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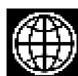

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Health System Strengthening

Issues Note

The World Bank Group

Moscow – Washington DC
November, 2005

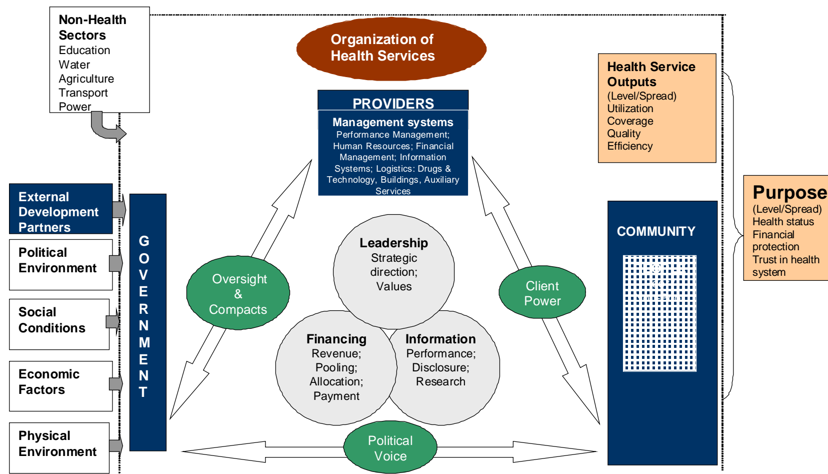
Health Systems Strengthening

Background

It is widely recognized in the international community that weak health systems present a critical barrier to the achievement of the health related Millennium Development Goals (MDGs). Most of the recent increases in new development assistance for health have focused on specific interventions or diseases -- immunizations, HIV/AIDS, tuberculosis and malaria -- creating incentives for the development of separate health service delivery silos to the detriment of the overall health system and other less well funded programs. In fact a recent study of donor aid for health found that only 20 percent of such aid was provided as non-tied budget support, while 30 percent was earmarked for specific projects and the other 50 percent by-passed government budgets altogether and went directly to NGOs, other private providers, and consultants[1]. Clearly such practices by donors severely complicate budget management and countries' abilities to focus on overall health services delivery systems objectives.

There are various generic definitions of health systems -- "the combination of resources, organization, financing and management that culminate in the delivery of health services to the population" (Roemer 1991); and "all the activities whose primary purpose it to promote, restore or maintain health" (WHO 2000)) -- and health system functions. Figure 1 below provides an idea of the complexity of both the functions and organizational arrangements.

Health services delivery framework



Source: David Peters, World Bank

[1] Foster, Mick. *Millennium Development Goal Sector and Poverty Reduction Strategies: Lessons from Experience*. Health, Nutrition and Population Unit Discussion Paper. The World Bank. October 2005.

However, while holistic approaches to dealing with health systems are being espoused by all donors, the various global funds and the countries themselves, little operational guidance exists on how to configure health systems to maximize health outcomes, while at the same time achieving efficiency by fully exploring joint production possibilities and economies of scale and scope synergies. Annex 1 contains a detailed presentation of health systems constraints and issues.

This is a critical issue for the G-8 as the success of its health related proposals on debt forgiveness, doubling aid to Africa, etc., are contingent on effectively functioning health systems. Recognizing that health systems capacity is a major bottleneck in delivering care, the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund to Fight AIDS, TB, and Malaria (GFATM), the President's Emergency Plan for AIDS Relief (PEPFAR), and the Africa Multi-Country HIV/AIDS Program (MAP) have each committed significant funding specifically for strengthening health systems. In addition, the global response to public health emergencies such as SARS and Avian Flu depends crucially on having adequate health systems capacity in developing countries. This is a period of great opportunity to channel donor funds for health into strengthening health systems in countries.

The G8 chairmanship provides the chance to take some of these critical issues forward. There is a need for a more coherent approach to donor assistance in the health sector that addresses broader, long term health systems strengthening. There is a need to document good practices on how countries have managed large inflows of external resources without fragmenting their health system (e.g. creating major distortions either in the health labor market or in other markets). With the large amounts of new funding promised by the G-8, European Community, there is great need and opportunity to enhance coordination in strengthening health systems.

Health Systems Strengthening Issues

Barriers to Health Systems Strengthening

Below is a detailed listing of health systems constraints in terms of households and communities, health services delivery, health systems' organization and functions, and accountability relations.

I. Household & community

Type of Constraint	Amenability to Funding	Dependence on Health System Factors	Dependence on External Factors	Time Frame for Change
Lack of demand for appropriate services	Medium	High	High	Medium
Financial barriers to effective services	High	High	High	Medium
Geographic barriers to effective services	Medium	Medium	High	Medium
Social/cultural barriers to effective services	Low	High	High	Medium

II. Health services delivery

Type of Constraint	Amenability to Funding	Dependence on Health System Factors	Dependence on External Factors	Time Frame for Change
Weak management of health services organizations	Medium	High	Medium	Long
Inadequate numbers, placement and skills of health workers	Medium	High	Medium	Long
Poor motivation, incentives of health workers	Low	High	Medium	Long
Poor pharmaceuticals & supplies systems	Medium	High	Medium	Short
Poor equipment and buildings management systems	Medium	Medium	Medium	Short
Poor information systems	Medium	High	Medium	Medium
Weak financial management	High	High	Medium	Medium

III. Health systems organization and functions

Type of Constraint	Amenability to Funding	Dependence on Health System Factors	Dependence on External Factors	Time Frame for Change
Distorting and redundant organizational forms	Low	High	Medium	?
Lack of leadership to provide vision and values	Low	High	High	?
Inefficient and unfair health financing systems	Medium	High	High	Medium
Rigid bureacracies for planning and monitoring health services	Low	High	High	Long

IV. Accountability relationships

Type of Constraint	Amenability to Funding	Dependence on Health System Factors	Dependence on External Factors	Time Frame for Change
Poor health policy environment	Low	High	High	?
No measurement of health organization performance	Medium	High	Medium	Medium
Inattention to private sector opportunities and risks	Medium	High	High	?
Little responsiveness of health organizations to community needs/preferences	Low	High	High	Medium

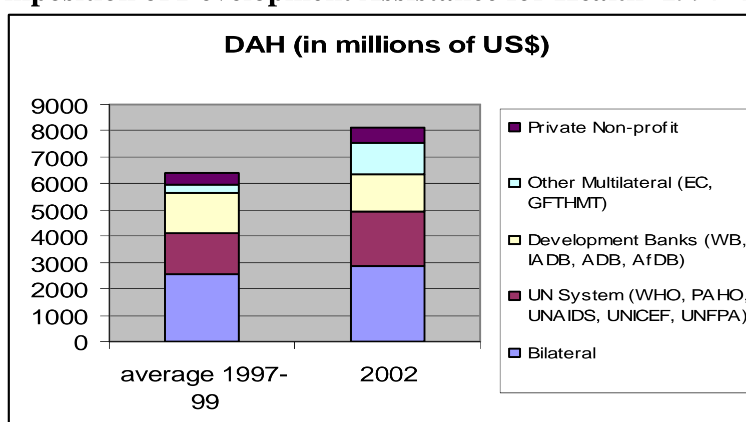
Source: David Peters, World Bank

These health systems constraints can be obstacles for countries to effectively employ large increases in health resources. Moreover, additional funding alone is not sufficient for overcoming structural weaknesses.

Trends in Development Assistance for Health

Development assistance for health has risen steadily since 1990 from about US$2 billion to some US$ 10 billion in 2003. In health, much of the post-2000 increase in development assistance for health can be credited to an increasing number of disease-specific global partnerships and private philanthropic funding - notably the Gates Foundation - which have joined efforts to increase awareness and finance aimed at the eradication of major diseases. Global programs such as GFATM, GAVI, MAP, Roll Back Malaria, PEPFAR, and several others represented roughly 15% of total development assistance for health in 2002 and 20% in 2003.

Composition of Development Assistance for Health[2] 1997 -2002



The impact of disease-specific programs on health care systems has recently become a major issue. On the one hand, disease-specific programs such as GFATM and GAVI:

- are effective in increasing the awareness of major global concerns such as HIV/AIDS, immunizations, SARS, Avian Flu
- introduce new technologies to countries
- are sometimes more effective than general government programs in delivering services to targeted populations

On the other hand, such programs are potentially disruptive to health systems because they:

- draw financial and human resources from the current health system to set up a parallel delivery operation contributing to delays in much needed institution

[2] World Bank (2005) *Health Financing Revisited*, The World Bank, Washington DC.

building in the health sector and potentially depriving other less favored programs from the country's limited delivery capacity.

- miss the opportunity to integrate priority programs into the overall health system
- fragment outreach services
- raise the demand for management skills that are already in short supply
- may generate expenditures that are not sustainable within the recipient country's budget constraints
- make governments responsible to donors instead of their citizens

As discussed above, in many countries donors require that assistance be kept in parallel budgets outside the Ministries of Finance which, among other detrimental effects, eliminates the possibility of appropriate planning and targeting of expenditures. In Tanzania off budget spending was estimated to represent more than 46% of total health spending in 2000. In Uganda off budget spending is estimated to be greater that 50% of total health spending. Although some of the off budget spending is domestically funded, such as the resources collected from user fees, it is largely donor funded. In part, donors encourage this behavior to be able to properly account for the direct impact of their resources.

The rapid increase in HIV/AIDS funding provides a good example of some of the issues surrounding the focus on disease-specific funding for health and its impact on health systems. The graph[3] and text box[4] at the end of this note summarize some of the main findings.

Clearly, there is scope for synergy gains by strengthening the positive effects of vertical programs on health systems and reducing negative ones. Vertical programs need to be appropriately designed, to take into account the capacity of the particular health system, and to plan in advance the necessary measures to avoid undermining the system as well as to make appropriate budgetary provisions.

Summary

Strengthened health systems and health service delivery are key pillars in enhancing access to health care for populations in need. The G8 chairmanship provides an opportunity to address some of the key issues identified, build momentum, and continue with the leadership of the G8 in this area. At the November Meeting of the High Level Forum on Health in Paris, Ministers and senior officials from The World Bank, IMF, WHO, African Development Bank, UNICEF, UK, France, Canada, U.S., Denmark, Norway, and several developing countries highlighted the importance of having a holistic approach to health systems development. Senior representative from GAVI and the Global Fund indicated the need and willingness to focus on health systems. They are seeking guidance on how best to invest in health systems so as to maximize their impact and diminish the distortions from the large amounts of funding that they are putting in countries. The World Bank, WHO, Partnerships for Health Reform, USAID, and

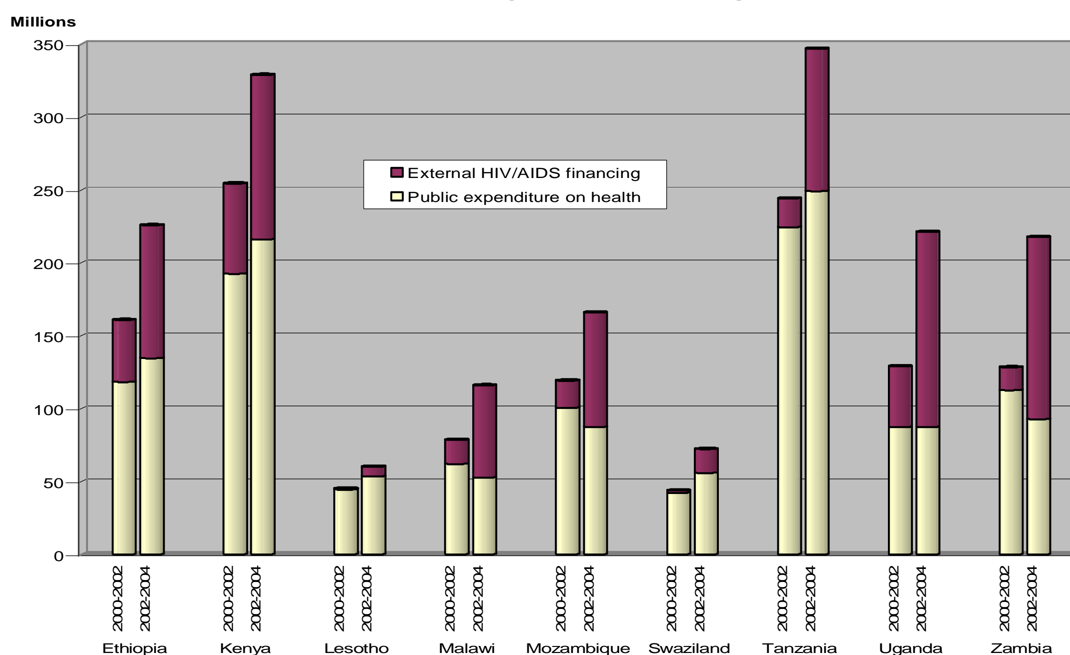
[3] Lewis, M. (2005) Addressing the Challenge of HIV/AIDS: Macroeconomic, Fiscal and Institutional Issues, Center for Global Development, Washington, DC.
[4] Lewis (2005) and World Bank (2005).

bilateral donors are all struggling for the best way to deal with this issue. The highly visible and politically charged debate on human resources for health has also recognized that human resources are one critical component of the overall objective of health systems' strengthening. The next chair of the G-8 will undoubtedly need to provide leadership on this issue.

There is a need to develop a consistent definition (or a typology) of the key functions and characteristics of health systems. These would include sustainable financing, regulation, stewardship, information systems, monitoring and evaluation systems, adequate human resources for health, logistics chains, pharmaceutical inputs, management capacity, etc. There is a need to document good practices on how countries have managed large inflows of external resources without fragmenting their health system (e.g. creating major distortions either in the health labor market or in other markets). Most critically there is a need for *operational* guidelines/road maps for countries and donors alike to invest in health systems.

In conclusion, the large amounts of new funding promised by the G-8, EC, and others coupled with the health systems absorptive capacity constraints listed above, highlight the need for a coordinated and implementation-oriented approach to dealing with health systems. Generic templates are not the solution. Yet, progress at the country level in this area is essential if the goals of the G-8, new efforts like the IFFim and investments from the French airline tax proceeds are to be effectively implemented. Development partners cannot ignore this issue, which has now been pushed to the forefront of the development agenda for health.

Figure 4.
Trends in Domestic Public Health Funding and External Financing for HIV/AIDS, 2000-2004



Summary of Impact of GFATM on Health Systems

Policy Processes

- § The majority of Global Fund supported proposals appear to be in alignment with overall national health policies and plans; issues regarding incompatibility or divergence arise during the implementation phase.
- § Global Fund-related planning processes appear highly centralized, even in decentralized contexts; this has led to problems as countries begin to implement Global Fund-supported activities, due to lack of ownership at sub-national levels.

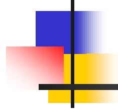
Human Resources

- § In none of the study countries were there overarching national level strategies or plans to address human resource constraints to scaling-up HIV/AIDS services. Plans that do exist relate to specific initiatives rather than the combined needs of all initiatives, and such plans do not typically take into account the potential implications of such scale-up on human resources for other programs within the health sector.
- § In the face of staffing shortages, and lack of clear guidance or plans on how to motivate and retain key staff, countries and various stakeholders within countries are experimenting with alternative types of incentive packages (financial, non-financial and in-kind). The effectiveness of such packages needs to be assessed.

Pharmaceuticals and Commodities

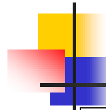
- § All participating countries had experienced delays in the procurement of drugs and commodities despite the fact that different procurement models – working through government systems, through private parallel systems, and through multilateral agencies – had been used. Procurement through government systems appears to have led to the most substantial delays.
- § Lack of consistency in the pricing of different commodities, pharmaceuticals and services supported by different funding sources was observed to be problematic in many countries. Identical resources or commodities flowing through the same distribution systems were charged for and handled differently according to whether the Global Fund, other donors or government had paid for them.

Annex 1



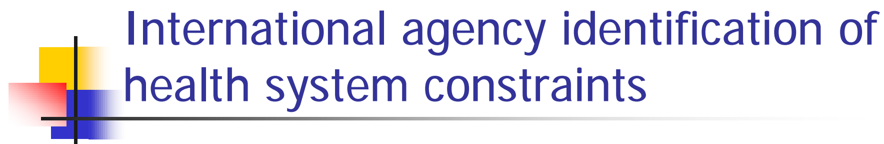
Overview of Health Systems Constraints in Developing Countries

David Peters
November 30, 2005



Graduate student ranking of health system constraints in low income countries

2001	2005
1. Inadequate funding	1. Poor management
2. Personnel – poor motivation & training	2. Corruption/poor governance
3. Corruption/poor governance	3. Personnel – poor motivation
4. Poor management	4. Poor systems to allocate funding



International agency identification of health system constraints

Constraint	World Bank	WHO	HLF	GFATM	GAVI	DFID
Poor management (at district & central levels)	X		X		X	X
Poor accountability of providers	X	X			X	X
Lack of incentives for health workers	X	X	X		X	X
Lack of trained health workers	X	X	X	X		X
Inadequate & unreliable public spending on health	X	X	X		X	X
Lack of knowledge by public	X	X	X		X	
Poor drug supply chain management	X		X	X	X	X
Poor monitoring of health services	X		X		X	

Broad international consensus

- Overall goals and priorities – MDGs, HIV
- Cost-effective interventions
- Importance of strengthening health systems
- Identification of health system constraints
- Commitment to increasing funding and donor harmonization/coordination

So why don’t health systems deliver?

What will it take?

- More time, more resources
  - A Global Fund for Health Systems?
- Real commitment to local leadership?
- More attention to performance?
- Less *ad hocracy?*

Levels of constraints

I. Household & Community
II. Health Services Delivery (inputs, processes, outputs)
III. Health Systems Organization & Functions
IV. Accountability Relationships
V. Context

Reasons

- Understand types of intervention required
- Recognize dependence on other parts of health system – know where to look for unintended consequences
- Recognize dependence on external factors
- Understand timeframe for change

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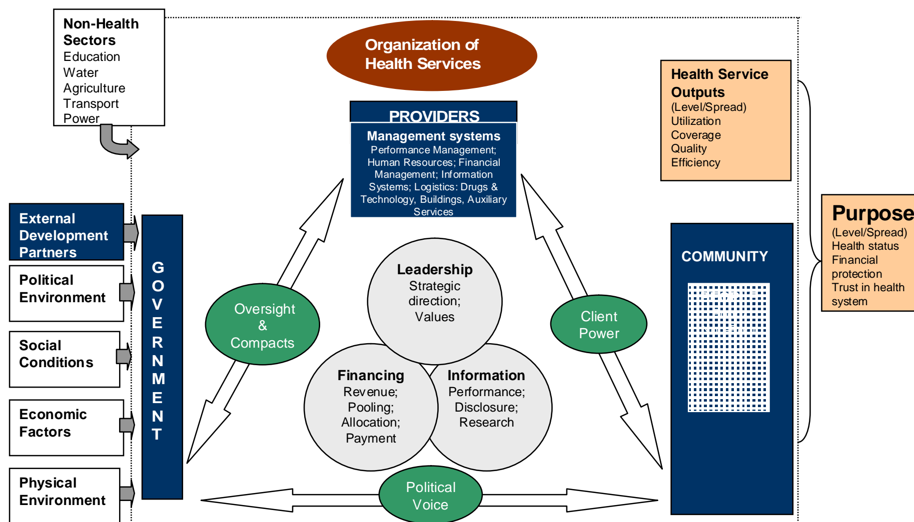
V. Context

Type of Constraint	Amenability to Funding	Dependence on Health System Factors	Dependence on External Factors	Time Frame for Change
High levels of poverty	Medium	Medium	High	Long
Weak rule of law	Low	Medium	High	Medium
Inadequate transportation, education, water, agriculture, and power services	Medium	Medium	High	Long
High exposure to disease risks due to environment (physical hazards)	Low	Medium	High	?

A paradigm for understanding health systems

- Purpose
  - Impact level
  - Health Service Outcomes level
- Actors and relationships
- Functions

Health services delivery framework



Some observations

- Health systems are complex and inter-dependent; intervening in one part of the system affects other parts
- How you organize assistance in a health system drives behavior of staff

HIV and health systems considerations

- Transmission is sparked by highly motivated behaviors – can't just address disease in health care setting
- HIV is highly stigmatized – greater trust in health system is needed
- Chronic disease requires repeated health care visits, tiered levels of care, increased financial vulnerability – higher demands from health system
- Co-morbidity and multiple disease manifestations, need for integrated services organized around patient and family rather than single sets of services

Some final questions

- Is there a magic bullet to fixing health systems, or do you need to address all parts of the health system at once?
- Can programmatic approaches “do no harm” to a health system?
- Can health systems focus on HIV and a few priorities and still succeed?
- How can you strengthen health systems to take on priority conditions?