9. Health systems strengthening[1]

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Health systems matter. However, the 'health system strengthening' discourse prevailing in global health policy debate has been dominated by the donor imperative and the imperial interest. Civil society activists working on health systems issues need alternative frameworks to guide their activism.

Introduction

The purpose of this chapter is to explore the 'principles' of health systems strengthening (HSS) from the points of view of civil society activists seeking to drive improvements in health policy making, implementation and accountability. In the last section of this chapter a 'bottom up' approach to health system strengthening is presented with some useful principles for activist engagement in this field.

The contemporary global health situation is a disaster, notwithstanding the UN Secretary General's view is that the glass as half full (2012 MDGs report). While each year millions of children die before the age of five and hundreds of thousands of young women die in childbirth (see Chapter 2), 'disaster' is an appropriate term. The disaster is in part a reflection of the social determinants of health (malnutrition, lack of sanitation, violence, etc;

1. Work in progress. Feedback to dlegge(at)phmovement.org appreciated.

see Chapter 11) but it also reflects lack of access to decent health care. There is an urgent need for health systems strengthening, where 'strength' includes: universal availability; high quality and efficient services based on primary health care principles; zero health care impoverishment; no financial barriers to accessing services and fairness in revenue raising.

The global health disaster is centred in the low and middle income countries (L&MICs, particularly in South Asia and Sub-Saharan Africa) but there are serious health care challenges in the high income countries (HICs) also. Most stark among these are the barriers to access, quality and safety in the USA but the exclusions in the US are reflections of the wider challenge of allocating limited resources across an expanding range of technologies in increasingly unequal societies. Where allocation is mediated through private markets, services available to low income people will be more limited, sometimes drastically. When allocation choices are entrusted to private providers, commercial suppliers and private insurers the objectives of efficiency, quality and equity are necessarily subordinated to private profit. Health systems strengthening involves the development of strong and accountable institutions for equitable and efficient resource mobilisation, allocation and utilisation.

People's health activists have a critical role in health systems strengthening. However, most of what has been written in research and commentary in this field takes the top down, 'one-size-fits-all', 'whole-of-system' approach that characterises the donor interest. Donors require that ministries of health put together a national health strategy as the basis for discussions with and between donors about who will fund what. Health system development in countries which are not donor dependent normally takes a much more incremental or bottom up pathway, starting with issues of concern and proceeding to analysis and reform.

This bottom up approach corresponds to the community perspective and the perspective of the social movement activist: starting with concerns and proceeding from there to analysis and reform. In this chapter I develop some principles which might inform activist practice in engaging with health system development. These principles might be summarised as follows:

- study health systems histories;
- critically engage with the changing discourses of global health systems policy;
- critically engage with the technical literatures of health systems science;
- engage in continuing policy analysis and policy development regarding the problems of your system with a particular focus on the problems which are faced by those most disadvantaged by the system;
- be prepared for emerging opportunities for advocacy and mobilisation; have the policy ideas ready and the networks primed;
- invest in policy capacity building;
- stoke the policy conversation through position statements, presentations, discussions and local research;
- project a vision of the health system we want which can inspire officials, politicians and civil society activists;
- build a constituency for health system reform, particularly among those who have most to gain and among the health activists and practitioners who care about those who have most to gain.

The logic of these principles will emerge from the substance of the chapter.

Outline

This chapter is presented in four main sections.

In the first section of this chapter I sketch some of the patterns and dynamics of health system development, drawing on the varied histories of particular countries. I demonstrate how health systems development is shaped by the big trends and events of history and how social movement activism, in its many different forms, works with and is part of those big picture influences.

In the second section of the chapter I trace the dominant themes in global health policy, as it has been applied to both HICs and L&MICs over the last half century. I show how the prevailing nostrums of global health policy (reflected in the advice proffered to (or forced upon) the governments of L&MICs) have reflected the priorities and pre-occupations of the governors of the global economic regime and, in particular, I draw out the links between neoliberalism and the prevailing orthodoxy of global health policy. However, I also show how the counter-hegemonic forces, including social movements and progressive governments of the global south, have resisted the imperial drive and the neoliberal program.

While the analyses and prescriptions which have dominated global health policy making have been strongly influenced by the ideological requirements of the neoliberal ascendancy, there is much of substance in the orthodox research and commentary which progressive forces need to access, even while maintaining some scepticism regarding the influence of the dominant power structures. In particular it provides much of the language in which we talk about health systems; the language in which we describe, explain, predict and prescribe. In the third section of the chapter I provide a broad introduction to the academic and policy literature regarding health systems and health systems strengthening. I commence with some notes on the politics of this field of research and then provide an overview of the 'building blocks' approach to health systems policy.

Finally, I return to the 'bottom-up' approach to health systems development drawing in particular on the political science perspective. I highlight in particular the implications of complexity, incrementalism and 'windows of opportunity'. I conclude with a tentative set of principles for activist practice (summarised above), including some instances of social movement activism which illustrate these principles in practice.

Health systems development: learning from history

The study of health systems must start with history; understanding health systems development in the context of the broader sweep of history. Iconic examples of this relationship (health systems in history) include: the development of social health insurance during the industrial revolution in Germany; the establishment of state run health care in the USSR after the 1917 revolution; the emergence of primary health care in the context of post-war decolonisation; and the dismantling of health systems under structural adjustment in the 1980s.

To demonstrate how health system development is shaped by the macro forces of history is not to say that it is pre-determined or that popular struggle has no part to play in health system development. On the contrary the agency of social movement activists

(including revolutionary movements and movements of national liberation) is part of those macro forces.

I shall comment on patterns and dynamics of health systems development under the following headings:

- the ‘health system’ is a lens through which we view society as a whole;
- conflicts, alliances and drivers of health system development;
- institutional continuities; building on what came before;
- influence of cultural norms in shaping how health systems develop;
- leadership;
- technological development;
- expenditure pressures;
- missionaries and philanthropists;
- class relations and health care funding;
- economic development;
- crisis of global capitalism and the neoliberal response; and
- community participation and social control.

The ‘health system’ is a lens through which we view society as a whole

WHO defines the health system in terms of the people and organisations who work *intentionally* to provide health care. This is a reductionist construction of the health system. It locates the health system as one of a number of parallel social systems (education, transport, education, etc) which in aggregate constitute the societal whole. This construction of the health system isolates it from the structures, processes and relationships of the wider society which are integral to an understanding how health systems work and develop.

Another way of thinking about the health system is as a lens through which we view the whole of society; in this sense ‘the health system’ actually coincides with the whole of society.

A simple example is road transport. Improvements in maternal mortality in Bangladesh over the last five years are at least partly due to improvements in road transport so that women can access skilled attention more easily. In Indonesia the capacity of the tertiary education system produce enough appropriately trained health professionals has been a critical road block in health system development. In this example tertiary education is part of the health system. A more systemic example concerns the relative sizes of the formal and informal employment sectors in the economy because this directly shapes health care financing and health care access. Social insurance can be established within the formal sector but health insurance is much more problematic in relation to the informal sector.

The social institutions and cultural norms inherited from the past strongly influence how health systems develop. The differences between health systems in the USA and in Europe correlate closely with the very different attitudes to government in the USA compared with Europe. One of the drivers of health care reform in Brazil has been the demand for a more equal and more inclusive society; this demand has been supported by activism within many different social movements – labour, women, indigenous, Afro-descended - as well as

the people's health movement. In a real sense this sentiment is a driver of health system development. (However, the same is true of the pushback from the elites.)

The place of health care in the wider economy varies widely and so shapes in different ways how health systems operate and develop. For example, intellectual property is a major source of export revenue for the USA, especially since the movement of much of its manufacturing to lower wage economies. This produces very different policy imperatives from those operating in India for example. In the US, the pharmaceutical industry is provided with high levels of protection and public support and domestic drug prices are unconstrained whereas in India generic drug manufacturers are supported by much more restrictive standards for intellectual property protection in order to keep prices as low as possible.

A different example of the macroeconomic significance of health care expenditure comes from China where there was a massive expansion of government funding for health care in the period from 2008. There had been an obvious need for additional funding, especially for rural health and for the 'floating population' for some years, but the precipitating factor which opened the funding flow arose from the need to stimulate the domestic economy following the global financial crisis and to get Chinese households saving less and spending more. It was hoped that providing universal health cover through the state would reduce the pressure to save and encourage households to spend more.

Conflicts and drivers in health system development

The decisions which shape health system development always have different implications for different constituencies and are generally fiercely fought over; in Sidney Sax's term, a 'strife of interests'(Sax 1984).

In more pluralist settings the strife of interests can produce compromise or even prevent action. The failure of the Clinton health care reforms in 1993 reflect the intense opposition from a number of different stakeholders (insurance companies, small business, pharmaceutical companies, etc) and the luke-warm support from those larger constituencies who might have benefitted. Some things are more easily achieved in dictatorships. Rwanda for example has clamped down on corruption, implemented a community health worker scheme and successfully implemented community based health insurance (largely funded through PEPFAR[2] and the GFATM[3]).

One of the axes of conflict of particular significance in shaping health care is that between different professional groups. Tensions between medicine and nursing have impacted on health service organisation and health care in many countries for many years. Legal protection of what only doctors can do and opposition from medicine to the upgrading of nurse education has affected the quality of care provided in many jurisdictions.

Prior to 1858 the UK had three different kinds of doctors. With the establishment of the General Medical Council in 1858 the surgeons, physicians and general practitioners came together to create a powerful single medical profession. Inter-professional politics in the USA at this time was much more open, with 'doctors' with a wide variety of qualifications competing. The Flexner reforms of medical education in the early 20th century were directed

2. President's Emergency Plan for AIDS Relief
3. Global Fund to Fight AIDS, TB and Malaria

at controlling the less well qualified practitioners and in due course produced a more unified medical profession.

Doctors are often in conflict with third party payers also, commonly over reimbursement rates and denial of benefit claims. Disputes between doctors and third party payers have shaped health care funding in Germany, Australia and China among many other jurisdictions.

Many important decisions which have shaped the ways health systems work have emerged out of conflicts between doctors and government, sometimes quite bitter conflicts. The American Medical Association has opposed many health care reform initiatives in the US, most notably the Clinton Reforms of 1993. Similar battles have been common in many other countries. The relative strengths of profession and government therefore are major determinants of health system development.

One of the strengths of the medical profession in many countries arises from its relationship with big pharma and other supply industries. Pharmaceutical marketing expenditure supports medical journals and medical conferences and often medical dinners. This kind of support for journals and conferences contributes to the coherence and wealth of the professional organisations. In those cultures where doctors have a high level of public trust governments are very wary of risking conflict with organised medicine.

The medical profession is not the only organised group which is intensely interested in health service development and which participates actively in shaping health system development. The opposition to the Clinton reforms included the pharmaceutical and insurance industries as well as organised medicine. However, Obamacare (2010) was supported by big pharma, partly because of concessions made to big pharma in its design, and was successfully introduced.

In countries where the private sector is strong, the regulation of private sector service delivery is generally weak. Certainly cost control can be very difficult in private dominated systems. This is partly because, where funds are raised through private insurance premiums rather than taxation, government agencies have less incentive to try to control expenditure patterns. The extreme case is again the US where health care expenditure amounts to 16% of GDP but quality and outcomes are patchy. It is also the case that the more stratified the health system (different insurance schemes for different income strata plus a publicly funded safety net for the poor) the weaker the sense of solidarity across rich and poor and the lower the safety net.

The World Bank and other donors have regularly argued for stratified health care financing, without regard for regulatory capacity over quality and efficiency in the private sector and without regard to preserving a sense of national solidarity. This reflects the view that private health care is just another business (and the greater the turnover the better) and that equity and solidarity do not matter.

The more governments neglect public sector health care (as in India) the more the private sector steps in to fill the breach and, since governments which neglect the public sector usually neglect the challenges of private sector regulation, the more problematic are private sector quality and efficiency. The promise that ‘market forces’ will deliver quality and efficiency fails to recognise the many sources of market failure and the challenges of

effective regulation in the context of such market failure. The matter is compounded by the variable quality of care in the private sector which may be excellent for the rich but mediocre for the poor.

In many low and middle income countries government neglect (or even oppression) of public sector health care can lead to private, not for profit, providers (voluntary, religious) taking up the slack. This has been common in Africa where mission hospitals are sometimes the only source of inpatient care outside the capital. In Central America on the other hand autonomous community controlled health care (Guatemala, El Salvador) has emerged to compensate for the state neglect of health care.

Another driver of health system development is the media scandal which is a very effective way of catching politicians' attention. A complex mix of new institutions was established in the UK under the general rubric of 'clinical governance' following a series of NHS scandals in the 1990s.

Institutional continuities: building on what came before

It is very common that institutional innovation associated with health services development builds on what went before and shapes what is possible. This pattern is well illustrated in Germany where the development of social insurance was based on the pre-existing sickness funds. Similarly the 1911 health funding reforms in the UK were based on the pre-existing friendly societies and then in 1948 the same general pattern (capitation for general practice) was used as the basis for GP funding in the NHS.

A different example of building on pre-existing institutions was the Chinese policy of integrating traditional Chinese medicine and Western medicine from 1949. In a desperately poor environment with very few Western trained doctors it made sense to build a primary health care infrastructure on traditional practitioners plus the barefoot doctors. This was able to bring basic primary care to the whole population and also to extend basic public health programs to the whole population.

Influence of cultural norms in shaping how health systems develop

Cultural norms play a powerful role in shaping health systems:

- health care seen as an expression of social solidarity *versus* health care episode as a commodity to be bought and sold;
- the role of government understood as interference in citizens' lives (and therefore suspect) *versus* publicly delivered social programs or regulation as a legitimate expression of collective will;
- acceptance of wide inequality *versus* acceptance of social protection provisions to reduce or mitigate inequality;
- legitimacy of regulatory norms (a general expectation that most laws, regulations and norms are reasonable and legitimate) *versus* a rejection of the legitimacy of such norms (which also normalises corruption);
- norms regarding gender relations (equal rights *versus* naturalisation of patriarchal assumptions);
- acceptance of diversity *versus* suspicion or hostility regarding 'the other'.

In some cultures (eg UK, Canada, Australia) health care provision is generally seen as an expression of social solidarity. In others, such as the US, health care is generally treated as a commodity to be bought and sold in the market place. Such attitudes are not static and do not exist in isolation. They reflect, as well as shaping, health care funding arrangements. They are powerfully influenced by ideological forces. In the NHS in Britain, for example, there has been pressure to reconstruct health care as a commodity through institutions such as the managed market and the purchaser provider split. This reflects in part a drive for greater efficiency as part of maintaining the integrity of the NHS and in part the pressures of neoliberalism to open up the public sector to private enterprise (see Chapter 4 for more).

In those countries which have achieved publicly funded universal health care managing the expenditure pressures associated with aging and expanding technical efficacy is a continuing challenge, particularly with the pressures for 'tax competitiveness' driving down tax revenues. In some cultures (Australia and the UK for example) there is an acceptance of queuing (properly managed) as an appropriate way of managing expenditure pressure. In other cultures (eg Germany, urban China) wait lists for elective surgery are regarded with horror.

These kinds of attitudes can reflect, as well as shape, existing arrangements for health care delivery. However, the more deeply entrenched particular attitudes are the more likely they are to shape health care and the less likely it is that institutional arrangements which run counter to them will be established and perhaps reshape such attitudes. The suspicion of government and the acceptance of inequality which characterise large swathes of US opinion illustrate this and are reflected in weak provisions for social protection and the continuing failure to implement universal health cover in the US.

Different attitudes to gender relations can also be seen as shaping health care arrangements. Changes in gender relations in Australia have led to increasing proportions of women in the medical workforce and in particular in general practice. This has been associated with diminishing opposition to salaried employment in recent decades.

Leadership

Leadership makes a difference. The leadership role of Florence Nightingale in hospital management and the development of nursing is widely recognised.

The pioneers of primary health care are less well known. These include:

- Dr CC Chen who developed the Ding Xian model of primary health care in China in the 1930s;
- Drs Mabel and Rajanikant Arole in Jamkhed in Maharashtra India from the late 1960s
- Dr Gunawan Nugroho and his wife who worked in Solo Indonesia from the early 1960s;
- Dr Carroll Behrhorst and the Chimaltenango Development Project in Guatemala from the early 1960s;
- Drs Sidney and Emily Kark who worked in both South Africa and Israel and influenced generations of health system thinkers and planners (including Australia's Dr Sidney Sax);
- Dr Milton Roemer, Dr James P Grant, Dr Kenneth Newell and many more.

These pioneers are cited here as representatives of the thousands of lesser known leaders whose different forms of leadership have contributed in many different ways to health system development.

Changing technologies

Changing technologies shape health care delivery in various ways.

The period from 1880-1920 saw the emergence of new medical technologies (in particular: artery forceps, anaesthesia and aseptic technique) which dramatically increased the therapeutic power of medicine. This period of increasing therapeutic efficacy was associated (in many industrialised countries) with improvements in the public standing of the medical profession with consequences for its political influence, the role of doctors in hospitals and medical remuneration.

The emergence of various forms of drug treatment have changed the face of health care delivery. Drug treatment for tuberculosis led to the wholesale closure of TB hospitals and TB wards in many countries. Likewise the emergence of psychotropic medications revolutionised the treatment of mental illness.

Innovation in medical technologies is in varying degrees serendipitous, driven by priority needs or driven by expectations of profit. The failure of private sector investment to prioritise disease conditions which particularly affect people in developing countries illustrates the significance of investment decisions in technological development.

War has played a significant role in fostering the development of particular medical technologies including blood transfusion, triage, emergency medicine, malaria control and burns treatment.

Expenditure pressures

Expenditure pressures impose powerful pressures on health systems, both in publicly and privately funded health systems.

These expenditure pressures are widely attributed to aging populations (with needs and opportunities for intervention increasing with age) and technological development (more interventions which are more efficacious). They also reflect in part the continuing pressures, associated with the neoliberal ascendancy, to reduce taxation.

In the public sector expenditure pressures are variously addressed through measures directed at increased efficiency, rationing or cost shifting.

Strategies for increasing efficiency may be directed at the inputs of care or the processes of care. More efficient use of human resources may involve working harder or working smarter. Improving efficiency in the processes of care may involve new technologies or new procedures directed at reducing waste through eliminating unnecessary, unsafe or ineffective procedures. More efficient use of capital assets involves reducing down time (eg change over time in operating theatres; extended hours of use of imaging equipment. Queuing can be an effective way of improving the use of capital where it involves smoothing out the peaks and troughs. The risks are that poor triage leads to prolonged suffering or deterioration in patients' conditions or where queuing blends into rationing.

Strategies for promoting efficiency include greater competition between providers, where improved efficiency is rewarded, and the use of modes of payment which are seen as rewarding efficiency. Efficiency should mean achieving better outcomes at the same cost or the same outcomes at lower cost. However, because of the difficulty of measuring outcomes health economists commonly treat efficiency in terms of the cost of procedures or episodes of care (and hope that someone else is worrying about quality and outcomes). Thus fee for service payment is sometimes cited as promoting efficiency because there is an incentive for each item of service to be delivered more efficiently. Whether the item of service is necessary or delivered at appropriate quality is commonly neglected. Fee for service also encourages maximising volume of services. Likewise the use of diagnosis related groups (DRGs) or other methods of activity based funding are said to promote efficiency but this also depends on there being protections against under-servicing and other distortions.

Rationing involves restricting access to services on the basis of ability to pay, travel times or distance, restricted entitlement ('benefit package'), capacity to benefit and other criteria. One famous example has been the use of public consultation in the US state of Oregon to limit benefit entitlements for Medicaid recipients. It is important to distinguish conceptually between queuing and rationing although they can blend imperceptibly.

Expenditure pressures can also be managed through cost shifting; shifting the financial risk to the consumer (increasing out of pocket payments) or to the provider (through various forms of pre-payment or fund-holding) or to the insurer (through premium controls and regulated benefits). In-kind cost shifting occurs with 'task shifting' from more highly paid to less highly paid staff (eg from doctors to nurses to assistants) or from hospital staff to families (through early discharge).

Expenditure pressures in the private sector will get actioned when insurance premiums are seen as too high (by households or employers); when consumers reject high out of pocket costs; and when government contributions to private care (often through tax expenditures) are seen as too high.

Expenditure pressures in the private sector are likely to generate a dance of cost shifting between health care providers, consumers and third party payers. The most dramatic successes in private sector expenditure control have been through managed care models where access barriers, limited benefit packages, tight utilisation controls, fund-holding gate keepers and other tools are used. Clearly these mechanisms involve trade-offs between equity, access, quality and cost control. In cultures where health care is treated as a commodity the only institutions limiting the sacrifice of quality or access are market based or legal. In cultures where government is seen as having some responsibilities for access to quality health care, regulation may have a role.

It is evident that these various approaches to expenditure control have the potential to dramatically change the ways in which health care is delivered. They also carry significant risks to quality of care and access to care.

It also needs to be recognised that while expenditure control may be seen as desirable in public policy terms or from the funder's point of view, from the point of view of the suppliers (eg the pharmaceutical industry, insurance industry) it is a threat to market opportunities and to be opposed for this reason.

Missionaries and philanthropists

The harm which has been done to many indigenous cultures by Christian missionaries is well known. In Canada the role of the Christian church in the administration of the 'native residential schools' has been well documented (Grant 1996; Miller 1996). In Australia the missions were complicit in 'taking the children away'; what has become known as the Stolen Generation (Commission 1997).

It is also the case that medical missionaries have played an important role in disseminating Western medicine within cultures in which it was not indigenous (although in some cases missionaries were also involved in the suppression of the knowledges and practices of indigenous healers). Medical missionaries contributed significantly to the modernisation of health care in China (Minden 1981) and continue to play an important role in the delivery of health care in many parts of Africa. From the early 1960s the Christian Medical Commission of the World Council of Churches played a key role in promoting primary health care (Litsios 2002; Litsios 2004).

Philanthropy has also played an important role in health system development. The Rockefeller Foundation has been working on health issues in the USA and various countries since its establishment in 1913 (Brown 1979). Under the leadership of James Grant the Rockefeller Foundation played a significant role in the development of modern medicine in China. The support that Rockefeller (through the China Medical Board) provided to Peking Union Medical College from 1915 provided a influential beachhead for scientific medicine in China.

The Flexner review of 1910 (Flexner 1910), which was supported by the Carnegie Foundation, had a profound impact on medical education in the USA, promoting the German approach to medical education which emphasised a strong foundation in the basic medical sciences. Other philanthropies which have had a significant impact on health care in the US include the Commonwealth Foundation and the Robert Wood Johnson Foundation.

The Bill and Melinda Gates Foundation has been a major player in global health since its formation, as the William H Gates Foundation, in 1994. See Chapter 8 for a more detailed review of the role of the Gates Foundation in international health.

Class relations and health care funding

Class relations are fundamental to health care funding. Mandatory social insurance was introduced in Germany, in part to forestall the threat of revolution. Large tax subsidies were introduced to support voluntary health insurance in the USA during WWII as a way of keeping industrial peace with the unions without sanctioning wage increases.

In many post colonial countries social insurance schemes restricted to public employees and the military has contributed to the emergence of two tiered or multi tiered systems.

In countries like India and Indonesia there has been a rapid growth of the private sector of medical care as a consequence of the dissatisfaction of the emerging middle class with public sector services. In both countries government expenditure on health care has been very low. The private sector is hard to regulate, particularly in low income countries.

Economic development

Economic capacity shapes health care delivery. In the early industrialisers (UK, Germany, France, USA, etc) modern medicine evolved in tandem with the development of economic capacity and so the technological development of health care proceeded with the growth in economic capacity.

In the late industrialisers such as the countries of East Asia economic development was prioritised and resources for health system development were progressively mobilised as resources became available.

China and the countries of the former Soviet Union constitute a separate class, the transition economies, transiting from a socialist to a market economy. The challenge in these countries has been the collapse of the health funding arrangements associated with the socialist system and the long delays in putting in place funding arrangements which correspond to the structures and resource flows of the market economy.

Health care development is vulnerable to economic shocks. This is particularly well illustrated in Cuba which has suffered from the US blockade, covert destabilisation and the withdrawal of Soviet support in 1989. Despite these pressures Cuba has developed a strong primary health care system with good health outcomes. Economic austerity as in Indonesia in 1997 and Greece in 2012 can demolish health care financing structures, weaken health services and create new barriers to access and quality.

Among the currently ‘developing’ countries a range of patterns are evident as countries explore different pathways for developing their health systems in consonance with their economic capabilities. One of the differentiating factors is the level of inequality. Universality depends on social solidarity which is attenuated by inequality. Another differentiating factor is governance and tax capacity.

Care should be exercised in linking the capacity of different countries to pay for decent health care to their ‘stage of economic development’ as if economic development is a pre-ordained pathway. As I have shown in Chapter 4, industrialisation and economic wealth depend on where each country is presently situated in relation to the stocks and flows of global capitalism.

Crisis of global capitalism and the neoliberal response

Global capitalism is in crisis with a massive imbalance between productive capacity and effective demand. This imbalance, which is getting worse, has relegated many countries to the ‘reserve army of the unemployed’ in the global system. For the rich countries the crisis has been staved off by the rapid growth of the finance industry which mediates the conversion of profit into debt and to support debt funded consumption.

The world capitalist system is more complex than simply rich countries and poor countries. Some countries have established significant manufacturing. Others are waiting to be brought into the low wage manufacturing system as wage rates rise in the earlier countries. Whether the nation state is the appropriate unit for the analysis of this system is moot as inequality widens and new class alliances across countries come to exercise significant influence. Thus the specific location of particular communities in the world system may explain more about the structures of health care available to them than some categorisation of their country.

Neoliberalism is the policy package adopted by the capitalist elites of the rich world to shore up their capacity to accumulate wealth despite the unfolding economic (and climate) crisis. The neoliberal package includes small government, low tax and light corporate regulation; it includes global economic integration on terms which sustain the elites but lock most poor countries into continued poverty.

The competitive pressures to keep tax rates low is part of the cause of the health care expenditure pressures discussed above. The pressures towards small government and deregulation compound the difficulties in regulating health care and in particular private health care and in regulating for public health. The need to open new fields for private investment underpins the drive for privatisation. Access to medicines is jeopardised by the rise and rise of intellectual protection through TRIPS and the IP chapters of 'free trade' agreements. The increasing pressure for increasing protection of IP reflects the rising significance of IP based export revenue for the US and EU.

Ideology is critical. The neoliberal offensive which paints politicians and bureaucrats as venal and promises universal beneficence from unregulated market relations is driving the reconstruction of health care as a commodity rather than an expression of social solidarity. The growth of private health care continues to cultivate hospital centric models of health care and the marginalisation of comprehensive primary health care.

Community participation / social control / social movements

Community participation is a critical part of the primary health care vision. This can include:

- joining a health centre committee (or voting for candidates for a health centre committee) or participating in a work group to build a centre;
- assisting other community members with their treatment program (eg community based DOTS in India);
- taking training and becoming a community health worker (health promoters in Central America);
- participating in public health campaigns (eg dengue control in Cuba);
- participating in community monitoring of health care delivery (the RTH campaign in India);
- joining a municipal health council (in Brazil);
- attending the national health assembly (Thailand);
- participating in popular mobilisation (eg around the demand for access to treatment in South Africa).

Some of the possible consequences when community participation is weak include:

- health care dominated by professional values and ideologies;
- lack of accountability of health care practitioners and managers;
- health policy dominated by the pressures of vested interests; and
- unchecked corruption and incompetence.

Community involvement in health care delivery and health system policy making can be very powerful but it cannot be assumed and may require support.

Conclusions

In this section I have reviewed the legacies, tensions, pressures, drivers, climates, serendipities, propensities, leaderships, resources and inspirations which shape health system development.

These legacies, tensions and drivers etc all point to the embeddedness of health system development within society, history and the global economy. They should warn us against viewing our local realities solely in terms of standardised health systems templates (such as WHO's building blocks (WHO 2000) or the Harvard control knobs (Roberts, Hsiao et al. 2008).

Global health systems policy

In this next section I trace some major themes in global health policy, as it has evolved in the high income countries (HICs) and been applied to low and middle income countries (L&MICs) over the last half century.

While the conversations concerning health systems in HICs and in L&MICs have been conducted separately (different journals, conferences, organisations) there have been strong influences between these discussions. Prevailing fashions in HIC health care have powerfully influenced the thinking of the donors and the international financial institutions (IFIs) in relation to L&MICs. Conversely, researchers who are funded by the donors to solve the problems of foreign aid, are at the same time contributing to the domestic conversation about health care in their own countries. The OECD stands as an important conduit between these two conversations, hosting discussions of health care reform in both HICs and L&MICs.

While health policy generally responds to immediate policy problems the dominant themes of health policy are increasingly shaped by the prevailing challenges facing the governors of the global economic regime. The apparently technical themes of global health policy reflect in part the strategic imperatives arising from the looming crisis of global capitalism.

However, there are also counter-hegemonic forces, social movements and progressive governments of the global south, which have resisted the neoliberal program and health systems policies are increasingly shaped by the contestations across this axis.

High income countries

My focus in this section is on policies which have influenced the development of rich country health systems and which have been international in their influence. Beyond the boundaries of this discussion are health policies which were not really about health systems *per se* and health system policies which were largely national in scope.

The concept of a 'health system' is relatively recent and it is not clear how closely earlier policies (for example, the education and regulation of the medical profession or the role of the Church in providing early hospital care) map onto the idea of a health care system. In fact the health *system* policies that are discussed below are largely centred on legislated systems for health care financing including public funding.

Mandatory social insurance

Bismarck in 1883 legislated for a mandatory employer contributions to health insurance for low income workers. Employer / employee contributions were paid to sickness funds which had existed as local voluntary self-help organisations since many years earlier.

The 1883 scheme was based on a scheme which had been introduced in 1849 for coal miners. Both in 1849 and 1883 worker unrest and the risk of revolution were significant drivers of the policy.

This model of mandated, employment based health insurance, managed through voluntary organisations has become known as social health insurance (or the Bismarckian system) and in the succeeding years has spread across Europe (with various modifications) and beyond.

Publicly owned, funded and delivered

The first comprehensive publicly owned, funded and delivered health system was established in the USSR following the Russian Revolution of 1917. The core elements of the Soviet scheme included: polyclinics, staffed by medical specialists, and feldshers who were less well trained community health workers. There was a hierarchy of hospitals from primary to tertiary and a highly formalised planning system based on population ratios for beds and staff.

The Soviet model was influential in Europe with many visitors to Russia speaking favourably on their return about what was being achieved. The model also inspired health workers involved in liberation struggles in the European colonies.

The establishment of the NHS in 1948 reflected in part the influence of the Soviet model but modified extensively to apply to the UK circumstances. After 1948 the NHS became a model for health policy thinking in many countries.

The NHS continues to be a highly commented upon model with the sequence of NHS reforms which have marked its history. Some of the highlights of these reforms were the highly formalised planning systems of the mid 19709s; the internal market of the early 1990s; clinical governance in the late 1990s; and corporatisation and privatisation in the 2000s.

Nationalised universal health insurance with mixed service delivery

From the 1950s onwards Canada started developing its model which provides universal health coverage through mixed (public and private) service delivery paid for on a fee for service basis and remunerated through provincially based tax funded, fee controlled health insurance. Australia adopted the Canadian system from the mid 1970s.

The use of the term 'health insurance' to describe the Canadian and Australian systems can be a bit confusing. It is not 'insurance' in the sense of a market place where different insurers sell insurance contracts to consumers to cover the risk of getting sick. Rather it is a unified national universal health costs reimbursement system.

This national universal reimbursement approach may be particularly suited to health systems where fee for service medicine through private practice is well established and accepted.

Stratified subsidised insurance-supported private FFS health care

The US health care system provides the beacon model for private enterprise, market based health care.

Health insurance took off in the 1930s, during the Depression when the voluntary hospitals were facing a budget crisis and set out to raise funds with discounted hospital fees as part of the incentive to contribute (these funds became known as the Blue Cross system). The AMA was initially hostile to health insurance but once it was clearly permanent the AMA joined the system with the AMA dominated Blue Shield funds. Health insurance in the US is a very mixed field. In the earlier part of the 20th century it included industry funds, community funds, private insurers, not-for-profit insurers associated with not-for profit hospitals and NFP insurers associated with the AMA. By the end of the 20th century the large commercial insurers dominated the field.

During WWII (as part of a deal to manage union pressure for higher wages) the Federal Government committed to supporting employment based private health insurance through tax benefits available for both employers and employees. In 1967, as part of the Kennedy Johnson 'Great Society', the Johnson administration introduced Medicare (a federally funded universal reimbursement scheme for older people) and Medicaid (a federal state cost shared safety net program for poor people). The purpose of Medicare and Medicaid were to extend health insurance (health cost reimbursement) to retired people (since they were no longer part of employment based health insurance) and poor people (although the threshold for entitlement varied widely between states). By taking over the retirees (higher risk older people) Medicare also enabled the private insurers to keep their premiums much lower than they would otherwise have been.

The story of health care in the US since 1967 has been shaped by the contradiction between the need for expenditure control and the commitment to private enterprise and profit making. The introduction of Medicare led to steep increases in expenditure pressures, partly because of previously unmet need but partly because of the very lax expenditure controls built into Medicare. From the 1970s a range of policy mechanisms was experimented with including:

- an attempt to control hospital capacity through formalised health planning and 'certificate of need' requirements (as a condition for accessing Medicare benefits) from 1974;
- formal state based systems for controlling benefit levels;
- restrictions on the Medicaid package (including the Oregon experiment with citizen participation to determine the benefit package in the 1990s);
- new technologies for utilisation review (retrospectively reviewing the necessity for individual clinical services) and utilisation control (requiring insurance company approval before proceeding with services);
- throughput funding for inpatient care via the 'diagnosis related groups' system (DRGs) from 1986.

Running parallel with these attempts to control public expenditure through Medicare and Medicaid was the emerging resistance of business to the continuing increase in the health insurance premiums that they were paying for their employees. 'Managed care' emerged out

of the increasing interest of big business to buy insurance packages which included some capacity to control costs.

Managed care involves three separate market places: the employer meets the insurer in the market place for health insurance cover (and design of insurance plan); the insurer meets the health care provider negotiating conditions on entitlement for reimbursement; and the consumer meets the provider (within the conditions imposed by the insurer). The key to understanding managed care is the recognition that the insurer provides a range of insurance plans ranging from comprehensive but expensive plans (for the executives) to minimalist and cheap plans (for low income workers). The more expensive plan, for the executives, may provide for full FFS reimbursement with no restriction on providers and no utilisation control. (Under Obamacare 'Cadillac plans' are subject to a 40% tax.) The cheap plan, for low income workers, provides for significant cost sharing (out of pocket payments), restrictions with respect to benefit entitlements, restrictions on providers, fund-holding (transferring risk to the providers) and tight utilisation control. (Obamacare prohibits out of pocket payments for services in the 'essential benefits package'.) Managed care has the capacity to control expenditure (at the cost of access and quality). It is limited by the resistance of workers to minimalist insurance plans, the resistance of the medical profession to the proletarianisation of medicine under managed care, and the resistance of consumers to access barriers and low quality. More fundamental is the resistance of the insurers themselves whose profit is related to total turnover and of the supply industries, in particular big pharma, who do not relish seeing their markets contained.

The underlying principles of managed care, in particular the three market places, have attracted interest in Europe and elsewhere. A form of controlled managed care has been implemented in The Netherlands.

Low and middle income countries

The international flow of health policy ideas in HICs include journals, conferences and study tours. These channels are influential also for the L&MICs but in addition, the 'development assistance' industry is also an important mediator through various forms of 'technical assistance', 'loan conditionalities' and 'development partnerships'.

Colonial health care systems

Post colonial societies inherited health care systems which were built around the needs of the colonists and the urban elite. It was a system which was centred on the medical specialists and their hospital workshop. Insofar as Western health care was provided in the rural areas it depended largely on mission hospitals. Post colonial societies also had their urban elites and in many cases the old system met their needs without too much reform. The experience of post-Apartheid South Africa appears to conform to this pattern.

A further influence on post colonial health systems has been the need to develop an indigenous medical profession. Since most of the doctors who had graduated before decolonisation had trained in Western medical schools it was natural that early health system policies also focused on the need for medical schools and teaching hospitals.

Meanwhile the World Health Organisation was under strong pressure, from the US in particular, to eschew any involvement in health system policy. The US was particularly concerned about the health policy influence of the USSR, the UK NHS and then later on

China on policy thinking of newly independent countries. In 1953 WHO adopted a policy of 'basic health services' but it remained quite inactive in this field. WHO at this stage included very few 'developing countries'.

Primary health care

By the early 1970s there was a much stronger representation of the newly independent countries at the World Health Assembly. Through the 'Non-Aligned Movement' and the Group of 77 (G77) there was new policy thinking about the various challenges facing these countries were facing.

From 1971 there was increasing pressure on WHO to provide more useful advice around health systems development; pressure which culminated in the Alma-Ata Declaration of 1978. There were several streams of influence which shaped the Alma-Ata Declaration. The Soviet delegates argued for the merits of their system (based on the polyclinics and feldshers in particular) and were quite insistent on holding the proposed WHO/UNICEF conference in the USSR. However, thinking within the WHO Secretariat was also strongly influenced by a number of case studies brought forward by the Christian Medical Commission of the World Council of Churches, in particular: Solo, Jamkhed and Guatemala. WHO's 1975 collection of case studies of primary health care(Newell 1975) also included accounts from China and Cuba which were also very influential. Also influential were the various experiments with primary health care in the West including community health centres in the US (note for example the Tufts-Delta community health centre established in the 1960s with funding from the Federal Office of Equal Opportunity(Geiger 2002)), the Peckham experiment in London(Pearse and Crocker 1985[1943]) and the work of pioneers such as Dr Sidney Kark around 'community oriented primary care'(Kark and Kark 1999).

The Alma-Ata Declaration needs to be read at several levels. Primary health care, as elaborated in the Declaration, has three different meanings. It is simultaneously: a sector/level of service delivery; a policy model including principles to guide service delivery; and it is a strategy of social change.

As a sector or level of service delivery PHC refers to first contact, continuing, generalist, comprehensive care. Comprehensive here refers to a service delivery model which encompasses prevention, treatment and rehabilitation rather than just curative services(Sanders 1998).

As a policy model or set of principles of service delivery PHC includes:

- priority to basic services where people live,
- community involvement (accountability, planning, prevention),
- mutually supportive referral systems,
- intersectoral collaboration to address the social determinants of health,
- appropriate multi-disciplinary workforce working as a team,
- appropriate technologies, and
- essential care.

(It is not clear how to interpret 'essential care' as used in the Declaration. It is a clear acknowledgement of resource limitations and may perhaps be interpreted as implying that the health care providers will have a budget and will be required to ration their services

according to need. Thus as resources become available more extensive services may be possible. Certainly 'essential care' should not be equated with the much later invention of basic benefit packages, see below.)

The Alma-Ata Declaration also incorporates a recognition of what later became known as the social determinants of health and a strategy for social change to address these. The Declaration refers explicitly to the proposed New International Economic Order which was an ambitious program of global economic reform promoted through the Non-Aligned Movement and adopted at the UN General Assembly in 1974(UN General Assembly 1974). The principles upon which the NIEO was based included: the need to control multinational corporations, the right to nationalise foreign property, the legitimacy of producer cartels and a trade regime that would support economic development.

Critical to the PHC model was the commitment to popular mobilisation towards health development. PHC practitioners were seen as having a role to work with their communities to work on structural determinants of health and to support communities in organising to address such determinants.

The Alma-Ata version of comprehensive primary health care was contested from the start. In 1979 Walsh and Warren published their paper (Walsh and Warren 1979) promoting 'selective primary health care' as an 'interim strategy for disease control in developing countries'. In 1981 UNICEF joined the 'selective' party with its 'child survival revolution' based on the four interventions of GOBI: Growth monitoring, Oral rehydration, Breast feeding and Immunisation. The three Fs were added to this in 1983: Female education, Family planning, and Food supplementation. For a thorough examination of selective PHC see Werner and Sanders 1997 book Questioning the Solution(Werner and Sanders 1997).

Despite its name, selective primary health care was the antithesis of primary health care, reducing the idea of locally based generalist service providers to these four highly specific interventions. In fact neither growth monitoring nor support for breast feeding are interventions that can be delivered vertically; both call for the proximity and continuity of local service providers. As a consequence GOBI was reduced to the delivery of a product, the packet of sugar and salts, plus immunisation.

Several other controversies have confused the dissemination of comprehensive PHC. One is the notion that somehow CPHC is a 'horizontal' model as distinct from alternative vertical models. This is inappropriate because the PHC model clearly assumes a supportive referral relationship with secondary and tertiary sectors. Nevertheless there has been some resistance to PHC from among stakeholders in the secondary and tertiary sectors in some countries.

UNICEF's support for selective PHC needs to be contextualised in relation to the recession of the early 1980s and the debt crisis. The debt crisis was rooted in the oil price rises of 1973 and 75, the profligate lending by private banks during the mid 1970s, the stagflation of the late 1970s and the interest rate increases of 1981 under the slogan of 'fight inflation first'. By the mid 1980s many developing countries had to turn to the IMF for assistance in rolling over their loans and with IMF bailouts came structural adjustment. See Chapter 4 for more details.

Community involvement

Much has been written about community involvement in health care delivery, variously referred to as community participation, community empowerment or community management as well as community involvement. These terms are quite elastic and the significance of such distinctions generally arises in the local settings where they are used. The word 'community' is something of a holdall, required to carry a range of different sometimes contradictory meanings. For example, it is sometimes used as code for 'engaging low income and marginalised people'; in other settings it can refer to the involvement of local elites in planning and managing service delivery.

There is some overlap between discussions about community involvement and discussions of *consumer* involvement (participation, empowerment, etc). Some caution is needed in relation to such uses of the term 'consumer'. The 'consumer' here is defined in relation to the act of health service delivery and the institutions through which health services are provided. Constructing people as consumers tends to obscure other aspects of identity, such as gender, class, and ethnicity, and the ways in which health status and the health care experience are embedded in power relations across these axes of analysis.

The emergence of 'the consumer' in health policy discourse reflects the rising influence of market models of health care delivery and the commodification of health care. Consumer empowerment within such models is often highly individualised. Consumers can be empowered by more effective complaints schemes and by league tables which rank providers according to their performance. In such usages consumer empowerment is a response to perceptions of market failure owing to information asymmetry and unequal power relations in the clinic. It is a somewhat combative approach which does not engage with the core issue of trust.

Against this background of ambiguity and conflict I need to explicate quite clearly how and why I am using the term 'community involvement' here. My focus in this chapter is on 'health systems strengthening' (as defined at the beginning of this chapter); more specifically, how to drive the strengthening process, having regard to the dynamics of health system development as discussed earlier. Health systems development is a contested field involving powerful stakeholders, domestic and international, and in some degree befogged by ideological mystification. In the context of unequal societies equitable access to quality health care is part of a broader struggle for equity, inclusion, social and economic development and ecological sustainability.

These considerations provide a useful frame of reference for defining 'community involvement', for the purposes of this discussion. I am talking about a political process so 'community' must refer to self-conscious (organic) communities with a capacity for collective political engagement (not restricted to geographically defined communities). I am talking about equity so the kinds of communities I have mainly in mind are those who have most to gain from more equitable access to decent health care. I am locating health system development in the context of a wider set of 'big picture' issues so I shall not constrain my usage to health care 'consumers'. Embedded in these big picture issues are many of the social determinants of health and of health inequalities. The term should include community involvement in social movements to address the social determinants of health as well as strengthen health care.

The primary health care model does not assume that community involvement arises spontaneously. Rather it argues that support for community involvement is an explicit function of primary health care agencies and practitioners, indeed of any health service based on PHC principles. This kind of support for community involvement has been practised successfully in different forms in many different settings. These range from:

- formal institutions of involvement, such as the health councils of Brazil or the community-owned, incorporated health services (as in Indigenous Australia); to the
- structured involvement of community members in service delivery (community health workers in many different settings); to the
- community monitoring of health services (such as the Indian Right to Health Campaign).

Supporting community involvement (for stronger health systems) is highly context specific; the principles to be realised in such practice need to expressed in quite abstract terms if they are to apply in widely differing contexts. They include:

- purpose and action should reflect the priority concerns of organic communities and must be driven, at least in part, by those communities;
- process should be self-reinforcing in that the benefits of involvement build the conditions for greater involvement;
- involvement must involve a reflexive moment; watching ourselves and developing our capacity; and
- there should be accountability between leading community activists and the constituencies on behalf of whom they are working.

Practitioners seeking to support community involvement in health require a range of skills and a certain set of values. Health care institutions seeking to support such involvement also need to have a certain organisational culture and commitment. This kind of community involvement is a core principle of the Alma-Ata Declaration on Primary Health Care. However, it is not easy; in some degree it is a vision to be worked towards as much as a strategy for achieving the vision. The practice will be easier when the vision has been achieved.

Health sector reform

By the late 1980s the damage which structural adjustment was doing to L&MICs, including health and education, was becoming more widely appreciated in the rich world (it had been self-evident in the poor countries). The brutal honesty of the IMF, 'pay your debts', was becoming an embarrassment to the global governors and the decision was made for the World Bank to invest more heavily in health policy in order to prevent further loss of legitimacy for the neoliberal project.

The WB announced its arrival in the field of global health policy with the World Development Report, *Investing in Health,* in 1993. Glossy, beautifully produced with lots of coloured diagrams *Investing in Health* set a new standard with respect to presentation for health policy documents. The report addressed a number of objectives. It:

- affirmed the productivity benefits of good health, developing the case that investing in health development was an investment in economic development;
- introduced the disability adjusted life year (DALY) for measuring the 'burden of disease' and the DALY per dollar for measuring the cost effectiveness of particular interventions;
- affirmed the logic and merit of constructing health care as a commodity, to be allocated according to market forces; and
- set forth a model for stratified health system development, incorporating essentially, private insurance and private provision for the rich, social insurance and private provision for the middle and a minimal safety net, publicly funded but provided through public, voluntary or private providers, for the poor.

The Report concluded that:

- it is possible to target funding to cost-effective interventions;
- cutting public expenditure is not necessarily bad for people's health;
- governments are notoriously and inevitably inefficient;
- public subsidy for water supply, sanitation and garbage removal is generally not cost-effective; and that
- much hospital care is not cost-effective.

The Bank concluded that structural adjustment lending can be consistent with health improvement if implemented in association with the recommended health policy packages. The Report argued for a limited number of minimal essential cost-effective interventions for the poor and for private sector provision and private health insurance for the rest.

The 1993 report was not the only contribution of the WB to health policy debate. It has also continued to drive the 'health sector reform' agenda including privatisation (Preker and Harding 2003), decentralisation and stratified health care with a minimal safety net based on a basic benefit package of selected interventions. More recently it has contributed to the conversation around universal health cover.

In 2001 the WHO Commission on Macroeconomics and Health reworked the ground covered 8 years earlier by the bank with the difference that while the Bank had argued on productivity grounds (health as an input to productivity), the Commission on Macroeconomics and Health argued on security grounds, 'globalisation is on trial!'.

The Commission developed a case for an increase in development assistance through which the rich nations would contribute to basic health care programs in the South. The Commission judged that $34 per person per year was the minimum required to provide basic health care and that the rich countries should ensure that no country was spending less than this.

Vertical disease specific programs

The conventional wisdom underpinning donor policies in the 1990s – in particular the interventionism, stratification and minimalism of *Investing in health* – was subject to increasing criticism from the late 1990s with the emergence of antiretroviral drugs for AIDS and the related controversies over intellectual property and TRIPS (in particular the

Treatment Action Campaign in South Africa). In parallel the Jubilee campaign for debt relief was also casting doubt on the G8 / WB ‘pay your debts’ policies.

The campaigns around access to treatment for AIDS constituted a threat to the legitimacy of the TRIPS regime, and the US project of increasing IP protection, particularly after the 2001 Doha Statement on Public Health. Accordingly massive funding was mobilised through the Global Fund and PEPFAR to fund AIDS treatment directly. In this period there was a rapid proliferation of GHIs and a massive increase in disease specific funding, particularly for AIDS, TB and malaria and for vaccines.

However, within a few years the fragmenting effects of vertical disease funding, effectively administered by foreign donors, on health systems in developing countries was becoming an embarrassment. One response from some of the GHIs was to graft ‘health system strengthening’ initiatives onto their vertical disease funding. The other was the return of the policy focus to health systems with the World Health Report of 2000 focusing on improving health systems performance and the establishment of the International Health Partnership Plus (IHP+) in 2007.

Universal health cover

The return to health systems was led by WHO with the health systems report in 2000, the report on PHC (‘Now more than ever’) in 2008 and the 2010 report on health care financing and universal health cover (UHC). The WHO was strongly supported in its campaign for UHC by the Rockefeller Foundation, indeed it may be that the shift from PHC in 2008 to UHC in 2010 was a response to Rockefeller urging.

In the 2010 report the WHO identified three dimensions to UHC: coverage of the whole population; coverage of all necessary services; and full coverage of the cost of each service. The campaign around UHC has been vague about the funding and service delivery arrangements required to deliver UHC. The Rockefeller Foundation is arguing that UHC must include the private as well as the public sector which suggests a health insurance approach. The World Bank has undertaken a useful study of 22 countries(World Bank 2013) which have achieved some progress towards UHC with a view to developing its guidelines. The PHM argues for public financing and publicly administered delivery.

In the period from the early 1950s global health systems policy has gone through some quite amazing contortions: from malign neglect in the early 1950s, to comprehensive primary health care in the late 1970s, to vertical interventionism of GOBI FFF during the 1980s, to the destruction of health systems under IMF direction during the later 1980s, to stratified health care with a minimal safety net promoted by the Bank in the 1990s, to vertical disease programs in the early 2000s and now perhaps a return to PHC and UHC. It is a record which does not inspire confidence in the prevailing structures of global health governance, nor in the various experts who shape their advice according to the needs of the governors.

Health systems science (and the perils of reductionism)

In the first section of this chapter I drew out some common dynamics of health systems development from an historical perspective. I demonstrated how health systems development is shaped by the big events and trends of history but how social movement activism can be part of those big events and modulate their impacts.

In the second section I traced the dominant themes in global health policy, as it has been applied to L&MICs over the last half century, and showed how the prevailing challenges facing the governors of the global economic regime have impacted on the kind of advice proffered to the governments of L&MICs. I have also shown how the imperatives arising from the looming crisis of global capitalism have shaped global health policy and how the counter-hegemonic forces, social movements and progressive governments of the global south, have resisted the neoliberal program and how these large canvas struggles have shaped global health policy.

Much of the expert advice and guidance provided to ‘developing countries’ is characterised by a one-size-fits-all, whole-of-system approach. This approach assumes that a broadly similar policy model can be applied across a range of different settings. It is generally conceived as a helicopter (top down) whole-of-system view. This is appropriate from the point of view of the fly in fly out expert or donor official. They want to see the whole picture; they want to be sure that their advice is strategic in the sense of steering the development of the whole health system.

This is a process which is somewhat divorced from the hurly burly of domestic politics where the international experts and donor representatives are talking directly to government. Certainly there is little space for civil society to participate under these circumstances. The top down, one size fits all, whole of system approach corresponds to the institutional relations of donor to government but more fundamentally it reflects the reductionism which dominates health systems science.

In this third section I provide a broad introduction to the academic and policy literature regarding health systems science and health systems strengthening. I commence by reviewing the development of health systems strengthening as a discernible discourse crossing a number of academic disciplines and with increasing engagement by intergovernmental organisations, donor states and non-government organisations. My purpose here is to give a sense of the institutional and ideological context of this conversation; the places where ‘health systems strengthening’ is discussed and why.

In the following subsection I provide a brief introduction to the languages, explanations and prescriptions of health systems science in relation to health systems resources (workforce, organisations, material resources, and information and technology); and health systems dynamics (patient flows, disease programs, information flows, financial flows, logical frameworks, and governance).

In relation to each of these components and dynamics the health system researchers have sought the evidence underlying causes and strategies. It is in the nature of the reductionist traditions of such research that context is controlled out in the search for evidence. The generalisations which emerge from this process thus tend to be divorced from the contingencies of context and also from other components and dynamics. What emerges is a set of universal truths regarding components and dynamics which are assembled in the whole of system models which inform the advice of the experts and donors.

Accordingly the prevailing technical analyses and ‘evidence-based’ nostrums are shaped in part by the ideological pressures of the neoliberal ascendancy and in part by the reductionist traditions of western science. Nevertheless, there is much of substance in the

research and commentary literature which progressive forces need to access even while maintaining some scepticism regarding the influence of global power structures and the perils of reductionism.

The political economy of health systems science

The discourse on health systems strengthening is relatively recent. While there has been a rich literature about health systems for many years, the explicit focus on 'health systems strengthening' (implicitly referring to donor assistance for health systems in L&MICs) only rose to prominence in the early 2000s, as the fragmenting effects of vertical disease focused funding became increasingly scandalous.

The pre-history of this discourse, can be traced through a number of different genres of study which emerged chronologically but have continued to develop in parallel albeit with productive interactions across these streams. These genres include:

- domestic research and commentary;
- reports and commentary on highly featured models;
- systematic comparative study of health systems;
- WHO support for PHC implementation;
- health care reframed as market commodity (WB);
- vertical disease funding programs (GHIs); and finally
- health systems strengthening (IHP etc).

Domestic research and commentary

The default genre in the pre-history of health systems strengthening has been research and commentary conducted within national boundaries and focusing on the domestic health system. This genre is widespread but most evident in the UK and the USA since these are where research funding and publication have been most strongly supported.

Domestic research and commentary in the UK has focused heavily on the challenges facing the NHS, during the 1960s and 1970s on planning technologies, and from 1990s on the practices of the internal market. The challenges of resource allocation in the NHS contributed to the development of a robust field of health economics from the 1960s including marginal utility analysis as a tool for thinking about planning and technology assessment. Developments in health economics arose from and contributed to the renaissance of neoclassical economics during the 1970s with evermore sophisticated methods for eliciting 'consumer preferences' and weighting and costing of (marginal) years of life gained or lost. The QALY (quality adjusted life year) has provided the foundational technology for drug trials and other applications of technology assessment. There is also a rich literature on the history of health care from the UK, some of which has been referred to earlier.

Domestic research and commentary in the USA has been strongly influenced by the challenge of expenditure control following the enactment of Medicare (federally funded health care reimbursement for older people) and Medicaid (federal state cost shared program for (very) low income people) in 1967. The cost escalation following Medicare led to a number of new technologies including certificate of need, utilisation review/control, benefit regulation and ultimately DRGs. Cost pressures in Medicaid and the 'Oregon experiment' (aimed at reducing the range of services covered by Medicaid) contributed to increased

funding of cost effectiveness research; ultimately leading to the DALY (disability adjusted life year) and the DALY per dollar as the metric for deciding which services were cost effective (and which provided the basis for the World Bank's minimal safety net model from 1993).

Meanwhile the rising costs of employee premiums in the corporate sector contributed to further developments in automated utilisation control and ultimately to managed care. Managed care has contributed radically to the concept of health care as a market commodity; adding a third market (where insurers meet providers) to the pre-existing two markets (consumers meet providers and employers meet insurers). Managed care has enabled the private market to match precisely access and quality of services to level of premium. The fact that the US health care system is inefficient, inequitable and of variable quality has not discouraged the World Bank from forcing privatisation and market based models onto L&MICs.

Closely related to the challenge of expenditure control is the challenge of quality of care and safety in the face of over-servicing, encouraged by fee for service, and under-servicing, encouraged by various forms of managed care. A rich array of quality and safety technologies have been developed in the US since the 1920s, ranging through hospital accreditation, death and complications reviews, criteria auditing to clinical risk management.

Health care research and commentary in other countries has been similarly creative and far reaching although less widely known because not published in English language peer reviewed (and indexed) journals. Early research into health care planning in the USSR was highly influential from the 1930s to the 1970s. Radical thinking in almost independent India led to the 1946 Bhore Report which has been influential in India although never implemented.

Commentary on highly featured models

Moving beyond domestic research on domestic problems has been the genre of international commentary on foreign health systems, sometimes because they are sites of radical innovation; sometimes because of the hegemony of the imperial metropolis.

The earliest example in the modern period is the invention of social health insurance by Bismarck in Prussia in 1883. The Prussian model, compulsory employer contributions to insurance premiums for low paid workers, has been adopted in one form or another in many countries since then. Retrospective interpretations of Bismarck vary from reflections on the benevolence of early German capitalism to lessons about the powerful impact that the threat of revolution can have on social policy.

Health care in the USSR was the focus of international interest from the 1930s to the 1970s and had a powerful effect in terms of promoting the principles of state responsibility for health care, public funding, primary health care and health planning. The Soviet model influenced developments in the UK (the NHS), the USA (HSAs), Canada and China to name a few and these models exerted further influence.

The NHS in the UK is of the most studied health systems internationally and has exerted a profound influence on health systems globally. Principles which have gained traction internationally from their exhibition in the UK include: public funding, universal access, public sector delivery, the managed market (purchaser provider separation), clinical

governance and many more. Sweden and Canada are two further HICs which have well performing health care systems which have attracted international commentary and interest.

China has attracted great international interest in its health care achievements and challenges. In the 1960s and 1970s there was intense interest in the 'barefoot doctors' and other features of China's commitment to primary health care. What is less well understood internationally is the collapse of primary health care and the three tiered referral structures with the move to the market economy in the 1980s.

Cuba continues to offer a beacon of inspiration for many people in L&MICs despite the continued US blockade and continuing attempts at destabilisation. The achievements of the Cuban revolution have demonstrated the practicability of universal access to quality services through public funding and public provision despite limited resources.

More recently the achievements of Thailand and Brazil have attracted widespread interest. Both countries have committed to and delivered universal access based on comprehensive PHC, in both cases on the back of popular democratisation movements.

Systematic comparative study of health systems

The establishment of the WHO from 1948 was a critical step in assembling the information base needed for the systematic comparative study of health systems. While the information was initially quite uneven, continuing support through WHO for national morbidity and mortality collections and standardised national health accounts provided the basis for much subsequent research and commentary.

WHO also promoted a variety of descriptive and analytical cross country reports from the early 1950s onwards. Many of these were reports of study group visits; others drew upon WHO's gradually improving information base.

Milton Roemer(Abel, Fee et al. 2008) was involved in many of these reports as a consultant to WHO in Geneva and also to different regional offices and his many publications (see his 1991 magnum opus(Roemer 1991) in particular) were very influential in establishing the comparative study of health systems as a distinct field of study.

While Roemer's interest was broad ranging and highlighted issues of health system design, ministries of finance all over the world were worried about increasing expenditures on hospitals, drugs and other elements of health care and their concerns drove a continuing sequence of health expenditure studies (see for example Hu, 1975(Hu 1975)) as well as the progressive improvement in WHO's information systems (see for example Abel-Smith, 1967(Abel-Smith 1967)). The corporate sector was also watching health sector expenditure grow albeit with different motivations (see for example Maxwell, 1981(Maxwell 1981)).

Another important contribution to this literature has come from the health systems historians who have demonstrated how health system development is embedded in the wider movements of history (see for example Stevens 1966(Stevens 1966) & 1971(Stevens 1971)). Unfortunately this literature is much stronger for the UK and the USA than for other countries (Immergut, 1992(Immergut 1992) is an outstanding exception).

The comparative study of health systems was critical in the development of primary health care as elaborated at Alma-Ata in 1978. A critical reference here is the publication in 1975 of Health by the People, edited by Kenneth Newell(Newell 1975). Litsios(Litsios 2004)

has described how key people associated with the Christian Medical Commission brought to the attention of Newell and Mahler critical case studies of primary health care in action, in particular, Chimaltenango in Guatemala, Solo in Indonesia and Jamkhed in India. These were very influential models in preparing for the Alma-Ata Conference.

The comparative study of health systems received a new impetus in the late 1990s with the establishment of the European Observatory of Health Systems, based in the European Office of the WHO but with the support of a number of European governments and intergovernmental organisations. The European Observatory (and similar observatories in other regions) has contributed greatly to the availability of reasonably uptodate comparative documentation of health systems.

WHO support for PHC implementation

A significant phase in the pre-history of 'health systems strengthening' was the sequence of publications out of WHO Geneva from 1978 directed to elaborating the concept and implications of primary health care (in many of which Milton Roemer played a key role, either as consultant, rapporteur or facilitator). From the early 1980s WHO Geneva had a 'Division of Strengthening of Health Services' which published a number of reports on various aspects of health systems strengthening.

These early reports were produced relatively cheaply with no colour or glossy pages and in some cases could have benefitted from more attention to design and production. In these respects they do not compare favourably with the onslaught of documents produced by the World Bank during the 1990s as it sought to displace WHO as the leading policy authority in health systems. On the other hand their content is generally wise, insightful and highly relevant to the progressive implementation of PHC. Many of these reports are worth re-reading because of the contribution they could still be making to strengthening health systems.

The 1983 report on research for the reorientation of national health systems(WHO Study Group 1983) provides a comprehensive discussion of the range of issues on which health policy research may be needed: organisation, management, resources, community participation and evaluation.

The 1984 report on strengthening ministries of health for primary health care(WHO Expert Committee 1984) explores key functions of ministries, reviews some common weaknesses and considers strategies for strengthening.

The 1987 report on strengthening district health systems(WHO 1987) explores in some detail district planning, community involvement, intersectoral collaboration at the district level, workforce issues, financing and resource allocation.

I mention these three reports specifically because one of the recent criticisms of comprehensive primary health care model has been that it is 'horizontal' in the same way as contemporary disease funding programs are 'vertical'. In fact the CPHC model clearly encompassed governance, management, district support structures, health systems research and referral relationships.

The tragedy of Alma-Ata is that, as 1978 came and went, a structural crisis of capitalism was looming. Protecting the rich world from the full impact of this crisis would

require massive tribute to be paid to the imperialist heartland by so-called ‘developing countries’ under the rubric of structural adjustment and the discipline of the IMF.

The economic perspective: commodified health care and interventionism

Investing in health foreshadowed a new approach to managing the debt crisis, a form of self-inflicted structural adjustment known as poverty reduction strategy papers (PRSPs). PRSPs were to be designed by the recipient government and so, presumably, free of the conditionality which had been a critical part of the IMF’s structural adjustment packages (SAPs). In fact the approval by the IMF of PRSPs would still be as conditional on approved macroeconomic measures as had been the SAPs (in some cases more so).

Investing in health promoted a kind of atomised stratification in its focus on specific services which ought to be included in the benefit package for the poor. Presenting health care as the buying and selling of commodified services rendered obsolete any concern for the back office functions of health care: planning, management, supply, quality processes and district health systems. Since the services to be included in the basic benefit package were to be provided by private, voluntary and in some cases public agencies, it was (presumably) assumed that the system infrastructure required to support such service delivery would be also provided on a sector basis. Certainly there was nothing included in these plans which would strengthen the support and referral relationship between primary and secondary/tertiary services.

The assumptions that went into the DALY per dollar calculations were consistent with the productivity paradigm in that the life years of young to middle aged adults were to be valued more highly than those of children or old people. However, some compromises were necessary to limit the cost of the report’s recommendations. Most notorious was the finding that reticulated water and sanitation were not cost effective and therefore not appropriate purposes for public subsidy. This was based on the decision to assign the full cost of clean water and sanitation to the projected health benefits alone; ignoring the productivity gains associated with decent urban infrastructure, including for example the opportunity costs of the time women spent collecting water.

Not highlighted in *Investing in health* was the privatisation of services not included in the basic benefit package. Service providers would receive payment for the basic benefit package but would be entitled/required to charge for all other services.

Investing in health offered a selective approach to primary health care, like that promoted a decade earlier by UNICEF and Rockefeller but without the emphasis on vertical service delivery. However, the focus on commodified services and the basic benefit package had comparable implications for health system development: fragmentation and hollowing out of support services. *Investing in health* was not an essay in health systems strengthening but, because of its destructive implications for health systems, constitutes an important part of the pre-history of the renewed focus on health systems strengthening in the late 2000s.

From vertical disease funding to health systems strengthening

The return to the discourse of health systems strengthening was in part a response to a rising criticism from the mid 2000s of the fragmenting effect of vertical disease focused programs(WHO Maximising Positive Synergies Collaborative Group 2009). Concerns

regarding these GHIs (global health initiative) included duplication, diversion of personnel and resources from comprehensive health services to vertical programs and the erosion of long-term capacity:

> *Although new resources, partners, technical capacity, and political commitment were generally welcomed, critics soon began to argue that increased efforts to meet disease-specific targets with selective interventions were exacerbating the burden on health systems that were already fragile. At the same time, the delivery capacity of GHIs was limited by the weaknesses that were present in country systems, such as inadequate infrastructure for service delivery, shortages of trained health workers, interruptions in the procurement and supply of health products, insufficient health information, and poor governance. The tensions that have been caused have contributed to a longstanding debate about the interplay of disease-specific programmes or selected health interventions with integrated health systems (World Health Organization Maximising Positive Synergies Collaborative Group 2009).*

WHO's initial response to this threat, its *Maximising positive synergies* project (WHO 2009), was a search for ways in which the resource flows associated with the GHIs could be coordinated and managed so as to strengthen rather than fragment health systems.

In a parallel development the International Health Partnership (IHP+) was launched in 2007(IHP+ 2013). The IHP+ is constituted by 'partner countries' (developing country governments who are seeking assistance) and 'development partners' (bilateral funders, intergovernmental organisations, private philanthropies and GHIs). Partner countries are required to have a national health development plan which will be assessed by the donors (under the Joint Assessment of National Health Strategies or JANS) who will then 'harmonise' and 'align' their aid in accordance with the JANS. A 'compact' is then signed between the partner country and the development partners committing both sides to cooperation as agreed (in accordance with the principles of aid effectiveness). Accountability for performance relies on formal monitoring protocols and civil society advocacy.

While the World Bank is a member of the IHP+ it is also a sponsor of the Health Systems Funding Platform (World Bank 2010) (which includes the GAVI Alliance, the Global Fund and the World Bank). These are all members of IHP+ and follow the principles of IHP+ but then seek to collaborate more closely in disbursing their contributions in accordance with the JANS.

The largest donor, the USA, does not participate in the IHP+. The US Congress imposes detailed earmarking on USAID and PEPFAR expenditures and requires full accountability, to a degree that is not compatible with collaboration with other donors.

Both MPS and IHP+ attempt to reconcile deeply contradictory approaches to health system development; it may be impossible. WHO appears to have followed a somewhat zig zag path in its response to the benefits and risks of the GHIs. From MPS and IHP it returned to PHC in 2008 and then UHC from 2010.

There is a huge research literature dealing in various ways with health systems strengthening. See Peters et al (2009) for an introduction to this literature.

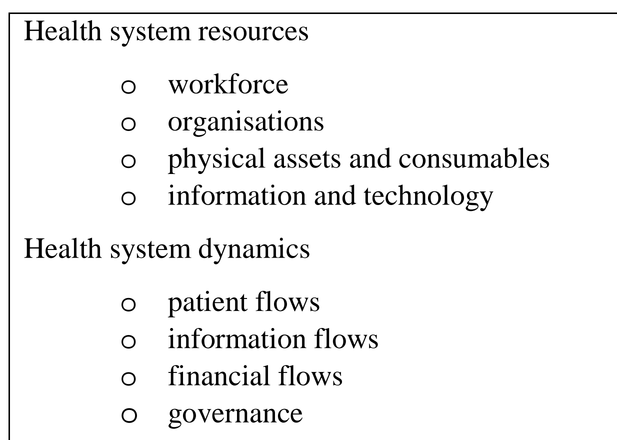
The contemporary discourse of HSS is broadly structured around the choices and world view of the donor officials and their experts in providing advice to (imposing programs on) government officials (ministry of finance officials as well as ministry of health) in recipient

countries. The national health strategy, as evaluated by the donors is the starting point for donor funding. This approach discounts the realities of domestic politics (and the governance structures of which these officials are part). The bounded, whole of system approach does not correspond to the realities faced by local officials and civil society activists whose focus is rather on local problems and priorities rather than whole of system reform.

Where a national health strategy is developed for the purposes of donors it tends to be developed in consultation with the donors and may not reflect the experience and aspirations of other stakeholders or recognise them as partners in health system development; in particular, it discounts the role of civil society and social movements. There are further disadvantages associated with the health economics approach which tends to treat people (both providers and communities) as objects to be incentivised which makes it harder to harness their good faith and commitment to improving their lives and their health care.

Building blocks and control knobs

In the following section I introduce the 'building blocks' framework including: health system resources (workforce, organisations, physical assets, information/technology) and the dynamics of health system functioning (patient flows, information flows, financial flows and governance).



Health system resources

- workforce
- organisations
- physical assets and consumables
- information and technology

Health system dynamics

- patient flows
- information flows
- financial flows
- governance

Box 1. Resources and dynamics: the building blocks of health care (modified from WHO 2000).

There is much of value in this body of work. However, it is well to keep in mind the reductionism which is an essential part of this research tradition. In order to derive generalisations regarding these various resources and dynamics it is necessary to 'control out' context. How these generalisations are then 'put together' again is quite problematic. Instruments such as PRSPs and JANS assume a set of ('evidence-based') standards by which national health strategies will be judged. Under these circumstances the emergence of 'one-size-fits-all' thinking is not surprising. (There are alternatives to which we shall turn in the final section of this chapter.)

Workforce

Problems regarding access, cost, quality and equity can all be traced in some degree to workforce issues. Proximal causes include:

- not enough health practitioners,
- intolerable working conditions (lack of resources, inadequate salaries),

- lack of adequate training,
- low professional commitment; low morale,
- lack of supervision and support, and
- low level of productivity.

Underlying causes may include:

- inappropriate workforce mix,
- weak educational institutions,
- weak organisational infrastructure to support professional practice,
- interprofessional conflict, and
- brain drain (sectoral, regional, international).

Policy strategies which may be needed include:

- proper training and support for community health workers;
- balancing doctors and nurses, or GPs and specialists;
- making space for traditional/indigenous practices as well as 'modern' Western health care;
- strengthening basic training: volume, appropriateness and quality of teaching;
- improving advanced training and support for professional development activities;
- adopting appropriate modes of employment;
- ensuring adequate levels of remuneration and modes of remuneration which optimise incentives;
- improving the productivity of the labour force;
- promoting equity in workforce distribution;
- ensuring adequate resources for professional practice (supplies, equipment, information, (eg clinical guidelines), decision support);
- taking a structured approach to clinical governance: promoting quality and safety; eliminating unnecessary services;
- mobilising community support as well as accountability.
- regulating health practitioners, including regulating the practice of private providers;
- innovating with respect to modes of service delivery;
- promoting research and research brokerage in relation to workforce issues.

Some useful sources of further information on human resources for health include:

- WHO World Health Report 2006: Working together for Health and Background Papers prepared for WHR2006
- Global Health Workforce Alliance
- WHO / Health Workforce
- Medicus Mundi International: HRH
- BMC HRH
- UNSW HRH Hub
- WB HRH

- Eldis HRH

Organisations

Many problems regarding access, cost, quality and equity can be traced in some degree to organisational structures and roles and relationships; both across and between organisations, as well as across and between practitioners.

Access barriers may arise from non-functioning referral relationships. Long waiting times may be due to low levels of productivity. High out of pocket costs may arise from autonomous unregulated private practitioners. Rudeness and incompetence may reflect low morale and poor working conditions. Unsafe practices may be due to lack of systematic structures to support clinical governance.

Organisational problems blend closely to management problems but they are worth listing separately because organisational reform is significantly different from management training or other managerial responses (see below).

Organisational reforms which may need to be considered include:

- strengthening district health systems infrastructure;
- creating a single line of responsibility and accountability;
- decentralisation;
- purchaser provider separation;
- organisational innovation and modernisation;
- new institutional structures to support evidence based medicine and clinical governance;
- complaints systems;
- regulatory reform.

Physical assets and supplies

Many problems regarding access, cost, quality and equity can be traced in some degree to the management of physical assets and supplies. While these areas are properly part of health service management (discussed below) they are sufficiently specialised to be worth mentioning separately.

Access barriers may be due to poor quality of physical infrastructure. Why is this? Was it poorly designed or has it been poorly maintained and if so why? Access may be a problem because of lack of ambulances or inappropriate specification of the ambulances.

Quality and safety may be jeopardised through lack of equipment or lack of repairs to equipment. Weak procurement and supply systems may lead to lack of some drugs in the clinic. Substandard drugs circulating may be due to weak drug regulatory capacity including marketing approval and surveillance, prescription and dispensing and quality use of medicines.

Working towards possible solutions may involve addressing:

- pharmaceuticals policy development (including intellectual property, pharmaceuticals reimbursement schemes, drug regulation and quality use of medicines),

- service development planning, capital planning and repair and maintenance;
- equipment purchase, repair and maintenance;
- procurement and supply;
- management training in asset management, procurement and supply;

Information and technology

Many problems regarding access, cost, quality and equity can be traced, perhaps indirectly, to the management of information and technology. Planning may be limited for lack of information systems and thereby contribute to access barriers. Lack of information and various technologies may lead to reduced efficiency and productivity. Pathways towards improving the supply of information and access to technology may involve:

- funding for research and development,
- development of clinical guidelines, and
- support for health services research and health policy analysis

Patient flows and programs of care

Many problems regarding quality, safety and efficiency can be approached from the perspective of patient flows, including programs of care. Understanding causes and working towards possible solutions may involve reviewing:

- referral relationships,
- clinical pathways,
- triage arrangements,
- appointment systems,
- program planning,
- chronic disease management programs,
- retrieval, treatment, rehabilitation, prevention,
- comprehensive primary health care, and
- systematic prevention and treatment programs.

Information flows

Problems in service delivery which may be due to or traceable back to issues of information flows. Pathways towards possible solutions may involve attention to:

- communication in the clinic,
- health agency information systems,
- system wide information systems,
- surveys and administrative collections,
- population wide information flows regarding health, disease and health care,
- balancing access and privacy, and
- commissioning hardware and software for institutional information systems.

Financial flows

Many problems in service delivery which may be due to or traceable back to financial flows:

- lack of money,

- fragmented funding arrangements,
- perverse incentives associated with payment pathways,
- unfair distribution of the burden of revenue raising,
- unfair distribution of public funds, and
- high administration costs.

Health care financing can be thought about in terms of three functions: raising funds, pooling funds and paying for services.

Policy analysis and development in relation to raising revenue will involve consideration of sources of revenue (different kinds of taxes, social insurance, voluntary insurance, user charges) and the distribution of the revenue burden (corporations, foreign enterprise, informal sector, etc).

Pooling refers to one or more funding pools, each with identifiable contributors and each with identifiable outgoings. The larger the pool, the more secure it is in terms of unpredictable outgoings. The smaller the pool, the more important it is to keep capital in reserve to protect against the risk of unusual demands. The pool also serves to mediate transfers, depending on who contributes. Pooling which encompasses the whole community (which will generally be based largely on taxation) will mediate transfers from the well to the sick because the well do not use the pool and the sick may draw more than they contribute. By the same logic the pool may mediate transfers from rich to poor and from young to old. From an equity, risk management and efficiency policy point of view we need to move from smaller fragmented pools towards a singular all encompassing pool.

The third function of health care financing is paying for health services. Policy analysis and policy development needs to consider: payment to practitioners, payment to agencies, procurement (paying for medicines, supplies and input services), payment formulae and the distribution of risk and the regulation of surrogate purchasing.

There are many different approaches to paying practitioners. These include salary, fee for service, pre-payment (capitation) and various forms of 'blended payment'. Each of these modes carries different incentives, both beneficial and perverse. The appropriate mode of remuneration depends on historical circumstances and local contingencies. Two warnings are in order: against absolutism (in particular salary versus fee for service); and against incentive engineering (which treats the practitioner as an object to be manipulated in the hands of the economist). In general a neutral 'incentive environment' which least distorts the good faith and professionalism of the practitioner is to be valued.

Similar principles apply to funding health care agencies such as hospitals. Available mechanisms include: user fees, vouchers, insurance, per diem, diagnosis related groups (DRG); pre-payment, etc). Historically the dominant forms of payment have been input budgeting in the public sector and fee for service in the private sector. Input funding has been criticised because the funder doesn't really know what they are purchasing and the manager is constrained by the negotiated budget. Generally input budgets are based on historical expenditures so there is no incentive to increase productivity. From the economic point of view the gold standard would be payment for outcomes but the measurement of (attributable) outcomes is very difficult. DRG based funding pays for episodes of care which means the funder knows a bit more about what they are buying and the manager has greater discretion

with regard to managing expenditure. Episode based payment for inpatient care episodes is a subset of 'activity based funding' which aspires to pay for meaningful passages of care, not just inpatient care. However, DRG funding may be a special case; most other streams of care, eg mental health, emergency care, aged care, etc do not have comparable tools for defining the episode of care.

Fee for service care is a kind of activity based funding and the economists claim that it promotes efficiency in the production of the service, but whether that service was the right service, was necessary and was embedded in a necessary sequence of services is another question. If efficiency is understood in terms of the cost of producing outcomes, rather than outputs, then FFS as a driver of efficiency is much more problematic.

Procurement (paying for medicines and consumables and input services) presents another set of issues, particularly, where hospitals or clinics make money by selling drugs.

Governance and management

Finally we turn to governance and management. Most problems in service delivery can be traced back, at least in part, to issues of governance and management. In developing policy solutions to problems in service delivery consideration needs to be given to:

- Leadership,
- Accountability,
- Regulation (laws, codes, accreditation, reporting, accountability),
- Management (and management training),
- Support for frontline service delivery (inputs, supplies, maintenance)
- Governance and management systems (the measurement and management of organisational performance; guidelines, standards, audit, clinical pathways, bench marking; innovation, re-engineering and modernisation),
- Patients (as individual 'purchaser' or as co-producers of health outcomes) and communities (as market or as owners).

A bottom up approach to health systems development

The purpose of this chapter is to explore the 'principles' of health systems strengthening from the points of view of civil society activists seeking to drive improvements in health policy making, implementation and accountability.

In the first section of the chapter I summarised some of the legacies, tensions, pressures, drivers, climates, serendipities, propensities, leaderships and resources which shape health care development. The underlying thesis of that section is that the 'health system' is not separate from 'society'; rather the 'health system' is a picture of society viewed through a health systems lens.

In the second section I reviewed the evolution of global health policy since WWII. Again the degree to which health policy reflects the priorities and perspectives of the global governors is striking. Some of the policies which have been promoted over this time would be quite absurd if viewed only in health system terms but they do make some kind of sense viewed in their wider political economy context.

In the third section I surveyed health systems science as a technical discipline. I commenced with some comments about the political economy of health systems science. I then surveyed and put some of these insights together to present a theoretical framework for describing and explaining the dynamics of health system development.

The donor approach to health systems strengthening involves a 'whole of system' perspective starting with a 'national health strategy' which is required by the donors (and the IHP+, JANS, HSFP etc) because they are dealing with the national government and need to have a menu of projects and programs which they can negotiate and perhaps fund. An alternative to this 'whole of system' reform which corresponds more closely to the perspective of the health activist is the 'bottom up' approach which starts with the problems which concern local communities (and local officials): problems of access, costs and quality in particular. In this final section we explore this idea of a 'bottom up' approach.

The political science perspective

Political science provides some very useful ideas in terms of re-thinking the processes of health system development from the civil society activist perspective. We shall discuss: convergence, path dependence, complexity, incrementalism, vision and 'windows of opportunity'.

Convergence

Much of the talk about health systems development emphasises the common factors which drive change, in particular, increasing technological efficacy, aging and cost pressures. This is sometimes referred to as convergence(Mechanic and Rochefort 1996) implying that health systems are converging to a common model. However, it would be a mistake to ignore the histories and specificities that also shape health systems development.

Apart from the common factors listed there are a couple of other pressures towards convergence. One of these is simply fashion. There is a global flow of policy influence from leading instances to local adaptors. Some of the instances of such policy flows include the influence of:

- mandatory social insurance in Germany on other European countries;
- health planning technologies adopted in the USSR on health planning in other countries (an influence which peaked in the 1970s);
- the UK NHS on both governments (often positive) and medical organisations (mainly taken as a warning of what to resist);
- quality assurance mechanisms developed in the USA on quality assurance in other countries;
- market inspired policy mechanisms developed in the US and later in the UK (eg from 1991).

It may be somewhat naïve to attribute all of these influences to 'fashion'. There are also systemic interests and forces globally driving policy reform in both rich and poor countries, in particular, the ideology of neoliberalism with its pressures to commodify and marketise health care. In the second section of this chapter I have explored some of the pathways through which such influences are mediated.

The activist may take note of the common factors driving cost pressures (technology and aging in particular) but should take a critical view of the ideological pressures for a particular set of (market based) responses to these pressures.

Path dependence

Running counter to the pressures of technology, aging, fashion and ideology are the legacies and specificities of particular jurisdictions: the histories, institutions, cultural norms and previous decisions.

The term 'path dependence' has been coined to describe how the past constrains the future in policy terms. One of the best illustrations of path dependence comes from Ellen Immergut who describes (1992) how the particular circumstances of the Vth Republic under General Charles de Gaulle from 1960-62 eliminated previous veto points and allowed de Gaulle's government to reorganise the hospital system, introduce full time salaried employment for hospital physicians and regulate doctors' fees; outcomes which would otherwise have been quite unlikely.

Path dependence can also be seen in many post-colonial health care systems (Indonesia would be a good example) where the hospital centric, specialist centric model, directed to looking after the colonial elite, becomes adapted to the needs of the urban elite in the post colonial context. A similar pattern is evident in post democratic reform South Africa where unequal access to health care under apartheid is reproduced under democracy and has been very hard to change.

Brazil likewise emerged from colonisation with wide social and economic inequalities and with national politics dominated by a small powerful elite. This was associated with highly stratified health care with private and social insurance for the rich but no risk protection (and often no health care) for the poor. Despite the return to democracy in the 1980s and the commitments of the 1988 Constitution, progress towards a more equal access has been slow.

Another example can be found in the decolonisation processes of Australia and Canada (negotiated without conflict) compared with that of the US (involving a famous revolution). It seems plausible that the hostility to government programs and regulation in the US (in comparison to the acceptance and extensive use of social protection in Australia and Canada) can be in some degree attributed to this difference in the decolonisation process.

The activist should note the concept of path dependence and might draw from this an appreciation of the need for a high level of creativity in adapting strategies and models developed elsewhere to the local situation.

Complexity, contingency and unpredictability

The choices that are available (and feasible) in any particular health system at any particular time are highly contingent on the specific pressures within the health system, but also on history, the current political and institutional configuration and external pressures.

Complexity theory provides a useful way of making sense of contingency and the key to this interpretation of contingency is the idea of society as a complex adaptive system. A complex adaptive system is made up of multiple autonomous agents, all 'watching' each other (in the sense of receiving various inputs arising from the behaviour of other agents) and

making 'choices' about their own behaviour. Two important properties of this system are emergence and unpredictability. Emergence refers to properties (patterns of system wide behaviour) which emerge at macro level from the micro choices of the agents who/which constitute the system. The collapse of the former Soviet Union in 1989 was not predicted by most commentators (unpredictability) but was precipitated by a system wide loss of legitimacy which arose from the behaviours and perceptions of the multitudes of agents who constituted that system. The idea of emergence also encompasses the idea of 'tipping points': transformations where the system as a whole moves from stability to radical change. This is most familiar in relation to climate change. Unpredictability (in the medium and longer term) arises from the high level of complexity involved in determining the behaviour of the system and the huge data requirements and computing power which would be needed to model and predict the behaviour of the system. Unpredictability refers to the medium and long term; in the short term there may be transformations forthcoming which can be clearly foreseen. The insight arising from complexity is that the horizon of predictability is surprisingly close.

Complexity theory cannot be applied to functionalist models of the health system which depict boundaries around the 'system' derived from the putative 'social purpose' of the system. Such models can by useful in program planning but not for policy oriented prediction and therefore policy development. Complexity theory applied to the health system would only make sense if the health system is understood as the whole of society seen through a health system lens.

The idea of complexity, and in particular the high level of unpredictability which flows from this, has great relevance for the activist. The idea of contingency reminds us that there are no far reaching formulae which can be applied without regard to context; it reminds us of the need for creativity in developing policy proposals. Uncertainty regarding the future trajectory of the system should carry some degree of hope, that positive change remains possible (despite the neoliberal dictum that 'there is no alternative'), and with that some sense of obligation to work towards creating the conditions out of which progressive change might emerge. However, there is no inevitability regarding such progressive change.

Incrementalism, coherence and vision

The idea of incrementalism can be used descriptively, to describe how systems develop, and strategically, to suggest that we should only aim for small incremental changes. We use it here purely descriptively but the recognition of the incremental nature of health system development has implications for political strategy.

Incrementalism, as a description of how health systems develop, describes the common experience that consensus support for radical system reform is less common than incremental reform emerging out of the contested objectives of partisan advocates (Sax's 'strife of interests'). However, there are 'windows of opportunity' when dramatic health system reform is possible, as in the de Gaulle case referred to above.

Recognising that incremental change is the most common pathway of change emphasises the need to think through the specific reform needs of different parts of the system and not to rely solely on far reaching strategies of reform. Recognising that far reaching reform might become possible emphasises the need for a vision about the system wide reform and the broad strategies which might be needed.

Propensity for change varies from periods when institutional relations are frozen to periods of greater flexibility. Opportunities for incremental change can be created but often arise unpredictably. From this comes the principle of readiness.

The idea of incrementalism raises a question about coherence: can we expect that a sequence of decisions taken across time will be coherent in the sense of the second decision complementing the first and putting in place the conditions for the third. The Chinese have an aphorism about 'feeling the stones to cross the river' which suggests that the sequence of decisions (where to put your feet) are guided by the goal of crossing the river. If the sequence of decisions taken by one decision-maker is to be coherent in this sense it will be because he/she has a vision of 'crossing the river', longer term objectives which guide the incremental decisions.

However, the development of health systems is effected by a myriad of decisions taken at different administrative levels and in different administrative sectors. Incrementalism is dispersed. Coherence in this context depends on a vision about where *we* are going which is shared by the decision making units in those different levels and sectors. This points to a further principle needed to achieve coherence under dispersed incrementalism: a principle of shared vision.

Health system strengthening depends on the effectiveness of each episode of reform and the coherence of the aggregate sequence of incremental reforms. Effectiveness depends on the setting of each episode, the quality of policy analysis which has gone into it, the readiness of the proponents and the effectiveness of implementation. Coherence across a tapestry of reforms (across time, level and sector) can be guided by shared vision. Leadership, readiness and vision are critical to managing the opportunities for change which ebb and flow.

The vision we might develop regarding 'the health system we want' cannot be viewed in isolation from 'the society we want' because as we have argued earlier the health system is society at large, viewed through the health system lens. It will be very difficult to achieve comprehensive primary health care, except in a society which values solidarity and the commitment to work together for a better, more sustainable society. However, working to achieve comprehensive PHC will be a significant contribution towards achieving a better more sustainable society.

Windows of opportunity

The concept of 'windows of opportunity' is critical in understanding health system development. Opportunities for incremental change can be cultivated but often arise unpredictably.

Windows of opportunity arise in all sorts of ways and places. The establishment of the NHS in the UK was a consequence of the relief of surviving the war, the sense of solidarity which had been strengthened during the war and the general commitment to post-war reconstruction. There was a fresh confidence in the power of medicine as a consequence of the development of antibiotics and other advances associated with the war. I have cited earlier the window of opportunity from 1960-62 associated with the period of presidential rule under General de Gaulle. The implementation of universal health insurance in Australia

in 1974 was a consequence of a series of serendipitous events in a short-lived but generally favourable policy environment.

For the activist there are two implications of the window of opportunity: first, the principle of readiness; and second, the creating of opportunities.

Principles for activist practice

Finally we are in a position to pull out some principles for civil society activism in regard to health system strengthening.

Study the histories of health systems

There is no better way to understand health systems development and the principles of health system development than to study the histories of health systems in a range of different countries, in the context of broader social and economic histories.

It is particularly helpful to have a detailed understanding of the histories of one's own country's health system and to be able to trace the braiding of influences: technological efficacy, aging, fashion, the pressure of ideology, external pressures and the dynamics of domestic policy making.

These kinds of historical understandings inform our judgement about the politics and science of health system development; about the global pressures and local contingencies; and about creating, and being ready for, windows of opportunity.

Engage with global health systems policy

The prevailing discourses of global health systems policy are shaped in part by research, in part by fashion and in part by powerful ideological forces. It is important for our own practice that we critically engage with these discourses; we need a clear understanding of what is relevant for us in this discourse as well as the macro forces feeding and driving these discourses. However we also need to recognise that other activists in other countries are also engaging with these discourses of global health policy. Containing the influence of the ideologists would be greatly assisted by communication and collaboration across the people's health movements from different countries.

Be prepared

The activist needs to be prepared for emerging opportunities for advocacy and mobilisation; have the policy ideas ready and the networks primed. Be prepared and be creative.

Follow the technical literatures

Despite the reductionism and ideologies which influence the technical literatures there is much there which can be of value for the activist. The challenge is to extract from these literatures the insights and models which might provide the key to the next policy engagement even while critically engaging with the politics of knowledge production.

Continue policy analysis and policy development

Readiness for opportunities, and mobilisation to create opportunities, both call for continuing policy analysis and policy development regarding the problems of the system, with a particular focus on the problems which are faced by those most disadvantaged by the

system. This requires creating obligations, meetings, communications which keep up a demand for creative policy criticism and development.

Build capacity for policy analysis and development

The people's health movement needs activists who are skilled in policy analysis and policy development as well as policy advocacy. The movement needs to invest in building policy capacity.

Stoke the policy conversation

Working towards a shared vision, helping to unfreeze institutional relations abd being ready for windows of opportunity all require that we stoke the policy conversation, through position statements, presentations, discussions and local research.

Project a vision

We need to project clearly a vision of the health system we want which can inspire officials, politicians and civil society activists and give coherence to the dispersed decisions being made (and advocated around) at different levels and in different sectors. This is not the same as a national health strategy although the latter may be an important vehicle for projecting the vision.

Build constituency

Most importantly we need to build a strong, self-conscious constituency for health system reform, based particularly among those who have most to gain and among the health activists and practitioners who care about those who have most to gain.

Conclusions

My principal intention in this book is to create a resource for activists; a collection of stories about the struggle for health which activists may be able to use in analysing the problems they face and devising strategies.

This is a collection of partial stories, not a complete map. Society is impossibly complex and the 'health system' is society at large, albeit seen through a 'health system' lens. Complexity is not the only difficulty; the possibility of objectivity is also an illusion. We are not dispassionate observers studying earthly health systems from some external, objective vantage point. We are in this system; we are part of it. (The act of drawing a map is an action of consequence within the system being mapped but it is only through Escher like diagrams that the map can include a representation of the map maker making the map.) Even if it were possible to present an objective all-encompassing account of 'health systems' it would not be of much use to people whose domain of struggle is essentially local and contingent.

This collection of partial stories (histories, models, theories, principles) provides activists with resources for building highly specific accounts of the priority problems which they and their communities are facing; accounts which are centred on the agency of the activist and the context and dynamics of local problems and which help to describe and explain those problems and sketch scenarios of possible futures associated with different strategies of engagement.

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