This issue of *Health Systems & Reform* presents reform processes from various perspectives and at various points in time: where reform is firmly placed on the political agenda and is awaiting the next steps forward; where reform was placed on the agenda but did not make it to the next step of actual change; and where reform was placed on the agenda and produced a legislative change that is being implemented. The issue also examines how global institutions can affect health systems: how global financing agencies relate to national stakeholders and policymakers in effective ways, and how to raise additional financial resources to address global pandemic emergencies. We also look to the future—to see how health systems are being transformed by the explosion of digital technologies all over the world. The issue concludes with two empirical articles assessing the capacity of people in the informal sector to prepay for health care in Kenya and models to improve the supply chain for essential medicines in Zambia. As I have done with previous issues, let me offer a summary and a few comments on each article.

The first commentary, by Sheelah Connolly and Maev-Ann Wren, examines Ireland’s efforts to move health reform forward. The authors note that Ireland is “unusual” in Europe, in not providing universal access to health care. Private health insurance continues to play a major role, covering 43% of the population. The authors report that some people confront barriers to access due to cost and long wait times. A newly elected government in 2011 committed to creating a universal health care system, and issued a landmark publication in 2017 called the Sláintecare report. As the authors concluded, “For the first time in the history of the Irish state, universal health care is now firmly on the political agenda.” But little progress has been made in implementing the proposed reforms. The authors draw on the experiences of other countries to identify what Ireland must do next: define universal health care for the “Irish context”; develop political consensus on that definition and assess the costs of the changes; and design strategies to prevent vested interest groups from blocking the changes, as has happened in the past. Whether this will happen in Ireland remains to be seen.
Two other articles in this issue show similar lessons about the reform process, one without success and one with.

Chile started a reform process, but it became stalled, perhaps stopped. The article by Pablo Villalobos Dintrans recounts how Chile also started a health reform process with a change in government in 2014 and also began with the formation of a commission to examine the problems and propose solutions. The commission rapidly concluded its work six months later in 2014 and released its report—but no policy changes have appeared in the following four years. Villalobos Dintrans calls this “a failed reform process, which he says is important to document, because too often we read only about successful reforms. He attributes Chile’s failure to a lack of agreement about the purpose of the commission (whether it was an end in itself or was supposed to lead to policy change), lack of time to build consensus among key stakeholders (both within the commission and outside it), and lack of clarity about the scope of its mandate (whether it was supposed to focus just on the private health insurance sector or the entire health system). In short, there was agreement about the need for reform, but “no agreement on why it was needed, what should be done, or how it should be implemented.” The result was stalemate (rather than checkmate).

The case of road safety policy reform in Argentina provides a sharp contrast—a case of successful reform. Kavi Bhalla and Marc Shotton examine when a country can establish institutions for road traffic safety, especially the political process that leads to legislative passage in a country with a decentralized federal system. They draw on ideas from John Kingdon’s model of multiple streams to explain Argentina’s policy change. They attribute the passage of a national road safety law in 2008 to a combination of factors: a tragic accident involving school children and a teacher, which became a national focusing event; the social mobilization of families related to the victims, which provided persistent political pressure for policy change; the efforts of policy entrepreneurs who proposed ideas for institutional solutions; and high-level political leadership from two national administrations (Néstor Kirchner followed by his wife, Cristina Kirchner). The new road safety agency was then supported by a $30 million USD loan from the World Bank, which was promoting the Safe System approach that emphasized institution-building for road safety. The authors conclude that this case illustrates how “the political processes that affect policy agenda are often domestically rooted and depend on, for example, public mood, advocacy campaigns, national disasters, and changes in political administration.” In this case study, the factors came together in a favorable way to create a successful reform process; as the two previous instances illustrate, it does not always happen that way.

Two commentaries in this issue examine global perspectives on improving national health systems, especially related to financing. The first presents the positive experiences of a global funding agency in relating to national stakeholders—how the Global Fund to Fight AIDS, Tuberculosis, and Malaria has created, evaluated, and adapted the Country Coordinating Mechanisms (CCMs). As the Global Fund’s Executive Director Peter Sands argues, the CCMs embody two fundamental principles: country ownership and inclusivity. This “significant innovation in global health,” according to Sands, ensures that Global Fund grants strengthen national plans and programs and enhances the quality of supported programs—two thorny problems in development assistance. Institutions (like the CCM) matter, especially when seeking to improve governance. The Global Fund has worked over time to evaluate and improve the CCM process—and they are proud about this contribution to global health policy and practice. Sands quotes the old saying, “a camel is a horse designed by committee,” but notes that sometimes “a camel can be indispensable in navigating difficult terrain.” It may take longer, it may involve more back and forth, it may require more negotiation, but in the end the CCM process is “both resilient and adaptable.” Other development agencies could benefit by learning from this experience.

The commentary by Keishi Abe and colleagues examines two global funding responses to the Ebola disaster and pandemic preparedness, one centered on the World Health Organization, and the other based in the World Bank. Both of the new financing mechanisms (the WHO’s Contingency Fund for Emergencies (CFE) and the World Bank’s Pandemic Emergency Financing Facility (PEF)) seek to accelerate the availability of sufficient financial resources when global disease emergencies occur. The commentary assesses the strengths and limitations of these two new institutions, and calls for a number of changes to assure their sustainability and flexibility. One major limitation is that only four countries are participating as major grantors so far: Germany, the UK, Australia, and Japan. Persuading more countries (where is the United States?) to join these efforts is a major challenge. The authors propose other resources that countries can contribute, beyond financial assistance. But they stress that there is a need for new and additional global resources to combat these pandemic threats—especially in the fragile contexts that suffer from insecurity and warfare, as currently demonstrated by the tragic Ebola outbreak in the Democratic Republic of Congo.
The last commentary, by Marc Mitchell and Lena Kan, proposes five ways that the global spread of digital technologies will transform how health systems work around the world. The authors look into their digital crystal ball and predict: 1) Access to Internet-based information will be universal; 2) Health workers will be digitally supported; 3) Most health care will be provided at home; 4) Transportation and logistics management could be revolutionized; and 5) Data will be central to health systems. They identify many challenges with the changes, including: “how individual privacy and confidentiality will be maintained, who will control both the technology and the data, who will pay for the technology, and how to deal with the inevitable resistance to the changes discussed by those who benefit from the status quo.” Despite the challenges, Mitchell and Kan view the changes as “inevitable” across the globe, especially in low- and middle-income countries. In short, the digital genie cannot be stuffed back in the box; policy makers (with our help) will need to figure out how to use these digital technologies for the “common good” in advancing public health.

The last two articles in this issue are empirical analyses on two critical questions for countries seeking to move toward universal health coverage (UHC): who can pay, and how to deliver medicines. Without sustainable funding, and without effective delivery mechanisms, UHC will be just another global slogan.

In their article on Kenya, Vincent R. Okungu and Diane McIntyre ask the question: Does the informal sector have financial potential to sustainably prepay for health care? About 80% of Kenya’s population works in the informal sector. Understanding their ability to prepay for health insurance premiums is an important factor in moving the country toward UHC. The authors used a questionnaire to collect data from both urban and rural populations, to examine monthly expenditures and the “financial potential” to pay premiums. They found “substantial sections of the informal sector” would “struggle” to prepay for health care, even though the nonagricultural informal sector includes many entities that “control significant financial resources and can afford to prepay for health care.” Kenya therefore needs to use government revenues to support the move towards UHC, to provide coverage for the informal sector. Rather than trying to collect premium payments from these workers, the authors recommend the use of innovative indirect taxes to “generate revenue from the informal sector”; by this, they mean taxes that are not regressive. They conclude, “a key task for policy makers is to find ways to minimize the regressive impact of indirect taxes to make them a feasible source of revenue in a noncontributory health financing system.” These non-regressive tax strategies could include taxes on mobile phone company turnovers, taxes on international financial transfers, and taxes on investment income. In short, policy makers need to focus on the potential regressive impacts of indirect taxes. For this to happen, more research is needed on the distributional impacts of both the financing and the benefits of moving towards UHC, so that UHC policies do not end up hurting the poor more than helping them.

The final article in this issue, by Monique Vledder and colleagues, reports the results of a large-scale randomized trial in Zambia to improve the supply chain for essential medicines. The study used 439 health facilities in 24 districts to test the traditional three-level distribution system (central supply agency to district level holding stock to health facility) versus an innovative “cross-docking” distribution system (with the district receiving pre-packaged shipments that are then transferred to health facilities). Lack of essential medicines at the point of delivery remains a persistent problem in many national health systems; yet few systematic studies have been conducted of the causes and how to correct them. This paper makes an important contribution to this field. The randomized intervention showed “a more streamlined distribution model [the “cross-docking” model] … was highly effective in increasing drug availability and storage conditions when compared to the ‘business-as-usual’ distribution system or a system with increased district technical capacity.” The study was carried out in Zambia in 2008-9, and provided the basis for changing the structure and process of the national medicines supply chain, introducing four distribution hubs that operate as cross-docking centers and shifting to smaller orders for health facilities. This article does not longitudinally evaluate the impacts of the changes carried after this RCT, but a supply chain assessment conducted in 2017 suggests that the system’s performance has improved for drugs which are in stock at the national level. Further studies are needed to understand how knowledge gained from RCTs affects what happens in practice, taking into account (as the authors recognize) that supply chain reform has “operational, behavioral and political issues” that affect outcomes.

We look forward to continuing to explore these questions in the next issue of Health Systems & Reform, which will focus on the political economy of health financing reform, sponsored by the World Health Organization’s Department of Health Systems Governance and Financing.

ORCID

Michael R. Reich @ http://orcid.org/0000-0003-3338-0612

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