Chapter 11

CONCLUSIONS

Good Health at Low Cost research team

This book has explored the experiences of five countries. Each was selected because it had made consistent progress in improving the health of its population and had improved access to key services. Some of these countries have fared better than many others at similar levels of economic development. And each has made progress in designing and implementing imaginative and innovative reforms to its health care system. Each has done so despite having limited resources. Some of these achievements have been sustained over long periods of time. Yet the countries are all quite different from one another. They have different political systems. They inherited different levels of resources, whether expressed in terms of money or in terms of people and physical infrastructure. And they have pursued different combinations of policies in developing their health systems. Our question is how have they achieved what they have? Are there lessons that we can draw that will be of relevance to other countries seeking to improve their health systems?

'Good health at low cost' remains an attractive slogan but confusing phrase. The original 1985 report *Good health at low cost* captured the aspirations of the moment: to ensure access to key low cost interventions, particularly within primary health care. The phrase highlights the achievements given low levels of resources. 'Low cost' was understood broadly, in terms of total financial cost, but also in terms of resources available (Halstead S. Personal communication at *Good health at low cost* meeting in Bellagio, August 2010). In our study, 'good health at low cost' was viewed as the achievement of good health in countries with a relatively low level of income. Our countries spend quite different amounts of money, whether viewed in terms of total or only government health expenditure. Although health expenditure has increased somewhat in absolute terms, it has not changed substantially as a share of GDP over the years in all five countries. Nonetheless, it appears that substantial health improvements have been made, without a substantial increase in the share of national resources spent on health. In this respect, our five countries do indeed appear to have achieved 'good health at low cost'. Our question is, how?

An obvious starting point is the original *Good health at low cost* report. Now 25 years old, its findings have stood the test of time. The case studies in this book, and the subsequent experiences of the original countries included in that report, confirm the importance of sustained investment in health systems, especially in primary care, with an emphasis on sustainable funding and the development of a skilled health workforce, strong political commitment to good health for the whole population, a high degree of community involvement, measures to ensure equity of access and use, and health-promoting policies that go beyond the health system. Indeed, some of these are more important than ever. This is clearly the case for a skilled workforce. The technology available 25 years ago

limited what could be done in low resource settings. This has changed dramatically and there are now many low cost interventions that can be life saving, but only if administered by skilled health workers. Each of the countries examined in this book provides examples of innovative strategies to increase the size and skills of the health workforce, especially in traditionally underserved rural areas.

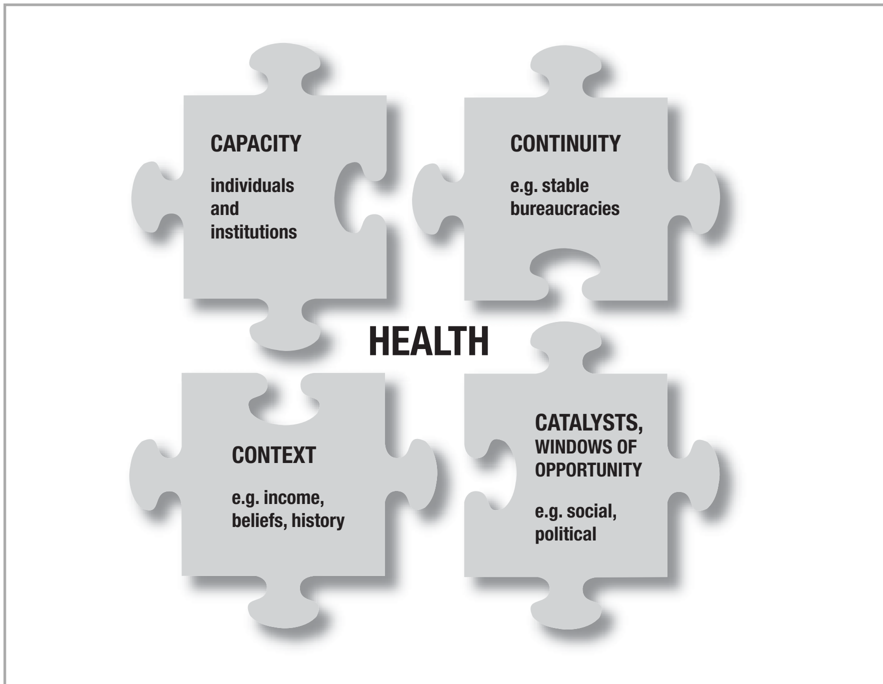
However, it is now possible to step back and ask what are the factors that enable some countries to adopt these measures while others do not? It cannot simply be a lack of knowledge. The arguments in favour of primary health care have been well-rehearsed[1], with the most recent evidence being assembled in the 2008 *World Health Report*[2]. The evidence for intersectoral action to promote health is also well established[3], having also been updated recently, in the *Report of the Commission on Social Determinants of Health*[4]. There is a wealth of scientific literature on how best to improve access to care. The answer must lie somewhere else than lack of evidence.

Work over the past decade has demonstrated that health systems are complex and require a systems thinking approach[5] that understands the relationships between different health systems components, the context in which the systems exist, and the sequencing of actions. Health system strengthening is much more than a mechanistic implementation of a series of essential interventions and there is great scope for unintended consequences[6].

Gathering the information in this book has involved each of us going on a journey. This journey involved more than crossing national borders to gather the information needed to assemble the case studies. Much more importantly, it involved crossing disciplinary and cognitive borders, requiring each of us to look at our own health system through the eyes of others, taking nothing for granted and asking fundamental questions about why things are as they are, how they got there and why they changed.

Four interlinked factors necessary for a health system to succeed emerged from this process (Figure 11.1). Conveniently, each can be expressed as a word beginning with C. They are *capacity* (the individuals and, especially, institutions necessary to design and implement reform), *continuity* (the stability required for reforms to be seen through to completion, coupled with the institutional memory that prevents the same mistakes being made each time), *catalysts* (meaning the ability to seize windows of opportunity) and *context* (or more precisely, the ability to take context into account when developing policies that are relevant and appropriate to the given circumstances). We will now consider each of these in turn.

Figure 11.1 Key themes emerging from the research



Capacity

Individuals matter. Our case studies contain many examples of individuals who have had a vision of where they wanted to be and have inspired those around them to get there. Some, but not all, have worked in the health sector. They include heads of governments, such as the current Ethiopian Prime Minister and the first Kyrgyz President after independence from the USSR, who simply wanted to make their country a better place to live. In both cases, achievements in health care have been accompanied by enhancements in education, transport links, safe water supplies and other areas that improve the lives of ordinary people while, in addition, alleviating the burden of disease and improving access to care. They also include health ministers, such as Tedros Adhanom Ghebreyesus, who articulated his four-step plan to achieve the health Millennium Development Goals (MDGs) in the *Lancet*[7]. We are, of course, aware that, despite their achievements, some of these individuals have attracted controversy as they sought to implement wide-ranging changes and we recognize that some have questioned whether the ends always justified the means. We simply conclude that addressing some of the challenges they inherited required very difficult decisions.

We also found many examples of individuals who, while they might not aspire to be leaders, also played a key role in making things happen. These are the bureaucrats, a term that is often seen in negative terms as a consequence of sustained attacks by political commentators looking to score easy points. Yet bureaucrats are essential if things are to change. Often poorly paid, always undervalued, many work tirelessly for little reward to improve the lives of their fellow citizens. Of course we realize that not all do so, and there are still many who exploit their positions for personal gain, with profound consequences for those often-voiceless people who depend on the services they administer. But in the countries we studied there was clear evidence that good practices were being encouraged while bad practices were being dealt with.

Individuals working alone can, however, only achieve so much. A second aspect of capacity that emerged strongly was that of strong institutions. Where these were most successful they provided a degree of stability that transcended the careers of individuals, ensuring institutional memory. The best are also learning institutions, drawing lessons from their own experiences but also from those of others working in similar situations elsewhere. They have access to emerging research and have systems in place to ensure that it is absorbed, adapted and implemented, something encouraged by the presence of long-term technical experts based within health ministries[8]. They also have a degree of autonomy, giving them the ability to think outside the box in order to arrive at innovative solutions to difficult problems. However, such institutions also have strong incentives to collaborate where they recognize that improving health is everyone's business and a common reason for failure is the inability to emerge from one's own sectoral silo[9]. In Tamil Nadu, district-level health managers and effective management systems have enabled expansion of access to primary care workers and essential drugs. We have also seen how a lack of institutional capacity can limit the success of reforms, as in the neighbouring state of Kerala following decentralization of social welfare provision, where local health planners were insufficiently prepared to manage scarce decentralized funds.

Individual institutions exist within a broader institutional framework. This can provide the basis for a set of formal and informal rules that facilitate the translation of evidence into practice, avoiding high transaction costs associated with a market-based approach[10]. The institutional framework interfaces with what is termed governance, which includes issues such as the rule of law, the ability to raise taxes and transparency. In their absence, it is very difficult to deliver effective and responsive health care for all. In most of the study countries we can see evidence of wider processes of state and institution-building that have created a framework for reform of health systems. Notable examples include Thailand and Kyrgyzstan, where health systems development has benefited from strengthening

systems of accountability. This is also apparent in China, one of the original *Good health at low cost* countries[11].

Yet the countries studied suffered from a severe inherited lack of health system capacity. Recognizing the gaps, they have been open to innovation in seeking to use these resources more effectively. For example, all face shortages of health workers, especially in rural and remote areas. In response, they sought to create a new community-based cadre of health workers (Bangladesh, Tamil Nadu, Thailand) or launched mass retraining of existing physicians as family practitioners (Kyrgyzstan), recognizing the need to be flexible in finding ways to respond to the needs of their populations given the scarce resources. The most successful health systems have also seized on existing capacities outside the health sector, such as exploiting improved road and communications infrastructure. For example, in Bangladesh, health assistants' use of mobile phones to communicate with clients and each other, and manage workload in isolated rural areas, has improved deployment and programme efficiency, and also responsiveness.

Finally, there is the issue of capacity to monitor what is happening. Even in the richest countries, there are often major gaps in the information to track progress towards the goals of reform. Our case studies included several examples of systems that had established effective monitoring mechanisms linked to the policy process, such as those in Thailand and Kyrgyzstan. Similarly, in Tamil Nadu, there is a process of learning from local innovation, ensuring that the lessons are incorporated into policy.

Continuity

Although there is a school of thought that welcomes turmoil, seeing opportunities in what is termed creative destruction, a key finding to emerge from our case studies is the importance of continuity. This is linked to the development of a vision that can be articulated and communicated to those who must implement it, something only possible with inspirational leaders and receptive institutions.

Health systems are complex adaptive systems. They require resources that take time to produce, and contain institutions that take time to change and people who take time to learn. What can be achieved – and how quickly – is constrained by where they started from, a phenomenon known as path dependency[12]. Health systems cannot be changed overnight and those who believe that they can do so with some kind of "big bang" are deluding themselves.

Many of the successes described in this book incorporated careful sequencing. Change was seen as requiring a sequence of steps, each interlinked and mutually

interdependent. For example, the Thai road to universal coverage took place in several stages, each based on ever more ambitious national plans. Expansion of access to key reproductive health interventions in Bangladesh and Tamil Nadu was incremental, learning lessons from previous experience every step of the way.

One way to ensure continuity is to create stable, professional bureaucracies. This will often require considerable investment in training to ensure that there are individuals with the requisite skills, as happened with the dedicated public health cadre unique in India to Tamil Nadu. This is easiest in countries which have stable governments, such as Costa Rica, one of the original *Good health at low cost* countries. However, it is possible, and indeed desirable, to develop mechanisms by which national plans and actions can transcend political and economic transition. Perhaps the best example is in Kyrgyzstan, where the key elements of the two consecutive reform plans (*Manas* and *Manas Taalimi*) survived intact despite several violent changes of government. However, the core elements of the Thai reforms also survived unscathed from the Asian financial crisis of the 1990s. In Costa Rica, the expansion of primary care in the early 1990s, regarded as the completion of the unfinished agenda to universalize access to primary care in the 1970s, was able to proceed despite a change in political administration. These health systems demonstrate a high degree of resilience, as do the systems in Ethiopia and Bangladesh that have established mechanisms to sustain health care delivery in the face of repeated natural disasters. Yet there is still much to be learned about how a health system can develop and maintain such resilience.

Several of the countries we studied were major recipients of development assistance. For them, continuity involves more than just their domestic institutions. It also involves managing what can be a remarkably complex collection of donor agencies. We found a range of examples of success in creating mechanisms to ensure synergies among donors and consistency of policies over time, for example the well regarded Sector–wide Approaches (SWAps) in Kyrgyzstan and Ethiopia.

Continuity was often evident in the effective engagement of the nongovernmental and private sectors, recognizing the important role of the private and voluntary sectors in delivering care in many countries. Successful reforms have pursued greater integration of public and private sectors, often building on private sector capacity, for example scaling up access to essential maternal and child services by underserved populations in Bangladesh and strengthening HIV/AIDS and tuberculosis prevention in Tamil Nadu.

Despite pluralistic health care provision in Bangladesh, Thailand and Tamil Nadu, government leadership is evident in formulating policies, initiating mutually beneficial collaborations and seeking to protect public interest. The

mechanisms that promote trends for closer engagement also promote continuity by negotiating shared goals and establishing ways of monitoring progress towards them.

Catalysts

There are many examples throughout history of health system reforms that have been implemented in the aftermath of a crisis. This has required individuals with the vision and ability to seize windows of opportunity. Examples of crises from our case studies include the achievement of independence by Bangladesh in 1971, and Kyrgyzstan in 1991. In Ethiopia, the opening up of the country and increasing donor involvement since 1994 has led to more intensive reforms in the health and other sectors. China's various experiences in health financing reform since the introduction of economic liberalization in the 1970s have provided important lessons on both the potential hazards of rapid economic growth for health and promising ways of reinvesting its new wealth to address them. Success is greatly assisted by having responsive, flexible institutions that can support the process, although in practice it has often been necessary to create them as part of the reform process, as was done in Kyrgyzstan.

Economic shocks can also catalyse health systems developments. After the collapse of the Soviet Union, the loss of subsidies from Moscow and regional trade links triggered a severe economic crisis in Kyrgyzstan, and brought the health system to a standstill. This situation helped to foster consensus about the urgent need to reform the health system and the enactment of the radical *Manas* programme in 1996, the most radical of its kind in central Asia.

Natural disasters have also acted as catalysts for strengthening health systems resilience through developing health systems preparedness to respond to external threats. This includes ability to plan early warning mechanisms and implement multifaceted strategies. The competencies associated with these efforts have led to improvements in overall service delivery in communities at risk in Bangladesh, Ethiopia and Thailand.

Context

Health systems are embedded in larger social systems, at national and international levels. They are influenced by their history and the histories of the countries in which they exist. They shape and, in turn are shaped, by policies in many other sectors. Most obviously, there is a synergistic relationship with the national

economy whereby economic growth can, if fairly distributed, support effective health systems, while effective health systems, by promoting a healthy workforce, can boost economic growth[13]. Similarly, investment in education creates a skilled health workforce and empowered, informed patients, while the promise of a longer and healthier life provides a stimulus for people to secure education for themselves[14]. It is these types of virtuous cycle that were established early in the original *Good health at low cost* countries and that underlie their continued health improvement.

Financial resources are only a part of the answer. The economic growth in some of the countries, such as Thailand and China, may have helped to create a momentum and population demand for expanding coverage and encouraged sophisticated reform initiatives in the health systems and in other sectors. However, the overall level of resources in the health system did not emerge as a key determinant of success across the countries, although reforms to enhance financial protection (Thailand, Kyrgyzstan, China) have played an important role in expanding access to essential services. Interestingly, health systems have not benefited disproportionately from increased national income. There is scope to spend more, improve financial protection, reduce out-of-pocket payments and address needs, and Thailand is moving in this direction.

Another element of the context involves cultural norms and national identity. Work undertaken to inform the development of this project identified the role played by ethnic and linguistic fragmentation in slowing progress in child health[15]. Essentially, it can be argued that countries where the ruling groups retain separate identities from others in the same country are less willing to invest in systems that redistribute resources, such as those to deliver health care. In this respect, the achievement of Ethiopia is notable. Despite the extreme degree of ethnic and linguistic diversity that characterizes the country, strenuous efforts have been made to carve out a coherent national identity supported by measures to achieve equitable allocation of resources. Another example of seeking a fit between health system strategies and population preferences is the emphasis on home-based maternal and reproductive care aimed at isolated and marginalized groups (Bangladesh, Tamil Nadu).

A third aspect of context relates to geography. Countries with widely dispersed rural populations, such as Ethiopia, or with particularly isolated groups, such as Bangladesh and Thailand, have had to find ways of deploying health workers with at least basic skills where they are needed most. Yet challenges remain as the Ethiopian Government embarks on the next stage, which is to reach out to the smallest villages and to the nomadic population[16].

Socioeconomic, regional and ethnic inequalities and the expansion of the private sector have led to widening health inequalities in several countries, despite considerable successes in improving average figures, and this problem is exemplified by China. The importance of providing a basic package of health care to those in need has been a driving principle in many of the countries included in both this and the original set of countries. This supports Amartya Sen's belief that "If a significant proportion of people are left out of ongoing health facilities for one reason or another, the health of the people will clearly suffer"[17]. While in some countries such as Thailand and Costa Rica, health sector developments have been underpinned by concerns to uphold equity, this remains rare. Reforms have promoted aggregate health gain, rather than achieving equitable health gain; the needs of specific population groups may not have been sufficiently addressed. This raises serious questions for the future and whether seeking both aggregate and relative health gains are possible.

In conclusion

Box 11.1 summarizes the pathways to improving health and access to care that have emerged from our research. The key message of this book is that success in improving health and delivering health care is facilitated by capacity, both individual and institutional, continuity, or the ability to maintain a course even when all around is changing, catalysts, or the ability to seize windows of opportunity, and sensitivity to context, so that policies that are adopted take account of the circumstances in which they will be implemented.

Although we have been able to chart many successes, it is clear that considerable challenges remain. It cannot be assumed that the countries in this study will sustain their achievements in the face of emerging challenges. Of the original four countries, only two (Sri Lanka and Costa Rica) have done so, although the achievements in Sri Lanka have continued despite a divisive, damaging and brutal civil war. In China, some of the earlier achievements have been reversed, due to growing income inequalities hampering access and to the dismantling of many community-based services during the reform process.

Each of the new countries included in this book still has some way to go to provide accessible and affordable services to the whole population, especially in remote rural areas and in the emerging pockets of deprivation in urban settings, and to achieve protection from catastrophic expenditure in the event of family illness. In some of them there are concerns about political stability. In each, the achievement of equity remains a long-term goal, although this is something shared with much wealthier countries. Thailand and Kyrgyzstan are, however,

Box 11.1 Pathways to improving health and access to care

- *Political commitment* to improve health outcomes, and effective leadership and willingness by governments to prioritize health, innovate and embed reform in systems, giving space for front-line workers to make a difference.
- Commitment by governments to *more equitable and pro-poor policies and female empowerment*.
- *Effective and stable street-level bureaucrats* that have institutional memory.
- *Collaboration* by different sectors, actors and programmes involving communities, grassroots groups and the media in order to increase the awareness of entitlements and rights and coverage of underserved populations.
- *Flexible use of health workers* to ensure that those with the most appropriate skills deliver care, particularly to women and children.
- *Building health system resilience*, to allow it to withstand shocks and emerging threats, combined with innovative use of scarce resources, and the capacity to incorporate bottom-up innovation.
- *Economic factors*, including strengthened infrastructure, economic growth, increased external funding, communication technology and the ability to draw on resources beyond the public sector.
- *Social development*, including government commitment to more equitable and pro-poor policies (e.g. empowering women, education).
- The presence of *individuals and political elites*, along with strong institutions implementing policies adapted to context, who choose to lead change, seizing windows of opportunity for developing viable and affordable health systems.

making significant progress in this direction. Progress is, perhaps inevitably, uneven; while Tamil Nadu has achieved a substantial decline in maternal and child mortality, it still faces widespread undernutrition, in large part as a consequence of its inability to tackle deeply rooted inequalities.

Looking ahead, a major concern must be the changing nature of the diseases that health systems must respond to. In this respect, they can be seen as victims of their own success. Having picked the low-hanging fruit that make up the common causes of childhood death, they must develop the capacity to move to the next stage of the epidemiological transition in which urbanization, and its accompanying lifestyles, fuel an epidemic of noncommunicable diseases. Some, such as Costa Rica, Thailand and Kyrgyzstan, have already had to do this and

have made notable progress; others, such as Kerala and China, continue to struggle. Yet others, such as Ethiopia and Bangladesh, are at a much earlier stage in the process. This will require interventions with an entirely different degree of complexity to those required now. We hope that the systems that have been put in place in the countries we have studied will help them to prepare for this challenge. By the time another 25 years has passed, we will know, one way or the other.

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