the local country office but the engineers or clinicians that actually have to use the lists remain unfamiliar with them.”
   - **Encourage bottom-up communications.** Inviting bottom-up communications is important to ensure selection is informed by a balanced set of both clinical and practical perspectives. There are many options for encouraging bottom-up communications, from improving notifications of selection to including observers from civil society in selection processes.
3. Help countries adapt the lists

- **Clarify the identity and purpose of the lists.** While WHO may be clear that the EML is a model list and not a model formulary, among countries and stakeholders there remains some confusion about the purpose of the lists, whether they are tools for prioritization or tools for futuristic planning.

- **Add granularity to the lists.** Several participants called for more information and categorization to be added to the lists so that it is easier to tell what is necessary and what is a bonus. For example, they suggested establishing a basic ‘core’ list differentiated by level of care.

- **Focus more on priority public health needs.** A suggestion for an increased focus on NCDs was particularly aimed at the EML, although could apply to all the lists. It was accompanied by a call for greater emphasis to be placed on rational use of health products and on antimicrobial resistance.

- **Classify lists by context.** Participants asked for lists to be classified by resource setting (and by type of health facility) and to include tier-based recommendations.

- **Establish baselines for use.** Building prerequisites for adoption and contextualization into lists.

- **Support prioritization.** Offer more practical ideas of how to prioritize within the lists, for example, by including extra information on need (epidemiological or capacity to benefit), clinical value, and broadly estimated cost-effectiveness.

- **Develop downstream tools and guidance.** Participants showed a large appetite for more tools and guidance to support countries, especially on selection, implementation and quality and safety monitoring (including standard operating procedures, or SOPs).

- **Develop capacity in country for integration and implementation.** This includes a broad range of activities, such as technical support and training. It also includes establishing better links to pathways and care services, and the support systems around those (especially for medical devices and assistive products).

- **Promote the process.** The process for selection of model lists (including the criteria for selecting committee members, the SOPs for establishing consensus and the mechanisms used for public transparency) is a strong product and should be promoted as a standalone product that can be adapted to country level.

4. Raise awareness and engagement

- **Increase awareness of the lists themselves, especially the non-medicines lists, at country level.** Participants suggested repeating the user survey in a year’s time to see whether awareness-raising efforts have been successful.

- **Promote ancillary products.** Do more to disseminate and promote existing supporting material, such as the upcoming how to guide and the existing inter-technology publications.

- **Target efforts at key influencers.** For maximum impact, target awareness-raising initiatives at the “triangle that moves mountains”: policymakers, civil society and technical officers.

- **Emphasize the links to SDG 3 and UHC.** This is particularly relevant when engaging policymakers. All countries are committed to delivering the SDGs and meeting associated targets on UHC; framing the WHO lists in this context can help ensure broader buy in and commitment.

- **Leverage networks for dissemination.** Use collaborating centres and participant networks to help share and promote the lists themselves as well as the supporting tools and guidance.
5. **Make a bigger impact**

- **Seek opportunities to make a broader impact.** Use the process of developing a national (or even sub-regional, as appropriate) list as a tool for health system strengthening.
- **Focus on the end goal of improving access.** Step up efforts to support countries in all the steps beyond creating a model list (including communications, piloting, adaptation, training in use etc).
- **Look beyond selection.** To be assured that what is selected is properly used, countries need to work along the whole value chain—from evaluation and selection to prescription, dispensing, use and monitoring.
- **Showcase examples of impact on access.** Document and demonstrate the different ways that using WHO lists can improve access, for example, by commissioning country studies and sharing impact stories.

6. **Improve accessibility**

- **Develop a comprehensive and searchable electronic database.** Digitize the lists (particularly EML) into an online database and make sure it is user-friendly and fully searchable. The database should enable users to filter information by levels of care, condition, adults/children and emergencies. It should also include information about which health products are not included in the lists (and why).
- **Make a strong contribution to UHC Menu.** See box below.
- **Support national data management needs.** Find ways to ensure health information management systems are available at national levels too, populated with relevant data and provided in appropriate languages.

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**THE UHC MENU**

WHO is in the process of developing a new global public good to support priority setting at country level. Called the ‘UHC Menu’, this new tool will pull all existing information on WHO recommendations into a single interactive intervention database. Users will be able to search the online database by various criteria (for example, disease or level of care) to:

- find data on intervention-specific resource needs, impact, cost-effectiveness, and financial cost implications; identify groups of interventions that can be bundled for co-delivery; and
- access guidance on country contextualization processes.

The first version of the UHC Menu will be launched in September 2019. Through it, WHO is already addressing some of the concerns raised by participants at the Geneva meeting and progressing some of their suggestions. The UHC Menu will:

- Make the link to pathways of care, to help ensure selection lists can be implemented.
- Introduce filters and search functions, making it quicker and easier to find the right data.
- Improve granularity by bringing all the layers of information together (acknowledging that there will be many gaps to start with).
- Strengthen the links between selection lists and UHC and SDGs.
- Improve the accessibility and usability of lists for all stakeholders.
- Support integration and encourage a broader perspective, to ensure countries consider the full spectrum of products and processes required to deliver an intervention.

Meeting participants were enthusiastic about the new tool and urged WHO colleagues involved in its development to promote the interests of this group and ensure the UHC Menu delivers on the benefits listed above.
7. **Tackle the finance dimension**

- **Explore options for addressing cost effectiveness.** Despite wide differences between countries, the finance dimension—cost, cost effectiveness, budget, price—is so critical it must be addressed. Participants suggested some options for doing so, for example by developing simple global models of cost effectiveness that could help inform local decision making where data is particularly poor.

8. **Monitor progress**

- **Develop implementation indicators.** These are needed for all four lists and should cover both how to use lists as well as how to support impact in country.
- **Develop indicators on availability and access.** Make sure that these extend across all four lists, and that they link with the SDG indicators on access (under Targets 3.8 and 3.b).

9. **Share learning**

- **Review and refine tools based on feedback.** Invite feedback on tools and packages from countries and other stakeholders; then revise those products based on feedback received. This will encourage more engagement and buy-in.
- **Convene a taskforce.** Establish a group of experts that come together regularly (potentially during alternative years of the EML) to discuss policies to improve access and affordability.
- **Share success stories.** Disseminate and promote market analyses linking selection with improved access so that others can learn from successful experiences.
- **Foster knowledge exchange across the lists.** This includes supporting an informal network of meeting participants, so they can keep exchanging experience and expertise and can continue to learn from one another.

10. **Leverage strengths**

- **Leverage existing brands.** Use the established EML brand to support other lists.
- **Leverage expertise for integration.** Harness expertise of different participants, partners and sectors to support integration, both across lists and with other relevant areas. Look for opportunities to synergize platforms for procurement, budget, selection etc.
- **Make the most of regional expertise.** Regional offices know the practical hurdles facing countries on the ground. They should play a larger part in adapting tools to regional and country contexts. They should also have a role in expanding on recommendations and priorities established at HQ (including those set forth in this meeting) and translating them into specific recommendations that are relevant to the regions.

“**All of us working together we can improve access to quality health care services for everyone everywhere.**”

“**Whenever you develop a new tool, I urge you to consult regional offices to get an adapted version, so you get the results you want.**”

“**This is the beginning of a conversation, not the end.**”

**Next steps**

The organizers have already shared a list of participants and all presentations from the meeting with participants. Before the close of the meeting, they articulated next steps:

- Meet with WHO staff participants to review outcomes of the meeting, including suggestions.
- Draft meeting report and share with colleagues and participants for feedback.
- Meet with WHO colleagues in HQ and regions, to review and prioritize suggestions for action.
Annex I: Online survey questions

For a full summary of the survey responses, please see separate file: EMP_survey_data_SL.xls.

Below follows an abbreviated version of all the online survey questions. Please note that respondents were asked to answer each of the following questions for each of the four lists.

1. **Are you familiar with the following WHO model lists?** (Yes/No/I do not know)

2. **Does your country have a reference/reimbursement/essential national list?** (Yes/No/I do not know)
   a. If yes, when was the last revision? (<1 year, 1-2 years, 2-3 years, 3-4 years, >5 years, I do not know)

3. **Does your country use the WHO model lists to inform the national lists?** (Yes/No/I do not know)

4. **Please comment on the following aspects of WHO model lists.** (Yes/No/Improvement required)
   a. The list is easily accessible on the website
   b. The lists address population needs
   c. The format is user friendly
   d. The recommendations are clear
   e. The recommendations are useful for your decision process
   f. The recommendations support access in your country
   g. The recommendations provide support to pricing and procurement negotiations

5. **Please indicate what activities you think could be undertaken to support the implementation of the lists WHO model list.** (Low priority, Medium priority, High priority).
   a. Nomination/submission of products for inclusion in the lists
   b. Enhance feedback from state and non-state actors for updates to the WHO model lists
   c. Developing or improving web-based technologies and databases to facilitate access to the WHO lists
   d. Improving notification to Member States when the WHO model lists are or will be updated
   e. Enhance technical assistance to support price negotiations on listed products
   f. Strengthening capacity at a country-level through training programmes
   g. Technical Support to Member States for creation/update of national lists
   h. Ensuring availability in the six WHO official languages

6. **If known, please list any specific health products that your country was unable to include in national lists as a result of budget constraints.**

7. **Any additional comments related to the WHO model lists on health products?** (optional)

Annex II: List of participants

- Francis Aboagye-Nyame, Program Director, Medicines, Technologies, and Pharmaceutical Services (MTaPS) Program, Management Sciences for Health
- Sizar Akoum, Biomedical Engineer, Ministry of Public Health
- Thiru Balasubramaniam, Geneva Representative, Knowledge Ecology International
- Marion Baudry, Health Procurement Consultant, United Nations Development Programme (UNDP)
- Peter Bollen, Technical Specialist, UNICEF Supply Division
- Esteban Burrone, Head of Policy, Medicines Patent Pool
- Jane Carter, Department Head, Clinical and Diagnostics Programme, AMREF International University
- Christina Cepuch, Pharmacist Coordinator, Médecins Sans Frontières
• Patricia Coffey, Senior Program Officer, PATH
• Anthony Emeribe, Professor, Department of Medical Lab Science, University of Calabar College of Medical Science University of Calabar
• Charles Gore, Executive Director, Medicines Patent Pool
• Santiago Hasdeu, Coordinator of Health Technology Assessment Unit, Ministry of Health of Neuquen
• Arianit Jakupi, President, National Chamber of Pharmacists
• Mariatou Tala Jallow, Senior Manager, The Global Fund to Fight AIDS, Tuberculosis and Malaria
• Mouna Jamaelddine, Head of the health technology assessment department, INEAS
• Karrar Karrar, Access to Medicines Adviser, Save the Children International
• Zachary Katz, Chief Access Officer, Foundation for Innovative New Diagnostics (FIND), Foundation for Innovative New Diagnostics (FIND)
• Paolo Lago, Director, Clinical Engineering Department, Fondazione IRCCS Policlinico San Matteo
• Cécile Macé, Senior Health PSM Advisor, United Nations Development Programme (UNDP)
• Liudmyla Maistat, Policy and Advocacy Manager, Medicines Patent Pool
• Hugo Marín Piva, Médico Evaluador, Área de Farmaco-economía, Dirección de Farmacoepidemiología, Caja Costarricense de Seguro Social
• Kylie Mines, Chief Executive Officer, Motivation Australia
• Atieno Ojoo, technical manager in Medicines and Nutrition Centre, UNICEF Supply Division
• Nicolas Pallikarakis, Board Chairman, Institute of biomedical technology (INBIT), University of Patras
• Gaboelwe Rammekwa, Chief Health Officer, Ministry of Health and Wellness
• Alfonso Rosales Lopez, Biomedical Engineer Advisor, Caja Costarricense de Seguro Social
• Cherise Scott, Technical Officer, UNITAID
• Albina Shankar, Director, Mobility India
• Shashi B Sinha, Advisor, Healthcare Technologies and Director WHO Collaborating Centre, National Health Systems Resources Centre
• Netnapis Suchonwanich, Senior Advisor, Health Intervention and Assessment Program (HITAP)
• Fatima Suleman, Professor, University of KwaZulu-Natal
• Elsie Hilde Ningalo Taloafiri, CBR National Coordinator, Ministry of Health and Medical Services
• Oleksandr Topachevskiy, Essential Medicines List Committee, Ministry of Health of Ukraine
• Elena Villanueva, Advocacy and Policy Manager, Medicines Patent Pool
• Sebonego Wandani, Technical Specialist, UNICEF Supply Division
• Chandanie Wanigatunge, Professor of Pharmacology, University of Sri Jayewardenepura
• Brenda Waning, Stop TB Partnership

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• Peter Beyer, Team Lead, Essential Medicines and Health Products, Headquarters
• Heidi Botero Hernandez, Policy Officer, Essential Medicines and Health Products, Headquarters
• Bernadette Cappello, Technical Officer, Innovation, Access and Use, Headquarters
• José Luis Castro, Advisor, Rational Use of Medicines, AMRO
• Allison Colbert, Technical Officer, Innovation, Access and Use, Headquarters
• Suzanne Hill, Director, Essential Medicines and Health Products, Headquarters
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• Chapal Khasnabis, Programme Manager, Essential Medicines and Health Products, Headquarters
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