Administering the health system

Lecture 7

De Maesenneer (2008)

"Evidence at the macro level (eg, policy, payment, regulations) is now overwhelming: countries with a strong service for primary care have better health outcomes at low cost. Systems that explicitly distribute resources according to population health-needs (rather than demands), that eliminate co-payments, that assume responsibility for the financing of services, and that provide a broad range of services within the primary care sector are more cost effective."

Market autonomy versus planned systems

- '[In universal systems it] is possible to allocate public funds according to need, regardless of ability to pay, whereas private payments to commercial providers cannot be allocated in this way.' (Whitehead & Dahlgren 2006, 2, p71)

Principles of public administration

- 'Public provision of a function is more equitable, reliable and democratic than provision by a commercial or voluntary body;
- Where a ministry or other public authority is responsible for a function, it normally carries out that function with its own staff;
- Where a public body provides a service, it is provided uniformly to everyone within its jurisdiction;
- Operations are controlled from the headquarters of the public body through a hierarchy of unbroken supervision;
- Employment practices are […] standardised […];
- Accountability of public servants to the public is via elected representative bodies' (Dunsire, 1999: 361).

A framework for understanding administration

- Policy authority—e.g., who makes policy decisions about what primary health care encompasses (such as whether such decisions are centralised or decentralised)
- Organisational authority—e.g., who owns and manages primary health-care clinics (such as whether private for-profit clinics exist)
- Commercial authority—e.g., who can sell and dispense antibiotics in primary health care and how they are regulated
- Professional authority—e.g., who is licenced to deliver primary health-care services; how is their scope of practice determined; and how they are accredited
- Accountability—who from outside government is invited to participate in primary health-care policy-making processes and how are their views taken into consideration

The sub-systems of administration

- Regulation of supply
- Workforce planning
- Management and budgetary control:
  - Planning
  - Budget and financial processes (a budget that allocates resources to multipurpose programmes rather than to special-purpose services and projects)
  - Information systems
  - Training
  - Supervision
  - Research (WHO, 1996)
- Evaluation and democratic control

Basic concepts - decentralisation

Decentralisation is used to mean different things:

- *devolution allows more responsibility to be vested in local Ministry of Health officials;*
- *administrative decentralization is a means of transferring responsibility for health to a local authority;*
- *autonomy for public providers is designed to endow health facilities with autonomy, within the public sector, based on legal status;*
- *separation of funding bodies from service providers allows competition between providers, whether public or private to be introduced […]. (WHO, 2005)*

Basic concept - integration

Non-market/universal definition: integrated health services are those 'necessary for the health protection of a given area provided under a single administrative unit, or under several agencies, with proper provision for their coordination.' (WHO, 1996)

Market/non-universal definition: In the US system, by contrast, integration refers to a system in which insurance and provider functions are coordinated in the context of voluntary insurance and competitive providers. Integration in this case is based on provider or enrolee populations not on geographic populations. It is not an equity mechanism.

In the **managed care** model of integration, insurers control clinical care providers in order better to manage costs.

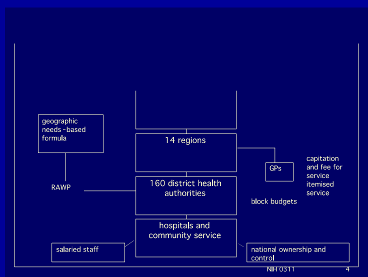
Needs-based resource allocation

- Needs-based resource allocation is an important equity-orientated alternative to historical budgets (budgets that may merely perpetuate inequalities). In this system funds are allocated according to districts' health care needs. Green (2000) points out that in a decentralised planning system needs-based allocations are a precondition of equity: 'Within such a decentralization process, one necessary precondition for achieving equity is the development of systems for allocating resources to districts in line with health needs. The objective is to develop an approach that allows for central resource planning and local health care programming.'

Integration based on geographic populations is an equity mechanism – because it is inlcusive

- allows delivery of a range of services selected to suit national health policies and local needs within a global budget
- incorporates inputs from different components of the health system and thus reflects the multidimensional concept of health
- has the capacity to take on new activities and react to disasters
- allows multipurpose use of resources, such as personnel, and allows more outputs to be achieved for a given input
- allows planning and management of area health services according to local circumstances with appropriate political, intersectoral and community involvement
- makes it easier to respond to user needs, which saves time, and encourages personalized service and continuity of care and thus increases convenience and user satisfaction
- allows a more holistic approach to health, centred on the health needs of individuals and communities

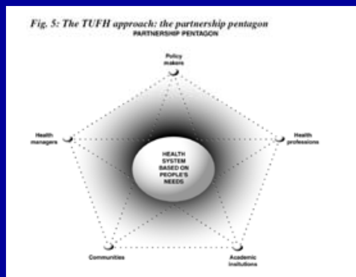
Population-based integration the pre-1991 NHS



Population-based integration - district health system model

In lower income countries health provision is frequently organised around district health centres. (See WHO ,1996:19ff; WHO, World Health Report 2008) for an account of the integrated district health system). A district health system is a more or less self contained section of the health system catering for a defined population. It includes 'all institutions and individuals providing health care in the district', all 'self-care and all health care workers and facilities' and 'the appropriate laboratory, other diagnostic, and logistic support services.' It covers a fully comprehensive range of promotive, preventive curative, and rehabilitative health activities.

‘Towards Unity for Health’ approach: De Maeseneer (2007)



The model was advocated in the Alma Ata declaration and incorporates the following principles

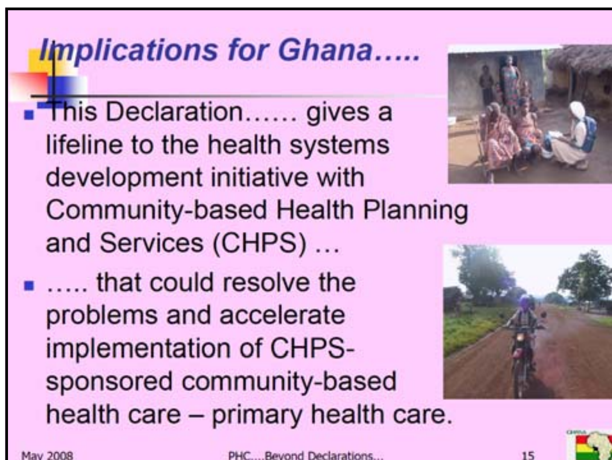
- Equity
- Accessibility
- Emphasis on promotion and prevention
- Intersectoral action
- Community involvement
- Decentralization
- Integration of health programmes
- Coordination of separate health activities
- Development of human resources (See WHO (1988) for detailed account of district health systems).

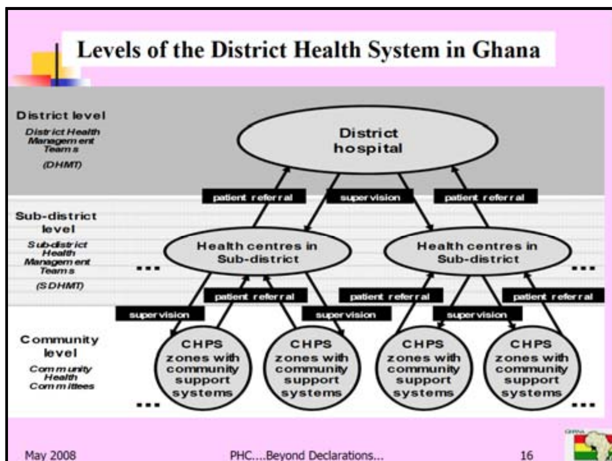
Ouagadougou Declaration 2008

The Declaration….

- .. recalls that '*phc 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*'
- .. And as '*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' -*

May 2008 PHC…Beyond Declarations… 8





Comparison of unintegrated 'vertical' systems and the PHC model

	Definition of health	Efficacy of health technology	Community	Health professions	Equity
Vertical programmes	Absence of disease Reduced incidence and prevalence	Selection of interventions which are biomedically cost-effective	Provides resources/ organization for health intervention	Provide health care Limited or no influence on determinants of health	Limited to specific component of vertical programme
Integrated PHC	Protection and promotion of health and well-being	Adaptation of interventions to local socio-economic and health conditions	Responsible for own community health programme and shares responsibility for health service	Provide health care and facilitate health promotion	Enhanced across wide range of health services

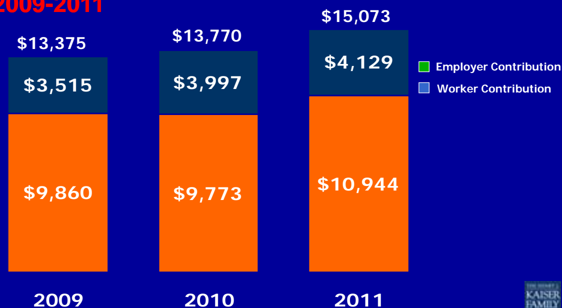
Market integration - managed care and the health maintenance organisation (HMO)

Managed care (and integration) is fundamentally different in systems where the payer has statutory duties to a whole population (e.g. a government) and where the payer only has responsibilities towards its members (e.g. a HMO).

The main mechanisms of managed care are:

1. integration of funding and provision to allow case management by funder
2. transferring economic risks from funders to providers via capitation or case payment
3. restricting the autonomy of providers in medical decision-making (e.g. pre-authorization)
4. limiting patient choice of providers.

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2009-2011



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2011.

Kellper, 2012

Lobbying & Health Care Policy

- In 2009 (during the reform proceedings), health care organizations spent $1.3 billion to lobby Congress.*
- 3,330 lobbyists participated: 6 for every member of Congress.*

In other words, policy is developed to favor the special rather than the public interest.

**Open Secrets. The Center for Responsive Politics*

Kellper 2012

Overview

The diversity of social insurance and tax-funded arrangements in Europe make generalization difficult. In the UK and Scandinavia the general model is tax-funded integrated systems with disintegration at the fringes, whilst in the social insurance dominated systems of Europe where provider markets are found elements of integration are often limited to the hospital sector. Administrative systems of SHI systems are potentially extremely complex because of the range of funders, payers and providers. In African countries where most health care is privately financed, public administration is often limited but PHC development is taking place.