New Preface for **Getting Health Reform Right: A Guide to Improve Performance and Equity**, Oxford University Press (Anniversary Edition, 2019)

"What We Have Learned in the 15 Years Since this Book was Published"

Remarkably, 15 years have passed since we sent this book to the publisher. In this time, demand for the book has continued apace, and we and many others have continued using the book in teaching and advising about improving health system performance around the world. Many of the book's ideas have weathered the test of time. As authors we are pleased by this continuing interest, but we also recognize that the world has changed. This new preface allows us the opportunity to reflect on what the book does well, but also what the book does not do well and what the book does not address adequately. We try, here, to convey some of these strengths, limitations, and oversights of the book, in a spirit of reflection, but without seeking to revise the details of the individual chapters or add new material that was missing in the original version. In many ways, the chapters of this book were the product of a particular historical moment, with the participation of a core author, our good friend Marc J. Roberts, who is no longer with us. It was hard to imagine revising those chapters and the many words he wrote—without him. So we decided on a less ambitious approach. Instead of producing an updated second edition of the book, we present the same book, with this new preface, reflecting on what we have learned since the book was published in 2004. Indeed, we worried that if we entered into the details of each chapter again, we might never emerge and finish.

We organize this around four questions. First, what have learned about teaching with this book? Second, what have we learned about helping countries reform their health systems using this book as a guide? Third, what have we learned about the strengths and weaknesses of the book? And finally, what have we learned about "getting health reform right"— the book's ambitious title?

Even when we were finishing this book, 15 years ago, we knew there were limitations to our writing, areas that we would have liked to develop, ideas that we would have liked to explore, topics that seemed important to include—but we could not address them, because of our own limitations of time and capacity as well as the limitations of where health systems studies stood back then. Finishing the book required some compromises. To write this new preface, and to achieve a point of detached reflection, we each agreed to re-read the book and then engage in a series of conversations over several months, to return to our earlier work with fresh eyes and thinking. This would, we thought, provide us with an opportunity to remember and address some of these limitations, in a provisional way, or at least recognize them explicitly.

What have we learned about teaching with this book?

We now have over two decades of experience in teaching courses with this book (starting with drafts before the book was finished) on how to improve health systems performance—courses at the global, regional, and national levels. One striking lesson is that the book works well as a tool for pedagogy. The model we created for health systems can be taught and understood by a broad range of students, from young undergraduates to seasoned bureaucrats to national leaders. We wrote the book with a narrative style that is easy to read, designed to engage, and accessible to non-technical audiences. The teaching we have done with the book shows us that it is possible to change ways of thinking and provide

participants with a common language for analyzing health systems. The book, when used in courses, can serves as a team-building mechanism. We have seen this happen to groups of course participants in many diverse cultural settings, from China, to Nigeria, to India, to Washington.

We have taught this approach to improving health system performance over the past two decades in the Flagship Course on Health System Strengthening and Sustainable Financing, through collaboration with the World Bank and other institutions, as well as in regular courses at Harvard and other executive programs.[1] During this period, over 20,000 people have participated in global, regional, and national versions of the Flagship Course.[2] The book and the course have been adopted (and adapted) by multiple international agencies for training purposes, for teaching government officials, agency officials, and others about health system performance. The agencies include the World Bank, World Health Organization, U.S. Agency for International Development, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and other organizations. The book has been translated into various languages (including Japanese, Korean, Arabic, Turkish, Chinese) for health reform practitioners around the world.

The book's health system model is relatively simple, and this is a positive attribute. All models simplify reality; they simplify in order to allow analysis and action, and in order to conduct predictions with some range of certainty. We focused our model on three final outcomes for health systems (health status, citizen satisfaction, and financial risk protection) that we believe are important and universal; and we identified five key factors that can be changed (the five "control knobs" of financing, payment, organization, regulation, and persuasion) in order to improve the performance of health systems in producing the three outcomes. The relatively simple structure and deterministic logic of our model distinguishes it from other health system models. One distinguishing feature of our model is its focus on actions that can improve performance, through causal linkages between health system components and both intermediate and final performance outcomes. This logical structure differentiates our model from other health system models, as we discuss below, which tend to be either exceedingly complex (and therefore not action-oriented) or focused on system inputs (and therefore lacking causal linkages).

In the classroom, we have found this approach to be effective. When used in courses, the book provides participants with a model they can remember and refer to over time. The model provides lessons that participants can retain in their minds—a few key points about how health systems operate and about how to change health system performance. These learned lessons reflect core points in the book. The model changes how course participants think about their health system and how they think about actions. When confronted with complex problems, they are reminded not to jump to solutions but to focus first on performance problems and to undertake a diagnostic journey, to ask "why" five times and seek policy areas where they exercise some control. They can then evaluate options for actions and decide on what to do.

The audience for our book, as a teaching guide, has always been policy makers and policy analysts, including the people who advise decision makers. Just to be clear, the book was never intended as an operational manual for operators or program managers; it does not provide that level of detailed instruction. But the book does connect theory with practice, as a guide that leads to action. The book's model helps readers identify problems in health systems that can be diagnosed and improved. This focus on *practical knowledge* reflects our academic base in a school of public health, and our commitment to advancing knowledge and also improving the world.

Our teaching with this book emphasizes two important conceptual models that have stood the test of time in the classroom: the *policy cycle*, which we have adapted to include our emphasis on both ethics and politics, and not just the technical aspects of moving a policy from ideas to action; and the *health system model*, which connects the five health system control knobs to three explicit performance goals.

We have thus learned that the book works well in the classroom as a textbook, especially when combined in the classroom with strategies of adult learning (using business-school style case study discussions and group work that applies the concepts and methods to participants' own health system problems as the course proceeds). Over the years, we have developed many teaching cases to illustrate how the book's concepts can be applied in specific contexts. We need more such teaching cases to bring the concepts alive and keep them up to date with evolving health systems and problems. And the teaching cases should be available as global public goods, so that they can be used in low- and middle-income countries that are the focus of the book and our teaching practice. We next turn to using the book in practice.

What have we learned about helping countries reform their health systems using this book?

This book emerged from our individual and collaborative engagements with countries and with national policy makers who were seeking to improve their health systems—in many settings around the world. In the way, the book's core concepts were based in actual experiences with health reform and in our personal exchanges with national efforts at health reform. This was shoe-leather policy engagement—not arm-chair reflection or arms-length advising. It was get-your-hands-dirty policy engagement, interactive and iterative, multiple meetings with government officials seeking to reform their own national health systems. Indeed, we wrote the book for these people, people who are responsible for improving national welfare and who want to take action and solve problems. And we have continued this commitment to engaging with national policy makers in applying and advancing the core ideas of this book.

This deep engagement with practice distinguishes our public-health–grounded approach from a classic social science disciplinary approach. We have worked on health reform with governments in many countries around the world—in China, Colombia, Egypt, Hungary, India, Iran, Malaysia, Mexico, Poland, South Africa, Sri Lanka, Turkey, United States, and Vietnam, to name just some examples. This engagement in practice in diverse settings around the world has allowed us to develop, test, and apply the ideas over time, and assess their value in the field.

From this engagements we have learned that policy makers relate easily and well to many of the ideas presented in the book. For example, take the controls knobs as areas of policy intervention. Many government health officials have a good sense of what they do and do not control. The control knob categories (financing, payment, organization, regulation, and persuasion) appear intuitively clear and helpful to people who manage health systems. Government officials are generally receptive to these categories and see how they can use those controls to improve their health system's performance.

In addition, the book's three broad categories of analysis—technical, political, and ethical— also make intuitive sense to policy makers. Concepts of applied philosophy, which are introduced in the chapter on ethical analysis, may be challenging to grasp at first, because they are a new language and discipline. But policymakers fundamentally agree that improving the performance of a health system must relate to basic questions of social values. And they appreciate a summarized view of applied philosophy to help

them reflect on their personal values, the values embedded in existing and proposed policies, and the values articulated by their nations, constitutions, and peoples.

We have also come to know national leaders who have used the book in helping them make decisions and take actions in *getting health reform right*. One example is former Minister of Health Recep Akdag of Turkey.[3] He told us that he kept "the green book" on his desk while serving as national minister of health and restructuring Turkey's health system over a period of ten years.

We have also learned that the book's ideas can be applied to bring together different ministries and constituencies within a country. Our work in countries requires addressing issues that cannot be handled by a ministry of health alone, and it requires reaching out to other government agencies, such as the ministry of planning and the ministry of finance. The book's emphasis on conducting applied political analysis of stakeholders, early and often, supports the importance of involving other ministries and constituencies in health system reform. National policy makers understand this point from experience and appreciate guidance on how to improve management of stakeholders. Solving the complex health challenges of today, such as the growing epidemic of noncommunicable diseases (including cancer and cardiovascular disease), will require effectively managing stakeholders beyond the ministry of health, beyond the government, and beyond one single country.

In many countries, our engagements have lasted months or years, not simple or one-off interactions, but ongoing exchanges and commitments. Health reform is not a simple process, and it requires multiple kinds of analysis for diagnosis and treatment (as explained in the book). Yet, somehow, these engagements have produced few published reports on how to use the book in guiding reform. One reason may be that policymakers and high-level analysts are not usually writers; they are doers more than recorders. (The book's approach has been applied to pharmaceutical reform, by Roberts and Reich[4]; to a comparison of the health systems of China and India, by Yip and Mahal[5]; and to Chagas disease treatment, by Manne and others[6]; but there are few published accounts of how to use the book's analytical methods in actually managing national health reform.)

One limitation we have learned, from working with decision makers, is that the book lacks a manual on how to do the related analyses that are needed. This guidance needs to be taken from other sources. For some analytical tools, instruction manuals do exist, including national health accounts, provider payment analysis, private sector assessment, political analysis, and problem diagnosis for policy development. Other forms of analysis do not yet have adequate instruction manuals, including assessments of regulation, behavior, organization, and implementation/delivery challenges needed to improve health system performance. It would be helpful to develop manuals on how to do these different analyses, and how to use the results in making decisions.

In working with policy makers and analysts, we have sometimes encountered a reluctance to follow the guidance provided in this book. Some policymakers, for example, resist the focus on final performance outcomes that we call for, or they disregard our calls for attention to equity and evaluation. They prefer to focus on methods and processes, or they would rather follow an input-based approach (more money, more people, more medicines) instead of starting with concrete problems in final performance goals. Policy analysts (including some academics), we have found, sometimes like to produce long lists of objectives or slides that show multiple priorities and recommendations (not ranked by importance). We also have experienced obstacles in engaging in open discussion with national teams as they design and implement reform policies. This reduces the opportunities to make mid-course corrections in moving

forward with reform (as we advocate in this book). In short, actually implementing our guidance about how to do reform is not easy.

In working with policymakers, we have learned that opportunities to think strategically about national health reform do not occur often in a country's political history. Those moments arise when political circumstances come together to create chances, and when political leaders decide to take both personal and social risks. We have sometimes called these “opportunities for large R reform”—when broad-scale systemic change is possible. These are the transformations that this book is most concerned with. Such systemic change is not a one-shot effort but typically continues over many years (and even decades), as a major reform is introduced and then adjusted and modified as new problems arise and are addressed. Reform is not simply about creating a law and getting it adopted; it is a years-long process of learning how to improve the performance of a health system, through trial-and-error, measurement and evaluation, systematic thinking, and analysis.

What we call "little r reform," by contrast, focuses more on incremental changes that typically engage health systems at the level of managerial adjustment, often at particular health facilities. These incremental reforms typically work on the inputs of health systems (the use of funding, management of human resources and med-ications, the role of information systems). Here is where the World Health Organization's focus on "building blocks" (discussed below) may be most appropriate. While this kind of change is important to improve health system performance (and is discussed in the book's chapter on organization), our book and our national engagements are fundamentally about broader systemic changes and analysis.

The nature of national health reforms considered and adopted seems to depend in part on a country's level of economic development. Middle-income countries are often able to adopt reforms that transform their health systems in ways that can be implemented (examples include Malaysia, Mexico, South Korea, and Singapore). Lower-income countries, on the other hand, may try to leap-frog steps in transforming their health systems, and then sometimes encounter problems in implementation and financial sustainability (such as has happened in Ghana and Colombia). For low-income countries (especially in Africa), there are no simple solutions to the challenges of providing effective health services in villages where the majority of the population still lives. In these situations, more money and better supply chain management alone will not produce needed changes; here there is a strong need for the kind of system approach advocated in this book.

Finally, in our engagements with national health reforms, we have found that the political process of reform often contains surprises. It is rarely a linear path, and sometimes the path of reform ends abruptly or veers off in unexpected directions. Sometimes there is no path, or the path is an illusion, or decision makers need to push through the jungle or wander the desert hills in search of reform success. In some cases, leaders may resist efforts to be outcome-based (in part because inputs generate more immediate results) or may avoid engaging in reform at all. Indeed, engaging in reform is a risky enterprise for political leaders and government officials; and they may be reluctant to embark on reform, depending on political circumstances, career issues, and personal attitudes toward risk. In those instances, advocates for reform may need to influence their leaders (managing up) and nudge them forward in the reform process.

From our perspective, as guides to reformers, we have learned to select our partners carefully, looking for individuals with a shared commitment to change health systems in a positive direction. We have

learned that using this book's methods can still encounter unexpected political events, which can both speed up and freeze reform processes. Windows of opportunity, which allow reforms to move forward, can shut down suddenly, with little advance warning. An auspicious environment can overnight turn stormy. Sometimes, the opposite happens. A top political leader may announce a new policy before anyone has prepared the relevant analysis or the technical contents, and pressure to implement rises sharply (such as before an election) before anyone is prepared to act. In those cases, everyone is pushed to scramble and the processes presented in this book are compressed and compromised. As they say, policy making is like sausage making, not something you really want to watch up close.[7]

In sum, we have learned that this book is useful in guiding practice about health reform, that repeated practice improves performance, but also nothing substitutes for experience, judgement, and good luck.

What have we learned about the strengths and limitations of the book?

It will be no surprise to readers of this preface that overall we believe this book works. After re-reading our book 15 years later, and reflecting on how we have used the book in teaching and in guiding reformers, we think it is still relevant. Of course authors are biased about their own products, but in this case we have tried to look at the evidence. The book has limitations (as we indicate below), but our sense is that on balance the book continues to make a positive contribution to understanding and supporting the complex processes of making health systems perform better.

On particular strength of the book is its action-oriented approach, focused on solving problems. The book draws on several core disciplines, (economics, philosophy, political science, organizational behavior, management) but always in the interest of explaining important problems and in efforts to support the process of making difficult decisions about what to do. This exercise is not analysis to advance disciplinary theory and knowledge, but the application of discipline-based theory to advance practical knowledge and improve well-being in the real world. Our calls for practical analysis and action-oriented proposals, with analysis conducted in a timely fashion, still make sense to us. We still believe that windows of opportunity for reform can be taken advantage of and used to produce tangible changes that benefit less advantaged groups in society.

Overall, the core concepts of the book still resonate with what we see in health reform processes: three ultimate performance goals of health status, financial risk protection, and customer satisfaction; five control knobs of financing, payment organization, regulation, and persuasion; three intermediate goals (not as ends in themselves) of access, quality, and efficiency; three broad kinds of analysis as technical, ethical, and political that are necessary in reform efforts; and the diagnostic journey that connects final performance problems to policy areas where leaders have some control. In short, the model makes sense to us, to students we teach, and to leaders and analysts we work with.

One strength of our health system model is the focus on concrete areas of action that can bring about tangible change and improvements in performance. As students of health systems know, our model is not the only one around. This is not the right place to conduct a prolonged comparative analysis of models, but a few comments are appropriate. Broadly speaking, there are two categories of other models. At one end of available models we find the approach of "systems thinking"[8] and "complex adaptive systems"; these models tend to propose many variables, which are highly interactive, so that the resulting figure is extremely complex. In our view, these complex systems models rarely offer or lead to clear guidance on what decision makers can do to improve health system performance. They are hard

to apply in practice and are not action-oriented. At the other end, we find input-based approaches (such as the "building block" model[9]) which provide static guidance or norms and do not offer clear causal relationships between inputs and outputs or outcomes. These input-based models reflect how Ministries of Health are organized and focus on decisions made largely with these ministries. In addition, measuring inputs is relatively easy (add more money, up to $XX per person; or hire more health workers, up to YY nurses per 1,000 population; or provide these essential medicines at all health centers). But changing the levels of inputs (to reach some target level) does not necessarily produce the desired outputs or outcomes, because the necessary analysis has not been done of health system processes and causes of problems. Nonetheless, it is important to recognize that the WHO has been very successful in promoting the Building Blocks model of health systems. The model has permeated every ministry of health worldwide, and (as we noted above) managing the inputs is critical to incremental improvements in health system performance, especially for program management. Understanding the role of inputs in our model is something we could have done more effectively and explicitly. We think that our model is both more action-oriented and more deterministic than either the complex systems approach or the input-based models.

Of course, our model will not solve all problems in a health system. The model was not intended to solve all problems. Instead, it uses a step-by-step incremental approach to identifying high-priority problems (including ethical reflection on what constitutes a "high-priority" problem), diagnosing causes, and then proposing policy solutions. Universal health coverage, the current holy grail of global health policy, cannot be achieved by a single reform. It requires a step-by-step incremental expansion of services, for specific populations, in ways that can be paid through pooled financial resources. There is no magical alternative to the kind of iterative reform process that we present in this book.

On the other hand, we acknowledge a number of weaknesses and limitations in our book and the model and methods presented. The chapters on organization, regulation, and behavior change tend to be weaker than the other chapters, a result of the limits of our own knowledge and the field's development when we wrote the book 15 years ago. We would write them differently today and draw on new research and knowledge that have been generated in recent years. For example, the field of behavioral economics and the practical knowledge about nudging have exploded in the past decade, and they offer many ideas about how to change human behavior or to improve the performance of health systems. Similarly, the world has become acutely aware about the lack of effective regulation of health systems in many respects, and the need for new approaches that can work in the difficult institutional environments of low-and middle-income countries. New digital technologies and collaborative approaches to regulation may help improve efforts to control the performance of providers, the quality of medicines, and even the processes of care delivery. We have updated these concepts and materials in our teaching, but the book remains bound in time.

Some themes would benefit from entirely new chapters for the book. We could imagine, for example, a new chapter on distribution and equity, including how to analyze it and how to improve it in practice. We emphasized distribution in our framework of ultimate outcomes, but we did not sufficiently explore it in the book. A separate chapter on measurement and evaluation would be helpful. And we have long thought that the book would benefit from more guidance on implementation, on how to drive policy into practice. Unfortunately, these additional chapters are beyond our personal capacity at this time in our lives; we recognize their critical role in the pursuit of health reform but we leave these themes to others to pursue.

The book also does not sufficiently explain the connections and interactions across the control knobs. Many performance problems require the use of several policy levers at once, making adjustments in payment and persuasion and organization, for example, in order to assure that medicines are used appropriately to control hypertension and reduce cardiovascular disease. But it is not always clear how to decide which control knobs to use, for which problems, or which specific policy interventions (for example, in payment) to select. These choices typically involve judgments based on experience and values, and they are difficult to model or prescribe. In our teaching and advising, we refer to specific cases that illustrate how different control knobs are used simultaneously or in sequence to achieve tangible improvements. This knowledge relates to the art of implementing health reform.

We are also sensitive to the limitations of language used in the book. Language is grounded in certain historical moments and fashions. As time changes, the commonly accepted terms shift and evolve. In global discussion, for example, the language of reform has moved from health sector reform, to health system strengthening, to universal health coverage. This book frequently uses the phrase of "health-care reform," reflecting the time when we wrote the book and the environment in which we lived. Today, we might refer to "health system strengthening" or "performance improvement."

We also selected words for certain concepts that we would do differently today. For example, the book refers to "behavior change" as the fifth control knob; in recent courses and reform work, we have used the term "persuasion" to indicate the activity (similar to the other control knob concepts) rather than the result (changing the behavior of providers or patients).

A more fundamental challenge of language is the term "control knob" itself. We selected this phrase reflecting our own historical and cultural contexts when we developed the model. We have spoken with people who view the mechanistic model of Figure 2.2 as anachronistic and too twentieth-century. As one millennial put it, "No one uses devices with dials anymore, the entire look is old-fashioned." The notion of a control knob is a metaphor; health systems don't actually have dials that you can turn or adjust. If we revised the book today, we would probably seek a different metaphor and a different phrase, with more temporal currency, for the five areas of policy control.

Finally, we recognize the need to update many chapters in the book, but especially the chapters on financing and organization. The past decade has witnessed many changes and advances in these fields, and the global movement to universal health coverage has given additional policy attention to the questions of financing and organization. In some cases, such as the categories used for financing types, policies and practices have evolved over time. The book's categories of analysis are not as distinct as they once were in describing what governments do in financing. The world's policies and practices evolved while the book's categories and ideas remained static.

For organization, many transformations and innovations in health delivery have occurred around the world, and the know ledge from these efforts is not presented in this book. Again, for reasons noted above, we leave the tasks of revising and updating knowledge about financing and payment for health systems to other researchers and other publications. For those who hoped that we would revise and update this book, we express our regrets.

What have we learned about “getting health reform right”?

We wrote this book based on our professional experiences as both scholars and practitioners of health sector reform. The ideas emerged from our engagements around the world with policymakers who sought major reforms to improve the performance of their health systems. We tried to understand what they were seeking to accomplish, the obstacles they encountered, and how we might help them with evidence, analysis, and thoughtful reflection. Our title for this book—Getting Health Reform Right—asserted an ethical principle that we shared as coauthors. In short, each effort at health reform needed to provide its own definition of what is "right," as policy makers and policy analysts engaged in ethical, technical and political assessments and debates, and interacted with multiple stakeholders about where to go and how to get there. In short, we argue in the book that the definition of getting health reform "right" should not be provided by external experts, international agencies, or other outsiders (including us).

But we also deeply believed that clear thinking, fact-based evidence, critical analysis, and honest debate can help nations and communities seek their own vision of health system improvement and can improve the process and the outcomes of health reform. We have learned that conditional guidance can help policymakers and policy analysts succeed in defining what is “right” for them in terms of values and policies, figure out the kinds of technical analyses they need to do to design appropriate policies, and assess the political landscape and design political strategies that can create conditions of political feasibility. This, for us, was what getting health reform “right” meant when we wrote the book. Outsiders can provide ideas and guidance and support. But at the end of the day the health reform process, seeking to improve the performance of a health system, depends on the skills, perseverance, and values of the health system leaders and analysts within each nation.

Our experience over several decades reminds us that health systems are indeed complex. Reform is not a matter of simple, one-off solutions. The actors in health systems—including government officials, public sector health care providers, private companies producing essential inputs, and insurers and payers—are not static subjects of reform interventions. Rather they act in response to change. Health care is changing rapidly with new medical discoveries and technologies. People's health needs and demands are also evolving, as a result of their own behavior, changes in physical and social environments, and adjustments in health systems. We have learned that health reform is a continuing process for both rich and poor countries and all in between.

Our commitment to a locally based vision of getting health reform “right” also means that there can be no single answer. Countries differ in the weights they give to the final outcomes of health status, citizen satisfaction, financial risk protection—and their distributions. But an appraisal of reform alternatives can still help the process. Reform can improve performance—but it can also worsen it.

“Getting health reform right” also relates to the evolving global discourse about health system goals. The concepts have evolved over decades with new definitions: primary health care, child survival, Millennium Development Goals, universal health coverage (UHC), and the Sustainable Development Goals. UHC was initially defined by WHO as all people receiving the care they need without financial hardship, and illustrated by the three-dimensional cube indicating people covered, health needs covered, and cost covered. But how to get there—that is the challenge of health system reform.

In conclusion, getting health reform right is not easy. The process is not for the risk-averse. We have learned that doing health reform right requires political courage and a willingness to move forward despite uncertainties. The process must be driven by leaders and their teams, navigating the rapid waters and hidden boulders that abound in health reform efforts. Recent health reform experiences in the United States, in the transition from the Obama administration to the Trump administration, underlines this point with painful clarity. This rocky transition in the United States also underlines for us one measure of reform "success"—the continuity of health policies from one administration to next, especially when the political party in power changes. On this score the experiences of Thailand and Chile are noteworthy. Although these two upper middle income countries are following somewhat different system reforms, they have retained commitments to their overall reform objectives through dramatic shifts in political parties in power, while introducing policy changes, mostly improvements, along the way. The experiences of these two countries, as well as that of the United States, underline the importance of political analysis and action to shape the agenda and adoption of national health reforms, and they sustain the policy reforms adopted.

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