Beyond Ebola: a new agenda for resilient health systems

A resilient health system is one able to absorb the shock of an emergency like Ebola and at the same time continue to provide regular health services, leaving other sectors of the country fully functioning. In Guinea, Liberia, and Sierra Leone, the 2014 Ebola outbreak has claimed many lives and laid waste to economies, food provision, and development. The World Bank's forecast[1] of tens of billions of dollars lost for the three affected countries and the broader west Africa region points to the interdependence between health and countries' wider socioeconomic landscape. It is clear, therefore, that a multisectoral, integrated approach, one that equips countries to absorb unforeseen severe shocks, is the only way to rebuild the health ecosystem and put these countries back on track for development.

This was the focus of a high-level meeting held in Geneva, Switzerland, on Dec 10–11, 2014, where Ministers of Health and Finance of Ebola-affected countries, international organisations, and development partners undertook to provide the technical and financial support, and effective development cooperation, to pull Guinea, Liberia, and Sierra Leone out of the crisis by establishing the grounds for resilient health systems.

Ebola became epidemic in Guinea, Liberia, and Sierra Leone in large part because the health systems in place were struggling to deal with routine care, let alone a deadly outbreak. Those systems already had gaps in all sectors, from workforce capacity to laboratory and other medical infrastructure, as well as a lack of adequate surveillance, information, and rapid response systems.

When the outbreak started, the limited public health services available were fully diverted to Ebola, leaving other health necessities uncovered. Additionally, health workers became ill and died from the virus.[2] The net result is that people have encountered substantial barriers in accessing needed care,[3] whether for Ebola or for more common health conditions, and as a consequence lost trust in the system.

But despite the tremendous challenges and human suffering that Ebola has engendered in Guinea, Liberia, and Sierra Leone, this crisis is also revealing itself to be a catalyst for much-needed change in our approach to global health. The lesson painfully learned shows that we do not need another vertical programme for a specific health condition or challenge.

As difficult as it might be to comprehend in the midst of the crisis, the day will arrive when Ebola will no longer be the principal health concern for the affected countries. Instead of focusing exclusively on Ebola, we need to build systems that are grounded in primary health-care principles and capable of responding to routine as well as unexpected challenges that might arise in the future. The work we have begun to do in Ebola-affected countries can serve as an example for all countries that might face shocks, now or in the future.

To accomplish this, the different levels of the health system need to work together in an integrated, cross-cutting way and link up with other sectors. In particular, national-level plans are essential to create a roadmap that all partners can use to define roles and responsibilities and to measure progress. Guinea, for example, is developing a national health plan that will emphasise universal health coverage and serve as a timeline with agreed roles and responsibilities.

Resilient subnational health systems are needed to provide person-centred, integrated, quality health services to the population. The local, district, and county levels are key focus points for planning and implementing for resilience. District-based approaches require strong coordination and management. Sierra Leone has already started to do this, by creating regional hubs with a full contingent of professionals who can act as stopgaps in service delivery and who can help to improve care quality through onsite training and supervision.

Andrew Aitchison/In Pictures/Corbis

Enhancement of community trust, engagement, and ownership will be key to building resilient systems for health.[4] This includes strengthening community health worker capacity and, more generally, partnering with communities in meaningful ways. More health workers are needed, and training must prepare them for the right competencies—ie, those that enable teamwork and flexibility. Investments should be focused on people. This will help to train more health workers and create employment, notably for young people. And this in turn will foster economic growth.

Early warning systems for all health threats should lead to full implementation of the International Health Regulations.[5] In parallel, information and surveillance systems need to be reinforced and might be most efficiently deployed at a regional level, through multicountry networks, to allow for cross-border control and response.

Substantial external financing will be needed to achieve many of these objectives. One important priority will be for countries to ensure donor coordination. Careful thought is needed about the financial landscape in these countries, as well as consideration of the financing policies needed to meet resource needs and ensure sustained recovery. The financing package will need to include mechanisms to reduce the burden of health expenditures for the populations by promoting financial protection, and to move towards universal health coverage goals.[6]

Finally, we need to consider how all partners can work together to maximise efficiency and effectiveness. This includes discussing roles and responsibilities that complement one another and take advantage of each one's relative strengths. Accountability for both countries and partners will be at the centre of building resilient systems for health. The work in supporting Ebola-stricken countries will need long-term commitments from all key actors. The durable gains associated with building a functional health system cannot be compromised for more visible but less effective "quick wins".

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Global health metrics needs collaboration and competition

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The most recent update on the global, regional, and national causes of death, presented in *The Lancet* by the GBD Mortality and Causes of Death Collaborators,[1] a large international consortium of researchers led by the Institute for Health Metrics and Evaluation, includes an unprecedented amount of data. The Global Burden of Disease Study (GBD) 2013 has provided internally consistent estimates of the causes of death for 1990–2013. The yearly number of deaths worldwide increased as a result of population expansion, from 47·5 million in 1990, to 54·9 million in 2013. In relative terms, mortality rates have steadily decreased, leading to an increase in global life expectancy from 65·3 years to 71·5 years.[1]

The clearest progress was in reduction of global child mortality from infectious causes such as pneumonia and diarrhoea, accompanied by decreasing mortality rates from cardiovascular diseases and cancer in high-income regions. The HIV/AIDS pandemic was the greatest challenge to overall progress during this period, resulting in substantially shortened life expectancy in sub-Saharan Africa. Non-communicable diseases gradually emerged as the most prominent contemporary threat to global public health. The ageing