Editorials

Health systems: more evidence, more debate

Richard G.A. Feachem[1]

The design and performance of health systems are now at the centre of the international health agenda. This month's special section of the *Bulletin* and *The World Health Report 2000* are both devoted to health systems. The next decade will witness a lively debate on these issues, increasingly fuelled by multicountry evidence and analysis.

Historically, the World Health Organization has not been heavily engaged in policy work on health systems or health economics and finance. Throughout the 1990s, the World Bank was the strongest influence in these areas. Since the election of its new Director-General in 1998, WHO has signalled its intention to strengthen its competence and influence in nonmedical areas such as economics and finance. This intention was marked dramatically in January 2000 by the launch of the high-profile Commission on Macroeconomics and Health. This month, with its two major publications on health systems, WHO takes a further step towards a leadership role in global thinking on health policy.

Health systems policy issues are intrinsically complex. The evidence is weak, no country has discovered an ideal model, and appropriate policies differ widely in different country settings. Publications in this field, especially if they are bold in their conclusions and prescriptions, are likely to prove controversial and attract criticism. This is to be welcomed. What the world needs is more evidence, more intercountry sharing of experience, and more debate. The global and idealistic prescriptions of the 1970s must be jettisoned in favour of policy formulation and evaluation grounded in the disparate realities of where countries really are today — not where they might wish to be.

As we look forward to the research and policy agenda in health systems for the next decade, two issues stand out as being especially important and difficult. These are the public–private interface and the trade-offs between spending more and spending better.

Public and private roles

Lower-income countries have health systems that are more private — in finance and provision — than higher-income countries. In Asia, and especially in India, health care is mainly purchased 'out of pocket' from private doctors and clinics. In many African countries, the proportion of finance and provision that is private is rising due to the reality and the perception (which has lagged behind the reality) of the inability or unwillingness of governments to pay for and provide even basic health services to the majority of the population. The governments of low-income and middle-income countries, together with the international agencies and the health policy community, have neglected or ignored this reality over the past decades. It can no longer be avoided. Central issues for health policy and health systems reform over the coming decade include the proper roles of governments and the private sector and the necessary actions by governments to improve the accessibility to and quality of services offered by the private sector.

Good governance, more cash, or both

Development assistance ("aid") as we know it today is barely fifty years old. The recent wave of analyses on its effectiveness are yielding judgements from "modest achievements" to "substantial failure", depending on one's viewpoint. Very little analysis has focused specifically on the performance of aid in the health sector, and this remains a priority for research.

In the absence of good evidence, a lively debate is under way between the 'good governance school' and the 'more cash school'. The good governance school points out that where the policy and institutional environment is sound and supportive, good outcomes occur in health even at low levels of expenditure and largely irrespective of foreign assistance. Conversely, where the policy and institutional environment is weak, one can find poor health outcomes even in the context of adequate expenditures and substantial aid. The more cash school argues persuasively that it is ludicrous to suppose that a low-income country spending a few dollars per capita per year on health can achieve much and that the problem is a massive underinvestment in health. Middle-income and large low-income countries, they argue, should spend a far larger proportion of their government budgets on health, while small and very poor countries need to receive far more foreign assistance from bilateral donors and the concessionairy lending arms of the development banks.

The answer, surely, is to emphasize the need for increased spending *in the context* of good governance. Without a supportive policy and institutional environment there is every likelihood that more money in the public system will be squandered or stolen, or both. In the absence of good governance, the best prospect of improving quality and access in the health system may come through the market behaviour of private actors. For example, the imminent explosion of private health insurance in India is likely to have a greater impact on quality than anything government can do in the near term. Insurers have an incentive to monitor and enforce quality standards in their provider networks. Providers wishing to benefit from the financial bonanza of Indian health insurance will have to "comply or die".

The marketplace of ideas

This month WHO enters the health systems debate with a flourish. The World Bank will continue, one hopes, to be very active. The academic community will increasingly step down from its ivory tower and engage in research at the coalface of health service delivery. Bravo to all this. Let us not strive for standardization of advice to countries — a patronizing goal — but rather for honest, apolitical, well-informed debate. From this will flow better policies and better implementation arrangements from which all countries will ultimately benefit. ■

[1] Editor-in-Chief, *Bulletin of the World Health Organization.*

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