KEY EVIDENCE-INFORMED POLICY
MESSAGES FOR ACCELERATING
UNIVERSAL HEALTH COVERAGE (UHC)

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DEVELOPMENT OF THE PRESENTATION

• Done within the context of the Terms of Reference (TOR) for the Speaker from the perspective of a policy maker.

• Relied more on the presentations of the Speakers, volunteered information by some participants and submissions made by rapporteurs

• Does not attempt to produce a comprehensive summary of the Symposium but to capture and present major “take home messages” from the policy maker’s point of view on evidence (HSR) and UHC.

Contributions of some 'key informants' and my assistant, Dr Sola Adeyemi highly acknowledged
WHY RESEARCH EVIDENCE IS NOT USED IN POLICY DEVELOPMENT

• Lack of understanding of the complexity of the policy development process by the researcher
• Many research works are not relevant to existing/real life problems
• Research findings communicated in channels or outlets/form (language) that are not accessed and understood respectively by the policy maker
• Lack of interaction between the policy maker and the researcher in identifying issues to research on and also in carrying out research
• Research results not available in a timely way for the policy maker

• Unrealistic recommendations or recommendations at variance with policy maker’s position.

• Basic technology & skills for policy maker to access research results not available

• Dearth of data to serve as basis for providing research evidence/data source not trusted by policy makers
• More compelling evidence than the research evidence from some other sources

• Absence or lack of research evidence on issues raised by policy makers seeking to draw on relevant evidence and experience
GENERAL THOUGHTS ON HOW HSR CAN INFORM POLICY-MAKER MORE EFFECTIVELY

• Set joint agendas with policy and practice people
• Increase capacity to generate more relevant research evidence i.e. invest more resources in HSR
• Be ready to respond promptly to clear policy signals
• Proactively put in place mechanisms for sustained links, dialogue and advocacy across policy, research and practice actors
• Actively promote networking within the research community on the one hand and between the research community and other actors on the other
• Have evidence available in accessible forms to policy makers such as policy briefs to enhance the uptake of research evidence
• Undertake ‘systematic reviews’ whose results can be handy for framing issues for decision-makers
• Involve policy and practice communities in the research process, especially in data gathering and analysis

• Use problem-solving (action-oriented) approaches like operations research (OR) and participatory action research (PAR)

• Establish/make use of knowledge broker organisations.
WHY FOCUS OF SYMPOSIUM IS ON HSR AND UHC

• Focus of the Symposium on HSR for Universal Health Coverage (UHC) is necessitated by many factors including:
  – the extremely low levels of coverage with single/packages of interventions as a result of some systemic and non-systemic factors
  – endemic inequalities that current level of coverage has created (e.g. poor less likely to be covered) and
  – some existing evidence of harm (e.g. lack of financial protection, unsafe or low quality services)
• Focus of the Symposium on HSR for UHC is also policy-relevant because UHC is: (i) strongly linked to MDGs attainment which, in turn, could contribute to breaking the vicious cycle of ill-health, poverty and underdevelopment in LMIC’s and also; (ii) a widely agreed policy objective (WHA Resolution 2005, WHR 2008, PHC, Commission on Social Determinants 2008, WHR 2010 on Health Financing and First World Social Security Report 2010 of the ILO)
KEY MESSAGES ON UHC/EVIDENCE TO POLICY MAKERS

• In designing and working towards UHC, it is important to balance its various dimensions namely: its depth, height and breadth.

• Factors such as financial and human resource availability, the size of the informal sector, levels of income inequality, history and culture of the people, interests of stakeholders, current and past state of the health system, and the nature of disease burden should inform, in a coherent and consistent manner, the design of policies to achieve UHC in LMIC’s.
• UHC requires sustained political will and commitment, adequate and sustainable financing and evidence-based analysis of options as illustrated by the experiences from some LMIC’s including Thailand, Mexico and Costa Rica.

• Global movement and support is needed beyond the efforts of the individual LMIC’s in order to achieve UHC
• UHC is not only laudable but promises to be **feasible** as progress in some countries (including Ghana, Columbia, Mexico, Thailand and Brazil) has shown.

• UHC also seems **affordable**. Investing in UHC could be at a small price to pay. The study by McKinsey and commissioned by Rockefeller Foundation shows that the cost of investing in UHC was about 2.6% of GDP. This might be heart-warming for policy makers who are struggling with their budget and find it difficult to raise extra funds.
• UHC policies that promote pre-payment systems are more equitable and efficient than financing based on out of pocket expenditures at point of service.

• Community-based health insurance schemes are very difficult to scale up and sustain.

• There is no single pre-payment and pooling financing system that fits all.
• ‘If we are to achieve UHC and address challenges that may be faced in the course of working towards it, we need “power of ideas” to influence the “ideas of power” (policy makers)’- Julio Frenk

• Evidence is needed not only on what has worked but also on what has not worked with regard to UHC
• Relevant experiences or lessons from some LMIC’s e.g. Thailand and some Latin American countries should be well documented and shared widely with other LMIC’s on UHC

• UHC should be implemented in such a way that the poor gains at least as much as the rich as coverage is extended (progressive universalism). This requires proper planning as well as monitoring during the implementation process
• The sustainability of the process to achieving UHC is vulnerable to changes in the political climate, especially changes in regimes. Evidence from rigorous health systems research can play a pivotal role in ensuring continuity by keeping “the quest for universal coverage” a high priority in the policy arena. Indeed, health systems research is important in highlighting the need for health system reform to achieve universal coverage.
• Robust Health Information Systems (HIS) are critical to continuously assess the performance of health systems in achieving universal health coverage. Policy makers need to use such sources of information in managing, monitoring and evaluating the performance of universal health coverage.
• The term “Universal Health Coverage” invokes different expectations and may have different meanings to various constituencies. A lack of alignment between UHC outcomes and expectations can easily lead to lack of support from the grass-root level and could negatively impact on the sustainability of UHC.

• Universal Health Coverage policies will only lead to universal access to health care when factors that contribute to gender inequalities in access to health services are systematically addressed.
• Early successes in the efforts towards UHC may be reversed if leadership changes, institutionalisation is weak, and political and economic fortunes take a downturn. There is a need to recognise fragility of reforms.

• Many powerful factors driving implementation to achieve UHC are beyond the health sector, including political stability and security, economic growth, legislation, regulation and government capacity to enforce compliance.
OUTSTANDING/UNANSWERED/INADEQUATELY ANSWERED QUESTIONS OF INTEREST TO POLICY MAKERS ON UHC

• How do policy makers manage expectations of the major stakeholders during the ‘journey’ towards the realisation of UHC?

• What is the cost of achieving UHC in all its ramifications? How feasible is the achievement of UHC in LMIC’s? What is the best mix of strategies for financing UHC?
• In implementing intervention s to achieve UHC, what is the best strategy to ensure that reaching the poorest of the poor and the most vulnerable receives adequate attention throughout the process?

• ‘Pilots’ have played and will continue to play an important role in striving towards the achievement of UHC. What is the best strategy for scaling up such pilots to achieve UHC?

• How can the achievement of UHC be sustained financially and politically in many LMIC’s that depend heavily on donor-funding and also where the political environment is not stable?
Thank You