Political Determinants of Health System Improvements Comparative Perspectives

Transcript Begins:

Sandhya Venkateswaran: Session will be moderated by Louise Tillin. And the second session will then examine what this means for India, so we have to discuss it. Nachiket and Yamini and we will do the detailed introductions later. So I'm going to request my co-host, co-moderator Louise Tillen today, who's the director of King's India Institute, to take it from here and moderate the first stage .Very very welcome once again.

Dr. Louise Tillin: Thank you very much Sandhya, and from my side a very warm welcome to the audience and to our distinguished panel today. As Sandhya said, my name is Louise Tillen. I am the director of the King's India Institute at King's College London, a reader in politics, and it really is a pleasure for the King's India Institute to be co-hosting this discussion on one of the most crucial questions facing India, not least as it transitions through the Covid pandemic, but also as it moves ahead on its path towards universalization of health. So, it is my um task to moderate the first panel. We are expecting one more speaker, so I will re-jig the order to accommodate his timing. So, to introduce our speakers, first of all we have Professor Rifat Atun, Professor of Global Health Systems at the Harvard T.H.Chan School of Public Health at Harvard University. Professor Atun has worked with more than 30 governments across the world, as well as the world bank, World Health Organization and the UK Department for International Development to design, implement and evaluate health system reform initiatives, and he'll be speaking to us today about the politics of health reforms in Turkey. After Professor Atun, I will invite Dr. Viroj Tangcharoensathien, who is a senior advisor at the International Health Policy program of the Ministry of Public Health in Thailand. Viroj trained in medicine, and I understand, received the accolade of being the Best rural doctor from the Thai Medical Association in 1986. He went on to receive a PhD in Health Planning and Financing at the London School of Hygiene and Tropical Medicine, and he is closely involved with the Thai government's public health program, and he'll be talking to us today, and surprisingly, about the politics of health universalization in Thailand. I hope that lastly we will be joined by Jose Antonio Gonzalez Anaya, who is a former finance minister in Mexico in 2017-2018. Prior to his tenure as finance minister, he was, firstly CEO of the petroleum company PEMEX, and before that General Director of the Mexican Social Security Institute, during which time he was closely involved in Mexico's health sector of once, and he holds a PhD in economics from Harvard. So, I'll turn first to Rifat Atun, and invite you to offer your reflections on the politics of health reforms in Turkey.

Rifat: Great. Thank you very much indeed for inviting me to contribute to this very interesting and very timely panel. I will not use slides, but I will speak freely. To share with you the experience of major transformational health reforms in Turkey, and I'm saying this in the beginning because, I think it's very important to understand, the extent, both the scale and the scope of the reforms that were undertaken by the then Turkish government, and explore what made this possible, and what made it successful, and also explore some of the lessons learned as well as some of the challenges that remain. But first, the study that we analyze this in great detail, and this was published as a paper in the Lancet in 2013. We analyze both the antecedents of the reforms, the reforms themselves, as well as the effects

of the reforms in terms of coverage and outcomes, and I will talk about those in turn. But, first of all, I'd like to say something about the politics of reform. I think it's very important to explore sort of the political determinants, but I want to leave you with that sort of important caveat in the beginning, that debt alone is not enough. I feel, over the years, what I've seen is that just, narrowly focusing on political determinants is far too narrow a lens to analyze what I call the receptivity of the context for reforms, introduction of reforms and scalable reforms.

So, I would suggest that the political analysis part of a broader analysis of the context, that is ever-changing and that is so critically important in countries like Turkey, Mexico, Thailand, India, where the context is changing very rapidly, and by that I mean the changes in the demography, the demographic structure of the population, the changes in the epidemiological profile of the country, the changes in the political environment, changes in the legal and regulatory environment, and by that I mean not just health policies but actually the legal treaties and agreements, regional agreements that countries enter into that may enable or hinder reforms or provide an input for reforms, as well as the changes in the socio-economic norms and expectations of citizens, critically important changes in the ecology, changes in the technology and very important, the changes in the economic environment.

Now, in order to undertake transformational reforms, as they say, all the stars need to be aligned, or many of these stars in the context need to be aligned to provide an enabling or a receptive context for the reforms to come onto the policy agenda, and to translate these policies into action. And it's very important, in the case of turkey, because just looking at the antecedents, we see a country, the reforms began in 2003, but in the run-up to 2003, for the last 20 years preceding, that so-called the lost decades, the 20 years of coalition governments, where health reforms were on the policy agenda but it was not possible even though the white papers were written for the laws. The parliament could not enact these. So, as a result, it was not possible to enact the reforms even though this was an important issue for many governments in the 1980s and 1990s. As a result of this lack of implementation and having the ability to introduce new legislation to transform the system, Turkey enters 2003 elections with inadequate and inequitable financing of the health system, with absolute shortages of key resources such as physical infrastructure as well as human resources, and as a result, inequities in the coverage, especially effective coverage, and also inequities in outcomes, particularly under-five infant mortality, maternal mortality, and see huge disparities between the east, and south-east, and the west, so-called industrial part of Turkey, and around Istanbul, the wealthiest parts of the country, where the coverage levels could vary by two-fold or three-fold, as would outcomes. Now, on top of this period of inequalities, Turkey, before the elections, experienced a huge shock. There was an earthquake in Marmara region of Turkey in the west. And the government as a whole was not able to respond to this earthquake. As a result thousands of people died and the response was very late. It was a lot of bickering, and citizens just, they were just fed up. They said, okay, these governments are not able to do anything. Then comes the elections, a new party with a strong message to improve citizenship, and improve economic well-being of the country, where the inflation had been very high, where the economic growth had been faltering, and to invest in health as a priority area. But universal health coverage had

been on the policy agenda for many years, actually, sort of since 1945, with the establishment of the social insurance organization.

That was followed by extension of this for civil servants in 1949, and then there was a first national health plan in 1954. This was followed by the very important law on socialization of health, that aimed to universalize health care and coverage. And then there was establishment of the insurance organization for artisans, and those in, sort of part-time, those in self-employed and small businesses. And in the early 1990s, the new constitution stressed the role of the state in universal health coverage, which was followed by a green card scheme that provided, in design, but not in effect, a non-contributory scheme for the poorer segments of the population, those households below a certain income level. But unfortunately, what this led to, was a segmented system, or a stratified system, with four parallel systems with very good benefits for the retired civil servants, followed by the blue collar workers, then those artisans and for small businesses. But the green card scheme targeting the poor segments of the population never really functioned. So, as we enter the elections, there's a very strong momentum for change, and for citizenship. And health is framed as part of this narrative by this new party, that health is part of the citizenship, it's a right and the role of the Minister of health is to protect the citizens and address the asymmetries and the imbalances, and to overcome the inequalities that exist. Now, this is important politically, because the power base or the electoral base of the AK party, was actually in the south, in central Turkey, Anatolia, in the east and also south east. And these are the areas where improvement was needed. So the government actually embarked upon a very ambitious health reform program. It was a risky strategy, but had it worked, it would have actually benefited the government. So that was the thinking.

So the reforms were introduced, actually Viroj was one of the conversations we were having with the minister of health at the time, and I remember Viroj describing the Thai experience and I sensed the minister at the time saying that we really don't have time, we have to move very quickly, we want the introduced reforms within a few years to see the results. So there was a very strong focus on not just introducing the reforms, but actually reaping the benefits to gain further political capital in order to sustain the reforms that very importantly sustain the government. So the transformation program was designed not just for improvements in health outcomes, but also to really strengthen the support of the electoral base and to gain further support for this new political party, which won an unprecedented sort of majority, and was able to form a government, not a coalition government, but a majority government. And the transformation program that was implemented was very interesting, in that not only was it comprehensive, the strategy was really informed by evidence and global experience. There was continuous monitoring and learning. It was very flexible in implementation as strategy, but with tactical changes, with a lot of listening to the citizens, and then to the populations, to try and meet their needs, to try and address what I said, in the context the expectations of the society at that point in time. It was also designed to address the sort of economic inequalities by providing conditional cash transfers to the poorer segments, and big emphasis was on levelling the benefits, and strengthening the green card scheme which had not been functioning. And there was a very big emphasis on rapid expansion of primary healthcare and community based healthcare, to expand coverage, especially for the segments of the population where care had not been very effective. So, just to give you some examples.

So, in 2003, of the five major public services, health was the worst performing, with satisfaction levels below 40 percent. In terms of insurance coverage, again there were huge inequalities. So those covered by the non-contributory green card scheme, the coverage level was 20 percent in the poorest decile, whereas in the richest decile the coverage was around 90 percent, and the very clear gradient between the poorest decile and the richest decile, and so that was in 2003. And the distribution of the resources, we can see a real dearth of health professionals in the south and southeast, where there had also been some sort of civil unrest. It was difficult to attract people, but also to retain them. So the priority of the government was to rapidly scale up. And the government did that by actually using novel approaches, using outsourcing, and creating a new family medicine model, that where the family health teams were contracted because the whole bureaucratic process of actually appointing new health workers, but also giving them performance related pay, would have been very complicated.

So flexible instruments were used to achieve rapid expansion and improve distribution to rural areas. Whereas between 1993 and 2002, the number of people working in the health professions only changed from 224000 to 256000. By 2012 after the election, just within 9 years, the number had almost doubled to 510000, and almost 130000 of those health professionals were attracted through contracting. And then distribution changed and coverage improved. Especially antenatal care, first attended by trained staff, we say a short fall. Also immunization levels improved. And we see a convergence, whereas there was a big difference between rural and urban areas, between income groups or different education levels, three or four-fold differences. We see sharp convergence after five years of introduction of reforms, where the underperforming groups reach those levels achieved by higher income groups, better educated groups and urban groups. And we should also see a sharp decline in outcomes. So what happened is, along with improvement in coverage, improvements in equity, there was also very important improvements in financial protection, where out-of-pocket expenditures fall because the green card scheme, which was 20 percent in 2003, by 2011 that increased to cover almost 80 percent of the poorest households, and all the income groups improved, even the higher income groups. So we see rapid increase in financial entitlement, but very importantly, the supply side scale-up happens. So that's a very important message for India, there's no point just having entitlements. You know, many countries have in their constitution, health is a right, health protection is a right, so on and so forth. But without supply-side interventions and rapid scale up, the citizens will not benefit, I will not see the benefits. And so this was the important change, with rapid change in the benefits, scaling up of all the benefits so that the four or five different schemes were now unified and had a common benefits, so there was no difference between the green card scheme and the civil servants, and there was a rapid scale up of the family health teams as well as hospitals. So, as a result, the satisfaction levels improved from less than 40 percent, to reach about 75 percent by 2011. And this is at the same level as the best performing services. So, the rapid increase in scale up and the improved experience of the citizens provides the health ministry the legitimacy to introduce further reforms and improves the importance of health within the broader government, such that the minister of health stayed in his position for almost 10 years. That's completely unprecedented, in the history of Turkey, where the ministers change almost every year, sometimes twice a year, this is the minister of health. So there's a sort of sustained effort on sustained improvement, which then provides the political support and electoral support to

the government and some say almost 15 to 19 percentage points of the electoral votes, was because of improvements in health.

So this is a very important story. But once you're successful, then that has to be sustained. You know, what are the lessons learned. Well, first of all, there was a very receptive context for change. Everything was aligned, health was positioned as a fundamental citizens right, economic growth was used as an opportunity to invest in health, and that enabled the enhanced role of the government. And there was sustained leadership and a transformation team put in place with flexible implementation response, to respond to citizens needs with careful sequencing of the changes and ongoing learning. And the reforms were implemented very speedily to prevent resistance, especially from professional groups. And very importantly, combine demand-side changes with supply-side changes. But, of course, the agenda is not finished, because citizens expect more. So the government has got to continue to sustain these benefits, which is fine when the economy is doing well, but now Turkey is experiencing economic difficulties, so the government is under pressure to sustain the very comprehensive benefits scheme that it has introduced. Also, after the introduction of family health medicine and improvements in community health medicine, there was a big investment in the hospital sector, which is consuming a large proportion of the budget. Now in my view, you know, obviously the government had its own reasons for that, but I think the money could have been better spent in further strengthening primary health care, because it's very expensive to sustain these hospitals. There needs to be ongoing investment in quality and safety, but all of this requires the fiscal space to sustain the reforms and sustain the political support. So, I'm going to stop there. It’s a very fascinating history, but universal health coverage took a long time, but when there was a political will, and when everything was aligned in the context, it was possible to introduce transformational change.

Louise: Thank you very much, that was fascinating. I'm going to turn now, to invite Dr Viroj Tangcharoensathien, to speak about Thailand.

Viroj: Thank you Louise, thank you Sandhya. I just want to endorse what Rifat has said. Our experience is quite similar, but in different contexts. We have achieved Univeral Health Coverage by 2002 and today we spend, health expenditure was around less than 4 percent GDP, and our pocket payment is 11 percent of current health spending, which much lower than the OECD average of 18 percent. So, that facto reflects very high level of fun to risk protection, and very low incidence of catastrophic spending and impoverishment from health spending. Government spending is around 16 percent of the annual government budget. Health has improved a lot. Under five deaths is 12 per 1000 live birth, still birth is nearly 100, so that means under five death is that low.

I have been working as a participatory observer and also actor, between 2001- 2002 that UHC was launched, until today we have two decades of experience. How many government we had, we had nine governments, nine prime ministers in 20 years, and we had 15 health ministers. So we had a very strong political conflict in the past two decades. But the UHC has been driving very well. It's amazing how it was not derailed by the opposition government, they took turn and they fight even today. We are in the middle of a constitution amendment. So, I work with my government, after the launch of UHC and work with 50

ministers. Even today, we had a good conversation with him on vaccine roll out. So what happened? I would like to structure my talk into three areas. One is about the Supply-side. As Rifat has said, without Supply-side, you lie to your citizens, that UHC is right on paper, but that never comes through. Then we make service available since 70. Government has a sustainable investment in primary healthcare, and a district health system consisting of district hospitals and sub-district health centers, for a catchment population of 5000. So we had a decade of center development, in 10 years we scaled up to 100 geographical coverage of sub-district health center, and we had a decade of district health hospital development, so we constructed new hospitals in all 800 districts. So this was a strong platform for UHC implementation. Without this you never talk about UHC. We had a joint study with Indonesia and the BPJS, which is the UHC in Indonesia, and it had a pro-rich outcome because the supply side is so unequal across Java, which has a lot of International cardiac surgeons, etc, and nothing in Papua New Guinea, which is a big island, a jungle island, without health infrastructure. Therefore, a premature early UHC without a strong platform of supply capacity is a premature movement. So, we fixed this, until full coverage of service in district in sub-district improvements by the late 1990s. So, that is on the supply side. Only infrastructure doesn't work, we need health workforce. Thailand has implemented well beyond the virtual guideline, on what is effective on retention of health workforce, in rural areas. We have financial incentives, mandatory three-year rural services and this batch of rural doctors become, in the past 40 - 50 years, they become high level policy makers in the MOH, as a permanent secretary, as a DG, etc, and the value driven in their mind helping explain working with the poor, with driving a pickup car and sending the diseased patient back home in the mid of the night, so they are an eyewitness of the pain, suffering, how the poor live in rural areas and this is a pro-poor ideological reformist bureaucrat. The term reformist bureaucrat is by a scholar called Joseph Haris, from Boston University, and he published a lot about the Thai political dimension of UHC, and he termed this as a reformist bureaucrat. You can search for his article on Thai-UHC, by Joe Harris.

So, that is on the supply side strengthening. On the financial risk protection, we had low income scheme for the poor in 1975. In 1982, we introduced the Royal Decree for Civil Servants medical benefit scheme, because government employees receive a very low income, low salary, therefore health benefits are a fringe benefit. In 1984, we introduced voluntary public health insurance, which is a premium contribution. And by 1994, I submitted a proposal to the cabinet, because the minister might do something to increase the coverage, then that voluntary premium finance scheme became public subsidized. So, that meant 50 percent of the premium was subsidized by the government, and in 1990 we adopted a socio-security scheme and I published it in an Indian Journal called Economic and Political weekly in 2012. I had introduced capitation payment for the social health insurance, the first ever I think, in each year and many people asked me “why you are stupid? You have to give liberty to your citizen to go elsewhere by free for all service”. I said capitation and primary care fund holder is one way to first ensure efficiency of using resources. Then, they publish a paper on how capitation was estimated. At that time, I got involved and had been working in the MOH as a health planner, a program budget director, and between 1970, 80, 90, 2000, it was a bureaucrat led, technocrat led ministry of health, and most of the ministers at that time, the previous bureaucrats would have an equity-laden value compared to, we don't have a system like IAS in India that you have, this is a professional, a civil servant. You have a transport minister become health minister, or transport secretary

become a health secretary. It is not the case in Thailand. Health secretary mostly comes from within the health sector, therefore there is a continuity of wisdom, continuity of policy. By 2002, we had 30 percent of population are un-insured, therefore we think that the opportunity had come. I interviewed the then prime minister, and the then health minister, that if you want the election, will you introduce UHC. From the democrat party, they were so conservative, they said no, we just ask the rich who can pay for their own services and we're only cattling the poor. And we talked to Thaksin Shinawatra and his group. He said I will make it as a political manifesto in the 2001 general election. Therefore that is the trigger. The question that Sandhya asked me to talk about, is the political determinant of reform or UHC. I conclude with the fact that it is quite a narrow interpretation. It is a multifactorial. First you need a supply-side capacity. You need faithful and good work ethics among helper channels. In Thailand, you do not have absenteeism. Of course, 40 years ago, when I was working in the district hospital, we had some absenteeism of teachers and doctors and nurses, but when gradually the health system evolved, people demanded more and absenteeism become history. Therefore on the supply side, it is so critical that we have a good and decent quality, equitable distributed throughout the country on the supply side. Second, financial risk protection. I published a paper in 2009, and we defined our UHC trajectory as a targeting piecemeal approach, targeting the poor, targeting the civil servant, targeting the private sector employee, targeting the non-poor informal sector, and later sub-public subsidized scheme, and then the particular window of opportunity came, then we introduced UHC, and that was so successful. Politics means policy agenda, of course we agree with that notion. but coming to policy formulation, it requires wisdom, it requires capacity of the country to decide its own provider payment method, design its own benefit package.

The World Bank expert consultant told me that while you introduce capitation, you need to give liberty to your citizen to travel anywhere by free for all service. I told him- you go back home, don't come to my country, it's my own business, it's not your business. Therefore Jim Kim said Thailand introduced UHC against the advice of his consultant. World bank wanted to publish a paper undermining our legitimate policy movement to UHC, and I strongly talked to the world bank resident coordinator in Bangkok, that this is unacceptable, and then Jim Kim told me that he was regretful that his consultant behaved that way, and we have told the world that we can do it, and today the schemes drive quite well because the government is so strong. We have civil society, five seats out of 32 seats sitting in the governing body of the UHC scheme. I'll stop there Louise, thank you.

Louise: Thank you ever so much, Viroj. I fear that, we have not been joined by our third speaker on Mexico, which is a shame. But it does enable us to have a longer conversation about the implications for India, of what we've just been hearing about Thailand and Turkey. So with that, I'm going to hand over to Sandhya to lead the next part of the discussion.

Sandhya: Thanks Louise, and thank you so much Dr Viroj, and Professor Rifat. I don't know what happened to our speaker from Mexico, because he just confirmed a couple of hours before. But anyway, I'm guessing something unforeseen has happened.

So our next session is, we have two excellent discussions. Having heard the journey of Turkey and Thailand, challenges that we're struggling with in India and what might be some

pathways going forward. So we have two discussions. Yamini Aiyar, Yamini is President and Chief Executive of the Center for Policy Research, which is one of the premier think tanks in India, and she was previously the founder of accountability initiative which, correct me if I'm wrong Yamini, one of the pioneering initiatives on budget tracking and it's the go-to place actually for budget tracking . Yamini's research focuses on multiple exciting issues like public finance, social policy, state capacity, federalism, governance, etc. It's a long list. And she's on many government and other task forces, boards, committees, so is, you know, inputting into policy discussion at very high levels. Nachiket Mor is a visiting scientist at the Banyan Academy of Leadership in Mental Health, as well as a senior research fellow at the Center for Information Technology and Public Policy at IIIT Bangalore. Nachiket was previously on the board of the Reserve Bank of India, and his research or his work currently focuses on looking at the design of health systems, both at national and sub-national levels. He’s also been on multiple task forces, committees, and the one that I will name is the one that was set up by the Government of India, focusing on Universal Health Coverage, and he's also been working with the State. So, we couldn't have two better people to basically discuss India. I have four questions and, let's see if we have time for all four of them. If we can basically spend about 10 minutes for each question. Yamini, I’m going to begin with you. We heard Dr Viroj talk about in some ways the social compact between the citizens and the government. He didn't mention too much today, but a previous conversation with him also talked about trust between the citizens and the government. And that, you know, makes me wonder how when we look at that, and the role that is played in terms of taking the reforms forward in Thailand, when we complement that with the electoral situation here, one of the things that is often lamented is that, and I mentioned earlier as well, that health is not an electoral ask. Is there a possible reason for that, that the trust between citizens and the government is not very high, that the citizens are not confident that the government system is going to be able to deliver? And could it be a case that even our leaders are not confident of the system being able to deliver? I'm really going out on a limb right now. So what does that say about India being able to prioritize health? You know, the whole issue of trust and the social compact, how does that pan out, and is there a way to fix it if that is indeed a challenge?

Yamini: Thank you, thank you so much Sandhya, Louise, and to everyone on this panel. This is such an important conversation, and it's been an absolute treat to listen and learn from the experiences of Turkey and Thailand. Thailand in particular gets presented as a sort of gold standard of UHC, and many conversations we've had in India about UHC and what pathways we ought to pick a tread, to get to UHC, and so it's really been a wonderful treat to listen and learn, because one hears so much about it, but doesn't get a good enough understanding of the complex dynamics through which those goals were achieved. And I think, Sandhya, you know a lot of what we heard both from Turkey and Thailand, and the issue that you lay out of trust, even though it perhaps was not articulated as such, really gets to the heart of the problem because I think in both cases, both speakers emphasize that a UHC is not just an entitlement. It's not just about a right. It's also about building the supply side capability, and I'm going to use the word capability, not capacity, and I'll come back come back to that in a moment. In order to be able to ensure that those entitlements are actually fulfilled, so we do not end up with hollow rights. And I think that, you know, we can call it supply side, but it's essentially at the heart of what frames of social compact which is trust. When you build and demonstrate the capability of the system, inevitably

political demand will emerge. So let's now look at where we are in India today. Last year in the early days of Covid crisis, so this was last, actually, literally July of last year. A group of colleagues at the Centre for Policy Research were working with the government, with the state government, trying to figure out what would be the most effective mechanism to expand and scale up testing in a way that, you know, because with Covid testing you're saying, if you want to use Covid testing as a tool to get a better understanding of disease dynamics and transmission dynamics. You're essentially at some level, okay, it's a needle in a haystack. And at that point testing was not so widely available, so it wasn't really demand driven, it was much more supply driven through the state. And we piloted just a small survey in a very urban part of the state where local block level officers essentially did a surveillance survey, and then handed out free vouchers to citizens who participated in the survey, to go out and go to a testing facility to undertake a test. We surveyed, if I'm not wrong, more than 400 households. Only about four actually showed up for this free test .

Sorry I'm getting a hollow sound which is a bit distracting.

And you know, to some of our colleagues, that was a surprise. And the conversation with government was particularly interesting because, you know, from government's point of view, the whole pilot was a complete failure, because they were out looking to see if we would be able to find correlates to where Covid would be, or there would be potential of Covid. And there was no question of finding correlates because nobody actually showed up to get tested. For us this was a really important insight into understanding how the citizenry was viewing the role of government in Covid. But that was not seen as relevant. What the government was looking at, was targets. We have to test X number, we have to figure out where the disease is spreading and then we have to start identifying containment zones. So, you know, at that point the language was very much about testing, containment, lockdowns. And in the course of, you know, we sort of push them a little bit further to say, let's find ways of trying to encourage people to come to test, and then a lot more investment was made in actually working with community mobilizers and, funnily enough, even block level election officers going house to house, having dialogues and conversations, both to understand why people were hesitant to test, and through that process encourage people to test. That had some limited amount of success, more people showed up to test. But what it also did tell us is that when once government actually goes out to start trying to understand what are constraints to people's response to the health system, you suddenly actually get to the heart of trust. People did not believe that if they went to, because the state is viewed as an instrument of coercive power. So the minute the state was saying come to test, there was deep fear at that point in time that that would mean we would end up in a containment zone, we would have to go to an isolation centre, our livelihoods would be stalled and that would have significant economic consequences. Citizens were acting rationally in response to a coercive state and also in response to a state that it doesn't actually have any visible understanding of ever having provided high quality health. So when citizens actually want to go to get health services, and we know this from Vishnu Das and others' work, they don't actually go to the government MBBS doctor that is often available in limited supply, but available nonetheless in parts of rural India. They most often go to the informal health workers. Again our supply side response to this has always been in the grammar of failure of government at one level, but also failure of the citizenry in forging a compact with the statement- the state provides the doctor, holds the doctor accountable

for showing up, for providing quality care and citizens are saying actually I don't trust that you'll do it, so I'm going to go to whatever context where I feel I will be treated in a way that will give me a certain kind of treatment. We may call that a consequence of information asymmetries or ignorance as some might say but this is about a certain kind of behaviour. So I think part of where the trust breakdown narratives that's becoming important is that both when we talk about supply side responses to health care, we don't really understand who the client is, to use, you know, that kind of language. And in fact, we often dismiss the perspective and the ways in which people seek health care. It's not like people don't seek health care, they do. When you fall sick you have to go somewhere to seek treatment.

What we need to understand is, where it is that they go, and what is it that moves people in that direction. Once you start building a response that actually builds that understanding in, that's when trust starts building, and ultimately I think that our speakers from Turkey and Thailand are absolutely right, and we need to understand that. The great puzzle of Indian democracy, how is it that they have such a vibrant democracy, where welfare is very much part of the political narrative. I think Louise's work speaks to that so very powerfully. It's not like citizens don't demand of the state and it's not that states don't respond, but the puzzle always has been why do health and education not come up at the heart of this debate? I think in education, it's a bit clearer, in some sense, in some ways, because the political economy of education seems to suggest people want to send their children to school, but they don't trust the state, so they'll look for private schooling as much as they can. In health it gets much more complex. And I think that that demand is not coming because people are seeking health care outside of the state with absolutely very limited expectation of the state providing health, and when people go to the states to seek care, or when the state asks people to seek care, it's usually done in a framework of state coercion, which essentially creates disincentives for that demand and I think Covid has been a really good example, at least in India. I think across the world, coercive measures were used to deal and continue to be used, to address Covid, and there is something to be debated about what is the relationship between coercion and public health, because obviously there are externalities in state coercion may well be necessary, but in India it became very much about framing a health problem in the context of law and order, which deepens the distrust rather than response to it at a time when the state was such an essential actor in responding. So, I think that trust, to close trust is at the heart of the social compact. Trust is broken, therefore the social compact is broken. And in some senses today, the onus lies on the state to demonstrate its capabilities before the citizenry starts demanding, and therefore perhaps the question that we've all been grappling with is- why is health not a burning political issue in a vibrant democracy, or at least in an electoral democracy, where elections are hotly contested across a whole range of issues? Perhaps we need to turn that question on its head and ask why is it that politicians don't seek political legitimacy through demonstrating that the health system can actually work? In order to be able to bridge the trust gap and then build a more robust conversation on what it means to reach the goal of UHC.

Sandhya: Thank you

(Technical difficulty).

Sandhya: Lovely. Thank you. So, I want to welcome Jose Antonio from Mexico, who's just joined us. He's, as Louise had already introduced him, a former minister of finance from Mexico and the Director General of the Social Security Institution.

We had actually started off, there was obviously some confusion ,and my apologies for that, but so glad that we have you here now. And as we were discussing the whole issue of trust and social compact, and Yamini you mentioned coercion. I'm wondering to what extent state capacity also plays a role, influences the trust delivered as per, let's say, my expectations, that is going to influence my trust and whether I go back to that service, or whether I go elsewhere, and that I'd like to get you in Jose, and talk about the experiences from Mexico, in terms of what really motivated the reforms and what role did state capacity….

(Technical difficulties)

…the social compact between citizens and the Mexican government play in initiating the reforms. Over to you. Oh, was it not clear what I said?

Louise: I think we probably heard enough. Maybe we could invite Jose now to speak?

Jose: Yeah, I think you can hear me now. Sorry, I was logged in twice. I have heard everyone's presentation. I was logged in from the beginning, but I logged in, I guess, as an attendant and not as a panellist. When you called on me, I was saying I'm here, I'm here, I'm here, but I wasn't here. So, I have heard the discussion. Thank you very much for the invitation, I was logged in twice, so that's why I was making an echo. Let me make some quick remarks since I had technical difficulties. You know, the experiences of Turkey and Thailand and, to some degree, India were familiar to me, when I was heading the Health Institute, because we were trying to see how these countries, who were before the Mexican latest round of health reform, approached it. I have some general topics to say. One is that one cannot start from zero. You know, when you're in a country, it's a temptation to think of it, the ideal health care delivery service, and try to implant it like that and try to ignore where you are. And that you can't do, in my humble opinion, and the political economy of trying to do that, which from my humble experience, has been a common mistake in Mexico, which is to try to jump into the NHS sort of solution, where everything works, doesn't really work. And to do that, I think the lesson is, you construct your healthcare delivery services little by little. So what I will talk about is the latest round of health reforms in Mexico. To put it in picture of where this started, we had, you know, of course, private sector delivery, high-end, expensive that could cover the very wealthy. Then we have a very large institute of health which is the one I headed, which covered all formal workers. Now, in theory, that should cover everyone. You know when you think of a developed country in Europe, the United States, everything, this is the way healthcare is given , and that's the way this was done in the 1950s, and that covers about 70 million Mexicans. There is a small institute that does the same for public servants, that covers another 10 million. But then the problems that Mexico was not able to address is, how do you provide service to the people with informal jobs? And here's the way. So, the challenge in Mexico was, how do we get health care, effective health care to everyone? The mandate is in the constitution. When I was speaking to Sandhya, she said, well, you know how people demand it? Well, in Mexico,

everybody demanded health care, and the legal mandate was to provide Universal Health Care. And the health ministry had a network of hospitals and primary care centres that provided health to the uninsured. But the problem was the quality, the effectiveness and how opportunistic this was. What happened, as the country grew, they all, as you know my colleague from Turkey said, there were a number of issues that came together. We changed our health transition from infectious diseases, to diabetes and cancers and chronic, you know, degenerative diseases. So that put an enormous amount of pressure on the system. So, whether you could go to the hospital or not, if you have an infectious disease you get an antibiotic or something and it's easier to get fixed. When you have Diabetes, you need a real health care system. And this provided the demand for a real, I wouldn't say a real reform but a further reform, another step in the reform, that will provide effective health care for the uninsured. And that, you know, I would say their last round, the last big round of and we created something called the Segura Popular, which is the popular insurance. And you know, the idea was to provide effective healthcare albeit limited to everyone. Now this is a problem. Because then you're providing the same services to different types of people, how do they auto select, how do they know where to go and to the right hospitals etc. So this was no small challenge to try to tell everyone what they had to do. But we did manage to ingrain the fact that it was a right, and that everybody had a right to health care. So you could go to the hospital where you had a right. What are some of the things that I think went well, and what are some of the things that did not go well. Health care expenditures increased, coverage increased, average quality increased. What were some of the things that did not go well? Well, now we have, you know, two very large health care networks. One is the National Social Security and Health Institute which has a national coverage. And then you have the Seguro Popular, and this is an interesting political economy as well, because it is funded mostly by the federal government, but the funds are transferred to the states and the states manage their own healthcare. So this is important because the point, in theory, was to separate financing from health provision. And one of the issues that has not been talked about in this discussion and I think it's crucial for the political economy as well is, you, in order to improve your health care, I would say you know you can centrally fund, but provision has to be decentralized. You can do it publicly, or privately so that there's competition and that citizens can vote with their feet and go to a different health facility that best serves their needs. That is only, we're in the middle of a transition in Mexico. So I'll stop there. Coming back to the original point, the political economy has two parts. It's not only the citizens and the states. The health institutions have their own political economy and they have their own political power. The Health and Social Security Institute has half a million health workers, and Seguro Popular has about 200,000. So then, they themselves create a political mass that also pushes for reforms. So, with that, I will stop. I again apologize for the technical difficulties ,but I'm glad I managed to say a few words.

Sandhya: Thank you so much, that was very helpful. And in fact you touched upon the very critical issue of Federalism. And I wanted to place that question, Nachiket, to you, and maybe Yamini can come in as well, because I know you both worked on it, that given in the federal structure, just building on what we just heard from Jose, why we know that health is a state subject, but there are rules played by the centre and played by the states? Is it that the architecture of our health delivery as well as our fiscal flows is somehow impeding…..

Louise: I think I maybe should take over here, you're breaking up a lot.

Sandhya: …states to take a stronger role and how might this be changed? What are the kind of interventions that are related to autonomy, and to be able to focus more on health? Nachiket to begin with you and then…oh dear, is my question clear?

Nachiket: Didn't quite get everything. Let me, because we are out of time I want to be sure that we do get some of these conversations, and I want to benefit from the presence of our three very eminent speakers here. We may not get them back again together, I'm always here.

Clearly, the state has to play, in my view, a stronger role. One of the issues that I think we have faced, and I'd be keen to hear from Dr Jose how they dealt with it, is that while in theory we have a federal structure, it's the Bihar health system's design that has been exported to the whole country. So we have taken the lowest common denominator, and we have said everybody must follow that. There isn't a single state that is following its own mandate. So, you know, my favourite example is, Kerala has 100 percent institutional delivery. It does not need to incentivize women to deliver babies in a health centre. It needs to keep that money aside to deal with high suicide mortality and mental health problems. Yet, since Bihar doesn't have a mental health program, Kerala doesn't have one, but both have a program of incentives. I don't know if I could turn to Dr Jose to see how the states were persuaded, you know in some ways looks like a child. The child has grown up now, you say to the child, wait, do your thing, you know. How does that actually happen?

Jose: I was saying that it's very difficult to do, and there are a couple of rules. One is, in the case Mexico, what was done is, you were giving a capital for every person you enrolled in your system. But you had to enrol them, and that meant there was a series of requirements that had to happen. It wasn't just signing up somebody's name. You have to sign their name, they have to fulfil requirements. You know, Mexico has had a good vaccination program for decades. So the vaccination will work, but it had to be systematized, and we created a regulatory entity, which is something that also has not been talked about, which is not the Ministry of health, not the provider, but a regulator. And the regulator also has to, you know, tries to certify that the health care is actually given within certain rules. So I'm making this up, but you're supposed to have all the children vaccinated, and there's a regulator who supervises that you are actually vaccinated. You are supposed to provide three or four visits to a mother who is expecting. You know, you go in and you try to supervise how this works. Now, all of this becomes very complicated if you don't have an electronic system, so that you can have electronic records, you know, how you do the reporting. So conceptually, the hard thing about health is that, it's easy to talk about it from 40,000 feet up in the air, but once you get down to the nitty-gritty, you know, it's hard to have a record of everybody who got a vaccine, it's hard to have a record of people visiting their doctors every six months, it's hard to have all of these records, and it's hard to make sure, for instance, we provide medicines as well. It's hard to make sure you have all the medicines in place so that you can provide the person with the prescriptions. So the easy answer to your question is, it's hard and you have to work on it, and but an additional ingredient that you need on all of this that we have talked about, is a regulator, and this provides the latest thing I think, which is, this transition, so that eventually you can have public financing with private

provisioning, or public-private provisioning at the same time and they can compete. And some other countries in the region in Latin America have done a very good job now. Chile and Colombia have done a good job at mixing this model that is more efficient because the public health institutes tend to have high administrative costs and inefficiencies, etc.

Nachiket: Why don't I turn it over back to you Louise, to see if there are other questions? Because we have 15 minutes, and I want to be sure that we get the most juice out of our deep experts. We can do another one with me.

Louise: Yes, I was going to pose Sandhya's question for her, because I think she's suffering from her poor internet connection. So this question I'll pose to all of the panellists. All of you in different ways, have spoken about the importance of contextual factors alongside the more narrow political determinants for focus on health, and to some extent, especially in the way that you depicted the scenario in Turkey Rifat. In the early 2000s, there was a confluence of factors that drew attention to very inequitable health outcomes, a connection between health and poverty issues which are at the forefront of the health problem in India, if you like at the moment. And why is the kind of similar context in India not driving the kind of political attraction that we've seen in other countries, and why is it that human capital development and particularly investments in health and education as well, will focus on health here. Why is it that human capital development is not clearly seen as a key variable in India's growth model? And I think, if I might add a little on to Sandhya's questions as well. The other big difference between India today, and Turkey in the early 2000s, or India indeed in the early 2000s, is that rather than entering into a period of high growth, we're in a phase of fiscal contraction and continued pressures on the overall rates of economic growth. So what does that do for the political demands for health? Yamini, if I might come to you first, and then I'll invite anyone else to comment.

Yamini: Well I'm actually really keen to hear from the others, so I wouldn't say too much. I really do think part of the challenge is about state capacity. I think that the average citizens experience in the public health system itself is a reminder that the system is so broken, that people actually don't see the state as a provider of health. They see other actors as providers of health. One of the consequences of economic growth from the 1990s, and the expansion to a degree of the private sector and its entry into health, was that the elites exited entirely from the state system and kept themselves firmly in the private sector, and you don't need to look very far. The CGHS, Central Government's Health insurance for for elite government have an empanelled network of some of the biggest private hospitals, and actually even in Covid, if you just take a list of where the politicians go, a very large number ended up in private hospitals, and fewer ended up in the All India Institute of Medical Sciences, which remains, till today, one of the premier institutions and premier hospitals in the country. On the other hand, if you look at the lower end of the income spectrum, most of the poor seek health outside of the public system. They usually go to the informal providers, and when they do enter into the government system, they encounter a system so broken and one that treats them in ways that don't actually build their trust, that they actually seek private health where they can afford it, rather than seek public health. So I'm not saying this to make the argument that the state should exit, that's not the argument at all. It is that, the state thus far has not demonstrated its capability of providing health and people have found alternative sources of where they go to seek help. And I think part of the

challenge here is that for politicians and for bureaucrats there are no clear ways in which they have available pathways to actually build the capability of a health system. It is so deeply broken that you have to go from the ground up and because we don't have good quick answers to that, the response always is actually to look at the potential private sector alternatives to the public health system, and we fail to understand that actually a health system is many systems, it's a public, it's a private and a regulatory architecture, all of which have to work simultaneously, and you have to believe in the state's capability to do this before you, and therefore start investing in them. So, what citizens ask of their politicians of health is usually access into the system. So we've had this conversation even within the Lancet group, where politicians will say it's not like we are not actively doing a lot on health, but what is it that they're doing? We're trying to get hospital admissions, we're trying to find doctors for people, it's those transaction intensive parts, it's not systems building. When politicians or policy makers and bureaucrats are looking to try and strengthen the health system, that long hard slog of taking a system that has been caught in a low level equilibrium, and we are seeing this a lot. I've been studying the education system very closely and I see this exactly in the same way, shifting a low equilibrium system to a high performing one requires a whole set of things to function together. It's not that we don't have any clear answers, and we have lost many years, particularly over the last decade or so, of not enough experimentation and innovation. And I think it's in that context that investments are not made, and therefore demand doesn't come, and it falls off the political agenda.

Louise: Thanks Yamini. Rifat or Viroj, would you like to come in here?

Rifat: Yeah, I think this is an important issue, I think I'm sure Viroj would like to comment as well. I think one has to be pragmatic, each context is very different. And in my view, if again providing entitlement will create a problem, because you have to supply the services to meet their expectations. And in a situation like this all the assets of the country must be used. Now, some of the most successful ,you know in in some settings, if they're state capacity, then the state could provide the services. In turkey, both public and private sector assets were used when scaling up the services. In other settings, there will be big investment and scale up of purely state assets. If there's a capacity competence and capability in others there could be a mix. In others actually, such as the National Health System, in England for example, the very successful part of NHS is primary healthcare and family physicians. Family physicians are independent contractors, they're not state employees. So one has to use different instruments and approaches to ensure effective coverage that is responsive to citizen's needs. So maybe, rather than if this state is not able to act as a competent provider of services, maybe the state capacity could be developed to make it an effective regulator, an effective commissioner of services. I'm using the word commissioner as opposed to the purchaser because it involves some strategic thinking rather than just a transactional payment of services. So, I think one has to experiment with different models, and learn from this. But what's important is to scale up and demonstrate benefits to citizens, to create this demand for services. In our work in Turkey what were able to show was that, as primary health care services were scaled up, utilization of services were scaled up very rapidly, and something interesting happened. Initially this was because accessibility had improved, but even though the citizens had the right to go to hospitals directly, access to primary care continue to increase because quality was an important

factor in determining that ,whereas the direct access to hospitals levelled off, even declined, primary care continued to rise because it was effective coverage that was responsive beyond just accessibility. Despite this investment monitoring and really understanding what is being provided under, how the citizens are responding is so critically important.

Sandhya: Dr. Viroj, if you're going to come in, it would be great to hear your thoughts as well. Just building on what Rifat said and what Yamini said. How does the state view the importance of actually building human capital? Because what we heard each one of you say was that the governments were responding to a certain context of inequities in health access, and there was a need to address those inequities. Whether people were demanding them or not that's what I understood. Correct me if that's not right . That means there was a basic perception that this is something that needs to be addressed, and citizens of each of these countries need to build their human capital through better health education, etc. That is not clear, in India that is the case. So your thoughts on that?

Viroj: From our experience we can conclude that the quality and health workforce competencies are the key social capital in the health system. In the past four decades that was gradually built up and shaped citizen trust, institutional trust, to the health system, very much so in government health institutions, and less so in private. And like Mexico you use a lot of private sector, the private sector in Thailand if you do not regulate well, they just cheat you. They just circumvent all the regulations, etc. Therefore if you contract private sector, you have to regulate very well. You have to regulate very well, this is the case of your system in India, because you contract a lot of private sectors, therefore I think the trust is so critical in health system, institutional trust, that you are trustworthy, then the demand for health services is there. We have very high contraceptive preference, 80 percent, because they have trust in the health system. Immunization coverage is very high, hesitancy is very low, because we have a good AEFI system, etc.

Sandhya: Thank you. Jose, you have something to add on that?

Jose: (Inaudible)

Sandhya: You're also breaking up a lot, struggling to hear you.

Okay, we are actually on time, we have a minute left. I am tempted to ask each one for some very quick parting thoughts, and then for Louise to, I can't say summarize, but close the meeting. Some quick parting thoughts from everybody?

Rifat: I'll go quickly. So, inform and engage the citizens, and ensure that the services provider is aligned with what they're expecting. Don't make this a technocratic solution. This needs to be very much designed to meet the citizen's needs. They need to be engaged, they need to improve their literacy, and then you need to create that symbiosis which will then create trust. But that requires not just entitlements on paper, supply side needs to be really in place with high quality, and highly responsive to citizens needs with the appropriate accountability.

Sandhya: Perfect, thank you. Dr Viroj, parting thoughts?

Viroj: Quick thought. I think a trustworthy supply side is the key entry point for India. Maybe a trustworthy, reliable, supply side government, because government distributes throughout the country, whereby the private sector go where the money is. Where there's no money, they don't want to go. Therefore into equity you have to have a government trust. Trust in government health institution as an entry point for UHC.

Sandhya: Thank you. Jose Antonio ?

Jose: I will come back just to say that health reform is a various event, and that one should build on what you have, slowly but surely to try to change the institutions, because you can't go to the end without going through. It's a cliche but it's absolutely true. We can't all have the UK's National Health Service overnight. So you have to build on what you have within your political constraints, your labour constraints, and your institutional concerns to get there.

Sandhya: Very well said, thank you. Yamini?

Yamini: Thank you. I think what we've learned from across the globe is, it is very much that state capability and political determinants of health are actually deeply intertwined, and so, perhaps we need to be framing these questions together. I think the trustworthy supply side response is at the heart of what will build robust political demand and that trustworthy supply side response comes through political will. I saw, I don't think that politics is taken out of that at all. I wanted to very quickly, as I was skimming through some of the questions in the Q&A box, and various people refer to Kerala, Maharashtra, India is not one health system, it's many health systems, different state responses are different. But I do think that in each of those where things have worked relatively better, are embedded exactly the same sets of lessons that we have learned from Mexico, from Turkey, from Thailand. So we also need to look at our states, and at no point is this conversation, especially because we talked about federalism, trying to suggest that India's health is one uniformly bad system. It's many somewhat bad systems caught in low equilibrium, and then it's many systems that perform somewhat better, but still have a long way to go. And therefore the question of what does it take to convert our current health architecture into a high performing capable health system or many health systems, is what we should be asking from an Indian perspective .

Sandhya: Absolutely, very well said, thank you. Nachiket?

Nachiket: So, I really enjoyed this discussion, and I want to quickly say one thing that I picked up from each of the speakers, just for me to reflect on. One, I think what Dr Atun said is that, building trust, because we are where we are, we can't magically transport ourselves to Switzerland. We are in India, we have what we have. Unleashing a reinforcing loop in which we do something well, whatever it is, maybe that's a place to start. The second, which I like what Dr Viroj said, which reflects my thinking, do your own thinking, don't wait for the world bank or somebody else to tell you. Build your own wisdom. Figure out what you want to do. And I think one point that Jose said, which I thought even Dr Atun echoed, is that, use the assets you have. Okay, we don't have X, we can lament about that. But we have actually

have Y, it's a point Yamini made so well. Now, it's an important point that Dr Viroj made, that if you are going to work with the private sector, you would better know how to deal with it. Because it's not obvious, but it's not entirely obvious to me as well, that given where we are, that the status quo is giving us better outcomes. So to me, these were the three interesting ideas that I took away from these three eminent speakers. Just a wonderful session, I wish we had another hour and a half to really get into it. But I gained a lot, thank you so much.

Sandhya: Thank you Nachiket. I was thinking that, in the real world, which is outside of the pandemic, this would have been at least a day-long conversation. But sadly, we are where we are. Louise, last word to you and closing thoughts.

Louise: Thank you Sandhya, and thank you to all of our speakers. It was a wonderful discussion, despite the challenges of doing this across continents on zoom. I think, if I were to pull out three key takeaways from the conversation, they would be as follows. I think firstly, we've heard that political windows of opportunity for taking on difficult health sector reforms are the product of multiple conjunctural factors, and they come along rarely. So I think that was the first real headline, in thinking about this. The second, and which follows from that in a sense, is that the focus ought to be more on supply-side reforms as a means of building trust in capabilities and that the voter demand, which I think we all agree, as being so important for maintaining accountability, and the perpetuation of longer-term durability of reforms, that that voter demand will follow on from the demonstration of capability. So that was the second key takeaway for me, the significance of the supply side. And I think the third key takeaway which we've touched on a bit and but I think there's a lot more scope to dive in deeper, is the role and the shape of the state, especially in a mixed health system, with a lot of private sector and community health work going on. So I think Jose made this point very well, which is that where you know you're in a lower low capacity equilibrium, it may be more important for the state to develop its role as a regulator than as a provider of health. And the other question which we touched a little on is the shape of the state. So the relevance and importance of thinking about federalism, the flow of financing for health as well as the location for design and implementation of health performances. There was much more in this ,and I also want to acknowledge that there were a lot of questions that came in, that we haven't been able to address, but i hope that this will be the first of many future conversations. So I do hope that you'll be able to carry on with us along that journey. So, thank you, goodbye for today.