Prince Mahidol Award Conference 2017 Remarks

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I am very honored to be part of this Prince Mahidol Award Conference, in this panel on "interventions to reach the vulnerable."

As I look at the disaggregation of interventions suggested in the excellent terms of reference we received before hand, I am pleased that financial incentives is an important category within demand side interventions. Not too many years ago the role of financial incentives, positive and negative, in social inclusion policies was frequently misconstrued.

Ambitious and even well funded social policies proved to be disappointing, as policymakers assumed that acting on the supply side alone would achieve the desired human and social impact.

I, for one, as a Minister of Education for Mexico in the early 1990s, learned the hard way, that building schools and clinics in the poorest communities in my country and making efforts to retain the teachers and medical personnel to provide the services, could have nil or negligible effect in keeping children in school and receiving medical care.

Despite our efforts on the supply side, children from the poorest families continued to fail to complete their basic education in a much bigger proportion than children from families with higher incomes.

Putting in place a sound policy that would help to break that vicious cycle became one of my key policy objectives when I became President of my country in late 1994.

The goal of having a truly technically sound program, that would stand a good chance to be effective, implied a rather long process of preparation, in fact almost three years, before we were ready to launch it.

I decided that a lot of thinking and inquiry should be done before deciding on the specific features of the antipoverty program to which I had committed as I was campaigning to be elected.

Once in office, the team in charge of developing a specific proposal, led by two outstanding Mexican social scientists Santiago Levy and José Gómez de León, undertook a thorough review of the literature and of practical experiences, good and bad, in Mexico and other places. We even carried out pilot testing of a number of aspects before giving the program its final form.

It was in this way that Mexico's pioneering conditional cash transfer (CCT) antipoverty program — that at the time we named Progresa — was launched in August of 1997. Interestingly, we did it in the midst of incredibly tough budgetary restrictions, a sequel of the 1994-1995 severe economic and financial crisis suffered by my country and just as the Asian financial crisis that also impacted us started to unfold.

We could do it, not because we had additional resources but because we gave up spending on other things including non-targeted food subsidies.

By now there is a vast literature on Progresa, its impact on poverty reduction in Mexico and its influence on many other CCT programs adopted in other countries after the Mexican program, so there is no need here to go into any detailed description of the Program and its results.

That Progresa became a model of antipoverty programs in just a few years certainly has to do with some of its key features, such as its laser-sharp targeting of the beneficiary population and its transparency and enforcement of key normative and operational aspects, not least the eligibility and selection requirements of the beneficiary population.

But even more significantly, in my view, its success has to do with the careful design of incentives put in place to generate an effective demand for the program. Essentially, the provision of its well-calibrated cash and in-kind subsidies were immaculately conditioned to nutrition, health and school attendance requirements. This feature was reinforced with a deliberate "good gender bias" expressed not only in higher subsidies for girls but also in designating the mother in the household as the legal recipient of the benefits.

Another key innovation was that the program was designed, practically from its inception, to be evaluated, and so it was by internationally recognized researchers, just 3 years after it was launched, with encouraging results that convinced the next Mexican Administration to preserve the program rather than scrap it as it had threatened to do.

Curiously, that early evaluation of Progresa also boosted the use of randomization as a method to measure the impact of development policy interventions, an approach nowadays widely used -and abused- by development economists.

Dear friends,

I have dared to bore you with an abbreviated history of how the pioneer CCT program came into being because it is about inclusion, but more importantly to emphasize the role of what I see as the four indispensable pillars of effective social policies — and actually of other kind of policies as well. Those pillars are, in my view: clarity of purpose, clarity of design, clarity of financing, and clarity of incentives.

Today I want to suggest, albeit in a rather sketchy and superficial way, that this essential framework can be useful to look at what I consider with fervent conviction — certainly animated by the work, arguments and examples of many of you — one of the most significant social policy commitments ever made: Universal Health Coverage, or as I prefer to call it following Sen and others, Universal Health Care.

The articulation of this aspiration has evolved, step by step, over time, first by what has been done in some countries now considered rich or developed, and later by the subscription of the ideal by an increasing number of developing countries in various multilateral declarations and certainly their concrete efforts towards accomplishing the goal. Among this latter group of countries, our admirable host, Thailand, is a great example.

But at the risk of being characterized as naïve, I wish to submit that we should take paragraph 3.8 under Goal 3 of the 2030 Agenda for Sustainable Development, adopted by the United Nations General Assembly Resolution on 25 September 2015, as a crucial milestone — if not the crucial milestone — to be leveraged globally to advocate for UHC.

I think we should all take at face value goal 3.8.

Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

As we take seriously this solemn commitment, despite not being bounded by a deadline to achieve it, we should reflect on its profound policy implications. I suggest doing it through the lens of the aforementioned pillars.

To highlight the importance of clarity of purpose, I feel tempted to rely on the currently fashionable use of tautologies by some political leaders and say: universal health care is

universal health care. The term UNIVERSAL should not allow nuances that justify or give rise to social exclusion. Much progress has been made in developing the concept of effective coverage, not least at the WHO. All must start by embracing this concept and even perfect it to insure true universality.

There should be no question that UHC is about the entire population and the entire system. Once this level of ambition is firmly established, given its political, social and economic implications, other far-reaching commitments are implicitly attached to it.

It should be recognized that a commitment to UHC is a commitment to a broader objective: economic growth and equitable development. It is not that countries should eschew the pursuit of UHC in the absence of economic growth, but in order to do it faster and better, having a sound economy where benefits are more equally distributed is important. A commitment to UHC in a context of a poor general economic environment soon ends up being an empty and failed commitment. Very importantly, an effective commitment to UHC supports enormously the accomplishment of a country's growth and equitable development objectives.

Furthermore a commitment to UHC is also a commitment to justice, rule of law and good governance. It is about justice because it is about fair equality of opportunity and treating all individuals as equals. Therefore, leveraging to its endmost consequences the essential principle, enshrined in many constitutions and fortunately in the Universal Declaration of Human Rights, of equality before the law is crucial. The enforcement of this principle is not possible without effective rule of law and good governance, endeavors that obviously pose enormous institutional challenges.

That also implies that the commitment to UHC is a commitment to confront and decide on hard policy choices with a long-term vision. The objective of UHC must be declared precisely and transparently along with a long-term plan or pathway to achieve it and governments must be accountable for complying with such a plan. To this end, a robust institutional process that the public can trust must be duly put in place.

Clarity of design involves first and foremost full consistency with authentic universality, a condition that is enormously consequential. It means that in determining the pathway towards UHC, the tradeoffs (the famous WHO cube) must be acknowledged at the outset and confronted.

Covering everyone with the most essential services, which must be clearly defined, should be the priority in most cases. The hard choices in deciding the modalities for delivery of health services must be admitted transparently.

Crucially, it is time we all admit that clarity of design compatible with universality is not consistent with the creation or continuation of fragmented health systems. It is not only that having coverage for some at the expense of coverage for others is not just — does not constitute justice, but also that it is a self-perpetuating condition. The persistence of multiple pools is an enormous economic and political obstacle to equity.

Clarity of both purpose and design would be worthless without clarity of financing. From what I have learned from many of you as well as from experience, direct payments at the time people need care is simply incongruent with UHC. Compulsory prepayments and risk pooling –in a pool as large as conceivably possible— must be the general approach to finance UHC. Compulsion and subsidization must be the anchors for the viability and sustainability of a genuine UHC system. However, not all compulsory payments are created equal. From theory and practice we must know by now that general tax revenues should be the preferred best financing source.

Fixing the Bismarck Pitfall of linking entitlement to formal employment is long overdue. Earmarked payroll taxes as a source of compulsory prepayment not only tend to perpetuate a fragmented system –and therefore are an obstacle to universality, but also create severe distortions in the economy that conspire against the creation of good jobs while enlarging informal, precarious and exploitative employment with deplorable equity consequences. This is one exemplary argument, but only one among many, of why having clarity of incentives in the health system is of paramount importance.

Transforming potential demand into real demand for health services, preventing abuses of the system by its consumers and providers, moderating cost inflation of health services, enhancing productivity and promoting cost-effective innovation are other key examples of objectives where the level and structure of incentives, positive and negative, play a decisive role.

Esteemed friends,

In the quest for social inclusion, hardly any other institutional policy will be as powerful as the pursuit of universal health care. Consequently, achieving this noble and indispensable objective must be undertaken with a sound strategy to make it financially sustainable and unequivocally compatible with other important social development objectives. Success in this endeavor, let me insist, requires clarity of purpose, clarity of design, clarity of financing, and clarity of incentives.