



Political Leadership for Health Care for All **Moving Towards Universal Health Coverage: A Roundtable Discussion**

Wednesday, 19 May 2010

I. Welcome and Introduction

Honorable Mary Robinson

- The group has come together today to discuss the question, “Why does political leadership in health matter?” The evidence has shown that strong political leadership drives major policy reform victories, when people take responsibility and decide to exercise leadership at the Ministry of Health and Head of State level. Ministries are always pleased when Heads of State see health more as an issue of development and less as an issue of cost.
- The essence of “health care for all” takes health care out of the individual family’s risk – a risk to one small set of individuals – and spreads it out in solidarity so that no one is driven into further poverty because a member of the family becomes ill or there is an unfortunate accident. We all subscribe to the end goal, without a particular path or modality in mind.
- It is important to bear in mind the complexity of health interventions/health reforms. Different countries have achieved varying levels of health coverage, and while these goals may take decades to achieve, they should be at the front of countries’ roadmaps for progress.

II. The Role of Political Leadership

Dr. Suwit Wibulpolprasert, Senior Advisor on Disease Control, Ministry of Public Health, Thailand

- There are four dimensions of “universal access”: geographical access (physical accessibility), economic access, quality, and cultural acceptability.
 - *Geographical access:* Countries need facilities close to where people live. These facilities must have the appropriate human resources needed to serve their communities and must receive appropriate funding – funding for health must be prioritized, even in times of economic hardship.
 - *Economic access:* While there might be a hospital in front of your home, if you do not have the money to pay for the services what can you do? Health care must be affordable for all, and health care providers must have the financial resources necessary to provide services to their communities.
 - *Quality:* Even when health care is free, if the quality of health care is poor, people will not want it. Thailand has conducted yearly surveys to monitor the satisfaction of patients and health care providers.
 - *Cultural acceptability:* Health care must be administered in ways that are culturally and contextually appropriate.

Honorable José Gomes Temporão, Minister of Health, Brazil

- Health care can be recognized as a priority and a right in country constitutions.
- A health care system must be universal, equitable, and holistic in its approach.

- An important aspect of health care is the family health team, made up of a doctor, a nurse, and six auxiliary health workers. These health teams provide a network of services, including basic care, support, and emergency care.
- It is important to make progress on health; this involves a political decision to not allow health to slow down because of questions around insurance or payments.
- During the 1970's, Brazil was in a military dictatorship, and during the fight for democracy we realized the importance of health. Academia, the public health sector, trade unions, opposition parties, students and the Catholic Church came together to fight for democracy. This movement was called "Democracy and Health." At the time we had a very fragmented, decentralized system. Most of the population was not included within the system since payments were out of pocket. Once the opposition succeeded, then the ideas on health were enshrined in the constitution. Health was a right for all and duty for the state, and health could be obtained through sound social and economic policies (universal health care).
- Brazil has tried to improve the system using concepts taken from economics— "creative destruction." They had to completely renovate the system to decentralize it.
- They universalized fragmented care, decentralized centralized areas and resisted the trend to privatize health. Nowadays the public health system covers 80% of the population, with primary health care for about 60% of the population. Brazil has access to family health, chronic care, transplants, etc. 20% of the population has health insurance, but they still use the public health system. HIV/AIDS prevention and treatment are also accessible.
- The government has worked to ensure universal vaccination – with a website showing the real time rates of vaccination. For example, the H1N1 campaign has covered over 3 million people in Brazil. The goal is 90 million.
- Obviously some inequalities remain, and there are regional variations. For example, there's a life expectancy gap of 20 years between the south and north.
- Child mortality is dropping—Brazil is experiencing a demographic change. Our population will likely rise until 2030, and then it will drop.
- Hunger is no longer a problem, but obesity is emerging as a problem. There are new family structures—women are working more and families are eating more prepared/package food.
- Brazil has had an on-going debate about universal health care. Some are opposed to this idea, and the experience of U.S. healthcare reform strengthens the experience in Brazil. Various systems, like Cuba, UK, etc. shape our experience.

Responses from MLI Countries: Ethiopia, Mali, Nepal, and Senegal:

Kebede Worku, State Minister, Ethiopia

- It is essential to ensure access to all services, including for communities in peripheral, less accessible communities. Political commitment includes ensuring universal access to bed nets, training and deploying health workers, institutionalizing a strong health system, and institutionalizing community health services.

Dr. Salif Samaké, Planning and Statistics Unit, Ministry of Health, Mali

- Geographic access is essential; health centers must be small enough to provide individual care but big enough to have a viable critical mass. Health centers in Mali are managed by communities with some support and supervision from the state.
- Mali works with MLI around *mutuelles* to ensure coverage.

- Mali benefits from the fact that its health sector does not revolve around the Ministry of Health alone, but also the Ministry of Social Development, which deals with issues of health insurance.
- Mali is moving towards universal health coverage, but this cannot be achieved without international solidarity.

Chet Raj Pant, Nepal Planning Commission, Nepal

- Health care for all and reproductive health care are basic human rights for the citizens of Nepal. All basic health care and reproductive health care for women are free of charge.
- The government of Nepal has established at least one health center in developing communities. It has also developed a national health sector plan for five years through a sector-wide approach and pool funding. This will be done through community health volunteers – females from their own communities.
- The most important strategy is a public/private partnership. Nepal is partnering with academia, private organizations, NGOs.
- Quality and acceptability: in days to come Nepal will focus on quality. One very new social innovation has been introduced: social audits, or a monitoring of quality to be completed by the society itself.
- There is a problem of sustainability: how can Nepal sustain all of these services that have been made available free of cost? Nepal is introducing a social health protection package through insurance, which will cover the poorest of the poor.
- Nepal will be the first country to achieve MDG4 by 2011.

Dr. Bocar Daff, Ministry of Health, Senegal

- History is very important in Senegal, particularly post-colonization. The public sector should be organizing the private sector, but we only realized this after 1955. Most institutions were localized, and the weak state needed a way to manage the various institutions. That's when we started the Bamako Initiative. Some communities had difficulties when the Berlin wall fell. The resources that were supposed to flow to Christian communities in Africa went to the East block instead.
- The *mutuelles* (community-based health insurance) started because one doctor decided to focus on the needs of one community. The government decided to try to further develop these community-based approaches. Senegal's development plan in 1995 included provisions for a health insurance system. There is a strategic plan for health coverage with 2 main directions—*mutuelles* and social insurance. This is a coherent plan, but Senegal's leaders found the movement too slow.
- Based on civil society organization's reactions and community feedback, Senegal has moved forward on specific programs like free c-sections. Dakar was excluded due to its wealth, but there are plans to extend coverage to Dakar.
- The political leadership decided that all people should be eligible for good care. Now people over the age of 60 can receive free care. Two months ago, dialysis became free because the president said that a free care policy for this service was needed. This means a lot for the people who need these treatments. Senegal has also decided to provide universal coverage for mosquito nets.
- Of course it's possible that these decisions were taken too quickly. What about services for diabetics, etc? Senegal has had a sustained community focus but has not accounted for institutions. Senegal wants to work through the right next steps with partners like MLI.

Audience Responses

- Sierra Leone has had an interesting experience with political leadership. They recently launched their free care policy for pregnant and lactating women and children under the age of five. The president has taken it upon himself to see this reform through. The president has chaired six-hour meetings that systematically analyze what needs to be sorted and refined. The entire health payroll was cleaned up in six weeks, and they removed 1,000 ghost workers to recruit front line workers (cost neutral). They have also increased salaries for doctors fivefold. Having the president behind an initiative shows that these things can move. He also placed pressures on external development partners to help fund additional pharmaceuticals. DFID & UNICEF came through, and the national drug system was reformed. There has been a six-fold increase in healthcare utilization by women and children. Every health facility will have a cell phone with a direct line to the Ministry of Health to report any abuses of this policy (privately funded through a phone company). This type of leadership galvanizes healthcare reform. Reducing financial barriers can really interest political leaders although this is an area that has not interested technocrats as much. The UK has established the centre for progressive health care financing, which will help countries learn from one another.
- “Politicians talk. They do not execute.” “Nothing moves without politics.” Ministers must engage the political environment in a positive way. In his visit to Nigeria, Bill Gates observed the signing of Abuja declaration. This moved leaders forward to focus on polio eradication. A focus of universal health care must be vaccines. During the World Economic Forum, Gates called for the decade of vaccines—including support for vaccine research, development and delivery. Want to save 1 million lives by 2020? Gates has committed \$10 million.
- Health ministries need validation and support and encouragement to engage with other ministries. Peer learning has been a strong outcome of MLI.

III. Global Perspectives on Emerging Support For Universal Health Coverage

Tim Evans, WHO, Global Symposium on Health Systems Research

David Evans, WHO, World Health Report 2010: Better Health for All

- The WHO’s history with UHC is very recent, and it is due to the political leadership of Tommy Douglas. He was a politician in rural Canada, and he found that when you are injured in Canada, you can lose your farm—there was something fundamentally wrong with losing your means of living. He introduced first Universal Health Coverage effort—doctors went on strike. He ultimately succeeded, and it quickly spread across Canada. Within 10 years, every province had UHC.
- UHC comes naturally to the WHO. Former Director General Halfdan Mahler was one of the principal architects of primary health for all. The aspiration of health for all remains quite universal and most member states agree that health is a right or entitlement. Mahler believed in vision accompanied by pragmatism. The values remain as pertinent as ever, but the strategy requires rethinking.
 - How do we align non health sectors to help promote health?
 - How do you engage leadership (all leadership is political)?
- There is also a need to bind the short term with the long term. We can learn a lot from the experience with immunization and sustainability.
- Is there a tradeoff between equity and efficiency? Economists find those incompatible, but it’s not clear that this is a necessary trade off. Efficient health financing is sometimes the most equitable.
- The concept of UHC is a world health resolution (from 2005). This resolution encouraged health

financing systems to expand access to everyone at affordable cost. There is coverage with services and coverage with financial risk protection. The new 2010 world health report builds on these 2 streams.

- Some countries have done well in terms of UHC, but there are still countries with significant challenges. Globally, we're a long way from universal coverage. The report considers how health financing can help address these challenges.
 - Heavy reliance on out of pocket payments prevents people from using services
 - Need to improve use of existing funds (efficiency, equity)
 - Countries face resource constraints—they need more money to ensure equitable access to a minimum package of services
- These are also messages for the international community. We need to practice what we preach. We have not reduced transaction costs at the international level. Programs have proliferated; they have not consolidated.
- At a global level it is not a given that the interest in UHC will be sustained. For example, attention might shift to budget deficits or climate change. We will need continued global advocacy.

IV. The Roundtable Discussion Continues

- We have made a lot of progress in global health recently, but we are still approaching problems vertically and undermining health systems. Development assistance is only 3% of health spending worldwide. ODA does not bear the brunt of health spending. People's own income will increase global health spending.
- There is a political demand for social protection. The crisis has emphasized the need for social protection, and UHC falls into this umbrella. The question is how feasible is it to implement and finance? Plans for UHC should not just consider existing capital, but the income that will be generated over years. India is moving in this direction and Ghana has had an incredible experience. We would like to see more countries move in this direction.
- Countries should share experiences in implementation. Once the political commitment is made implementing UHC requires a lot of knowhow—IT, financing, etc.
- We need more evidence based research in this area. The social sciences can make an important contribution in this area.
- We are working on a social and macroeconomic rationale for UHC. We need everyone's commitment in moving this agenda forward—World Bank, G8, etc.
- Through the Joint Learning Initiative (JLI), we have seen that there has been a growing demand for practitioners to learn from another. How can countries solve problems? There are technical and political challenges that countries share. In February, the JLI had a meeting of 6 countries (Ghana, India, Indonesia, Philippines, Thailand, and Vietnam) and donors—outcomes: Ghana is sending a delegation to India and Thailand to learn more about “how you do it.” Thailand has emerged as a leader in UHC.
- In the health area we have several well-established areas of research, particularly clinically. However, systems research is a new field that requires a lot of attention. Ministers endorsed the development of systems research in Bamako in 2008.
- Leadership requires bold vision and calculated risk taking. It takes planning to design adequate systems for health care for all.