

A Health Systems Development Agenda for Developing Countries

Time to be clear and visionary

A discussion document for civil society and NGOs

Produced by the Global Health Watch



The Global Health Watch is an initiative aims at presenting southern-based critique of international and global responses to the current state of global health. This critique is encapsulated through the production of an alternative world health report. The watch is a broad collaboration of public health experts, non-governmental organisations, civil society activists, community groups, health workers and academics. It was initiated by the People's Health Movement, Global Equity Gauge Alliance and Medact.

What is the issue?

Health care systems in many low-income countries are in a state of collapse. Many others remain incapable of providing effective and equitable essential health care.

In spite of the importance of adequately resourced and effectively governed, managed and organised health care systems, there is no coherent and long-term health systems development agenda amongst the international health community. Instead, uncoordinated, piecemeal and increasingly 'vertical and selective' interventions are being applied in the absence of a road map for the strengthening and long-term development of health care systems.

This discussion paper argues for the development of an advocacy agenda to promote comprehensive health systems development in developing countries. It aims to promote discussion amongst health policy experts and civil society organisations (CSOs) about the need for and content of a health systems advocacy agenda.

The targets for this advocacy are: governments in developing countries; the official development agencies of donor countries; the World Health Organisation and other relevant UN agencies; the World Bank and IMF; key private organisations and donors, such as the Bill and Melinda Gates Foundation and the Rockefeller Foundation; and Global Health Initiatives such as the Global Fund for the Fight Against AIDS/HIV, TB and Malaria (GFATM) and the Global Alliance for Vaccines and Immunisation (GAVI).

This document is intended to stimulate discussion and is accompanied by a pro-forma document to facilitate your comments, opinions and recommendations in shaping the content of a health systems development agenda and the way forward for appropriate health care systems development.

Identifying the causes for poorly functioning health care systems

There are many reasons for why health care systems are in a state of collapse, or functioning poorly.

The inadequate resource base of health care systems is well known, as highlighted by the 2006 World Health Report. It is also recognised that volatile and unreliable health care funding makes it difficult for countries to establish the medium to long-term plans required to develop health care systems.

But there are other reasons for the collapse and chronic under-development of health care systems. These include the effects of fragmentation. At the level of governance, planning and management, the health care systems of many countries resemble an orchestra of competing musicians playing different tunes without a conductor! Official development assistance (ODA) programmes, new GHIs, private foundations, UN agencies, the World Bank, IMF and international NGOs are pulling communities, health workers and Ministries of Health in different directions. This not only undermines coherent health systems planning, but also weakens Ministries of Health through: a) inappropriate conditionalities and externally-imposed agendas, often designed to suit the interests and needs of the external agency; b) the loss of skilled personnel from the public sector into the non-government sector, thereby reinforcing the dependency of Ministries of Health on external agencies; and c) the imposition of large transaction costs upon Ministries of Health and health workers who have to liaise with and report to a multitude of stakeholders.

The fragmentation of health systems governance, planning and management is also associated with a fragmentation of programmes and service delivery. The last few years have witnessed a proliferation of vertically-organised programmes and selective health care interventions, particularly in the poorest countries. These programmes and initiatives have arisen as a consequence of dysfunctional health care systems, as well as the imperative to urgently extend coverage of life-saving interventions.

However, they also aggravate the lack of coordinated and effective health systems governance and management; create an inefficient duplication of systems and services (for example parallel drugs and supplies systems); cause health workers at the coalface to be pulled in different directions by the demands of different selective and vertical programmes; and retard the development of integrated, context-based local health plans. And where vertical programmes and selective health care initiatives are implemented through non-government actors, they can contribute further to the 'internal brain drain' from public to non-government sector.

The problems of weak and fragmented health systems are also a reflection of poor and weak public leadership and management. This reflects 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. In addition, it may reflect deficiencies with government as a whole: corruption, a weak parliament and judiciary, civil conflict and a lack of

civil society institutions and mechanisms to hold governments to account.



The effects of structural adjustment programmes have been another cause of dysfunctional health care systems. One consequence was the growth of an unregulated, commercial primary care sector, which arose as a result of cuts in public sector expenditure. Downsizing and resignations led health workers to the private sector, adding to the numbers of informal and unregulated drug vendors, 'pavement doctors' and other private practitioners. As public services deteriorated, cash payments for the purchase of care and medicines became more common, the impact of which has been disastrous, particularly for the poor. User fees have deterred people from accessing health care and generated poverty or deepened the poverty of those who are already poor.

In addition to the expansion of a largely unregulated, fee-driven primary care system, equitable health care systems have been undermined by the development of private insurance markets for those who can afford them. This 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 health care system, and leaving the public service as a 'poor service for poor people'. They also run against the policy advice of WHO and others to pool health care financing as much as possible so as to optimise risk-sharing, cross-subsidisation, economies of scale in the purchase and management of health care, and stewardship over the provider market.

It is argued that by encouraging higher income groups to finance their care privately and thereby take them out of the public sector, the public sector will be able to focus on the poor and ensure universal access to a minimum package of basic services for all. However, a private sector for higher income groups (even if entirely privately financed) still draws on a limited pool of health professionals and on limited foreign exchange for the import of drugs and equipment. Often it sucks out more health care resources than it relieves the public sector of workload. It also inevitably 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 commercialisation and market-driven care, with its attendant problems. These include health care providers pricing health care to maximise income rather than access and benefit; 'over-servicing' and inducing demand for health care that is unnecessary or

inappropriate; accentuating a bias towards biomedical interventions at the expense of public health approaches to prevent illness and promote good health; the replacement of provider collaboration with provider competition; and a deterioration in trust between patients and providers.

Global economic integration and 'free trade' have further accelerated the impact of market-driven health care outcomes. The international brain drain of skilled human resources from poor to rich countries is well known. But in addition, the scarce domestic health care resources of some countries are being diverted away from national priorities and the needs of the poor towards a growing 'health tourism industry' serving economically-advantaged foreigners and towards the provision of services (e.g. histopathology and radiology services) to contractors in high-income countries. And through new trade rules, multinational health corporations now have the ability to force the break up of universal, public health care systems in order to extract profits from the health care market, particularly in countries with a critical mass of high-income consumers.

Finally, health care systems in many countries have to struggle with a growing burden of disease and poverty. The AIDS epidemic on its own threatens to overwhelm the capacity of many health care systems. And in sub-Saharan Africa, the doubling of the numbers of people living in poverty since the 1980s means that more people are vulnerable to the threat posed by infectious diseases, as well as to the costs of seeking health care.

The vision of a 'good' health care system

There are no simple, quick-fix solutions to the numerous reasons for poorly functioning health care systems. The strengthening and development of health care systems will require a multi-dimensional programme of reform and change, guided by a long-term vision and commitment towards a set of clear health systems goals.

However, health care systems can exist in different shapes and forms, and thereby, can achieve different outcomes in terms of equity, effectiveness and efficiency. In setting out an agenda for health systems development, it follows that a set of concepts and principles is needed to inform the kind of health care system we want developed.

This document calls for health care systems that secure a central role for governments and public provision, equitable financing and access to health care, and responsiveness and public accountability.



It views health care systems as social institutions that require effective, accountable and capable public institutions. It also argues for universal and inclusive systems of health care capable of promoting social solidarity and ensuring a balance between population / community-based approaches to health and individualised health care, as opposed to systems that segment health care financing and provision in a way that reflects and accentuates the underlying socio-economic disparities of societies.

One argument for the central role of the public sector is that people have a right to health care that is not dependent on their ability to pay or the vagaries of the market. Governments are critical to ensuring that these rights are fulfilled. However, this document argues that while public services should target the poor, they should not become limited and marginalised as 'poor services for the poor'.

The call for health care systems to be effectively governed and managed as public institutions also reflects the view that health care systems require careful organisation. Public sector stewardship allows rational and publicly accountable planning. By contrast, fragmented systems of private care and market-driven health care systems are inefficient and inequitable. Furthermore, existing evidence suggests that the larger the role of the public sector in health care systems, the better the aggregate health outcome within countries. An adequately financed public service also offers the best means of breaking the link between the income of health care providers and the delivery of health care – a critical condition for the development of ethical behaviour and values within health systems.

Health care systems that are equitable in terms of access would entail raising health care finances through progressive contributions (i.e. where higher income groups contribute a higher proportion of their income), pooling (domestic and external) health care financing to allow cross-subsidisation and risk-sharing, shaping health care expenditure and consumption in accordance to need, rather than on demand for care or on the ability of people to pay and counteracting the influence of groups who want health care expenditure and consumption to mirror socio-economic disparities rather than mitigate them.

A public-based, national health care system, however, does not mean the creation of a monolithic, inefficient and bureaucratic health care system. National health care systems can be decentralised and shaped according to local needs; form partnerships with non-government actors; be publicly accountable (health

care systems can also act as a catalyst for improving public accountability and good government more generally); and support community empowerment.

Key elements of a health systems development plan

With these principles in mind, what might be the key elements of a health systems development agenda for low-income, developing countries?

Human resource planning

Getting the right number, mix and competencies of the health workforce is possibly the single most important element of a health care systems development strategy. The 2006 World Health Report describes this challenge in greater detail.

Some of the demands that can be made by civil society are to see evidence of:

- A comprehensive situation analysis of all existing public and non-government workforce. Such an obvious and simple first step is often absent in most countries and points to the need for immediate investments in human resource (HR) information systems and data bases to assist with HR planning and management. This should be followed by regular periodic audits of the geographic distribution of health workers, set against locally derived norms.
- A ten year human resource for the health sector that would incorporate:
 - a clear definition of the number and skills mix of the health workforce required to provide essential health care (including important non-clinical personnel, such as health economists, accountants and human resource logisticians who are vital to improving the management capacity of the Ministry of Health),
 - A medium term investment plan in schools of nursing, medicine, public health and other disciplines in order to attain the medium and long term production

TARIFS-MEDICAMENTS		P.U Produits	P.U Produits
duits			
icillin 2M4	400F	Palyject 0.20	150F
1M2	250F	" 0.40	" " C
		Primperan inj	210F
inj	175F	Paracetamol cp	100F
gite		" SP	600F
SP	600F	Quinine 600	150F
CP	10F	Spasfon cp	60F
CP	10F	" inj	60F
emide cp	15F		

targets for the desired number and skills mix of the health workforce.

- A measurement of the ratio of public: donor sector: non-government health workers with an explicit target for changing this ratio as required.
- A wage structure that would enable public sector health workers to behave ethically and function effectively, and which would compare favourably with the wage structure in the non-government and private sector - the disparity in incomes between public and private providers should be regularly monitored to draw attention to the need for active measures to reduce the gap. Extra support and incentives for health workers in isolated and difficult circumstances is also required. The table below illustrates the importance of documenting salary differentials and working towards a reduction in disparities.

By incorporating the human resources of these three sectors into a single HR plan, there would be more informed consideration of how the sectors interface with each other and how they can work with greater synergy.

- A commitment from donors to be willing to co-fund the recurrent salary costs of public sector health workers for at least the medium term (five to ten years). In Malawi, the UK Department for International Development (DfID) has agreed to commit official development assistance (ODA) towards the topping up of public sector salaries for six years as part of an Emergency Human Resource Programme. Such decisions now need to be the norm

Table 1: Variation in salary scales in the Ethiopian health sector

	Base salary per month (SUS)			
	Ministry of Health	Addis Ababa University	Mid-range NGO	US bilateral agency
Driver	20-45	24-48	70-120	120-450
General medical practitioner	157-252		330-530	
Senior medical specialist	273-420	352		450-600
Expert medical specialist	354-513	400	568-968	950-1200
Public health professional, MPH/PhD			744-1268	1 200-1500

rather than the exception. Civil society could call for an international declaration for the donor community to co-fund core public sector health worker salaries on condition that countries have reached reasonable targets for the investment of domestic revenue into the health sector and that there is evidence of an effective human resource administrative system.

- The development of non-financial, professional incentives to reward good performance, coupled with the implementation of clear civil service rules and codes of conduct, and public accountability mechanisms at different levels of the health care system.

Resource generation

A meaningful and adequate human resource plan would require an increase in the health budget. Furthermore, it would require sustainable, reliable and long-term increases in the budget.

The cost of a comprehensive human resource plan, together with other key health systems costs such as medicines, transport and infrastructure development, could form the basis of an indicative sector-wide budget for the core infrastructure required to provide essential health care to all.



A demand that could be made by civil society would be for:

- Every country to develop such an indicative budget, measure the financing gap between it and current expenditure, and publish a plan for plugging the gap with additional domestic and external financing.

Within countries, governments must be enabled to strengthen their capacity to increase tax revenue in a fair manner, and prevent unethical capital flight. Civil society could advocate for:

- All countries to set a target to raise at least 20% of their GDP as tax revenue, and to allocate at least 15% of total government expenditure to health. A complementary target would be for public health expenditure (government and donor finance) to be at least 5% of GDP.
- A more effective tax-collecting system, which would include more effective mechanisms for preventing unethical capital flight. Health sector activists and NGOs need to develop better collaboration and alliances with experts on tax regimes to guide the formulation of recommendations and demands.
- The outright cancellation of unfair debt.

As far as external sources of financing are concerned, high-income countries should rapidly reach the long-standing target of allocating 0.7% of GDP to ODA. Donors should also commit to long-term and reliable funding for periods of five to ten years to allow predictable budgeting and stable planning cycles. At the same time, the international community must recognise the limitations of aid programmes and voluntary 'public-private partnerships' to finance development and health improvement, particularly in light of the failure to promote sustainable and equitable growth to eradicate poverty. New strategies and sources of public financing are required to fund global health and enable a more effective means of resource redistribution globally. Civil society should advocate for:

- The development of an international tax authority to assist countries to reduce the hundreds of billions of dollars of lost public revenue due to tax avoidance (and tax competition). In addition to generating public revenue, the more effective regulation of capital flight, tax havens and secret bank accounts will contribute towards the cleaning of corruption and bribery within governments.
- The introduction of new sources of global public financing such as a currency transaction tax, and airline, arms trade or fuel taxes.

Sector-wide approach for public and external sources of financing

Improving the size of the pool of health financing at the national level will not only assist with more coherent health planning and the ability to fund the core human, physical and management infrastructure of the health care system, but it will also optimise the aims of achieving cross-subsidisation and risk sharing within the health care system. Civil society must advocate for:

- A revitalised commitment to the sector-wide approach that would enable countries to manage donor funding, and public revenue more coherently and effectively.
- The funding of independent research to observe and monitor the participation and commitment of external actors to a sector-wide approach and the development of the capacity of developing country Ministries of Health. Apart from improving coordination amongst donors, UN agencies, the World Bank, GHIs, private foundations and international NGOs, there is a need to develop a counterweight to the culture of self-promotion and the insistence that countries show results specific to the grants of specific actors. External funding should be

judged by the performance of the overall health care system over time.

Abolish user fees

User fees in poor countries are an unjustifiable barrier to health care. Efforts must be made to abolish user fees in the public sector. Civil society could advocate for:

- Countries to adopt a target to reduce direct out-of-pocket payments to less than 20% of total health care expenditure, with timetable of steps towards the full abolition of the vast majority of out-of-pocket payments.
- Donors to support governments to help maintain quality of care in the face of increased utilisation following the abolition of user fees.

Strengthening health sector management

To achieve the goal of a strong, effective and publicly-based health care system, more investment needs to be directed at strengthening public sector health management capacity at all levels of the health care system. As mentioned earlier, HR planning and management requires particular attention. Other aspects of health management that should be highlighted include: resource management and planning; expenditure monitoring; financial management; essential drugs management; and improvements in health systems research. Civil society can advocate for:

- The regular production of national health accounts to describe the way in which health care is financed, as well as the pattern of health care expenditure, including measurements of the per capita expenditure variations between geographic areas, between socio-economic groups, and between secondary / tertiary hospitals and district health services.
- Evidence of investments in the strengthening of the financial management systems of the public health sector.
- Governments, donors and NGOs to enable public understanding and discussion about health sector financing.
- Expenditure targets, to be set over three to five year time frames, such as:
 - expenditure on district health services to be at least 50% of total public health expenditure, of which half (25% of total) should be on primary level health care;



- expenditure on district health services to be at least 40% of total public and private health expenditure; and
- a ratio of total expenditure on district health services in the highest spending district to that of the lowest spending district to be less than 1.5.

- An essential drugs programme which would include efficient systems of procurement, supply and distribution and the development of rational, standard treatment guidelines
- More investment in health systems and problem-solving operational research that is embedded as part of health management and planning activities (rather than as a parallel activity), and an integrated health information system.

Managing the tension between vertical, selective health care with comprehensive health systems development

One of the biggest challenges for many developing countries is to correct any imbalance between the trend towards multiple,

selective health care interventions (many of which are implemented through vertical and parallel structures) and the need for a single, cross-cutting health systems plan designed to meet all the priority health needs of a country. Although selective and vertical interventions make important and urgent health gains, the present configuration of multiple, fragmented

and selective funding channels and programmes hinder coherent health systems development, cause inefficiency and risks being unsustainable. An explicit sector-wide approach to health planning, with more funds being pooled nationally to develop the core, cross-cutting infrastructure of the health care system, will help improve this situation.

Civil society can advocate for:

- Agreement on a common and cross-cutting set of health systems goals to be shared by all programmes.
- The many new sources of financing from selective global health initiatives to allocate a significant proportion of their funds to a sector-wide budget to finance the core infrastructure for a functional health care system.
- Agreement on the principle that certain aspects of a health care system, such as the supply and distribution system of medicines and laboratory services, should never be duplicated so that parallel systems exist for different diseases or programmes.

At the global level, there is a need to debate the current architecture of global health policy making and governance. Civil society can:

- Call for a discussion to consider whether we have too many separate international and GHIs adding to the already uncoordinated field of official donor agencies, and whether there is a need for a paradigm shift in the way the international community responds to the health crisis in sub-Saharan Africa and other poor regions / countries. For example, rather than multiple strands of health funding attached to disease-based or selective interventions, there could be a single fund for comprehensive health systems financing which would then form the platform for designed disease-based or selective interventions.



provides a platform for the integration of policies, programmes and priorities emanating from the centre; forms the basis for resource-allocation decisions; and promotes integration between hospitals, clinics and community-based health care.

WHO and others have for many years promoted the rationale of the DHS model which remain as valid today as ever.

However, implementation has been undermined by the effects of structural adjustment programmes; the persistence of vertical programmes and top-down management cultures; and the reluctance to invest in district-level health management structures with authority, status and skills. Civil society can advocate for:

- The promulgation of the DHS model as an organisational basis for the management and planning of integrated and comprehensive essential health care. In countries where non-government providers provide a significant amount of health care, health districts can form the basis for improved collaboration and joint planning with public sector providers.

Public and community involvement in health care systems

For public sector bureaucracies to work effectively, efficiently and fairly, they need to be held accountable internally through rules and codes of conduct as well as 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. The design of health care systems can enhance community involvement by incorporating community structures and forums such as district health committees, clinic committees and hospital boards into the health governance structure; inculcating a culture of consultation and respect for lay people; disseminating information about the rights of service users; and publicising disparities in key indicators such as maternal mortality and immunisation coverage. Civil society can call for:

- Streams of funding to support civil society engagement in such activities, either from sector-wide budgets or external sources.

An organisational framework for the health care system – the District Health System

The District Health System (DHS) model provides an organisational framework for a health systems development agenda. It creates a framework for health plans and programmes to be tailored to the needs and characteristics of local populations; decentralises management authority and capacity; facilitates community involvement in health;

Regulating and shaping the private sector

In many countries, a large bulk 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'. Many governments do not have the capacity to monitor the quality of this health care let alone improve its quality and safety. This neglected area of health systems policy must now receive greater attention from governments and donors so as to shift disorganised and commercialised health care markets in the direction of greater equity and efficiency. Civil society can advocate for:

- The completion of a situation analysis of the unregulated and disorganised primary level private sector
- Appropriate strategies to integrate this unregulated sector into a system that operates under a structured and accountable framework of standards, quality and provider remuneration.

In some countries, further steps may need to be taken to regulate organised private insurance markets, amalgamate them into larger pools of financing (where appropriate) and reduce any polarisation that exists between public and private financing. Civil society can call for:

- A structured review of the state of private insurance markets and private hospitals, including an analysis of their impact on the public sector.

- Laws and regulations to enforce community rating and prescribed minimum benefits where private insurance schemes exist, and to block payment systems that encourage over-servicing and supplier induced demand.
- Regulations to control and improve the geographical distribution of all private health services, such as the issuance of certificates of needs.
- Appropriate strategies and policy instruments (such as licensing requirements, formal accreditation and price controls) to regulate and improve the quality of care of this sector.

What next?

The vision, principles and recommendations presented here are generic, and would need to be tailored to the historical, economic and political contexts of different countries. Furthermore, fragile states and countries in states of conflict or under oppressive rule are likely to need different approaches.

One of the next steps is to promote discussion about the challenge to strengthen health care systems and provoke questions about the appropriateness of the current paradigm and efforts to improve health in developing countries. It is only with a greater civil society consensus and momentum that donors and governments are likely to be influenced by such a challenging set of recommendations and aspirations. The Global Health Watch therefore invites you to respond to this proposed advocacy agenda and to recommend further key actions that could be taken to facilitate further dialogue and discussion.



Beyond the immediate step of prompting discussion and debate, there may be some practical actions that can be taken to help move this agenda forward. These include:

- Conducting a detailed assessment of the feasibility and appropriateness of the vision, principles and recommendations of this document in a number of selected countries. It may be useful, for example, to explore how such an agenda might be translated to the real-life situation of a country like Malawi or Bangladesh.
- Developing a set of core health care systems indicators that could act as a partial measure of the state of health care systems, and the state of their development / deterioration. This could then be packaged into an instrument for civil society organisations to audit their country's health care system and enable a more informed public understanding of the strengths, weaknesses, limitations and opportunities of the health care system.

The Global Health Watch invites you to comment on these recommendations and make further suggestions. To facilitate this, a structured feedback form has been designed

Contact us

An electronic copy of this document and structured feedback form are available at:
www.ghwatch.org/advocacy

Please send your comments through:
www.ghwatch.org/contact

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