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MMI Discussion paper

## QUESTIONS AND ANSWERS ON UNIVERSAL HEALTH COVERAGE ...AND SOME MORE COMMENTS AND OPEN QUESTIONS



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## Questions and answers on Universal Health Coverage ...and some more comments and open questions

Like many other actors in global health, the Medicus Mundi International Network (MMI) is overwhelmed by the attention given to the concept of Universal Health Coverage (UHC) in the last two years<sup>1</sup>, mainly by the World Health Organization and related to the debate on health in the post-2015 development agenda. We have followed this debate with great interest, as the “UHC hype” brought health systems strengthening, a core concern of MMI, back to the top of the global health agenda.

The current discussion paper presents key elements of the concept of UHC as promoted by the World Health Organization and reflects them based on our own ambition of Health for All such as stated in the MMI Network Policy.

In the three sections (1) “What is in Universal Health Coverage?”, (2) “Financing UHC”, and (3) “UHC and health equity” of the discussion paper we will directly refer to two helpful “questions and answers” papers recently published by the World Health Organization:

- Questions and answers on Universal Health Coverage. WHO 2013<sup>2</sup>
- Questions and answers: Universal Health Coverage and the post-2015 Framework. WHO 2013<sup>3</sup>  
As our discussion paper does not focus on UHC as a post-2015 development goal, we only refer to selected sections of this document marked with an asterisk (\*).

In each section we will first quote the WHO “questions and answers” and then add some of our reflections and open questions, hoping to contribute with this to the further discussion within and beyond our Network.

The paper was drafted by an ad hoc working group of the MMI Network and adopted by the MMI Board on 13 August 2013 as discussion paper for MMI Network members and partners. Your feedback is most welcome!



Medicus Mundi International Network  
Thomas Schwarz, Executive Secretary

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# 1. What is (in) Universal Health Coverage?

## WHO Q&A: What does universal health coverage mean?

Universal health coverage means that all people have access to the health services they need (prevention, promotion, treatment, rehabilitation and palliative care) without the risk of financial hardship when paying for them.

This requires an efficient health system that provides the entire population with access to good quality services, health workers, medicines and technologies. It also requires a financing system to protect people from financial hardship and impoverishment from health care costs.

Access to health services ensures healthier people; while financial risk protection prevents people from being pushed into poverty. Therefore, universal health coverage is a critical component of sustainable development and poverty reduction, and a key element to reducing social inequities.

Universal health coverage is not something that can be achieved overnight, but all countries can take action to move more rapidly towards it, or to maintain the gains they have already made.

## WHO Q&A: What is needed to achieve it?

For a community or country to achieve universal health coverage, several factors must be in place including:

- A strong, efficient, well-run health system that meets priority health needs through people-centered integrated care by: informing and encouraging people to stay healthy and prevent illness; detecting health conditions early; having the capacity to treat disease and helping patients with rehabilitation; ensuring sensitive palliative care where needed.
- Affordability – a system for financing health services so people do not suffer financial hardship when using them.
- Availability of essential medicines and technologies to diagnose and treat medical problems.
- A sufficient capacity of well-trained, motivated health workers to provide the services to meet patients' needs based on the best available evidence.
- Actions to address social determinants of health such as education, living conditions and household income which affect people's health and their access to services.

## WHO Q&A: What services should be included in universal health coverage?

Essential health services (including for HIV, tuberculosis, malaria, non-communicable diseases and mental health, sexual and reproductive health and child health) should be available to all who need them.

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The dilemma for most countries, in particular low-income countries, is that they are not able to provide everyone with all the health services they need at an affordable price, even with the large increases in external donor assistance for health since 2000.

The goal should be to provide an increasing number of health services over time while at the same time reducing out-of-pocket costs to patients. Decisions about the services that can be guaranteed to the population initially, and which ones should be added over time, are based on peoples' needs, public opinion and costs.

The priority should be to ensure access to the key interventions targeting the health Millennium Development Goals – births attended by a trained health worker, family planning, vaccinations, and prevention and treatment of diseases such as HIV, malaria and tuberculosis – while considering how to address the growing problem of noncommunicable diseases.

## **WHO Q&A: What is the impact of universal health coverage on the population?**

Universal health coverage has a direct impact on a population's health and welfare. Access and use of health services enables people to be more productive and active contributors to their families and communities. It also ensures that children can go to school and learn. At the same time, financial risk protection prevents people from being pushed into poverty when they have to pay for health services out of their own pockets.

Universal health coverage is thus a critical component of sustainable development and poverty reduction, and a key element of any effort to reduce social inequities. Universal coverage is the hallmark of a government's commitment to improve the wellbeing of all its citizens.

## **WHO Q&A: How can we measure universal health coverage?**

As universal health coverage is a combination of whether people obtain the health services they need and financial risk protection, measurement needs to include both components. Coverage of health services can be measured by the percentage of people receiving the services they need: for example women in fertile age groups accessing modern methods of family planning or children immunized. On the other hand, financial risk protection can be evaluated by a reduction in the number of families pushed into poverty or placed under severe economic strain due to health costs. The impact of these steps on population health and household financial wellbeing can also be measured, as can many of the factors that make it easier to increase coverage. These include the availability of essential medicines, for example.

The main challenge is that many countries do not have the capacity to measure coverage of all of the many health interventions that their populations needs. So they will need to choose a set of key indicators to track performance in service coverage. A sub-set of these could be used to compare performance between countries.

## **WHO Q&A\*: Is UHC too ambitious a goal?**

Universal Health Coverage is a dynamic process. It is not about a fixed minimum package, it is about making progress on several fronts: the range of services that are available to people; the proportion of the costs of those services that are covered; and the proportion of the

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population that are covered. Few countries reach the ideal, but all – rich and poor – can make progress. It thus has the potential to be a universal goal. Countries will move towards this goal at different paces depending on disease problems, levels of income and many other factors. In human rights terms, there needs to be a vision of where the country wants to go, and how it plans to get there, with a clear indication of how it aims to improve the availability and quality of services over time.

## WHO Q&A: Are countries succeeding in implementing universal health coverage?

Countries at all income levels can take steps to move closer to universal health coverage.

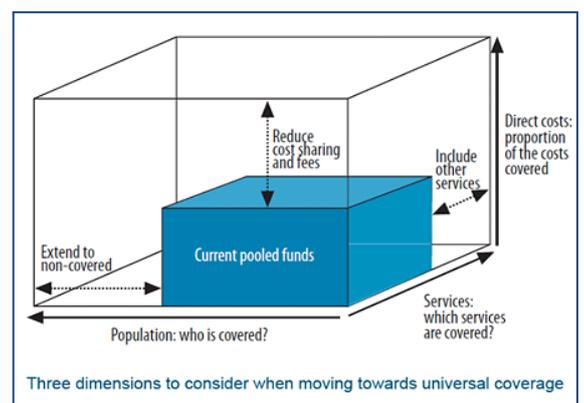
- Nepal, where free universal health care was introduced in 2008, is now on track to achieve its health-related MDGs.
- In 2008, the Afghan Government, using considerable donor funding, removed user fees in public health facilities and healthcare utilization more than doubled.
- Thailand has just celebrated ten years of its universal coverage scheme which has dramatically reduced impoverishment caused by out-of-pocket payments.
- More recently, El Salvador has launched an ambitious plan to expand health coverage including abolishing user fees and strengthening primary health care in remote and poor rural areas.
- Other countries moving forward in Africa include Liberia, Gabon, Ghana, Sierra Leone and Rwanda.

## MMI Network: Elements for the discussion

The goal of achieving UHC has two inter-related components – coverage with needed health services and coverage with financial risk protection. If you add “for everyone” to these two statements on what needs to be covered, you come to the famous “UHC cube”<sup>4</sup>.

However, there has been little said about feasible and sustainable ways to extend the range of services within a national health system. There is a great risk that if the road towards UHC is not based on clear values, the cube becomes a black box in which any health intervention can be labelled as contributing to UHC. These values must include a commitment, via the extension of health services, to reduce inequity and promote human rights.

The focus on the goal (more services covered) and the neglect of the means to achieve it has already been one of the problems of the Millennium Development Goals (MDGs). The UN resolution on UHC<sup>5</sup> promoting national ownership in the implementation of UHC suggests that every country is free to choose the best way towards UHC. So it seems not to matter if we have a system in a poor country that has a lot of vertical programmes because this is the quickest way to reach many people, scaling up services and, if there is international funding available, reducing the financial burden for the individual. Looking at .....



all the vertical global health initiatives that address particular health conditions and illnesses, a rush to UHC in a sense of rapidly scaling up the range of health services covered might support quick fix health care solutions for the poor (see “One Million Community Health Workers until 2015”<sup>6</sup>). In a globalized health care (and health aid) market, such scaling up initiatives are often driven by the push for new pharmaceutical or technological solutions to real or presumed health needs, in what is known as disease mongering<sup>7</sup>, and not integrated in an overall health policy.

### **Who defines the needs and priorities?**

As in other global or national health systems programs, UHC organized top-down risks to oversee the people it is intended to serve. There is not enough emphasis on community participation and ownership in the framing and implementation of UHC. A very old and awkward questions needs to be asked again: Who shall define the health needs and priorities? What about the local acceptability of globally or nationally promoted solutions?

The experience of MMI Network members and partners shows that the success of every program depends not only on money and on comprehensive global and national plans, but on the ownership by the people, those actors on behalf of their own health who are able to tackle the problems from the bottom.

As it stands UHC is just the business of governments (with or without external support) to set up systems which serve the purpose. People and communities should have a say in all, as citizens, actors and owners of the health system, and not just be considered as clients and beneficiaries.

Monitoring of the progress toward UHC should therefore not just refer to the outcome, but include monitoring of the process, by using indicators such as satisfaction and participation of the population.

### **Take care of the system**

Health is a complex adaptive system<sup>8</sup>, within wider cultural (and educational), social and economic complex adaptive systems. Changes in access to health brought about by UHC are likely to affect other building blocks within the health system and in other sectors. Systems thinking<sup>9</sup> is therefore key for policy and decision makers dealing with UHC, as well as planners and researchers. This would be easier if UHC was integrated into a wider social protection framework.<sup>10</sup>

### **The journey is the destination (isn't it?)**

The WHO has provided a strong and convincing statement that Universal Health Coverage is a dynamic process and not merely a fixed minimum package, but actually contributes to the reduction of health inequalities within and between countries. We are nevertheless worried that the attention currently given to UHC is misused for easy promotional messages in the field of health financing. “We achieved UHC”, such as we recently heard from Mexico<sup>11</sup>, is misleading and demotivating. It destroys the dynamic of further investing in public health and the national health system. On the other hand, “progressive realization” (of UHC, of the Right to Health) should not allow just waiting and seeing. Countries are responsible both for undertaking all necessary steps to realize universal coverage and for developing indicators for monitoring this progress, so that they can be hold accountable.

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## First conclusions and open questions

The MMI Network Strategy 2011-15<sup>12</sup> defines the strategic focus of the Network for the current years as follows: “Contributing to health system strengthening will be the common denominator of joint enterprises and political statements of our Network.” Implementing this strategy, and having initially focused the Network’s attention related to health systems strengthening on the role and integration of NGOs and private not for profit health care providers in national health systems, we now will watch the debate on UHC with a particular attention to its consequences for the national health systems.

Working with the people and communities, and not just for them: this is where the members of the Medicus Mundi International Network involved in international health cooperation are rooted in. This is where we come from, and this is what allows us to contribute our experiences and know-how to the debate on UHC. “To put in a blunt way, there should be more health workers and practitioners involved in the debate on UHC, and perhaps a bit less economists and financial experts...”<sup>13</sup>

Issues needing further investigation include:

- Addressing the health systems crisis in a systemic way
- Health systems integration
- UHC and the quality and effectiveness of health services
- Pathway to UHC for MIC and LIC and fragile states
- Cultural barriers for achieving UHC

## 2. Financing Universal Health Coverage

### WHO Q&A: How can UHC be financed?

Universal health coverage is fundamental to ensuring social protection for health. The poorest populations often face the highest health risks and need more health services.

A key element of financing for universal health coverage is sharing resources to spread the financial risks of ill-health across the population.

The system should collect large pools of prepaid funds that can be used to cover the health care costs of those in need, regardless of their ability to pay.

The countries that have made the most progress on providing universal health coverage have implemented mandatory contributions for people who can afford to pay through taxation, and/or compulsory earmarked contributions for health insurance.

Reducing the reliance on direct, out-of-pocket payments lowers the financial barriers to access and reduces the impoverishing impact of health payments.

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## WHO Q&A\*: Is UHC a way to promote private insurance?

UHC is a way to increase access to health care for all without fear of financial ruin. The way countries do this will vary according to their incomes, institutions and values. Two things are clear from country experience.

First, the health costs of the poor need to be met by government revenue. Governments do that in different ways. In the United Kingdom, for example, everybody receives health services paid directly by the state with resources raised by general taxation. In Thailand's Universal Coverage Scheme, the government pays the insurance premiums of the poor from general revenues. Countries cannot provide health services to everyone by relying principally on voluntary private insurance.

Second, fragmentation of insurance systems – where the rich or the formal sector have their own forms of health insurance while the poor are covered by government separately – makes it very difficult to ensure solidarity between the rich and poor and between the healthy and the sick. Fragmentation should be avoided wherever possible as once it exists, it is very difficult to prevent the development of a two or three-tier system with different standards of health services for rich and poor.

## MMI Network: Elements for the discussion

### Public, tax based funding is key

UHC risks to be seen as synonymous of health insurance schemes that would fund a limited package of services and allow infiltration of the private sector into national health systems, potentially undermining the public health sector. To avoid this, UHC should aim at increasing the proportion of health care services that are owned and governed by the public sector and financed by progressive taxation systems. No country in the world has made substantive progress towards UHC by relying on voluntary contributions to insurance schemes, so it is not “just” prepayment that is important, but mandatory prepayment, in the form of taxes (be it income, payroll, VAT) in some cases combined with mandatory contributions.

Public funding is essential for UHC, but national public budgets are under stress. The current debates about financial crises and macro-economic stability strongly influence the UHC debate: UHC and social protection mechanism will be severely affected in those countries that "choose" for macroeconomic stability, e.g. via tax funded bailing out its bankrupted banks, privatisation of public services and financial austerity of social and health services (see Greece, Spain, and Portugal as examples).<sup>14</sup>

### Fiscal reality cast in stone?

On the other hand WHO, UN and World Bank papers suggest that fiscal reality is cast in stone and that only within this fiscal reality countries have the political space to move forward to UHC. This approach, in essence, tells us something about the sad situation we have come to live in. But what are the mechanisms that cause and maintain resource scarcity in low income settings? And what is needed to counter those mechanisms for the sake of a more just distribution of resources and wellbeing?

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It is a fact that untaxed private wealth hinders many countries to finance strong public systems to reach or maintain Universal Health Coverage. In many emerging economies, such as South-Africa and Indonesia, but also in European countries with traditional generous social security systems, there is strong political pressure to remain attractive for international (financial) investors. In parallel there is similar pressure to reduce public spending on health care and create space for health insurance companies in the market of (mandatory) social insurance packages. Authors have coined this process of tax competition “a race to the bottom in slow motion”, with specific policies becoming less generous without disappearing, or creating a public debt that will eventually force their termination.

The question is whether all the countries that are now supporting the cause of UHC are willing to make progress on the reform of their fiscal policies in order to extend the current budget limitations.<sup>15</sup>

Finally it is well known that globalization has widened health inequalities. However, more emphasis should be given to the fact that the transforming of health services into commodities, the linkage of access to health care to individual purchasing power, the dismantling of public health systems, has only been possible in the context of the neo-liberal ideology, a concept that has replaced social values and institutions such as solidarity and common goods by self-responsibility and individual entrepreneurship and widely affected those who are suffering its negative consequences, the global poor.<sup>16</sup>

#### **“Globally Universal Health Coverage” - a transnational issue and an international responsibility**

There is no question that, ideally, investments in health care and health determinants be financed with domestic resources. No question also that national ownership and stewardship is key.

But there is also no question, though, that many low-income countries do not have the resources to offer universal health services to their entire population. The report by the WHO Secretariat on Universal Health Coverage clearly indicates that “despite increased health spending, funds are still insufficient to ensure universal coverage with even a minimum set of health services (that is, to support prevention, promotion, treatment, rehabilitation and palliative care) in many countries.”<sup>17</sup> For these countries, UHC risks becoming a meaningless concept. How to get out of this trap?

First, we are worried that this WHO report speaks again about a “minimum set of health services”. This is not what we understand as UHC. But more important, universality is a global issue, and transnational issues and international responsibilities are so far underserved in the discussion on UHC. In doing so, the question of how countries impact on UHC across their borders is often overlooked. Or it is acknowledged but then left aside, because it is complicated. It is high time we do start dealing with it.

The UNGA resolution urges for political national commitment toward UHC as part of the sustainable development agenda. A lot of attention is placed on what poor countries need to do to realize UHC within their capacities.<sup>18</sup> Mechanisms to overcome national limitations are still based on development assistance. However, we need to move beyond aid and the underlying charity concept to a new global solidarity based on the human right to health and the resulting obligations.

We already talked about global mechanisms behind the national fiscal realities. We add here that UHC cannot be left up to individual poor countries, but that it is high time to extend national obligations to international or even global obligations and entitlements. In the following we propose to extend the concept

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of financial coverage of health services to a shared global responsibility. It would then be “Globally Universal Health Coverage”.

Without international financing and/or redistribution mechanisms, UHC risks becoming a hollow promise. Such mechanisms must at their core have a redistributive mechanism, one that is based on a binding global agreement between states. Fair domestic and international progressive taxation policies (e.g. on carbon emissions) are properly suited to provide the necessary funds for such a global redistributive agreement. Indeed, in an interdependent, globalized world, we ultimately might come to a global solidarity fund to retain peace and stability.

Health care systems based on the principle of solidarity (still) exist in European countries, where they form part of the foundations of societies. Most likely these systems can only be defended by extending them to the international level. To bridge the gaps, an international financing mechanism is required that obliges rich countries to contribute also to the health budgets of poorer ones.<sup>19</sup>

### **Towards global governance for health: three R's**

Following this path, UHC becomes a matter of “global domestic health policy” and global governance for health. The overarching principles and recommendations for global governance for health can be summarized in three points (the three R's): Systemic resource redistribution between countries and within regions and countries to enable poorer countries to meet human needs; effective supranational regulation to ensure that there is a social purpose in the global economy; enforceable social rights that enable citizens and residents to seek legal redress.<sup>20</sup>

### **First conclusions and open questions**

With its current broader and more comprehensive approach, WHO has already moved further than in its World Health Report 2010 on “Health systems financing: the path to universal coverage”. The title of that report clearly put health financing as core of UHC: raising sufficient funds for health, providing financial risk protection in order to increase access to services, and using the funds in the most equitable and efficient way possible, accepting the very different financial starting points of every country.

From a point of view of “global domestic policy” and solidarity, we cannot accept that each country will need its own road map in order to achieve the core principles of UHC<sup>21</sup> based on its financial capacities, but aim for more. Even if the Medicus Mundi International Network is rooted in international health cooperation and health aid, we are aware that the solution for the future cannot be charity, but justice.

Issues needing further investigation include:

- Models for globally universal health coverage (Framework Convention, Global Health Fund)
- Focusing at the national level: which financing options are acceptable, and which ones should be rejected and denounced?
- How to link Universal Health Coverage with broader social protection systems?
- How to avoid the healthcare bureaucracy (which in the US increased health cost by 45%!)<sup>22</sup>

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### 3. Universal Health Coverage and health equity

#### WHO Q&A: Are the most vulnerable people covered?

In terms of financial protection, the most vulnerable people should have access to the health services they need without restrictions. In all countries, it has been found that governments have to use general budget revenues to meet the health costs (and/or insurance premiums) of poor and vulnerable people.

Ensuring access to health facilities, workers and medicines in remote, rural areas is also important, as is providing special interventions for stigmatized populations.

Universal coverage is firmly based on the WHO Constitution of 1948 declaring health a fundamental human right and on the Health for All agenda set by the Alma-Ata declaration in 1978. Equity is paramount. This means that countries need to track progress in providing access not just across the national population but within different groups (e.g. by income level, sex, age, place of residence, migrant status and ethnic origin).

#### MMI Network: Comments and open questions

We define equity as a core ethical concept intimately linked to the notion of justice. It deals with the willingness to give to each that which they deserve, or “to each according to her/his needs”. The objective of health equity thus is to be seen in the context of a wider search for social justice. Achieving health equity requires social policies of empowerment and a redistribution of social wealth. “Equality results from having equity just as inequality results from having inequity.”<sup>23</sup>

Past experiences have shown that “some reforms, often implemented in the name of expanding coverage, may actually compromise equity”<sup>24</sup>. For Universal Health Coverage to contribute to – or at least not to harm – health equity, it is crucial to take lessons from past experience into account, and to monitor progress using indicators that address both equitable and effective access to health services and financial risk protection.

Reducing inequity in health is a core element of Universal Health Coverage. However, in the famous cube (see above), it is only implicitly there and the commitment to equity is not as broadly shared as many of us might like it to be.

Programmes aimed at universal coverage at country level can have inequitable effects. It is crucially important to reach a broad understanding of and commitment to the underlying values of the health system reform through an inclusive and democratic process, to continuously monitor the equity impact of interventions and to have the will to adjust the design of an intervention if the impact turns out to be inequitable.<sup>25</sup>

To avoid this, Davidson Gwatkin<sup>26</sup> promotes “progressive universalism” opposed to a “trickle down pattern” of coverage that is often used and has increased inequity. Gwatkin calls for “a determination to ensure that people who are poor gain at least as much as those who are better off at every step of the way toward universal coverage, rather than having to wait and catch up as that goal is eventually approached. Of

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course, to show that progressive universalism is feasible is not to argue that implementation will be easy. But consider the alternative: in the absence of a determination to include people who are poor from the beginning, drives for universal coverage are very likely, perhaps almost certain, to leave them behind.”

### **UHC – the road to health equity and Health for All?**

To many people, UHC may sound like Health for All. However, what is currently proposed as Universal Health Coverage differs substantially from Primary Health Care (PHC) as proposed in 1978 in the Declaration of Alma Ata.

There is no problem with (good) old wine in new bottles, but what is different between PHC (or Health for All) and UHC is that PHC was much more a political ambition, whereas UHC tends to be a technical approach and then even further reduced to financial dimensions. That reflects the spirit of our time: (health) economists are very present in international debates about health and other development issues.

Primary health care included education, nutrition, water and sanitation, in addition to essential health care. And it intended to transform health systems, as opposed to health care systems, within a broader social transformation. “The signatories of the Alma Ata Declaration were aware of the importance of the social determinants of health well before the report of the WHO Commission on Social Determinants of Health”<sup>27</sup>

Unless UHC is implemented within a framework of social and economic transformation, it will not transform health as profoundly as hoped. “Paradoxically, an excessive focus on UHC could divert attention and resources from other sectors with a bearing on health.”<sup>28</sup> So we might re-read the Declaration of Alma Ata. Or eventually some of the strong statements in the report of the WHO Commission<sup>29</sup> just as the following ones:

- “Social injustice is killing on a grand scale.”
- “A toxic combination ... of poor social policies and programmes, unfair economic arrangements, and bad politics ... is responsible for the fact that a majority of people in the world do not enjoy the good health that is biologically possible.”

...and then act accordingly;

...and then not necessarily call this “Universal Health Coverage”, but eventually “UHC plus”.

### **First conclusions and open questions**

Universal Health Coverage is in essence linked to political demands, choices and inherent power relations, both at the national and global level. This is not new for us, as the Medicus Mundi International Network is rooted in the spirit of the Declaration of Alma Ata and its vision of and call for Health for All.

If the Medicus Mundi International Network is to promote Universal Health Coverage in view of improving health equity, then we should be willing to be truly involved in the political and ideological battle that will unfold over the coming period. Unless the international community pushes the right to health up in its scale of values and stops considering health as a dependent variable of the global economy, and unless it makes the respect of human rights mandatory and those who violate them legally accountable, UHC is unlikely to yield the expected results.

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Issues needing further investigation include:

- Universal Health Coverage and gender equity (almost entirely missing in the current debate)
- Universal Health Coverage and sustainability
- The political economy of Universal Health Coverage
- The transformative power of the UHC concept for social mobilisation and political change towards Health for All

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## Notes and references

- 1 Recent papers, calls, and reports: see MMI thematic guide on Universal health coverage, <http://www.medicusmundi.org/en/topics/health-systems-strengthening-starting-points/thematic-guide-universal-health-coverage#recent-papers>
- 2 Questions and answers on Universal Health Coverage. WHO 2013, [www.who.int/entity/contracting/documents/QandAUHC.pdf](http://www.who.int/entity/contracting/documents/QandAUHC.pdf)
- 3 Questions and answers: Universal Health Coverage and the post-2015 Framework. WHO 2013, [www.who.int/entity/contracting/documents/QandA\\_UHC\\_post-2015.pdf](http://www.who.int/entity/contracting/documents/QandA_UHC_post-2015.pdf)
- 4 UHC Cube taken from the World Health Report 2010, Health systems financing: the path to universal coverage, page XV, <http://www.who.int/whr/2010/en/index.html>
- 5 Social Protection and Universal Health Coverage. UNGA resolution, December 2012, [www.un.org/ga/search/view\\_doc.asp?symbol=A/67/L.36](http://www.un.org/ga/search/view_doc.asp?symbol=A/67/L.36)
- 6 One Million Community Health Workers until 2015 (this is NOT a satire). Thomas Schwarz in: MMI Network News, April 2013, [www.medicusmundi.org/en/mmi-network/documents/newsletter/201304](http://www.medicusmundi.org/en/mmi-network/documents/newsletter/201304)
- 7 Moynihan R, Doran E, Henry D. Disease mongering is now part of the global health debate. PLoS Med 2008;5:e106, [www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0050106](http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0050106)
- 8 See MMI colloquium „Health-y answers to comple#ity: Are we able to move beyond the control panel?“ in Brussels, November 2013, [www.bit.ly/mmi2013-brussels](http://www.bit.ly/mmi2013-brussels)
- 9 de Savigny D, Adam T. Systems thinking for health systems strengthening. WHO, Geneva, 2009, and other key documents: see MMI thematic guide, [www.medicusmundi.org/en/topics/health-systems-strengthening-starting-points](http://www.medicusmundi.org/en/topics/health-systems-strengthening-starting-points)
- 10 Universal Health Coverage - reflections from a development perspective. Viktoria Rabovskaja, GIZ discussion on Social Protection, [www.giz.de/Themen/de/dokumente/giz2012-social-protection-universal-health-coverage-reflexions-from-a-development-perspective.pdf](http://www.giz.de/Themen/de/dokumente/giz2012-social-protection-universal-health-coverage-reflexions-from-a-development-perspective.pdf)
- 11 Mexico achieves universal health coverage, enrolls 52.6 million people in less than a decade. [www.hsph.harvard.edu/news/features/mexico-universal-health/](http://www.hsph.harvard.edu/news/features/mexico-universal-health/)
- 12 MMI Strategic Plan 2011-15: [www.medicusmundi.org/en/mmi-network/documents/mmi-strategic-plan-2011-2015.pdf](http://www.medicusmundi.org/en/mmi-network/documents/mmi-strategic-plan-2011-2015.pdf). See also MMI thematic guide: [www.medicusmundi.org/en/topics/health-systems-strengthening-starting-points](http://www.medicusmundi.org/en/topics/health-systems-strengthening-starting-points).
- 13 Communication by Bart Criel, ITM Antwerp
- 14 See: Financial crisis, austerity, and health in Europe. Marina Karanikolos et al. in: Lancet, Vol 381, April 13, 2013, [www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2960102-6/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2960102-6/abstract)

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