Chapter 1

INTRODUCTION

Good Health at Low Cost research team

In 1985, the Rockefeller Foundation commissioned a report (published as a compendium of papers and thematic analyses) exploring the question of why some poor countries were able to achieve better health outcomes than others at similar levels of income[1]. The report, entitled *Good health at low cost* (GHLC), identified China, Costa Rica, Kerala State in India and Sri Lanka as such countries[a] and sought to identify factors underpinning their relative success. 'Good health at low cost' was used as a catchy way of referring to success in improving health with relatively limited economic resources.

The original *Good health at low cost* volume reflected a contemporary interest in eliciting the multiple determinants of health and understanding how these are distributed across populations. The report was published in the aftermath of a series of economic difficulties, including the oil crisis of 1973, at a time when structural adjustment programmes advocated by the International Monetary Fund (IMF) and World Bank were being implemented in many low-income countries. It demonstrated a new understanding of the importance of comprehensive and community-oriented primary health care as a key element of the health system, a view expounded a few years previously at the 1978 joint World Health Organization (WHO)/United Nations International Children's Emergency Fund (UNICEF) conference on primary health care at Alma-Ata.

The *Good health at low cost* volume has become an iconic publication, influencing the international debate on health systems, and political and practical strategies to improve health. Its key contribution was to highlight the social determinants of health, now widely accepted but then far from the dominant paradigm. By highlighting the existence of multiple causes of ill health interacting in many complex ways, it was able to show how social, economic and health policies contributed to improvements in health status. The report convincingly dispelled the myth that economic growth is a sufficient driver of development and, with it, better population health. For the first time, it brought together a corpus of empirical evidence to support what had previously been mainly theoretical arguments[2] to show how many low-income countries had achieved vast improvements in a number of measures of health, often reaching levels comparable to those seen in developed countries, even though they had experienced only modest growth in income and, in the case of Sri Lanka, internal conflict.

One important finding was that all the countries studied had achieved above-average investment, in both financial and human terms, in their health systems, and particularly in primary health care. However, the original *Good health at low cost* volume concurred with the view set out at Alma-Ata that primary health care

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[a] For convenience, "countries" is used as the generic term, although Kerala is a state within India.

was not just a means of delivering a package of interventions, as was then being promoted, among others, by UNICEF. Instead, it was the focal point of the health care system and a platform to address other social issues, such as participation and empowerment. All the countries studied also showed commitment to prevention, as judged by their patterns of expenditure. Crucially, in the view of the report's authors, these policies were underpinned by a commitment to equity both within the health system and beyond. This was seen as ensuring that provision of services was tailored to the needs of the most vulnerable groups in the population, whose status was, simultaneously, being advanced by enhanced engagement and political participation, especially by women (Box 1.1). A second finding was the importance of good governance, seen as a government's commitment to development. In time, this influenced the WHO's health system framework[3], where governance is fundamental to all other aspects of the health system. The factors identified by the report's authors are set out in Table 1.1.

Box 1.1 Factors contributing to good health, from GHLC 1985

- Political and historical commitment to health as a social goal
- Strong societal values of equity, political participation and community involvement in health
- High-level investment in primary health care and other community-based services
- Widespread education, especially of women
- Intersectoral linkages for health.

Each country implemented health care strategies that reflected their individual circumstances. In both Kerala and Sri Lanka, there was an emphasis on expansion of primary health care programmes as a means of improving essential care and, in particular, greater utilization of essential maternal and child health services such as immunization, antenatal and postnatal care, skilled birth attendance, and prompt intervention to treat infections. In Kerala, "ancillary nurse midwives" were deployed in underserved rural areas. In contrast, Costa Rica adopted a broader development perspective, recognizing the need to employ a combination of strategies to tackle neonatal mortality (for example, promoting family planning to reduce fertility, extending and improving inpatient services) and post-neonatal mortality (improvements in immunization, clean water and sanitation). In China, the barefoot doctor system was seen as a way of rapidly scaling up the basic provision of care in rural areas, while patriotic health campaigns addressed some of the broader determinants of health, such as sanitation. Such links to broader policies were identified elsewhere too. For example, a malaria control campaign in Sri Lanka was an integral component of land reform and the social development agenda during the 1950s and 1960s. The reform was designed not only to tackle historical inequities but also to enhance

Table 1.1 Social and political factors supporting 'good health at low cost'

Political and historical commitment to health as a social goal	Legislation Government expenditure on health Establishment of health facilities Historical and cultural influences
Social welfare orientation to development	Preventive orientation Support for basic necessities Educational programmes Land reform
Participation in the political process	Universal franchise and political engagement Extent of decentralization Community involvement
Equity-oriented services	Health, education and nutrition status of women, minorities, etc. Urban–rural coverage Income–asset distribution
Intersectoral linkages for health	Mechanisms to ensure linkage Incentives to ensure linkage Recognition that health is socially determined

Source: Adapted from reference 4

agricultural productivity and thus improve income and food security, as well as to reduce the transmission of malaria. Many other health policies also benefited from it indirectly; associated improvements in transportation infrastructure benefited economic growth but also improved physical access to health facilities.

All of the countries studied provided examples of explicit policies to address inequalities of different types. These included gender equity (promotion of female literacy in Kerala), social exclusion (measures to tackle the inherent inequalities in the caste system in Kerala), urban–rural disparities in coverage (expansion of primary health care in rural areas, particularly maternal and child health services, coupled with universal health insurance in Costa Rica), and disparities in distribution of income and assets (land reform in Sri Lanka and Kerala, trade union friendly policies and action to increase wage levels in Kerala).

The countries studied also demonstrated that access to at least basic health care was seen as a fundamental human right. Strong political commitment to making this happen was manifest in different ways. One was in the creation of

structures, as in Costa Rica, where the government had established social security and health insurance systems that were effective in reaching out to the entire population. Another was in the priority given to different types of expenditure. Costa Rica had abolished its armed forces in 1948, spending money instead on social development. Kerala had the highest per capita expenditure on health care (14.5% of total government expenditure in 1981) of any Indian state.

Political factors were important. These included the existence of a universal franchise (although, as in China, not necessarily multi-party elections) and political engagement of communities and grassroots groups. To varying degrees, all of the countries were left wing. Unusual among Indian states, Kerala has had Marxist governments for much of the time since independence, while China remains a communist state. Political engagement by women also emerged as a potentially important factor, facilitated by high levels of female literacy in, for example, Kerala and Sri Lanka; this may have created political pressure to develop services relevant to the needs of women. In China, the largest of the countries studied, decentralization of many administrative functions, although tightly regulated by the centre, was seen as contributing to strong local administrative structures that could manage health care delivery effectively. Cultural factors also played a part. Sri Lanka had a long tradition of public welfare, which the authors of the report linked to both the Ayurvedic system of medicine and the British legacy of free public services; after independence, this tradition was apparent in areas such as food subsidies, land reform and pro-poor pricing policies.

Since the original *Good health at low cost* report was published, coverage of effective health care has increased worldwide. Life expectancy has increased markedly in many countries, with the exception of those countries in Africa and the Caribbean worst affected by the HIV/AIDS epidemic and a few countries suffering from conflict (such as Iraq and Afghanistan) or gross political mismanagement (Democratic People's Republic of Korea). Some of these gains have resulted from "picking the low hanging fruit", for example through vector control to reduce transmission of malaria or Integrated Management of Childhood Illness (IMCI) to prevent death from easily treatable conditions. Yet there is still much to be done and, in many countries, progress towards the health-related Millennium Development Goals (MDGs) is either slow or, in some cases, regressing. Of the 68 countries that account for the vast majority of child and maternal deaths in the world, 49 are unlikely to meet the child health goal[5]. At the same time, many new challenges are emerging.

The first relates to the nature of disease. Acute illnesses from which victims either recovered spontaneously or died have been replaced by complex chronic disorders. These include the increasing prevalence of AIDS, due to a combination

of disease spread and enhanced survival, and the growing burden of non-communicable diseases driven by successes in areas such as food security[6], coupled with access to motorized transport and agricultural mechanization that has led to rapid increases in risk factors such as injuries, accidents and obesity. A second development has been the growth in therapeutic capability. The handful of effective medicines in the 1940s has expanded into an enormous armamentarium, with a particularly large increase in drugs that require long-term administration, often for life, as well as monitoring to ensure optimum treatment and avoidance of side-effects. A third development has been the recognition that optimal care often requires the involvement of multi-professional teams working across different levels of care. Two conditions, diabetes and AIDS, exemplify these challenges, requiring long-term management by a range of health workers who handle not just the primary disorder but also, and often more importantly, its complications.

This poses enormous challenges to health systems[7]. To close the gap between what is possible and what is currently available for a large proportion of the world's population, it is necessary to put in place systems that can deliver skilled health workers, reliable supplies of medication, appropriate facilities to treat patients, lifelong learning to ensure that those delivering care are using the latest knowledge, and managerial processes that can make all this happen in a way that is both effective and affordable. Yet it is now very clear that such complex responses do not emerge spontaneously, as is the case in many of the world's poorest nations. Despite economic recession, almost all industrialized countries (with the exception of Italy) have confirmed or even increased their commitments to development assistance, exemplified by their commitment to the eight United Nations (UN) MDGs[8]. These initiatives enshrine the lessons of the original GHLC report, demonstrating increasing acceptance of the principle that social development can be addressed only via comprehensive multisectoral strategies, involving many partners at both national and international level.

At the same time, new global structures have been created to facilitate the flow of assistance. The Global Alliance for Vaccines and Immunisation (GAVI) was established in 2000 and the Global Fund to Fight AIDS, Tuberculosis and Malaria (now Global Fund) followed in 2001. While the resulting massive scaling up of resources has had some success (in the rollout of antiretroviral treatment for example), it has also confronted the limited absorptive ability of many health systems[9]. Progress has also been hampered by the absence of many of the factors identified in the GHLC report, such as political commitment and policies to promote broader social change. As a result, donor and recipient governments are now reassessing their policies.

A key conclusion emerging from this reassessment is the importance of strengthening health systems. Much of the additional funding has been delivered through vertical approaches that, although improving access to specific treatments, have not succeeded in building sustainable capacity within the health system. This goes beyond the longstanding debate about vertical and horizontal approaches to health care delivery; in fact, in many cases, the differences have been overstated, as programmes designed as vertical at the top have horizontal elements at lower levels. For example, centrally designed and donor-funded programmes are often delivered by frontline staff who are actually responsible for a broad range of primary care services[10]. As a consequence, many global organizations are modifying their approach[11,12], devoting an increased share of resources to health system strengthening, now accounting for 30% of the overall budget of GAVI. This increased focus on health systems reflects not only their obvious role in the delivery of care but also their role as an entry point to address wider social problems, including improving the status of women and access to other public services.

Yet the recognition that health systems matter is not being accompanied by an adequate understanding of what health system strengthening actually involves[13]. Current experience suggests a need for investment in expertise within donor organizations and recipient governments to ensure that such funds are spent effectively[14]. In parallel, there is a need for evidence on what works. Recent years have seen a vast range of "health sector reform" initiatives, including cost sharing, decentralization, market-based models and community financing, few of which have been adequately evaluated.

In this new study, we update and extend the original analysis in *Good health at low cost* which looked at the constellation of factors that affect health, tracing the subsequent experience of the four countries in the original report (China, Costa Rica, Kerala and Sri Lanka), asking whether their earlier achievements have been sustained given the extensive political, social and economic changes each country has undergone. However our main focus has been to explore five new countries that have achieved significant success in improving health – in particular maternal and child health – compared with other countries with similar levels of economic resources. This study, conducted through a partnership of research teams in each of the countries and at the London School of Hygiene & Tropical Medicine, includes Bangladesh, Ethiopia, Kyrgyzstan, the Indian state of Tamil Nadu and Thailand.[b] The research process was underpinned by

[b] Partners: ICDDR,B, Bangladesh; Miz-Hasab Research Center, Ethiopia; Health Policy Analysis Center, Kyrgyzstan; Indian Institute of Technology (Madras), India; International Health Policy Program, Thailand; LSHTM, United Kingdom.

effective participation and interaction of all partners at every stage of the process through a series of meetings and regular communication. A steering committee provided strategic leadership. All partners met in Bellagio, Italy, to discuss emerging findings and identify cross-cutting themes beyond individual country experience. The research process built on our long-term engagement with each country partner and previous work amassing a critical body of knowledge.

Our major focus is on the role of health systems, which we treat as an entry point to understanding the complex interrelationships among different determinants of health. By employing established frameworks for studying health systems, we seek to identify what factors contribute to their success.

Our starting point is the original *Good health at low cost* report and, in particular, the factors that it identified as important. One was the key role played by the state. A commitment to development was critical and the public sector provided the infrastructure, financing and multisectoral development policies that led to good health; the role of the private sector in health was relatively small. Since 1985, however, the relationship between the public and private sectors has changed significantly; the private sector is expanding rapidly, in different forms (offering extensive services in low- and middle-income countries, including primary care, private insurance, training, cross-border services, etc.). Given the already high and growing inequalities within countries since the 1980s, this situation has major implications for "good health" in the future, especially among the poor or marginalized groups that are often least attractive to private investors.

Another key factor that was identified as leading to good health is primary health care and expanded access to essential services, with developments in both the public and private sectors. However, we recognize that the term "primary health care" has been interpreted in many ways in different places. We ask whether particular aspects of primary care now emerge as especially important. For example, can effective and accessible primary care be attributed to the existence of formal programmes, the availability of health workers, mechanisms to deliver services in outlying and otherwise underserved areas, implementation of packages of basic services, or coordination and institutional support? Clearly, the existence of a formal programme developed by national leaders does not necessarily mean that it is actually operating at district level.

We then seek to identify key drivers for health system performance, considering organization and financing, delivery of services, policy processes and regulation and governance arrangements. We extend the earlier work by taking a whole

system approach, seeking to explain why and how changes came about, and to understand what combination of factors explain success in a particular setting.

While the original report listed a broad range of factors, we seek to disentangle the complex interrelationships among these factors. Analysis focuses on the multifaceted interaction among three types of factor: health systems-related factors; public sector provisioning and policy factors; and broader contextual factors (for example, the political system in a country).

In a further extension to the original study, we then identify plausible pathways through which these factors influence health. For example, while factors identified in the original report such as empowerment of women and female literacy have long been known to be associated with improved health outcomes, the ways in which they affect health have been less well understood. It may be that literate, empowered women are more aware of services and can communicate more effectively with providers, or it may be that female empowerment operates through political processes, increasing the likelihood that appropriate services will be made available for all women, regardless of their level of literacy. We also explore the context in which all of these factors operate and interact, seeking to elicit the circumstances under which specific policies and interventions are likely to be successful.

Finally, this is a comparative study, so we take advantage of the similarities and differences among the five new countries and the four original *Good health at low cost* countries. Our countries share a history of success in delivering good health at modest income levels but are in many other ways quite different, with differing burdens of disease, income levels and resources used to deliver health care. Where possible, we extend our comparisons to include countries' neighbours, while also looking at changes over time. These "within and across" country analyses make it possible to generate putative explanations for differences in outcomes.

In Chapter 2 of this book, we describe the purpose, analytical approach and methods employed in conducting the research. In Chapters 3–7, we examine the experience of each of the study countries, while in Chapter 8, we explore the changes in the four original countries since publication of the 1985 report. In Chapters 9 and 10, we discuss cross-cutting themes and features of the health systems and beyond that emerge from the study and have been found to promote good health and access to care in diverse settings. Finally, in the concluding Chapter 11, we offer reflections on the implications of the findings.

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