

Health Transitions: Progress or Paralysis?

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It is an honor to be the recipient of the 2018 Frank E. Calderone Prize, which celebrates the inspirational life and legacy of a towering figure in public health. I would like to thank Dean Linda Fried, the Calderone family, and the selection committee for their generous decision.

It has been three years since I started my life as President of the University of Miami, and I feel privileged to return to my academic roots in order to receive an award from a school that has made so many important contributions to public health. It is an additional honor to add my name to a list of outstanding individuals who have received this prestigious prize, most of whom have been admired friends and role models for me.

As you know, the explicit purpose of the Calderone Prize is to honor individuals who have made transformational contributions to the field of public health. When I read this statement, I was even more humbled by the decision of the jury. This feeling urged me to identify elements of my career that, first, could be considered contributions to my professional field, and, second, could be of interest to revisit in my lecture for the award ceremony. I came up with two big topics, which are closely related, namely, my work to develop a new public health agenda and my contributions to the study of the health transition, that is to say, the long-term patterns guiding the remarkable transformation in the epidemiologic profile of populations and the complexity of health systems.

I do not intend to repeat ideas that I have discussed at length in the different academic and policy settings where I have had the privilege to participate. Instead, I will use these ideas as a reference to examine

the evolution of health systems around the world. In that context, I will address an emerging and worrisome trend, which could be called 'backward transitions in health care.'

After the end of World War II, most societies adopted a mindset of linear progress: the idea that the victory over totalitarianism and the continuous advancements in science and technology would bring uninterrupted improvements in social organization and the human condition.

Several recent processes, such as the spread of terrorism, xenophobia, hate crimes, and authoritarian populism, are questioning this extended belief and reminding us that progress is rarely unceasing; it can experience setbacks and regressions.

This reality makes my lecture today particularly timely, even though some of the underlying concepts have evolved over a career that now spans three decades.

But let me start from the beginning. My professional journey began with the decision to study medicine, like the three generations of Frenks before me. However, unlike my great-grandfather, my grandfather and my father, when I finished my basic medical training, I decided not to follow a career in clinical care but in public health—to make the whole of society my patient, as it were. I headed to the University of Michigan in Ann Arbor to study under the mentorship of Avedis Donabedian—who, by the way, began his pioneering studies about the quality of health care here at Columbia. If I were to summarize what Avedis taught me I would say two things: First, he nurtured my ability to think in a rigorous way—whether to design a research protocol or find a solution to a policy

problem—and, second, he inoculated in me the passion for linking ideas to action. Thanks to him, my entire professional life has been guided by the conviction that rigorous thinking is a requirement for effective action.

After finishing my graduate studies at Ann Arbor, I returned to Mexico, where I joined Guillermo Soberón, a progressive and innovative minister of Health, in an effort to build a new academic institution. By the 1980s, Mexico had excellent research institutions in the medical field, but none devoted to public health. The newly created Center for Public Health Research would produce essential evidence that could inform scientifically rigorous policy decisions. The Center made major contributions and, after a few years, was elevated to the National Institute of Public Health.

Today this Institute is one of the leading academic organizations in the developing world, as exemplified by the fact that it became the first non-US member of the Association of Schools and Programs of Public Health.¹ I had the privilege of serving as founding director of both the Center and the Institute.

What I would like to emphasize is that the design of these institutions was based on an explicit conceptual framework about the essence of public health, which served to orient research and graduate training programs.

The core ideas of this framework were published in a 1993 article with the bold title “The new public health.”² There I tried to define the elusive concept of ‘public health.’ We proposed a parsimonious construction whereby ‘public’ refers to a level of analysis—the population level—, and ‘health’ refers to two objects of analysis: on the one hand,

the health *conditions* of a population and, on the other, the organized social *response* to those conditions, which in modern societies is structured through differentiated and complex health systems.

Building on these ideas, I became interested in developing a dynamic understanding of health processes through the overarching concept of the ‘health transition.’ Corresponding to the two objects of study of public health, this encompasses, first, the epidemiologic transition—the long-term patterns of change in the health conditions of populations— and, second, the health-system transition—the transformation of the organized social response to health problems.

Let’s start with the changes in the patterns of disease, disability, and death that have taken place since the 20th century. These changes are so dramatic that they have been characterized as a health revolution. Its clearest manifestation is the doubling of life expectancy that took place during the 20th century, from a global average of 30 years in 1900 to about 68 by the year 2000. Not only did the overall levels of mortality drop, but the dominant pattern of causes of death also experienced a tectonic shift. This is the process that the theory of the epidemiologic transition seeks to describe and explain.

The original formulation of this theory, by Abdel Omran in 1971, states that all modern societies eventually undergo a replacement of infectious diseases by non-communicable diseases as life expectancy increases due to better living conditions, disease prevention, and improved health care.³ According to Omran, countries move in the same direction, passing through identical stages, each of which has a dominant pattern of morbidity and mortality. In his view, there are three

distinct models of the transition: the *classical model*, experienced mainly in Europe; the *accelerated model*, represented by Japan; and the *delayed model*, present in most developing nations.

Along with several colleagues in Mexico, we challenged this linear and unidirectional formulation by demonstrating that many developing countries experience what we called a 'protracted polarized model' of the epidemiologic transition.⁴ To begin with, the stages suggested by Omran are not necessarily sequential. Two or more stages may overlap, generating what is now known as the 'double burden of disease.' In most low- and middle-income countries, the unfinished agenda of common infections, malnutrition, and maternal mortality coexists with a rising prevalence of non-communicable diseases (NCDs). Furthermore, the evolutionary changes in the patterns of morbidity and mortality are reversible, and may give place to what could be called 'counter-transitions.' The best examples are re-emerging infections such as cholera, dengue fever, and malaria. With growing global interdependence, many of these reversals are due to the international transfer of health risks.⁵

Now, what about the other object of study of public health, the organized social response to health conditions? Is there a health-system transition, parallel to the epidemiologic transition?

Alongside the spectacular reduction in mortality, there has been a second health revolution characterized by the emergence of differentiated, specialized, and complex health systems, which have become a dominant feature of the social fabric in all but the most marginalized corners of the planet. Together, health systems absorb

10% of the world economy, about 7.5 trillion U.S. dollars per year. Of course, there are huge differences in access to these resources. While the United States spends every year close to \$10 thousand dollars per person on health, many countries in sub-Saharan Africa invest less than \$30.

In contrast to most of human history, today health systems permeate all corners of economic activity, dominate political debate, generate cultural interpretations, spur technological innovation, create deep ethical dilemmas, and accompany human beings at the most crucial moments of their existence, from birth to death. And yet, despite the revolutionary changes in the way that societies organize and finance the delivery of health care, we don't have anything that resembles a theory of health-systems transition. As has been said many times, there is no other industry of this size that spends so little in understanding its dynamics, evaluating its own performance, and learning from its best and worst practices.

I have spent a good part of my professional life trying to develop coherent, comprehensive, and comparative ways of thinking about health systems. Time does not allow me to discuss the insights that I may have gained through this effort. Suffice it to say that, among the many innovations in this arena, four stand out as truly transformative.^{6,7}

The first one is the notion of access to health care as a right.^{8,9,10} Indeed, most countries have amended their constitutions or approved laws to recognize health care as a social right and have used these legal frameworks to expand access to comprehensive services.¹¹

The second transformation refers to the organizing principle for health systems.¹² As they seek to expand services, many countries initially segregate different population groups based on their income or labor-market status and create separate health care arrangements for each. However, in a growing number of countries such segmented systems have been superseded by universal arrangements, in the double meaning of the word ‘universal’: a system that covers every person *and* does so with equivalent rules and entitlements. Instead of organizing the health system by population groups—for example, by setting up different arrangements for the poor or for salaried employees—, truly universal systems are organized by the cross-cutting functions that apply equally to everyone—stewardship, finance, service delivery, and resource generation.¹³

The third paradigm shift refers to the search for integration across the multiple dimensions that have traditionally been treated as false dilemmas: prevention versus treatment, primary care versus specialized care, vertical versus horizontal programs, infections versus non-communicable diseases (NCDs), local versus global, knowledge versus action.¹⁴ A particularly relevant effort at integration has emerged with the concept of ‘population health.’ In its best usage, this notion points to a potential connection between clinical care and public health. In particular, high-performing health systems realize the synergies between extending access to care and acting on the upstream social determinants of health. For instance, efforts to extend health insurance can only be financially sustainable if they are accompanied by vigorous actions to stop people from getting sick in the first place.

Finally, the fourth transformative innovation refers to the systematic adoption of mechanisms to promote transparency and accountability.^{15,16} Salient among them are anti-corruption efforts in countries at all levels of development, along with the slow but consistent introduction of procedures to evaluate programs and policies. This way we can build a body of knowledge about what reforms work under which circumstances, thereby enabling a process of shared learning across countries.

After a quarter of a century thinking and writing about complex health systems, I had the rare and precious opportunity of actually applying all I had learned. In the year 2000, at a historic juncture following the first fully democratic election in Mexico, I was appointed Minister of Health there. The first thing I did was to place at the center of my desk a card with a quote from Winston Churchill, which served as a reminder of my responsibility every day of my six-year tenure. The card said: "To each there comes in their lifetime that special moment when they are figuratively tapped on the shoulder and offered the chance to do a very special thing, unique to them and fitted to their talents. What a tragedy if that moment finds them unprepared or unqualified for the work which would be their finest hour."

My "very special thing" was to introduce a program of universal health insurance in Mexico. Again, there is no time to describe this reform in any detail. For those who are interested, I can say that, given my own commitment to evaluation, the Mexican experience has spawned a substantial body of literature, with over 120 articles in peer-reviewed journals and even some doctoral dissertations.

For our purposes today, suffice it to say that this reform was a textbook case of evidence-based policy.¹⁷ Indeed, a series of careful studies had revealed alarming rates of catastrophic health expenditures as a result of the fact that approximately half of the population, 50 million people, lacked insurance. This analysis brought to light an unacceptable paradox: We know that improving health is one of the most effective ways of fighting poverty, yet 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 2003 we secured support from all political parties for legislation aimed at correcting that paradox. The vehicle for doing so is a public scheme called *Seguro Popular*, funded predominantly through federal and state subsidies. By 2015, over 55 million people were enrolled in it, and the country was on track to achieving the goal of universal coverage.¹⁸

The benefits of this reform have been documented both in specialized journals and in publications aimed at a broader audience. For instance, the influential magazine *The Economist* recently featured *Seguro Popular* in a cover article on global efforts toward universal health care. This was its main conclusion: “Studies suggest that Seguro Popular has drastically reduced the number of Mexicans facing catastrophic health costs and reduced infant mortality.”¹⁹

The Mexican reform applied the four health-system transformations discussed earlier. Several other countries around the world have also done so. The key question now is whether such elements of progress are irreversible, or whether there is a risk of

backward movements. As in the case of the epidemiological transition, can health systems also experience “counter-transitions”?

Recent events show that ideological preconceptions and short-term political interests can distort what experts may optimistically consider to be the “natural” evolution of public policies.

A prime example of this risk is offered by the repeated efforts to repeal the key provisions of the Affordable Care Act. While this legislation did not include all elements of the health-system transition, it did represent a major step in the right direction and was improving insurance coverage, especially among the poor.²⁰ It is estimated that the recent actions by Congress and the Administration could leave 18 million Americans without coverage this year and 32 million more by 2026.²¹ If such a reversal is not itself reversed, the United States will continue to stand out as the single developed country without a universal health system.

Mexico is also at risk, now that it has recently joined the global trend to elect populist governments. If there too ideology replaces evidence in the formulation of public policy, *Seguro Popular* could be in jeopardy, despite the evidence of its benefits mentioned before.

What these cases illustrate is the fact that progress in health policy is not linear; it has ups and downs, forward-moving stages and reversals.

We tend to believe that the improvements and institutions brought about by enlightened policies speak for themselves; that they are self-preserving because they have proven their worth; that they have a sort of shield that guards them against biased and narrow-minded attacks.

This is simply not true. No matter how well they perform, we should never take programs and institutions for granted. We should always try to improve them, but we must also protect them, actively.

The first half of the 20th century suffered from the actions of authoritarian leaders willing to destroy what had been built gradually with enormous efforts. It is now obvious that the 21st century will not be exempt from this type of risk.

In such turbulent times, the role that universities play in society is becoming more important than ever. In my current position, I often reflect on the need for universities to be *exemplary* institutions. By this I mean that through the values they embrace and the behaviors they exhibit, universities can be a model or example for the larger society of which they are a part.

We do that, for instance, when we demonstrate that it is possible to engage in civil and civic discourse to process disagreements in a respectful way, which seeks to understand rather than dismiss differing points of view. At a time when the credibility of institutions and expertise is often questioned, we become exemplary as we uphold the value of basing decisions on rigorous evidence, rather than ideological prejudice, and as we reaffirm our commitment to the pursuit of truth, no matter how complex and contradictory it may be.

There is no question that our societies urgently need to bridge the painful divides that fracture us along economic, educational, ethnic, and cultural fault lines. To do so, universities must continue to serve as the most legitimate engines of opportunity and upward social mobility.

While progress is not inevitable, paralysis is not an option. Our efforts to keep advancing cannot falter. As engaged members of the commonwealth of universities, we have no choice but to persevere in our pursuit of knowledge as the most powerful force for enlightened social transformation.

I thank you again for selecting me as the 2018 recipient of the Calderone Prize, which honors the achievements of public health professionals and encourages all of us to continue striving for progress.

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