Leadership for Universal Health Coverage: The Technical, Political, and Ethical Pillars of Reform

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Excellencies, ladies and gentlemen, colleagues and friends:

It is an honor for me to be here at this ministerial conference, being held in Germany, the cradle of social insurance for health. I would like to thank our German hosts, especially Ministers Philipp Rösler and Dirk Niebel, as well as Matthias Rompel from GTZ and Jens Holst, for the invitation to deliver this keynote address. I would also like to thank and congratulate our esteemed colleagues at WHO, in particular Margaret Chan, Carissa Etienne, and David Evans, for having produced a timely *World Health Report 2010* on one of the most crucial topics for the future of health systems in every corner of our interdependent planet.

It was for me an additional source of satisfaction to have heard yesterday the presentation by the minister of health of my country, Dr. José Ángel Córdova. His presence in this special conference is indeed emblematic, since, as you heard yesterday, Mexico will reach universal social protection in health by next year.

Fortunately, Mexico is not alone in this quest. The cases presented yesterday during the ministerial panels attest to important progress. As further examples, China recently launched an ambitious reform to

extend insurance to hundreds of millions of persons. India just announced the creation of a High-Level Expert Group on Universal Health Coverage convened by the Prime Minister. Even the largest economy in the world, the United States of America —the country where I now reside— has approved landmark legislation after an intense political debate that is still ongoing.

Around the world, countries at every level of economic development and with all types of political systems are searching for better ways of organizing and financing their health systems. This health reform movement is looking for solutions to accelerate the fulfillment of the Millennium Development Goals, while anticipating the new challenges that are already upon us.

So the launch of the *World Health Report 2010*, devoted to health systems financing as the key to universal coverage, offers a unique opportunity to take stock of where we are and chart the path towards further progress.

My message today is straightforward: If we wish to make further progress in the quest for universal health coverage, it will be necessary to engage in a process of shared learning, so that each health system

may be able not so much to **adopt** as to **adapt** the lessons derived from experiences around the world. In order to elaborate on this message, I will first highlight some of the challenges facing health systems at this unique juncture in history. Next, I will underscore the value of evidence in promoting better policies. I will then conclude with a set of lessons that can be summarized as the ABCDE of successful reforms. This city, with its unique history, offers the best framework to bring down intellectual and political walls so that we may all learn from each other.

The *World Health Report 2010* sees the light at a time of unprecedented change. We are in the midst of a **tense** and **intense** health transition unlike anything the world has seen before, which is linked to broader demographic, social, and economic transformations. The most dramatic expression of the health transition is the fundamental shift in the patterns of disease, disability, and death. Most countries in the world are facing a **triple** burden of ill health: first, the unfinished agenda of infections, malnutrition, and reproductive health problems; second, the emerging challenges represented by non-communicable diseases and injury; third, the health risks associated with globalization, including the threat of pandemics like AIDS and

influenza, the trade in harmful products like tobacco and other drugs, the health consequences of climate change, and the dissemination of harmful lifestyles.

Our biggest challenge today is that most health systems in the world simply have not kept up with the pressures derived from this complex transition. As a result, we are facing a number of unacceptable paradoxes. I will mention only four. First, never before has the power of science been greater, yet millions continue to die unnecessarily from diseases whose prevention and treatment were solved decades ago. Second, countless countries simultaneously have rural communities without doctors and urban doctors without jobs, underscoring the need for an urgent rethinking about the education of health professionals in the 21st century. Third, while unprecedented sums of financial capital in the form of aid are flowing from North to South, intellectual capital moves in the opposite direction through the migration of health personnel, thus rendering much of that aid ineffective. Fourth, whereas health is a key factor in the fight against poverty, health care itself becomes a cause of impoverishment when hundreds of millions of uninsured families have to pay out of pocket for services and drugs.

These are indeed perplexing paradoxes. They come at a time when health systems have experienced unprecedented growth. Today the differentiated set of organizations we call the health system have become a dominant feature of the social fabric in all but the most marginalized corners of the planet. Together, health systems absorb 10% of the world economy, about 5.5 trillion U.S. dollars per year — and growing. Of course, there are huge differences in access to these resources. While the United States spends seven thousand dollars per person in health annually, Burundi barely spends three dollars a year.

When we speak of the health revolution of the 20th century, we typically refer to the spectacular decline in mortality and the dramatic shift in the dominant causes of ill health. But equally spectacular and equally dramatic has been the rise of health systems which now permeate all corners of economic activity, dominate political debate, generate cultural interpretations, spur technological innovation, create deep ethical dilemmas, and accompany human beings at the most crucial moments of their existence, from birth to death.

This is why it is so important to understand health systems. Yet, as has been said many times, there is no other industry of this size that

spends so little in evaluating its own performance and learning from its best and worst practices.

Now, at the start of the 21st century, the amazing pluralism that has populated the global health scene, coupled with the accountability pressure represented by the Millennium Development Goals, has fueled a renewed concern for health systems and universal health coverage.

The increasing interest in health systems is very good news indeed. However, it is not sufficient condition for progress. It has now become commonplace to use —not always with the proper attribution— the felicitous phrase of the legendary Professor Ramalingaswami of India: We need more money for health, but we must also deliver more health for the money. There is growing recognition that additional funding can only be effective if national and local health systems are strengthened. In a virtuous circle, better results will be crucial to maintain the momentum of increased funding for health.

Achieving results is precisely what defines health system performance. So if we are to advocate for greater resources, we also

need to improve the performance of health systems, and the key ingredient for the improvement of performance is evidence.

That is why we should celebrate the publication of a series of world health reports devoted to the dissemination of evidence to improve health systems performance. This new wave of interest had a very visible moment exactly ten years ago with the publication of the *WHR 2000*, which had the title *Health Systems: Improving Performance.* Since then, most of the WHRs of this first decade of the 21st century have been devoted to health system topics. At the same time, many international initiatives to strengthen national health systems have been launched. The *WHR 2010* will enrich this global movement towards the construction of a body of knowledge on what works and what does not, so that each country is better equipped to take advantage of the lessons learned from every other nations, bringing the world closer to the common goal of better health for all.

And this leads me to the last part of my lecture, about the need for shared learning across countries. To be successful, health reforms must be built on what my colleague Michael Reich has identified as the three pillars of public policy: technical, political, and ethical.[1] The three

are closely interrelated, since they must act in harmony to support the complex edifice of reform. In particular, the political agreements that are essential for success can only be reached when they are guided by **ideas** and **ideals**.

Ideas take the form of knowledge derived from science. Ideals take the form of values derived from ethics. Ideas can be transformed into the evidence base for sound decision making. Ideals can be transformed into the integrity base for coherent action.

The technical pillar of reform requires a firm knowledge base. We now understand that most of the health gains achieved since the 20th century can be attributed to the advancement of knowledge, which gets translated into evidence to guide the formulation and implementation of better policies.

Let me illustrate this notion through my own experience with comprehensive health system reform in Mexico. I will not go into the details of this case, which my esteemed successor described yesterday in the first ministerial panel. In addition, the Mexican reform has been the subject of a large number of articles, including a series of seven papers published in *The Lancet*, one of the leading scientific

journals in the world.[2,3,4,5,6,7,8] For the purpose of this lecture, it will suffice to mention that this reform is probably a textbook case of evidence-based policy, since it was designed and implemented making use of the best available knowledge.

Thus, a series of careful studies revealed alarming rates of catastrophic and impoverishing health expenditures as a result of the fact that approximately half of the population, 50 million people, lacked health insurance. This analysis brought to light the unacceptable paradox that I referred to before: We know that health is one of the most effective ways of fighting poverty, yet medical care can itself become an impoverishing factor for families when a country does not have the social mechanisms to assure fair financing that protects the entire population.

The reform was designed to correct this paradox through universal coverage. The vehicle for achieving this aim is a public scheme called *Seguro Popular*, funded predominantly through federal and state subsidies to means-tested family premiums. As Minister Córdova mentioned yesterday, the program has elicited an enthusiastic response from the population, so that by the end of this year 42 million

people are enrolled in it, and the country is on track to achieving the goal of universal coverage by 2011.

The point that I would like to bring to your attention is that, in the case of Mexico, the effort to produce good evidence actually generated the necessary advocacy tools. Evidence empowered policymakers with convincing means to challenge the status quo and promote change. In this way, it helped to build the political pillar of the reform, which demanded the development of a consensus among all stakeholders through active conciliation of interests between private and public actors, federal and local authorities, patient advocacy groups, trade unions, legislators, and political parties. The consensus-building process culminated in April of 2003 when a large majority from all political parties in the Mexican Congress approved a legislative reform to establish a system of universal social protection in health, to be operationalized through the *Seguro Popular*.

A hallmark of the Mexican experience has been a substantial investment in research to design the reform, monitor progress towards its implementation, and evaluate its results, both through observational

studies and through a randomised design. Because of this feature, the Mexican experience can hold interesting lessons for other countries.

The value of evidence for enlightened decision-making is underscored by the worldwide search for better ways of strengthening health systems. Because of the gaps in our current knowledge, every reform initiative should be seen as an experiment, the effects of which must be documented for the benefit of every other initiative, both present and future. This requires a solid investment in research on health systems. Each innovation constitutes a learning opportunity. Not to take advantage of it condemns us to rediscover at great cost what is already known or to repeat past mistakes. To **reform** it is necessary to **inform**, or else one is likely to **deform**.

Until now I have stressed the technical pillar of the Mexican reform and made a brief comment on its political dimension. I would like to say just a word about the third pillar of public policies, the ethical pillar.

The Mexican reform was aided by ethical deliberation on the moral implications of the existing arrangements, which, as mentioned before, excluded half of the population from effective social protection. The

guiding principle for the ethical pillar was the notion that health care is not a commodity or a privilege, but a social right.

As a result of its democratization process, Mexico had made considerable progress in the exercise of political and civil rights, but it was clear that the next challenge was to ameliorate inequalities by assuring the universal exercise of social rights, including the right to health care.[9] Although this right had been recognized by the Constitution in 1983, in practice not everyone had been able to exercise it. Only half of the population enjoyed the protection of social insurance. What was lacking was the definition of the entitlements or that ensued from the legal recognition of the right to health care, as well as the financial and organizational vehicles to translate them into effective health services for all.

The point of departure of the Mexican reform was precisely the definition and costing of these entitlements guaranteed benefits. The new law stipulates that budgetary transfers to the states (responsible for the provision of services) are based on the number of families affiliated to the *Seguro Popular*. The allocation per family was calculated to finance the provision of two explicit package of services:

a package of essential services for conditions of high incidence and relatively low cost covering all services at the primary and secondary levels, and a package of high-cost interventions with potentially catastrophic consequences for families, which expands as more resources become available with increasing enrollment. In this way, the reform includes the three dimensions of universal coverage proposed by the *World Health Report 2010*.

As you can see, the ethical pillar feeds back into the technical dimension, and both interact to assure long-term political support for reform.

So let me conclude by drawing the global lessons from the Mexican reform experience as we did in *The Lancet* series. I will summarize those lessons as the ABCDE of successful reform.[2]

A stands for **agenda**. The first ingredient for success is to link health to the broader agenda of development and security. Public health experts must learn to address the larger concerns of heads of government, legislators, ministers of finance, and other policy makers who have to balance the claims of many different sectors. In this advocacy effort we can make use of global evidence showing that, in

addition to its intrinsic value, a well-performing health system contributes to the overall welfare of society by relieving poverty, improving productivity, increasing educational abilities, developing human capital, protecting savings and assets, and directly stimulating economic growth with a fairer distribution of wealth.

This leads me naturally to the **B**, which stands for **budget**. By placing health at the center of the development agenda of a country it is possible to endow it with the degree of priority that it deserves. These arguments enhance the negotiating power of ministers of health, who can then convince decision makers to allocate **more money for health**.

And this takes us to the **C**, which stands precisely for **capacity**. There is no substitute for long-term investment in capacity building in two main areas. The first refers to health-service delivery, through investments in physical infrastructure and, most importantly, in human resources. The second has to do with the development of institutions that can undertake the necessary research and analysis to generate sound evidence for policy. In the case of Mexico, the current reform has reaped the benefits of 20 years of sustained efforts to establish

and nurture organizations such as the National Institute of Public Health and the Mexican Health Foundation. These centers of excellence have produced relevant research and policy analysis, trained researchers who occupy key policy-making positions, carried out independent and credible evaluations, and greatly enriched the quality of information.

With this capacity, we can then move to the **D**, which stands for **deliverables**. A key ingredient to gain public support for a reform is to identify and communicate its specific benefits. The best way to do so is to focus on priority diseases and risk factors. In this way, the public can link abstract financial and managerial notions to concrete deliverables. This is also the way to bridge the divide between two public-health traditions: on the one hand, the "vertical" approach, focusing on specific disease priorities, and, on the other, the "horizontal" approach, aimed at strengthening the overall structure and functions of the health system. In order to go beyond this false dilemma, it is necessary to extend the geometry metaphor and develop what Jaime Sepúlveda calls the "diagonal" approach,[10] namely, a strategy in which explicit intervention priorities are used to drive the required improvements into the health system. A fundamental lesson from the Mexican experience

is that health-system capacity can be built up through the scale-up of effective preventive and therapeutic interventions against specific priority problems grouped in an explicit package of guaranteed benefits.

Finally, **E** stands for **evidence**. The Mexican experience confirms what several researchers[11,12] have pointed out: that the health of people in rich and poor countries alike is depending more and more on their ability to locally adapt knowledge that has been generated as a global public good.

In this respect, the Mexican case shows that the dilemma between local and global research is a false one. The process of globalization can turn knowledge into an international public good that can then be brought to the center of the domestic policy agenda in order to address a local problem. Such application, in turn, feeds back into the global pool of experience, thus generating a process of shared learning among countries. This virtuous process can only take place if we mobilize international collective action for the common good of all countries.[13] This is what gives such value to our multilateral institutions.

Fortunately, the topic that gathers us today –the value of knowledge to inform policy– involves at its essence the possibility of sharing. It is a topic in which we can all participate and from which we can all benefit. It is a topic where the **self interest** of each country coincides with the **common interest** of all nations.

One of the thinkers who best captured the sharing character of knowledge was Thomas Jefferson, who almost two centuries ago stated:

> "He who receives an idea from me, receives instruction himself without lessening mine; as he who lights his taper at mine, receives light without darkening me."

By illuminating the complex topic of health systems financing as the key for universal coverage, the *World Health Report 2010* will help to light many candles. These will shine even brighter if we all commit to sharing our experiences, as we are doing in this conference.

The path is clear: scientifically derived evidence must be the guiding light for designing, implementing, and evaluating reforms in national governments, bilateral aid agencies, and multilateral

organizations. This is the path that will lead to more equitable development through better policymaking for health.

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