

# **An introduction to understanding Health systems**

**For people-centred change**

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# Health problems

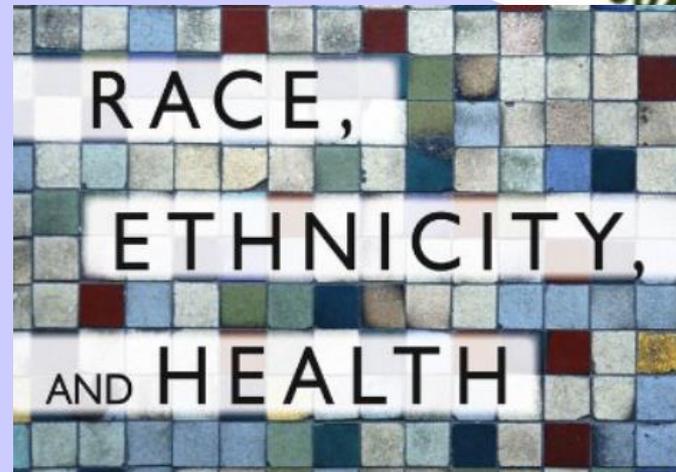
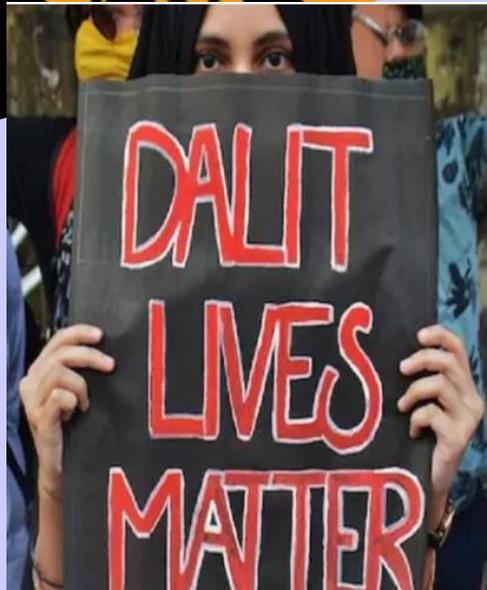


## Accidents and injuries





# Health needs and demands of various sections of people



**Health problems**

**Health facilities and services**

**Health needs and demands of various sections of people**

These are our starting points for engaging with health issues.

But understanding these is not sufficient,

to engage and change we need to

probe deeper and wider and understand

## **Health Systems**

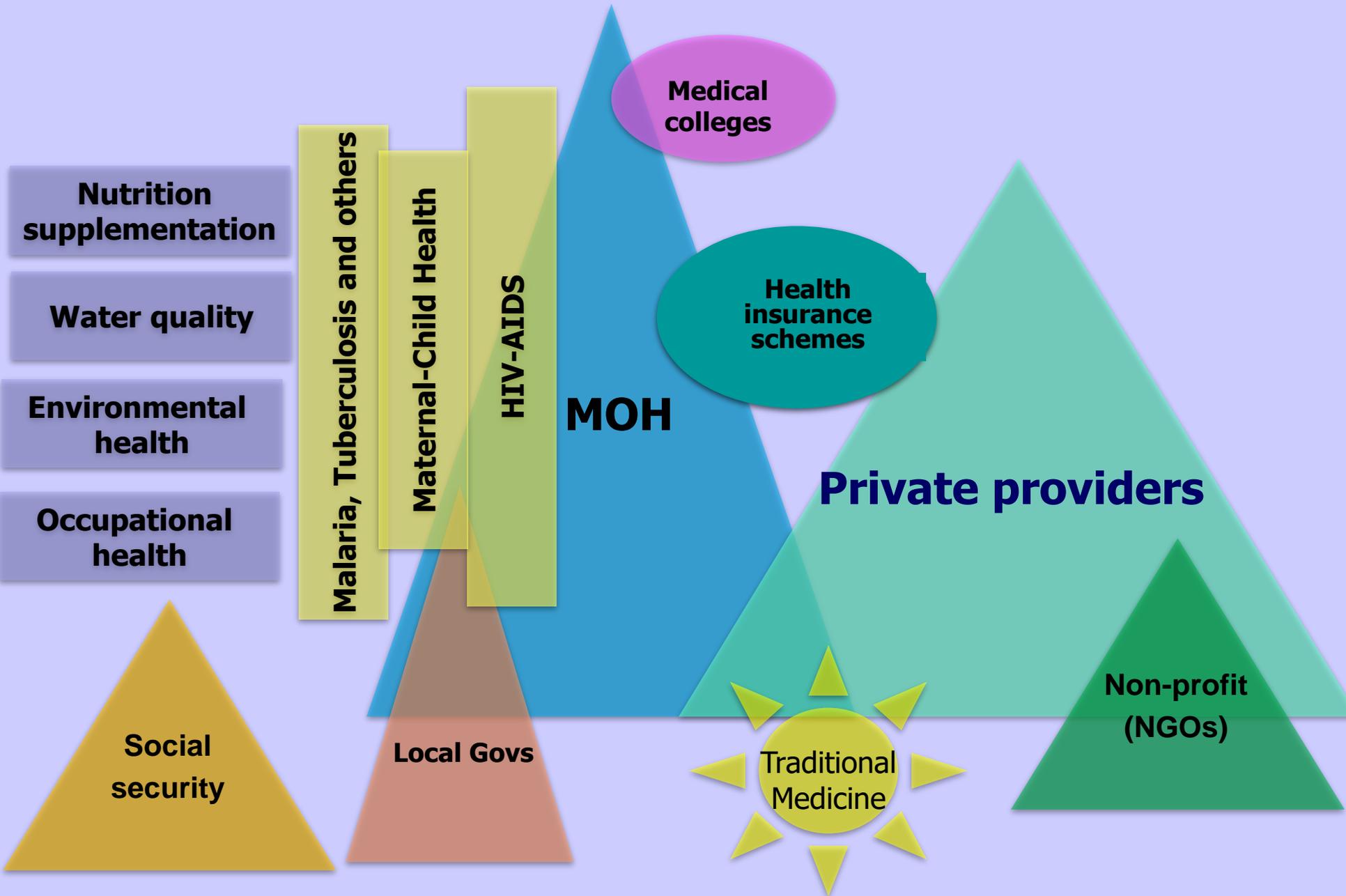
**To ensure people's access to quality  
healthcare and healthy conditions,**

**changes in health system are required which  
need an understanding of these systems**

# What is a health system?

A health system is the integrated whole of all the organizations, institutions and resources whose primary purpose is to improve people's health. (WHO)

# Common fragmentation of Health related bodies and actors



Taking a

# **health systems approach**

means integrating policies and activities related to all organisations and actors, who are primarily concerned with protection and promotion of health.

Interconnectedness in systems means that change in one part of the system may have significant, and even unexpected effects on various other parts – so this needs to be kept in view while making any change.

**Is this policy in keeping with a health systems approach?**

**Doctors are necessary to provide health care.  
So more doctors need to be produced.**

**Hence more private medical colleges should be started, which will improve people's access to health care.**



# 'Bounded rationality' prevents system wide approaches

- ❖ Bounded rationality is very rational in a part of the system, or at micro scale, but unable to see the larger system
- ❖ Superficially appears logical but actual results may be unexpected, because entire system not taken into account
- ❖ Example – each shopkeeper calculates for their business very carefully, but no one foresees the massive financial crash and recession



# Moving beyond bounded rationality

- ❖ **Look wider** – related systems, broader systems
- ❖ **Look from different angles**, viewpoints of different stakeholders
- ❖ **Look deeper**, explore processes under the surface
- ❖ **Look longer term** – past, present and future of the system
- ❖ **Look at contradictions and dynamics** - every system is not static, but is unfolding and constantly changing; we need to understand various underlying tendencies and locate our efforts in this context

# WHO model of Health systems

## SYSTEM BUILDING BLOCKS

SERVICE DELIVERY

HEALTH WORKFORCE

INFORMATION

MEDICAL PRODUCTS, VACCINES & TECHNOLOGIES

FINANCING

LEADERSHIP / GOVERNANCE

ACCESS

COVERAGE

QUALITY

SAFETY

## OVERALL GOALS / OUTCOMES

IMPROVED HEALTH (LEVEL AND EQUITY)

RESPONSIVENESS

SOCIAL AND FINANCIAL RISK PROTECTION

IMPROVED EFFICIENCY



- ❖ Delivery of effective, safe, quality personal and non-personal **health services and interventions** to those that need them, when and where needed, with minimum waste of resources.
- ❖ Well-performing **health workforce** is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances
- ❖ Well-functioning **health information system** is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.

- ❖ Equitable access to **essential medical products, vaccines and technologies** of assured quality, safety, efficacy and cost-effectiveness, scientifically sound and cost-effective use.
- ❖ Good **health financing system** raises adequate funds for health, in ways that ensure people can use needed services, and are protected from impoverishment associated with having to pay for them.
- ❖ **Leadership and governance** involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.

(WHO)

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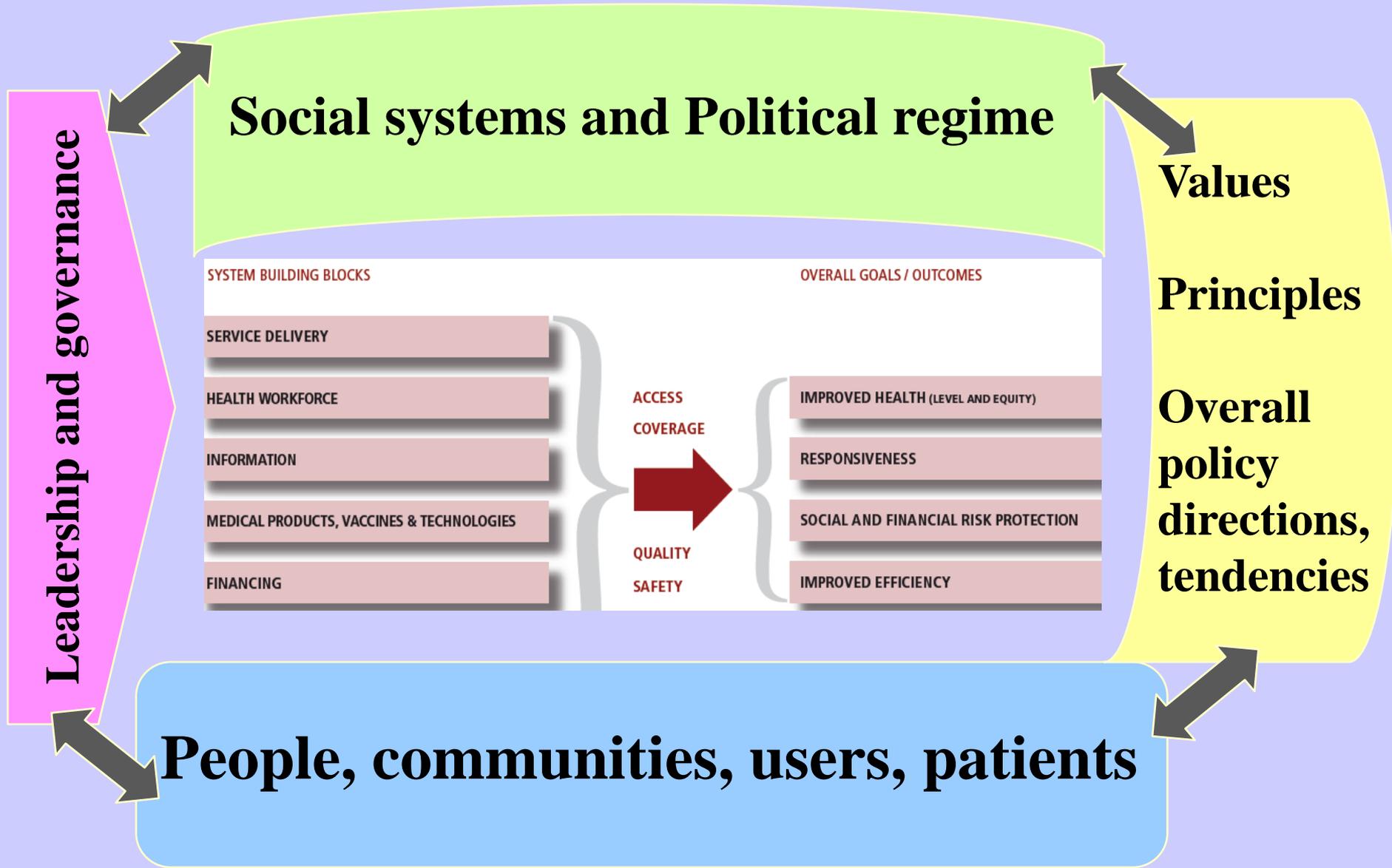
RESPONSIVENESS

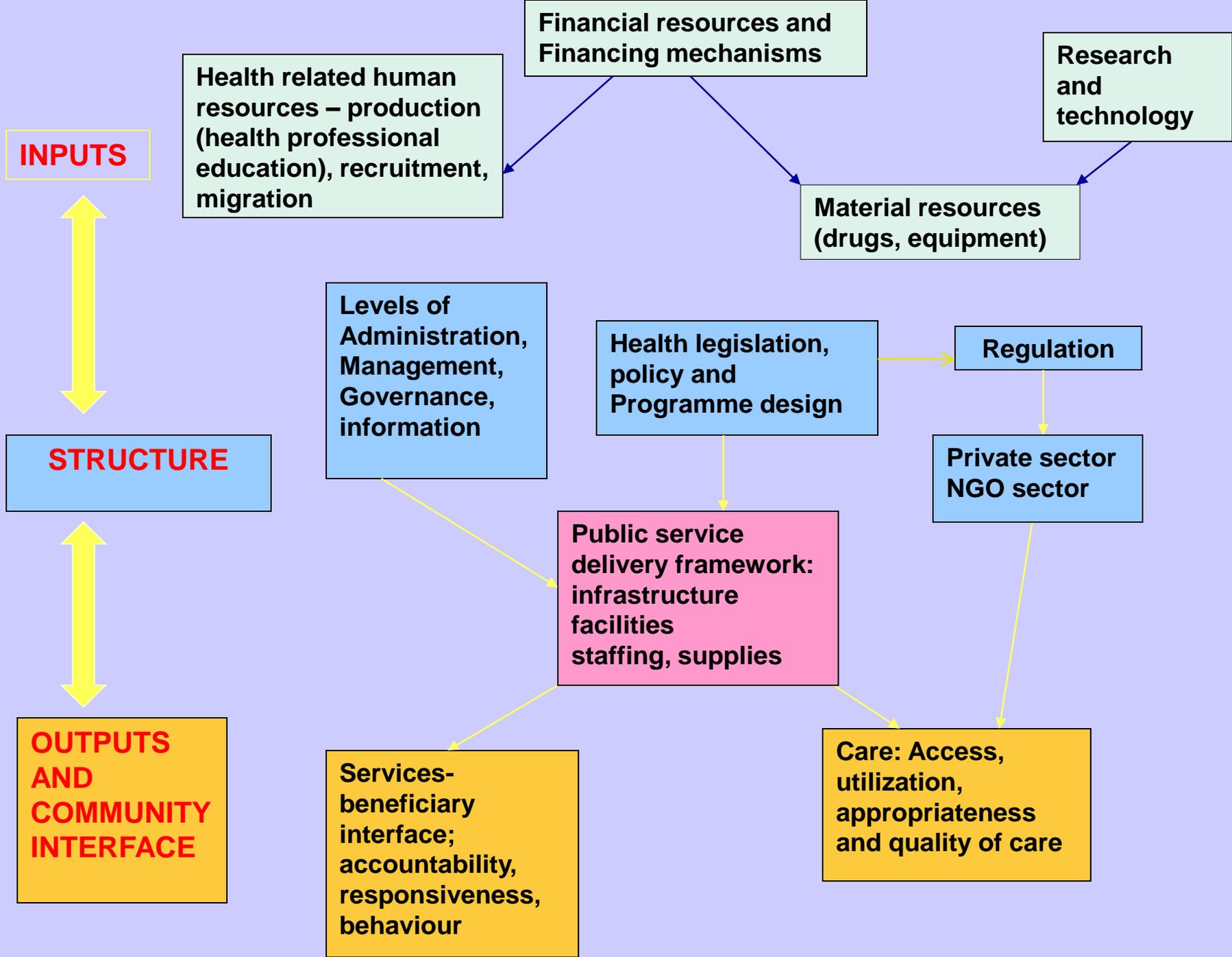
SOCIAL AND FINANCIAL RISK PROTECTION

IMPROVED EFFICIENCY

**What needs to be added to this model?**

# Socio-politically grounded view of health systems





Health systems are important  
**social institutions.**

They are an organic part of existing  
social-political systems, and are  
powerfully shaped by politics.

**Health systems have both technical  
and social dimensions,** both need to  
be understood together while  
intervening for change.

# Private Sector Dominated Mixed Health Systems Syndrome

**Unregulated, predominant private sector**

**Underfunded,  
weakly managed  
Public sector**

**Absenteeism,  
neglect**

**Weak referral  
linkages within  
public system**

**Lack of medicines  
and diagnostics,  
poor maintenance**

**Legal and illegal  
private practice**

**Patients channelised to  
private hospitals**

**Flourishing private  
diagnostic centres  
and medical stores**

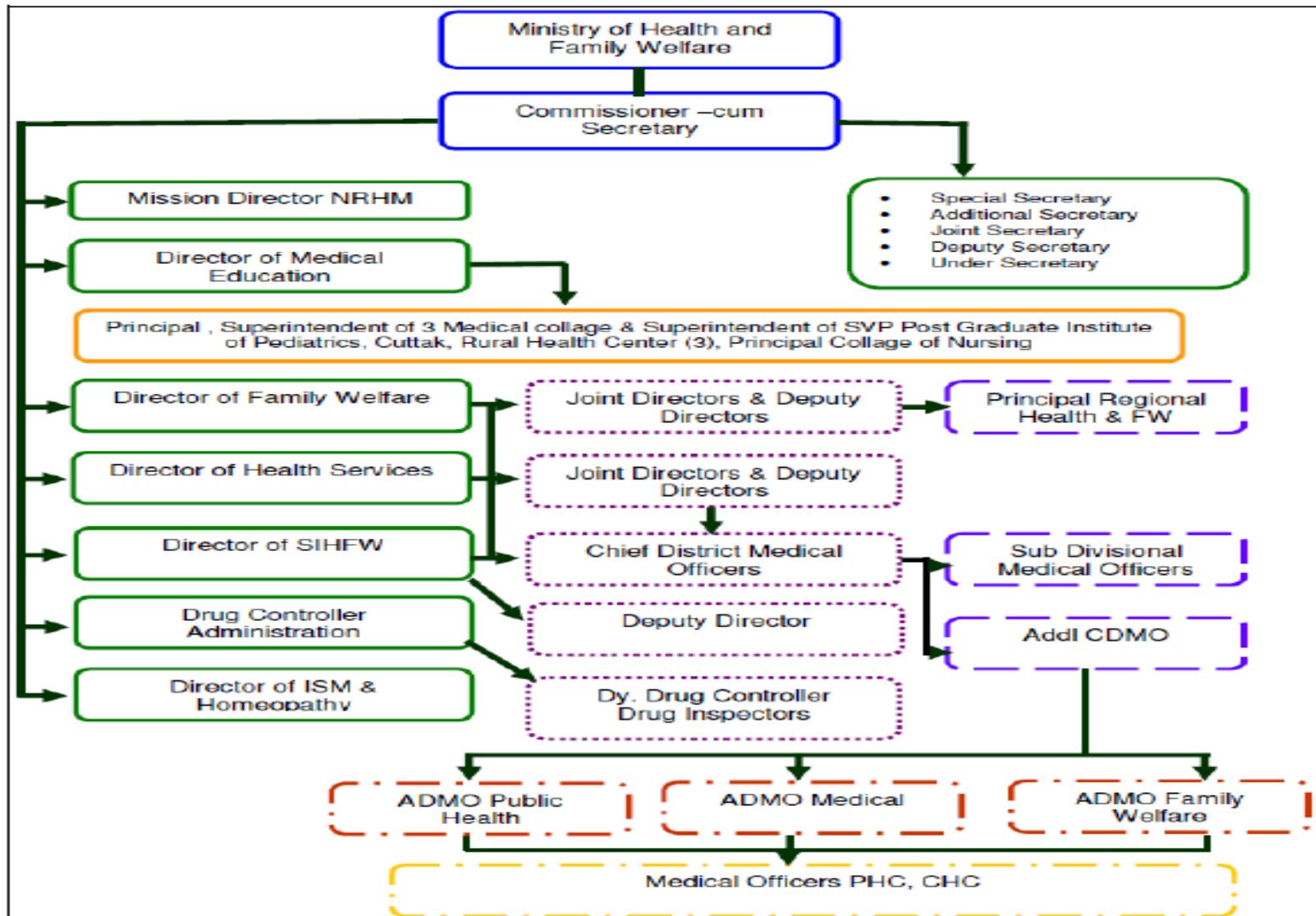
**Inadequate quality of  
public health services**

**High costs and irrationality  
in private medical care**

**Public health services** are a pivotal and central component of Health systems.

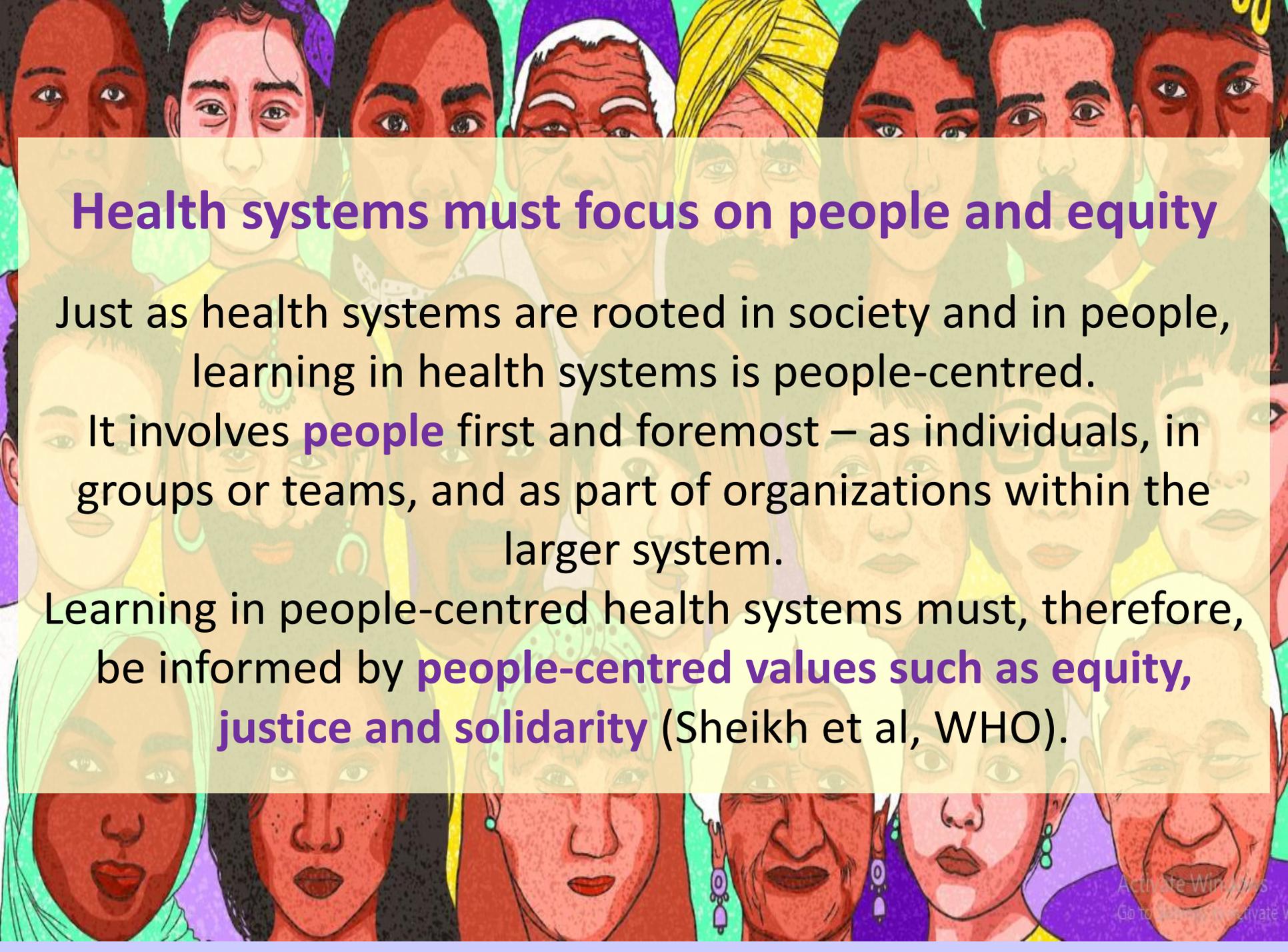
Conventional approach to public health services views this as a top-down, **command-and-control system** – where most decisions are taken at the top or higher levels and are ‘relayed’ to the frontline.

# Health services as bureaucracies governed by 'Rules' and 'Orders'



# Need for an expanded approach to Public health services

- ❖ Need to recognise and configure **dynamic, two-way and synergistic interactions of PHS with:**
  - ❖ Social service departments (Nutrition, Water supply, Sanitation etc.)
  - ❖ Larger government and various political and social forces
  - ❖ Communities of people and users whom it serves, civil society groups, social movements
- ❖ Need to explicitly deal with Private healthcare sector from public health perspective (regulation, accountability etc.)
- ❖ Require better appreciation of motivation of staff and justice, critical role of feedback from users and communities, role of co-production of health care in collaboration with society



## Health systems must focus on people and equity

Just as health systems are rooted in society and in people, learning in health systems is people-centred.

It involves **people** first and foremost – as individuals, in groups or teams, and as part of organizations within the larger system.

Learning in people-centred health systems must, therefore, be informed by **people-centred values such as equity, justice and solidarity** (Sheikh et al, WHO).

## Common challenges faced by many health systems

- ❖ Inadequate financial and human resources for public health, due to neoliberal economic policies
- ❖ Segmentation between vertical programmes
- ❖ Selective health care (not comprehensive)
- ❖ Growing privatisation and commercialisation
- ❖ Inadequate gender equity and social inclusion
- ❖ Governance problems – corruption, militarization, weak accountability, rigid regulations place constraints on innovation, public officials place their own interests above public need

# Practical implications of working with a health systems approach

- ❖ **Viewing various components as interlinked**, being prepared for emergent, unexpected outcomes of interventions
- ❖ **Crossing department boundaries**, bringing actors addressing parts of the problem around the same table.
- ❖ **Overcoming hierarchies** within and around the health system, ensuring equitable collaborations and openness to inputs
- ❖ **Learning and improving through continuous review**
- ❖ **Creating forums for interaction** between multiple, diverse viewpoints incl. social organisations and non-official actors
- ❖ **Critical role of ensuring feedback** from users, communities, frontline workers – esp. for improving Public health systems – importance of health rights and social accountability processes
- ❖ **Politics influences health systems, but health system changes can also shape political processes!**

# People's action in various forms is crucial for improving health systems!



## Diverse countries, differing health systems

| <b>Country</b> | <b>Child mortality rate (U5MR)</b> | <b>Government health expenditure per capita \$</b> | <b>Per capita income PPP \$</b> |
|----------------|------------------------------------|--|---------------------------------|
| Bangladesh     | 29                                 | 9  | 5812                            |
| Cambodia       | 26                                 | 28   | 4930                            |
| India          | 33                                 | 21   | 7333                            |
| Indonesia      | 23                                 | 59   | 12,431                          |
| Myanmar        | 44                                 | 10   | 4831                            |
| Nepal          | 28                                 | 13   | 5690                            |
| Pakistan       | 65                                 | 13   | 5224                            |
| PNG            | 44                                 | 38   | 4445                            |
| Philippines    | 26                                 | 58   | 9061                            |
| Sri Lanka      | 7                                  | 76   | 13,638                          |
| Thailand       | 9                                  | 212  | 19,004                          |
| Timor Leste    | 42                                 | 52   | 3119                            |

# Discussion

- ❖ Why is there so much variation in levels of Child mortality across our countries (7 to 65)? Is this related to levels of wealth? Is there also some relationship with functioning of health systems?
- ❖ Some countries allocate much more resources for health systems – why is it so?
- ❖ Some countries allocate less resources for health systems, even when they have better per capita income – what may be the reasons for this?
- ❖ Some countries have somewhat better child mortality rates despite relatively lower levels of health resources – what might be the reasons?