WEEK 8 ADMINISTERING THE HEALTH SYSTEM

Objectives/learning outcomes

Students will be able to:

Recognise, understand and critically examine concepts of decentralization and integration.

Seminar: Where does planning authority lie?

Apply the Lewin et al (Lewin, 2008) governance framework to a specific health system and determine where authority lies with respect to at least two of the following:

- 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
- Consumer and stakeholder involvement—who from outside government is invited to participate in primary health-care policy-making processes and how are their views taken into consideration

You should refer to WHO databases when preparing a short class presentation.

Lecture summary: The continuum of administrative tools

Administrative structures reflect the goals and functions set for a health system and complement financing as a redistributive mechanism. They can be viewed on a broad continuum according to their reliance on public or market planning systems. Publicly administered redistribution (as distinct from allocation through the market) requires structures for allocating resources according to health care needs, namely, adequate planning tools and resources, planning powers and appropriate population-based data. Market planning requires different tools. In this lecture we will contrast administrative systems designed for universal access with those designed for other purposes.

Set reading

Essential:

Lewin S (2008) Supporting the delivery of cost-effective interventions in primary health-care systems in low-income and middle-income countries: an overview of systematic reviews*. Lancet*; 372: 928–39.

De Maeseneer, J., Willems, A., De Sutter, A., and Van de Geuchte, I., Billings M. (2007). Primary health care as a strategy for achieving equitable care. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

Additional:

World Health Organization (2008) *World Health Report 2008*. Geneva: WHO, overview and chapter 1.

Black N and Gruen R (2005) *Understanding health services*. Maidenhead: Open University Press. (Section 5)

Lecture

Introduction

The system of health service administration complements financing as a means of pooling the risks of ill health. Publicly administered redistribution (as distinct from allocation through the market) requires reliable mechanisms for allocating resources according to health care needs, namely, adequate planning tools and resources, planning powers and appropriate population-based data.

Contemporary accounts of health administration place too little emphasis on these basic characteristics and often focus instead on high level generalisation about governance systems, 'decentralisation' and 'integration', terms that are not always used in a consistent way.

In this lecture we examine these basic descriptive categories and review models of administration that are now current.

Background

We cannot discuss health system administration properly without first acknowledging changes in the terms of such discussions over the last 20 years. In that period the ideas of 'new public management' have become extremely influential and with their rise traditional forms of public demonstration have tended to be described, often pejoratively, as relatively 'statist', 'centrist' or bureaucratic. In debates about the role of markets in health systems you will often here a contrast made between 'command-and-control' systems patient or user-centred systems. Traditional administration is generally taken to fall into the first category.

However, traditional institutions of government action were not discussed at the time in these ways but in terms of valued civic principles. Dunsire (1999) paraphrases these principles as follows:

1. 'Public provision of a function is more equitable, reliable and democratic than provision by a commercial or voluntary body;
2. Where a ministry or other public authority is responsible for a function, it normally carries out that function with its own staff;

3. Where a public body provides a service, it is provided uniformly to everyone within its jurisdiction;
4. Operations are controlled from the headquarters of the public body through a hierarchy of unbroken supervision;
5. Employment practices are […] standardised […];
6. Accountability of public servants to the public is via elected representative bodies' (Dunsire, 1999: 361).

When set out like this it becomes clearer that one of the most important characteristics of traditional administration is not that it is undemocratic but that it is anti market. This is an important analytical point for health system administration.

Administrative systems can be placed on a broad continuum according to their adaptation to needs-based allocation or market allocation. At one end of the continuum are administrative systems that are wholly universalistic in that they include sufficient powers and mechanisms for public authorities to ensure that the health needs of geographic populations are met. At the other end of the continuum are largely privatised health systems in which publicly controlled redistribution mechanisms are poorly developed and resource allocation is largely market-driven. There are of course many intervening stages.

The contrast is due to the autonomy required by market actors. As Whitehead and Dahlgren note: '[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) (This is not to argue that redistribution does not take place under private or market systems, only that it is not under the control of public authorities. Universal systems involve public mechanisms of resource allocation. Resource allocation mechanisms are private in market systems).

In this lecture I will introduce the concepts that are generally used to classify administrative systems. The key terms in the literature are decentralisation and integration. But these terms are contested, and also the boundaries of the systems they are used to characterise (Lewin et al (2008)). The second aim of this lecture will therefore to be to contrast four commonly occurring administrative systems and to set out some common analyses of administrative themes.

Basic concepts

Allocating public funds according to need requires planning data and planning powers (information and control). But health systems are complex and varied, involving pubic and private elements. Basic terms for describing health system administration are frequently used in ways that obscure this fundamental difference. Although key terms like decentralisation and integration are common in accounts of administrative systems, there is no agreed conceptual or analytical framework with which to examine them.

Standard research or performance assessment studies offer useful insights into the problem of conceptualisation.

Concepts can be based on typical evaluative approaches. For example,, Lewin, following Lavis (Lewin et al, 2008; Lavis et al, 2002), identifies the standard performance questions with respect to authority in primary care 'governance arrangements', which for our purposes I will equate with administration:

> *What are the effects of changes in or interventions to improve*
>
> • 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
>
> • Consumer and stakeholder involvement—who from outside government is invited to participate in primary health-care policy-making processes and how are their views taken into consideration

Questions about authority are linked to those about financing and funding. How is finance raised and how are programmes paid for? How are resources allocated to different parts of the system and how are providers paid?

Decentralization and integration are terms that attempt to capture the complexity of these variables and inevitably it can be misleading when they are applied to very different arrangements. How are they generally defined?

Defining decentralisation

Decentralisation refers to the locus of control or authority within a health system. Mills (Summary of Mills (1990: 16-38) Health system decentralization. Geneva: WHO) distinguishes four types of decentralization differentiated by legal status, function and financing method. These are: deconcentration, devolution, delegation and privatization.

Deconcentration, the least extensive form of decentralization, denotes the transmission of some administrative (but not political) authority 'to locally-based offices of central government ministries.' Devolution involves the creation of local authorities with 'recognized geographical boundaries, a number if functions [..], and statutory authority to raise revenue and make expenditures'. They are not usually completely autonomous. Delegation refers to situations in which managerial responsibility is transferred from central government to outside bodies sometimes referred to as parastatal organisation. Privatization

involves the transfer of government function to private bodies, with varying degrees of continuing government control.

Provider autonomy is a concept widely used in the legal analysis of decentralisation. The 'purchaser-provider' split, where planning and provider functions are undertaken by different organisations, is a central component of market reform programmes involving the switch from direct management to financial or market incentives. But as the WHO notes, provider autonomy and privatisation are distinct policies (although the former might be intended to lead to the latter). Autonomy can be engineered *within* a public system:

> *Policy-makers have several choices: 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)*

Variants of decentralization can also be classified by the type of function decentralised. The following functions can be decentralised: legislating, revenue-raising, policy-making, regulation, planning and resource allocation, management, intersectoral collaboration, interagency coordination, and training.

This type of analysis is particularly relevant to district health organisation and the question of what authority to vest at local level.

Sources of finance affect the type and degree of decentralisation, argues Mills. In developing countries, local authorities often have little scope for levying taxes and are dependent on grants funded through national revenues raised from customs. (Where user charges are levied, an important issue is whether or not they are retained a local level. See Singh (2003)).

A key process is the route and method by which national funds are allocated locally. In many countries, including developed countries, it is common for block grants to be allocated on an historical basis (that is, as increments to a traditional budget).

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.'

Defining integration

The term integration is used in universal (non-market) and non-universal (market) contexts to refer to the degree of administrative unification within a health system.

a) Non-market/universal definition

The WHO defines integration in organisational terms **with reference to geographic areas**: 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) Integration of health care delivery. Technical Report Series 861. Geneva: WHO, p4) Integration so understood is an equity mechanism. It:

- allows delivery of a range of services selected to suit national health policies and local needs
- 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

b) 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. The most important model of US integration is known as the **managed care** model, in which insurers extend their control and influence to clinical care providers in order better to manage costs.

Administrative sub-systems

- 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

Models of integration

The NHS model - population-based integration

The UK's national health service was originally designed to ensure direct flows of tax funding to pay for the health care needs of geographic populations (Pollock, 2005). The UK NHS is a good case study because it was the model maker for many universal systems. The NHS system was designed on non market, integrated principles - there was no price mechanism or contract. Its core features are geographic populations, area based planning and integrated planning.

The building blocks are prevention and promotion, primary care, secondary and tertiary care. (There is not space to examine these aspects of health system organisaiton. For further details see Black and Gruen, 2005).

In 1948 the NHS was brought under public ownership and control with some key exceptions. Administrative tiers responsible for the provision of services ensured total patient coverage to all patients within their catchment area. These administrative tiers were subdivided into two main planning tiers to ensure economies of scale and coordination for common conditions (district level) and for rare and expensive treatments and interventions (regional level).

Integration was achieved by bringing services under the control of the administrative tier and further economies of scale were achieved in having only one pay roll office HR office etc. Resources were allocated to areas according to needs based formulae which were constantly under refinement and budgets allocated to services which were directly managed units (the issue of resource allocation within the system or the flow of funds is dealt with in the next lecture). There was public accountability through area boards that had responsibility for meeting needs and local services. There were national terms and conditions for staff and training and education budgets. The administration costs were very low, less than 6%, because there was no billing, invoicing or marketing. The strengths of this system were there was strong decentralised public control over resource allocation and service provision and very great efficiency.

The NHS has been criticised for sustained underfunding and a persistent failure to fully integrate. Examples of lack of integration (in the geographic population sense) include the relationship between primary care and social services, and primary care and secondary care; the independent contractor status of GPs, dentists and opticians; private practice rights; and weak democratic mechanisms. (NHS plc: chapter on long term care).

An important advantage of the system is its low 'transaction costs'. Markets cost money to run, even 'internal markets' (where the purchaser-provider split remains entirely within the public sector). In 1990 administrative costs in the NHS accounted for 6% of total costs. Woolhandler (2003:768-75) contrasts

administrative costs in the USA's market system and the Canadian integrated system. In 1999 'administration accounted for 31.0 percent of health care expenditures in the United States and 16.7 percent of health care expenditures in Canada. […] Providers' administrative costs were far lower in Canada. Between 1969 and 1999, the share of the U.S. health care labor force accounted for by administrative workers grew from 18.2 percent to 27.3 percent. In Canada, it grew from 16.0 percent in 1971 to 19.1 percent in 1996.' (Both nations' figures exclude insurance-industry personnel.)

District health system model - population-based integration

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.

This 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).

Unintegrated 'vertical' systems – non-population-based

Vertical programmes: disease control programmes are widely used in externally (donor) funded health programmes such as those facilitated by global partnerships like the Global Fund for Malaria, AIDS and TB. The following table contrasts their main characteristics with those of integrated systems. An important difference is that vertical programmes are guided by cost effectiveness criteria not by universality goals.

Table: Assumptions and beliefs underlying vertical programmes and integrated primary health care

	Definition	Efficacy of health	Community	Health	Equity

	of health	**technology**		**professions**	
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

Source: WHO, 1996, p11.

Buse discusses 'seven habits' of global health partnership practice that affect health system performance:

- skewing national priorities by imposing external ones;
- depriving specific stakeholders a voice in decision-making;
- inadequate governance practices;
- misguided assumptions of the efficiency of the public and private sectors;
- insufficient resources to implement partnership
- activities and pay for alliance costs;
- wasting resources through inadequate use of recipient country systems and poor harmonisation;
- and inappropriate incentives for staff engaging in partnerships (WHO,1996: 6; WHO, 2008: chapter 1; Buse, 2007)

'Integrated' market systems - managed care – membership based integration

Managed care is a form of integration that is based not on geographic populations but on insurance company membership. It is a product of the private insurance system.

Private, voluntary, competing insurance and competing providers dominate the health system in the USA. The predominant model of organisation within this system is known as 'managed care'. Managed care is a system adopted by health maintenance organisations (HMOs) intended to insulate themselves from financial risks. HMOs are essentially combinations of insurers and providers in which the insurer (or payer) influences provider policy in order to manage the financial risks of health insurance. (See Donaldson and Gerard (2005: 62) and Morris et al, 2005).

Managed care has become an international organisational model widely promoted in health system reform programmes (Liu, 2003):

- there is no universally accepted definition of managed care: 'Some authors define managed care as the integration of financing and delivery of health services; others define it as care provided under the control of a third party.' (Liu, 2003: 85)
- The most comprehensive definition is as follows: 'managed care refers to the mechanisms, organizational forms and techniques used by a third party (e.g. government, insurer, employer or other payer) to influence the provision of health care services in a cost-efficient manner.' This contrasts with the traditional system in which the third party payer is only responsible for paying the bills.
- 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 include (Liu, 2003, 85):

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

HMOs provide (or arrange and pay for) comprehensive health care for a fixed periodic per capita payment (or premium) which is paid by the consumer (usually with a subsidy from employers or social security). The premium is set in advance and is independent of the volume of services provided to the individual during the period.'

Generalising about health system administration in Europe

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.