# 1. UNDERSTANDING HEALTH SYSTEMS & CURRENT ISSUES OF HEALTH SYSTEMS

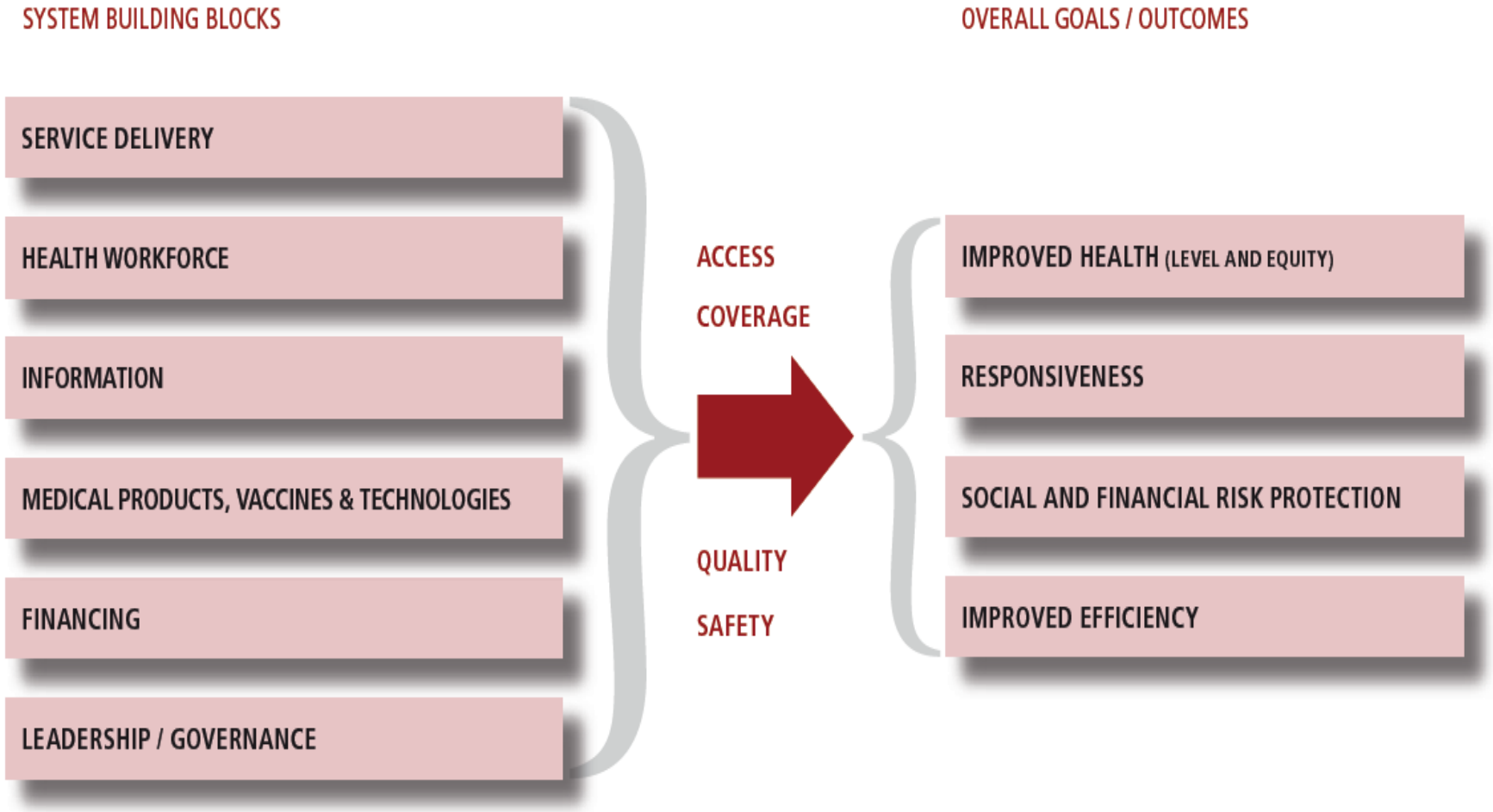
IPHU, November 2nd, 2019

# A matter of definitions…

- **Public Health :** ‘ the science and art of preventing disease, prolonging life and promoting health, through the organized efforts of society”. (Acheson, 1988)
- **Public Health System**….is a term used to refer to government health programmes and government health facilities and to the regulatory functions over the entire health sector – public and private health system.
- **Health sector** is used to refer to both public and private sector in health care provision
- **Health systems:** The various structures, institutions and processes that interact to achieve a set of goals related to health and healthcare in the population

- A system is any natural or man- made entity perceived as sets of interacting parts. A system is more than the sum of its parts- it includes their interaction. ( natural : solar system, human body, eco-system man-made: health system, social systems,)
- To know each part well by themselves and as part of the system, know how inter-relationships operate, how these are managed, how information flows through…

# A Systems Approach !….The WHO Health Systems Framework…



# The Declaration of Alma Ata:1978

- Para 1: defines health – declares it a fundamental right….defines it as a  social goal.
- Para 2: Declares health equity as a goal.
- Para 3: Declares social and economic development as necessary for health and health as necessary for social and economic development.
- Para 4: people have a right and duty to participate in decision making in health.
- Para 5: declares health as the responsibility of the government. And primary health care as the key strategy..

# The Declaration of Alma Ata, 1978

Para 6 and 7 defines c*omprehensive* primary health care- lists 20 components:

- Health education; food supply and nutrition, safe water and sanitation, maternal and child care, family planning, immunization, control of endemic disease, appropriate treatment of common illness and injuries, provision of essential drugs,
- Lists 8 related sectors,
- Mandates community participation as central
- Mandates referral systems as integral.
- Defines the health human resource needed…

# 1. Organization of Service Delivery

1. Raising demand of services- preventing exclusions, reaching the unreached.
2. Organization of preventive and promotive care services
3. Defining/Organizing the set of assured medical services in public facilities/ or the package in insurance
4. Continuity of care in the provider network with appropriate access (HSC, PHC, CHC, DH etc)
5. Quality and safety of care- efficient use of resources, constant improvements ( the leadership and management issues)
6. Infrastructure and Logistics.

# 2. Human Resources for Health

1. Generating enough and appropriate HR.
2. Basic Workforce Management:
3. Building, retaining, updating  the necessary skills in the workforce.
4. Organizing and supporting them for providing effective care and good quality of care and rewarding good performance.
5. Attracting and retaining them to serve in public sector/areas where we need them most.

# 3. Medicines and Technologies

1. Universal access to essential medicines & devices/equipment. Reducing OOPs on drugs and diagnostics.
2. Rational and appropriate use of medicines and diagnostics.
3. Better procurement and logistics in the public health systems.
4. Quality assurance and value for money in medicines and devices
5. Clear identification of needs for existing and for new technologies. Promoting innovation and discovery as required.

# 4. Financing

1. Securing the required budgets. Advocacy in both public and within govt. for enhanced public expenditure.
2. More efficient and timely absorption and “value for money” of funds made available.
3. Reducing out of pocket expenditures and ensuring cashless services at the point of delivery of care.
4. Affirmative action as required for social protection of the poor against cost of illness.
5. Transparency and accountability in use of funds.

# 5.Information

1. **Generate population based data and facility based data-** on morbidity, mortality and access to services, and cost of care: from census, surveys, hospital/facility records, service delivery data(HMIS) and studies.
2. Detect, Investigate, communicate and contain events that are threat to public health security- as soon as possible. ( disease surveillance).
3. Have capacity to synthesize and use information to inform decision making and action at decentralised levels- and to support policy making at national levels.
4. Support providers to ensure better quality and continuity of care
5. Provide access to public on information needs with regard to their own and with respect to public health.

# 6. Leadership and Governance

1. Policy Guidance: Priority Setting:
2. System Design: Building institutions:
3. Oversight- Supervision, Accountability
4. Building Partnerships.
5. Regulation.

# Essential Readings:

1. Declaration of Alma Ata, 1978
2. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action, WHO, Geneva, 2007*

# Understanding Health Systems: A political economy approach

Nature of health systems depends upon:

- the political system and distribution of political power;
- the ownership and social structure of production;
- distribution of income and resources; and
- historical attributes (the role of labor movements, the rise of the welfare state, the response to peoples movements : In LMICs : the legacy of colonialism, de-colonization, the Alma Ata Declaration, the imposition of structural adjustment policies and resistance to it, the ongoing Universal Health Coverage).

# Political ideology and health systems…..

1. *Mainly Market Based,* liberal-swear by free-enterprise: which provide only a minimum safety-net (e.g., the United States, which offers basic health and social services for the elderly and some indigent groups);
2. *Welfare States: wage earner welfare states,* which are more generous than liberal free-enterprise states and provide largely employment-based (rather than citizenship-based) benefits (e.g., Australia,)
3. *Social democratic welfare states,* which are the most redistributive, providing universal benefits to all residents (e.g., Nordic states. United Kingdom, many other European nations)
4. *Socialist and centrally planned*: Soviet Union, Cuba etc.

# Financing and Provisioning

| | Public Provisioning | Private Provisioning |
|---|---|---|
| Public Financing | Government Hospital- with little or no user fees. | • Publicly financed insurance<br>• Public Private Partnerships/ contracts<br>Also referred to as Government Purchasing care: |
| Private Financing | User fee based cost recovery- negligible role | Fee for service @ point of care:<br>Private Insurance |

# Amongst Industrialized Nations

| | Public Provider | Private Providers |
|---|---|---|
| Public Finance (including employer funds) | United Kingdom->90%<br>Spain- > 90%<br>Scandinavian><br>Cuba- 100%<br><br>Thailand- > 90% | Germany<br>France<br>Japan<br>Canada<br>New Zealand<br>Australia |
| Private Finance | No Nation- | USA (44% public finance) |

# Low and Middle Income Countries

- At Decolonization- Inherit very limited urban based, elite oriented systems
- Expansion of public health services was very limited: largely due to financial constraints, constraints in human resources and conflicts.
- Shaped by internal crisis and external donors to focus on few diseases.
- Most respond favorably to the Alma Ata call- begin to develop nation-wide health systems: but not for long

# Structural Adjustment Policies of the nineties-

- Fiscal crisis in most LMICs- as nations are unable to repay IMF loans- accept tough conditions.
- Collapse of the Soviet Union and setback to principles of socialism world wide
- Rise of Neo-liberal thought.
- Structural Adjustment:
  - Cut back in all public investment and services and employment
  - Introduction of user fees, restriction of public services to highly selective package
  - Privatization push.

# Resistance to the SAP

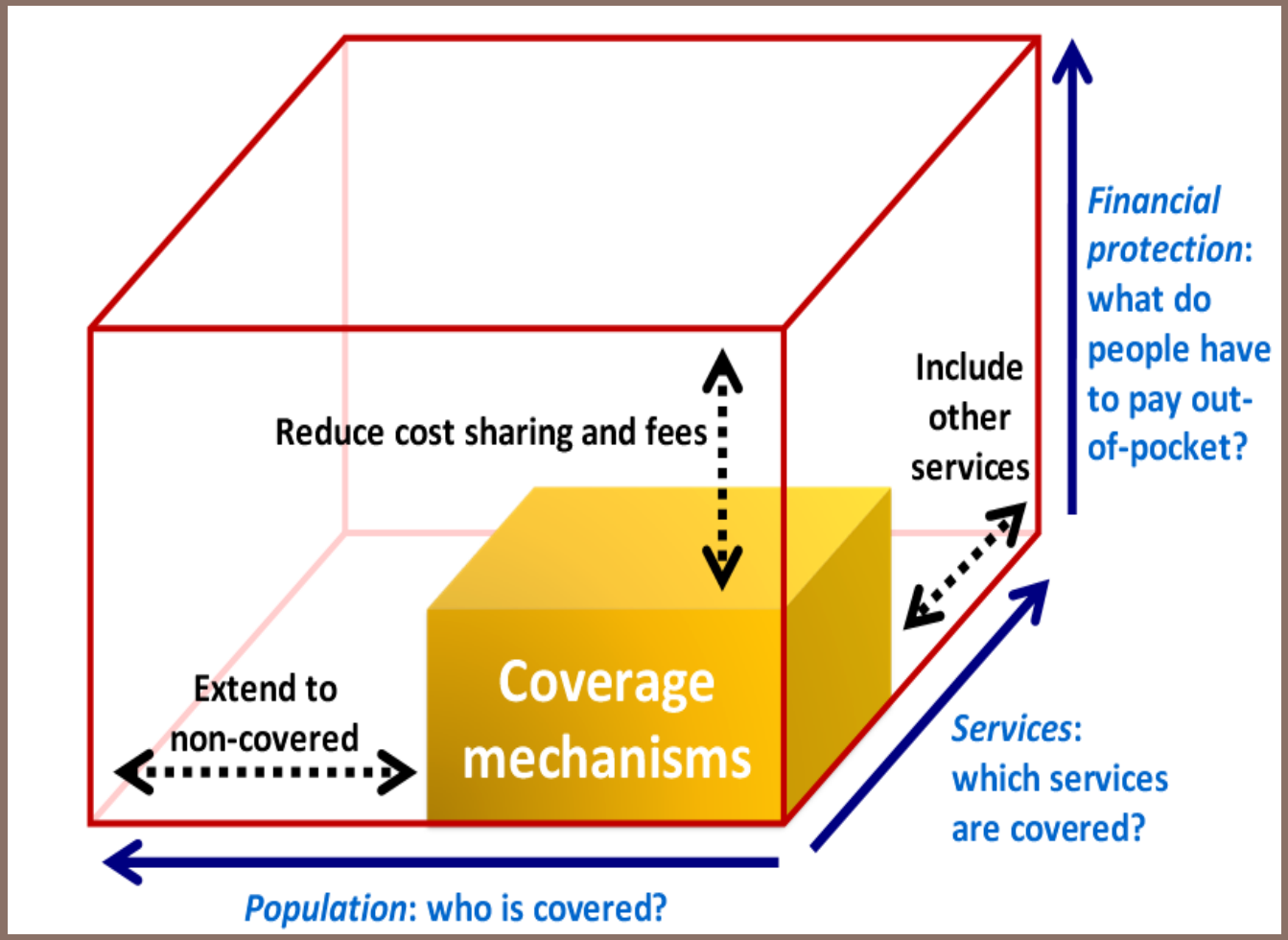
- Some nations ignore or negotiate their way ahead:
  - Cuba, Brazil, Sri Lanka, Thailand, Costa Rica
- In all nations protests against privatization of health services and protests against the adverse consequences of globalization in all spheres
  - Movements by trade unions and health workers
  - Movements by womens organizations and civil society.
- In year 2000, the rise of the Peoples Health Movements

# “ The “Universal Health Coverage” discourse..



- *“ Those who are in need of health care services, are able to access services of adequate quality without having to face financial hardship.”*
  - *What proportion of those in need of health care are able to access health care that is effective without financial hardship?*
  - *What proportion of those in need of health care could have been prevented from needing care by appropriate preventive or promotive health measures?*

# THE VISUAL IMAGE OF UHC ….




1. Height

2. Depth

3. Breadth

# The changes in the first decade

- Initially some efforts at strengthening primary health care
- But by 2008, the rise of the Universal Health Coverage discourse:
  - Using weakened public health services as rationale; a push to move towards government funded health insurance systems-
  - Changing the role of government from provider to purchaser. Different forms of contracting seen as solution.
  - Under-playing or ignoring the task of strengthening public services.
- In times of a new global economic crisis, healthcare is seen as one of the few avenues for global capital to invest.
- Rise of health care industry and increasing oligopoly- worsening of health equity and increasing incidence of catastrophic health expenditure.

# Thank You