HEALTH SYSTEMS KNOWLEDGE NETWORK (KN)

DISCUSSION DOCUMENT No.1

PROPOSED AREAS OF INVESTIGATION FOR THE KN: AN INITIAL SCOPING OF THE LITERATURE

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by

The Health Systems Knowledge Network Hub

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Acknowledgements and caveat

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The paper has benefited from extensive comments provided by reviewers of an earlier document (Doherty, Gilson and TARSC/EQUINET 2005). These reviewers included members of the consortium running the Knowledge Network Hub, the Secretariat of the Commission on the Social Determinants of Health, and the World Health Organisation, as well as some of the Commissioners. Our thanks are due to these reviewers who helped us to identify and clarify priority areas for consideration. However, the views expressed in this paper are those of the authors and do not necessarily represent the decisions, policy or views of WHO, IRDC, Commissioners or the Health Systems Knowledge Network.

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1 Background

During July and August 2005 the Health Systems Knowledge Network Hub produced a wide-ranging literature review for discussion at a meeting in India between Hubs and the rest of the Commission on the Social Determinants of Health (Doherty, Gilson and TARSC/ EQUINET 2005). The review was based on literature sourced from within the consortium managing the hub as well as from institutions networked with the consortium members. Some key references from existing materials were also followed up. Given the wide scope of work on health systems, it was not feasible to conduct a general electronic search. Nor was it possible to access substantial quantities of grey literature, given the difficulties associated with identifying and locating copies of this type of literature. Because of time constraints, the review focused on reviews of international experience and articles documenting new lines of investigation. Articles that were, at the time, in press were specifically sought out to ensure as up-to-date an evidence base as possible.

The review began by presenting data showing that health services tend to be used proportionately more by richer than poorer social groups. It analysed the social factors affecting access to, and uptake of, health services and showed how these interact with inequitable features of the health care system. Overall, the review argued that the interaction between household health-seeking behaviour and experience of the health system generates differential health and economic consequences across social groups. The long-term costs of seeking care often impoverish poorer households, reinforcing pre-existing social stratification.

The review then examined in some detail the features of the health care system that contribute to inequity (such as certain approaches to priority-setting, resource allocation, financing, organisation, human resources, and management and regulation). Discussions at the meeting in India, as well as subsequent interaction with reviewers and the Commission, suggested that the future work of the Health Systems Knowledge Network (KN) should focus not so much on these individual features, but on the high-level policy approaches – and on the macro-level 'architecture' of the health system – that create an environment where health equity and health care equity can be promoted. For example, while persistent health inequities appear to be the norm in many countries, there are instances where good improvements in health status have been achieved across socio-economic groups, even within the context of low average per capita income: what are the characteristics of health systems and strategies of government in these settings that have enabled this to occur?

Consequently, the Commission Secretariat has defined the scope and purpose of the Health Systems KN as presented in **Box 1** (the full terms of reference are provided separately). This discussion document, then, extracts parts of the original review that talk to the issues prioritised by the Secretariat. It is intended to provide a starting point for deliberations at the first meeting of the Health Systems KN (from 6-8 March 2006) around pieces of work that should be commissioned under its aegis (a summary of initial ideas on such pieces of work will be provided at the meeting).

Box 1: Scope and purpose of the Health Systems KN as laid out in its Terms of Reference

Scope

The way health systems are designed, operate and financed act as a powerful determinant of health. They modify the effects of other upstream determinants on health and thus by design should be sensitive to overcoming these barriers to access to health care. Evidence on the effectiveness of different models for health systems to improve health equity outcomes will be reviewed. In an effort to gather and subsequently mainstream knowledge and action on how to overcome social barriers to health, the focus will be on innovative approaches that effectively incorporate action on social determinants of health (eg. integrated goal setting and budgeting, intersectoral programming and financing etc.) and on strategies of policy development and implementation. The recommendations of this group will be highly relevant in those resource scarce country contexts where budgets are allocated vertically to a variety of government bodies which forces them to compete fiercely for funds.

Purpose

The purpose of the Knowledge Networks is to synthesize knowledge to inform the Commission of opportunities for improved action on social determinants of health by fostering the leadership, policy, action and advocacy needed to create change.

2 A framework for understanding the health system as a social determinant

This section adapts the Commission's conceptual framework (Commission on Social Determinants 2005) to the health systems domain. The boxes in the upper section of **Figure 1** describe the 'vicious cycle' set up by inequity, with social stratification leading to differential exposure and vulnerability to ill-health, resultant health inequity and finally differential consequences of ill-health, which in turn reinforce and perpetuate social stratification.

The boxes in the lower section of the Figure show how social determinants influence this cycle. Structural determinants (such as income, education, gender, ethnicity and social cohesion) set up social stratification. The dotted arrow above this box symbolises policies and interventions that may influence structural determinants so that they worsen social stratification, leave social stratification untouched, or confront social stratification so that the 'vicious cycle' becomes less intense or disappears. Negative or neutral impacts on equity may reflect a failure to respond to equity concerns (deliberately, unwillingly or inadvertently) or problems with implementation.

Intermediary determinants ensure that social stratification is carried forward into the next steps of the cycle (again, policies and interventions may influence these determinants in a negative, neutral or positive way, and may reflect either a failure to develop policy or a failure to implement).[4] Amongst these intermediary determinants, living conditions, working conditions and food availability have primarily been seen to influence the generation of differential exposure and vulnerability (but may have impacts further along the cycle as well, as shown by the Figure). The health system has primarily been seen to influence the translation of differential exposure and vulnerability into health inequity through providing access to health care. However, it also has prior impact through contributing to the barriers to adopting health-promoting behaviour, and subsequent impact through the creation of differential consequences (for example, in that the cost burdens of ill-health can contribute to the impoverishment of households).

Importantly, structural and intermediary determinants influence one another (as shown by the double-lined arrows between the two grey boxes). Thus, gender inequalities in society at large may translate into power relations within the health system that favour men and lead to decisions within the health system that reinforce patterns of gender-based access to resources. Conversely, health system features that reduce social exclusion within communities, for example, could elevate the status of marginalised communities, improving their access to resources in general. These features might include participatory decision-making structures or mechanisms for ensuring health system accountability to the population.

Likewise, there is interaction between the various sorts of intermediate determinants (as shown by the double-lined arrow that loops back on itself just to the left of the intermediary determinants box), with health policy literature paying particular attention to the potential for the health sector to influence policies around social welfare, education, nutrition, water and sanitation, in the interests of good health. This implies that policies to reduce health inequity must of necessity be multi-factoral.

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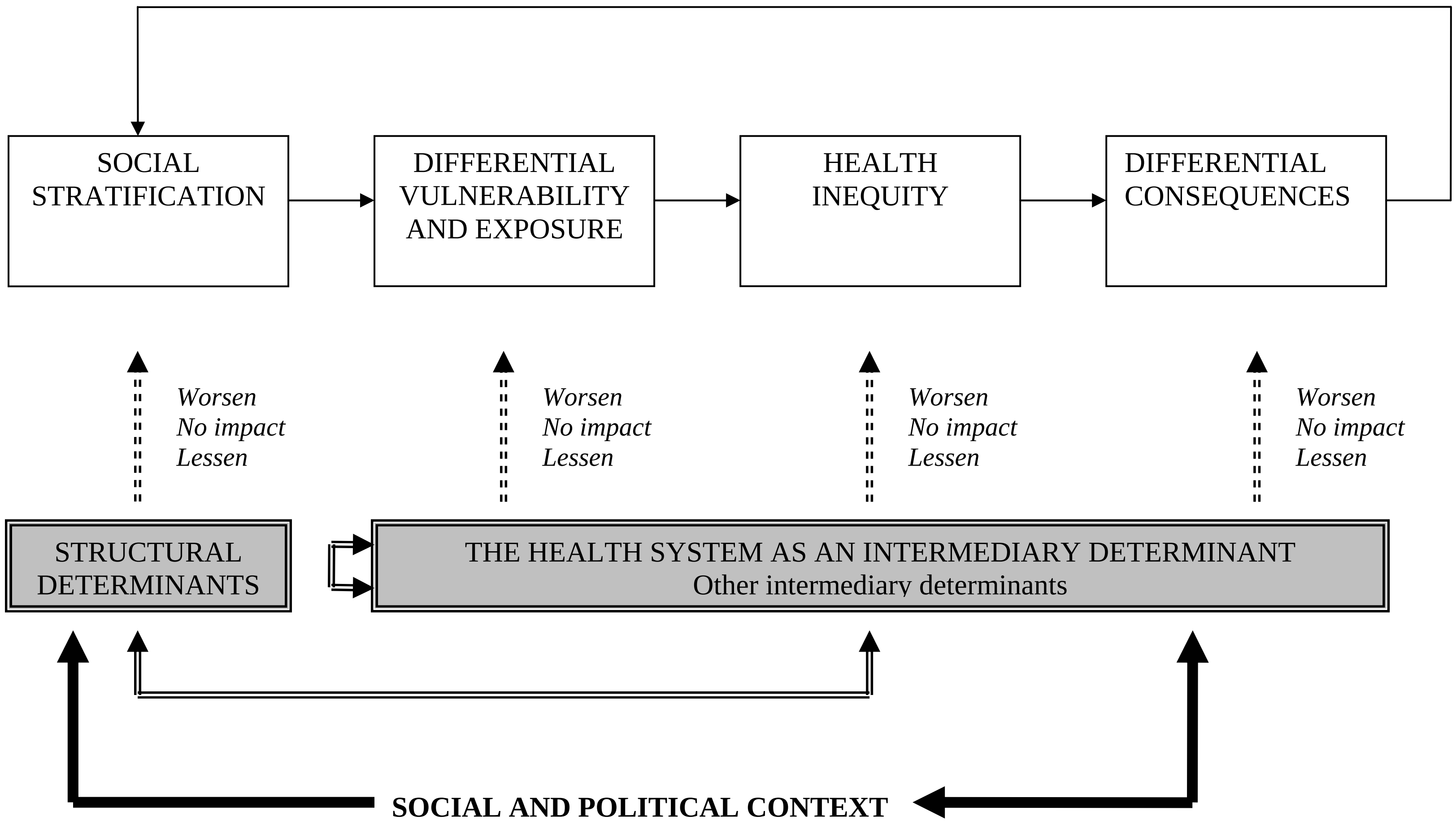
[4] For example, the health system can a) fail to identify or mount a response to an existing inequity (for example, by failing to include reproductive health services in an essential package), b) aggravate an existing inequity and its differential consequences (for example, by imposing retrogressive user fees which lead to impoverishment) or c) fail in its implementation of an intervention (for example, by failing to target the poor appropriately through an exemption mechanism for user fees).

Figure 1: Framework demonstrating the role played by the health system as a social determinant of health



As the dark arrows at the bottom of the Figure show, the social determinants of health arise within a wider global, national and local context of values, rights and macro-level policies that influence health (the impact of globalisation is pertinent here, for example). The bi-directional nature of the arrow between 'context' and the health system points to the potential for policy change within, and by, the health system to influence that context. Indeed, Mackintosh (2001) suggests that health systems are 'a key site for contestation of existing inequality.' This is echoed by the UN Millenium Project's Task Force on Child Health and Maternal Health which states that 'as core social institutions, dysfunctional and abusive health systems intensify exclusion, voicelessness, and inequity, while simultaneously defaulting on their potential – and obligation – to fulfill individuals' rights and contribute affirmatively to the building of equitable, democratic societies' (Freedman *et al.* 2005).

The rest of this document discusses some of the international experience of instances when the health system has realised its affirmative potential, focussing on what seem to be priority areas for action if the health system is to address health inequity and the social determinants of ill-health, namely:

- **Building the national policy space for health policies that seek social justice;**
- **Ensuring effective governance of health systems and policies intended to secure social protection and universal coverage;**
- **Using the health sector to leverage inter-sectoral actions that address the social determinants of health;**
- **Designing key features of health system architecture to secure social protection and universal coverage; and**
- **Strengthening management and stewardship capacities within the health sector.**

The work of the KN over the next year will be to deepen understanding of the international evidence on how such actions may be achieved.

3 Building the national policy space for health policies that seek social justice

The literature on how policy-makers can maintain the space – at global, national and local levels - to build health systems based on values of equity and social justice in the face of broader forces such as market reforms, conflict and globalization, is scant but growing. Much of it has emerged as a result of critiques of health sector reforms in the 1990s, which are characterized as largely technocratic in character and founded on a neo-liberal ideology that elevates the role of the private sector (see, for example, Global Health Watch 2005-6, Ravindran and de Pinho 2005). This body of literature suggests a number of strategies that re-assert the importance of the state in securing health (see, for example, World Health Organisation 2000), and emphasizes the importance of values and community views in shaping the health system. Some examples that signal the critical importance of political factors in achieving equity-promoting change are discussed below.

Sri Lanka is an example of a country that, for many decades, has explicitly upheld equity as a key driver of its policies, resulting in excellent health outcomes relative to its GDP. In Sri Lanka, the government has assumed the responsibility of providing universal health care free at the point of entry, has established an extensive network of public health services, and ensured that hospital care is available for catastrophic illness. The reasons for Sri Lanka's success include (McNay, Keith and Penrose 2004): cultural, social and historical reasons (such as relative gender equality, democracy, consensus on national priorities); synergies between health and other policies (including free education, subsidization of food, and improvements in water and sanitation); and policy decisions in health which, in many ways, ran counter to the received wisdom of the international community (including an emphasis on public financing of inpatient rather than outpatient care, the creation of a motivated and trained workforce, and the rejection of cost recovery as a financing policy).

Like Sri Lanka, China, Costa Rica, Cuba and the Indian state of Kerala have also achieved remarkable improvements in health outcomes in the past. With Sri Lanka, they shared five common social and political factors: historical commitment to health as a social goal; a social welfare orientation to development; community participation in decision-making processes related to health; universal coverage of health services for all social groups; and inter-sectoral linkages for health (Halstead, Walsh and Warren 1985, Commission on Social Determinants 2005). However, all of these countries' health systems have proved vulnerable to external shocks and domestic political change (Commission on Social Determinants 2005).

The Brazilian Government has underpinned its policies aimed at universal comprehensive and redistributive health services with a constitutional provision of the right to health. This enables social and legal processes to secure the principles of the system against encroachment from contrary political influence and economic policies.

Mexico City has recently embraced notions of equity and experienced considerable success in providing free health care and drugs to the poor, and food support to the elderly (Laurell, Zepeda and Mussot 2005). The free health care programme covered 65 percent of the target population after only three years. Unfortunately, the literature does not yet analyse what facilitated the introduction of these new policies by the new city council when prior governments had focused on pro-market policies and small-scale, targeted programmes, although the election of a new political party, strong leadership and values-based actions (such as the tackling of corruption and reduction of unnecessary expenditures) are likely to have been critical factors. The paper by Laurell, Zepeda and Mussot (2005) signals that many of the initial gains were made by a redistribution of available resources within the public social welfare system, and that the mobilisation of new resources from economic activities was more difficult to lever. Interestingly, the successful experience of Mexico City occurred within a health system which in general had little impact on fair financing, quality of care and democratic governance, although reforms were instituted in the late 1990s that had some impact on access by the poor to health care (Gomez-Dantes, Gomez-Jauregui and Inclan 2004).

Unfortunately, the available health literature about these experiences suffers from several weaknesses. First, limited attention is paid to understanding the influence of contextual features in explaining the trajectory of country experiences, which makes it difficult to derive lessons on ways in which context can be taken into account when developing and implementing policy. Second, although some literature is emerging, there remains little understanding of how to build, organise and consolidate the political support for equity and social justice where states are fragile, particularly in the many conflict and post-conflict settings of Africa. Third, little connection is generally made to the wider literature examining how states have managed socio-economic development more generally, yet such literature has important lessons for the health sector. Fourth, there is little examination of the particular strategies used in managing the powerful national and local level actors influencing health systems that are commonly resistant to equity-promoting change.

In relation to this last point, it has previously been mentioned that re-orienting health systems towards an equity focus is not simply a technical process structured around evidence. It is rather a process based on values, where there are likely to be competing interests, and which demands political, health sector and social leadership (for example, Nelson 1989, Williams and Satoto 1983). These competing interests may manifest within the public health system itself (for example, through resistance to change from health professional organisations or from front-line health workers), or within the rest of government (for example, Ministries of Finance may resist reforms that affect patterns of taxation). Particularly strong opposition may derive from the private sector, such as private providers and the pharmaceutical industry. In the era of globalisation, international interests may be challenged: for example, multi-national corporations have had a strong influence on international policies on trade in goods and intellectual property rights, with a view to protecting corporate interests (and in many cases strengthening monopolies), with negative implications for access to drugs in developing countries.

Indeed, the increasing role of World Trade Organisation agreements in services and health-related policy has important implications for pro-equity health policies. For example, a country that has opened its market to financial services, including foreign insurance firms providing health insurance, may find it more difficult to implement a redistributive, universal social health insurance scheme, reinforcing societal segmentation. Thus, there are debates as to whether, in practice, there is the policy space and capacity for states to ensure that in any conflict between limits posed by trade agreements and public health obligations, the latter are respected and honoured. The impacts on health of new trade agreements such as the General Agreement on Trade in Services (GATS) is still relatively unaudited and unknown: it is understood that these impacts will be more thoroughly discussed within the Globalisation Knowledge Network.

Globalisation is linked with, but not entirely responsible for, the increased commercialisation of health care. Thus, health sector reforms in the 1990s encouraged bigger roles for the private sector in providing health care services. This was partly in response to perceived inefficiencies and poor quality care in the public sector. Yet commercialisation holds the political danger of undermining support for equitable systems by allowing the development of different interests and concerns across more and less powerful social groups (Nelson 1989). As a result, the legitimacy of the state's stewardship role across the whole health system may also be undermined, leaving it unable to implement its governance and regulatory functions.

This emphasises the fact that leadership from the health system is required to manage actors inside government, across different sectors, and outside government to create support for, and take advantage of, windows of opportunity to introduce change. It also requires that political leadership at higher levels enable and reinforce these processes. In order to manage competing interests and to prevent government policies that promote equity from being de-railed, Gilson *et al*. (1999) suggest that political leadership needs to be supported by sound technical analysis but that, conversely, the strategic skills and awareness of technicians also need to be strengthened.

4 Ensuring effective governance of health systems and policies intended to secure social protection and universal coverage

The authority of the state will be recognised, and the state will be most effective in carrying out its dual role as regulator and provider, when it is viewed as legitimate and is trusted by its citizenry, and when its autonomy is protected in the face of powerful local and international interests. Conversely, action by the state can reinforce its legitimacy. This is particularly important when governments develop and implement reforms aimed at securing social protection and universal coverage, because of potential resistance from entrenched interest groups.

Thus, Russell (2005) notes that in Sri Lanka, for example, the fact that the state has clearly taken on the responsibility of making universally available health care free at the point of delivery has built the foundation for public trust in the state, and contributed to the success of, for example, public financing arrangements. Recognising 'the still slim but growing body of multidisciplinary research and literature in this area,' Freedman *et al*. (2005) specifically suggest that public trust and government legitimacy can be enhanced by policy actions that improve access to health care, reinforce the commitment to health as a right and improve health resource allocation to under-served areas.

At the same time, they emphasise that such actions must be complemented by steps to strengthen the voice of the poor and marginalized to claim entitlements, where entitlements reflect commitments made by the state to its citizens in terms of, for example, access to and quality of care. As an entitlement, health care access becomes a right of all citizens, not a gift given by those who are powerful. Claims to health rights are asserted through social action, through formal legal or regulatory mechanisms and through procedural systems that build relationships between citizens and the state and through which mutual obligations of entitlement and accountability are expressed (Freedman *et al.* 2005). London (2004) has pointed out that the social rights to health of poor communities are more likely to be claimed through collective political and social action, given the weak access such groups have to legal and procedural mechanisms.

To strengthen the claims of poorer communities, governments and civil society have taken many different sorts of action, some of which are complementary. Some of the actions that have been documented are listed in **Box 2**.

Box 2: Documented mechanisms to improve community participation in governance and strengthen the voice of the poor

- holding of consultations with stakeholders on policy
- constitution of permanent or time-bound stakeholder fora for policy formulation and monitoring of implementation
- placing of advertisements in media and holding of public hearings around public inputs on proposed policies
- pressure from below on health policies, legislation and their implementation
- decentralisation of health management
- promotion of community financing
- formation of community health structures for managing local health clinics and hospitals
- creation of task forces to strengthen health service accountability
- citizen monitoring of health expenditure and quality
- audits into, for example, mortality
- client regulation through patients' rights charters
- right-to-information campaigns
- consumer protection Acts, consumer forums, and public interest litigation ombudsmen centres
- self-regulation by professional associations

Source: Murthy *et al.* 2005

While field studies have found these mechanisms useful in enhancing public involvement in health systems, they also report a number of factors constraining their representativeness, performance and power. These include: weak participation from the poorest groups; limited access to resources, information and training; and resistance from health professionals who perceive them as having weak formal authority and interfering in primarily technical decisions (Gilson *et al* 1994, Bennett *et al* 1995, Kahassy and Baum 1996, Mubyazi *et al* 2003, Rifkin 2003, Loewenson *et al* 2004, Ngulube *et al* 2004). Programmes that aim to build participation thus need to explicitly recognize and deal with such barriers, and do so in a sustainable and consistent manner to build more meaningful forms of participation, particularly for poor communities (Rifkin 2003).

Such problems indicate that accountability mechanisms and forms of participation are located within the wider framework of relationships and interactions between the state and society, and the wider context of how power is exercised. In this context, Sen emphasises the importance of the public taking action itself in demanding state responsiveness and accountability. Such action is argued to promote the political incentive for governments to be responsive, caring and prompt. Thus, the public is both beneficiary and primary instrument.

However, these relationships between citizen and state are changing, as are the values that inform them. They are differently expressed and organised in state-driven welfare systems centred on the principles of solidarity, universality and equity, compared to systems built on flexible labour and liberalised markets (Navarro *et al.* 2003). Thus, trends towards commercialisation of health services through fee charges and privatisation of essential health-related services like water supplies is reported to have changed the status of communities, from citizens with public rights and responsibilities into consumers with varying degrees of market power. In these circumstances there is evidence that it is the more powerful medical interest groups, or the wealthier urban elites, who have been able to exact concessions under these reforms, sometimes at the cost of poorer, less organised rural health workers, or the urban and rural poor (Van Rensburg and Fourie 1994, Bennett *et al* 1995). This has raised new debates around how to strengthen the voice of poor communities in health (Kalumba 1997, Storey 1989). While in the past the primary focus for communities is at national level, marginalized communities now also need to gain a voice in systems where decisions affecting health and livelihoods are made beyond the national level in global institutions and exchanges, and within the boardrooms of foundations and multinational companies.

5 Using the health sector to leverage inter-sectoral actions that address the social determinants of health

The adoption of the Health for All strategy in 1978 marked a forceful re-emergence of social determinants as a major public health concern, explicitly stating 'the need for a comprehensive health strategy that not only provided health services but also addressed the underlying *social, economic and political causes of poor health'* (original emphasis) (World Health Organisation and UNICEF 1978). The PHC philosophy made an explicit linkage between health and social development and included inter-sectoral action to address social and environmental health determinants.

During the 1980s, the concept of inter-sectoral action for health (IAH) took on increasing prominence, with 39th World Health Assembly discussions including working groups on a range of sectors. The 1986 Ottawa Charter on Health Promotion then identified eight key determinants of, or prerequisites for, health: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. It was understood that this broad range of fundamental enabling factors could not be addressed by the health sector alone, but would require coordinated action between different government departments, as well as between non-governmental and voluntary organizations, the private sector and the media.

According to the Commission's background paper, while a formal commitment to IAH became part of many countries' official health policy frameworks in the 1980s, the track record of national implementation was poor (Commission on Social Determinants 2005). The paper attributes this to countries attempting to implement IAH in isolation from the other relevant social and political factors supporting this framework, namely: broad commitment to health as a collective social and political goal; the crafting of economic development policies to promote social welfare; community empowerment and participation; and equity in health services coverage.

Further, IAH was weakly supported by decision-makers in other sectors who complained that health experts were often unable to provide quantitative evidence on the specific health impacts attributable to activities in non-health sectors such as housing, transport, education, food policy or industrial policy, particularly given the complexity of causal networks and time lags in producing these effects. This was compounded by institutional factors such as: vertical boundaries between sections in government; integrated programmes often being seen as threatening to sector-specific budgets, direct access of sectors to donors, and sectors' functional autonomy; the weak position of health and environment sectors within many governments; few economic incentives to support inter-sectorality and integrated initiatives; and government priorities often defined by political expediency rather than rational analysis.

In recent years in the developed world, however, integrated planning by different sectors in the interests of health has gained ground. Sweden and Britain under the Labour government stand out as countries that have taken a social-determinants-of-health approach to government policy (Canada is another example although, more recently, the strength of this approach may be declining) (Commission on Social Determinants 2005). In Sweden, policy is based on a culture of solidarity that makes equity a central and explicit aim. National health objectives are targeted at determinants rather than health status, and a variety of sectors is involved in the process of health policy development from the early stages. The British approach is distinctive for 'simultaneous emphasis on broad redistributive efforts coordinated at national level and on locally managed area-based initiatives' (Commission on Social Determinants 2005). For example, income, employment, education, early childhood development and regeneration initiatives were combined in disadvantaged areas through 'Health Action Zones' involving partnerships between government, the private sector and communities that developed innovative ways to reduce health inequalities, breaking through organisational boundaries.

The growing emphasis on the inter-linkages between health and economic development at a macro-level (Commission for Macroeconomics and Health 2001) may also provide an entry point for renewed inter-sectoral action in developing countries. In addition, the integration of health across sectors has increasingly come to be seen as part and parcel of sustainable development (see, for example, Harrison, Flynn and Brown 2004, who provide a list of the capacities – in terms of infrastructure, processes and tools – required to achieve this integration effectively).

However, as the Commission's background paper (Commission on Social Determinants 2005) notes, one of the biggest problems in achieving inter-sectoral action for health in developing countries remains achieving sustainable co-ordination across different government sectors (and even across different sections within health ministries), especially in the local government sphere. Blaauw *et al.* (2004), in looking at governmental relationships and HIV/AIDS service delivery in South Africa, provide some insights into concerted action at the local government level, noting that 'there is a tension between achieving short term delivery objectives – through mechanisms such as centralization and verticalisation – and broader, more long-term developmental goals – such as the strengthening of the local sphere of government.' They emphasise, too, the importance of 'coordination of coordination' mechanisms and activities, including the development of shared values between different parts of government. Gilson and Erasmus (2005) highlight the barriers to achieving coordination resulting from the different mindsets of different sectors of government. From experience in Africa, for example, they argue that Ministries of Health generally play a weak role in encouraging the inter-sectoral action necessary to underpin policy implementation around human resources for health. This weakness reflects the different mindsets and language of, say, health and finance ministries, the weak capacity for human resource planning and management within Ministries of Health and the generally complex nature of health system governance in any country that has itself been subject to massive reform over the last ten to twenty years.

6 Designing key features of health system architecture to secure social protection and universal coverage

A vision of universal coverage drives health systems dedicated to the promotion of equity. Implicit in the concept of universality is cross-subsidisation of the poor and sick so that payment for services is determined according to the ability to pay, and access to services is facilitated according to need. While the state is not necessarily the only funder or provider under this scenario, it plays a vital stewardship role, constantly working towards the integration and harmonisation of different aspects of the health system in support of universality (see, for example, World Health Organisation 2000). Thus, drawing on the Latin American experience of fragmentation, Londono and Frenk (1997) argue that health care systems should be founded on a universal entitlement to services which is rooted in citizenship, and that entitlement should be funded through financing approaches which enable and promote cross-subsidy and be met through a range of providers.

Such an approach reflects a different vision for the health system, particularly in developing countries, than has prevailed over the last decade or so. The UN Millennium Project's Task Force on Child Health and Maternal Health summarises this 'new' vision in **Table 1**, contrasting it to what they term the 'conventional approach,' although the values they espouse have much in common with those elucidated by the World Health Organisation in the late 1970s and early 1980s and typified by the Alma-Ata Declaration (World Health Organisation and UNICEF 1978).

Table 1: Task Force approach to health systems

Item	Conventional approach	Task Force approach
Primary unit of analysis	Specific diseases or health conditions, with focus on individual risk factors	Health system as core social institution
Driving rationale in structuring the health system	Commercialization and creation of markets, seeking financial sustainability and efficiency through the private sector	Inclusion and equity, through cross-subsidization and redistribution across the system
Patients/users	Consumers with preferences	Citizens with entitlements and rights
Role of the state	Gap-filler where market occurs	Duty-bearer obligated to ensure redistribution and social solidarity rather than segmentation that legitimates exclusion and equity
Equity strategy	Pro-poor targeting	Structural change to promote inclusion

Source: Freedman *et al*. (2005)

Importantly, national health systems founded on the values of equity, solidarity and redistributive justice may reflect normative values, and value and entitle citizens, in ways that differ from other national and transnational systems operating within wider economic contexts, including market-oriented macroeconomic policies, conflict and globalisation. Indeed, pro-equity health systems may provide an entry point for broader societal transformation in the interests of poor and marginalised people, both through structural and cultural or value-drive change (Freedman *et al.* 2005).

There are in fact several examples of developed countries – and a few of upper-middle income countries such as South Korea and Costa Rica – that have embraced universal entitlement as a basis for addressing social inequality and exclusion. The welfare state in Western European countries such as the United Kingdom, Sweden and Germany also highlight the redistributive role that health systems can play. A universal financing approach is emerging in Thailand, and has long been present in Canada.

Health systems that are moving towards universality tend to display the following features: financing reform directed towards cross-subsidisation of the less well off; equitable resource allocation; decentralisation of some sort; and a focus on primary care delivered through the district health system. Each of these features is discussed in turn below.

Financing reform is the first of the features of a health system moving towards universality, with **national or social health insurance** proposals attracting a lot of attention in several countries. This form of insurance is mandatory for the population it targets, and engineers income cross-subsidies from the more affluent to the poor. However, Palmer *et al* (2004) note that most studies investigating national and social health insurance are descriptive in nature. What data there are (for example, from Columbia and Costa Rica) tend to be inconclusive in their analysis of impact. Nonetheless, a more recent article from Thailand shows that, with the introduction of national health insurance, the country has been able to demonstrate a reduction in the incidence of catastrophic expenditure and the number of households that were impoverished as a result of out-of-pocket health care payments (Limwattananon, Tangcharoensathien and Prakongsai 2005).

There is some indication, though, that, where social health insurance is implemented in piecemeal fashion and not integrated with other financing mechanisms, it can lead to widening inequity between those belonging to a scheme (typically those employed within the formal sector) and those who do not (typically those employed within the informal sector) (Ravindran and Maceira 2005). In addition, health insurance premiums can be inequitable when there are insufficient cross-subsidies between income and risk groups: there is some evidence from Latin America, for example, that women are charged higher premiums (because of the costs associated with reproduction) (Weller *et al.* 2005).

An innovative solution to such problems may be a system which is being proposed in Ghana. This seeks to combine social health insurance for formal sector workers with district-wide community-based pre-payment schemes. Contributions for low-income households will be subsidised by government and donor funds, while there will be risk-equalisation between all the individual schemes that make up, in effect, a universal national health insurance system (McIntyre and Gilson 2005).

International interest in national health insurance notwithstanding, van Doorslaer *et al* (1999) and McIntyre and Gilson (2005) find, in OECD countries and developing countries respectively, that **tax-based funding** generally tends to be most strongly pro-poor in its overall redistributive effects of any financing mechanism. This underlies initiatives to increase tax-based funding of the health sector, such as the Abuja Declaration of 2001 whereby African Heads of State committed their governments to working towards spending 15% of government funds on the health sector (Organisation of African Unity 2001). However, improved debt relief and cancellation is required to enable governments in developing countries to improve the amount of tax funding available to social services (McIntyre and Gilson 2005).

The WHO Commission on Macroeconomics and Health has demonstrated that the health systems of poor countries are chronically under-funded and called for massive investment in health systems, including a doubling of **development aid** over time to fund an essential package of adequate coverage (Commission on Macroeconomics and Health 2001). While additional aid is sorely needed, development aid has a history of being tied to programmes that are not necessarily national priorities or are vertical in nature (with damaging effects on the broader health system).

Sector-wide Approaches (SWAps) have been introduced in many African and some Asian countries to pool government and donor funds in order to replace many donor-funded projects with one, sector-wide programme. Under this system, national leadership needs to be strengthened in order for governments to play a proper role in determining priorities (Walt *et al*. 1999) while aspects of SWAps that impact negatively on health care equity should be limited (for example, the lack of ear-marking of pooled funds for priority services, the predominance of financial accounting mechanisms over service delivery and quality, and the reduction of the financing stream to non-governmental organisations, many of which service the poor) (Ravindran and Maceira 2005). Of some concern is the recent move away from SWAps by some donors who favour general budget support through allocation of donor funds to Treasuries. The ability of Ministries of Health to influence how money is spent will probably weaken under this arrangement (McIntyre and Gilson 2005).

A <u>second</u> feature of health systems moving towards universal coverage is equitable resource allocation processes. Historically, such processes have tended to favour better-off areas and communities (Bennett forthcoming). To counter this, needs-based formulae are a mechanism that has emerged in the 1990s to re-direct public financial (and hence other) resources to more needy areas, especially rural areas with less-developed health services. At their simplest, these formulae depend entirely on estimates of relative population size, and the EQUINET Resource Allocation Theme Group (2005) have shown that such formulae may be perfectly adequate in estimating the direction and size of resource re-allocations in low-income contexts. More complex formulae adjust population figures according to age and sex breakdowns and standardised mortality ratios.

In countries with sophisticated data, like the United Kingdom, deprivation indices are also included. In fact, McIntyre, Muirhead and Gilson (2002), using data from South Africa and deploying small area analyses, were able to develop a general index of deprivation in a data scarce context, and show that, because of its close correlation with ill-health, it would successfully lead to more equitable resource allocation among provinces if included in the current, less sophisticated formula. The index also has the potential to be useful for intra-provincial resource allocation, in order to deal with the problem of identifying pockets of deprivation within better-off provinces. While indices of this sort are used to compensate for geographic disparities in the public sector, risk equalisation mechanisms fulfil a similar function in the context of private insurance, adjusting for the different risk profiles of different schemes, essentially integrating members into a single risk pool, and maximising cross-subsidisation.

Different forms of decentralisation (a third feature of a pro-equity health system) can work together with resource allocation formulae to shift expenditure patterns at the local level. Bossert *et al.* (2003b), in a study in Colombia and Chile, found that equitable levels of per capita financial allocations were achieved at the municipal level, with local funding choices and, in the case of Chile, a horizontal equity fund, adding to the impact of a formula. Importantly, the equity fund partially re-allocated resources raised by wealthier municipalities to more disadvantaged ones. Although resource re-allocation is more likely to succeed under devolved systems, Bossert, Chitah and Bowser (2003a) found that, under the Zambian system of more limited decentralisation, equitable resource allocation between districts was achieved by means of a formula. Equally, though, there have been several instances where decentralisation and/or formulae have not led to a reduction in the overall level of inequity (Goudge, Khumalo and Gilson 2003). This highlights the importance of distinguishing between functions that should, and should not, be decentralised under different contexts.

In making this distinction, it is important to acknowledge that resource re-allocation is not simply about the technical process of deciding on relative need. Green *et al.* (2000), Okorafor *et al.* (2005) and EQUINET Resource Allocation Theme Group (2005) all comment on the strong political interests that are challenged through resource re-allocation. These are likely to block change (as was the case when decentralisation reforms were introduced into an area in Pakistan (Green *et al.* 2000)), especially when the capacity of technicians can be called into question. Decentralisation may enable poorer citizens to acquire control over the disposal of resources and the shaping of services, by participating in decision-making processes so that politicians truly reflect their interests. Gwatkin, Bhuiya and Victora (2004) note that the focus should be on 'creating an effective demand and pressure for relevant health services on the part of poor people, to counterbalance the influence of well-off groups that traditionally define priorities and design programmes.'

Although in theory decision-making by local bodies should best represent local interests, this only occurs when power is truly devolved to the local level and certain conditions to promote the voice of the marginalised prevail. Murthy *et al.* (2005) include in these conditions: the transfer of resources; free and fair elections to local bodies, with quotas for representation by marginalised groups; provision for elected bodies at lower levels to be represented at higher levels of decision-making, so as to influence policy; and the transfer of adequate information and powers to elected representatives so that they may adequately assume their roles. Many of these provisos relate to the problem of ensuring that local elites do not capture or distort the representativeness and outcome of community participation initiatives, as discussed in an earlier section.

There is however some caution that efforts to strengthen the voice of poor communities need to be complementary to, and not a substitute for, health care systems that provide the procedural systems to respond to the needs of poor communities (Loewenson forthcoming, EQUINET Steering Committee 2004). In addition, the process of shifting resources needs to be well-paced and managed, to ensure that new funds are absorbed and utilised effectively.

The importance of combining local decision-making with co-ordinated efforts to improve the functioning of the local health system is expressed within a new concept called ‘MESH’ which is based on the experience of resource allocation for Aboriginal health care in Australia and being proposed in South Africa (Thomas *et al.* 2005). It is based on Mooney’s proposals for using capacity to benefit as a key principle in resource allocation (Mooney 2003), which involve four steps: establish the good to be achieved, in collaboration with those who will benefit; see how that good can be made better with the resources available; where regions need help creating the infrastructure needed to do better, adjust the allocation formula to allocate funds for this purpose; and make due allowance in the allocations for variations in the cost of access across regions. The infrastructure of relevance is encapsulated in term MESH, referring to the Management, Economic, Social and Human infrastructure necessary to create a sustainable and effective foundation for primary health care. Here, management capability refers to the management of finances and service provision as well as leadership, the process of eliciting community preferences and health care needs, and planning infrastructural improvement. Building economic infrastructure relates to improving geographic access to health facilities and the development of other amenities, services and employment. Social cohesion includes unity and organization within communities, as well as interaction between communities and government and between the different spheres and sectors of government. Human infrastructure includes the effective deployment of human resources and the development of appropriate skills. The concept of MESH locates priority-setting firmly within a comprehensive approach to local health system development centred around primary health care.

Indeed, there is widespread evidence to show the equity gains that result from budget re-allocations towards primary care (see, for example, Starfield 2001, 2002 and 2005, Starfield and Shi 2004, Shi, Green and Kazakova 2004). In a review of relevant literature Tollman et al. (forthcoming) explain that, as a <u>fourth</u> feature of equity-driven health systems, primary care services act as a fulcrum of a comprehensive care and support system – providing a link to programmes working in the wider community as well as facilitating patient access to district referral services. They identify the equity-enhancing aspects of primary care to include: physical, financial and cultural accessibility; the provision of comprehensive, integrated, personalised and continuous care; responsiveness to patients’ non-health needs (such as courteous and respectful care); the role of primary care facilities as a community resource use and their focus on the elements of the disease burden that disproportionately affects poor people. Well-functioning primary care level services, thus, represent the face of the health system for many and have the potential to inspire trust in the system as a whole. However, such gains do require the provision of good quality and responsive care through a properly resourced and extensive network, well-linked to a referral system. Indeed, essential to equity-promoting health systems is the concept of universal coverage, especially at – but not limited to - the primary health care level (where coverage is defined in a broad sense as discussed, for example, in Tanahashi 1978).

7 Strengthening management and stewardship capacities within the health sector

Public sector management capacity tends to be weak across the developing world. This contributes to inefficiencies, to the malaise felt by front-line health workers, and to difficulties in implementing change. Many equity-promoting policies flounder because of problems in implementation: this makes it difficult to sustain progressive initiatives and erodes the legitimacy of the state. Unfortunately, with some exceptions, the literature seldom analyzes the reasons why interventions fail (or even succeed), making it difficult for policy-makers and planners to learn from past experience. One text that looks specifically at strategies to enhance equitable access by poor households to health care (Goudge, Khumalo and Gilson 2003) draws out lessons from experience across the developing world (see **Box 3**). These lessons highlight the multi-factoral nature of intervention, the need for implementation to be carefully managed, and the importance of adaptability to changing circumstances.

This is true even within the public sector, as such policies challenge the norms, traditions and hierarchies within health systems which themselves reflect the wider patterns of social inequality (Mackintosh 2001). These institutions shape health professional practice, influencing who gets access to health services, as well as the treatment and nature of care offered to different social groups. Experience in Africa suggests that a core obstacle is the practice of power within health systems, linked to the hierarchical and quite authoritarian nature of public sector bureaucracy. Recent experience in Tanzania, for example, demonstrates how poor people’s experience of abuse at the hands of providers is a key facet of their experience of their social exclusion (Tibandebage and Mackintosh 2005). In South Africa, meanwhile, nurses’ critical attitudes towards groups such as pregnant teenagers, teenage mothers, patients with HIV/AIDS and poor patients judgements have been shown to be rooted in their own values which, in turn, reflect the class and other divisions in the society as a whole (Jewkes *et al.* 1998).

Resistance to policies from within health systems is illustrated by health worker responses to the removal of fees in South Africa, which included greater rudeness towards patients (Walker and Gilson 2004). These problems also reflected the increased workloads that resulted from the policy change, weak preparation for its implementation and the limited communication with health workers about it.

Box 3: Lessons for implementing strategies to enhance economic access

1. Take the views of the poor into account in policy design (whether it be resource allocation, community financing, drug use interventions or exemptions).
2. Enable implementation and management to be flexible in order to meet the unforeseen needs of the poor.
3. Create a sense of ownership and control by communities to ensure commitment to a policy.
4. Root policy design and implementation on an adequate understanding of the characteristics of poverty – the mobility, lack of participation in formal systems, differing needs to due vulnerability and insecurity of income, the stigma associated with being poor, and greater reluctance to take risks.
5. Ensure that the non-poor accept that the poor should be beneficiaries, including politicians and bureaucrats.
6. Ensure the commitment and motivation of health staff, responsible for implementation is crucial for success.
7. Recognise the importance of solidarity and the willingness to share risks, particularly in success of community financing schemes, where to some extent the wealthier groups will subsidize the poorer groups.

Source: Goudge, Khumalo and Gilson (2003)

Part of successful implementation is therefore overcoming internal resistance to change. Gilson and Erasmus (2004) suggest that equity-promoting policy implementation is likely to require changes in organisational culture based on shared values and objectives, respect and open communication, both in relation to patients but also to those who work within the health system. Gilson (2003) notes that reforms in the 1990s to improve management, termed ‘the New Public Management,’ have been criticised ‘for endangering the trust and long-term co-operation between client/patient and provider critical to the effective delivery of health and welfare services, by replacing high trust relationships between employees and managers with low trust ones.’ Khaleghian and Das Gupta (2004) describe a wider number of the features of the New Public Management and show how these are not always applicable to essential public health functions. Indeed, given existing capacity constraints, Mills *et al.* (2001) suggest that the radical and wide-ranging reforms envisaged by the New Public Management are not an appropriate strategy for low income countries. They propose, instead, more gradual reform processes that encourage necessary improvements in capacity to be built over time.

Khaleghian and Das Gupta (2004) suggest that government bureaucracies should rather concentrate on building management capacity, improving accountability (both hierarchically within government and externally to the public), and improving the organisational climate. This last point is echoed by Blaauw *et al.* (2003) who assert that too little attention has been paid to what they call the ‘software’of health systems, namely their organisational cultures, as opposed to the ‘hardware’ (such as physical infrastructure, number of personnel and drugs).

Management transformation is thus key to the process of strengthening the capacity and the legitimacy of the state, and of tackling norms and hierarchies that shape practice, sometimes to the detriment of equity. This means that, apart from equipping managers with technical skills backed by operating systems, it is important to equip them with skills that help them to build trust, shift the organisational culture, develop organisational relationships and networks and strengthen engagement with the public (Blaauw *et al.* 2003). This includes redressing inequities that afflict the workforce itself, including gender issues. The aim would be to encourage a values-based style of management that is particularly committed to serving the needs of the poor and marginalised. The form of management required in the public sector generally has, thus, considerable differences from that required in the private sector.

8 Towards a work-plan for the Health Systems KN

As a rapid scoping exercise, the review presented above suffers from the limitation of only having tapped into the readily available literature. Grey literature has not been explored; neither has the literature on the Eastern European experience, and on conflict and post-conflict situations. It is the work of the KN to consider how to fill these gaps, through further literature review, consultation with experts and key informant interviews.

Early deliberations of the KN, and further dialogue with the Commission, will have to prioritise studies that can be commissioned by the KN in order to develop evidence-based recommendations for actions under the headings **3** to **7** above, and fulfil the KN’s terms of reference. It would be useful, in preparation for the KN’s first meeting from 6-8 March, for participants to reflect on their own and other experiences that might contribute to such studies.

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