Excellencies, distinguished scientists, ladies and gentlemen.

We meet in a city known for its natural beauty and cultural history. A city that has inspired writers from Lord Byron to Henry James to Ernest Hemingway. Montreux is where Stravinsky composed part of “Rite of Spring,” and where Tchaikovsky wrote “Concert for Violin.” It’s home to one of the world’s greatest jazz festivals… not to mention—for those of us who look back fondly on the 1970s—Freddie Mercury Memorial Day.

But now, we’re adding another dimension to the great history of Montreux, through this first-ever global gathering on health systems research.

It may not sound as poetic or lofty, as Byron or Stravinsky but its human impact is just as compelling. Imagine the human potential unleashed by… improving health outcomes, health services, and health equity around the world.

In my time today, I want to talk about four things, to set the stage for the conference ahead:

- Why health systems matter;
- Why health systems reform is integral to universal health coverage
- What the Rockefeller Foundation is doing to build momentum and support;
- And what I hope we can all do, together.

Our job here is to harness the creativity and collaboration—that can extend health benefits to all, worldwide.

Our efforts can build extraordinary advances in human welfare.

In the last 40 years, we’ve seen average life expectancy rise from 59 to 70.

School enrollment has grown from 55 to 70 percent.

Per capita incomes have doubled to more than $10,000 on average.¹

In the past 20 years, infant and maternal mortality have declined by more than 30 percent.

Today, 8 out of every 10 people live in countries where poverty is decreasing.

But still, not everyone’s lives, nor their health, are improving fast or equitably enough. We still face significant challenges that test our collective will.
In some cases, it’s because our prior agenda remains unfinished. Take hookworm for example. Just over a century ago, John D. Rockefeller made a million dollar grant to launch a campaign to eradicate hookworm in the United States. The campaign was successful—as similar efforts have been throughout much of the world. Yet this awful disease, which saps the strength not just of individuals but of entire communities, remains the world’s leading cause of anemia and protein malnutrition…afflicting an estimated 740 million people in developing nations.

In other cases, the problem is how to scale proven interventions and deliver them to the people who need them most. Every year, 8.8 million children and newborns die from preventable causes. Nearly 350,000 women perish due to complications during pregnancy or childbirth—a tragedy that is doubly heartbreaking because we have the means and tools to save them.

Or, take life expectancy. A baby girl born in Switzerland today can expect to live until 84. A baby girl born in Sierra Leone can only hope to make it to her 40s. As we know well, these kinds of disparities exist not only among countries but within them—reflecting the persistence of economic and social inequities that tend to hurt the most vulnerable the most.

Meanwhile, as global lifestyles evolve, new challenges are creating new stresses. According to the European Charter on Counteracting Obesity, half of all adults and one in five children are overweight. Childhood obesity is 10 times higher than it was in 1970 and adult obesity is responsible for up to 6 percent of health care expenditure. In developing countries too, we see the dramatic impact of behavioral change, as diabetes and cardiovascular disease take a rising toll—a result of increased tobacco use, poor diet, and obesity.

And we know that poverty and disease in any country has an impact on every country.

Why? Because we are living in an era of globalization—when national borders matter less…and our common humanity matters more.

Today, health challenges and opportunities increasingly are shared—and linked to a host of vulnerabilities that jeopardize wellbeing, such as food shortages…economic shocks…our changing global climate…and the continued and growing migration of people to crowded urban areas.

Yet, at the Rockefeller Foundation, we believe that, together, we can harness this interdependence for good.

We call it “smart globalization.”

It means helping more individuals, communities, and institutions tap into growth and opportunity while becoming more resilient to threats and challenges.
It means helping more people in more places connect with the ideas and innovations to survive, learn, adapt, create, and flourish—even as we work collectively to address our common risks.

In the last century, my predecessors led efforts against scourges from hookworm and yellow fever to polio.

More recently, we worked with the health community to spark a massive worldwide push for public-private partnerships that accelerate the development of drugs and vaccines to end HIV/AIDS, malaria, tuberculosis, and other devastating diseases.

But today, ten years into the 21st century, we face a new kind of health challenge.

For, despite impressive vertical efforts against priority diseases, the “health systems” that deliver and sustain life-saving interventions are ailing and weak.

Too often, as U.S. AID Administrator Raj Shah has said, “Our siloed, single-disease focus means that in many countries, the same health system that can prevent the transmission of AIDS to an infant is unable to prevent that same child from dying of diarrheal disease before she turns five.”

We see health system weakness in the form of poor stewardship…dysfunctional service delivery…and inequitable financing. Further, in many cases and especially in low- and middle-income countries, health systems are not prepared to take on the long-term responsibility of caring for patients suffering from non-communicable diseases, nor the growing aging population.

According to Save the Children, "99 percent of child and maternal deaths occur in developing countries where mothers and children lack access to basic health-care services."

And let’s be honest: When it comes to health care access and health care quality, we know the discrepancies that burden the poor are not limited to poor countries. While global spending on health has increased to some $7 trillion annually, access to affordable, quality services has not—including in my own country, the United States.

Yet, a window of opportunity is opening for meaningful health systems reform.

It’s being driven by epidemiologic shifts, such as aging populations…by increased public awareness and expectations for affordable, accessible care…

And by economic hardships that are prompting people to put more pressure on their governments to expand their social safety nets, including health protection.
In addition, as we enter the final stretch on the Millennium Development Goals, we can seize the momentum to steer reforms toward better health outcomes and financial protection, especially for poor and vulnerable groups in countries around the world.

This window of opportunity is what prompted Rockefeller to make the transformation of health systems our next revolutionary goal, around which we’ll help promote innovation… broker partnerships… and find sustainable solutions.

Improving human resources and scaling up specific health services are critical to this enterprise. To that end, we’re supporting governments with the technology, talent, tools, and training to become better stewards of their national health systems, and improve planning, financing, and quality of services.

But that won’t be enough. To measurably improve the health status and financial resilience of the poor, we need to build a global movement in support of universal health coverage – which WHO defines as “access to appropriate health services for all, at an affordable cost.”

Consider:

Beyond the perils of disease, more than 150 million individuals worldwide face catastrophic healthcare expenditures…and, as a result, approximately 25 million households are pushed into poverty every year.

High out-of-pocket expenditures also prompt parents to withdraw children from school, using education fees to cover medical costs.

The world’s poorest people pay the highest percentages of their wealth for health. The World Bank reports that in low-income countries, out-of-pocket spending accounts for 93 percent of private spending, and more than 60 percent of total health spending.

And while, on average, only 5 percent of people fall ill in a given year, the lack of health insurance and effective social protection programs means that these people pay the lion’s share of the national health spending bill.

Universal health coverage would mean better health outcomes… greater equity… and lower poverty.

And we can help make it happen.

Because achieving UHC is not so much about mobilizing more capital…as it about reorganizing health financing at the country-level.

The key is shifting 50 to 80 percent of total health spending to appropriate public and private risk pools, so that resources can be funneled toward high-impact health interventions and the most vulnerable populations.
Lower-income countries from Rwanda to Thailand are illustrating through action that UHC is not just laudable but feasible.

With similar UHC reforms in other countries in Asia and Africa alone, by 2020 we could imagine doubling the number of people covered and halving the out-of-pocket expenditures.

Now, of course it’s true that the cost of shifting from out-of-pocket expenditures toward fair risk-pooled financing will require resources beyond the regular health budget. The McKinsey report we supported that was launched here yesterday made this clear.

But the report made it equally clear that these investments – which are relatively small when measured against current health budgets – have an outsized impact on health systems around the world.

For example:

Ghana invested approximately $115 million in institutional reform over six years. This is equivalent to 2.5 percent of its total health expenditure. This investment, together with a major health reform effort that was financed by a newly introduced value added tax, enabled a dramatic boost in coverage – from 5 percent of the population covered to approximately 75 percent coverage, even as the country’s health expenditure as a percentage of GDP remained close to 6 percent.

In India, the state of Andhra Pradesh invested $60 million over three years in infrastructure and management institutional reform. This, together with the reform of their health financing paradigm, enabled them to extend coverage from 10 percent to 85 percent of the population, including hospitalization and surgery.

The additional investment, together with new revenue sources to fund other aspects of the health reform effort, in order to shift from an out-of-pocket financing model to a risk-pooling model, amounted to 5 percent of the public health budget. The result? A significant reduction in out-of-pocket expenditures.

In other words, there is empirical evidence that this paradigm shift will produce a real payoff, for decades to come.

In the cases of Chile and Turkey—countries that principally focused on deepening coverage for their populations—investment in institutional reforms and management capacity required just 0.1 to 0.6 percent of total health expenditure over the period of reform. Their example shows that these reforms can be a sound investment for middle-income countries, too.
We believe that these successes can lead to other successes – that is, if the international community can learn from these achievements and replicate the model in other parts of the world.

Unfortunately, that isn’t a given. Too little attention has been afforded to health systems and UHC. Too few of the lessons learned have been shared. Research in the area has been neglected for too long.

In the face of these challenges, there are three avenues for action and you are critical to all of them:

First, we need more information. As countries renegotiate their social contracts for health, they need accurate, dependable data to guide their efforts. They need more research on the mechanisms that link UHC with poverty alleviation and with improved health outcomes.

And they need more collaboration between researchers and policymakers, so that proven solutions are put to work right away.

Second, we need to provide national governments with the technical and financial support they need to transform their health systems.

Third, we need to make the case that health sector reform toward UHC is a solid financial investment and should be a priority target for foreign aid in the next decade, if requested by a national government.

The Rockefeller Foundation has adopted several strategies for acting on these imperatives.

We’re dedicating resources to supporting research on universal health coverage. That includes studies on the macroeconomics of universal health coverage and comparative systems analyses, as well as new centers for research and training on UHC in Bangladesh and Vietnam among others.

We’re supporting nations in their pursuit of health systems reform by convening cross-border partnerships and holding workshops for health officials. In collaboration with a number of donor and developing country partner groups we’ve organized a “Joint Learning Network” of countries implementing Universal Health Coverage, which allows donor organizations to provide policy assistance and a sounding board for new strategies as well as enabling developing countries to share practical lessons on implementing UHC. One result has been the deepening of a partnership between the International Health Policy Program in Thailand and the Ministry of Health in Vietnam. They and several donors are working together to design the Diagnosis Related Groups, or DRG system, for Vietnam.
And earlier this year, we brought together health officials from Ghana, Vietnam, Rwanda, India, Indonesia, and the Philippines for a workshop in India, to trade best practices and share ideas for implementing universal health coverage. Taken forward, based on country demand, future work will focus on provider payments, use of Information Technology, quality, and addressing hard to reach populations.

These programs have served as catalysts for other initiatives. After our India workshop, one member of the Joint Learning Network – the International Health Policy Program in Thailand – volunteered to host another workshop on provider payment, a topic that had triggered extensive discussion. Thailand has extensive experience with provider payment system design and implementation, and I’m confident that workshop participants will benefit enormously from the opportunity to learn from each other.

We’ve also made an effort to align efforts on achieving universal health care in low- and middle-income countries, by convening a “Global Task Force on Universal Health Coverage.”

The Task Force’s Secretariat is based in Washington, DC and Dhaka, and is made up of national and multilateral leaders. This group convened for the very first time just last night, here in Montreux and I salute you.

But achieving universal health coverage is not only a matter of research, or partnerships, or visibility.

We need urgency.

We need purpose.

Above all, we need leadership.

Time and time again, the leadership of the global health community – researchers, practitioners, and donors alike – has been pivotal in catalyzing change across nations and across the globe.

This time is no different.

If universal health coverage is to be a reality, it can’t only be a catchword. It has to be a movement – a community acting with purpose, reaching out to actors beyond the field of health research to build a truly global coalition, mounting a worldwide effort to bring health coverage to every individual in need.
This meeting is an example of the energy and momentum we need to build such a movement. A few years ago, the global health research agenda was divided into silos: separate individuals and organizations, each working on their separate agendas – new vaccines, HIV/AIDS, malaria. There were few, if any, large meetings dedicated to a broad “health systems” agenda.

So our conference represents a significant step toward a broad, diverse coalition working toward a common goal: universal health coverage. The Rockefeller Foundation is proud to have been the first donor to support the great idea behind our gathering.

But this is only the beginning. The ideas that emerge from our discussions, the relationships that are forged here, the shared sense of urgency and commitment and hope – these things must not end here. What begins here in Montreux must become the foundation for a new movement to bring health care to all.

At the start of this speech, I mentioned this city’s special connection to Freddie Mercury, the lead singer of Queen. He wrote a song about Montreux that came to my mind when I first stepped off the plane. It’s a song about a place that is both quiet and magnificent, a place filled with great possibility.

In his words, “There’s a kind of magic in the air… with the dreams of the world in the palm of your hand.”

In your work at this conference, remember, you hold the world’s dreams in the palm of your hands. We know where to start – we know how to start.

So let’s begin here… today.

Thank you.

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\(^1\) From VOA article on UNDP HDR 2010, by Margaret Besheer.

\(^2\) Source: State of the World's Mothers 2010, Save the Children, http://www.savethechildren.org/atif/cf/%7B9def2ebe-10ae-432c-9bd0-\hfill \text{df91d2eba74a%7D/SOWM-2010-Women-on-the-Front-Lines-of-Health-Care.pdf}


\(^4\) Source: State of the World's Mothers 2010, Save the Children, http://www.savethechildren.org/atif/cf/%7B9def2ebe-10ae-432c-9bd0-\hfill \text{df91d2eba74a%7D/SOWM-2010-Women-on-the-Front-Lines-of-Health-Care.pdf}