

Keynote speech at UHC2030 meeting by Jeannette Vega, Chile.

Health systems strengthening today: Challenges, needs and opportunities at country and global levels

I want to thank WHO for inviting me to join this meeting to discuss some ideas about working together to strengthen health systems to achieve UHC. I am honored to share the session with my colleagues from Sierra Leone, Indonesia and Japan and to have the privilege of hearing from Dr Chan and our Civil Society discussants. Universal Health Coverage (UHC) has gained tremendous global momentum in the last few years. Achieving UHC means that all people in the world can access the quality health services they need without suffering financial hardship.

In 2010, the World Health Organization released a seminal report calling for UHC. UHC is now central to the UN Sustainable Development Goals (SDGs), adopted in September, 2015, with a specified target in SDG 3— ensure healthy lives and promote wellbeing for all at all ages.

It's easy to see why UHC has become a global target: beyond protecting the human right to health, investing in UHC pays off from an economic perspective. Every dollar invested in health systems today is projected to yield \$9-\$20 in benefits by 2035. Conversely, the wrath of Ebola in West Africa is a painful reminder of the costs of neglecting health systems.

The question is no longer whether to pursue UHC, but how. One important resource for countries should be real-world examples of how other countries have expanded access to health with financial protection.

I want to discuss with you today four points that from my perspective are particularly noteworthy if we are serious about achieving UHC across countries in the world:

First: The impact of a global ageing population

Across the world life expectancy rate has extended to a maximum unthinkable a few decades ago. People retire, and their active life continues and does not decline abruptly. On the contrary, according to the World Health Organization, by 2050, the proportion of elderly will reach 22 percent of the world's population. Although more developed countries have the oldest population profiles, the vast majority of older people—and the most rapidly aging populations—are in less developed countries. Between 2010 and 2050, the number of older people in less developed countries is projected to increase more than 250 percent, compared with a 71 percent increase in developed countries. By 2050, 80% of all older people will live in low- and middle-income countries.

In this scenario, the way we understand health institutions and social protection arrangements that accompany, are exhausted. The demographic and epidemiological transition has caused the disengagement of biology of human life from labor market, education and health models of social protection.

It is therefore urgent to rethink the social arrangements that provide health, education and social security throughout life. This rethinking includes envisioning health protection within a wider social protection system, requiring the convergence of social and economic spheres and policy instruments. Thus, health policies and systems must actively seek to address social determinants of health, such as socioeconomic status, race, gender, disability status and age. Even in 2016, we live in a world where being born a woman or to a poor family can dramatically lower one's chances at achieving a healthy life with dignity and without discrimination. Health systems that focus only on specific diseases and not on the most marginalized populations will fall short of their full potential, because those same populations continue to bear the brunt of disease. Instead, countries must recognize the human right to health without hardship or discrimination, and advance UHC

within a broader social context. There are countries from where to learn. In Brazil, for example, households making less than \$30 per person can access job opportunities, income transfers, and public services including health. This program has successfully lifted millions of people out of poverty and led to substantial health gains.

Second: The future looking health systems that we need

We need health systems for the future focused on promoting health and not curing diseases. Health systems that not only focus on solving acute problems, but are directed to the prevention and treatment of chronic diseases that will accompany most of the citizens for at least one third of their lives. Our goal, then, is more than to live more, to live well.

The transformation of health systems from a hospital-centred and illness-based system to a person-centred and health-based system, needs to be accelerated and funded if we want to achieve UHC.

Integrated People-Centred Health Service is about ensuring equitable access to health services as a means of achieving UHC. We know that globally, more than 400 million people lack access to essential health care and where it is accessible, care is often fragmented and focused on supply-oriented models rather than being responsive to the needs of people and communities.

This shift will require a massive increase in services in homes and communities and new ways to empower front-line staff, enabled by technology, to manage the complex needs of patients across different services and organisations. It will also require the involvement of many different partners and providers. Above all, however, there needs to be the far greater engagement of patients and careers in decision making and care, and enabling them to live as independently as possible.

We are at the right time to project and address the enormous impact of the epidemiological, demographic and social changes on health. We have to address challenges such as: how to integrate health with broader social systems; how to incorporate 'personalized' prevention measures within a population health framework; how to define the type of technology that

should be pursued to achieve our health our system goals; how to use participatory methods and processes to facilitate socially driven health promotion and prevention, how to take advantage of technologies such as smartphones and electronic health records; and how to use comparative analyses that help us understand which interventions work best in specific contexts and that fuel shared learning from and with other countries.

I believe in the near future the first level of care should become increasingly closer to where people live (households) and work. At the same time services will have to move from the current dominant focus on treatment to encompass a spectrum of promotive, preventive, screening, curative and regenerative interventions for wellbeing. This is entirely possible. Today, many illnesses, such as Hypertension and Diabetes Mellitus - affecting a quarter of the world population can be controlled through remote devices and telemedicine.

The use of technology will also allow us to devolve diagnostics support to community level personnel. We have the opportunity to empower people to play a more direct role in health interventions, at individual and community level linking through daily use technologies like smart phones. Information technologies and social networks can widen opportunities for collective intelligence, and for linking personalized interventions to population health knowledge and practice. We need to put health not only in the hands of doctors, nurses, pharmacists or dentists- but health must also be in the hand of the active citizen.

We must expand the resolution range of the primary care centers and design them as places to solve what cannot be solved at home, with higher resolution of more complex health problems and introducing more sophisticated diagnostic and therapeutic procedures.

We have to rethink hospitals as highly specialized smaller facilities that can provide specialized care to much more complex conditions, that cannot be solved at home or at a redesigned first level of care. We must resize and rethink - all levels of care -

Regarding clinical training, most of the health problems that afflict our population today are chronic and age related. The reform of medical education is an imperative and should aim at developing better social, networking and communication skills with the patient, competencies to enable and promote networks and alliances, and to introduce promotive and preventive approaches to improve population and individual health. Our medical schools need to pull down the walls around them, to interact with the disciplines, communities and corporate activities that impact on the determinants of health, on health and on access to health care.

This transformation will require funding, to achieve the transformation of the system, to meet the growing needs of a global ageing population and to bring together health, social care and, potentially, other local service budgets where this is not already happening for maximum efficiency and impact.

Third: A common vision on how to finance health

Agreeing on the adequate way to fund health systems to maximize financial coverage for health is an imperative. Governments should avoid fragmentation derived from creating separate pools and health coverage schemes for rich and poor populations.

Many countries separate populations based on their social class or employment status. The problem with creating these buckets is that it actually fuels existing inequalities instead of addressing them. People in the first bucket — typically well-off individuals with jobs — are often covered by formal mechanisms of social security or insurance agencies with more funding and better quality care. The poor in the second bucket are often covered by an underfunded Ministry of Health, receiving worse care for high out-of-pocket costs. This approach traps the most vulnerable communities in a cycle of poverty, going against core tenets of UHC: equity and prioritization of the poorest.

The road to UHC requires solidarity-based financing models that rely heavily on the countries' capacity to increase public expenditure and reduce the proportion of out-of-pocket spending, as Brazil, Costa Rica and my own country Chile in LA have done. There is a growing consensus around the world

that countries should publicly finance their health systems if they want to achieve UHC. Health-care user fees must be abolished, and services must be provided free at the point of delivery. User fees inevitably punish the poor.

Fourth: The need to strengthen citizens participation in decisions that affect them.

Finally, transparency, accountability, and social participation are key elements of an effective and equitable extension of health coverage. Social participation has been a key component of advances toward UHC, most notably in the efforts to expand access to Drugs in countries in Africa and Latin America.

While there may not be a one-size-fits-all approach to UHC, all countries stand to benefit from comparing experiences and identifying common threads of success. As the old saying goes, we shouldn't let perfect be the enemy of good; rather than waiting for a fool-proof UHC formula, governments can and should begin working toward UHC now, drawing from other countries' experiences.

Today, an important step towards the goal of UHC takes place here in Geneva. We are meeting to establish the International Health Partnership for UHC 2030, announced by Dr Chan last December, as a formal global health systems coordination platform.

As the Lancet editorial last week stated, this partnership will seek commitments from all parties as to next steps in the movement towards UHC. 2017 will be a milestone year for UHC. It promises to be the moment when words are translated into deeds. UHC 2030's role is not only to ensure that this opportunity is seized but also that governments don't renege on their promises and commitments

It will be a multi-stakeholder platform. It will be the place where a shared global vision for health systems and UHC is nurtured, emerging priorities are framed, bottlenecks identified, recommendations reviewed and remedial action taken

Success for UHC 2030 would entail:

- A shared vision of with broadly recognised principles for sufficient, appropriate and well-coordinated resource allocation to HSS
- Improved country-led coordination of health systems strengthening efforts in support of UHC and integrated approach by development partners
- Increased focus on results and measurement of progress to inform country-led multi- stakeholder review and remedial action for accelerated progress towards UHC
- Convergence towards a single and strengthened accountability mechanism for progress towards UHC, linked to the UN established process for the SDGs.

I'm not the only one growing impatient to begin the task. Yesterday, December 12 was the anniversary of the UN resolution on UHC, and we celebrated the Universal Health Coverage Day to urge governments to continue prioritizing health for all.

Because UHC is an attainable and much-needed goal, and the time to achieve it is now.