

**Integrated health systems strengthening:
An operational framework**



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Integrated health systems strengthening: An operational framework

Introduction

This paper was initially prepared as a working document for a workshop on health systems strengthening (HSS) in WHO's South East Asia (SEA) Region.¹ The rich exchange of country experience and in-depth discussions facilitated by the meeting have been included here for wider dissemination and use. This discussion paper is of particular current relevance given the on-going level of activity in the area in response to the Global Alliance for Vaccines and Immunization (GAVI) HSS funding window.²

The purpose of this paper is to outline an operational framework for integrated health system strengthening at country level. The purpose is not to prescribe particular systems strategies to countries but, rather, to use existing conceptual work and country experience to propose core strategic actions needed to initiate a health systems strengthening process.

In developing an outline for integrated health system strengthening, the paper addresses four questions. ***What are health systems and why are they important?*** The paper first re-caps the health systems framework and its importance for health. This background places health systems at the heart of the health agenda and underlines the importance of health systems strengthening for achieving national health goals as well as the MDGs. ***How are health systems performing in the SEA Region?*** In the next section, the paper focuses on health systems in SEAR countries: their performance and strategies aimed at improving performance. Using benchmarks from the health systems framework, evidence suggests that systems have, in fact, not been successful in addressing health needs in the SEA Region, particularly those of the poor. ***What has been the experience with health reform/health systems strengthening in countries of the SEA Region?*** Assessing specific strategies is beyond the scope of this paper – the purpose here is to generalize key aspects of individual country experiences into an operational framework for a systems strengthening process more broadly. According, the paper summarises constraints to scaling up services and areas for systems strengthening identified to overcome these constraints. A case study of Thailand provides a dynamic perspective on how systems constraints interact with each other and how associated policy changes and strategies could

¹ *Regional Workshop on Health Systems Strengthening - An Integrated Approach* (New Delhi, 27-29 Sep 06). Countries in the SEA Region: Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor Leste.

² 72 countries world-wide are eligible to apply for GAVI-HSS funding. All nine of the 11 SEA countries eligible have expressed an interest in the HSS stream, DPR Korea's proposal has already been accepted (with changes) from the first round of applications. The volume of funding available through this window provides countries with a unique opportunity to strengthen health systems – potentially, over US\$ 500 million could be available for investment in eligible SEA countries alone over the next five years. For more information see www.gavialliance.org

reinforce or undermine each other. ***What is the significance of health systems strengthening for disease specific programmes?***

Disease specific efforts like GAVI (as noted above) and the Global Fund to fight AIDS, TB and Malaria (GFATM) are now emphasizing the need for strengthening health systems. Section III examines the debate around reconciling a vertical approach to health intervention with a more 'horizontal' and broader systems strengthening strategy to scaling up services. Clearly, achievements of vertical programmes will ultimately be constrained by overall health systems bottlenecks, making *integrated* health systems strengthening 'everyone's business'.

What does this experience mean for an operational framework to initiate an integrated health systems strengthening process? This final question is answered using the above analyses. The five core elements of this framework:

- Building evidence for analysis of systems issues.
- Identifying the key systems constraint on national health goal.
- Developing a strategy for overcoming systems constraints.
- Getting political support.
- Identifying a platform for advocacy and discussion.

The discussion and analysis presented in the paper is summaries in the final section.

1. What are health systems and why are they important?

a. What are health systems?

WHO has defined *a health system to include all the activities whose primary purpose is to promote, restore or maintain health.*³ It furthered categorised these activities into systems functions and specified the purpose of these functions as systems outcomes. There has since been an on-going debate on the most appropriate grouping of functions and sub-functions. For the present discussion, the relevant issue is how these functions and sub-functions are performing in countries and constraints they place on improving health outcomes. From this operational perspective, the actual grouping into categories is less important and, for the present discussion, the systems framework being applied by countries is used.

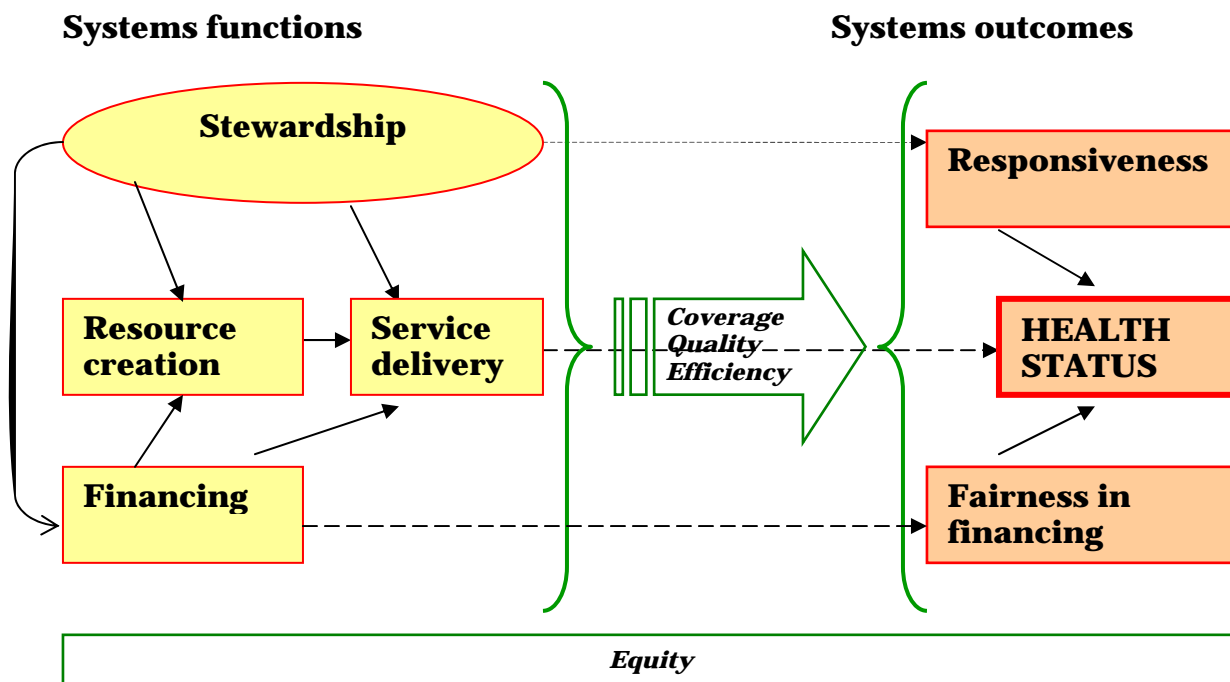
Figure 1 is now a familiar, simple presentation of systems functions and outcomes as developed in the World Health Report 2000⁴. It is important to note the linkages between systems functions as these impact the (reinforcing or undermining) interaction between function-specific policies and strategies. Synergies here determine *coverage* of those who need health services, the *quality* of these services and the *efficiency* with which resources are used in their delivery.

³ WHO (2000), page 5.

⁴ WHO (2000).

And, these in turn determine systems outcomes. Finally, *equity* is an underlying and cross cutting issue throughout a health system – how equitable systems functions are will determine equity in systems outcomes.

Figure 1: Health systems functions and outcomes



Based on WHO (2000).

b. Why are health systems important?

- **Health systems are the means to deliver health policy goals**

The overall health policy goal as expressed by different countries and various international initiatives is encapsulated by WHO's goal of *the attainment by all peoples of the highest possible level of health*.⁵ In country planning, this has been captured by 'universal coverage'. And, the equitable scaling up of health systems is the core strategy to realize this policy goal. Thus, health systems are the means to deliver policy goals -- the system that actually plans, finances, manages and monitors health services for universal coverage.

- **Health systems are key to operationalising any policy approach to address the health needs of a country**

Countries have used different policy approaches to address health needs. Two commonly used approaches are vertical programmes and the more 'horizontal' approach of primary health care. 'Vertical' and 'horizontal' classifications are not to suggest these are opposite or mutually exclusive approaches – in fact, for example, HIV and AIDS vertical programmes rely on primary health care components, particularly community involvement, for implementing key

⁵ See www.who.int

programme activities. The difference is in the health focus and management of systems functions. As Box 1 highlights, vertical approaches are disease specific in their health focus and manage intervention-relevant systems functions through vertical structures. Broader, horizontal approaches address a wider range of health issues and may focus on a particular level of service delivery, with appropriate linkages with the rest of the system. And, this approach requires a more holistic management of health systems. Importantly, as Box 1 underlines, *health systems* are central to operationalising *both* approaches.

Box 1. Main policy approaches in health: vertical programmes⁶ and primary health care⁷

Vertical programmes are responses to key public health issues prioritized by the government. These disease specific programmes are planned by the central ministry and financed through earmarked funds. Implementation is managed through programme-specific vertical structures within the existing health system: drugs and other resources are usually procured through a parallel process; health workers are also often dedicated exclusively to programme-related activities; and, programme supervision and monitoring procedures are independent as well. India, for example, has nine disease specific programmes managed in this vertical manner: vector borne diseases, filarial, leprosy, TB, blindness, iodine deficiency disorder, mental health, HIV and AIDS, and cancer.

Primary health care was brought to the forefront of the international health agenda by the Alma Ata Declaration (1978) and reinforced by Health for All by the Year 2000 as being key to attaining set targets. The approach has three essential components: ▪ addressing the health needs of the community ▪ through a mechanism anchored at the lowest level of care ▪ in the context of overall country characteristics. As a *policy* position with respect to these essential components, primary health care is still a relevant approach for universal coverage. As a *strategy* to scaling up services in the SEA Region, primary health care may need review with respect to two specific aspects: ▪ areas of public health which are the focus of primary health care but where problems continue. Particularly relevant here are systems constraints underlying the persistent high levels of preventable causes of mortality and morbidity. ▪ health transition in countries, notably the challenge posed by HIV and AIDS to the entire health system of countries.

▪ **The health system is an important platform for interaction between multi-sector stakeholders in health**

The health systems functions of stewardship, financing, resource creation and service delivery capture health-related activities of a variety of actors – (all levels of) government, the private sector (for-profit and not-for-profit) as well as donors. Corresponding to these supply-side entities, household and communities constitute the important demand-side of health systems. The health system then is an important platform for interaction between all stakeholders: policy makers and implementers, financiers, providers and consumers of health. Also important are the institutions through which stakeholders carry out these health system functions – governments and ministries, public and private organizations as well as community structures. Operationally then, the health sector may be perceived

⁶ Government of India, Ministry of Health (2006). <http://mohfw.nic.in/healthprogmain.html>

⁷ Declaration of Alma Ata (1978). <http://www.who.int/hpr/archive/docs/almaata.html>

as being constituted by stakeholders performing both systems- and demand-related health functions and the institutions that facilitate their functioning.

It is important to note that there are actors outside the health sector whose core function is not health but whose actions, directly or indirectly, have a substantial impact on health outcomes – e.g. stakeholders in water and sanitation, food security and education sectors. Synergies with these sectors may be captured when planning, budgeting and implementing activities for the health sector. Thus, health systems also provide an effective platform for integrating these multi-sector health activities.

- **Health system components are important areas of interface between health and development**

A country's health sector operates in the context of its overall political, social and economic setting. Health systems components are important entry points for each of these development aspects and, importantly, areas of interface with the potential for health to influence the overall development agenda. For example, priority setting and policy formulation for health supported by the stewardship function has direct relevance for national development planning; the financing function is closely related to both annual national budgets/medium term development expenditure plans as well as to a country's broader macro issues; and, the demand side of health systems represented by communities is key to addressing social determinants of health and development.

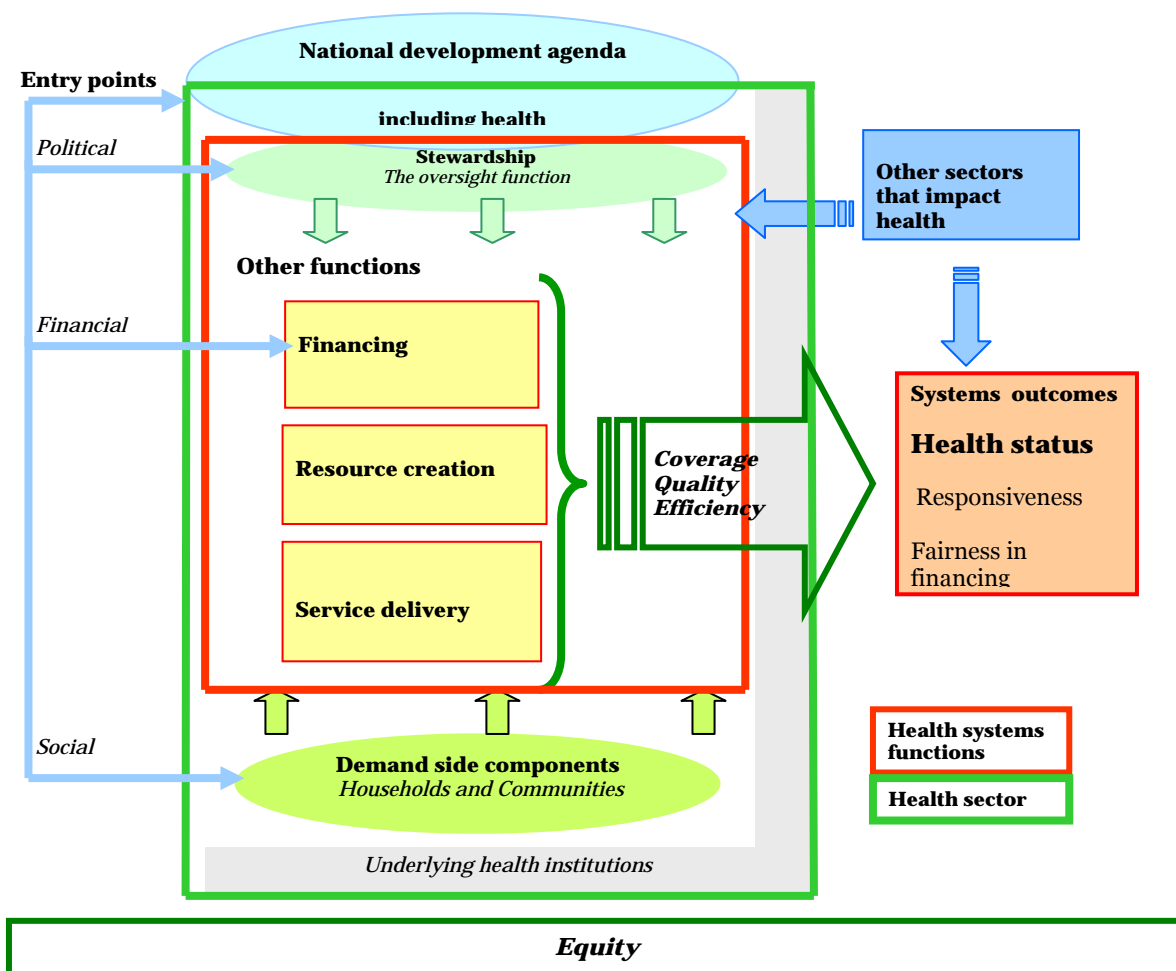
Equally relevant are the opportunities these interactions present for profiling health in a country's development agenda and advocating for health as a critical area of investment for development.

Summing up

Figure 2 sums up the discussion so far on the health systems framework and its importance for health and development.

Health systems form the backbone of a country's health effort. They are:

- the means to deliver policy goals and key to operationalising a selected policy approach to address the health needs of a country
- *scaling up health systems constitutes the core of a strategy to achieve universal coverage*
- an important platform for interaction between multi-sector health stakeholders
- important of interface between health and overall development

Figure 2. Health systems linkages with health and development

Source: Author

2. How are health systems performing in the SEA Region?

- **Health outcomes have remained short of set targets in most countries of the SEA Region**

Figure 3 presents progress with reducing under-five mortality against MDG targets as well as previously agreed Health For All 2000 targets. Under-five mortality rate is a common **health status indicator** used to assess systems effectiveness: the extent to which a system can reduce the probability of dying due to preventable childhood diseases is a good measure of its performance. About half the countries in the Region could not achieve the Health For All 2000 target and the picture vis-à-vis the MDGs does not look very promising for these countries either.

Figure 3

Under-5 Mortality Rate
 (Reduce by two-thirds b/w 1990-2015) (UN MDG Goal-G4, T5,

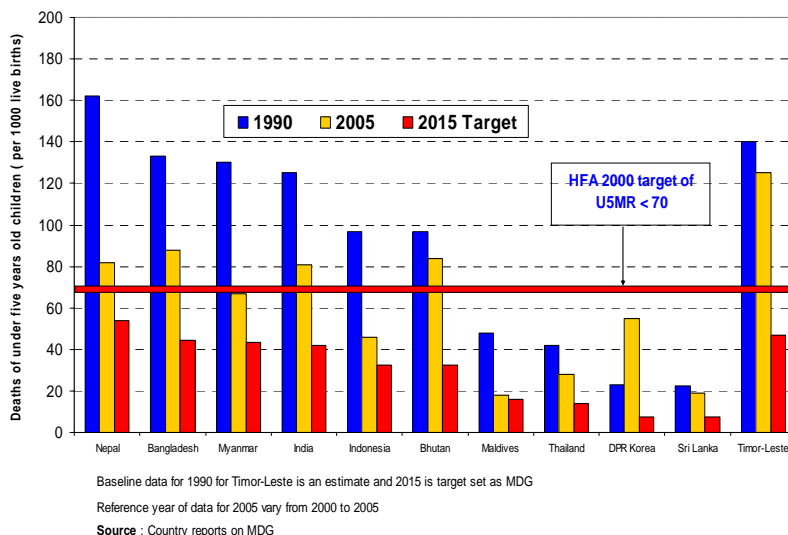
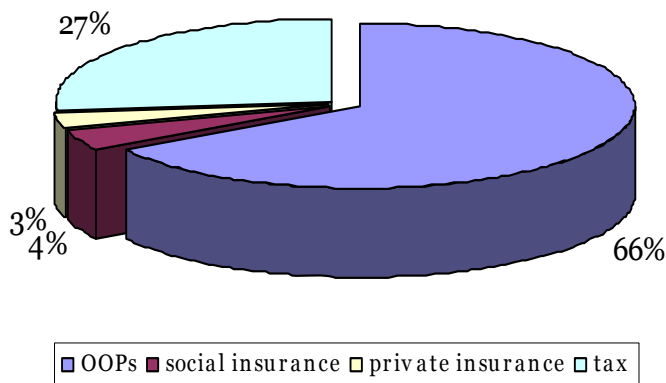


Figure 4 below shows that **financial access** to care in the Region is funded largely by out-of-pocket expenditure. This is direct spending by households for health services, without reimbursement of any kind and is considered the most regressive option for funding health systems – funding through general taxes and social

Figure 4

Composition of total health spending in SEAR



Source: WHO (2006a)

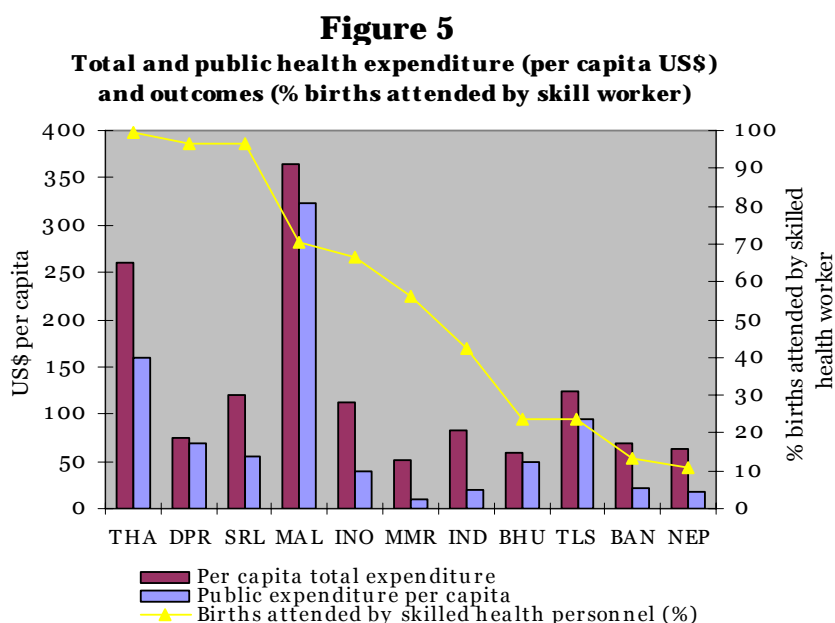
insurance being most equitable forms of health financing. 66 per cent of all health expenditures in SEA countries are out-of-pocket of which a substantial proportion is spent on the purchase of drugs.⁸ And, estimates suggested that as much as 30%

⁸ WHO. (2006b).

of new poverty in some countries is caused by the catastrophic cost of accessing health care.⁹

Systems **responsiveness** is difficult to measure and while indicators are available, there is still considerable debate around their use. However, clearly, availability of health workers themselves is a prerequisite to responsiveness and consumer satisfaction. As Figure 5 illustrates, in five countries of the Regions less than 50 per cent of births are attended by skilled attendants, a key indicator for MDG 5: improving maternal mortality.

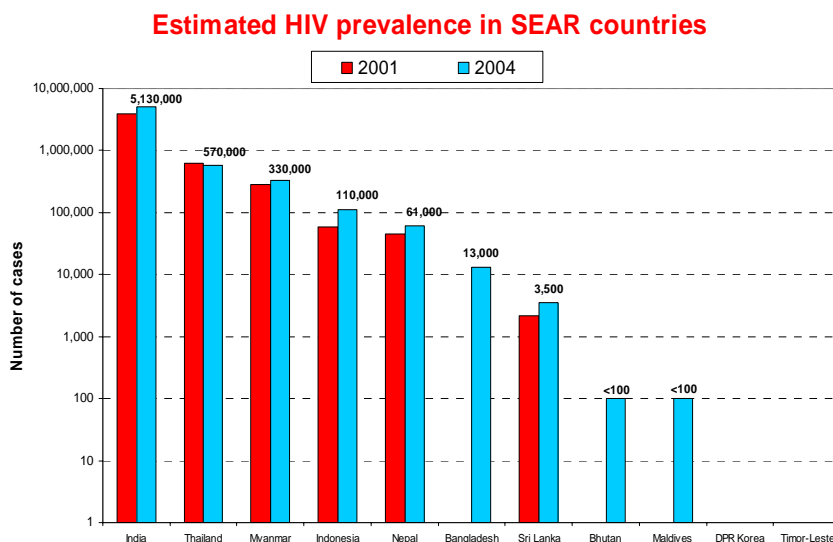
(As will be noted from Figure 5, countries that have performed better in terms of health indicators have a relatively large share of public expenditure invested in public health. However, as Figure 4 shows, less than one-third of total spending in the Region is based on mix of taxes and/or social insurance.)



Source: WHO (2006a,b)

Superimposed on the unfinished health agenda of continued high morbidity and mortality due to preventable causes are **new health challenges**, particularly HIV and AIDS. Figure 6 reports an increase in the number of reported cases of HIV in all countries of the Region for which data was previously available, except Thailand. The MDG of halting and reversing the spread of HIV and AIDS is getting out of grasp for most countries.

⁹ WHO. (2006b).

Figure 6

Source : WHO/SEARO, HIV/AIDS Unit, May 2006

Summing up

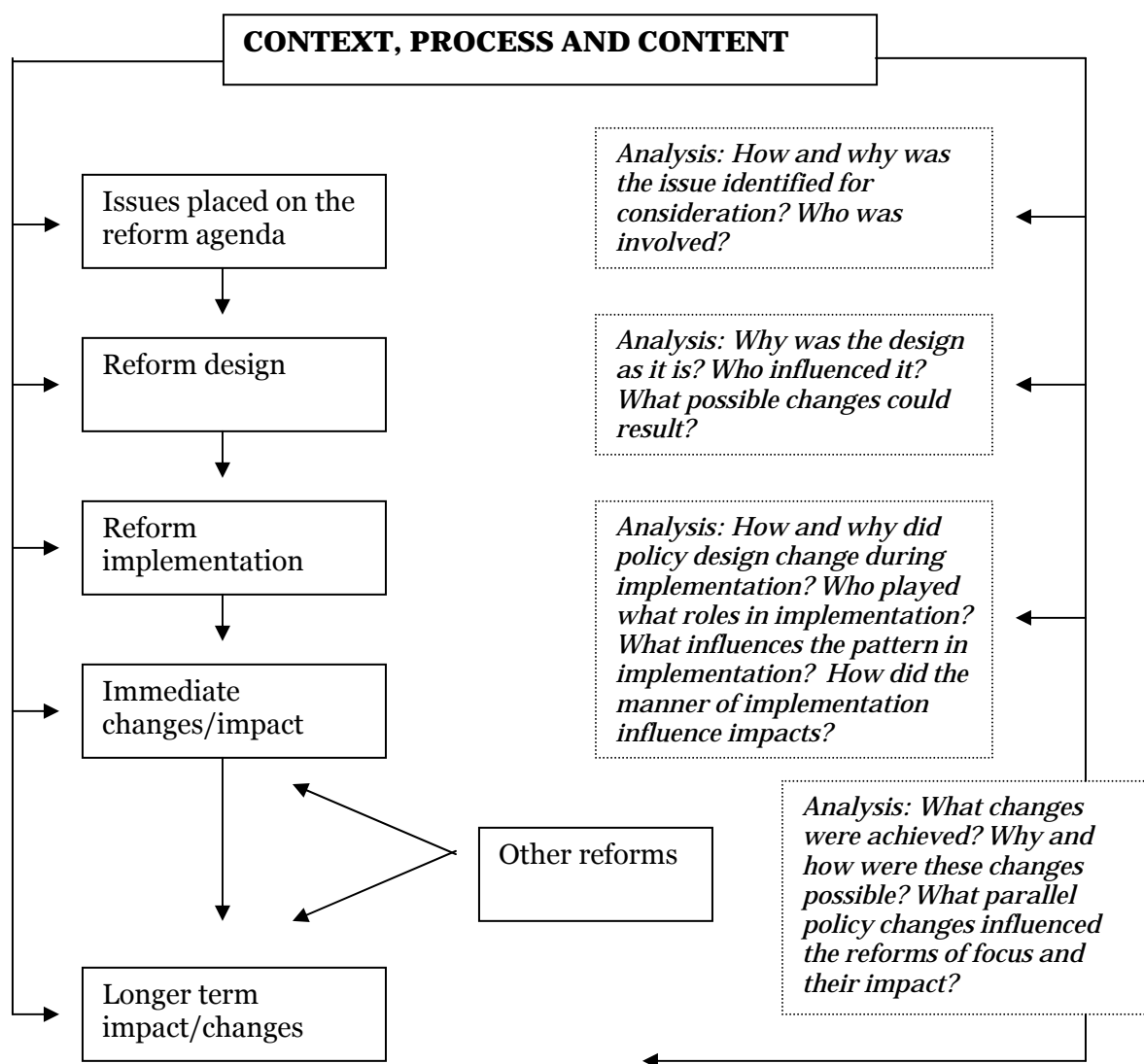
- Health systems have failed to adequately address preventable causes of mortality and morbidity
- Other systems outcomes – fairness in financing and responsiveness – are also poor
- Weak health systems are further challenged by the increasing burden of HIV and AIDS and non-communicable diseases

3. What has been the experience with health reform/health systems strengthening in countries of the SEA Region?

‘Health reforms’ cover a large area and is contextualized in complex ways in individual countries. Gilson and Thomas (2001) have proposed a useful conceptual framework for health sector reform analysis summarized in Figure 7 below. Table 1 captures main area of health systems strengthening undertaken or being considered in each country of the Region as part of the reform process.¹⁰ Using the three main elements of the conceptual framework – context, process and content -- summary analysis of these experiences is presented below.

¹⁰ Source: WHO SEARO (2006).

Figure 7
A conceptual framework for health sector reform analysis



Source: Gilson and Thomas (2001).

Summary analysis from country experiences with health sector reform as presented and discussed at the *Regional Workshop on Health Systems Strengthening - An Integrated Approach (New Delhi, 27-29 Sep 2006)* suggest:

In the **context** of health reform, system strengthening is central -- in addressing constraints to achieving national policy goals i.e. constraints to achieving universal access.

- With respect to **process**,
 - **the reform issues** or constraints to scaling up may be inherent to one or more health systems function which then forms the basis of reform. Or, a country may choose to focus on a specific systems function to 'lead' its health sector reform.

- political support and commitment underpins the success of any selected systems strengthening strategy.
- In reform **content**,
 - accounting for technical linkages between functions is critical for **long-term impact** as function-specific strategies could reinforce or undermine each other with respect to coverage, quality, efficiency and equity. Thus **design and implementation** of changes in the systems function(s) 'leading' reform must phase in **other reform** in linked systems functions as needed.
 - further, systems-wide adjustments need to be made in capacity related to
 - skills and knowledge
 - institutions
 - key support structures

It would of course be useful to examine each country experience in detail to capture the interaction between these summary observations. Unfortunately, such an in-depth review cannot be carried out here. Instead, Thailand's reform for universal coverage led by the "30 baht scheme" is presented as a country case study to illustrate the dynamics of health reform and system strengthening strategies.

Case study: Thailand's health reform.¹¹

In the 1900s, the Thai healthcare system, particularly public expenditure, favoured the middle income over poorer families because of their greater use of public facilities, the system's reliance on user fees and the inequitable distribution of public subsidies. In response, the "30 baht scheme" was a bold reform for universal access through subsidized health care and was backed by strong political support.

Initiated in 2001, the policy (summary below) extended coverage to 18.5 million people who were previously uninsured (out of a total population of 62 million). This move was combined with a radical shift in funding away from major urban hospitals in order to build up primary care. However, driving major reforms in healthcare delivery through changing financing mechanisms in such a manner carried with it problematic side effects. Three main shortfalls were:

- Reallocation of resources within the existing system, from urban hospitals to primary care, without mobilization of additional resources left substantial gaps in hospital funding. *Reform needed to include a strategy to expand the sources of finance beyond general taxation. Also, greater opportunity for private sector participation and competition in urban areas needed to be explored.*

¹¹ Towse et al (2004).

- Similarly, reassignment of health workers to primary care did not keep pace with the policy redirection. *Reform needed a strategy to strengthen the rural district health system with adequate and re-oriented clinical staff.*
- Importantly, demand needed to be reoriented towards the new emphasis in policy to elicit the desired response. *Reform needed a strategy to 'sell' the new direction in service delivery – e.g. greater patient choice could have been explored.*

All three shortfalls also required protecting key national functions such as teaching and research to sustain the initial gains of the '30 baht scheme'.

Key lessons learnt

- Linkages between the systems functions are important for the success of reform – adjusting other functions to changes in the function 'leading' reforms needs to be carefully planned from the start.
- In addition to policy changes in the 'lead' and linked functions, for effective implementation, reform also needs to strategise for systems-wide adjustments in skills, institutions and support structures.

4. What is the significance of health systems strengthening for disease specific programmes?

The importance of systems strengthening for disease specific programmes has been brought to the forefront by the HIV and AIDS pandemic. Prior to this, low and middle income countries were making some progress in improving health outcomes with relatively limited resources. However, the demands of HIV and AIDS are proving to be overwhelming for the already under-resourced and weak health systems of developing countries. Studies¹² have predicted: (a) a worsening of existing health and health care inequities; and (b) the weakening of public health systems due to inadequate coordination of vertical programmes and inappropriate use of non-governmental providers.

Recognising this, GFATM, in its fifth call for proposals explicitly encouraged the development of health systems strengthening strategies in addition to programmes aimed at the three targeted diseases.¹³ More recently, in early 2006, GAVI announced a health systems strengthening funding window that includes three thematic areas: district health systems, human resources and drugs (see Note).

The GFATM call sparked a useful debate on the importance of overall health systems strengthening vis-à-vis disease specific programmes. Following are the two main points of view expressed:

¹² EQUINET. (2004).

¹³ AIDS, TB and Malaria.

Summary discussions on the most appropriate approach for a disease specific initiative to take for overall health systems strengthening.¹⁴***A. Arguments in support of separate health system strengthening component.***

- This would provide better possibilities to develop and implement integrated approaches among the three diseases or even with other prevalent disease, according to the local epidemiological or operational situations.
- The low quality of health systems and duplication of effort created by single-disease interventions impact the effectiveness and ultimate value of the GFATM initiatives.
- Health systems strengthening is ‘everyone’s business’ and funding through a unique component would give strategic attention or priority in the context of ‘frontline’ interventions.
- The current health system in developing countries is weak and not structured to empower community and household levels, which are the levels at which fighting diseases like malaria is most effective.
- The introduction of a “health systems strengthening” approach as a separate financed component allows best practice sharing among specialists; training aimed at raising the level of professional skills; financing research work, etc.

B. Arguments in support of other donors being encouraged to fund health systems strengthening.

- The GFTAM should avoid duplicating other donor activities and concentrate its effort on the three targeted diseases – sustainability is better achieved by synergizing donor efforts rather than donors duplicating each other.
- A further contention is that previous (substantial) donor investment in strengthening health systems has not produced clear results.

Summing up:

- Constraints to full implementation/scaling up disease programmes are usually related to systems functions.
- Vertical structures operate within the wider system and will ultimately be constrained by overall health systems bottlenecks: exclusive, disease-specific system strengthening is not sustainable, even with respect to the relevant disease-specific goals.
- Integrated health system strengthening provides an effective means to consolidate the health efforts of disease-specific programmes.

From the discussion in this section, a working definition of integrated health systems strengthening may be suggested:

‘Integrated health systems strengthening’ encapsulates the effort to remove systems constraints to achieving national health goals, including disease-specific goals. It has two essential components:

¹⁴ GFATM. (2006).

- 1. comprehensive technical enhancement of systems functions taking into account linkages between functions, and**
- 2. improving requisite systems-wide capacity vis-à-vis key underlying skills, institutions and structures**

5. What does this experience mean for an operational framework to initiate an integrated health systems strengthening process?

From the discussion above, five steps emerge as forming the core of an operational framework for integrated health systems strengthening at country level:

A. Building evidence for analysis of systems issues.

- Is there adequate and reliable information to analyze the need for health systems strengthening? Are there gaps in data that must be filled to ensure that policy and strategy formulation is fully informed?

This is a critical to lay the ground for effective health systems strengthening.

B. Identifying the key systems constraint on national health goal.

- Is there a shortcoming in a specific health systems function? OR Are all systems functions performing equally poorly?

These questions are relevant even if the key constraint is disease-specific – e.g. what are the systems bottlenecks to scaling up the response to HIV and AIDS?

C. Getting political support.

- What would be the most strategic direction to address a particular systems constraint vis-à-vis securing political support?

In addition to being technically sound, a systems strengthening strategy must secure political backing to be successful. For example, trying to find footing for a systems-wide approach alone when there is political momentum around HIV and AIDS would not be a strategic approach. One option could be to highlight measurable improvements in HIV and AIDS as a key goal and outcome of the systems strengthening strategy. Another could be to initiate systems strengthening through the HIV and AIDS programme with a medium-term strategy for integration.

D. Developing a strategy for overcoming system constraints.

Table 2 illustrates examples of interventions to overcome systems constraints. From an operational perspective, following are some relevant issues in developing a systems strengthening strategy:

- Is a particular system function and associated strategy the most viable option to 'lead' reform - technically, administratively and politically? (This may not be the key system constraint). What are the relevant linkages between the selected 'lead' strategy and other system functions?
- Are there any reinforcing or contradictory strategies within the systems? How can the former be best used and what adjustments need to be made in the latter? How should these be phased in?
- What are the underlying systems-wide capacity requirements vis-à-vis skills, institutions and support structures?
- What are the financial implications of the strategy?
- What are some important benchmarks against which progress may be measured? And, what are some important outcomes against which 'success' may be assessed?

E. Identifying a platform for advocacy and discussion.

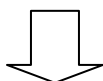
- Is there a platform or process that may be used for advocacy for integrated system strengthening as well as discussion and review of actual strategies?

This is important for broad-based consensus and, as Table 1 indicates, countries have existing processes involving a range of stakeholders that may be developed into effective platforms for advocacy, debate and endorsement of an integrated system strengthening strategy.

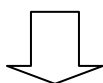
Summing up.

Five core steps of an operational framework for integrated health systems strengthening at country level are:

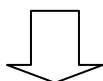
1. Building evidence for analysis of systems issues



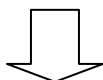
2. Identifying the key systems constraint on national health goal.



3. Getting political support.



4. Developing a strategy for overcoming systems constraints.



5. Identifying a platform for advocacy and discussion.

6. Summary of discussion and analysis for an operation framework for integrated health systems strengthening

1. What are health systems and why are they important?

Health systems form the backbone of a country's health effort. They are:

- the means to deliver policy goals and key to operationalising a selected policy approach to address the health needs of a country
 - *scaling up health systems constitutes the core of a strategy to achieve universal coverage*
- an important platform for interaction between multi-sector health stakeholders
- important of interface between health and overall development

2. How are health systems performing in SEAR?

- Health systems have failed to adequately address preventable causes of mortality and morbidity
- Other systems outcomes – fairness in financing and responsiveness – are also poor
- Weak health systems are further challenged by the increasing burden of HIV and AIDS and non-communicable diseases

3. What has been the experience with health reform/health systems strengthening in countries of the SEA Region?

- Systems strengthening is central in health reforms -- in addressing constraints to achieving national policy goals i.e. constraints to achieving universal access.
- Constraints to scaling up may be inherent to one or more health systems function which then forms the basis of reform. Or, a country may choose to focus on a specific systems function to 'lead' its health sector reform.
- Accounting for technical linkages between functions is critical for success as function-specific strategies could reinforce or undermine each other with respect to coverage, quality, efficiency and equity.
- Further systems-wide adjustments need to be made in capacity related to
 - skills and knowledge
 - institutions
 - key support structures
- Political support and commitment underpins the success of any selected systems strengthening strategy.

4. What is the significance of health systems strengthening for disease specific programmes?

- Constraints to full implementation/scaling up disease programmes are usually related to systems functions.
- Vertical structures operate within the wider system and will ultimately be constrained by overall health systems bottlenecks: exclusive, disease-

specific system strengthening is not sustainable, even with respect to the relevant disease- specific goals.

- Integrated health system strengthening provides an effective means to consolidate the health efforts of disease-specific programmes.

5. What does this experience mean for an operational framework to initiate an integrated health systems strengthening process?

The core elements of an operational framework for integrated health systems strengthening at country level are:

- **Building evidence for analysis of systems issues.**
- **Identifying the key systems constraint on national health goal.**
- **Developing a strategy for overcoming systems constraints.**
- **Getting political support.**
- **Identifying a platform for advocacy and discussion.**

Table 1. Health systems constraints on scaling up and strengthening efforts: Experience from countries of the SEA Region			
Stewardship	Financing	Resource	Service delivery
Bangladesh			
<i>Note on health system: The health effort is lead by the Health Nutrition and Population Sector Programme (HNPS) initiated in 2003 and which includes a range of vertical programmes. Particularly notable is the role of the private, not-for-profit sector in health provision and finance.</i>			
Constraints identified in scaling up health systems			
1. Inadequate monitoring and evaluation for effective management, including a weak surveillance system	1. Low levels of overall allocations to health and particularly for extension services (mobile services) 2. Lack of smooth flow of funds	1. Shortage of skilled staff 2. Inadequate number of skilled staff 3. Deployment practices not based on need	
Constraints identified in scaling up vertical programmes			
1. Inadequate monitoring, evaluation and supervision system	1. Inadequate volume and weak management of resources	1. Inadequate health worker skills	1. Family and community health practices
Areas identified for strengthening efforts			
<i>Platform for policy debate: Quarterly and annual meetings of the HNPS with other ministries and civil society</i>			
1. Sector-wide programme management and local level planning, including participation of private, not-for-profit sector 2. Research and development 3. Medical Information Services 4. Health education and promotion 5. Hospital management, including quality management	1. Financial management	1. Human resource management, planning and development (Policy on regularisation of health staff) 2. Procurement, logistics and supply management	1. Focus on essential service delivery
Bhutan			
<i>Note on health system: Basic, free health care (allopathic and traditional) delivered through a primary health care approach with appropriate referral linkages and managed through a decentralised structure. Privatisation of service provision under review for scaling up under difficult geographical constraints.</i>			
Constraints identified in scaling up health systems			

1. Inadequate planning and management capacity	1. Inadequate financing 2. Sustainability in financing given dependency on health imports	1. Shortage of human resources	1. Problems in service delivery due to difficult geographical terrain
Areas identified for strengthening efforts			
<i>Platform for policy debate: Quarterly and annual meetings of Ministry of Health with all key stakeholders as well as at the National Planning Commission</i>			
1. Decentralisation, including community participation 2. Legal framework for medical services, including quality of care	1. Financing sustainability through domestic resources: funding of essential care by the Bhutan Health Trust Fund; cost sharing for high cost and non-essential care	1. Human resource development and deployment	1. Infrastructure expansion 2. Tele-medicine for improved out reach 3. Garnering in private provision in line with public priorities
India			
<i>Note on health system: Health response organised as (a) centrally funded vertical programmes in disease areas identified as major public health issues and (b) states responsible for other health efforts within the broad national goal of universal coverage. Service provision and finance is largely private.</i>			
Constraints identified in scaling up health systems			
1. Gaps in effective linkages between centre and state in planning and management of health	1. Inadequate total health financing in relation to burden of disease; inadequate government financing given public health challenges and poverty; one of the highest levels of out of pocket expenditure in the world 2. Critical bottlenecks in financial structure and flow of funds		1. Large, unregulated private sector, including in practices other than allopathic
Constraints identified in scaling up vertical programmes			
1. Inadequate capacity for decentralised management 2. Inadequate disease surveillance and monitoring		1. Poor vaccine management 2. Weak management capacity at facility level	
Areas identified for strengthening efforts (encapsulated in the National Rural Health Mission)			
<i>Platform for policy debate: National Planning Commission; notable in last health policy formulation (2002) was an open e-discussion.</i>			

1. Integration of vertical health and family planning programmes 2. Integration of traditional medicine into public health 3. Decentralisation to district level -- management of all health services 4. Integrated disease surveillance programme	1. Financial management capacity at district level	1. Female health worker (accredited social health activist - ASHA) in each village 2. Exploring strategies to secure doctors for rural areas	1. Quality of community health centres with a view to meet hospital standards 2. Mobile medical units for out reach to poor access areas
Indonesia			
<i>Note on health system: A decentralised management structure and predominantly public provision; also, 40 per cent of the population covered by state sponsored health insurance</i>			
Constraints identified in scaling up health systems			
1. Disparities in successful planning and implementation between provinces/districts 2. Effective decentralisation yet to be achieved	1. Overall under-funding of health 2. Inadequate and inequitable health financing (between provinces/districts as well as income groups) 3. Inefficient management of financial resources (allocation)	1. Human resource shortages (numbers as well as distribution issues)	1. Inequities in quality and coverage of services
Areas identified for strengthening efforts (including from successes in vertical programmes: MCH, immunization and nutrition)			
1. Systems management including supervision	1. Effective financial coverage of the poor with social insurance	1. Capacity building for health staff	1. Mobile medical units for out reach to poor access areas
Maldives			
<i>Note on health system: Four departments at the centre look after one area of health each at various levels of care: public health (lowest level), medical services (next three levels) and at the central level: the food and drug authority and the Indira Gandhi Memorial hospital. All these are coordinating by the overarching Ministry of Health. High levels of public expenditure on public health have produced remarkable outcomes in recent years.</i>			
Constraints identified in scaling up health systems			
1. Weak legal framework on health, including quality assurance	1. Rising health care costs 2. Inadequate financial protection	1. Human resource gaps -- numbers and capacity	1. Inadequate response to new and re-emerging communicable diseases. 2. Inadequate response to address increased incidence of non-communicable diseases

Areas identified for strengthening efforts

1. Improving public knowledge on healthy practices 2. Streamlining management of services for improved effectiveness	1. Developing and implementing a social health insurance scheme	1. Human resource development	1. Quality of care 2. Nutrition status 3. Partnerships with the non-public sector
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Myanmar

Note on health system: Led by a high-level inter-departmental National Health Committee, a hierarchical structure from the centre, through the state/division and district/township levels, organises health service delivery to communities through a primary care approach at village level. Pluralist provision, including private practice in non-allopathic medicines.

Constraints identified in scaling up health systems

1. Inadequate management capacity at sub-national level to operationalise decentralisation 2. Poor monitoring and supervision, including quality assurance 3. Inter-departmental and inter-sectoral collaboration lacking	1. Lack of adequate financing and financial management limits all activities	1. Inadequate number of health workers, especially in public health 2. Insufficient logistical support for medicines and supplies	1. Coverage particularly poor in border and other hard to reach areas
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Areas identified for strengthening efforts

Platform for policy debate: National Health Committee (at Central level).

1. Systems management at all level, particularly at district level		1. Health infrastructure 2. A 'second generation' of programme workers	1. Identifying public health needs in underserved areas
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Nepal

Note on health system: A Health Sector Reform Strategy and Implementation Plan (2004-2009) is underway, emphasizing three programme outputs: provision of an essential health care package; decentralised management of health services; and public provide partnerships. Notable presence of international and private, not-for-profit organisations in health provision and finance.

Constraints identified in scaling up health systems

1. Lack of stability in agenda due to political uncertainties	1. National budgetary allocations inadequate 2. Donor priorities not always in line with national priorities	1. Human resource development not matched to needs 2. Deployment and retention of skilled health workers in rural areas poor	1. Difficult geographical terrain 2. No established system for public health services in urban areas
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Areas identified for strengthening efforts

Platform for policy debate: National Planning Commission; various multi-stakeholder health-related committees headed by MoH&P

1. Decentralisation of management of health facilities 2. Monitoring and supervision	1. Financial management	1. Community participation at lowest level of care, including female volunteers 2. Updating overall human resource development master plan 3. Revision of essential drugs and equipment package to health facilities	1. Public private partnerships in service provision
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Sri Lanka

Note on health system: Significant health achievements for level of GDP based on a wide and effective network of public funded public health services.

Constraints identified in scaling up health systems

1. Inadequate research and health information system for evidence base	1. Inefficient allocation of available resources: curative versus preventive and urban versus rural	1. Lack of laboratory services 2. Migration of skilled health workers	1. Limited access to secondary and tertiary services
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Constraints identified in scaling up vertical programmes

1. Continued public commitment to EPI	1. Continued donor support		1. Vaccine wastage
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Areas identified for strengthening efforts

1 Decentralisation of health services management and resource allocation 2. Legal protection of both provider and patient 3. Development of e-package to strengthening disease surveillance and health information		1. Human resource development: availability, skills and incentive for retention and quality care particularly in public health	1. Partnership with private sector
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Thailand

Note on health system: Universal coverage implemented through the '30 baht' health insurance scheme anchored in a primary health care approach with appropriate referrals in a pyramid- structured delivery system.

Constraints identified in scaling up health systems

1. Monitoring and evaluation needs to be improved to support management	1. Financial viability of the 30 baht scheme -- capitation rate below real unit costs	1. Human resource numbers and distribution needs to be improved	
Areas identified for strengthening efforts			
<i>Platform for policy debate: Annual policy makers meetings; monthly ministry meeting (chaired by Minister)</i>			
1. Health information system 2. Improve standard guidelines for technical work		1. Increasing trained health workers over time	

Source: WHO SEARO (2006 a).

Table 2 – Examples of interventions designed to overcome health system constraints			
Level	Constraint	Disease-focused interventions designed to address system constraints	System-wide interventions designed to address system constraints
Household / community-level	<u>Financial</u> : inability to pay, informal fees, lack of risk sharing	Exemptions/reduced prices for focal diseases	Risk sharing/insurance schemes Subsidization of poor
	<u>Physical</u> : distance to facility	Outreach for focal diseases Subsidies for transport Contracting with private providers	Reconsideration of long term plan for capital investment and siting of facilities Coordination and joint planning with Departments of Transport and Roads
	<u>Information</u> : lack of appropriate information on value of service	Behavior Change Communication	
Facility-level	<u>Staffing</u> : shortage and maldistribution of appropriately qualified staff, low health worker motivation	Continuous education/training workshops to develop skills in focal diseases Financial incentives to reward delivery of priority services	Development of overarching human resource strategy Reform of basic education, recruitment procedures, performance review and management Provider payment reform
	<u>Management</u> : weak technical guidance, program management, and supervision	Continuous education/training to develop skills in planning and management Financial support to supervision. Supervision checklists	Quality standards / accreditation
	<u>Drugs and supplies</u> : inadequate drug and medical supplies	Contracting out of drug procurement responsibilities	Reform of drug procurement and distribution systems
Health sector-level	<u>Resource allocation</u> : inequitable and inefficient distribution of health resources <u>Planning and management</u> : weak and overly centralized systems for planning and management <u>Procurement and distribution</u> : weak drug policies and supply systems <u>Quality assurance</u> : weak quality standards, inadequate regulation of service delivery and pharmaceuticals <u>Cooperation</u> : lack of intersectoral action and partnership <u>Incentives</u> : Weak incentives for providers to be efficient and responsive	Development of individual financial sustainability plans Strengthening procurement for specific drugs and commodities Establishment of intersectoral committees focused on specific diseases (eg. National AIDS Committees)	Reform of resource allocation mechanisms Priority setting through laws and regulations Decentralization Financial planning (NHA) Reform of drug procurement and distribution systems Quality assurance standards Provider Payment reform Performance based contracts

Source: WHO. (2005).

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