

## **B I Health systems advocacy**

After years of neglect, ‘health systems strengthening’ in poor countries is receiving some attention. For example, the proposed health agenda for the G8 meeting in July 2008 focuses on health systems (Reich et al. 2008). The GAVI Alliance has invested \$500 million for health systems strengthening from 2006 to 2010 (GAVI 2007) and the World Bank’s (2007) most recent health strategy strongly emphasises health systems strengthening. Additionally, the World Health Organization’s (WHO) 2008 annual report will focus on primary health care and its role in health systems strengthening.

However, it is unclear what is meant by health systems strengthening. But this is important, especially because policies advocated to strengthen health systems may actually end up harming them. It is also important because the way in which health systems are financed and managed also influences the amount and distribution of income of those who produce and provide health care. There are many vested interests at play in discussions about health systems policies.

For example, some health-care practitioners might be keen on policies that will maximise their incomes; drug companies might be keen to maximise expenditure on medicines; and upper income groups may wish to promote health systems that separate them away from the poor. A strong health system may mean different things to different people.

Health systems policies also influence the orientation of health-care provision – for example, determining the mix of biomedical and social interventions, or the extent to which people are viewed as consumers who purchase a commodity versus citizens who receive health care from providers providing a service.

This chapter outlines the factors that undermine health systems, and describes a vision for what makes a ‘good’ health system.<sup>1</sup>



**IMAGE B1.1 An ill child with diarrhoea arrives by boat and is carried to a health clinic in Matlab, Bangladesh**

### **Health systems factors**

Several factors in low-income countries are often responsible for various negative health systems outcomes, notably: unfair, delayed or unavailable access to health care; inefficient (often unnecessary) health care; medical impoverishment resulting from out-of-pocket payments and a neglect of the underlying social and environmental determinants of ill-health.

In many countries, the resource base of health-care systems is inadequate. Volatile and unreliable health-care funding adds to the problem by making it difficult for countries to make medium- to long-term plans.

Another problem is disharmony. The governance and management of many health-care systems is like an orchestra with musicians playing different tunes without a conductor. The poor coordination of multiple donors and global health initiatives undermines coherent health systems planning, imposes large costs upon ministries of health and health workers who have to liaise with and report to a multitude of stakeholders, and fragments the provision of health care. When inappropriate conditionalities and agendas are imposed by external agencies it can weaken ministries of health.

While vertically organised programmes and selective health-care interventions have arisen partly as a consequence of underfunded and dysfunctional health-care systems, they can also aggravate the problem, cause duplication of systems and services, drain away skilled personnel from the public sector, and prevent integrated, context-based local health planning.

Weak public leadership and management in some countries may reflect the difficulty that ministries of health have in retaining good personnel, as well as the demoralisation that has accompanied the chronic deterioration of public-sector working conditions over the years. It may also reflect other broader deficiencies of governance such as corruption, a weak judiciary, civil conflict or a lack of capacity among civil society institutions to hold governments to account.

The enduring effects of structural adjustment programmes are another cause of dysfunctionality. The commercialised primary care sector, which accounts for the bulk of primary-level expenditure in most low-income countries, grew as a result of cuts in public-sector expenditure, and is largely disorganised and unregulated. As public services deteriorated, cash payments for the purchase of care and medicines became more common, deterring people from accessing health care and entrenching poverty.

More so in middle-income countries, private insurance markets can 'segment out' higher income groups into a separate system of health care, distancing them from the health needs of the poor and the problems of the public system. Although it is argued that the public sector will be able to focus on the poor and ensure access to a basic package of services, often a private system mainly catering for upper income groups will siphon out more resources than it relieves the public sector of workload. It also weakens the social commitment to cross-subsidisation, risk sharing and equitable health care.

The collapse of public-sector services and the increased share of private financing have led to greater market-driven care, and its problems of 'over-servicing'; accentuating a bias towards biomedical interventions at the expense of public health approaches; replacing provider collaboration with provider competition; and deteriorating levels of trust between patients and providers.

Supply-and-demand-driven care also underlies the international brain drain of skilled human resources from poor to rich countries, the diversion of scarce resources in some countries towards a 'health tourism industry' serving economically advantaged patients and contractors from high-income countries. Currently, the medical tourism industry has an estimated turnover of \$67 billion, a figure set to rise by 20 per cent a year (Macready 2007). Most of this turnover will be captured by commercial, private providers.<sup>2</sup>

### **The vision of a 'strong' health-care system**

There are no quick-fix solutions. Strengthening health systems requires a multidimensional programme of change and development, guided by a long-term vision. It also requires a set of guiding principles, specifically around:

- progressive health financing;
- pooling health finance to optimise risk-sharing and cross-subsidisation;
- fitting health-care expenditure and utilisation patterns according to need, rather than demand or the ability to pay;
- balancing population-based approaches to health with individualised health care;
- balancing needs-driven and rights-based health provision against commercialisation.

A strong health system should also operate as a social institution that promotes social solidarity, good governance and the right to essential health care.

Ideally, service providers would be adequately paid through a system that delinks their income from the delivery of health care (a critical condition for ethical behaviour and values within health systems), whilst encouraging quality and responsiveness through monitoring and evaluation, competition for non-financial rewards, fostering a culture of excellence and community empowerment.

With these principles in mind, a nine-point health systems development agenda for low-income countries was put forward by Global Health Watch (2006). This chapter now discusses key issues related to this agenda.

#### **I *Comprehensive human resource plans***

The nature of the human resources (HR) crisis in low-income health systems is well known (WHO 2006). There are too few health workers. Many of those are, furthermore, demotivated and inadequately trained, supported and supervised. There is also often a maldistribution of health workers, with a high concentration in urban areas. In many countries the public sector struggles to retain skilled staff because of low salaries relative to the private and non-government sector.

One positive development was the creation of the Global Health Workforce Alliance in 2006 and a Global Forum on the Human Resources for Health Crisis, which was held in Kampala in March 2008. But, overall, there has been inadequate progress made in addressing the crisis.

Another less recent but extremely positive initiative was Malawi's six-year Emergency Human Resource Programme (EHRP), supported by the UK

Department for International Development and a grant from the Global Fund (Palmer 2006). The EHRP takes a five-pronged approach:

- improving incentives for recruitment and retention of public-sector and CHAM staff through a 52 per cent salary top-up for eleven professional and technical cadres, coupled with a major initiative to recruit and re-engage qualified Malawian staff;
- expanding domestic training capacity, including doubling the number of nurses and tripling the number of doctors in training;
- using international volunteer doctors and nurse tutors as a short-term measure to fill critical posts while Malawians are being trained;
- providing technical assistance to bolster Ministry of Health capacity in HR planning, management and development;
- establishing robust HR monitoring and evaluation capacity.

In addition, the programme explicitly recognises the importance of improving policies on postings and promotions, training and career development, and incentives for deploying staff to underserved areas (which includes a major effort to improve staff housing).

Sadly, the degree of international support for strengthening and replicating this programme to other countries has been limited. In many countries, effective human resource planning cannot even begin because of a lack of data on the existing number, distribution, location and income of health workers (McCoy et al. 2008). There is a particular lack of data on health workers in the private sector, which makes it difficult for ministries of health to shape the labour market according to sector-wide, priority health needs. Governments, the WHO, the International Labour Organization, research funders and research institutions need to ensure that the data required to produce detailed HR situation analyses are generated. In addition, they need to encourage much greater investment in HR policy research, an aspect of health research that is greatly neglected (Chopra et al. 2008).

Ministries of health, NGOs and donor agencies should also coordinate their HR recruitment and deployment policies rather than competing with each other over scarce staff. Recently, a group of international NGOs developed a code of conduct to discourage NGOs from inadvertently undermining the public sector by, among other things, recruiting its staff.<sup>3</sup>

In the meantime, many responses to the HR crisis have focused on the delegation of tasks to 'lower' and less costly cadres of health worker. Such efforts have shown that well-trained nurses, non-physician clinicians and lay workers can be trained to carry out skilled tasks (Dovlo 2004).

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However, a system of fair pay will be important to maintain morale and avoid exploitation.

Interventions to improve the retention, motivation and payment of health workers in the public sector remain mostly neglected, especially for health workers operating in isolated and difficult circumstances. These include enhancing working conditions and the quality of supervision; addressing on-the-job safety and security concerns; and improving management of the payroll.

Despite efforts by the Commonwealth Secretariat to promote voluntary ethical codes of conduct when it comes to high-income countries recruiting health workers from low-income countries, commercial recruitment agencies still operate aggressively in resource-poor countries (Mills et al. 2008). This practice could be stopped if the international community was serious about tackling the crisis.

Finally, for the public sector, there has been insufficient progress made in getting the International Monetary Fund (IMF) and ministries of finance to lift inappropriate ceilings on public-sector wage bills, which prevent some governments from paying public-sector health workers an adequate wage or expanding the public workforce (CGD 2007; Marphatia et al. 2007).

#### *2 Adequate, sustainable and reliable public financing for the health system*

An adequate human infrastructure for health systems in low-income countries will require increased levels of health expenditure. There are three possible strategies. First, low-income countries can improve health expenditure by increasing their public budgets through more efficient and effective systems, and then allocating a higher proportion of the public budget to health. Second, high-income countries could reach the long-standing target of allocating 0.7 per cent of gross national income (GNI) to development assistance, and commit to reliable transfer of funds for periods of five to ten years. Third, in a globalised world economy, public finance should be generated at the global level, possibly through an international tax authority of some sort that could help reclaim the hundreds of billions of dollars of public revenue lost due to tax avoidance and tax competition (Tax Justice Network 2007). In addition to generating revenue for health and poverty eradication, regulation of global finance and banking could help reduce levels of corruption.

In terms of the first strategy, civil society action to raise the level of domestic public spending on health has been inadequate. Few African countries have reached the Abuja target of allocating 15 per cent of their public budget to health, and in many low-income countries public revenues are a small proportion of gross domestic product (GDP). The effectiveness

and accountability of national tax regimes in many low-income countries can and should be strengthened.

So far as the second strategy is concerned, high-income countries have begun to increase volumes of development assistance in recent years. However, it is still a paltry amount that falls far short of the UN target (see D2). Furthermore, much health aid is used poorly, as discussed in later chapters in this book.

So far as the third strategy is concerned, there is still limited political appetite for tackling the problems of capital flight, tax avoidance and tax evasion. The Tax Justice Network campaigns to help low- and middle-income countries reclaim their lost public revenue – they need greater support from the health community, who in turn would benefit from higher levels of health expenditure.

One recent positive development came in 2006 when an international air ticket ‘solidarity levy’ was established by France, Brazil, Chile, Great Britain and Norway. The money raised is dedicated to projects addressing HIV/AIDS, TB and Malaria and is pooled and administered by a new organisation called UNITAID. By the middle of 2007, thirty-four countries had committed to implementing this levy. UNITAID’s expenditure of about US\$300 million in 2007 is a relatively small amount of money, but it does represent an innovative new source of global public revenue generation.<sup>4</sup>

### **3 *Harmonised, sector-wide coordination and planning***

Effective and coherent health systems development requires effective and coherent health-sector stewardship. In many countries, this doesn’t exist for two reasons. First, external development assistance for health is uncoordinated and fragmented. Second, ministries of health are not providing enough effective leadership. Much greater attention needs to be paid to sector-wide funding, budgeting and planning; developing the capacities of ministries of health to provide effective leadership; and enabling civil society organisations to hold both donors and governments to account. These issues are discussed in greater detail in Chapters D1.1 and D1.4.

### **4 *Unhindered access to essential health care***

User fees remain an intolerable barrier to essential health care. In many countries, the abolition of user fees in the public sector requires an increase in public health budgets, as discussed earlier. All countries should, as a first step, adopt a target to reduce direct out-of-pocket payments to less than 20 per cent of total health-care expenditure.

Community-based health insurance (CBHI) – also called community-based financing, mutual health organisations, and micro-insurance



**IMAGE BI.2 Women in Sudan attend a birthing ceremony**

programmes for health – is sometimes suggested as a way to mitigate the impact of user fees. The aim of CBHI is to encourage individuals to make prepayments for health care which can be pooled and then used to insure households against the costs of health care. However, the potential of CBHI is limited for several reasons (least of all the fact that poor households would find it difficult to contribute to such a scheme), which are discussed in an accompanying GHW document that can found at [www.ghwatch.org/](http://www.ghwatch.org/).

Another proposal for raising and organising health finance is social health insurance (SHI), where money is raised directly from the payrolls of employed individuals and then pooled into a health insurance fund. In some countries, SHI only covers those in formal employment, leaving those in informal employment or who are unemployed to be covered by a separate system of public financing. In some countries, SHI schemes receive public subsidies to include those who are unemployed, indigent or working in the informal sector. In many countries, policies to encourage SHI may represent a positive step forward, but there are various pros and cons that need to be carefully weighed. This is discussed in an accompanying GHW document that can found at [www.ghwatch.org/](http://www.ghwatch.org/).

A number of options are open to countries to remove the harmful and inequitable impacts of user fees. Civil society organisations (CSOs), however, need to study the political, economic and health systems context of each country carefully before adopting a campaigning strategy for health financing that is appropriate and feasible.



### **5 *Effective health-sector management***

The clear need to improve public-sector governance and management at all levels of the health system in many countries appears to be largely ignored by donors and international health policy experts. As well as improving HR planning and management, other aspects of health management which need to be highlighted include resource management and planning; expenditure monitoring; financial management; information management; essential drugs management; and operational research. These are all aspects of health systems strengthening that civil society organisations need to be monitoring just as carefully as they monitor progress in relation to coverage of disease-based clinical interventions.

In order to force the issue, CSOs in low-income countries could be supported to demand the regular production of national health accounts to describe how health care is financed as well as the pattern of expenditure across geographic areas, socio-economic groups, and between secondary/tertiary hospitals and district health services. This will improve government and donor accountability and strengthen health and management information systems.

However, the current predisposition towards organising health systems as a patchwork of vertical programmes and fragmented projects is distracting attention away from the 'slow-fix' solutions required to tackle deep-rooted deficiencies in health systems management.

### **6 *Vertical and horizontal alignment***

Although selective and vertical interventions make important contributions to health, the present configuration of multiple funding channels and programmes is hindering the important requirement for integration and coherent health systems development. Rationalisation of the global health aid architecture and sector-wide coordination and management will help improve this situation. But there is a need for a more bottom-up approach and agreement on a common and cross-cutting set of health systems indicators that can be shared by all agencies and programmes. There could also be agreement that certain aspects of a health-care system, such as the supply and distribution system of medicines and laboratory services, should not be duplicated, and certain key components of management, such as information systems, should be aligned.

### **7 *Public accountability and community involvement***

For public-sector bureaucracies to work effectively, efficiently and fairly, they need to be held accountable internally through rules and codes of

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conduct, and to communities and the public. Sector-wide budgets and a commitment to public stewardship are insufficient in themselves to get health systems working well – the public sector also needs to be kept honest and accountable. The scope of civil society activities involved in strengthening health-care systems include advocacy, monitoring and participating in planning and decision-making. Civil society can call for streams of funding to support civil society engagement in such activities, either from sector-wide budgets or from external sources.

##### 8 *The district health system*

The district health system (DHS) provides a framework for the integration of policies, programmes and priorities emanating from the centre; for health plans and programmes to be tailored to the needs and characteristics of local populations; and for better community involvement in health. The WHO and others have for many years promoted the rationale of the DHS model. However, implementation has been undermined by the effects of structural adjustment programmes; the persistence of vertical programmes and top-down management cultures; market-based policies; and a reluctance to invest in district-level health management structures with authority, status and skills.

Civil society can advocate for the promotion of the DHS model as an organisational basis for health systems. In countries where non-government providers supply a significant amount of health care, health districts can form the basis for improved collaboration and joint planning with public-sector providers.

##### 9 *A private sector harnessed to serve the public good*

In many countries, a large proportion of health-care provision is carried out by the private sector, much of it by unregulated, small-scale and disorganised private dispensaries, clinics and ‘pavement doctors’. This unregulated network of private provision threatens to expand in the current commercial climate favoured by actors such as the Gates Foundation and the World Bank.

Many governments currently lack the capacity to monitor the quality of this health care, let alone improve its quality. This capacity needs to be developed. Meanwhile, civil society can advocate for:

- the completion of in-depth studies of the quality of care provided by the primary-level private sector;
- strategies to integrate the private sector into a structured and accountable framework of standards;

- policy instruments, such as licensing requirements, formal accreditation and price controls, to regulate and improve the quality of care of this sector.

In some countries, further steps need to be taken to regulate organised private insurance markets and to amalgamate them into larger pools of financing, where appropriate. Civil society can call for:

- a review of private insurance markets and private hospitals, and their impact on the public sector;
- laws to promote community rating and prescribed minimum benefits where private insurance schemes exist, and to block payment systems that encourage over-servicing.

### Final comment

While it may be easier to advance the goal of ‘health for all’ through the more straightforward agenda of diseases, it is vital that civil society organisations are able to demystify the set of multiple and technical issues related to health systems in order to campaign on behalf of detailed health systems policies that will promote equity, effectiveness and sustainability in the long run.

### Notes

1. For a detailed discussion on health systems, see *Global Health Watch 2005–2006*.
2. See [www.ghwatch.org/](http://www.ghwatch.org/) for a more detailed description of medical tourism.
3. See <http://depts.washington.edu/haiuw/news/newsletters/2007–09.html>.
4. See [www.unitaid.eu](http://www.unitaid.eu) and [www.ghwatch.org/](http://www.ghwatch.org/) for more details.

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