

Analysing Health Systems To Make Them Stronger

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Executive Summary

The attention for Health Systems (HS) and Health Systems Strengthening (HSS) has re-emerged in the frontlines of global debate since several years. This document aims to clarify the authors' ideas and visions on HS development by presenting a framework for description and analysis. *The book outlines a framework that can be used by anybody wishing to analyze and strengthen HSs and it elaborates a vision for discussion.*

This working paper is the *product of a consultative process* that started with a literature review on models and frameworks on HSs and HSS. In consecutive discussion group meetings, including members of in- and outside the department, and invited visitors from partner institutions, more than twenty persons participated in the first draft of the text. The editorial team wrote out the paper's drafts, which were circulated for comments, before finalizing it. Thus, this book is broadly supported beyond the authors' team.

The framework presented is developed for the analysis of any HS at national, intermediate or local level. Furthermore, it can be loaded with specific values and principles so that it becomes normative. As such, it can contribute to the development of strategies for action. *Ten elements* or functions are identified as essential and constitutive of any HS (see fig): 1) goals & outcomes; 2) values & principles; 3) service delivery; 4) the population; 5) the context 6) leadership & governance; and 7-10) the organisation of resources (finances, human resources, infrastructure & supplies, knowledge & information).

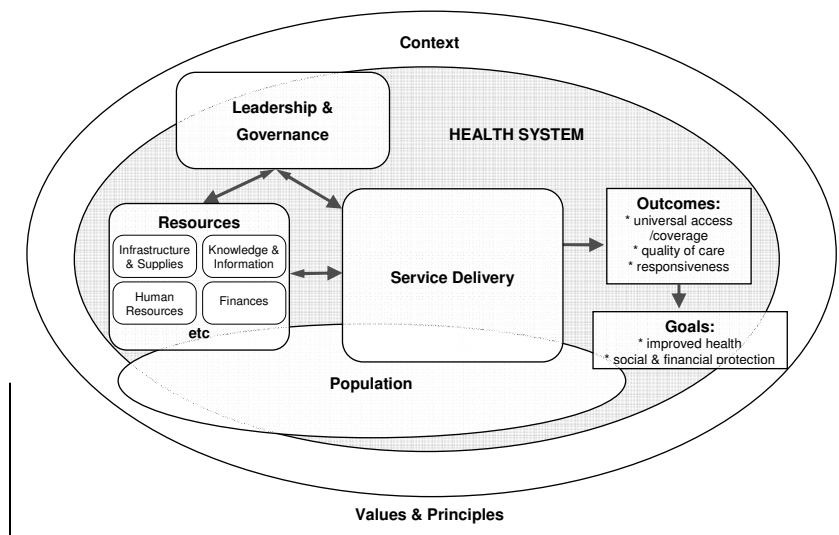


Figure 1. The HS framework in its generic form

The emphasis of the framework is on *outcomes and goals*. As such, it looks at performance, but it takes into account the important influence of the other factors in- and outside the system. *Service delivery* needs managerial and organisational attention in order to produce outputs that lead to outcomes. And, services cannot be productive without proper

allocation and management of resources. Both these functions are to be governed, which means that the *leadership* role of the system is crucial. But, a HS is part of the public domain, which implies the involvement of the *population* is involved, on the receiving end as patients and, via representation and other means, in having control over all HS functions. Finally, HSs have only a partial influence on the final outcomes. Many other *factors outside the system* determine people's health, like hygiene, sanitation, education... And, many factors have a direct interaction with and profound influence on the system's functioning, e.g. the international community and donors, the economic status of the country, pharmaceutical companies, et cetera.

The arrows in the framework indicate that the relations between the elements are reciprocal and interconnected. The context encircles the HS, able to influence whatever part of the HS. And the population touches on all elements of the system, indicating its omnipresence. Indeed, *HSs are complex adaptive systems.* This implies interdependence and interaction between its elements, including feedback loops, emergent, generative and non-linear processes, leading to dynamic equilibriums between operating forces and to sometimes or partly unpredictable results.

This book consists of three parts. The first is the main part and develops in depth the characteristics of all ten elements and discusses their interactions. The authors' views are each time highlighted and controversial topics described. The second part gives a view on HSS and deepens the processes of problem analysis, stakeholder analysis and coordination of interaction and adaptation. It ends with five guiding principles to guide decision-making and action. The third part illuminates how the framework can be used, applied to different levels and ends with three illustrative case studies. The annex gives an overview of frameworks that have been developed by other authors, and that have been instrumental as a starting point for the deliberations that led to the present framework.

Our vision in summary

The *goals* for a HS are improved health, social and financial protection, and responsiveness to the expectations of the population. To contribute to these goals, the HS should organise health services that ensure universal access, for all citizens, to care of good quality that is responsive to the actual needs. This requires strategies with a collective and an individual dimension. Financial protection refers to the protection of people against the economic consequences of disease, whilst social protection also embraces the vulnerability of ill people.

Access relates to how many people can use a health service, while coverage is traditionally used to define the proportion of a target population that benefits from an intervention. Providing access implies searching for a balance between responsiveness to people's felt need and excessive medicalisation and overconsumption of health care. Utilisation rates can be used as an indicator of comparison. *Quality* of care and of other health service interventions comprises effectiveness, efficiency, safety, patient-centeredness, integrated and comprehensive care, continuity within and beyond a single episode of disease and beyond the visits to one specific health institution. *Responsiveness* is being responsive to the needs and demands of the population and its different subpopulations, at individual level and community level. Package of care should be defined taking into

account both rationally defined health needs and the broader demand of individual patients and the population for health care. It should evolve along with changes in those needs and demands.

Often implicit, *values* influence the debates around HSs and the choice of directions. Examples are 'health care as a right', 'participation', 'solidarity', 'choice', 'autonomy', 'security and protection'; 'efficiency and effectiveness'; 'maximization or optimization'; 'individual and collective perspective'; 'a cosmopolitan or national paradigm of social justice', 'equity', 'sustainability'. The variation in interpretation and valorisation of values and principles and the underlying tensions result in major challenge to decide on common goals and values in a HS. The values at stake and the balance are unique in each context. Priority setting should take place at country level, in view of technical and rational criteria and broader societal values, whereby existing power balances cannot be ignored.

HSs are overall shaped and influenced by wider societal change and function as social institutions reflecting the society in which they are embedded. *Interaction with the context* involves a continuous reaction and adaptation to social, economic, technological, cultural, political, regulatory and environmental developments and transitions over time.

Health services are all services that have as primary purpose the improvement of health. They are very diverse in nature and are delivered to the population via multiple modes and channels. The context of scarce resources, rationing and optimisation of results often leads to a selection of prioritised interventions. The choice for delivery platforms depends on the nature of the service, the capacity of these platforms and other factors such as regulation and disease burden. A strong HS is composed of a mix of platforms that is highly path-dependent, but somehow balanced.

The character of service providers can be described as private or public, for-profit or not-for-profit, formal or informal, professional or non-professional, allopathic or traditional, remunerated or voluntary, although boundaries are blurred. Most HSs are pluralistic, constituted of a complex mixture of categories, partly as a result of planning and organisation and partly due to personal initiative or spontaneous evolutions. We believe that at local level, HSs should function as an integrated system, meaning that there are no gaps in access, an optimal flow of patients and information and the patient is helped at the most appropriate level. The first line health services are at the core of this system.

The *population* is involved in the HS as patients or customers, but also as citizens having certain rights and obligations and as funders or even suppliers of care. The concept of participation includes a wide variety of approaches on a scale towards increasing empowerment, from mobilising people to contribute to inputs, over common decision-making processes, towards increased capacity to autonomously recognize and act upon situations. The striving for empowerment as an important goal, both at individual and at community level, needs different approaches at the supply and demand sides. As customers, people's health seeking behaviour is determined by choices that are usually based on a pragmatic and eclectic basis. Important determinants are physical and financial access, the reputation of and trust in a provider or a facility and contextual socio-cultural constraints.

Service delivery is closely linked with all other elements in the HS. The availability of resources, especially qualified staff, and the organisation of their use determine the

possibilities for service delivery. It is a governance task to determine the optimal delivery models for different health services in society and to steer and motivate providers to behave accordingly.

Governance is defined as policy guidance to the whole HS, coordination between actors and regulation of different functions, levels and actors in the system, an optimal allocation of resources and accountability towards all stakeholders. Although many actors have an influence on governance, there is a central role for the state in ensuring equity, efficiency and sustainability of the HS. This requires a strong capacity at the Ministry of Health (MOH), its decentralised structures and local governments. The HS is accountable to the population at all levels, from the individual provider towards the patient and from the MOH towards the overall population.

Financing involves the acquisition, the pooling and the allocation of financial resources in such a way that it contributes to goals and outcomes, taking into account equity, efficiency, accountability and sustainability. The way in which different health services are financed and how providers are paid influences directly what type of services are being delivered in which way and thus the access to services in general.

The transaction intensity of many health services makes professional staff one of the scarcest resources in many HSs. The *health workforce* can only meaningfully contribute to the performance of the HS, if health workers are available, competent and performing up to standards. To create an enabling environment, human resource management ideally consists of a mix of financial and non-financial incentives, control and sanctions and values and ethics.

Developing the HS *infrastructure* implies enough health facilities, within proper reach of the population that are well-equipped and well-maintained. *Drugs* are a crucial commodity in any HS. Frequent problems are their poor availability, supply and quality, the poor financial accessibility and inadequate prescription or use.

Information and knowledge is needed for monitoring, evaluation and research, clinical decision-making, organisational management and planning, analysis of health trends and communication. The priority of routine information systems should be their potential to contribute to sound decision making, limiting the collection to those data that are necessary for that purpose and be kept as simple as possible. Knowledge and information needs to be shared in all directions, vertically and horizontally, so that the ongoing processes of research and practice can feed each other. This urges for research of all sorts, for pilot projects, for communication and sharing of results, and for the assessment of constraints to further implementation.

HSS is a continuous development to improve the performance of existing HSs. It involves a root cause analysis of problems and an analysis of the power and interests of important actors in relation to the issues at stake of their relations. HSS interventions often lead to tensions between actors and resistance to change, because they affect the existing power relations or the distribution of resources and because they require adaptations of actors. The steering of this process is part of governance and leadership, which encompasses the coordination the interaction and negotiation between actors; the creation of mechanisms for priority-setting; balancing of different interests; and steering actors. The following principles should guide any HSS efforts: 1) The most important

capacities of HS need attention first: the governance function, the health workforce component and the service delivery component; 2) Strengthening the overall system capacity requires the coordination of efforts based on a *coherent* policy, vision and long-term view, clearly linked with goals and values; 3) Strengthening governance is a long-term effort, necessitating continuity in time and the creation of structures to ensure institutionalisation of processes; 4) Alignment and coordination should be improved through dialogue, in addition to other steering mechanisms such as bureaucratic control and financial incentives; and 5) HSS entails a continuous interaction with and adaptation to context and transformations in time, in which gradual change prevails.