WEEK 2 DEFINING HEALTH SYSTEMS

Objectives/learning outcomes

Students will be able to:

- recognise and understand international norms for health system functions and development;
- recognise and understand distinctions between universal access, universal coverage and sustainable health systems;
- analyse economic and public health approaches to health systems.

Lecture: Defining health systems

All governments accept some responsibility for the allocation of health care throughout society and most countries have signed up to international charters proclaiming a universal right to health. However, there are different interpretations of health system goals and different health care systems produce different allocations. In this lecture we examine recent developments in approaches to achieving universal health systems and consider their relationship with definitions of 'health systems'.

Set reading

Figueras and McKee (2011), chapter 1, 'Health systems, health, wealth and societal well-being: an introduction'.

G8 Hokkaido Toyako Summit Follow-Up (2009) Global Action for Health, System Strengthening, Policy Recommendations to the G8, pp9-25. (http://www.hrhresourcecenter.org/node/2397)

World Health Report 2000, Overview, ppxi-xix. (http://www.who.int/whr/previous/en/)

Alma Ata Declaration, http://www.who.int/publications/almaata_declaration_en.pdf

Lecture summary

Introduction

All governments accept some responsibility for the allocation of health care throughout society and most countries have signed up to international charters proclaiming a universal right to health. However, there are different interpretations of health system goals and different health care systems produce different allocations. In this lecture we examine recent developments in approaches to achieving universal health systems and consider their relationship with definitions of 'health systems'. We will review the beginnings of international efforts to improve access to health care and public health in the Alma Ata Declaration and the 'health for all' initiative of the WHO, examine the contemporary focus on "health system strengthening" and its context of international donor aid, and critically examine the "health and wealth" thesis. We begin with some basic health system concepts.

Locating the debate: Health and wealth – the rationale for health system strengthening

The right to the highest attainable standard of physical and mental health is a human right endorsed by almost all countries. Nonetheless, there are widespread, systematic inequalities in health both within and between countries. The health divide (the difference in health status among socio-economic groups) is growing in areas like the former Soviet republics and sub-Saharan Africa. Life expectancy in the Russian Federation today is lower than it was 40 years ago, and since 1980 the health divide between the Russian Federation and west European countries has grown from 4 to 14 years. (Whitehead and Dahlgren, 2006, volume 2, p14)

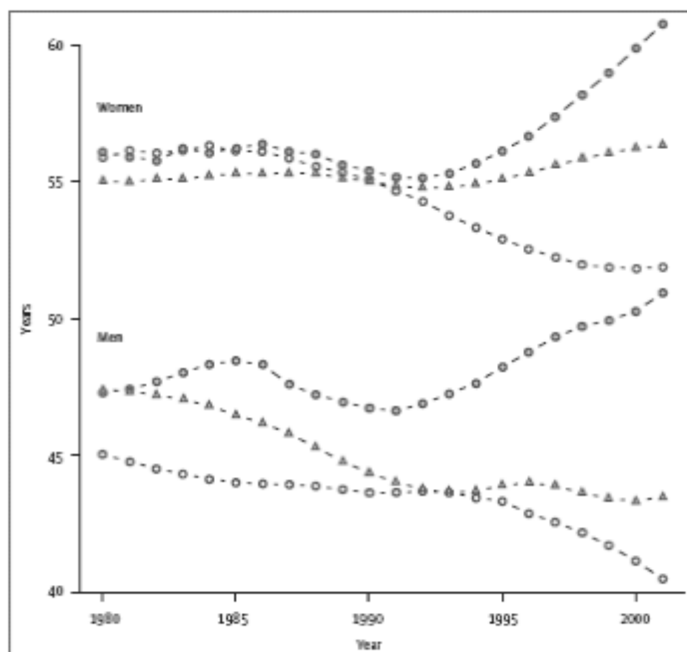

Figure 3: Trends in male and female life expectancy at age 20, by educational attainment, Russia
Figure shows values for educational levels: elementary (open circles), intermediate (triangles), and university (filled circles). Source: Murphy and colleagues, 2006.[11] Reproduced with permission.

The growing divide is also evident in international comparisons:

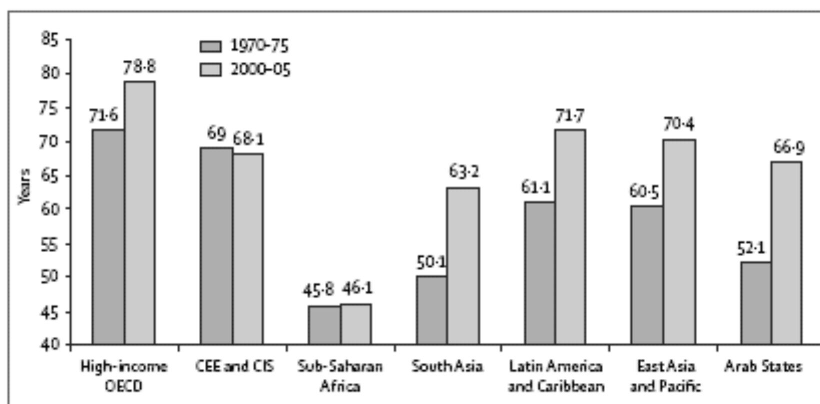

Figure 1: Life expectancy at birth by region, 1970–75 and 2000–05

Source: Marmot, 2007

As well as signing up to international charters proclaiming a universal right to health many countries have committed themselves to developing universal health care in which everyone has access to health services[1]. Recognition of a right to health places governments under a duty to secure access to health care and universal access is an objective of the World Health Assembly, the democratic body that oversees the World Health Organisation.

Current debate suggests that international agreements have refocused health policy on a commitment to universality after a twenty-year preoccupation with an economic analysis that prioritised cost containment. Figueras and McKee (2011) refer to "a new wave of thinking" termed the "health and wealth" debate in which health is "hailed as a driver of economic growth" rather than an impediment to it. (The Commission on Macroeconomics and Health was the originator of this rationale for health care spending). The approach provides an economic growth rationale for health system investment and is a counter to arguments that health spending is an economic burden.

Definitions of 'health' and health systems analysis – the emphasis on redistribution

Our understanding of health systems is linked to ideas resource distribution in society.

The definition of 'health' influences the analytical framework. 'Health' can be defined negatively as the absence of disease or it can be defined *positively* as 'a state of complete physical, mental and social well-being'[2]. The second definition

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[1] See the key instruments of the Millennium Development Goals, the 1979 Alma Ata Declaration on universal health care, the Bangkok and Mexico statements on universal cover, the WHO's World Health report 2010, and the Paris Declaration and Accra Agenda for Action.

[2] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The Definition has not been amended since 1948. http://www.who.int/about/definition/en/print.html (accessed 10 October 2009).

is generally known as ‘positive health’. Positive health is the preferred definition of the WHO.

These definitions determine what factors are to be included in the definition of a health system. For convenience we can distinguish between broad and narrow conceptualisations corresponding to the two definitions. The broad conceptualisation includes health and other social, environmental and industrial policies; the narrow concept focuses on medical or health care interventions.

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:

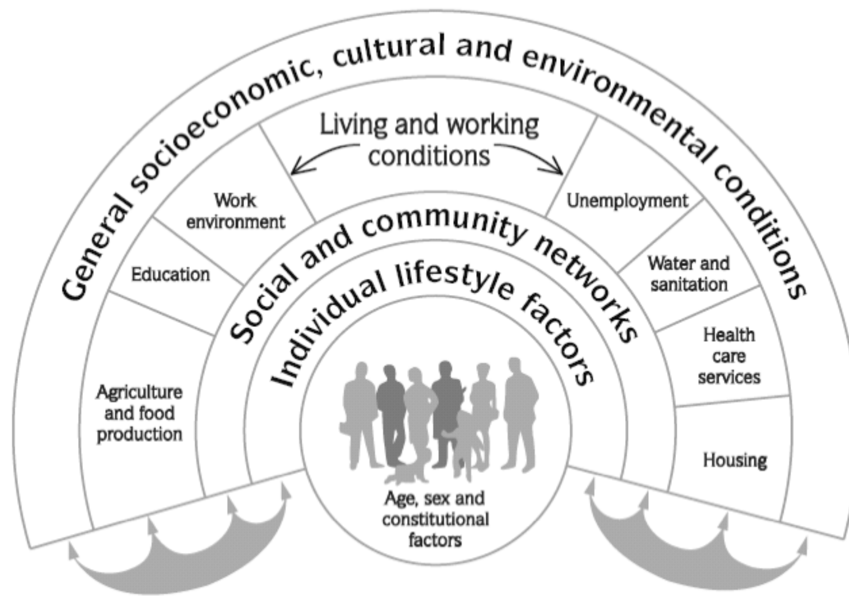
> *The WHO has identified poverty as ‘the greatest single killer’ [...] [It] is clear that several of the major risks to health such as child underweight, unsafe water and sanitation, and indoor air pollution are strongly associated with **absolute poverty**.*

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.

These connections are expressed in the standard account of the social determinants of health (figure 1):

Figure 1

The Main Determinants of Health



Source: Dahlgren and Whitehead, 1993

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. Articles 6 and 7 state:

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> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made <u>universally accessible to individuals and families in the community</u> 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.
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> Primary health care:
> 1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
> 2. addresses the main health problems in the community, providing promotive,
> preventive, curative and rehabilitative services accordingly;
> 3. includes at least: education concerning prevailing health problems and

> the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
> 4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
> 5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
> 6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
> 7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.
> (http://www.who.int/publications/almaata_declaration_en.pdf, emphasis added)

The declaration is the founding document of the WHO's 'health for all' policy, including the goal of universal access to health care. Its redistributive focus can be seen in the emphasis on universal access as well on wider resource allocation questions.

Definitions of universal, comprehensive health systems

Equity goals underline the importance of the distribution of health care resources. But how should health care systems approach the question of disribution? Some form of cross-subsidisation of health costs is necessary to ensure that there is equity of access among all social groups. Cross-subsidisation involves equalising resources across society and health systems are important means of redistribution. Universal and comprehensive health systems pursue equity in this sense. However, 'universality' is a term which has also been the subject of recent debate. Here we clarify the group of concepts with which it is associated.

a) Defining universal systems

Governments adopt different access goals. The two basic approaches are 'universal' and 'targeted' health systems. Universal coverage is defined by the WHO as follows:

> · "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).

Funding arrangements are basic to universality.

> "Universal coverage of health care means that everyone in the population has access to appropriate promotive, preventive, curative and rehabilitative health care when they need it and at an affordable cost. Universal coverage thus implies equity of access and financial risk protection. It is also based on the notion of equity in financing, i.e. that people contribute on the basis of ability to pay rather than according to whether they fall ill. This 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)

That is, universality requires that a high proportion of spending on health systems is mandatory funding (not out-of-pocket payments or private insurance) because mandated payment is the mechanism whereby the rich pay a higher proportion of their income towards health care than the poor.

The funding system is one of the main determinants of equity in health care because it involves the transfer of funds from those who are generally richer and fitter to those who are poorer and sicker. A universal health care system is generally understood to be one in which funding (and therefore the risks of ill-health) are pooled across a whole geographic population. Accordingly, health systems are often analysed and classified according to their funding systems. This is the subject of a later lecture.

European health systems are mainly universalistic. Most rely primarily on mandatory revenue collection (through taxation or social insurance) and the level of direct payments is relatively low (with the exception of Greece (40%), Italy (31%), Portugal (37%) and Finland (21%)) (Mossialos et al, 2002). The USA is the only industrialised country not to have adopted universal health care as a goal.

Many less developed countries are working towards universality and the WHO provides technical advice on how that policy can be pursued. An important criticism is that there may simply be insufficient domestic resources to finance a universal system and that universality directs scarce resources to those who could otherwise afford to pay.

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).

b) Defining comprehensive (relevance to needs)

As we have seen, 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). (How need is defined and measured at the service level as distinct from the patient level is the subject of a later lecture).

Health systems can provide comprehensive services or a selected range of 'essential clinical care'. Comprehensive health care forms part of the primary health care concept of 'appropriate treatment of common diseases and injuries'. By contrast, the World Bank's policy of "essential clinical services" (World Bank 1993) was enunciated in its landmark 1993 World Development Report which

announced the entry of the Bank into policy areas traditionally occupied by the World Health Organisation.

> **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**

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."

Analytical differences in approaches to health systems

Health systems are defined and analysed in a variety of ways (see especially Nolte, 2005). The traditional approach is to conceptualize and define health systems in terms of services, bed numbers and physician numbers (Roberts, 2005). In 1991, Roemer (1991) produced an influential argument that five main characteristics were important – productive resources, organization of programmes, economic support mechanisms, management methods and service delivery. Mills and Ranson (2001) take the straightforward view of identifying within a country's health system four key actors (government or professions, population/patients, financing agents, and providers of services) and four key functions (regulation, financing, resource allocation, provision).

But the complexity of health systems means that even the simple framework of Mills and Ransom involves difficulties of categorization and comparison. This is because there is almost always a complex mix of different systems at work. Nolte (2005) points out, for example, that the US health system is often described as a market or private system and yet about 50% of total expenditure on health services is from state and federal spending. Similarly, the description of the NHS as an integrated public health care system might lead us to miss growing differences between England and Scotland with respect to privatization of service provision.

Moreover, how does the idea of 'system' apply to low resource countries where most health care is bought privately and the government plays a relatively small role? Indeed, if a question behind health system analysis is, what goals do nations want their health systems to achieve?, few governments actually produce health system strategies and many do not have the power or control necessary to implement them.[3] For example, the US government is unique among OECD countries in having little influence over the payers and providers of health care, and total spending on health. That is one important reason why total health spending is so high relative to other countries. (See below).

The general message from the literature is that health systems are conceptualized and defined in different ways depending on the question being asked (Nolte, 2005).

Theoretical frameworks underpinning health system analysis

Asking questions should involve a theoretical framework or an account of why the categories into which systems are analyzed matter and what happens when configurations vary. For example, Nolte (2005) provides an account of Elling's political-economic classification of health systems in order of the increasing strength of a country's labour movement (core capitalist; core capitalist/social

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[3] There have been several studies of national health strategies in Europe (see Figueras, 2005: 143 for details), but none so far as I am aware outside Europe. According to Figueras, 'While many countries have a written policy document promoting health, most 'express the desirable rather than the actual situation'. Most policies are inspirational rather than managerial or technical tools to achieve change, indicated by the relative paucity of quantitative health targets or specification of ways to achieve them.'

welfare; industrialized socialist-orientated; capitalist dependencies; socialist orientated/quasi-independent). This Marxist account seeks to explain a country's 'superstructure' (in this case, the health and welfare system) in terms of economic power relations in society, and it would predict a link between democratic control and health system equity (provisionally, the extent to which people receive health care according to need). (See Navarro's study (2006) of the link between politics and health policies).

By contrast, an OECD classification of 1992 categorizes health systems in economic terms, specifically, the extent of private economic control and ownership. Mills and Ranson (2001) describe the key categories as follows:

- Whether the prime funding source consists of payments that are made voluntarily (as in private insurance or payment of user fees) or are compulsory (as in taxation or social insurance)
- Whether services are provided by direct ownership (termed the integrated patterns, where a ministry of health or social insurance agency provides service itself, by contractual arrangements (where a ministry of health or social insurance agency contracts with providers to delivers services), or simply by private providers (paid by direct out-of-pocket payments)
- How services are paid for (prospectively – where financial risk is transferred to providers, or retrospectively –where the cost of care is reimbursed)

The focus of these two theoretical frameworks is clearly very different. The first is concerned with relations between health system organization and political and economic power. The second is concerned with the relative economic efficiency of systems. In this case a market economics theoretical framework is adopted in which the significant analytical factors are the dimensions along which market forces do or do not operate.

Although often insufficiently recognized in books on health systems, political context is very important because public health relies extensively on governments for policy implementation. Equally, support for state or collective health care has political origins (Kunitz, 2007: 56). The historical dimension also accounts for health system diversity and for what Nolte (2005: 16) calls the path dependency of analysis: 'Many of the national specificities of each health system are determined by particular historical circumstances such as the emergence of western European social insurance systems from strong sets of relations between employers and employee associations in Germany and France following the industrial revolution, the rejection of state control in the countries of central and eastern Europe that emerged from communist rule in the 1990s, the shared wartime experience that led to the creation of the British NHS, or the rugged individualism and non-conformism that characterizes much of American life, and by extension the delivery of health care.'

One might include here the experience of colonial countries in which settler populations were well provided with developed health care that was, or was not, extended to the indigenous population. (See for example, WHO, 2000: chapter 1

for the argument that British colonialism in Africa provided a health care system exclusive to the settler population). And also the historical influences on health systems in the former Yugoslavia (Bredenkamp, 2007) where the Stampar model of mandatory social insurance) persists in health financing in Macedonia, Serbia, Montenegro, and Bosnia and Herzegovina. The Albanian model is based on the Soviet Semashko (tax-funded) system. Health insurance was only introduced to the region in 1995 and is less prominent.

These rather crude potted histories are contested. For example, substantial solidarity has been reported in the origins of US health care. Nonetheless, the point is made that health systems have a history enshrined in what is very often a substantial and long-standing infrastructure of practices and relationships, legislation, expectations, buildings and equipment. Although inconsistent with a formal systems approach, this conception of path dependency or history should not be overlooked but is to a large extent.

A third important theoretical framework is that of public health. This framework is concerned with associations between health systems, service organization and access to health care. It is the basic orientation of this lecture series.

A key debate in health system policy is the practicability of pursuing Alma Ata objectives

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, 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)

At the same time, Alma Ata goals are subject to reinterpretation. Since 2009 the World Health assembly has passed two resolutions on "sustainable health financing" for "universal coverage" in which emphasis is placed on affordability. "Universal coverage", which is defined as access "at an affordable cost", is deemed "consistent with WHO's concepts of health for all and primary health care". (WHA A58/20: https://apps.who.int/gb/e/e_wha58.html) Mixed funding is also promoted on the principles that health care financing must be sustainable (appropriate to government financial resources) and that "no health system meets the full cost of health services out of the prepaid and pooled funds collected by tax or insurance contributions." This line of argument can be used against tax-financed schemes with very low levels of user charges, such as the NHS system. And yet in the past the WHO has held up the NHS as a model.

Criticisms of Alma Ata play have played an important role in international policy debate because they encapsulate the differences between a public health based and an economics based analysis of health systems based on ideas about economic efficiency and consumerism.

According to Segall (2003), the World Health Report (2000: 13-17) relegated primary health care to a new generation of reforms and sought to align WHO and World Bank policy on health systems: "According to this account, failures of primary health care are to be ascribed to weakness in policy design, specifically to a neglect of people's demand for health care, which is influenced by perceived quality and responsiveness of service. Instead primary health care focused on health service supply based on presumed population needs. This inadequate attention to health care demand is interpreted mainly as a neglect of market mechanisms and the private finance and provision of care. Third generation reforms are to correct this neglect by introducing a market orientation to the health sector along the lines recommended by the World Bank (1993).'

The World Heath Report 2000 (2000:15) adopted the Bank's analysis: 'The approach emphasized in the primary health care movement can be criticized for giving too little attention to people's *demand* for health care, which is greatly influenced by perceived quality and responsiveness, and instead concentrating almost exclusively on their presumed *needs*. Systems fail when these two concepts do not match, because then the supply of services offered cannot possibly align with both. The inadequate attention to demand is reflected in the complete omission of private finance and provision of care from the Alma-Ata Declaration, except insofar as community participation is construed to include small-scale private financing.'

More recently, substitution of "universal coverage" for "universal access" is to be found in the "health and wealth" approach outlined by Figueras and McKee (2011). The substitution is characteristic of a social welfare or utilitarian approach to health systems in which the defining goal of a health systems is said to be "to improve health" rather than to ensure universal access to heath care or primary health care principles (Figueras and McKee, 2011: 23). Maximising health gain is a standard approach in health economics and In a later lecture we examine why this perspective does not necessarily lead to a policy commitment to universal access.