Good Health at Low Cost 25 years on: lessons for the future of health systems strengthening

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Lancet 2013; 381: 2118–33
Published Online
April 8, 2013
http://dx.doi.org/10.1016/S0140-6736(12)62000-5

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In 1985, the Rockefeller Foundation published *Good health at low cost* to discuss why some countries or regions achieve better health and social outcomes than do others at a similar level of income and to show the role of political will and socially progressive policies. 25 years on, the Good Health at Low Cost project revisited these places but looked anew at Bangladesh, Ethiopia, Kyrgyzstan, Thailand, and the Indian state of Tamil Nadu, which have all either achieved substantial improvements in health or access to services or implemented innovative health policies relative to their neighbours. A series of comparative case studies (2009–11) looked at how and why each region accomplished these changes. Attributes of success included good governance and political commitment, effective bureaucracies that preserve institutional memory and can learn from experience, and the ability to innovate and adapt to resource limitations. Furthermore, the capacity to respond to population needs and build resilience into health systems in the face of political unrest, economic crises, and natural disasters was important. Transport infrastructure, female empowerment, and education also played a part. Health systems are complex and no simple recipe exists for success. Yet in the countries and regions studied, progress has been assisted by institutional stability, with continuity of reforms despite political and economic turmoil, learning lessons from experience, seizing windows of opportunity, and ensuring sensitivity to context. These experiences show that improvements in health can still be achieved in countries with relatively few resources, though strategic investment is necessary to address new challenges such as complex chronic diseases and growing population expectations.

Introduction

Why do some countries achieve better health outcomes than do others at similar levels of income? In 1985, the Rockefeller Foundation convened a meeting in Bellagio, Italy, to consider the experiences of four countries or regions seen as success stories: China, Costa Rica, Sri Lanka, and the state of Kerala in India. All had achieved substantially better health outcomes than other nations at similar levels of development. The result was a publication entitled *Good health at low cost*[1] that not only dispelled the then widely believed myth that economic growth was necessary for health improvement but also identified specific factors associated with success. These were a commitment to equity, effective governance systems, and contextually appropriate programmes addressing the wider determinants of health. Politics also mattered, and every country or region was run by left-wing governments of various hues. 25 years later, the threats to health and the scope to respond are much more complex. Do the lessons of 25 years ago still apply?

In 2011, we revisited the original countries and regions and looked at five different places that were judged to have succeeded in either achieving long-term improvements in health and access to services or implementing innovative reforms relative to their neighbours (table).[2] We used a conceptual framework (figure) to assess how access to health care and good health are affected by context (global and national), sector (public and private), and systems (health and non-health). The nature of the success varies; some have achieved substantial health gains whereas others have improved coverage or health system performance but are yet to see the full effect. Here, we review the experiences of Bangladesh (panel 1), Ethiopia (panel 2), Kyrgyzstan (panel 3), the Indian state of Tamil Nadu (panel 4), and Thailand (panel 5) and reflect on lessons they offer to other countries of low and middle income that are attempting to strengthen health systems in constrained or uncertain circumstances.

In 2009–11, we undertook a series of historical case studies to investigate how and why these five countries or regions made progress in health and access to care (panel 6). Our conceptual framework (figure) was based on existing published work[65,80–82] and was used to identify a comprehensive range of factors related to health

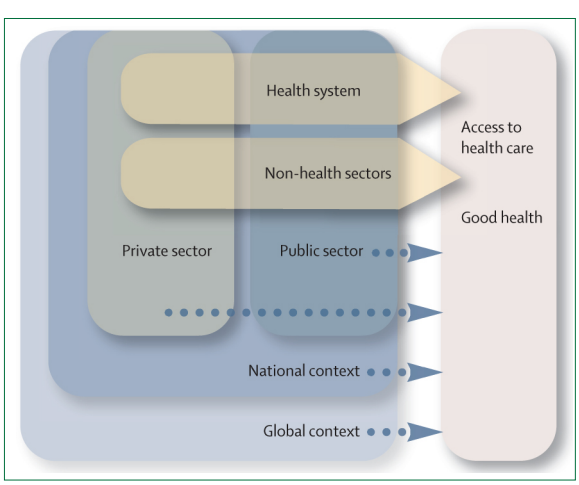

Figure: **Conceptual framework used for research**
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