Commission on
Social Determinants of Health

Bridging the Divide:
Comprehensive Reform to Improve
Health in Mexico

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First of all, I would like to express my gratitude to the government of Kenya, and especially to my esteemed colleague Charity Ngilu, for hosting this important meeting. I also wish to thank Sir Michael Marmot for the invitation to address this distinguished audience. Thanks to Tim Evans, I had the privilege of witnessing the launch of the Commission on Social Determinants of Health in Chile, under the auspices of President Ricardo Lagos.

The Commission is a timely initiative that seeks to systematize our understanding of the broader factors which determine the level and distribution of health in a population. Such an understanding will help support the application of interventions to improve social conditions that affect health.

This is an enlightening perspective that can empower national policy makers as we strive to build better health systems. After almost six years as minister of health, I am convinced that a key component of the stewardship role is to mobilize all the tools of public policy to improve health. Indeed, health cannot be seen simply as a specific sector of public administration, but must be understood as a social objective. Therefore, it is not enough to develop health policies in the strict sectoral sense; we also need healthy policies that mobilize interventions from other sectors in order to pursue the social objective of better health.

Such a comprehensive perspective has become even more necessary today, as most developing countries undergo a protracted and unequal health transition that is adding new layers of complexity to the patterns of disease, disability, and death. Through a web of multiple
causation, those countries are facing a triple burden of ill health: first, the unfinished agenda of infections, malnutrition, and reproductive health problems; second, the emerging challenge of noncommunicable diseases and their associated risk factors like smoking and obesity; third, the growing scourge of injury and violence.

The complexity in health conditions is mirrored by the complexity in the social arrangements to respond to those conditions through health systems. Indeed, we must strive to understand the interactions between the broad social determinants of health and the set of institutions that constitute the health care system. We know today that there is huge variation across countries in the performance of 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 they do matter in determining which of those cycles occurs in a given country.

One area of special concern is the relationship between poverty and health financing. We have known for a long time that poverty is a major determinant of health conditions and also of health systems. More recently, we are becoming aware that the relationship may also operate in the opposite direction. 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 mechanisms to assure fair financing that protects the entire population. In fact, WHO has recently estimated that every year 150 million persons and
25 million households, most of them in developing countries, are impoverished through out of pocket payments on health care.

As we can see, countries all over the world are facing a growing degree of complexity both in their health conditions and in the social response to those conditions through the health system. The only way to deal with the challenges deriving from this complexity will be to adopt a comprehensive strategy. In particular, we must bridge the divide among three intellectual and programmatic traditions in public health. The first one has focused precisely on the mandate of your Commission, namely, the social determinants of health, with the conviction that the way to achieve sustained improvement in health is through long-term transformations of the structures and relationships of a society. The second tradition has focused on specific interventions for specific disease categories. This has been the so-called “vertical” approach to public health. Lastly, the third tradition has taken a systemic or “horizontal” approach, seeking to modify the general structure and functioning of the set of organizations constituting the health system.

What we need today is to integrate these three traditions into a coherent policy framework for health. Integration implies transcending a number of false dichotomies. First is the artificial division of health into sectoral and intersectoral. As Giovanni Berlinguer states most eloquently, "health is indivisible." Health is a social value for which all sectors are responsible and accountable. Second, we should go beyond the traditional stand-off between the vertical and horizontal approaches by extending the geometry metaphor to search for what Jaime Sepúlveda has called the “diagonal,” that is to say, as strategy in which we use explicit intervention
priorities to drive the required improvements into the health system, dealing with such generic issues as human resource development, financing, facility planning, drug supply, rational prescription, and quality assurance. In turn, diagonal health policy must be placed in the framework of a broader healthy policy, as I mentioned earlier.

In this presentation, I would like to share with you the main insights deriving from an intense reform experience in my country aimed at bridging these divides in order to implement a comprehensive strategy. In particular, I would like to point out the way in which a number of knowledge-related global public goods were influential in shaping policies that are transforming the health system in Mexico. Since such global public goods are the main product from commissions such as yours, I believe that concrete country experiences may reaffirm the enormous value of your work.

Knowledge is not only the product but also part of the substance of this Commission’s remit. Indeed, one of the social determinants of health is the creation and diffusion of knowledge. We find ourselves in the era of the knowledge society: how can the Commission influence its direction for the health benefit of all? There is a growing body of evidence showing that knowledge represents one of the major driving forces for health progress. We all agree that research is a value in itself, an essential part of culture. At the same time, knowledge has an instrumental value as a means to improve health. This is achieved through three mechanisms.

First, knowledge gets translated into new and better technologies, such as drugs, vaccines, and diagnostic methods. This is the best-known mechanism through which it improves health. But, second, knowledge is
also internalized by individuals, who use it to structure their everyday behavior in key domains like personal hygiene, feeding habits, sexuality, and child-rearing practices. In this way, knowledge can empower people to modify their lifestyles in order to promote their own health. The power derived from knowledge also allows individuals to become informed users of services and citizens conscious of their rights. Third, knowledge becomes translated into evidence that provides a scientific foundation for advocacy and decision-making both in the delivery of health services and in the formulation of public policies.

Recent developments in my country illustrate this last point. In the mid-1990s a review of research findings and an extensive consultation with local and international specialists guided the design and implementation of an ambitious initiative intended to enhance basic capabilities of families living in extreme poverty.

Initially called PROGRESA and later renamed Oportunidades, this program is an early example of the comprehensive approach aimed at bridging the divide among the three traditions mentioned earlier. First, Oportunidades acts on several social determinants 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, most notably school attendance and improved nutrition--two major determinants of health. Further, the program is guided by a gender perspective, since scholarships are higher for girls in order to prevent discrimination. In addition, cash transfers are received and managed by women, something that empowers them within the household. Evidence
also shows that mothers are more likely than fathers to spend additional resources on their children’s health and welfare.

Another element of co-responsibility is attendance to a health clinic. In a case of revitalized primary care through the diagonal approach, the program has fostered a major expansion and strengthening of local health systems, achieved through an explicitly defined package of health promotion and disease prevention interventions, including basic sanitation, reproductive health, nutritional and growth surveillance, and specific prevention measures mostly for communicable diseases, but increasingly also for high blood pressure, diabetes, and injury.

As can be seen, Oportunidades utilizes concurrent improvements in income, education, nutrition, and health care to create a synergy that has been hypothesized to help families break the cycle of chronic poverty. 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 evidence to fine-tune implementation. The use of this evidence to improve know-how has proved critically important.

In addition to its technical aspects, rigorous evaluation has had an enormous political value to assure the continuity of the program through a change in administration. Indeed, scientific evidence persuaded the present government not only to continue with the program, but to greatly expand its geographical coverage to cover also the urban poor and to add new productive opportunities for youngsters and a pension scheme for senior
citizens. *Oportunidades* is presently benefiting 5 million families, which comprise 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 epidemiological transition by enhancing the survival of children to reach ages where expensive noncommunicable diseases are more prevalent. It is this dynamic that 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 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 care not included in the initial basic package of interventions which, as mentioned before, was mostly focused on the pre-transitional pattern of disease burden. Yet a reality too often overlooked in the search for equity is that problems only of the poor, like many common infections and undernutrition, are no longer the only problems of the poor, who also suffer higher rates of many noncommunicable diseases, mental disorders, injury, violence, smoking, obesity, and other risk factors.

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

The reform of the Mexican health system is probably a textbook case of evidence-based policy. Indeed, sound analysis made decision makers and the public aware of critical realities that required solution. Thus, the
careful calculation of national health accounts revealed that more than half of total expenditure in Mexico was out-of-pocket. This proved to be a direct result of the fact that approximately half of the population lacked health insurance. Furthermore, out-of-pocket expenditures were shown to be highly regressive, since they represented a higher proportion of income in poor households than in non-poor ones.

These findings were unexpected as it was generally believed that the Mexican health system was based on public funding. Instead, the analysis revealed the unacceptable paradox of which I spoke earlier: far from being a key factor in the fight against poverty, health care itself was a direct cause of impoverishment since the economic consequences of illness generated a poverty trap.

The realization that millions of households had been paying catastrophic out-of-pocket sums generated 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 the assessment of health systems performance. This framework highlighted fairness of financing as one of the intrinsic goals of health systems.

As a result of its high levels of out-of-pocket spending, Mexico performed very poorly on the international comparative analysis of fair financing. Instead of generating a defensive reaction, this poor result spurred detailed country-level analysis in 2001 that showed that
catastrophic expenditures were concentrated among poor and uninsured households.

The country-level analysis was based on data from the national income and expenditure surveys for Mexico, yet another global public good. These surveys are produced by many countries in the world and provide homogenous data sets that are key for cross-national comparisons.

The careful interplay between national and international analyses generated the advocacy tools to promote a major legislative reform establishing a system of social protection in health, which was approved by a large majority of the Mexican Congress in 2003.

This system is reorganizing and increasing public funding by a full percentage point of GDP over seven 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% of GDP in the year 2000, a level that was insufficient to deal with the pressures posed by the triple burden of disease.

The new financial scheme will make it possible to provide universal health insurance, including the 50 million Mexicans, most of them poor, who had been excluded until now from formal social insurance schemes because they are self-employed, are out of the labor market or work in the informal sector of the economy.

The increased funding is spearheading a major effort to realign incentives throughout the health system. Poor families can now enroll in a new scheme called “Popular Health Insurance,” or Seguro Popular, which is
the basis for allocating federal funds to states. 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 complemented by a micro-level management reform, which is strengthening delivery capacity through a series of specific interventions on critical areas like human resource development, long-term facility planning, efficient schemes for drug supply and rational prescription practices, quality assurance, and outcome-oriented information systems These elements of the health system have required extraordinary strengthening precisely to better serve the poorest populations living in the most marginalized areas.

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 as the guiding criteria. Apart from serving as a priority-setting tool, the package is a means of empowering people by making them aware of their entitlements and is also a key instrument for accountability on the part of providers.

By the way, Chile has been a pioneer in this approach, through the innovative AUGE plan promoted by President Lagos. AUGE is a Spanish acronym for the notion of universal access with guaranteed benefits. Making the rights of people explicit helps to improve the performance of health systems by empowering citizens with knowledge. Mexico certainly has learned a lot from the Chilean experience.
The net result has been a dramatic increase in the number of entitlements. 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. Even within this comprehensive package, there are opportunities to implement the diagonal approach by strengthening overall health system capacity through clearly identified priorities. Having already achieved over 95% coverage with one of the most complete immunization schedules in the world, the next frontier for equity was to reduce maternal mortality, which is actually the Millennium Development Goal where Mexico needs to improve the most. The various financial and managerial measures adopted as part of the reform are being focused on a special initiative to address this top priority.

In addition, the seven-year transition period stipulated in the new law to achieve universal coverage of families is accompanied by the coverage of an expanding set of "high-cost" interventions. Through a transparent and collective priority-setting mechanism, the new insurance scheme is already providing universal coverage for AIDS treatment, childhood cancer (which is the second cause of death among school-age children), uterine cancer (the first cause of death among women over 25 years), and cataract extraction (the main cause of preventable blindness), among other interventions. Each of them provides yet another opportunity to enhance health system performance through the attainment of explicit priorities.

But the benefits of the new system are not restricted to curative actions. For the first time in Mexico, the new system has created a separate Fund for Community Health Services, which protects the budget for health
promotion and disease prevention interventions. As a result, a recent survey shows a significant increase in the utilization of early detection services, aided by an accompanying scheme of health cards with a gender and life-course perspective.

The reform has also included an unprecedented effort to strengthen health-related public goods, such as epidemiological surveillance, environmental health services, regulatory actions to protect the public, and more generally the set of intersectoral interventions that define a healthy policy capable of modifying the social determinants of disease. In this way, we have made an explicit attempt at bridging the gap among the three public health traditions identified at the beginning of this paper.

The evaluation experience gathered through Oportunidades is being applied to the current structural reform. Rigorous monitoring and evaluation is also being applied at the state level to benchmark health system performance and measure the impacts of the reform. The encouraging results shown by the ongoing evaluation will hopefully serve once again 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 progress towards its 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.
The need for sound research to enlighten decision-making is underscored by the worldwide search for better ways of strengthening health systems. Because of the gaps in our current knowledge, every reform initiative should be seen as an experiment, the effects of which must be documented for the benefit of every other initiative, both present and future. This requires a solid investment in research on health systems. Each innovation constitutes a learning opportunity. Not to take advantage of it condemns us to rediscover at great cost what is already known or to repeat past mistakes. To reform it is necessary to inform, or else one is likely to deform.

The Mexican case also shows that the dilemma between local and global research is a false one. As we have seen, the process of globalization can turn knowledge into an international public good that can then be brought to the center of the domestic policy agenda in order to address a local problem. Such application, in turn, feeds back into the global pool of experience, thus generating a process of shared learning among countries.

Finally, the Mexican reform illustrates the way in which knowledge public goods can empower local decision makers to advance the health agenda amidst the competition for attention and public resources. Especially in their interaction with 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 fairer distribution of wealth. Equitable health systems represent themselves important social determinants of development and wellbeing that must not be overlooked or taken for granted.

These arguments have been a powerful tool to convince decision makers to mobilize more money for health. But, in the words of the legendary Professor Ramalingaswami from India, we must also assure that we achieve more health for the money.

The experience I have shared with you illustrates the growing consensus around the notion that the pace of diffusion of knowledge into a country is one of the major social determinants of the pace of health improvement.

In turn, the spread of knowledge-related global public goods will depend on a renewal of international cooperation in health. In closing, let me suggest three key elements for such a renewal, three "e's": exchange, evidence, and empathy.

First, the communications revolution provides the opportunity to exchange experiences about the ways to deal with the common challenges being faced by health systems all over the world. I am certain that the work of the Commission on Social Determinants of Health will be play a crucial role in speeding the dissemination of policy-relevant knowledge, for the benefit of ministries of health, other arenas of public action, and civil society organizations.

To be informative, such exchange should be based on sound evidence about alternatives, so that we may build a solid knowledge base
of what really works and may be transferred across countries when it is culturally, politically, and financially reasonable. The path is clear: scientifically derived evidence must be the guiding light for designing, implementing, and evaluating programs in national governments, bilateral aid agencies, and multilateral organizations.

But there is another value. The British philosopher Sir Isaiah Berlin has proposed the comparative study of other cultures as an antidote against intolerance, stereotypes, and the dangerous delusion by individuals, tribes, states, ideologies or religions of being the sole possessors of truth. And this leads us to the third element, empathy, that human characteristic which allows us to emotionally participate in a foreign reality, understand it, relate to it and, in the end, value the core elements that make us all members of the human race.

The work of your Commission is an excellent example of what global health requires today: global partnerships for the creation of global public goods that will foster global understanding to help us address common global problems.

By taking a comprehensive approach, the Commission is placing health at the center of a broader social agenda and is therefore underscoring its larger value to the national and global goals of equitable development. In our turbulent world, health remains as one of the few truly universal aspirations. It therefore offers a concrete opportunity to reconcile national self-interest with international mutual interest. More today than ever, health is a bridge to peace, a source of shared security, a way to give globalization a human face.
It is this kind of interconnection that lies at the heart of the Commission’s mandate. Such a comprehensive perspective was reflected in the words of a universal person, Dr. Martin Luther King Jr., who wrote in 1968:

“It really boils down to this: that all life is interrelated. We are all caught in an inescapable network of mutuality, tied into a single garment of destiny. Whatever affects one directly, affects all indirectly.”

I am certain that in your exciting work you will contribute to weave the destiny of better health for all the inhabitants of our common world.