

The chapter argues that, in general, the response of the health sector and societies to these challenges has been slow and inadequate. This reflects both an inability to mobilize the requisite resources and institutions to transform health around the values of primary health care as well as a failure to either counter or substantially modify forces that pull the health sector in other directions, namely: a disproportionate focus on specialist hospital care; fragmentation of health systems; and the proliferation of unregulated commercial care. Ironically, these powerful trends lead health systems away from what people expect from health and health care. When the Declaration of Alma-Ata enshrined the principles of health equity, people-centred care and a central role for communities in health action, they were considered radical. Social research suggests, however, that these values are becoming mainstream in modernizing societies: they correspond to the way people look at health and what they expect from their health systems. Rising social expectations regarding health and health care, therefore, must be seen as a major driver of PHC reforms.

Unequal growth, unequal outcomes

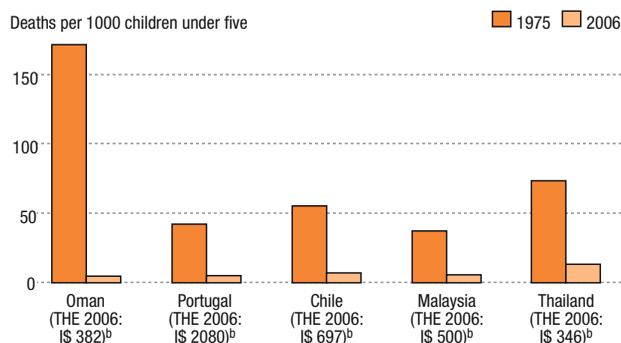
Longer lives and better health, but not everywhere

In the late 1970s, the Sultanate of Oman had only a handful of health professionals. People had to travel up to four days just to reach a hospital, where hundreds of patients would already be waiting in line to see one of the few (expatriate) doctors. All this changed in less than a generation¹. Oman invested consistently in a national health service and sustained that investment over time. There is now a dense network of 180 local, district and regional health facilities staffed by over 5000 health workers providing almost universal access to health care for Oman's 2.2 million citizens, with coverage now being extended to foreign residents². Over 98% of births in Oman are now attended by trained personnel and over 98% of infants are fully immunized. Life expectancy at birth, which was less than 60 years towards the end of the 1970s, now surpasses 74 years.

The under-five mortality rate has dropped by a staggering 94%³.

In each region (except in the African region) there are countries where mortality rates are now less than one fifth of what they were 30 years ago. Leading examples are Chile⁴, Malaysia⁵, Portugal⁶ and Thailand⁷ (Figure 1.1). These results were associated with improved access to expanded health-care networks, made possible by sustained political commitment and by economic growth that allowed them to back up their commitment by maintaining investment in the health sector (Box 1.1).

Figure 1.1 Selected best performing countries in reducing under-five mortality by at least 80%, by regions, 1975–2006^{a,*}



^a No country in the African region achieved an 80% reduction.

^b Total health expenditure per capita 2006, international \$.

* International dollars are derived by dividing local currency units by an estimate of their purchasing power parity compared to the US dollar.

Overall, progress in the world has been considerable. If children were still dying at 1978 rates, there would have been 16.2 million deaths globally in 2006. In fact, there were only 9.5 million such deaths¹². This difference of 6.7 million is equivalent to 18 329 children's lives being saved every day.

But these figures mask significant variations across countries. Since 1975, the rate of decline in under-five mortality rates has been much slower in low-income countries as a whole than in the richer countries¹³. Apart from Eritrea and Mongolia, none of today's low-income countries has reduced under-five mortality by as much as 70%. The countries that make up today's middle-income countries have done better, but, as Figure 1.3 illustrates, progress has been quite uneven.



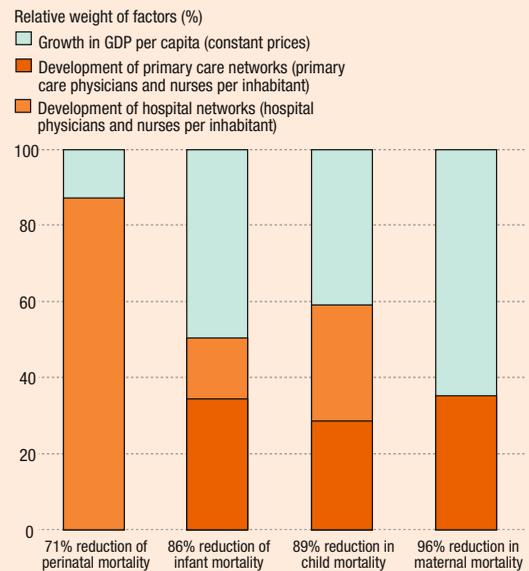
Box 1.1 Economic development and investment choices in health care: the improvement of key health indicators in Portugal

Portugal recognized the right to health in its 1976 Constitution, following its democratic revolution. Political pressure to reduce large health inequalities within the country led to the creation of a national health system, funded by taxation and complemented by public and private insurance schemes and out-of-pocket payments^{8,9}. The system was fully established between 1979 and 1983 and explicitly organized around PHC principles: a network of health centres staffed by family physicians and nurses progressively covered the entire country. Eligibility for benefits under the national health system requires patients to register with a family physician in a health centre as the first point of contact. Portugal considers this network to be its greatest success in terms of improved access to care and health gains⁶.

Life expectancy at birth is now 9.2 years more than it was 30 years ago, while the GDP per capita has doubled. Portugal's performance in reducing mortality in various age groups has been among the world's most consistently successful over the last 30 years, for example halving infant mortality rates every eight years. This performance has led to a marked convergence of the health of Portugal's population with that of other countries in the region¹⁰.

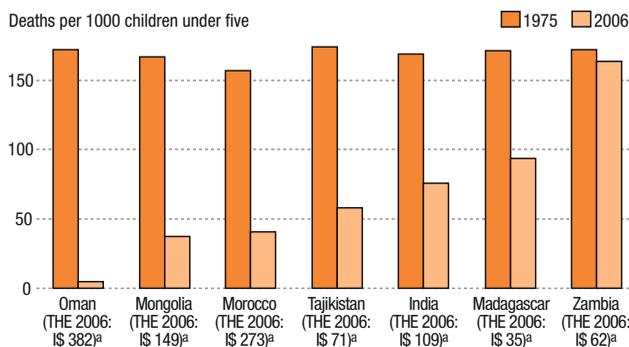
Multivariate analysis of the time series of the various mortality indices since 1960 shows that the decision to base Portugal's health policy on PHC principles, with the development of a network of comprehensive primary care services¹¹, has played a major role in the reduction of maternal and child mortality, whereas the reduction of perinatal mortality was linked to the development of the hospital network. The relative roles of the development of primary care, hospital networks and economic growth to the improvement of mortality indices since 1960 are shown in Figure 1.2.

Figure 1.2 Factors explaining mortality reduction in Portugal, 1960–2008



Some countries have made great improvements and are on track to achieve the health-related MDGs. Others, particularly in the African region, have stagnated or even lost ground¹⁴. Globally, 20 of the 25 countries where under-five mortality is still two thirds or more of the 1975 level

Figure 1.3 Variable progress in reducing under-five mortality, 1975 and 2006, in selected countries with similar rates in 1975^a



^a Total health expenditure per capita 2006, international \$.

are in sub-Saharan Africa. Slow progress has been associated with disappointing advances in access to health care. Despite recent change for the better, vaccination coverage in sub-Saharan Africa is still significantly lower than in the rest of the world¹⁴. Current contraceptive prevalence remains as low as 21%, while in other developing regions increases have been substantial over the past 30 years and now reach 61%^{15,16}. Increased contraceptive use has been accompanied by decreased abortion rates everywhere. In sub-Saharan Africa, however, the absolute numbers of abortions has increased, and almost all are being performed in unsafe conditions¹⁷. Childbirth care for mothers and newborns also continues to face problems: in 33 countries, less than half of all births each year are attended by skilled health personnel, with coverage in one country as low as 6%¹⁴. Sub-Saharan Africa is also the only region

in the world where access to qualified providers at childbirth is not progressing¹⁸.

Mirroring the overall trends in child survival, global trends in life expectancy point to a rise throughout the world of almost eight years between 1950 and 1978, and seven more years since: a reflection of the growth in average income per capita. As with child survival, widening income inequality (income increases faster in high-income than in low-income countries) is reflected in increasing disparities between the least and most healthy¹⁹. Between the mid-1970s and 2005, the difference in life expectancy between high-income countries and countries in sub-Saharan Africa, or fragile states, has widened by 3.8 and 2.1 years, respectively.

The unmistakable relation between health and wealth, summarized in the classic Preston curve (Figure 1.4), needs to be qualified²⁰.

Firstly, the Preston curve continues to shift¹². An income per capita of I\$ 1000 in 1975 was associated with a life expectancy of 48.8 years. In 2005, it was almost four years higher for the same income. This suggests that improvements in nutrition, education²¹, health technologies²², the institutional capacity to obtain and use information, and in society's ability to translate this knowledge into effective health and social action²³, allow for greater production of health for the same level of wealth.

Secondly, there is considerable variation in achievement across countries with the same income, particularly among poorer countries. For example, life expectancy in Côte d'Ivoire (GDP I\$ 1465) is nearly 17 years lower than in Nepal (GDP I\$ 1379), and between Madagascar and Zambia, the difference is 18 years. The presence of high performers in each income band shows that the actual level of income per capita at a given moment is not the absolute rate limiting factor the average curve seems to imply.

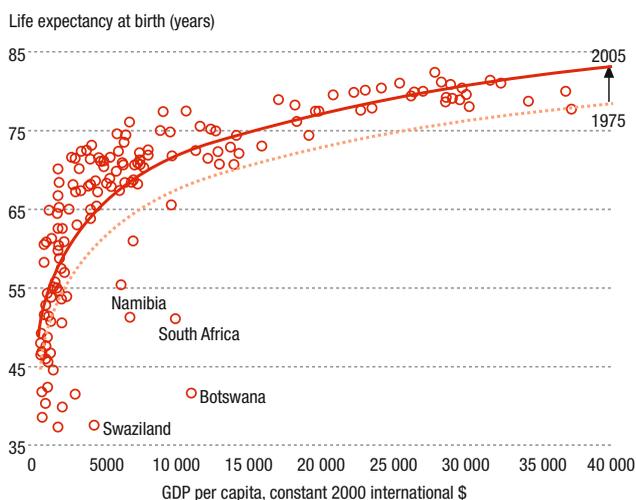
Growth and stagnation

Over the last 30 years the relation between economic growth and life expectancy at birth has shown three distinct patterns (Figure 1.5).

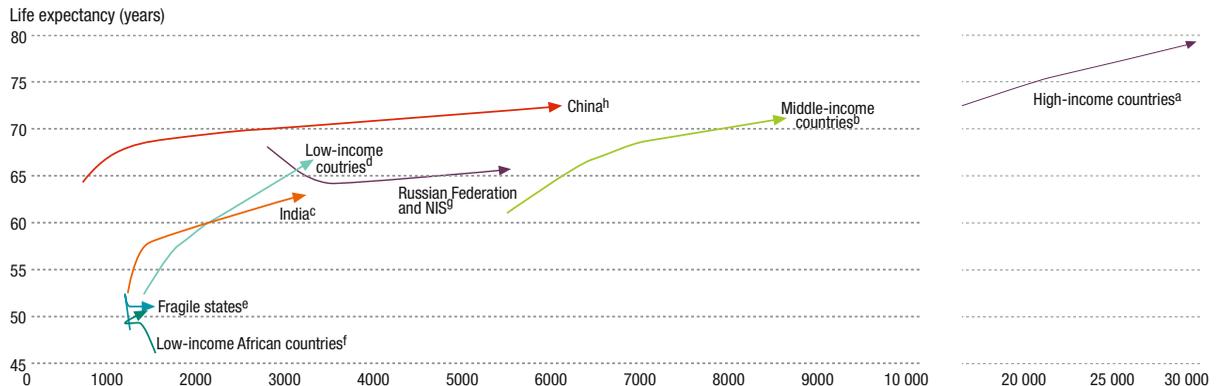
In 1978, about two thirds of the world's population lived in countries that went on to experience increases in life expectancy at birth and considerable economic growth. The most impressive relative gains were in a number of low-income countries in Asia (including India), Latin America and northern Africa, totalling 1.1 billion inhabitants 30 years ago and nearly 2 billion today. These countries increased life expectancy at birth by 12 years, while GDP per capita was multiplied by a factor of 2.6. High-income countries and countries with a GDP between I\$ 3000 and I\$ 10 000 in 1975 also saw substantial economic growth and increased life expectancy.

In other parts of the world, GDP growth was not accompanied by similar gains in life expectancy. The Russian Federation and Newly Independent States increased average GDP per capita substantially, but, with the widespread poverty that accompanied the transition from the former Soviet Union, women's life expectancy stagnated from the late 1980s and men's plummeted, particularly for those lacking education and job security^{24,25}. After a period of technological and organizational stagnation, the health system collapsed¹². Public expenditure on health declined in the 1990s to levels that made running a basic system virtually impossible in several countries. Unhealthy lifestyles, combined with the disintegration of public health programmes, and the unregulated commercialization of clinical services combined with the elimination of safety nets has offset any gains from the increase in average GDP²⁶. China had already increased its

Figure 1.4 GDP per capita and life expectancy at birth in 169 countries^a, 1975 and 2005



^a Only outlying countries are named.

Figure 1.5 Trends in GDP per capita and life expectancy at birth in 133 countries grouped by the 1975 GDP, 1975–2005*

^a 27 countries, 766 million (M) inhabitants in 1975, 953 M in 2005.

^b 43 countries, 587 M inhabitants in 1975, 986 M in 2005.

^c India, 621 M inhabitants in 1975, 1 103 M in 2005.

^d 17 Low-income countries, non-African, fragile states excluded, 471 M inhabitants in 1975, 872 M in 2005.

^e 20 Fragile states, 169 M inhabitants in 1975, 374 M in 2005.

^f 13 Low-income African countries, fragile states excluded, 71 M inhabitants in 1975, 872 M in 2005.

^g Russian Federation and 10 Newly Independent States (NIS), 186 M inhabitants in 1985, 204 M in 2005.

^h China, 928 M inhabitants in 1975, 1 316 M in 2005.

* No data for 1975 for the Newly Independent States. No historical data for the remaining countries.

Sources: Life expectancy, 1975, 1985: UN World Population Prospects 2006; 1995, 2005: WHO, 9 November 2008 (draft); China: 3rd, 4th and 5th National Population censuses, 1981, 1990 and 2000. GDP: 2007.³⁷

life expectancy substantially in the period before 1980 to levels far above that of other low-income countries in the 1970s, despite the 1961–1963 famine and the 1966–1976 Cultural Revolution. The contribution of rural primary care and urban health insurance to this has been well documented^{27,28}. With the economic reforms of the early 1980s, however, average GDP per capita increased spectacularly, but access to care and social protection deteriorated, particularly in rural areas. This slowed down improvements to a modest rate, suggesting that only the improved living conditions associated with the spectacular economic growth avoided a regression of average life expectancy²⁹.

Finally, there is a set of low-income countries, representing roughly 10% of the world's population, where both GDP and life expectancy stagnated³⁰. These are the countries that are considered as “fragile states” according to the “low-income countries under stress” (LICUS) criteria for 2003–2006³¹. As much as 66% of the population in these countries is in Africa. Poor governance and extended internal conflicts are common among these countries, which all face similar hurdles: weak security, fractured societal relations, corruption, breakdown in the rule

of law, and lack of mechanisms for generating legitimate power and authority³². They have a huge backlog of investment needs and limited government resources to meet them. Half of them experienced negative GDP growth during the period 1995–2004 (all the others remained below the average growth of low-income countries), while their external debt was above average³³. These countries were among those with the lowest life expectancy at birth in 1975 and have experienced minimal increases since then. The other low-income African countries share many of the characteristics and circumstances of the fragile states – in fact many of them have suffered protracted periods of conflict over the last 30 years that would have classified them as fragile states had the LICUS classification existed at that time. Their economic growth has been very limited, as has been their life-expectancy gain, not least because of the presence, in this group, of a number of southern African countries that are disproportionately confronted by the HIV/AIDS pandemic. On average, the latter have seen some economic growth since 1975, but a marked reversal in terms of life expectancy.

What has been strikingly common to fragile states and sub-Saharan African countries for

much of the last three decades, and differentiates them from the others that started out with less than \$ 3000 per capita in 1975, is the combination of stagnating economic growth, political instability and lack of progress in life expectancy. They accumulate characteristics that hamper improvement of health. Education, particularly of females, develops more slowly, as does access to modern communications and knowledge-intensive work that broadens people's intellectual resources elsewhere. People are more exposed and more vulnerable to environmental and other health threats that, in today's globalized world, include lifestyle threats, such as smoking, obesity and urban violence. They lack the material security required to invest in their own health and their governments lack the necessary resources and/or commitment to public investment. They are at much greater risk of war and civil conflict than richer countries³⁰.

Without growth, peace is considerably more difficult and without peace, growth stagnates: on average, a civil war reduces a country's growth by around 2.3% per year for a typical duration of seven years, leaving it 15% poorer³⁴.

The impact of the combination of stagnation and conflicts cannot be overstated. Conflicts are a direct source of considerable excessive suffering, disease and mortality. In the Democratic Republic of the Congo, for example, the 1998–2004 conflict caused an excess mortality of 450 000 deaths per year³⁵. Any strategy to close the health gaps between countries – and to correct inequalities within countries – has to give consideration to the creation of an environment of peace, stability and prosperity that allows for investment in the health sector.

A history of poor economic growth is also a history of stagnating resources for health. What

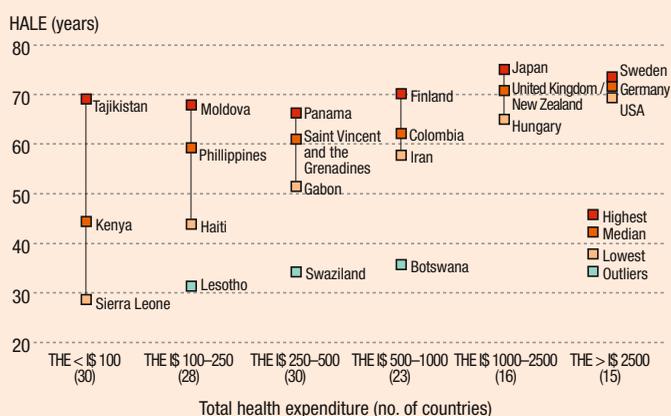
Box 1.2 Higher spending on health is associated with better outcomes, but with large differences between countries

In many countries, the total amount spent on health is insufficient to finance access for all to even a very limited package of essential health care³⁹. This is bound to make a difference to health and survival. Figure 1.6 shows that Kenya has a health-adjusted life expectancy (HALE) of 44.4 years, the median for countries that currently spend less than \$ 100 per capita on health. This is 27 years less than Germany, the median for countries that spend more than \$ 2500 per capita. Every \$ 100 per capita spent on health corresponds to a 1.1-year gain in HALE.

However, this masks large differences in outcomes at comparable levels of spending. There are up to five years difference in HALE between countries that spend more than \$ 2500 per capita per year on health. The spread is wider at lower expenditure levels, even within rather narrow spending bands. Inhabitants of Moldova, for example, enjoy 24 more HALE years than those of Haiti, yet they are both among the 28 countries that spend \$ 250–500 per capita on health. These gaps can even be wider if one also considers countries that are heavily affected by HIV/AIDS. Lesotho spends more on health than Jamaica, yet its people have a HALE that is 34 years shorter. In contrast, the differences in HALE between the countries with the best outcomes in each

spending band are comparatively small. Tajikistan, for example, has a HALE that is 4.3 years less than that of Sweden – less than the difference between Sweden and the United States. These differences suggest that how, for what and for whom money is spent matters considerably. Particularly in countries where the envelope for health is very small, every dollar that is allocated sub-optimally seems to make a disproportionate difference.

Figure 1.6 Countries grouped according to their total health expenditure in 2005 (international \$)^{38,40}



happened in sub-Saharan Africa during the years following Alma-Ata exemplifies this predicament. After adjusting for inflation, GDP per capita in sub-Saharan Africa fell in most years from 1980–1994³⁶, leaving little room to expand access to health care or transform health systems. By the early 1980s, for example, the medicines budget in the Democratic Republic of the Congo, then Zaïre, was reduced to zero and government disbursements to health districts dropped below US\$ 0.1 per inhabitant; Zambia’s public sector health budget was cut by two thirds; and funds available for operating expenses and salaries for the expanding government workforce dropped by up to 70% in countries such as Cameroon, Ghana, Sudan and the United Republic of Tanzania³⁶. For health authorities in this part of the world, the 1980s and 1990s were a time of managing shrinking government budgets and disinvestment. For the people, this period of fiscal contraction was a time of crippling out-of-pocket payments for under-funded and inadequate health services.

In much of the world, the health sector is often massively under-funded. In 2005, 45 countries spent less than I\$ 100 per capita on health, including external assistance³⁸. In contrast, 16 high-income countries spent more than I\$ 3000 per capita. Low-income countries generally allocate a smaller proportion of their GDP to health than high-income countries, while their GDP is smaller to start with and they have higher disease burdens.

Higher health expenditure is associated with better health outcomes, but sensitive to policy choices and context (Box 1.2): where money is scarce, the effects of errors, by omission and by commission, are amplified. Where expenditure increases rapidly, however, this offers perspectives for transforming and adapting health systems which are much more limited in a context of stagnation.

Adapting to new health challenges

A globalized, urbanized and ageing world

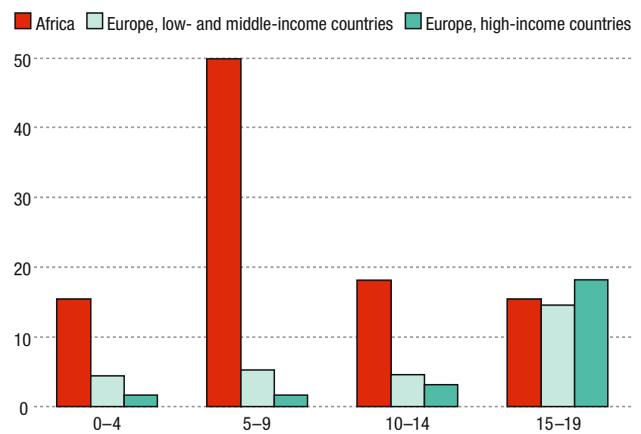
The world has changed over the last 30 years: few would have imagined that children in Africa would now be at far more risk of dying from traffic accidents than in either the high- or the low- and middle-income countries of the European region (Figure 1.7).

Many of the changes that affect health were already under way in 1978, but they have accelerated and will continue to do so.

Thirty years ago, some 38% of the world’s population lived in cities; in 2008, it is more than 50%, 3.3 billion people. By 2030, almost 5 billion people will live in urban areas. Most of the growth will be in the smaller cities of developing countries and metropolises of unprecedented size and complexity in southern and eastern Asia⁴².

Although on average health indicators in cities score better than in rural areas, the enormous social and economic stratification within urban areas results in significant health inequities^{43,44,45,46}. In the high-income area of Nairobi, the under-five mortality rate is below 15 per thousand, but in the Emabakasi slum of the same city the rate is 254 per thousand⁴⁷. These and other similar examples lead to the more general observation that within developing countries, the best local governance can help produce 75 years or more of life expectancy; with poor urban governance, life expectancy can be as low as 35 years⁴⁸. One third of the urban population today – over one billion people – lives in slums: in places that lack durable housing, sufficient living area, access to clean water and sanitation, and secure tenure⁴⁹. Slums are prone to fire, floods and landslides; their inhabitants are disproportionately exposed to pollution, accidents, workplace hazards and urban violence. Loss of social

Figure 1.7 Africa’s children are at more risk of dying from traffic accidents than European children: child road-traffic deaths per 100 000 population⁴¹



cohesion and globalization of unhealthy lifestyles contribute to an environment that is decidedly unfavourable for health.

These cities are where many of the world’s nearly 200 million international migrants are found⁵⁰. They constitute at least 20% of the population in 41 countries, 31% of which have less than a million inhabitants. Excluding migrants from access to care is the equivalent of denying all the inhabitants of a country similar to Brazil their rights to health. Some of the countries that have made very significant strides towards ensuring access to care for their citizens fail to offer the same rights to other residents. As migration continues to gain momentum, the entitlements of non-citizen residents and the ability of the health-care system to deal with growing linguistic and cultural diversity in equitable and effective ways are no longer marginal issues.

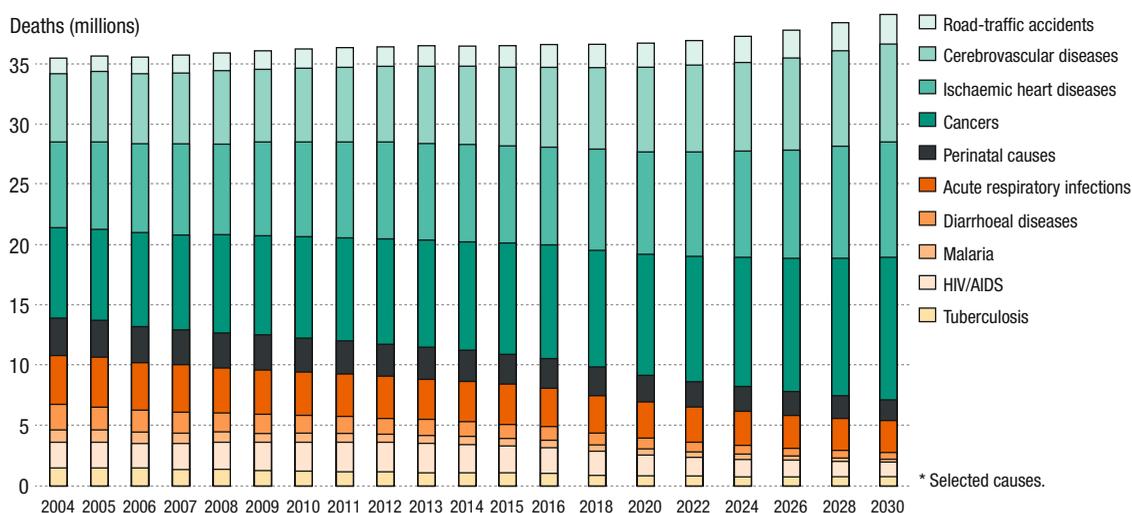
This mobile and urbanized world is ageing fast and will continue to do so. By 2050, the world will count 2 billion people over the age of 60, around 85% of whom will be living in today’s developing countries, mostly in urban areas. Contrary to today’s rich countries, low- and middle-income countries are ageing fast before having become rich, adding to the challenge.

Urbanization, ageing and globalized lifestyle changes combine to make chronic and noncommunicable diseases – including depression, diabetes, cardiovascular disease and cancers – and

injuries increasingly important causes of morbidity and mortality (Figure 1.8)⁵¹. There is a striking shift in distribution of death and disease from younger to older ages and from infectious, perinatal and maternal causes to noncommunicable diseases. Traffic accident rates will increase; tobacco-related deaths will overtake HIV/AIDS-related deaths. Even in Africa, where the population remains younger, smoking, elevated blood pressure and cholesterol are among the top 10 risk factors in terms of overall disease burden⁵². In the last few decades, much of the lack of progress and virtually all reversals in life expectancy were associated with adult health crises, such as in the Russian Federation or southern Africa. Improved health in the future will increasingly be a question of better adult health.

Ageing has drawn attention to an issue that is of particular relevance to the organization of service delivery: the increasing frequency of multi-morbidity. In the industrialized world, as many as 25% of 65–69 year olds and 50% of 80–84 year olds are affected by two or more chronic health conditions simultaneously. In socially deprived populations, children and younger adults are also likely to be affected^{53,54,55}. The frequency of multi-morbidity in low-income countries is less well described except in the context of the HIV/AIDS epidemic, malnutrition or malaria, but it is probably greatly underestimated^{56,57}. As diseases of poverty are inter-related, sharing causes that

Figure 1.8 The shift towards noncommunicable diseases and accidents as causes of death*





are multiple and act together to produce greater disability and ill health, multi-morbidity is probably more rather than less frequent in poor countries. Addressing co-morbidity – including mental health problems, addictions and violence – emphasizes the importance of dealing with the person as a whole. This is as important in developing countries as in the industrialized world⁵⁸.

It is insufficiently appreciated that the shift to chronic diseases or adult health has to come on top of an unfinished agenda related to communicable diseases, and maternal, newborn and child health. Efforts directed at the latter, especially in the poorest countries where coverage is still insufficient, will have to expand¹². But all health systems, including those in the poorest countries, will also have to deal with the expanding need and demand for care for chronic and noncommunicable diseases: this is not possible without much more attention being paid to establishing a continuum of comprehensive care than is the case today. It is equally impossible without much more attention being paid to addressing the pervasive health inequalities within each country (Box 1.3).

Little anticipation and slow reactions

Over the past few decades, health authorities have shown little evidence of their ability to anticipate such changes, prepare for them or even adapt to them when they have become an everyday reality. This is worrying because the rate of change is accelerating. Globalization, urbanization and ageing will be compounded by the health effects of other global phenomena, such as climate change, the impact of which is expected to be greatest among the most vulnerable communities living in the poorest countries. Precisely how these will affect health in the coming years is more difficult to predict, but rapid changes in disease burden, growing health inequalities and disruption of social cohesion and health sector resilience are to be expected. The current food crisis has shown how unprepared health authorities often are for changes in the broader environment, even after other sectors have been sounding the alarm bell for quite some time. All too often, the accelerated pace and the global scale of the changes in the challenges to health is in contrast with the sluggish response of national health systems.

Even for well-known and documented trends, such as those resulting from the demographic and epidemiologic transitions, the level of response often remains inadequate⁶⁴. Data from WHO's World Health Surveys, covering 18 low-income countries, show low coverage of the treatment of asthma, arthritis, angina, diabetes and depression, and of the screening for cervical and breast cancer: less than 15% in the lowest income quintile and less than 25% in the highest⁶⁵. Public-health interventions to remove the major risk factors of disease are often neglected, even when they are particularly cost effective: they have the potential to reduce premature deaths by 47% and increase global healthy life expectancy by 9.3 years^{64,66}. For example, premature tobacco-attributable deaths from ischaemic heart disease, cerebrovascular disease, chronic obstructive pulmonary disease and other diseases are projected to rise from 5.4 million in 2004 to 8.3 million in 2030, almost 10% of all deaths worldwide⁶⁷, with more than 80% in developing countries¹². Yet, two out of every three countries are still without, or only have minimal, tobacco control policies¹².

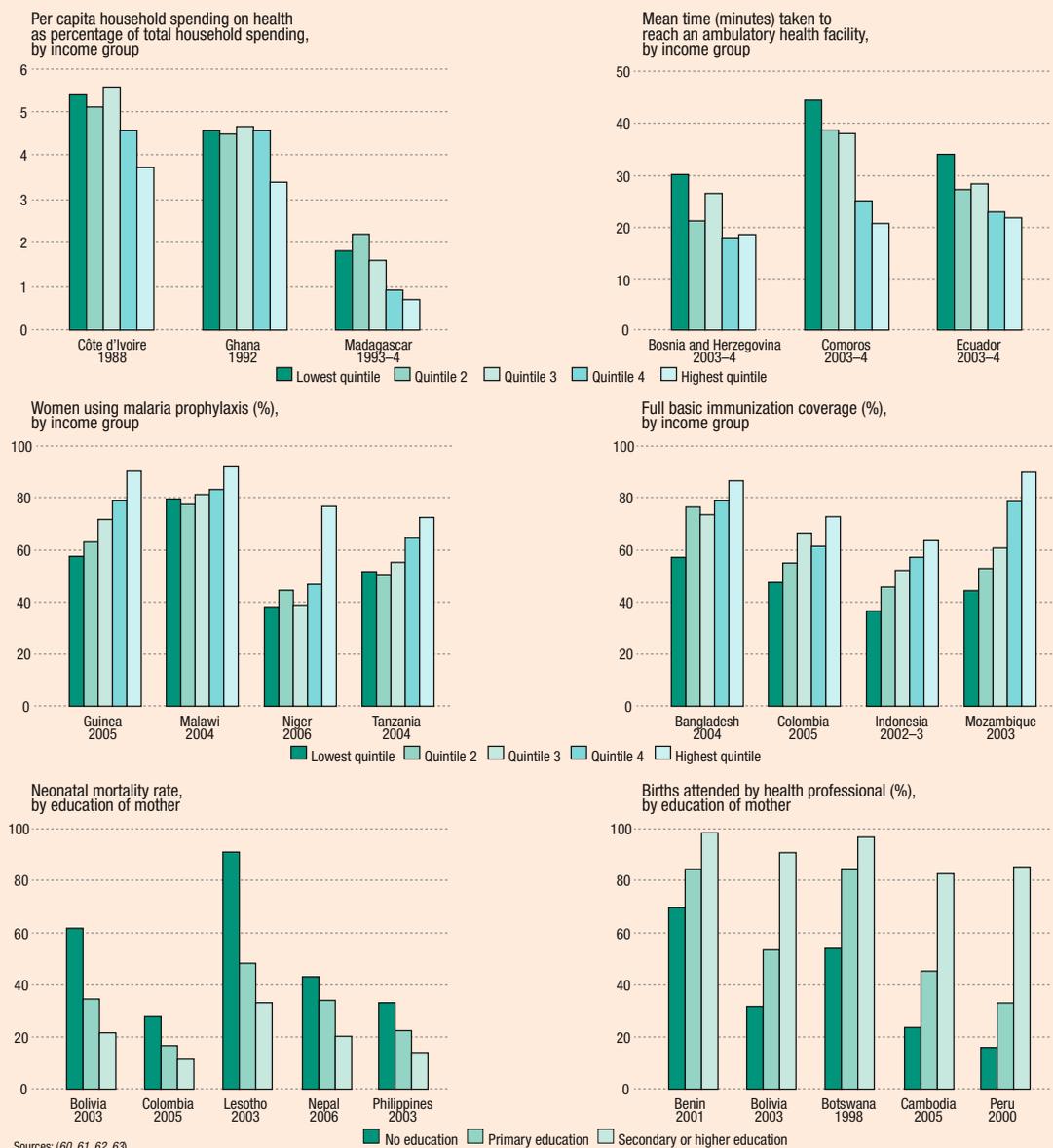
With a few exceptions – the SARS epidemic, for example – the health sector has often been slow in dealing with new or previously underestimated health challenges. For example, awareness of the emerging health threats posed by climate change and environmental hazards dates back at least to the 1990 Earth Summit⁶⁸, but only in recent years have these begun to be translated into plans and strategies^{69,70}.

Health authorities have also often failed to assess, in a timely way, the significance of changes in their political environment that affect the sector's response capacity. Global and national policy environments have often taken health issues into consideration, initiating hasty and disruptive interventions, such as structural adjustment, decentralization, blueprint poverty reduction strategies, insensitive trade policies, new tax regimes, fiscal policies and the withdrawal of the state. Health authorities have a poor track record in influencing such developments, and have been ineffective in leveraging the economic weight of the health sector. Many of the critical systems issues affecting health require skills and competencies that are not found within the medical/public health establishment. The failure

Box 1.3 As information improves, the multiple dimensions of growing health inequality are becoming more apparent

In recent years, the extent of within-country disparities in vulnerability, access to care and health outcomes has been described in much greater detail (Figure 1.9)⁵⁹. Better information shows that health inequalities tend to increase, thereby highlighting how inadequate and uneven health systems have been in responding to people's health needs. Despite the recent emphasis on poverty reduction, health systems continue to have difficulty in reaching both the rural and the urban poor, let alone addressing the multiple causes and consequences of health inequity.

Figure 1.9 Within-country inequalities in health and health care



Sources: (60, 61, 62, 63).



to recognize the need for expertise from beyond traditional health disciplines has condemned the health sector to unusually high levels of systems incompetence and inefficiency which society can ill afford.

Trends that undermine the health systems' response

Without strong policies and leadership, health systems do not spontaneously gravitate towards PHC values or efficiently respond to evolving health challenges. As most health leaders know, health systems are subject to powerful forces and influences that often override rational priority setting or policy formation, thereby pulling health systems away from their intended directions⁷¹. Characteristic trends that shape conventional health systems today include (Figure 1.10):

- a disproportionate focus on specialist, tertiary care, often referred to as “hospital-centrism”;
- fragmentation, as a result of the multiplication of programmes and projects; and
- the pervasive commercialization of health care in unregulated health systems.

With their focus on cost containment and deregulation, many of the health-sector reforms of the 1980s and 1990s have reinforced these trends. High-income countries have often been able to regulate to contain some of the adverse consequences of these trends. However, in countries where under-funding compounds

limited regulatory capacity, they have had more damaging effects.

Hospital-centrism: health systems built around hospitals and specialists

For much of the 20th century, hospitals, with their technology and sub-specialists, have gained a pivotal role in most health systems throughout the world^{72,73}. Today, the disproportionate focus on hospitals and sub-specialization has become a major source of inefficiency and inequality, and one that has proved remarkably resilient. Health authorities may voice their concern more insistently than they used to, but sub-specialization continues to prevail⁷⁴. For example, in Member countries of the Organisation of Economic Cooperation and Development (OECD), the 35% growth in the number of doctors in the last 15 years was driven by rising numbers of specialists (up by nearly 50% between 1990 and 2005 – compared with only a 20% increase in general practitioners)⁷⁵. In Thailand, less than 20% of doctors were specialists 30 years ago; by 2003 they represented 70%⁷⁶.

The forces driving this growth include professional traditions and interests as well as the considerable economic weight of the health industry – technology and pharmaceuticals (Box 1.4). Obviously, well functioning specialized tertiary care responds to a real demand (albeit, at least in part, induced): it is necessary, at the very least, for the political credibility of the health system. However, the experience of industrialized countries has shown that a disproportionate focus on specialist, tertiary care provides poor value for money⁷². Hospital-centrism carries a considerable cost in terms of unnecessary medicalization and iatrogenesis⁷⁷, and compromises the human and social dimensions of health^{73,78}. It also carries an opportunity cost: Lebanon, for example, counts more cardiac surgery units per inhabitant than Germany, but lacks programmes aimed at reducing the risk factors for cardiovascular disease⁷⁹. Inefficient ways of dealing with health problems are thus crowding out more effective, efficient – and more equitable⁸⁰ – ways of organizing health care and improving health⁸¹.

Since the 1980s, a majority of OECD countries has been trying to decrease reliance on hospitals,

Figure 1.10 How health systems are diverted from PHC core values

