

A functioning health system is a prerequisite for good health care

During the past decade, efforts to attain the UN Millennium Development Goals have triggered a number of global health initiatives intended to provide simple, targeted measures against the diseases that constitute the greatest burden for poor countries. These initiatives have shown that it is possible to muster substantial resources for health programmes. But the results do not meet up to expectations. Many do not benefit from effective health programmes because the health system that is supposed to deliver them fails to do so.

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Health is neither fairly nor equitably distributed among the citizens of the world. The inhabitants of Africa are encumbered with a quarter of the world's total burden of disease, but only have access to three per cent of the world's health-care personnel and less than one per cent of the world's financial resources (1). Of the more than eight million children under the age of five who died in 2009, 99 per cent lived in low- and middle-income countries. Two thirds of these deaths could have been avoided by effective health interventions – proper care at birth, vaccinations, antibiotics and other such simple measures (2). We are aware of this, and that is why the global community has contributed more than ever over the past decade to important health measures in poor countries, such as financing vaccination programmes and treatment for HIV/AIDS and many other infectious diseases.

Although child mortality is now declining in a number of regions in the world and far more people living with HIV/AIDS have access to anti-retroviral treatment, the overall results still do not meet expectations. Women's pregnancies and births are nearly as risky as those of their mothers before them, and people are still subject to suffering, disability and death as a result of diseases that are simple to prevent or treat

in a functioning first-line health-care service. It is the health systems themselves that now need to be strengthened if health-care services are to reach the people who need them.

Health is regarded today as a human right, and it is the nation-states that are responsible for fulfilling this right by promoting and protecting the health of their peoples. Since it will be a long time before the poorest countries have the capacity to meet these commitments on their own, the global donor community must make a concerted and targeted effort. But to contribute to lasting improvements in public health by building sustainable health systems, it is not sufficient merely to pour in money, targeted or not. Our contributions must also promote fairness and equity. In this article, we argue that western donor enthusiasm must not only be accompanied by evidence-based knowledge about what works, but must also be based on explicit values in order to ensure that sustainable health systems are developed and that effective health services are distributed fairly and equitably.

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What ails the health systems?

The World Health Organization (WHO) states that a health system shall improve the health status of individuals, families and local communities. It must protect the population against health threats and the destructive financial consequences of disease. The health system must offer equitable access to humane health services and ensure that the local communities are

involved in decisions that influence their health and health system (3). Access to medical personnel, management, procurement and distribution of equipment and medicines, financing systems and systems for generating and using information are the key factors underlying system failure in low- and middle-income countries (4).

A practical example

Zambia is one of the poorest countries in Africa. In principle, health services are free and available to all, but the country spends only 4.8 per cent of GDP on health despite the target of 15 per cent by 2015 (5). One of the authors of this article has first-hand experience from a regional hospital that serves about 60 000 inhabitants. The hospital is connected to a network of ten local clinics which all are engaged in systematic work to increase the availability of qualified maternity assistance and to improve the identification of high-risk pregnancies. However, it is difficult to recruit qualified medical personnel, particularly because there is a shortage of housing for personnel. The four young doctors who work at the hospital have no plans to follow their many African colleagues to better conditions in Europe or the USA. But they all want to be surgeons, and they will leave at once if they receive an offer of specialist training.

Diagnostic equipment and drugs are available to treat the many serious malaria cases that are admitted, but funding for the malaria prevention programme has been stopped. Operational planning is difficult because the hospital budget is based on donor aid earmarked for specific disease programmes and the funds cannot be reallocated. The hospital was recently given an autoanalyser that nobody had asked for. The cost of operating the machine at full capacity is equivalent to half a doctor's salary. The purchase cost alone would have covered the planned nurses' housing project and paid the growing debt to the electricity supplier. And there would still have been money left over to put new wheels on the defective trolley that carries bodies along

the pot-holed road from the hospital to the mortuary – and to repair the road.

The example from Zambia is by no means unique in an African context. Health systems suffer under unpredictable funding, and specialist health services receive priority over health promotion, preventive work and primary health care. The administration of the health services is challenged by an uncoordinated series of programmes and projects subject to stringent donor requirements and pervasive commercialisation of health services in poorly regulated systems (3).

How did this situation come about?

The global health discussion for the past fifty years has pivoted about two alternative strategies: either to concentrate on a limited number of cost-effective health interventions targeting the diseases that in quantitative terms cause the greatest suffering and mor-

tality, or to build up a holistic system with a balance between preventive and curative treatment, based on a well developed primary health care service. In the 1950s, the health sector was very largely a medical matter, and health did not rank very high on the political agenda. Emphasis was placed on curative treatment at medical centres.

But towards the end of the 1960s there was growing recognition that a high proportion of disease was related to poverty, and not caused by biology alone. At the same time, public sector investment increased. Market mechanisms functioned poorly in developing countries and, in the economic thinking of the time, this legitimised governmental intervention to correct the market (6). The priority given to health and social development created an optimism that grew into a global movement, culminating in the Alma-Ata Declaration in 1978

(7). The declaration promoted a holistic approach with strong emphasis on building health systems on a foundation of primary health care (Box 1).

However, with the advent of Margaret Thatcher (1979) and Ronald Reagan (1981), neo-liberal economic thinking gained ground. Developing country debt, instability and inefficiency were interpreted as failed economic policy. Because of their central role as lenders to developing countries, the World Bank and the International Monetary Fund (IMF) could demand economic and political reforms (6). In the health sector, this was reflected in large budget cuts, the emergence of private services and out-of-pocket payments for the patients. The public health sector in many low- and middle-income countries withered through the 1980s and 1990s. In these difficult times, the AIDS epidemic hit Africa like a thunderbolt.

But the rapid spread of HIV/AIDS also acted as a wake-up call, and in due course mobilised the world community into a concerted effort for global health. The Millennium Development Goals were established in the year 2000, and in the following years a number of high-profile global disease-specific initiatives were launched. Between 1990 and 2007, resources allocated to global health increased from USD 5.6 billion to USD 21.8 billion annually. So far, only a very small proportion of these funds has been earmarked for developing health systems (8), and the global health initiatives have received considerable criticism for overriding and undermining the existing health service. On the other hand, health has been awarded a central place on the global agenda during this period, and valuable new knowledge has been developed about the implementation of health measures.

Today the discussion is again tending towards the more comprehensive approach to global health. With the Paris Declaration of 2005, the international community undertook to arrange aid in such a way that the individual country can prioritise and plan public sector development (9), and in 2008 the WHO launched its report on the social determinants of health (10). This is to be followed up in autumn 2011 with the planned Rio Declaration, which is intended to secure global commitment to action.

New measures must avoid old traps.

There is a lively debate in progress as to which specific elements of the health systems should be fortified in order to handle the most precarious inadequacies. The WHO has identified a set of important building blocks which together form the well functioning health system: service delivery, health workforce, information, medical products, vaccines and technology, financing, and leadership and governance (11). However, one should not fall into old traps



The people must be regarded as a part of the health system. The girls in the picture are from Limpopo province, South Africa, where the women's network Elim Care Groups has been at the very forefront of the health system's prophylactic health work for more than 30 years. Photo: Inger B. Scheel

Box 1

Main points

The Declaration of Alma-Ata, 1978

The Declaration of Alma-Ata of 12 September 1978 urges all authorities, all health and development workers and the world community to protect and promote the health of all the peoples of the world.

- Health is physical, social and mental wellbeing, not merely the absence of disease
- Health is a fundamental human right and an important social goal that requires action across all sectors
- The gross differences in health between different countries are politically, socially and economically unacceptable, and therefore of concern to all countries
- Health for all is fundamental to sustainable economic and social development, quality of life and world peace
- The people have the right and duty to participate in the planning and realisation of their health service
- Governments have a responsibility for the health of their people which can be fulfilled only by the provision of good and fair health and social programmes through primary health care
- The goal is that by the year 2000, all the citizens of the world should attain a level of health that permits them to live a socially and economically productive life
- The primary health-care service shall be available where people live and work. It shall be based on both research and experience, and shall contribute to promotive, preventive, curative and rehabilitative services. Health-care work demands full participation from the local community
- Health-care workers shall cooperate to meet local health needs, and the primary health service shall be the first element of a continuing health-care process
- The government must demonstrate a political will to mobilise the country's resources to develop and maintain the primary health service as part of a comprehensive health system
- All countries must cooperate in an equitable partnership to provide health services for all because the health of one country directly concerns every other country
- Health for all by the year 2000 can be achieved through better use of the world's resources
- Considerable resources are spent today on armaments and military conflict. A policy of peace will release resources that can be used for peaceful purposes as a part of social and economic development

with new reforms. Reaching agreement on *what* should be done is important enough, but we believe that *how* it is done is essential for bringing about lasting changes.

*Viewing the health system**in the light of its functions and objectives*

A proper health system should naturally have a measurable effect on public health. But a good health system should also be a social institution that responds to the needs of the people and promotes equitable access to basic health services for all. The health system can provide a sense of belonging, coherence and security; it can give people confidence that help will be provided when disease strikes, without the threat of financial ruin, and at its best the health system can be the most important contribution to levelling out the unjust health disparities that always hit the most vulnerable groups hardest.

Interventions initiated from the outside can have widespread and measurable success, but sometimes at the expense of these value-based, community-building functions (6). Each contribution from the global society should therefore be carefully attuned so as not to undermine the social functions that are absolutely essential to the sustainability of the system over time.

*Viewing the people**as a part of the health system*

The inhabitants of a country should not be regarded as passive recipients of public services. By virtue of their position as patients in need of treatment, consumers with expectations, taxpayers and hence a source of financing for the health system, partners in the production of health through health-promoting behaviour, and citizens with a right to a fair health service and to influence the design of the services, the people are a part of the health system itself (12). The WHO therefore bases its framework for strengthening health systems on the values from the Alma-Ata Declaration (11).

The public also has another important role to play with respect to the health system. The authorities are to be made accountable for their dispositions by civil society. In consequence, capacity building in civil society institutions should also be included when the health systems are strengthened.

*Contributing to nation-building**by creating strong public health institutions*

Good institutions require wise leadership, room for comprehensive planning, adequate resources and a place for health on the political agenda to ensure commitment across all sectors of society. This demands capacity, and many major donors do, in fact, earmark their contributions in a manner intended to strengthen expertise and capacity among health personnel and, to a somewhat lesser extent, health sector man-

agers. But the functional capacity of the health sector's administration is sapped by paperwork. Disease-specific reporting requirements from an uncoordinated series of donors and unpredictable financing make comprehensive planning and budgeting

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impossible. These working conditions attract neither the best brains nor the visionary leadership talents.

The new wave of commercialisation of health through foreign investment may also weaken the health system as an institution. The public sector risks losing valuable health personnel to a wealthier employer and the people risk being presented with a good private health service for the wealthy and an impoverished public one for the poor. A private health sector will inevitably prioritise the most profitable services at the expense of important, though less profitable tasks such as health monitoring, preventive work, rehabilitation and care, and the assurance of a fair distribution of health benefits. Even with public procurement of private health services, the chore of administering and regulating ambitious and affluent market operators may prove to be overly demanding for an already over-burdened health administration, and leave little capacity for running a comprehensive health system.

Health, politics and international engagement

An equitable and fair distribution of both health and health services is dependent on far more than the health system alone. It involves fairness in the organisation of society and the social systems, and respect for the importance of health for human lives and freedom (13).

Interventions in national institutions therefore face us with the need to consider the underlying values. There is a substantial element of nation-building in the development of a good health system, and the health system serves in many respects as a display window for the general distribution policies of the nation-state. A good health system must be founded on national values and national culture, not on the values and

interests of donor groups or the medical industry. Donors must pave the way for beneficiary countries to build up normative institutions. Many countries have a long way to go before their own institutions have this kind of capacity. Therefore we must continue to support the WHO, which is the most influential, and perhaps only global institution with an impartial agenda that is able to provide normative guidance for the development of sound health systems for those in most need of them.

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