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U.N. Foundation

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Mexico

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Ministry of Social Protection
Colombia

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P R O C E E D I N G S

MS. BRAINARD: Good morning, and welcome to Brookings. We are really delighted today to be co-hosting with the new World Health Organization-backed Health Financing Task Force, a three-part series of panels on the critical issue of global health financing.

From private philanthropic efforts to summit-level discussions at the G-8, global health financing is one of the top items on the international agenda. It is an area where we know the challenges are great, but the opportunities if we get it right are also huge. I think we all are a little bit disappointed at least here at Brookings that global health really fell off the agenda in St. Petersburg. It received a lot of momentum last year, and somehow it did not stay on the agenda in the way that we were hoping. As everybody knows, ODA levels are well below the promised levels, having to do with domestic politics rather than how effectively they can be spread abroad, so the aid budgets for health are not as ripe and rich as one would really like at this point.

What this group is going to talk about today and over the next few days is the urgent need to rethink global health financing, the importance of maximizing impact in developing countries of the money that is spent, both public and private, and the need to build more resilient newer alternatives for raising and challenging finance.

As many of you know, the idea of advanced market commitments first had its birth here at Brookings when Michael Kremer was working on this

years ago, and here we are several years later and we still have not gotten the push that we need. There are other ideas under discussion like the airline tax, and, yet again, we have not seen the kind of consensus that would be needed to really transform the landscape for global health.

Brookings is now starting I think with this event to launch a global health initiative that will focus exactly on this set of issues, looking at new and innovative financing mechanisms and trying to figure out what the particular types of mechanisms would need to look like to address very particular needs at the country level and at the global level.

We are very, very fortunate in this endeavor to have David de Ferranti who has 25 years of experience at the World Bank, most recently as Vice President for Latin America, coming here to launch this effort. Today's panel is going to focus on the country-level challenges, looking at innovative country-driven health financing solutions and challenges and recommendations. Tomorrow there is going to be a panel in the afternoon on global-level challenges, in particular, global health financing gaps and some of the innovative financing solutions. Then on Wednesday, the final concluding panel is going to look at mobilizing additional resources for health, and especially looking at the role of the private sector.

The other person we are incredibly delighted and fortunate to have joining here at Brookings will be moderating the panel this morning, Amanda Glassman. Many of you know her. She has come over from the IDB and has

been working in the field of public health for many years. So with that I will hand over to Amanda and to this terrific panel.

MS. GLASSMAN: Welcome. As in the G-8, the Middle East crisis has led to a very large event next door, so you can imagine that we are duplicating that situation.

I am very pleased to introduce this panel of distinguished speakers on behalf of the Health Financing Task Force which is an independent initiative launched in the February of this year at the request of the World Heath Organization. With this panel we are seeking to introduce the task force to the policy community in Washington and share evidence and practical insights on country-driven systemic health financing strategies that make a real difference for the sick and the poor.

First, we are honored to have with us Mary Robinson, Executive Director of the Ethical Globalization Initiative, former U.N. High Commissioner for Human Rights, and President of Ireland. Mary's presentation will frame the issues and keep us focused on our objective, how financing can make the right to health a reality.

Also joining us is Dr. Julio Frenk, Minister of Health of Mexico, who will describe his country's efforts to protect the poor from impoverishment related to illness, and extent cost-effective services to the entire population.

Following Minister Frenk will be Teresa Tono of the Ministry of Social Protection in Colombia who will analyze what can be learned after 10 years of health financing reform in Colombia.

Finally, David de Ferranti who is the chair of the task force and will tell you a bit more about the task force and highlight some global challenges.

I will ask each panelist to speak between 15 and 20 minutes, and then we will have questions and answers.

MS. ROBINSON: Good morning. I am very happy to be here and pleased to participate in the task force on financing for health, but I want to make it clear at the beginning that I have perhaps two handicaps that a number of you in this room probably do not have. I am not an expert on health, and I am not an expert on financing for health, but I do have a certain expertise on the human right to health. So I will begin with talking a little bit about the relevance of health as a human right to frame our discussion.

First of all, what in fact does it mean to call health a human right? Does it add anything? Is it just rhetoric or does it have some significance. I think it is important that a lot of work is being done at the U.N. level initially, and it is beginning on the national level, in fleshing out what we mean by the human right to health. It is a right that is addressed in the Universal Declaration of Human Rights, in the Constitution of the World Health Organization, in conventions such as the Convention on the Rights of the Child, the Convention of the Elimination of Discrimination Against Women, and in particular, the Covenant on Economic Social and Cultural Rights. I do not really want to go into too much academic discussion of that. I want to come to the focus now on the Special Rapporteur Paul Hunt, a New Zealander, who was appointed to that mandate when I was still High Commissioner for Human Rights.

Individuals matter, and sometimes we can be very lucky and get a really good Rapporteur of the United Nations in a particular area, and Paul Hunt is a particularly good Special Rapporteur on the right to the highest attainable standard of health, or for short, right to health. He has framed the right to health in a recent report to the General Assembly as essentially being the right to access to a functioning health system for basic health care, so he is very much in line with what our discussion is going to be today.

The project that I lead, Realizing Rights, the Ethical Globalization Initiative, I should maybe pause for a moment and explain the importance of this very long title for a very small initiative. The initiative itself is not self-standing. It is linked to three organizational partners, the Aspen Institute, and we have colleagues at Dupont Circle and very close to here, and colleagues in an office in New York, and also in our other institutional partner here in the United States, Columbia University. So in our work on health, we link very closely with the Mailman School of Public Health at Columbia.

The third organizational partner is the International Council on Human Rights Policy based in Geneva, the only international body focusing on human rights policy as opposed to issues of human rights protection or promotion, and, therefore, a very valued partner.

We initially called it the Ethical Global Initiative with its three institutional partners, and my Irish friends were quick to say that this was a hell of a highfalutin title for a very small initiative. They were right, of course, but my

Irish response was to lengthen the title, so now it is known as Realizing Rights, the Ethical Globalization Initiative.

Realizing Rights has two meanings, first of all, that everyone in the world should recognize that they have human rights, that the guarantees in the Universal Declaration in 1948 and all of the covenants and conventions are actually legal commitments of government. They do it voluntarily, but once they do it and ratify these instruments, they have a legal obligation to comply with them. But of course we know that millions and millions of people worldwide have no idea that they have human rights, do not know the rights language, and insofar as they hear the words "human rights," they are not sympathetic to them. They tend to be finger-pointing, cold, not close to the reality of those who live in poverty, those who are vulnerable and marginalized. So we have a lot of work to do in helping people to realize they have human rights.

The second meaning is those with power should realize those rights, and those with power nowadays is a wide area, if you like. It used to be and it still is the primary responsibility of governments to implement and to progressively realize economic social and cultural rights such as the right to health. The obligation under the International Covenant on Economic Social and Cultural Rights and the Convention on the Rights of the Child, the Convention for the Elimination of Discrimination Against Women, and a number of the regional conventions, is to progressively realize without discrimination within existing resources. That is the actual legal obligation.

But we now look to international organizations primarily across the United Nations, and I had a task as High Commissioner of mainstreaming human rights within all of the policies and programs of the United Nations, and that has more or less come to pass. Indeed, in his most recent report "In Larger Freedom," Secretary General Kofi Annan made a direct link between human rights, human security, and human development. He said there would be no security without development, there would be no development without security, and there would be neither development nor security without human rights. So he was linking perhaps what we are talking about here and what is being talked about in the larger room where the Middle East issues are to the fore.

We also work closely with the corporate sector, with multinational companies and the corporate sector generally, on their responsibility on relation to the right to health. Paul Hunt is doing particular work on the pharmaceutical sector which we are supporting to address the responsibilities that pharmaceutical companies have in the appropriate context of power and the way in which they exercise that power.

How does this relate to the question before us of financing for health? It has been very obvious to us in working in African countries, and other countries, and our project focuses primarily on Africa and African countries because we put it simply that when African countries begin to benefit from globalization, it will be a fairer, more ethical globalization, so it is a good way of assessing this.

We work on the ground in a number of African countries on different projects. I will just outline a couple of those projects. We work with a number of partners on a project encouraging parliamentarians to put more focus on women's health, on maternal mortality, and on the vulnerability of women and girls to HIV and AIDS, and you know the statistics of that. We come across the problems of financing of health, and we come across the problem of the fact that if there are any payments to be made at the local level, then the poorest will not be able to access health care. That has brought home to us the importance of having a different approach, having a more ethical approach, to financing health.

A year ago with the Mailman School of Public Health, Madeleine Albright, myself, and Allan Rosenfield, brought together 65 experts on women's health to a conference a little bit like this, but really focusing on how to prioritize women's health. We ended up with the Wye River Call to Action, Strengthening Health Systems for Women's Health. That is on our Website which is at realizingrights.org, and many other Websites, because several hundred organizations interested in health have signed on to that.

In parallel with that, we also got a number of former presidents, prime ministers, and well-known figures such as Bono to sign on a single-page statement on the right to health and what this meant in practice, and that, again, was an advocacy tool. But we really felt that it was necessary to start putting together other pieces of how to ensure that there would be a holistic approach to financing for health.

One of the projects that we are beginning to work in is about midlevel providers in a number of African countries, midlevel providers being midwives with special training, assistant medical officers in some countries, and this project will be operating in Tanzania, Mozambique, and Malawi. The Project for Parliamentarians also operates in Tanzania, and that is the only overlap country, in Botswana, Namibia, and Kenya. It became clear that we need to harness political will if we are going to have more support for financing for health, and where there is leadership and good political will it can make a difference.

We followed the impact of the financing for health under the Paris Declaration on Aid Effectiveness. Again, I assume many of you are familiar with the move by European donor governments in particular towards general budget support, being prepared to work with governments on their poverty reduction strategies, on their own planning for their own health, and then to give general budget support, and task governments with their responsibility and remind developing country governments particularly in Africa of their commitment under the Abuja Declaration that they would seek to reach 15 percent of their budget for health. I think I am right in saying that no African country has reached that target yet, but it is a pressure that can be put on individual developing countries to meet their share.

Although this Paris Declaration is intended to avoid the time and energy that poor governments have to put into reporting to donors under so many different schemes, and is trying to be more efficient and more effective, I am

hearing from health ministers in Africa and from senior officials in their departments that under a general budget support, health may lose out. It may lose out within its own cabinet because health ministers are not strong within their ministries and they are not necessarily on the budget committee of their ministries. In fact, this happened 3 years ago, linking another hat that I wear. I happen to be Chair of the Council of Women World Leaders and it also operates out of Aspen here in Dupont Circle. The council itself consists of the current and former women elected presidents and prime ministers. I could do a test-run question to you and say how many are in this council. I bet you would underestimate. There are, in fact, 36 members, most recently Ellen Sirleaf Johnson and President Bachelete of Chile.

The council uses its kind of moral authority and convening power, if you like, to bring together women ministers and their portfolios, and there is quite an active network of women ministers of the environment. We did 3 years ago during the World Health Assembly bring together for a long working lunch women ministers of health, and we did it last year, and nothing really came of it. But this year we invested more energy into it and we also got support from the Gates Foundation to build this network. We have two very good co-chairs, the Minister of Health of Kenya, Charity Ngilu, and of Spain Elena Salgado, and they are very committed. We are going to bring the ministers together again in Maputo for the African Ministers of Health Meeting, and then possibly again in Geneva in November.

What we are trying to encourage them to do is to strengthen their own ministries to learn from the experience that Charity Ngilu had as Minister of Health in Kenya, which she has told me quite publicly, I do not think there is any breach of confidence in retelling her story, and some of you may be familiar with it, she discovered that she was not as the Minister of Health on the budget planning committee of her government, so she was strong enough in her own personality to muscle her way on to that budget committee, something I strongly recommend all health ministers do in that particular context. When she arrived for the first meeting that she was attending, she was the only women there, discussion continued, and then she saw the figures. She turned to her President and she said, "President, is Kenya at war with anyone?" The President said, "No, Charity. No, we are not at war." And she said, "Why is the budget for the military so high?" She said to me, "And I got an extra 10 percent out of that discussion." So it matters where ministers are.

It also matters that ministers of health have the kind of resources and support, and have the kind of information that we are going to be discussing, about health financing. I think some of you may have picked up a recent Email about the situation in Uganda which recounts a similar sort of meeting in Uganda where health is actually diminishing, the budget for health is going down rather than increasing, and where there is a discussion about the possibility of moving towards some kind of an insurance system for health.

The last point I would make in my own learning curve of the many complex pieces that need to come together really relates to the experience that I

have on the GAVI board which funds the GAVI Alliance and the work in immunizing children. I know that Alice Albright, the Chief Finance Officer of the GAVI will be addressing you tomorrow and she has been doing incredible work with her colleagues not only in working on the funding that has come initially from the Gates Foundation and now from a number of governments, significant funding, for the immunization of children and bringing on new vaccines, but also the new finance facility that Gordon Brown was particularly instrumental in bringing forward, and now six governments, and support what is called the IFFIm, the Finance Facility for Immunization. Some of us on the board under Graca Machel, as a very dedicated chair who knows a great deal about women's health and about the lack of improvement in figures, for example, of maternal mortality, have been trying to focus on how to ensure that vertical interventions like the Vaccine Fund and Vaccine Alliance focused on one issue, immunizing children, must take responsibility for a strengthening of the public health system. GAVI has actually allocated $500 million, and we have a meeting in Berlin in November when we will hear more about the plans for that kind of strengthening of the health system.

I know that Richard Feachem of the Global Fund for AIDS, Malaria and Tuberculosis also feels very strongly that it is important that all of the interventions work towards the public health system. I do not think he has the same luxury of being able to allocate the same kind of level of financing for it, but the thought is there, the idea is there, and I think there is a big management issue which hopefully when you are discussing more with the private sector there can

be discussion of. If we are going to make progress in financing health systems, we also are going to have to have more coherence in the management of the various interventions because, clearly, we cannot go back to a mid-20th century approach when government was looked to to provide most of the services in health. That will not work on developing countries, and there are difficulties about it working, but government obviously has to have a key role in the planning, in the determination, and in the method of financing of health. But it seems to me that there needs to be a lot more emphasis on the management issues, on the importance of e-medicine, of telemedicine, in ensuring that those who are providing health in health districts in very poor areas have a communication system that reinforces their professional abilities.

Finally, one of the other issues that we focus on in Realizing Rights is migration, and we have been doing a lot of work on health worker migration, the terrible brain drain out of the countries with very high disease prevalence, particularly in Africa. Indeed, on September 12 we are convening a major meeting in New York on health worker migration issues on how to stem the brain drain while recognizing that the human rights of individuals to go and to pursue their careers, how to link diasporas, how to have support policies such as we are seeing now in Malawi where DFID in the U.K. is providing a huge support for retention of health professionals. All of this it seems to me to require the kind of thinking that we are engaged in, and I am looking forward very much to hearing the two examples of Mexico and Colombia that we will listen to. But I think we need to really use the opportunity over the next couple of days to see

how we can have a holistic approach to the financing component of strengthening health system, because if we do, and if we can make progress on that, then we making progress on what I started with, on the right to health. Health should not depend on income, health should not depend on whether there are any health professionals in your region. So often I have seen in health clinics and you have a nurse with 18 assistant nurses for an area encompassing 60,000 people about an hour-and-a-half outside of Kram, Ghana, where they had no electricity except for small solar lighting and where they did not have proper medicines. They had a very committed staff, but obviously completely inadequate. That is where the right to health is starkly not being provided, and that I think is the heart of our endeavor. Thank you.

(Applause)

MR. FRENK: Good morning to everyone. I would like, first of all, to thank the Brookings Institution and the Health Financing Task Force, especially David de Ferranti and Amanda Glassman, for the opportunity to speak this morning before this distinguished audience.

It is an additional privilege to share this panel with a woman of such outstanding achievement, Mary Robinson, as well as my esteemed colleague Teresa Tono.

For almost 6 years, Mexico has been immersed in a process of transformation of its health system that may hold important lessons for other developing countries. The purpose of my presentation is to share this experience with you, especially the use of evidence in the design, implementation, and

evaluation of the reform. Tomorrow afternoon I will be speaking again more about the need to make sure we finance the knowledge-related global public goods that generate a lot of this evidence that then are applied in a national context to improve the health systems, but today I will focus more on the experience itself.

Mexico, as most of you know, is a heterogeneous middle-income country with a population of 103 million. The point that I want to make is that its high degree of social inequality means that it replicates the gamut of health problems affecting the entire world. Like most developing countries, Mexico faces a protracted and unequal epidemiological transition that is adding new layers of complexity to the patterns of disease, disability, and death. Through a web of multiple causation, this country and developing countries must deal with a double burden of ill health. On the one hand, the unfinished agenda of infections, malnutrition, and reproductive health problems. On the other, the emerging challenges represented by noncommunicable diseases, along with their associated risk factors like smoking and obesity, by mental disorders, and by the growing scourge of injury and violence.

The complexity in health conditions is mirrored by the intricacies in the organization, financing, and management of health systems. We know that there is huge variation across countries in the performance of their respective health systems, even at the same level of income and health expenditure. Depending on such performance, a society may face either a virtuous or a vicious cycle between its level of development and the workings of its health system.

The conclusion is clear; policies for health are social choices, and the ways in which they are formulated and implemented matter very much in determining which of those cycles will occur in a given country.

One area of special concern is the relationship between poverty and health. It has been known for a long time that poverty is a major determinant of health conditions and also of health systems. More recently it has become clear that the relationship also operates in the opposite direction. But in particular, many developing countries are facing today an unacceptable paradox. Even though better health is one of the most effective ways of fighting poverty, medical care can itself become an impoverishing factor for families when a country does not have the social mechanism to assure fair financing that protects the entire population.

The WHO has recently estimated that every year, at least 150 million persons and 25 million households, the vast majority of them in developing systems, are impoverished through out-of-pocket payments on health care. The reform of the Mexican health system was designed to correct precisely this paradox.

An important antecedent in this regard was an ambitious initiative implemented since the 1990s to enhance basic capabilities of families living in extreme poverty. Originally called PROGRESA and then renamed Oportunidades, this program adopted an intersectoral strategy to fight poverty by creating incentives for families to invest in their children's human capital through cash transfers that are conditioned on the fulfillment of certain elements of co-

responsibility, namely, sending children to school rather than to work, providing them with a specially formulated nutritional supplement, and attending a clinic in order to receive a specified package of health-promotion and disease-prevention interventions. This includes basic sanitation, reproductive health, nutritional and growth surveillance, and specific prevention measures mostly for common communicable diseases.

From its inception, the program has had an evaluation component that has been robust enough to attribute substantial improvements to the various interventions, and has also generated information to fine-tune implementation. In addition to its technical aspects, rigorous evaluation had an enormous political value to assure the continuity of the program through a changing administration. Indeed, scientific evidence persuaded the present government not only to continue the program, but to greatly expand it. Oportunidades is presently benefiting 25 million persons, one-quarter of the total Mexican population.

But in health, we are always victims of our own success. The improvement itself in basic health conditions fuels the epidemiologic transition by enhancing this revival of children to reach ages where expensive noncommunicable diseases are more prevalent. It is this dynamic which makes health a never-ending challenge. Even as Oportunidades was proving its value in reducing poverty and improving health, the beneficiaries were experiencing new disease burdens while their expectations for a higher quality of care were growing. Ironically, a considerable proportion of the cash transfer received by poor families from Oportunidades was being used to finance health care not

included in the initial basic package of interventions which, as I mentioned before, was focused mostly on the pre-transitional pattern of disease burden.

Yet the reality too often overlooked in the search for equity is that problems only of the poor, like many common infections and undernutrition, problems only of the poor, are no longer the only problems of the poor, who also suffer from higher burdens of noncommunicable diseases, of mental disorders, of injury, of violence, of smoking, or obesity, and other risk factors.

On the basis then of the successful platform provided by Oportunidades, it was therefore necessary to expand social protection for all families that had been hitherto excluded from such benefits. With this purpose in mind, a major structural transformation was launched by the present administration.

In order to understand the reform of the Mexican health system, it is important to bear in mind that as Michael Reich has insisted public policy is built on three pillars: ethical, political, and technical. I am going to talk mostly about the technical, but let me just briefly touch on the other two. First, the ethical pillar.

The point of departure of the Mexican reform was a rights-based approach, and I was very happy, and, of course, I recognize the enormous work that Mary Robinson has done in this respect, like many other developing countries, the Mexican health system had created distinctions among several groups in societies, thus interfering with the possibility of achieving universal coverage. Even though social insurance was introduced in 1943, it had been

limited to salaried employees in private firms or in public-sector institutions and to their families. This arrangement excluded the self-employed, the unemployed, and those who are out of the labor market or work in the informal sector of the economy. The net result was that by 2000, nearly half of Mexican families, the vast majority of them poor, lacked social protection against the financial consequences of ill health. This type of occupational segregation in access to health care is incompatible with the notion that such access is a human right as stipulated in the U.N. Covenant for Economic, Social and Cultural Rights that Mary Robinson has already alluded to.

Whereas Mexico had made strides in the exercise of political and civil rights as a result of its democratization process, it was clear that the next challenge was to ameliorate social inequality by assuring the universal exercise of the right to health care. The term "universal" in this context has two meanings. It means to cover everyone, but also to do so without any discrimination of any sort; universal is the opposite of segregated. This was the overriding ethical framework in which the reform was presented. From it, a series of specific values and principles were derived. These are all publicly available in a number of papers and I will not deal with the principles and values, but the overall idea was a rights-based approach that said that we needed to complete our democracy by expending not just the exercise of political and civil rights, but also social rights, including, centrally, the right to health care, this proved to be a major, major element advocating for change.

That leads me to the second pillar, the political pillar. This pillar in the good sense of the word "political," I know we are in Washington and where can misunderstand that word, but in its good sense it means the development of consensus in order to achieve socially valued objectives. Through very intensive dialogue which I will not give you the details of, the remains that I am talking about were approved by a vast majority from all parties represented in the Mexican Congress.

Finally, let me focus on the technical pillar, and I would like to emphasize that these three pillars interact enormously. Ethnical deliberation is a powerful and persuasive force when doing the political work of reaching consensus, and both of those, of course, are nourished by good technical work providing good evidence about what you want to do and what is the nature of the problem.

In this case, I would say that the Mexican reform invested very heavily on the generation and application of relevant knowledge in what I think is probably a textbook case of evidence-based policy. Indeed, the combination of internationally adopted methods of measurement with national analysis required critical realities that require a solution. Thus, the calculation of national health accounts demonstrated that more than half of total expenditure in Mexico was out of pocket. This proved to be a direct result of that fact that, as I mentioned before, approximately half of the population lacked health insurance.

Furthermore, out-of-pocket expenditures were shown to be regressive since they represented a higher proportion of income in poor

households than in nonpoor ones. These findings were totally unexpected, because it was generally assumed that the Mexican health system was based on public financing. Instead, the analysis revealed that every year, 2.3 percent of households paid catastrophic, impoverishing sums for medical care and drugs in an analysis carried out by Felicia Knaul at the Mexican Health Foundation.

In this way, sound evidence made the public aware of the reality that had hitherto been outside completely the policy debate, namely, that health care itself could be a direct cause of impoverishment since the economic consequences of illness generated a poverty trap for uninsured families. This realization shifted the agenda by generating a different perspective on the operation of the health system. Policy makers extended their focus to include financial issues that proved to have a great impact on the provision of health care and on levels of poverty among Mexican households.

Another global public good that helped to make the local case for reform was the WHO Framework for Assessment of Health System Performance which showed Mexico performing very poorly because of its high level of out-of-pocked expenditure. Rather than generating a defense response, this analysis promoted careful analysis at the national level, and it was this careful interplay between national and international tools that generated the advocacy instruments to promote a major legislative reform establishing a system of social protection in health that was approved in the year 2003.

The system is reorganizing and increasing public funding by a full percentage point of GDP over 7 years, mostly from federal general taxes

supplemented by state-level contributions. This growth in funding is affordable since the starting point for total health expenditure was a mere 5.7 percent of GDP in the year 2000, a level that was insufficient to deal with the pressures posed by the double burden of disease.

Having come into effect on January 1, 2004, the new financial scheme will gradually protect 12 million uninsured families, close to 50 million persons, thus achieving universal coverage by 2010. The vehicle for achieving this aim is a public voluntary scheme called Popular Health Insurance, or Seguro Popular. While the transition period makes the initial funding sustainable, it also demands a major organizational effort in order to enroll 1.7 million families annually, around 37,000 every single week.

Currently, in the third year of implementation, the Seguro Popular has elicited an enthusiastic response from the population so that by the end of 2006 it will have enrolled a targeted 5.1 million families, which is close to 22 million persons by the end of this year. The increased funding is spearheading a major effort to realign incentives throughout the health system. Enrollment in the new scheme is now the basis for allocating federal funds to states which are responsible for the delivery of services. In this way, the old model of bureaucratic budgeting which subsidized providers without regard to performance is being replaced by democratic budgeting whereby money follows people in order to assure an optimal balance between quality and efficiency.

To achieve this aim, the macro-level financial reform is being complimented by a micro-level management reform which is strengthening

delivery capacity through a series of specific interventions such as long-term planning of new facilities, technology assessment, efficient schemes for drug supply, and rational prescription practices, human resource development including managerial training, outcome-oriented information systems, facility accreditation, provider certification, quality assurance, and performance benchmarking among states and organizations.

The element that articulates the financial and the managerial reforms is an explicit package of benefits which has been designed using cost-effectiveness and social acceptability, again, the ethnical pillar is here, as the guiding criterion. Apart from serving as a priority-setting tool, the package is a means of empowering people by making aware of their entitlement, again, what Mary Robinson was saying, making people realize their entitlements, and it also a key instrument of accountability by providers.

The net result has been a dramatic increase in the scope of benefits. From the original Oportunidades basic package of only 13 interventions, the Seguro Popular encompasses now over 250 which include all interventions at the primary and secondary levels of care. The comprehensive package of benefits serves as a tool to strengthen overall health system capacity through clearly identified priorities.

In addition, the budgetary increases along the 7-year phase-in period stipulated in the new allow for the coverage of an expanding set of high-cost interventions defined through a transparent and collective priority-setting mechanism. The most dramatic example has been the Program Against

HIV/AIDS. Thanks to the participation of civil society organizations, there has been a huge increase in allocations, and this has funded now a strategy, a comprehensive policy also based on three pillars, prevention, campaigns against discrimination and stigma, and universal access to comprehensive treatment including anti-retrovirals. In this last respect, AIDS treatment has been targeted for a special track of accelerated universal coverage. Thus, any uninsured person requiring treatment can immediately be enrolled in the Seguro Popular. The same scheme applies to childhood cancer which is already the second cause of death among school-age children, to uterine cancer, which is one of the top causes of death among poor women over 25 years of age, and cataract extraction in senior citizens which is the main causes of preventable diseases, among other interventions. Someone said this is a diverse selection, and my answer is, yes, the business of public insurance is adverse selection. That is why it is there.

But the benefits of the new system are not restricted to curative actions. For the first time in Mexico, this new system of social protection has created a separate fund for community health services which protects the budget for health promotion and disease prevention interventions. A peril in financial reforms is that enhanced actions to curative services may be achieved at the expense of the budget for community-based interventions which often do not generate spontaneous demand by the public. The separate fund was established in order to avoid this type of distortion which, ironically, adds to the cost of curative care by neglecting cost-effective programs for prevention and early detection. Finally, this, of course, has also included the funding of some public goods to

enhance human security through epidemiologic surveillance and improved preparedness to respond to emergencies and potential pandemics.

The evaluation experience gathered through Oportunidades is being applied to the current structural reform. The encouraging results shown by the ongoing assessment of the Seguro Popular will hopefully serve to preserve the continuity of the reform through the change of government scheduled for the end of 2006. As can be seen, a hallmark of the Mexican experience has been a substantial investment in research to design the reform, monitor process towards implementation, and evaluate its results. This is a clear example of the possibility of using science to promote social change by harmonizing two core values of research, scientific excellence, and relevance to decision making.

Let me close by proposing an A, B, C, D, E, of successful reform as a way of summarizing the global lessons that derive from the Mexican experience. A is for agenda. The first ingredient for success is to advance the health agenda amidst the competition for attention and public resources. Especially in the interaction of ministers of finance, health officials 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, generating employment, protecting savings and assets, enhancing competitiveness, and directly stimulating economic growth with a fair distribution of wealth.

B is for budget. By placing health at the center of the broader development agenda of a country, it is possible to endow it with the degree of priority that it deserves, that the experience of Kenya reveals. Such priority enhances the negotiating power of ministers of health in their quests for increased budgetary support. Using evidence on the value of health for development can also help convince policy makers to mobilize more money for health. But it is also necessary to demonstrate our capacity to deliver more health for the money, as the legendary Professor Ramalingaswami from India used to say, not just more money for health, but also health for the money.

This leads to the C which is for capacity. There is no substitute for long-term investment in capacity building. These efforts must be focused on two main areas. The first one refers to health service delivery for investments in physical infrastructure, and most importantly, in human resources. The second area has to do with the development of institutions that can carry out the necessary research 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 like 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 currently occupy key policy-making positions, and carried out independent and credible evaluations.

D is for deliverables. A key ingredient to garnering public support for a reform is to 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. A fundamental lesson from the Mexican experience is that it is possible to build up health system capacity through the scale-up of effective preventive and therapeutic interventions against specific priority problems.

Finally, E, as you would suspect, is for evidence. As demonstrated in this presentation, evidence derived from scientific knowledge has an empowering effect to transform health systems. The path is clear, sound evidence must be the guiding light for designing, implementing, and evaluating programs in national governments, bilateral aid agencies, and multilateral organizations. This is the path that would lead to more equitable development through better policy making for health. I thank you for your attention.

(Applause)

MS. TONO: I am very happy today and very grateful to be here. Thank you, David. I will first give you today a question I am most often asked. The effort in Colombia is now 10 years old. Health care reform in Colombia was a major endeavor, and I am going to briefly present this endeavor to you. I will speak to you about our trials and tribulations, or to be politically correct, the challenges and opportunities that these 10 long, difficult but I believe very rewarding years have brought to us. And finally, I will lead you into this question of whether this was worth it or not.

The reform in Colombia was passed in 1993, and implementation began in 1995. I am very proud to be able to say that I was part of the effort,

along with Minister Frenk and many others, a couple of whom are sitting here today with us, and it is with them with whom we have to share I believe the credit for what has been achieved in Colombia.

It is an extremely ambitious and complex reform which affected all the organizations and functions of the health sector in Colombia. As was the case in Mexico, we had a national health system, a social security system directed especially to public formal employees, and to private formal employees, and then we also had the private sector which was mostly out of pocket and privately run.

What we have today is a mandatory social insurance employment-based universal integrated system. It has very strong subsidies, it is very progressive, and I will tell you some more about this. It has a very generous health services package which applies managed competition and a dimension which integrates the three separate systems into one. And there is another line there which says that it combines all the public-private delivery of services into just one system. The objectives of the reform were and still are to achieve universality, equity, solidarity and efficiency; and the overall goal, of course, was and remains to improve the health conditions of the population.

If you think about universality as making sure that every Colombian and every resident of Colombia is included in the system, what we had was, and still have, two systems of financing and one system for delivery. How are people enrolled? We have a contributory regimen which is the system where individuals with earnings above two minimum wages are enrolled. As you can see on that diagram, you have the employer and the employee contributing 12

percent of this person's income into a huge solidarity fund, and these revenues come in to this big purse that the FAS's, or *Entidad Promotora de Salud*, Health Promotion Entities, which act as insurance agencies with the social purpose of acting on behalf of all individuals as wide purchasers of services. They are the ones who go out and look for better-priced and for better-quality services, which they contract with these providers and then provide this set of services which we call the *Plan Obligatorio de Salud*, or the basic health services package.

What happens then if you are not employed or have income above the two minimum wages that I just mentioned? In order to enroll these individuals that are the ones that we are mostly interested in considering that our objective, our main goal, is to improve the quality of the health conditions of the population, we came out with a subsidized regimen. This subsidized regimen is funded through the contributions of government, or all individuals in the contributory, and has a special characteristic to it, and that is the funds come through the municipalities, and the municipalities are responsible to identify the individuals in need of this enrollment, so they go out and they means test the population, assign then a subsidy, and those families which are somewhere between 55 and 60 percent of the population who are entitled then to the subsidy are enrolled in the subsidized regimen and they do this through the FAS's, the promotional entities, or the subsidized regime, which in turn, again, contracts out with the providers the provision of the services in the health services package.

The second objective is solidarity. The way this is operationalized in Colombia is through a strong set of subsidies, which I mentioned before makes

Colombia have a very progressive way of financing health services, and which helped earn us the title of which we are very proud of, being recognized as having the most equity in our financing in the year 2000 report. The way this works is that in the contributory regime, you have individuals with strong subsidies. This works through cross-subsidies where individuals contribute the 12 percent of their income, even if it is just two minimum wages or one minimum wage if you are a formal employee, and since that is probably not going to be enough to cover the cost of your premium, that capitation which is written there, the individuals who are high earners and contribute with their 12 percent more than the cost of their capitation, are the ones who of course cross-subsidize individuals who even though they are workers are not contributing enough.

On the other hand, you have the subsidized regimen which of course as its name suggests is strongly subsidized, and the sources for these subsidies are one-twelfth of the contributions on the contributory side, plus general taxes. In the beginning, and this was one of our great tribulations, that for 1 peso that was collected on the contributory account, the government had committed to contributing another peso. To this day because of a major recession and the agreement with the monetary fund that came with it, it is down to 25 cents. And in addition to those, all of those subnational taxes as a result of which today we are up to 85 percent of enrollment in Colombia. These are administrative data. I will show you some of the survey data in a minute.

Equity. How have we operationalized equity in Colombia? The way we did it is that we made sure some of the co-payments and certainly the

contribution, as I just mentioned, are income-based. Health care providers' fees are not influenced in any way, so we hope. We are looking into it right now by the socioeconomic status of the patient or the person who needs services, and the basic health services plan was built, and this is another one of our tribulations, around the health services needs of the population.

In order to achieve this objective, and this has been a major criticism of our reform, we set out to transform our supply-side subsidy which basically means that the government used to send all hospitals from their central budget the historic budget that they politically manipulated to make sure increased annually based on their ability to influence policies in Bogota, and those were transformed into demand-side subsidies which of course introduces strong incentives for efficiency. And along with that, there are strong reasons for FAS's, the insurance agencies, the promotion entities, to control costs.

So what are our trials and tribulations? Many years later, there have been many political challenges to Colombia's welfare reform. The first one which is quite amazing, and hopefully you will not go through that one in Mexico, I understand we will find out in a couple of weeks, is that the following administration in Colombia vowed not to implement the reform. Even through we passed the reform in 1993, it was December, administrations change. We had presidential elections in March or April in Colombia, and a rival group from the same party, a very rival group, came into office the following August. So we had barely 6 to 7 months in office as a lame duck administration to set in place all the norms and regulations that were required in order to start implementing the

reform in 1995, but by then we were out of office. Since then, and for the following 8 years, the Colombian reform went through nine ministers of health some of whom approved of the reform, but were never there long enough to be able to clearly focus on the implementation of the reforms. There was in every legislature, and still are, proposals to reform the reform, so we have gone through every possible political challenge, and we have as a result of this, gone through the most interesting process, and that is that despite the fact that it has been challenged politically because it is such a strong reform by every possible group, it is the citizens, those enrolled in the subsidized regimen, who have come to defend the reform.

In Colombia, if you attempt as someone did barely a year ago to change the way that people receive their ID cards through which they feel their entitlement to the services, in particular, the subsidized services, there were riots in Colombia. A year ago I was saying in Bogota, the *Secretaria de Salud*, the Secretary of Health in Bogota, asked all individuals to come to this major commercial plaza because he was going to retest all individuals on their means test, and there was a riot and one person died in the middle of this riot because poor individuals in Bogota thought that their benefits were going to be taken away from them. So at this point in Colombia, politicians know and they fear that if you attempt to reform the way the poor, those subsidized, perceive their benefits from the system, they will face riots. Individuals will walk, they riot, you cannot take their carnay (?) which is way they call them away from the poor in Colombia.

So the amazing thing we have now regarding the political challenges is that many feel, especially those in the opposition, that the Colombian reform is far too progressive, that it has affected hospitals, and I will present this to you briefly, and that they would like to reform it. Yet it is the citizens who will not allow them to do this. Still we face very important political challenges to this day.

When we were back at the beginning of this administration after those 8 years, and that was barely 3-1/2 years ago, we found that the reform's implementation was only halfway done. At that point, it was very evident that the supply-to-demand subsidies' transformation was going to be extremely difficult to enforce. What this means was that when it is clear to us that we were not going to get more money from the central budget, we had already increased expenditures in health care a great deal. So what we were going to attempt to do was to pull the subsidies out of the public hospitals and turn them all into demand-side subsidies. But by then, hospital directors and local politicians had understood that the basis of their local political elections, the hospitals, and probably are in many other countries, were threatened. As a result of that, and I would present to you the solution we came up with, this enormous challenge which is that we have to fund both the demand subsidy, and at this supply subsidy as well.

The basic health services package was challenged by the unions. The unions in our country which were the ones who mostly enrolled in the social security system we had before had come to consider their health services package to be never-ending. It was extremely comprehensive. Everything was included.

It was not even explicit, it was just everything. So in 1994 when the time came to calculate what was to be included in the basic health services package, we were challenged by the unions and they expressed their extreme discomfort with our attempt to make it explicit and to make it based on evidence of what was and what was not affected in combating disease.

As a result of that to this day we have a basic health services package which is extremely inclusive, and because not everybody has enrolled, we still survive. Once we reach 100 percent enrollment, I do not know what is going to happen in Colombia, and that is one of the challenges that we face.

The other endangered political challenge is that we have very unhappy health professionals. I am married to an orthopedic surgeon in private practice. High earners in Colombia, physicians and other health professionals, are very booked. I deal with it every night. We hear from them every day. They do not like the fact that their incomes have been greatly reduced. Nonetheless, when you look at the income of most physicians and most professionals, their incomes have increased. They are not that vocal, though, so we are still having problems from the National Academy of Medicine and other academies in Colombia. We have yet to deal with them as well.

Technical difficulties have included very markedly reduced revenues caused by a very important recession which started in 1995, and the subsequent agreement with the monetary subsidy. In addition to that, we have studied and found marked evasion on the part of employers and employees. We have finally set in place a good information system, and the country is out of its

recession. Revenues are getting better again, and our President during his second campaign, he was just reelected, came to terms with the notion that there is not a poor citizen in Colombia who is going to allow their carnay to be taken away. So he has promised enough resources for 100 percent of the population to be enrolled and we hope that this can be achieved during the first 2 years of his second administration.

Public hospitals, which are big, which are two-thirds of our hospitals, as I mentioned, they were traditionally on an historic budget. Because of the reform, we asked the hospitals to actually bill for the services they provided, and they went berserk. Psychotic is a mild word. They did not know how to bill, they were not used to this. They were not used to collecting. To this day we are still struggling with it. However, thanks to the support of several institutions of a couple of people who battled through this with us, especially Amanda who sits here, we came up with a hospital reform that has enabled us to provide them with some mechanisms in order for them to come up to date with the reform and the expectations of all citizens in Colombia.

In addition to the public hospital problems, the municipalities which, as I mentioned in the graph, are the ones in charge of identifying citizens in need around our country, they were not prepared. In some cases they were openly corrupt, and we had to deal with those difficulties as well.

Very briefly, what happened with public hospitals? When we came into office for the second time in the year 2002, this is what we found. They were extremely inefficient, there was a marked increase in their revenues,

with an even greater increase in their expenditures. The increase in expenditures was mostly due to an increase in personnel, not only in the number of people working in the hospital, but also in their wages, despite which their production of services had not increased, and in some cases it had even decreased. What you see here is total discharges, total deliveries, and total consults. What you can see is that hospitals had become the places where people went for their jobs, but the citizens were not getting that much out of it as a result of all that increase expenditure.

So we came with a solution which we have been implementing during the past 3 years with the support of several international agencies, which hospital reform, public hospital reform, which was a collection of very specific strategies. The first one was the development of hospital networks. In all of our countries we have been talking about the referral system. At this point what we did was that we clearly identified where the people went and where they were referred based on individuals' perceptions in the rural areas and what the community felt were the best ways to get to the hospital, and those were the networks that were developed. Marked personnel reductions, and that was funded by the central government along with payment of all the current debts of the hospitals, in exchange for which we established with them performance agreements that were signed by the national, the departmental, and the municipal authorities, along with the hospital directors. The reason for all these people signing in was that you required the promise on the part of the politicians that they were not going to interfere with the performance of the hospitals for political

purposes, as they did before. We provided technical assistance, and we closed unneeded, poor-quality hospitals. Yes, you heard right. We closed hospital. As you can see in that graph a marked variation in personnel expenditures which are the first couple of columns, comparing hospitals of equal characteristics which were intervened and the ones that were not. Increased production. And decreased unitary costs of production of services.

Other opportunities. We developed and implemented a health care quality assurance system. An information system which is required to identify the people who are entitled to the system and hopefully enrolled into the system. Norms and regulations have been organized. The allocation of public funds for the municipalities is now based on population enrollment, a much more equitable formula. And there is a strong effort to strengthen the Ministry of Social Protection where the health sector is now a part of the social protection system of Colombia.

And I pose to you, is it worth it, all of these tribulations, all these difficulties? Let me show you. Enrollment has been going up, and it has been going up markedly among the poor. Equity, and you are going to have to take my word for this, has increased to a great extent. Of course, I am showing you my best graphs. Nonetheless, you find that not as marked as this one, but you have striking results in terms of the ability of people to enroll and use services in relation to your income. This is a Gini and equity not unlike what Wagstaff proposed in his papers where you have that in 1995 the probability of a woman enrolling in a rural area was markedly associated to her income, and it became

that blue line which is a zero association between income and probability of enrollment in Colombia. Ability to pay as a barrier has been decreasing markedly. These are all year 2003 survey results. We have a lot of administrative data, but I thought being a scientist I would show mostly survey data. And use of services has increasingly improved over the past 10 years. At this point we are conducting research in Colombia which suggests that there is a causal effect, yes, causal effect, between enrollment and use of services, and preliminary results are showing, and we expect to have this study out in about 6 months, that there are causal effects with the decrease in infant mortality in Colombia.

In addition to that, you see in those two graphs that expenditure went up and it stabilized. You see that there is a dip there as a result of the recession. But as was the case in Mexico, we found using national health accounts that expenditure in health care was mostly coming out of the private sector out of pocket. That has decreased markedly. Those are the red and pink bars on your first graph. And in exchange, in contrast, you have on the yellow and the orange bars which are going up, expenditure from the public sector and the social sector. And my graphs for mortality which I hope are a result of good health care policy.

Thank you so very much. I so wish for another 20 minutes. I have so many graphs to show you, but thank you.

(Applause)

MR. DE FERRANTI: Thank you to all. I am looking around the room, and it is great to see so many familiar faces, people who are doing and have done great work in this area.

I think if there is one message that I want to leave with you in my brief remarks, and I will be brief because you have been such a tolerant audience, I think you actually all deserve immediate universal coverage which Mexico, Ireland, and Colombia have greatly offered for your attendance here.

(Laughter)

MR. DE FERRANTI: If there is one message I would like to leave with you, it is that the work that you and your institutions are doing we see as a task force we can be a helping hand in getting those messages further along towards acceptance, towards change, towards progress. I am going to come back to that, but you are inventing things, or there are plenty of good people including people here, who are inventing things. Where we see a need, where we think we can helping is taking these ideas, evidence, strong basis for moving ahead, and helping that move forward.

We designed this session with the thought that the presentations that you have heard would be both of interest in their own right, as I personally feel they certainly have been, and I hope everyone here does, and examples of what the task force is setting out to do. As part of this session that I would finish, again briefly, talking a little bit about what is the task force and how does it relate to the kinds of things that you have been hearing.

So, what is it? First, it is Mary, it is Julio, it is me, it is others who could not be here today such as Ngozi Okonjo-Iweala who is now the Foreign Minister in Nigeria—she was the Finance Minister as many of you know. It is also Verog Tang Arsarkian (?) from Thailand, and we expect to add others. We are talking here of people with leadership experience, and quite deliberately some from within health, and some from without, because part of this task of getting acceptance, and it came up in all of our presentations, is the ability not only to talk within the health community, but to carry messages convincingly beyond the health community to the others who need to be convinced.

The task force also is a wonderful and diverse group of experts and people who are contributing as part of this effort and as part of their own efforts to the assembling of the evidence that can provide a way forward, such as Teresa, such as Felicia, such as others in this room, and a long list of others that we will be over time drawing on.

The task force also is independent, and by that we mean that although it was instigated by WHO which is a fancy way of saying that Tim Evans bludgeoned me until I finally decided the only way to get him to stop bothering me was to say yes, but we insisted that we should be independent, not beholden or hostage to the processes or the approval of any institution including WHO, because we felt that that independence could be a crucial asset, and with the kinds of assets in terms of voices that we seek to bring to bear that that independence is important and it enables us to speak out a little bit more

forthrightly than might be the case for any institution that is worrying and looking over its shoulder at what its governing authorizing environment is having to say.

Before we actually said yes and started this effort; we asked around and did a kind of informal survey to find out what really needs doing, if anything, in this subject area at this time. We are all busy. We do not need one more thing to keep us busy. And we also knew that there are many efforts, have been and are, doing wonderful work on some of these issues including what many individuals that I see in this room are working on at the international institutions, multilateral and bilateral, including the banks, the WHO itself, European donors are financing quite a bit, at the think tanks, academia, several special initiatives, good books have been and are being written, and there is no need to we concluded repeat all that.

But what we also found in our informal survey is a lot of people telling us that although a lot of work is going on, the success rate in getting good ideas adopted could be better. We have heard some cases today where the success rate has been good, but not with a lot of pain along the way, I would say, and there is something to learn from that as well. What is the political economy, or as Julio put it, the political pillar which feeds on the ethnical pillar and the technical pillar that helps get messages adopted?

So we felt we were getting a pretty strong message that a helping hand in getting good ideas accepted, not only within the health community, but with finance ministers, with decision makers, whether they are at the G-8 or whether they are in country cabinets, was needed. And we also received

messages saying that this kind of effort with this kind of leadership experience, assembling strong, credible, independent voices could help in that process using the connections that we have, access to fora and to individual leaders.

And I would say that there are two other related thoughts here. One is that is a broader thought that I have come to feel is important not only in this area, but in many areas. In so many areas there are terrific ideas and there are leaders, and they are not connected or they are not feeding on each other well enough. Recently we had in town here we had the Initiative for Global Development which is the Bill Gates Sr. event. There was a terrific gathering of leaders from the President Bush and many people around him, to others in previous administrations and business leaders and so on eager to help without much knowledge or awareness of what these ideas are, and then around the periphery are people with ideas. So in a small way, what we hope this task force can do is to help bring the leaders of the world and the ideas closer together.

There is also this second very practical consideration, and that is there is so much turnover in the people who make decisions that you have to continually help that communication to occur. As I think is often said, after you have said something and worked with somebody on it 800 times and you think I cannot possibly add any value, you will discover you can because it is a new person in a key position.

How best to do that? It is not for us to write more long books. Books are being written and it is very important that they are, and good people are doing that. What we need to do is to find and exploit ways to communicate

messages, and hypothesis at the moment is that one of the good ways to do that is country experiences of the kind that you are hearing. Stories. Well-documented stories, stories that stand up under scrutiny, but stories, stories with facts and figures because that is what is remembered and gets across. So that is the hypothesis that we are going to be working on until we learn that maybe we are making mistakes and we need to do better.

We are very conscious of a relatively modest role for us in this. As I have laid it out, others are doing the original work, others are doing the initial rounds of communication that occur within the technical community. We are coming in at what we are told is a key link where their help is needed, which is to help carry those messages to a broader level. In some sense, it is terrific that there is more emphasis today than in the past on dissemination, but dissemination always brings to my mind the notion of scattering seeds more or less randomly and hoping that something will grow. What we are talking about is a little bit more intensive, hydroponic, I think, advocacy, if you will let me use that term.

A few more things. I want to reemphasize as has come up, that geographically, Africa, Asia and the Southeast are really important to us. You happen to see a selection here from LAC because we are in town for other purposes, but as we take our traveling circus to different fora, we will be doing similar things with emphasis on other parts of the world.

Related to that, obviously, is low-income countries. We were hearing about two middle-income countries, but the challenges are even greater in

low-income countries, and there we face many situations, as I look around the room, are well familiar where the answers are not clear.

We are partnering with other efforts, so we are at a moment in time when the latest round of disease-control priorities has come out, as you have seen, and those who have worked on that have asked us to link with them in some efforts including in India, and these seem like good opportunities. I mention that as one example. We are happy to and look forward to partnering with others, and if anyone in this room and the efforts that you are connected with suggest to you ways that we can partner with you, once again, we are on the receiving end carrying the messages forward and we would be delighted to talk about that.

We are not only looking at countries as we hard today, but also at cross-country policy questions and asking ourselves are there some cross-country questions that it would be helpful for us to focus on. For example, much has been said and written and debated about health-related sin taxes such as tobacco. Because we are an independent voice, should we, can we usefully add to that in a way that other institutions would not able to be quite so forthright?

We are also looking at issues not just about financing within countries, but also at some of the global issues about development assistance and other flows, and that is part of the discussion from related but separate work that will be discussed tomorrow.

I have lots more to say, but I just want to close with you have been hearing with me about a lot of process, and I would like to say something briefly about what are some of the core ideas, almost values, that are driving us very,

very briefly. I think that the top one here, I have phrased it as a question but it kind of leads to its own answer, at least I hope, if we look around the world, and I have a little data I am going to show you on this, and we see health care systems where the costs of getting health care are borne mainly by the sick and their families. This is out-of-pocket payments. Is that the way the world should be run? Or are we as a global civilization ready to step to arrangements whereby everyone, sick and healthy, share in those burdens together?

We globally made choices about that decades ago in education which is borne by everyone, and by so many other things, security, defense, and I think part of the message that you have been hearing today includes some steps of countries that are moving towards that fundamental principle, that health care costs should be shared by everyone. That is not a new concept and does not seem like rocket science, but I mentioned it also because we are looking for messages that can be politically compelling, that can bring as many people into the tent as possible. It seems that this way of putting it in even a term like out-of-pocket payments does not resonate and does not mean a whole lot to some people, but once they get into it, this kind of language does.

Let me relate that to these next three things that are here. Basic health care, the job is not finished. A lot of people here have been working years when we thought that this would have been solved, if we go back to Alma-Ata and primary health care, but basic health care is not finished. This was part of Julio's message even for Mexico, and so the question is, should some minimal level be assured for all. As you can see from the way we framed it, we think so.

The next step up is catastrophic illness, and should protection against financial ruin be assured for all. Then the most ambitious for all is universal coverage or expanded coverage for other things. There are a great many other things and I will not go into them, but very briefly, many people here are familiar with this data, but for those who are not, and it is interesting, we are in an institution here, Brookings, that has focused over its lifetime much more on U.S. issues and often this kind of data is not familiar to those who have not been in the international sphere at lot.

We have grouped together all kinds of payments, and this is WHO's data, into three categories. The light blue is out of pocket, the purple is private pooled, and the green is public which is a combination of tax and some social health insurance. If you that the fourth bar there which is high income, if you broke it down into the U.S. versus the rest, the bar between the purple and the green for the U.S. is farther to the right, but the bar for out-of-pocket payments is not too far from where it is there.

The point that sometimes comes as a surprise, although not to others in this room, is that the poorer the country, the heavier the reliance on out-of-pocket payments. Remember, out-of-pocket payments also includes what people pay to traditional healers, a chicken for a health incantation, whatever it is, or a day's labor to a drug seller, whatever it is, the poorer the country, the more predominant those things are. So we have an upside-down scenario in which the countries where the resources are the least are the countries that relying so heavily on out-of-pocket payments, and this we see should change.

To close, the basic health care, some estimate of about over 2 billion people lack some combination of these basic things, core health care services, safe water, or sanitation. As to catastrophic illnesses, more than 150 million people yearly get impoverished by them. And with other health services, we recognize that is going to be a long transition, particularly in the poorer countries.

I am going to stop there, and thank you again as an audience. I think Amanda is going to lead us not in a little bit of Q and A.

(Applause)

MS. GLASSMAN: Thank you to our panelists. We have about 10 minutes for questions. There will be someone walking around with a microphone. Also, suggestions and comments are welcome as well.

MR. WEIL: My name is Cesar Weil (?) from the IDB. Actually, I have a question for Teresa Tono. One thing that is very interesting to me is how Colombia combines this very advanced health system, but on the other hand, we have been hearing reports that some of the basic health tasks that the government should do are not performed properly. One example is vaccinations.

MS. TONO: I know.

MR. WEIL: Colombia is a country that for its level of income should have vaccination coverage close to 100 percent, but it is much lower than that. Can you comment a little bit on how this paradox arrives, how you have this great health financing system on the one hand, but then you have problems providing, for example, vaccinations?

MS. TONO: It is not an example. It is one of our greatest technical difficulties. Vaccination in Colombia, and this is probably true for many other countries, was a very vertical program. It was born as a program which was greatly supported by PAHO and other institutions around the world, and it was integrated into the government's responsibilities only about 20 years ago, and it was very vertical. Our reform is a wonderful thing that is terrible for vertical programs. It is absolutely horizontal. So vaccination was introduced into the basic health services package along with everything else, and the problem was that, let me put it to you this way, if you ask me what it was we should have done differently, knowing what I know today 12 years later, I would tell you that what we did worst was that we did not carefully implement the stewardship function. We did not quite understand the role of the minister and the leaders in coordinating, in directing, in regulating, the operation of the system. We were used to being the operator, not the leader, not the promoter, not the coordinator.

What we did with vaccination as the most horrific example, fortunately, only TB, malaria, and vaccination which were the main vertical programs of the government that underwent this crisis, was that we as a result of the reform transferred the responsibility to the municipalities and to all the promotion entities, but we never told them how to do it because as a ministry we were very weak, we did not quite understand our role, and there was so much political turmoil during the first 8 years that nobody of those who were in office during the first 8 years was quite clear on what this role for the ministry should

look like, so it was not implemented. Some of them hated not operating the vaccine program, so, yes, there is a paradox in Colombia.

Fortunately, the good news is, for the past 2 years, and only the past 2 years, we are getting our act together with the vaccination program, TB and malaria, and we now understand that what we have to do is that we have to strengthen the municipalities such that they will assume and operate these extremely important programs and do it properly, and we have had to learn how to keep our hands off with the operation. It is a temptation to have vertical programs. It is very tempting. We do not want to do it. We do not think it is right in our system, but it is very difficult. It is very visible and we have been widely criticized. You are right.

MR. FRENK: If I can just say that one lesson we learned in Mexico from the Colombian experience was exactly this, and that is why we realized that you cannot adopt an insurance approach to some of what are truly health-related public goods. But also, a number of personal health services where you have major failure in a number of preventive or even early detection campaigns like tests for cancer of the cervix or early detection of breast cancer. Those programs without becoming verticalized have to have separate funding, and that is traditional public financing logic because these are revealing real public goods like the epidemiologic surveillance or extreme cases of market failure where you probably just have no spontaneous demand for some of those. And that is what we put into a separate fund precisely to avoid the fact to have

this sophisticated insurance system, but insurance is not the way to fund a lot of these particular services, both the public goods and personal services.

MS. TONO: If I may add, what we are doing with vaccines is that the central government is purchasing all the vaccines. We are in charge of distributing the vaccines throughout the country, and it is then the local agencies who make sure that they are delivered, but we have learned the hard way. I am glad you guys are not doing it our way.

MR. MUSGROVE: I am Philip Musgrove, and I was, as of last October, a deputy editor of the publication "Health Affairs" which for most of the last 25 years has been publishing about health policy almost exclusively in the United States with occasional glances at other rich countries.

We have a grant from the Gates Foundation to go global, to summarize it briefly, to start publishing a great deal more material about low- and middle-income countries. My suggestion is that you think of “Health Affairs” as an obvious place for this pushing the dissemination of experience and of learning to the rest of the world, and particularly to the 25,000 or 35,000 people who already read "Health Affairs" every 2 months. You have there an audience who will be very interested in the kind of stories we have just heard, and they ought to be heard a lot more widely than just the contents of this room. I think you all know how to reach me when you have a manuscript that we like to see. Thank you.

MS. GLASSMAN: Thanks, Phil. Wonderful.

MR. TOPLUKANOV: I am Asifan Toplukanov (?) from GDZ, and I also here on behalf of the WHO-ILO-GDZ consortium on extending social protection in health.

I want to say thank you to David de Ferranti and Amanda for inviting me. It is really a pleasure to be here, and thank you for all these very inspiring presentations. I want to say that we as a consortium feel that this initiative is very much needed.

What we have been doing has been focusing very much on providing technical assistance to the countries who have been wanting to go into reform of their health insurance systems, and we had a network of experts who could provide this technical assistance, and from our experience, we were able to go a fairly long way. But we were blocked at the point when it came to the highest-level decision in some cases. In fact, Kenya, which you mentioned, is one example where the Ministry of Health had wanted health insurance for all types of models and the technical papers were prepared and tabled in Parliament, and still today this law is waiting to be passed, although it was nearly passed already 1-1/2 years ago, and it was blocked, in fact, at the Ministry of Finance at the crucial point. If the task force had already been there and if you had already been able to talk to the Minister of Finance, perhaps this process would already be one step further. So I think it is really very, very much needed.

The second point which I think is also an important task is to discuss with the countries the essential packages that should be included, and I was very glad to hear that the issue of women's health was raised, and that is one

issue which, again, we feel is often neglected in the discussion of what should be included in the essential package, how far should antenatal care be included, obstetric care, and the whole agenda of the ICPD is forgotten in the discussion on providing financing for social health care, and I think these two should be linked more strongly.

Finally, just a few ideas from a recent meeting we had with other partners in Copenhagen. There, some of the other countries, particularly Finland and some others from Southeast Asia, felt that it was important to include health promotion financing in the discussion on health care financing, and to include also issues linking environmental health and health protection.

Finland mentioned at that point that this was going to be something they were going to take forward during their E.U. presidency and that they have nationally now introduced a policy of "Health in All Policies." Again, this is something that could also be taken forward through this task force.

Finally, just one appeal regarding the regions which your attention is turned to, and it just an appeal not to forget the region of the countries in transition, the countries of Eastern Europe, who are also very much struggling with health care financing issues and certainly need that support and discussion at the highest level as well as at the technical levels. Thank you.

MR. PLEKA: Alex Pleka (?) at the World Bank. I had a question for the panel. How does one translate global strategies into local action? The context for that question is that I think if one looks back at the last say 20 years of so, we have had the World Bank Strategy 97, the World Health Organization

"World Development Report 2000," and then we had a follow-out with the Macroeconomic Commission, Jeff Sachs led that, and then more recently, two or three high-level forum meetings where I think the issue of health financing has been an underpinning for getting health and development and was quite strongly underscored and was seconded I think by international meetings such as Monterey and other fora where certainly political commitment was expressed that these were important issues and issues that should be taken very seriously.

I was personally part of two meetings, one in South Africa and Thailand, where the links between all of this and human resource capacity building in the Africa region without another 1 million health workers who we are just not going to get through the Millennium Development Goals, and, of course, 1 million health workers is going to cost a lot of money.

The question really is, and I think you have well stated in the panel here that the intention of this task force is not to write more books or papers, but really to find practical solutions to some of the problems or insights that we have had so far. That is not simple, however, and I just was wondering if there were any sort of preliminary insights as to how to make that bridge and how really to translate that into action on the ground, notably in the context of my work in the Africa Region where we have had in the last year now a very strong commitment by heads of state and the ministries of health to move on the health financing agenda. A recent review showed that since that commitment was made in 2000, we are now coming back 4 or 5 years later, 50 percent of the states had actually made progress with the commitment, but 50 percent of the states had actually

gone backwards. The question is, even with high-level political commitment at the ministry of finance and ministry of health levels, that may not be enough, so how do we push this down further than that? Thank you.

MS. GLASSMAN: David?

MR. DE FERRANTI: That is a great question, Alex, and I think one very important point to make is that there is no substitute for having local not just ownership, but enthusiasm in the leaders. That is one ingredient. The second is to equip those leaders with the information, ideas, and support.

I think that the examples that have been cited, the Kenyan example that Mary reminded us of, Julio's and Teresa's recounting of their own experience, that is obviously an important point because we are living in a time when we have a lot of global initiatives that have a tendency to say we are going to drive down from on top and fix it ourselves, but I personally am a believer that you have to have local leadership.

That poses a lot of challenges. Where it exists, it can be strengthened, it can be supported and maybe we can help along with others here. Where it does not exist, that is tougher, and I do not think we can pretend in situations where there is no commitment or no ability to translate commitment into action, you can get around that.

It is interesting that you said there have been commitments by the ministers of health and by heads of state, but that to me underscores once again those two entities need the help to be able to convince the other.

MS. ROBINSON: If I might respond also because some of the issues behind your questioning also encouraged us to strengthen this network of women ministers of health because from experience we know that health ministers within the cabinet, as I said, are not very often particularly strong and sometimes their ministries themselves need a great deal of very practical support. So I think this is the first time that ministers and their ministries have been looked at in a kind of networking for support way, and we can bring the good examples of countries that are addressing these issues like the two examples we have had, and we can bring the financing for health thinking to the health ministers themselves. We have had a very positive response from them particularly this year because of some foundation support to strengthen in a personnel way.

Another thing that I am learning because I am on a learning curve, as I said, is the importance of the extent of the delivery certainly in African countries by midlevel workers. I was astonished going into the Amana Hospital in Dar es Salaam to find less than half a dozen fully qualified doctors, and all of the procedures were carried out by trained midlevel workers. The more I see the more I think it is clear that there are new issues of how to look at the human resources, particularly, as I said, from the countries that I am aware of in Africa. So we are trying to in one project with the Maliman School and with a network of those who have been working in 20 African countries and drawing on the experience, have tried to enhance the visibility and awareness of what these trained midlevel workers are doing as a way of strengthening the health system.

If we gain good information from this as I think we will, we will trying to bring that to more of the health ministers, but in particular I think from the point of view of technical assistance, health ministers in their ministries and in their relationship with the cabinet need a lot more support than was recognized before.

QUESTION: (Off mike) from WHO. Thank you very much, first of all, for your very interesting talks. Thank you also, David de Ferranti, for getting this independent task force well underway.

(Interruption)

QUESTION: (In progress) —or are the subsidies lacking, or what are the main challenges in this area?

MS. TONO: Funding, financing. I would like to add to your comment something that I think helped that is going to help me illustrate my response. What I am going to say is part of the internal doings of the finance ministry, but we found a tool that gave us in the Health Ministry, now Social Protection Ministry, enormous clout. We worked with the banks. Amanda is here, some of our colleagues from the World Bank and IDD are here. In the middle of the Monetary Fund agreement, at the beginning the government required extensive amounts of cash and the matrixes were set up by the banks in such a way that they were quite keen in protecting enrollment in the subsidized regimen as a result of which we had enormous clout.

I had the opportunity to sit at the ministry at the budgeting committee along with my minister and we would sit there and refuse to comply

with the matrixes if they did not agree to provide all the funding, and the banks were quite careful in helping. I am going to put it that way. The banks made an enormous difference in Colombia during the past 4 years in that they helped us gain political power, so we are now a major player when it comes to budgeting in Colombia.

If you add to that the effect of the citizens' march and riot, there is not one opportunity when the budget is being drafted that we are not on the table, unlike education. Should they be there? Yes. Do they have the clout? No. We have it.

But we need even more funds. We at this point are still lacking the extra 75 cents per peso that we should have, and the people who are being left out who have yet to enroll are mostly the not so poor because people in the lower deciles are enrolled now. Some of them are still lacking. We have to actively pursue those in the faraway regions, and, oddly enough, in the greater slums of the larger cities. We have had difficulties identifying them and providing them with insurance.

We have also had great difficulty identifying those who are not rich enough to be in the contributory regimen but who are not desperately poor, so they are not immediately enrolled in the subsidized regimen. In addition to that you have some wealthy people who are not as risk-adverse who have not enrolled and apparently are not interested in enrolling either.

MS. GLASSMAN: I want to wrap up. I want to thank very much our panelists for joining us today. I think what is clear is that these are complex

issues and we are in the midst of an international environment that continues to call for billions of dollars of additional resources without giving much thought on how best to organize and use those additional resources, or to make best use of their existing resources. So are hoping that you have enjoyed the panel and you will stay engaged with us as this process goes forward.

Thanks very much for coming, and thank you to the panelists.

(Applause)

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