



## **Keynote Address**

On the occasion of the 11<sup>th</sup> International Conference on Urban Health (ICUH)

5 March 2014, Manchester, UK

**"Universal Health Coverage and urban settings:  
implications and opportunities"**

by

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Opening Remarks by  
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*(Check against delivery)*

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Lord Mayor, Sir Howard, Dean Jacobs, Sir Michael, Dr Verma, colleagues from the Manchester Academic Health Science Centre and the Manchester Urban Collaboration on Health, Distinguished Presenters and Participants, colleagues from WHO, ladies and gentlemen, Good afternoon.

On behalf of Dr Margaret Chan, WHO Director-General, and the entire WHO family, it is my great pleasure and honour to be here today to discuss issues that are of great relevance to ensuring the health of people globally, nationally, and locally. We live in a world that is experiencing extraordinary advances in science, medicine, and technology. Yet, there are many people without access to basic health services, a situation further exacerbated by rising health and economic inequities.

The essential and unique theme of this conference is its focus on the urban setting, as well as “crossing boundaries” enabling engagement across many sectors. The rapid growth in urbanization is one of the key megatrends defining the 21<sup>st</sup> century, along with unprecedented

demographic changes such as increasing ageing, population growth, migration, fundamental changes in epidemiology, particularly the marked increase of non-communicable diseases, as well as major environmental health risks. These trends are converging, and in the context of each nation's and city's development and socio-economic conditions, they present challenges and opportunities for how health services are conceived, organized, and implemented, and they compel us to craft practical approaches to address the determinants of health.

Fifty percent of the world's population already live in cities, which is projected to increase to seventy percent in 35 years. The 50% threshold was exceeded long ago for many of the countries represented here today. Yet, another rising trend confronts us in the form of worsening inequities in health, wealth, and access to services. As we approach 2015 and the deadline for achieving the current Millennium Development Goals, we know that the world will not fully achieve them and we all recognize that a glaring omission from the MDGs was the lack of disaggregated data to track health inequities.

Our WHO Kobe Centre recently reviewed all available Demographic and Health Survey datasets between 1990 and 2011 for 67 countries to allow us to have a glimpse of the interaction between inequities, urban health and achievement of the health MDGs. They discovered that socioeconomic inequities in urban areas are higher than for rural areas for key health outcomes such as malnutrition and under-five mortality. For example, urban children under-five in the poorest quintile were three times more likely to be underweight, and twice more likely to die than children in the richest quintile. Urban women were nearly three times more likely to be obese as rural women, while urban men were nearly as likely to smoke as rural men. Analysis such as these are needed to demonstrate how health inequalities, including in urban areas, are impeding progress towards health-related MDGs. Addressing the issue of health inequalities is a core elements of the Universal Health Coverage (UHC) approach, and will hopefully be reflected in the post-2015 development goal agenda.

Over 90% of the increasing urbanized population is in developing countries. Consequently, urban dwellers residing in slums is a major concern, where nearly a billion

people live, characterized by abysmal living conditions and poor health outcomes (which are worse than in rural areas). And their growth continues.

Complex dynamics of migration exist, with multiple implications for access to services. Whereas the greatest growth in urban populations arises from natural growth of cities, there will continue to be migration of rural poor to cities, where they often become the urban poor. In some countries, seasonal and internal migrants to cities further compound the challenges for health service delivery—such as in China, with 300 million such migrants annually.

Ladies and gentlemen, while availability of health and other social services in urban areas is higher than in rural areas, large sections of the population are unlikely to have access to such services because of costs, social exclusion and other factors. The most important determinants of urban health lie beyond the direct control of the health sector – they are social and political in nature, and they can be shaped by policies, in multiple sectors.

The enormous growth in non-communicable diseases (NCDs) and rapid increase in ageing populations are now posing enormous opportunities and challenges for cities. For example, the population over 60 is projected to increase threefold and reach 2 billion by 2050 or one in five people on the planet. Life expectancy and ageing populations will continue to increase in the next 30-40 years worldwide, with the greatest growth in low and middle income countries. WHO's Global Burden of Disease suggests that 46 percent of all persons over 60 years of age have some disabilities. Greater increases in sheer numbers of aged persons and those over 75 will create greater demands for health care and social services, and put pressure on national health, social and family budgets.

In the past year, WHO, the World Bank, and our Member States have come together to advocate for Universal Health Coverage or UHC. But, what is UHC? In brief, it is an approach that unites the concepts of **universal access** to a comprehensive set of services—**prevention, promotion, treatment, rehabilitation, and palliative care**, while also ensuring that individuals and families are **protected against financial ruin** due to health

care costs. As there are many different country and city contexts concerning levels of resources, nature of health systems, and epidemiological profiles, this is not a one-size-fits all approach. Rather, UHC recognizes the need for **progressive realization** in its implementation. Integral to UHC is equity and social justice, as well as a reliance on the actions of other sectors to address determinants for health. The WHO Director-General noted that UHC is a “powerful equalizer that abolishes distinctions between the rich and poor, the privileged and the marginalized, the young and old, ethnic groups, and women and men.”

WHO and the World Bank will soon release a monitoring framework that will help countries and cities monitor their respective progress on UHC.

As we further refine strategies and approaches for countries to design, implement, and monitor their health systems, the concept of UHC is also influencing the debate on defining the post 2015 sustainable development goals.

The longstanding experience of many countries, such as the United Kingdom and Japan, present lessons for UHC design and rollout. Japan implemented UHC when its economy was still developing after the Second World War. Recently, Thailand, Turkey, and Bangladesh represent countries embarking on expanding UHC. Economic recession and increasing inequities, however, present an imperative to ensure that UHC is implemented well to ensure access and financial protection for the most vulnerable.

These concerns are at the forefront of WHO’s agenda.

As we proceed towards UHC, countries and cities must ask basic questions. Which populations are obtaining access to services and which are not? What types of benefit packages are appropriate to a given setting, and what are the gaps? How to further expand good quality prevention, health promotion programmes, as well as rehabilitation and palliative care in addition to the traditional treatment service? How can communities be truly engaged, and how can they be part of the monitoring system? What are the opportunities for

addressing different social, political, environmental and economic determinants for health and for engaging different stakeholders? What are the early warning signs for financial risk for families? How can we better link specific disease programmes with underlying health system requirements: financing, health workforce, quality assurance, and organization of services?

How do we practically and meaningfully engage the community? And, how to encourage innovation using technologies and new models of care and support?

There is no magic bullet to health system design nor to the mix of providers, services, reimbursement, or increasingly involvement of other sectors to contribute to health outcomes. But having a dialogue with the people themselves helps prioritize actions.

Thus, UHC, the increased focus on determinants for health, and urbanization present unique opportunities for mutually reinforcing our desired outcome of equitable and improved health. How can we include the urban setting in thinking about, designing, implementing and monitoring UHC?

In addition to encouraging dialogue across levels of government, there are three key contributions for which WHO can support.

The **first** is supporting measurement of urban health equity and contributing risk factors, and helping cities take action to develop relevant policies and interventions towards reducing such inequities.

WHO, through our WHO Kobe Centre, has developed a very user friendly tool, the Urban Health Equity Assessment and Response Tool or Urban HEART that has been used in over 60 cities, both in developing and developed countries. It is based on evidence collected from a wide variety of reliable and readily available data to identify health inequities and to plan actions to reduce them. Using a determinants of health approach and core set of indicators, cities are able to measure inequities across neighborhoods and districts. The

approach also unveils patterns and trends that are otherwise statistically hidden through averages.

A simple traffic light dashboard enables decision makers to rapidly visualize trends across the city and progress over time. I saw this first hand in Tehran recently, where the Mayor dramatically was able to show progress and challenges across the city. Toronto recently began applying Urban HEART and described it as “a quick way to take the pulse of a city.”

Each city has specific population groups, epidemiological patterns, service gaps, and inequities. For some cities, the issues are clean water, sanitation and basic education and immunizations; for others it is lack of physical exercise opportunities; and, for other cities, large pockets of urban poor in slums present specific challenges.

The essence of the success of Urban HEART is a long process to engage politicians, experts, the community, and organizations, as well as different departments in the city that have data. For example, in Toronto as in many cities, Urban HEART measured how well each of the city neighbourhoods are doing in specific categories:

- Economic opportunities (such as unemployment rates, percentage of residents consider low income or who receive social assistance)
- Social and human development (such as education levels and high school graduation rates)
- Governance and civic engagement
- Physical environment and infrastructure (such as walkability and accessibility of such things as green space or healthy food)
- Population health (such as premature death rates, mental health status, prevalence of diabetes and preventable hospitalizations for chronic disease).

Over time, Urban HEART can be used to monitor inequities, trouble spots, and progress. Ultimately, which populations are at risk? Which neighborhood? Why? In 2010, WHO and UN

Habitat released the first Global Report on the topic of urban health inequities, *Hidden Cities*. WHO and Habitat are working now to update this report with an intended release in late 2015.

Imagine how Urban HEART and similar efforts to track health inequities can contribute to UHC monitoring.

The **second action** is to develop programmes and interventions, including those bringing different sectors and actors together, to address health inequities and their determinants.

There needs to be a more proactive approach to urban governance and planning. Countries that are rapidly urbanizing need political commitment to ensuring that cities are well-planned, for example in China. WHO recognizes that health is an important entry point to address the many determinants, and that practical measures and best practices are needed to enable different government departments and community stakeholders to work together. Sharing those lessons is critical. Two examples highlight the possible:

Over a seven year period, New York City developed and implemented Active City Guidelines that fundamentally changes the face of the city to enable greater walkability, safety, and physical activity that has led to a reduction of five percent in childhood obesity. In Liverpool, a coalition of city departments such as health, environment, sports and recreation, education with sports clubs, workplaces, civil society groups designed and implemented a programme to create public gyms, enhanced green spaces, and school based programmes. The outcome over four years has been a 2.5% increase in the proportion of the population active for 30 minutes, three times per week, and that 91% of children (in years 3 to 6) are now participating in at least 120 minutes of curriculum physical exercise each week.

Actions to ensure continued wellbeing will reduce NCD's, their risk factors, and contribute to longer term reductions in functional decline. Additional evidence is needed, but we must recognize the challenges in attribution of specific interventions to outcomes for a number of determinants of health. We know that municipal leaders and health actors have a greater



opportunity to have direct influence over a wide range of health and social services, and health determinants such as: housing and transport policies, social services, childhood education and nutrition, smoking regulations, air pollution, violence, improving the built environment, as well as policies and programmes related to food marketing and sales, and decisions about what foods and beverages are available in schools. These, in turn, influence risk factors for diseases such as unrecognized hypertension, tobacco use, lack of physical exercise, unhealthy diets, and excessive alcohol use can prevent disease, compress morbidity periods, and increase quality of life without great cost to the individual or health care system. And, they, in turn influence diabetes, cancer, respiratory diseases and cardiovascular diseases.

The urban setting also can directly ensure social connectedness across generations, prevent loneliness, support social, economic and environmental policies, as well as to minimize the duration of ill health, disabilities and dementia.

The **third action** is to organize health services, inclusive of the facilities, workforce, and reimbursement systems to increase community-based care and support systems that offer accessible and quality services. Working with the community is essential, and the urban setting offers important entry points. Re-learning the basics of community engagement enables how we redefine our societies, communities, and improve quality of life.

To conclude, there has never been as great interest in public health than today. The range of issues continues to grow, beyond infectious and communicable disease control into an entirely new context involving the role of non-health actors and conditions related to social cohesion and inclusion, environmental policies, community participation, and urban planning.

Ensuring equity should be at the core of the urban health system and post-2015 goal discussions, and it is key to achieving UHC.

The city is at the center of the opportunity to contribute to better access to health and social services, and to create more liveable environments for all of us. Let us aim to eliminate

the situation whereby we see differences of twenty years or more in life expectancy at birth in neighborhoods that are separated by one or two subway stops.

Increasingly, international and national policy makers are turning to municipal leaders to take action. The increasing visibility of the importance municipal leaders play in addressing today's health challenges demonstrates the continuing need to mainstream urban health initiatives with partners, UN agencies, and with multiple levels of government, while focusing on the issue of equity.

**Ladies and gentlemen,** all of WHO, including our HQ, Kobe Center, and Regional Offices, are committed to working with you in supporting measurement, collecting evidence and best practice, and jointly walking with you in the quest for universal health coverage, inclusive of access to comprehensive and quality services, financial protection and equity.

Cities are here to stay and they offer enormous opportunities for innovation and creativity.

Thank you.