Health systems – definitions and international norms

Lecture 2

Topics

- What do we mean by health systems?
- Three international norms
- The policy implications
- Policy debate – is Alma Ata affordable?

Defining health systems

- The convention is to include in health systems both health care services and other activities that promote health and prevent disease. However, controversy surrounds the identification of causes of ill health and the extent to which governments are held responsible for them. There is also the difficulty that much public policy has some sort of health effect and therefore could be considered as part of the health system. This is generally resolved by distinguishing between policies that are directly aimed at improving health and those that merely have incidental health effects.
- The political significance of broadening conceptions of health and its causes becomes clearer when we consider that the broad analysis of health systems places considerable emphasis on poverty as a cause of ill health and therefore on policies to address it. For example, Beaglehole & Bonita (2004: 62) provide a standard account of the significance of poverty for health status:
- *The WHO has identified poverty as 'the greatest single killer' [...] [It] is clear that several of the major risks to health such as child underweight, unsafe water and sanitation, and indoor air pollution are strongly associated with* ***absolute poverty****.*
- Since poverty is concentrated in certain social groups (for example, in relatively wealthy countries, most of those in poverty belong to one of five groups including single parents, the unemployed and the elderly (Beaglehole and Bonita, 2004:59)) it follows that public health policy is likely to attach considerable weight to redistribution of resources in society.
- In this series of lectures our focus will be on health care systems

Three norms

There is no single, agreed method of describing health systems. Description generally confirms to policy focus or question.

At the most general level, health systems are defined in terms of basic purpose.

There are three international norms:

- Alma Ata 1978
- World Development Report 1993
- World Health Report 2000

Alma Ata and the 'primary health care model'

- The broad definition of health systems has gained in influence from (and was partly responsible for) the declaration in 1978 of the primary health care movement (Alma Ata) and its strong focus on redistribution. The principles of Alma Ata have been the focus of much health systems debate. Article 6 states:
- **Primary health care** is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Essential care (World Bank, 1993)

The challenge for most governments is to concentrate resources on compensating for market failures and efficiently financing services that will particularly benefit the poor. Several directions for policy respond to this challenge:

- Reduce government expenditures on tertiary facilities, specialist training, and interventions that provide little health gain for the money spent.
- Finance and implement a package of public health interventions to deal with the substantial externalities surrounding infectious disease control, prevention of AIDS, environmental pollution, and behaviors (such as drunk driving) that put others at risk.
- Finance and ensure delivery of a package of essential clinical services. The comprehensiveness and composition of such a package can only be defined by each country, taking into account epidemiological conditions, local preferences, and income. In most countries

World Development Report 1993 and the 'global burden of disease'

Appendix B. The global burden of disease, 1990

The systems or welfare approach of WHO 2000

- "[…] while improving health is clearly the main objective of a health system, it is not the only one. The objective of good health itself is really twofold: the best attainable average level – goodness – and the smallest feasible differences among individuals and groups – fairness. Goodness means a health system responding well to what people expect of it; fairness means it responds equally well to everyone, without discrimination."
- Accordingly, WHO 2000 put forward a composite index of health system goal attainment, i.e. it ranked health system performance

If the organizational basis and the quality of primary health care often failed to live up to their potential, much of the technical footing remains sound and has undergone continuous refinement. This development can be sketched as a gradual convergence towards what WHO calls the "new universalism"– high quality delivery of essential care, defined mostly by the criterion of cost-effectiveness, for everyone, rather than all possible care for the whole population or only the simplest and most basic care for the poor (see Figure 1.1).

Figure 1.1 Coverage of population and of interventions under different notions of primary health care

	Population covered	
Interventions included	Only the poor	Everyone
"Basic" or simple	"Primitive" health care ←	→ Original concept
"Essential" and cost-effective	"Selective" primary health care →	New universalism
Everything medically useful	(Never seriously contemplated)	Classical universalism

Adapted from Frenk J. *Building on the legacy: primary health care and the new policy directions at WHO.* Address to the American Public Health Association, Chicago, IL, 8 November 1988.

A technocratic approach that masks the politics – Almeida et al, Lancet, 2001

- Data were unavailable to calculate measures reported for 70–89% of countries.
- Although key informants came from only 35 countries, 191 countries were ranked on health-system responsiveness; informants were not representative even of the 35 countries.
- The measure of health inequalities does not reflect concerns about equity.
- The measure of fair financing does not reflect a conceptually sound or socially responsible view of fairness and does not differentiate among countries.
- Important methodological limitations and controversies are not acknowledged.
- 26 of the 32 cited methodological references are non-peer reviewed internal WHO documents and only two of the 32 references are by authors other than those of the World Health Report 2000.
- The measures of health status have been widely criticised for their problematic implications for equity and under-valuing the lives of disabled people.
- The multicomponent indices are problematic conceptually and methodologically; they are not useful to guide policy, in part because of the opacity of their component measures.
- Primary health care is declared a failure without examining adequate evidence, apparently based on the authors' ideological position.
- These methodological issues are not only matters of technical and scientific concern, but are profoundly political and likely to have major social consequences.

Their associated health system terms

- Universal/comprehensive
- Targeting the poor
- Basic health care
- Selective/vertical programmes

Defining universal health care

- "a situation where the whole population of a country has access to good quality services according to needs and preferences, regardless of income level, social status, or residency
- "an absolute concept in relation to population coverage (100%) with the same scope of benefits extended to the whole population (but the range of benefits varying between contexts)
- "incorporates policy objectives of equity in payments (the rich should pay more than the poor), financial protection (the poor should not become poor as a result of using health care) and equity of access or utilisation (implying distribution according to need rather than ability to pay, and requiring equity in the distribution of spending and resources)" (Gilson, 2007:27).

Universality implies that "a major source of health funding needs to come from prepaid and pooled contributions rather than from fees or charges levied once a person falls ill and accesses services." (WHO technical note containing guidance on how to move to a universal (equitable) system of health funding: WHO (2005) Achieving universal health coverage. Technical note No 1. Geneva: WHO. On Web CT and: http://www.who.int/health_financing/pb_1.pdf)

Targeting the poor

Universality is contrasted with 'targeting' where limitations are placed on people's access to pooled resources and 'eligibility to social benefits involves some kind of means-testing to determine the "truly deserving" (Gilson, 2007).' Scarcity provides the rationale for targeting.

There are several criticisms of targeting:

- Identifying the poor is technically difficult
- It is very costly
- Appropriate information and administrative systems may simply not be available, especially in poorer countries
- Targeting stigmatises groups of the population and overlooks the ways in which social policies affect social status
- It can lead to substantial inequalities in the quality of care available to different social groups.

For a discussion see Commission on Social Determinants of Health (Gilson, 2007: 63). Targeting may also involve selecting cost effective interventions (Murray, 1995) – the 'basic health care package'.

Comprehensiveness

- Health systems can provide comprehensive services or a selected range of 'essential care'.
- The provision of comprehensive, integrated and appropriate health care […] makes an important contribution to improving health. […] [I]nternational comparisons of industrialised countries show that countries with stronger primary level services have populations with better health, particularly when health policy is generally supportive of a primary level orientation (Commission on Social Determinants of Health, 2007).

Comprehensive health care

Universality involves comprehensive health services. What are these? What services should or do form part of publicly-supported health care (the 'benefits package')? The notion of 'essential services' has played a key role in this debate but the term can be used in the sense of services to meet all health care needs or to meet people's main needs. Arguments that Alma Ata represents an unattainable ideal frequently involve substituting the second meaning for the first.

In order to discuss what public health care ought to be provided we need an understanding of health 'need'. (See Black and Gruen, pp. 82-90 for a standard distinction between need, demand and supply. See also Nolte and Mckee (2003) for the concept of "avoidable mortality"). Need in the context of health care services is generally defined as 'the ability to benefit in some way from health care'. (Black and Gruen, p85).

Targeting cost effective services: WDR 1993 famously linked essential ('cost effective') care and health service charges

Reforming health systems: promoting diversity and competition

Ensuring basic public health services and essential clinical care while the rest of the health system becomes self-financed will require substantial health system reforms and reallocations of public spending. Only by reducing or eliminating spending on discretionary clinical services can governments concentrate on ensuring cost-effective clinical care for the poor. One way to do so is by charging fees to affluent patients who use government hospitals and services. In Chile, Kenya, Lesotho, and other countries governments are increasing user fees for the wealthy and for those covered by insurance and are strengthening the legal and administrative systems for billing patients and collecting revenues.

Selective health care and vertical programmes

- The selective approach was first enunciated within three years of the Alma Ata declaration. It has been criticized for ignoring the realities of primary care which needs to be equipped to handle a wide range of presentations. (Tollman in Mills et al, 2006: 1194)
- Disease-based or vertical programmes are associated with (but not limited to) essential clinical care in the World Bank sense. Vertical programmes often focus on drugs-based initiatives to tackle infectious diseases and are the typical policy focus of international health aid programmes such as the Global Fund and GAVI. A recent review of evidence concerning of vertical programmes found the following (Atun, 2009: 4):
- "The available evidence on the relative benefits of vertical versus integrated delivery of health services is limited and too weak to allow for clear conclusions about when vertical approaches are desirable.
- "The limited evidence available suggests that integrated approaches to delivering health services, compared with vertical approaches, improve outcomes in selected areas including HIV, mental health and certain communicable diseases. In several countries in the eastern part of the WHO European Region, for example, vertical programmes appear to have impaired the effective management of HIV, tuberculosis, substance abuse and mental health.
- "Nevertheless, vertical programmes may be desirable as a temporary measure if the health system (and primary care) is weak; if a rapid response is needed; to gain economies of scale; to address the needs of target groups that are difficult to reach; to deliver certain very complex services when a highly skilled workforce is needed."

Other terms for essential care

- Selective primary health care
- Minimal packages of care
- Benefit packages
- Priority programmes

- The definition of benefits package is a key factor in the cost of health systems. In many health systems different benefits packages are available to different social groups, e.g. the military, civil servants, the formal sector, the informal sector – and their benefit packages usually differ with some being more generous than others.

Interventions In 1993 WDR Basic Package

Intervention	Per capita cost (1990 $)
EPI Plus	$0.5
School Health (education plus deworming)	$0.3
Other Public Health Programs (including family planning, health and nutrition information)	$1.4
Tobacco and Alcohol Control	$0.3
AIDS Prevention Program	$1.7
Short-course Chemotherapy for Tuberculosis	$0.6
Management of Sick Child (treatment of pneumonia, diarrhea and malaria)	$1.6
Prenatal and Delivery Care	$3.8
Family Planning	$0.9
Treatment of Sexually Transmitted Diseases	$0.2
Limited Care (pain alleviation, minor trauma and infection)	$0.7
TOTAL	**$12.0**

Source: DFID, Mark Pearson, June 2000.
EPI Plus = expanded programme on immunization (diphtheria, pertussis, tetanus, poliomyelitis, measles, TB) plus yellow fever, hepatitis B, and vitamin A and iodine supplementation.
Cost is total cost per capita per year

The key debate: is universal health care affordable?

Alma Ata principles remain current despite substantial challenge in the 1980s. The recent WHO Commission on the Social Determinants of health endorsed the view that "health inequalities, between social groups or populations, which are deemed avoidable by reasonable means, are unjust." (Marmot, 2007) It also maintained that although the main determinants of health lie outside the health-care system, nonetheless, the health care system has three important functions:

- To ensure universal access
- To advocate for action on the social determinants of health
- To facilitate routine monitoring for health equity. (Marmot, 2007)