
EVERYBODY'S BUSINESS

STRENGTHENING HEALTH SYSTEMS TO IMPROVE HEALTH OUTCOMES

WHO'S FRAMEWORK FOR ACTION



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FOREWORD

The strengthening of health systems is one of six items on my Agenda for WHO. The strategic importance of Strengthening Health Systems is absolute.

The world has never possessed such a sophisticated arsenal of interventions and technologies for curing disease and prolonging life. Yet the gaps in health outcomes continue to widen. Much of the ill health, disease, premature death, and suffering we see on such a large scale is needless, as effective and affordable interventions are available for prevention and treatment.

The reality is straightforward. The power of existing interventions is not matched by the power of health systems to deliver them to those in greatest need, in a comprehensive way, and on an adequate scale.

This Framework for Action addresses the urgent need to improve the performance of health systems. It is issued at the midpoint in the countdown to 2015, the year given so much significance and promise by the Millennium Declaration and its Goals. On present trends, the health-related Goals are the least likely to be met, despite the availability of powerful drugs, vaccines and other tools to support their attainment.

The best measure of a health system's performance is its impact on health outcomes. International consensus is growing: without urgent improvements in the performance of health systems, the world will fail to meet the health-related goals. As just one example, the number of maternal deaths has stayed stubbornly high despite more than two decades of efforts. This number will not fall significantly until more women have access to skilled attendants at birth and to emergency obstetric care.

As health systems are highly context-specific, there is no single set of best practices that can be put forward as a model for improved performance. But health systems that function well have certain shared characteristics. They have procurement and distribution systems that actually deliver interventions to those in need. They are staffed with sufficient health workers having the right skills and motivation. And they operate with financing systems that are sustainable, inclusive, and fair. The costs of health care should not force impoverished households even deeper into poverty.

This Framework for Action moves WHO in the right direction, on a course that must be given the highest international priority. WHO staff, working at all levels of the Organization, are its principal audience, but basic concepts, including the fundamental "building blocks" of health systems, should prove useful to policy-makers within countries and in other agencies.

Margaret Chan
Director-General



EXECUTIVE SUMMARY

It will be impossible to achieve national and international goals – including the *Millennium Development Goals* – without greater and more effective investment in health systems and services. While more resources are needed, government ministers are also looking for ways of doing more with existing resources. They are seeking innovative ways of harnessing and focusing the energies of communities, non-governmental organizations (NGOs) and the private sector. They recognize that there is no guarantee the poor will benefit from reforms unless they are carefully designed with this end in mind. Furthermore, they acknowledge that only limited success will result unless the efforts of other sectors are brought to bear on achieving better health outcomes. All these are health systems issues.

The World Health Organization (WHO) faces many of the same challenges faced by countries: making the health system strengthening agenda clear and concrete; creating better functional links between programmes with mandates defined in terms of specific health outcomes and those with health systems as their core business; ensuring that the Organization has the capacity to respond to current issues and identify future challenges; and ensuring that institutional assets at each level of the Organization (staff, resources, convening power) are used most effectively.

The primary aim of this Framework for Action is to clarify and strengthen WHO's role in health systems in a changing world. There is continuity in the values that underpin it from its constitution, the Alma Ata Declaration of Health For All, and the principles of Primary Health Care. Consultations over the last year have emphasized the importance of WHO's institutional role in relationship to health systems. The *General Programme of Work (2006-2015)* and *Medium-term Strategic Plan 2008-2013 (MTSP)* focus on what needs to be done. While reaffirming the technical agenda, this Framework concentrates more on how the WHO secretariat can provide more effective support to Member States and partners in this domain.

There are four pillars to WHO's response, each with its set of strategic directions:

A single Framework with six building blocks

A key purpose of the Framework is to promote common understanding of what a health system is and what constitutes health systems strengthening. Clear definition and communication is essential. If it is argued that health systems need to be strengthened, it is essential to be clear about the problems, where and why investment is needed, what will happen as a result, and by what means change can be monitored. The approach of this Framework is to define a discrete number of "building blocks" that make up the system. These are based on the functions defined in World health report 2000. The building blocks are: **service delivery; health workforce; information; medical products and technologies; financing; and leadership and governance (stewardship).**

The building blocks serve three purposes. First, they allow a definition of desirable attributes – what a health system should have the capacity to do in terms of, for example, health financing. Second, they provide one way of defining WHO's priorities. Third, by setting out the entirety of the health systems agenda, they provide a means for identifying gaps in WHO support.

While the building blocks provide a useful way of clarifying essential functions, the challenges facing countries rarely manifest themselves in this way. Rather, they require a more integrated response that recognizes the inter-dependence of each part of the health system.

THE SIX BUILDING BLOCKS OF A HEALTH SYSTEM

- Good **health services** are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.
 - A 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 (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).
 - A 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.
 - A well-functioning health system ensures equitable access to essential **medical products and technologies** of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.
 - A good **health financing** system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.
 - **Leadership and governance** involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability.
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Health systems and health outcome programmes: getting results

WHO's involvement in all aspects of health and health systems constitutes a comparative advantage. Nevertheless, it is clear that, in too many instances, WHO's support can be fragmented between advice focusing on particular health conditions (that may not always take systems or service delivery issues into account) and advice on particular aspects of health systems provided in isolation. While there are good examples of how both streams of activity can work together, the challenge is to develop a more systematic and sustained approach that responds better to the needs of Member States.

Several productive relationships have been established, bringing together “programme” and “systems” expertise. These include work on costing and cost-effectiveness; the *Treat, Train and Retain (TTR)* initiative linking systems work on health service staffing with improving access to HIV/AIDS care and treatment, and the work across WHO stimulated by the Global Alliance on Vaccines Initiative (GAVI) Health Systems Strengthening window.

Three complementary directions to a more strategic response are proposed: extending existing interactions; better and more systematic communication and awareness among all WHO staff on how to think systematically about health system processes, constraints and what to do about them; greater consistency, quality and efficiency in the production of methods, tools and data reporting across WHO. Attention to institutional incentives is also needed.

A more effective role for WHO at country level

Countries at different levels of development look for different forms of engagement with WHO as they seek to improve their health systems' performance. Some are primarily interested in exchanging ideas and experiences in key aspects of policy (such as health worker migration); getting wider international exposure for important domestic agendas (such as patient safety or the health of indigenous populations); and developing norms and standards for measuring performance. Countries at all levels of development look to WHO for comparative experience in relation to different aspects of reform. But it is countries at a lower level of income – as evidenced increasingly in WHO Country Cooperation Strategies (CCS) – that seek more direct involvement in overall policy and health systems development.

Four strategic directions are proposed. First, there is a need to improve capacity to diagnose health systems constraints. Second, WHO should seek more active and consistent engagement in overall sector policy processes and strategies. In this context, engagement in key policy events should involve all levels of the Organization. Third, WHO's efforts should be directed towards building national capacity in policy analysis and management. Lastly, tracking trends in health systems performance needs to be geared first and foremost towards national decision making.

The role of WHO in the international health systems agenda

In addition to supporting health systems strengthening in individual Member States, WHO has an international role. The international health environment is increasingly crowded. There are three main directions for WHO. First, the Organization continues to produce global norms, standards and guidance. These include health systems concepts, methods and metrics; synthesizing and disseminating information on “what works and why”, and building scenarios for the future. The second direction concerns the building or shaping of international systems that impact on health. These include systems and networks for identifying and responding to outbreaks and emergencies. They also include WHO's role as a key actor in influencing aid architecture as it affects health systems. The third direction concerns how WHO is working more directly with other international partners on their support for health systems strengthening. This can be through global health partnerships (GHPs), such as the Global Fund and GAVI, the larger philanthropic foundations, the World Bank and regional development banks and bilaterals, as well as stakeholders in the non-government and corporate sector.

Success will depend on how well WHO uses its institutional assets and instruments. WHO must make greater use of existing staff: by strengthening their capacity in health sector policy and strategy development; by developing a professional network of staff working on health systems; and by getting a better match between supply and demand in specific policy areas. It must look at the business rules that govern planning and budgeting, and explore ways in which the integrity of WHO's MTSP can be maintained, while promoting joint work across different programmes. Several health systems specific partnerships have been launched in the last two years, including the Global Health Workforce Alliance and the Health Metrics Network. WHO needs to leverage the benefits these partnerships offer to countries and international partners, and negotiate ways for partnerships to support WHO core functions. In terms of judging results, the MTSP defines specific results for WHO's activities in health systems development.



INTRODUCTION

Health outcomes are unacceptably low across much of the developing world, and the persistence of deep inequities in health status is a problem from which no country in the world is exempt. At the centre of this human crisis is a failure of health systems. Much of the burden of disease can be prevented or cured with known, affordable technologies. The problem is getting drugs, vaccines, information and other forms of prevention, care or treatment – on time, reliably, in sufficient quantity and at reasonable cost – to those who need them. In too many countries the systems needed to do this are on the point of collapse, or are accessible only to particular groups in the population. Failing or inadequate health systems are one of the main obstacles to scaling-up interventions to make achievement of internationally agreed goals such as the Millennium Development Goals (MDGs) a realistic prospect.

There is widespread acceptance of the basic premise underlying this Framework – that only through building and strengthening health systems will it be possible to secure better health outcomes. The key question is what does this mean in practice? The growing recognition of the importance of health systems increases the urgency of this question.

Objectives

- **Promote common understanding**
We need a common understanding of what a health system is, and what activities are included in health systems strengthening – in countries at different levels of development and with different social, institutional and political histories.
- **Address new challenges and set priorities**
Health systems worldwide are having to cope with a changing environment: epidemiologically, in terms of changing age structures, the impact of pandemics and the emergence of new threats; politically, in terms of changing perceptions about the role of the state and its relation with the private sector and civil society; technically, in terms of the growing awareness that health systems are failing to deliver – that too often they are inequitable, regressive and unsafe, and so constitute one of the rate limiting factors to achieving better development outcomes; institutionally, especially in low-income countries, in having to deal with an increasingly complex aid architecture. Some of the main challenges and priorities, both old and new, are discussed in the next section.
- **Address questions of health system financiers**
For those who finance healthcare – from the general public, through national ministries of finance, development banks, bilateral agencies and global funds – the issue is not just one of refining definitions and concepts. If health systems are to be strengthened, where is more spending most needed? How and by whom should it be financed and how can that financing be sustained? How can financiers monitor the progress of change? What indeed are the characteristics of a “strengthened system” and how can they be measured?
- **Strengthen WHO’s role in health systems, in a changing world**
There is a growing demand for WHO to do more in health systems. While this may include greater levels of investment, it will also require a consideration of whether WHO could use its resources more effectively, either through different patterns of allocation or different ways of working.

The importance of health systems as part of the global health agenda and in terms of WHO’s response is reflected in the *11th General Programme of Work (2006-2015)* and the *Medium-term Strategic Plan (2008-2013)*. This Framework spells out in more detail the policy challenges faced by countries, and the steps for a more effective institutional response by the WHO Secretariat.

How will the Framework for Action add value to WHO's work? Support for health systems strengthening is the most frequently mentioned priority in WHO Country Cooperation Strategies¹ (CCSs). Two sorts of expertise are wanted from WHO: first, in specific technical areas of health systems; second, in strategic support to governments as they strive to reconcile competing priorities and sources of advice. That said, however, establishing WHO's position as a key provider of health systems support at country level - given the many actors in this area - needs to be based on a clear understanding of priorities, capacity and comparative advantage.

Several regional offices have defined regional health systems strategies and/or technical strategies in specific areas such as health financing. Similarly, several technical programmes in WHO are developing work programmes on systems strengthening. This document sets them within a Framework for Action for the Organization as a whole.

The Framework is about ways of working in WHO. Two sets of issues are particularly important. How can we develop more synergistic working relationships between the technical programmes, which focus on particular health outcomes, and the specialist health systems groups in the organization? And, how can we ensure better links between WHO's engagement in policy processes at country level and the health systems strengthening activities that flow from them? The importance of working in new ways gives the Framework for Action its title. **Health systems strengthening is "everybody's business"**.

Health system basics

Any strategy for strengthening health systems needs a basic shared perception of what a health system is, what it is striving to achieve, and how to tell if it is moving in the desired direction.

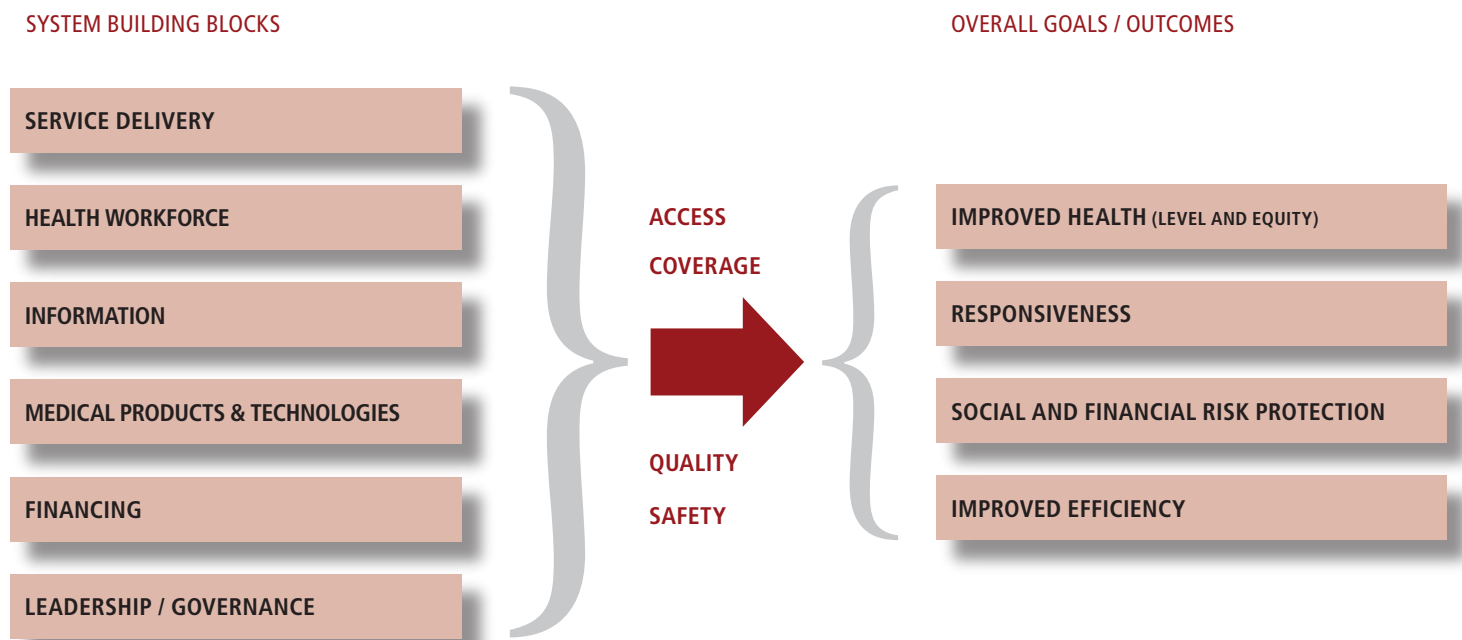
- **What is a health system**
A health system consists of all organizations, people and actions whose *primary intent* is to promote, restore or maintain health². This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation. It includes inter-sectoral action by health staff, for example, encouraging the ministry of education to promote female education, a well known determinant of better health.
- **Guiding values and principles**
The directions set out for WHO in this document are determined by the values and goals enshrined in the Alma Ata Declaration; WHO's commitments on gender and human rights³ and the World health report 2000.
- **Health system goals**
Health systems have multiple goals. The World health report 2000 defined overall health system outcomes or goals as: improving health and health equity, in ways that are responsive, financially fair, and make the best, or most efficient, use of available resources. There are also important intermediate goals: the route from inputs to health outcomes is through achieving greater access to and coverage for effective health interventions, without compromising efforts to ensure provider quality and safety.

1 WHO Country Presence 2005: CCSs provide the medium-term strategic framework for WHO's work at country level.

2 This is an expanded version of the definition given in the World health report 2000 Health Systems: Improving Performance.

3 Declaration of Alma Ata, 1978; Universal Declaration on Human Rights 1948; WHO Gender Policy 2002. The Right to Health and other human rights instruments institutionalise in law many aspects of Primary Health Care.

THE WHO HEALTH SYSTEM FRAMEWORK



THE SIX BUILDING BLOCKS OF A HEALTH SYSTEM: AIMS AND DESIRABLE ATTRIBUTES

- Good **health services** are those which **deliver** effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources.
- A well-performing **health workforce** is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances. I.e. There are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive and productive.
- A well-functioning **health information system** is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status.
- A well-functioning health system ensures equitable access to essential **medical products and technologies** of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.
- A good **health financing** system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or 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, the provision of appropriate regulations and incentives, attention to system-design, and accountability.

- **Health system building blocks**
To achieve their goals, all health systems have to carry out some basic functions, regardless of how they are organized: they have to provide services; develop health workers and other key resources; mobilize and allocate finances, and ensure health system leadership and governance (also known as stewardship, which is about oversight and guidance of the whole system). For the purpose of clearly articulating what WHO will do to help strengthen health systems, the functions identified in the World health report 2000 have been broken down into a set of six essential 'building blocks'. All are needed to improve outcomes. This is WHO's health system framework.
- **Desirable attributes**
Irrespective of how a health system is organized, there are some desired attributes for each building block, that hold true across all systems.

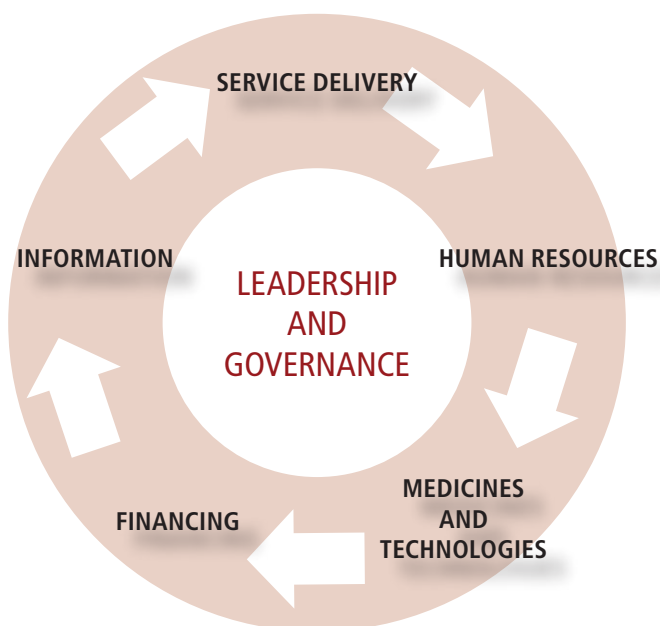
- **Multiple, dynamic relationships**
A health system, like any other system, is a set of inter-connected parts, that must function together to be effective. Changes in one area have repercussions elsewhere. Improvements in one area cannot be achieved without contributions from the others. Interaction between building blocks is essential for achieving better health outcomes.
- **Health system strengthening**
is defined as improving these six health system building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes. It requires both technical and political knowledge and action.
- **Access and coverage**
Since notions of improved access and coverage lie at the heart of this WHO health system strengthening strategy, there has to be some common understanding of these terms.
- **Is progress being made**
A key concern of governments and others who invest in health systems is how to tell whether and when the desired improvements in health system performance are being achieved. Convincing indicators are needed, that can detect changes on the ground.

'ACCESS' AND 'COVERAGE': UNDERSTANDING CURRENT USAGE

Throughout the world, countries try to protect the health of their citizens. They may be more or less successful, and more or less committed, but the tendency is one of trying to make progress, in three dimensions. First, countries try to broaden the range of benefits (programmes, interventions, goods, services) to which their citizens are entitled. Second, they extend access to these health goods and services to wider population groups, and ultimately to all citizens: the notion of universal access to these benefits. Finally, they try to provide citizens with social protection against untoward financial and social consequences of taking up health care: of particular interest is protection against catastrophic expenditure and poverty. In health policy and public health literature the shorthand for these entitlements of universal access to a specified package of health benefits and social protection is universal coverage.

The words access and coverage are also used to denote measurable targets, as well as aspirational goals. For example, many epidemiologists and

disease control programme managers use the term "coverage" to measure the proportion of a target population that benefits from an intervention. On the other hand, when policy makers or health economists in Thailand, France or the USA talk about moving towards universal coverage, they are striving for access to a broadening range of benefits, for all citizens without exclusion, and with the necessary social protection. Depending on the context, the accent may be primarily on broadening the package; or on extending coverage in excluded groups; or on improving social protection. In all cases though, what is at stake is the public responsibility for ensuring all citizens' entitlements to the protection of their health – the political idea that led WHO to promote Health For All. These differences in usage are a fact of life in the multi-disciplinary field of health. What is important is that the differences are understood.



WHAT CAN WE LEARN FROM THE PRIMARY HEALTH CARE VALUES AND APPROACH?

Primary Health Care, as articulated in the **Alma Ata Declaration** of 1978, was a first international attempt to unify thinking about health within a single policy framework. Developed when prospects for growth in many countries were bright, Primary Health Care remains an important force in thinking about health care in both the developed and developing world. Although often honoured more in the breach than in the observance, its **underpinning values – universal access, equity, participation and intersectoral action** – are central to WHO's work and to health policies in many countries today. The Primary Health Care approach also emphasizes the importance of health promotion and the use of appropriate technology. As the non-communicable disease burden rises and the menu of diagnostic and therapeutic technologies expands, these principles – backed up by an increasing body of evidence on intervention cost-effectiveness – are as important for health policy makers to keep in mind today as they were thirty years ago.

The term Primary Health Care is important in a second way. The term signifies an important approach to health care organization in which the **primary, or first contact, level** – usually in the context of a health district – acts as a driver for the health care delivery system as a whole. Again, while the language may have changed – for example the term 'close-to-client' care is

also used, and a wide range of service delivery models have evolved – the principle of providing as much care as possible at the first point of contact **effectively backed up by secondary level facilities that concentrate on more complex care**, remains a key aim in many countries. The concept of **integrated** Primary Health Care is best viewed from the perspective of the individual: the aim being to develop service delivery mechanisms that encourage continuity of care for an individual across health conditions, across levels of care, and over a lifetime.

The values and principles of Primary Health Care remain constant, but there are lessons from the past, which are particularly important when looking ahead. First, despite increased funding, resources for health will always be limited, and there is a responsibility to achieve the maximum possible with available resources. Second, past efforts to implement a Primary Health Care approach focused almost exclusively on the public sector. In reality, for many people – poor, as well as rich – private providers are the first point of contact, and responsible health system oversight involves taking account of private as well as public providers. Third, while keeping its focus on the community and first contact care, Primary Health Care needs to recognize the problems associated with relying on voluntarism alone.



HEALTH SYSTEMS CHALLENGES AND OPPORTUNITIES

Health systems have to deal with many challenges. As the spectrum of ill-health changes, so health systems have to respond. Their capacity to do so is influenced by a variety of factors. Some operate at a national or sub-national level, such as the availability of financial and human resources, overall government policies in relation to decentralization and the role of the private sector. Some operate through other sectors. Increasingly, however, national health systems are subject to forces that affect performance, such as migration and trade factors, operating at an international level.

Some health policy challenges are primarily of concern to low-income countries. However, despite national differences, *many policy issues are shared across remarkably different health systems*. Concerns such as the impact of aging populations, the provision of chronic care or social security reform are no longer the concern of industrialized countries alone. Similarly, the threat posed by new epidemics, such as avian or human pandemic influenza, requires a response from all countries rich and poor. The differences lie in the relative severity of challenges being faced, the way a particular health system has evolved, and the economic, social and political context – all of which determine the nature and effectiveness of the response.

Given the size of global spending on health and concerns about health systems performance, the question is, “Why aren’t health systems working better?”

Managing multiple objectives and competing demands

In the face of fierce competition for resources, governments worldwide have to manage multiple objectives and competing demands. As they strive for greater efficiency and value for money, they must seek ways to achieve more equity in access and outcomes and to reduce exclusion. They are under pressure to ensure that services are effective, of assured quality and safe, and that health providers are responsive to patients demands. Progress in one direction may mean compromise in another. For example, the pressure to increase access to HIV/AIDS care and treatment, which has helped bring visibility to the human resources crisis in Africa, brings its own pressures on the capacity of the health system to handle other causes of ill-health. Progress in increasing staff retention in the public sector through better pay packages may mean compromise in containing costs.

Competition for resources may be between hospitals and primary level care; between prevention and treatment; between professional groups; between public and private sectors; between those engaged in efforts to treat one condition versus another; between capital and recurrent expenditures. This means health system strengthening requires careful judgement and hard choices. It can be better informed by evidence and by the use of technical tools, but ultimately it is a political process and reflects societal values.

A national health sector strategy is one way to reconcile multiple objectives and competing demands. To be robust, a sector strategy requires sound logic and sufficient support. Plans need to be costed; budgets have to balance ambition with realism. The necessary processes have to be managed in an inclusive way, and linked with national development planning processes such as poverty reduction strategies. These, together with transparent systems to track effects, are the key to unlocking more resources.

A significant increase in funding for health

Health systems are a means to the end of achieving better health outcomes. In many countries, resources for health have increased from both domestic budgets and, in lower- and middle-income countries, from external development partners as well.

There is growing interest in the array of domestic financing mechanisms that can be drawn upon to move towards universal coverage, including tax-based funding, social health insurance, community or micro-insurance, micro-credit and conditional cash transfers. All of these mechanisms make major demands on managerial capacity. On the other hand, where providers depend largely on out-of-pocket payments for their income, there is over-provision of services for people who can afford to pay, and lack of care for those who cannot.

Much of the increase in investment by external partners has focused on particular diseases or health conditions. The global health landscape has been transformed in the last ten years with the emergence of multiple, billion-dollar global health partnerships such as the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria and the GAVI Alliance. These have helped generate growing political support for increasing access to care and treatment for many critical health conditions, and have also thrown a spotlight on longstanding systems issues such as logistics, procurement and staffing. Moreover the growing demands for provision of lifelong treatments highlights the need for policies that protect people from catastrophic spending.

'Scaling-up' is not just about increasing spending

It is increasingly recognized that scaling-up is not just about increasing investment. Close scrutiny of what is involved points to a set of health systems challenges, most of which are equally pertinent in higher as well as low-income settings.

Countries both rich and poor are looking for ways of doing more with existing resources. In many health systems, existing health workers could be more productive if they had access to critical material and information resources, clearly defined roles and responsibilities, better supervision and an ability to delegate tasks more appropriately. Changes in overall intervention-mix and skill-mix could create efficiencies.

In many instances, extending coverage or quality cannot be achieved simply by replicating existing models for service delivery or focusing only on the public sector. In addition, decision-makers seek innovative ways to engage with communities, NGOs and the private sector. Promising experiences, such as working with informal providers to expand TB care, the social marketing of bed-nets or contracting with NGOs, need to be shared. It is important to take note of what did and did not work in the past. Careful analysis is needed about which local initiatives are genuinely amenable for replication and expansion. Multiple barriers cannot all be addressed or overcome at once. Judgements have to be made between pushing to quickly get specific outcomes and building systems and institutions. Managing the tension between saving lives and livelihoods and starting the process of re-building the state is a particular challenge in fragile states.

There is no guarantee that the poor will benefit from reforms unless they are carefully designed with this end in mind. It is well-known that the child health MDG target can be reached with minimal gains among the poorest. And in many countries, groups such as the poor – and too often women more than men – migrants and the mentally ill are largely invisible to decision-makers. These require specific attention, but introducing strategies that promote equity rather than the converse is not straightforward, as the debates around rapidly scaling-up HIV/AIDS treatment showed. Demand-side factors also determine use, so understanding the incentives and disincentives for seeking care is also important.

HEALTH SYSTEMS: A SHORT HISTORY

Health systems of some sort have existed as long as people have tried to protect their health and treat disease, but organized health systems are barely 100 years old, even in industrialized countries. They are political and social institutions. Many have gone through several, sometimes parallel and sometimes competing, generations of development and reform, shaped by national and international values and goals. **Primary Health Care** as articulated in the **Alma Ata Declaration** of 1978 was a first attempt to unify thinking about health within a single policy framework. Developed when prospects for growth in many countries were bright, Primary Health Care remains an important force in thinking about health care in both the developed and developing world. The financial optimism of the 1970s was soon dispelled in many parts of the world by a combination of high oil prices, low tax revenues and economic adjustment. Countries seeking to finance essential health care were faced with two difficult prescriptions: focus public spending on interventions that are both cost-effective and have public good characteristics (the message of the World Development Report 1993), and boost financing through charging users for services. Whilst many governments started to levy fees, most recognized the political impossibility of focusing spending on a few essential interventions alone. The results were predictable. The poor were deterred from receiving treatment and user fees yielded limited income. Moreover, maintaining a network of under-resourced hospitals and clinics, while human and financial resources were increasingly pulled into vertical programmes, increased pressures on health systems sometimes to the point of collapse.

As the crisis in many countries deepened in the 1990s, so many governments looked to the wider environment for new solutions. If the health district was

not working well it was because insufficient power was decentralized within government. If health workers were unproductive, then look to civil service reform. If hospitals were a drain on the budget, reduce capacity in the public sector. Infused with ideas from market-based reforms in Europe's public services, and with new experiences emerging from transitional economies, **health sector reform** focused above all on doing more for less. Efficiency remained the watchword. It was not until towards the end of the decade that the international community started to confront the reality that running health systems on \$10 per capita or less is just not a viable proposition. In this regard, the work of the Commission on Macroeconomics and Health and costing the global response to the HIV/AIDS pandemic finally broke the mould, making it acceptable to talk more realistically about resource needs.

In the first decade of the 21st Century, many of the pressures remain. In the developed world, the public looks for signs that increased spending delivers results, while planners look nervously at the impact of ageing populations. In the developing world, there are more resources for health but most are linked to specific programmes. But there are also signs of change. There is a wider recognition of inter-dependence and the importance of wider policy choices on health systems, particularly the impact of migration and trade. Similarly, it is clear that governments do not have all the answers. Productive relations with the private sector and voluntary groups are both possible and desirable. Governments have a much wider range of policy levers at their disposal. The challenge for WHO as their adviser, is to understand the whole menu and know when and how to mix the right combination of ingredients.

HEALTH SYSTEM CHALLENGES: A FEW FACTS AND FIGURES

- Globally, health is a US\$3.5 trillion industry, or equal to 8% of the world's GDP.
 - Large health inequalities persist: even within rich countries such as USA and Australia, life expectancy still varies across the population by over 20 years.
 - Recent essential medicines surveys in 39 mainly low- and low-middle-income countries found that, while there was wide variation, average availability was 20% in the public sector, and 56% in the private sector.
 - Each year, 100 million people are impoverished as a result of health spending.
 - Extreme shortages of health workers exist in 57 countries; 36 of these are in Africa.
 - In over 60 countries, less than a quarter of deaths are recorded by vital registration systems.
 - An estimated 50% of medical equipment in developing countries is not used, either because of a lack of spare parts or maintenance, or because health workers do not know how to use it.
 - Private providers are used by poor as well as rich people. For example, in Bangladesh, around ¾ of health service contacts are with non-public providers.
 - In 2000, less than 1% of publications on Medline were on health services and systems research.
 - Globally, about 20% of all health aid goes to support governments' overall programmes (i.e. is given as general budget or sector support), while an estimated 50% of health aid is off budget.
 - There has been a rapid increase in global health partnerships. More than 80 now exist, of which WHO houses over 30.
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Success will be limited unless efforts of other sectors are brought to bear on achieving health outcomes. Scaling-up requires the following: working with ministries of finance to justify budget demands in the context of macroeconomic planning, and ensuring health is well reflected in poverty reduction strategies and medium-term expenditure frameworks; working with ministries of labour, education and the civil service on issues of pay, conditions, health worker training and retention; working with ministries of trade and industry around access to drugs and other supplies; and, with increasing decentralization, working with local government. Attention to health determinants must be maintained, as investments in education, housing, transport, water and sanitation, improved governance or environmental policy can all benefit health. Actions by other sectors can also have adverse effects on health, something that is recognized by the growing requirement for health impact assessments.

The health systems agenda is not static

Patterns of disease, care and treatment are changing. Eighty per cent of non-communicable disease deaths today are in low- and middle-income countries. Systems for managing the continuum of care – be it for HIV/AIDS or hypertension – pose different demands from those needed for acute intermittent care. New delivery strategies may create new demands on the health system. For example, the shift from traditional birth attendants to skilled birth attendants has implications for staffing, for referral systems, and in terms of upgrading facilities to deliver emergency obstetric care. New approaches to mental health and non-communicable diseases emphasize primary prevention, community care and well informed patients, all of which entail shifts from the traditional focus of institutional care.

The introduction of new drugs, vaccines and technologies have an impact on staffing and training, but equally on health financing and service delivery. For example, some hospital-based treatments can now be delivered through day care centres. This is leading to a reappraisal of traditional service delivery models and strategies for increasing efficiency.

Health systems are at the heart of how countries respond to new disease threats such as Severe Acute Respiratory Syndrome (SARS), avian flu, pandemic human influenza. International networks for identifying and responding to such security threats depend for their effectiveness on the 'weakest link'. Accordingly, disease control efforts must be internationally coordinated. As well as testing the alert and response capacity of weak health systems, the attention such outbreaks generate presents important opportunities to catalyse and orchestrate support for improving them: by building epidemiological and laboratory capacity in the context of revised International Health Regulations, addressing patents and intellectual property rights, improving supply chain management and so forth.

An estimated 25 million people are displaced today as a result of conflict, natural or man-made disasters. In such situations, local health systems become rapidly over-whelmed and multiple agencies often move in to assist. This leads to the paradoxical situation in which leadership is weaker than usual because it has been disrupted or divided, but the need for leadership is even greater. The continuing search for ways to strengthen leadership at such times includes emergency preparedness programmes, norms and standards, creating contingency funds and more interaction between UN agencies and other actors.

Changes in public policy and administration, particularly decentralization, makes new demands on local authorities and may change fundamentally the role of central ministries. After years of relative inattention, there is now a resurgent interest in the role of the state. However, the emphasis is on 'good governance' and effective stewardship, rather than a return to earlier 'command and control' models. The public in most countries no longer accepts a passive role and rightly demands a greater say in how health services are run, including how health authorities are held accountable for their work. The information technology revolution has accelerated this change.

There is a major emphasis on demonstrating results and value for money, not just in terms of health outcomes but also in being able to demonstrate progress in systems strengthening. There is also greater focus on corruption in the health sector, with distinctions being made between grand larceny, mismanagement and behaviours such as salary supplementation through informal payments.

Development partners have their impact on health systems

Development partners impact health systems through support for the new global health partnerships – as well as through measures that can increase the predictability of aid – ideally making it easier for finance ministries to finance the long-term recurrent costs of salaries or life-saving medicines.

Perhaps most importantly, the barriers to more rapid progress at country level observed by GHPs have helped to dispel the simple notion that health systems can be built around single diseases or interventions. At the same time, the emergence of new funds has highlighted challenges already faced by countries in managing multiple sources of finance. Multiple parallel policy processes or reporting systems have led to unnecessarily high transaction costs, and a concern that narrowly focused support is drawing scarce personnel away from other essential services and compromising a healthy balance of health services. As a result, many GHPs, along with bilateral agencies, are searching for ways to better harmonize and align their activities with national policies and systems.

In short, countries face many challenges: making the case for more effective investment in health systems in a competitive funding environment; creating better functional links between programmes with mandates defined in terms of specific health outcomes and those with health systems as their core business; ensuring capacity to respond to current issues and identify future challenges; and ensuring that resources are used as effectively as possible. WHO faces these same challenges.

REDUCING HEALTH INEQUALITIES IN THAILAND

Between 1990 and 2000, Thailand significantly reduced its level of child mortality and at the same time halved inequalities in child mortality between the rich and the poor. These impressive results can be explained partly by substantial economic growth and reduced poverty over this period. However there were a number of other important strategies that contributed, many of which began to be put in place before 1990 but which were extended and maintained. These include improved insurance coverage and more equitable distribution of primary health care infrastructure and intervention coverage.

From the 1970s onwards, a series of pro-poor health insurance schemes improved health service coverage. The initial step was to waive user charges

for low-income families. This was followed by subsidized voluntary health insurance, then the extension of the government welfare scheme in the 1990s to all children under 12, the elderly and disabled, and to universal coverage from 2001. Also from the 1970s, health infrastructure and services were scaled up with a particular focus on Primary Health Care and community hospitals targeting the poorer, rural populations. Increased production, financial incentives and educational strategies led to a more equitable allocation of doctors in rural areas in the 1980s. This combination led to increased utilization of health services. For example, vaccination coverage rose from 20%-40% in the early 1980s to over 90% in the 1990s; skilled birth attendance rose from 66% to 95% between 1987 and 1999.

Sources (see Annex 2, References): Vapattanawong P et al, 2007; Tangcharoensathien V et al 2004.



WHO'S RESPONSE TO HEALTH SYSTEMS CHALLENGES

The analysis of challenges in the previous section provides some clear messages. WHO needs to communicate about health systems, in plain language, to the increasing range of actors involved in health. Health systems are clearly a means to an end, not an end in themselves. There needs to be a focus on providing support to countries in ways that better respond to their needs. Lastly, there is a major role for WHO at the international level. These messages determine the four inter-connected pillars of WHO's response:

- A. A single framework with six clearly defined building blocks**
- B. Health systems and programmes: getting results**
- C. A more effective role for WHO at country level**
- D. The role of WHO in the international health systems agenda**

As the UN technical agency in health, WHO draws on its core functions in addressing these challenges. Some of the functions are not unique to WHO: other agencies are actively involved in, for example, developing tools or technical support. However, WHO's mandate, neutral status and near-universal membership give it unique leverage and advantage. Indeed, having so many players active in health today does not reduce but rather accentuates the importance of WHO's role in strengthening health systems.

- WHO is involved in all aspects of health and health systems. It is therefore well-placed to understand how health system strengthening affects service delivery on the ground.
- WHO is perceived by governments as a trusted adviser in a value-laden area because it is directly accountable to its Member States, and because it is not a major financier, so its advice is independent of loans or grants.
- In addition to its normative role, WHO's network of 144 country and six regional offices puts it in a strong position to link national and international policy and strategy.
- Continuous country presence makes WHO well-placed to support rapid responses to crises and also longer-term interventions needed for sustained improvement in health systems.

In WHO's key strategy documents, health systems are a priority. The General Programme of Work, "Engaging for Health", provides the broad agenda for WHO in health systems development. The draft Medium-term Strategic Plan 2008-2013 has two strategic objectives explicitly concerned with health systems. However, other strategic objectives (listed in Annex 1) also include activities designed to strengthen health systems. As such, all WHO programmes are involved in some aspect of systems development. This reinforces a central principle of this health system strengthening Framework – it is "everybody's business."

WHO's involvement in all aspects of health and health systems is a strength and, too often, an under-utilized resource. Advice on health systems strengthening must be informed by: an understanding of what is needed to make sure that clinic staff address major causes of child or adult mortality; recognizing that the way hospitals deal with major accidents or complicated deliveries determines whether people are impoverished by the catastrophic cost of treatment; taking experience of the HIV/AIDS community in getting governments to work more effectively with private providers and those living with the disease. At the same time, of course, one cannot advise on health systems financing from the perspective of malaria or child health alone.

WHO needs to set priorities. However, WHO cannot focus on one aspect of health systems development at the expense of another. Indeed, adopting a more holistic approach is a priority in itself. This section provides a broad view of where the main focus will be for each pillar of the strategy. The last section then sets out some of the implications that implementing the four pillars will have for the way WHO works.

A. A SINGLE FRAMEWORK WITH SIX CLEARLY DEFINED BUILDING BLOCKS AND PRIORITIES

As previously mentioned, a health system, like any other system, is a set of inter-connected parts that have to function together to be effective. This pillar summarizes the main directions of WHO's work in each of the health system building blocks, and where there are important linkages between them.

PRIORITIES BY BUILDING BLOCK

- 1 **Service delivery:** packages; delivery models; infrastructure; management; safety & quality; demand for care
 - 2 **Health workforce:** national workforce policies and investment plans; advocacy; norms, standards and data
 - 3 **Information:** facility and population based information & surveillance systems; global standards, tools
 - 4 **Medical products & technologies:** norms, standards, policies; reliable procurement; equitable access; quality
 - 5 **Financing:** national health financing policies; tools and data on health expenditures; costing
 - 6 **Leadership and governance:** health sector policies; harmonization and alignment; oversight and regulation
-

1. SERVICE DELIVERY

In any health system, good health services are those which deliver effective, safe, good quality personal and non-personal⁴ care to those that need it, when needed, with minimum waste. Services – be they prevention, treatment or rehabilitation – may be delivered in the home, the community, the workplace or in health facilities.

Although there are no universal models for good service delivery, there are some well-established requirements. Effective provision requires trained staff working with the right medicines and equipment, and with adequate financing. Success also requires an organizational environment that provides the right incentives to providers and users. The service delivery building block is concerned with how inputs and services are organized and managed, to ensure access, quality, safety and continuity of care across health conditions, across different locations and over time. Attention is needed on the following:

- Demand for services. Raising demand, appropriately, requires understanding the user's perspective, raising public knowledge and reducing barriers to care – cultural, social, financial or gender barriers. Doing this successfully requires different forms of social engagement in planning and in overseeing service performance.
- Package of integrated services. This should be based on a picture of population health needs; of barriers to the equitable expansion of access to services, and available resources such as money, staff, medicines and supplies.
- Organization of the provider network. The purpose of an organized provider network is to ensure close-to-client care as far as possible, contingent on the need for economies of scale; to promote individual continuity of care where needed, over time and between facilities; and to avoid unnecessary duplication and fragmentation of services. This means considering the whole network of providers, private as well as public; the package of services (personal, non-personal); whether there is over – or under – supply; functioning referral systems; the responsibilities of and linkages between different levels and types of provider including hospitals; the suitability of different delivery models for a specific setting; and the repercussions of changes in one group of providers on other groups and functions (e.g. on staff supervision or information flows).

⁴ Non-personal services are also called population-based services.

- **Management.** The aim is to maximize service coverage, quality and safety, and minimize waste. Whatever the unit of management (programme, facility, district, etc. any autonomy, which can encourage innovation, must be balanced by policy and programme consistency and accountability. Supervision and other performance incentives are also key.
- **Infrastructure and logistics.** This includes buildings, their plant and equipment; utilities such as power and water supply; waste management; and transport and communication. It also involves investment decisions, with issues of specification, price and procurement and considering the implications of investment in facilities, transport or technologies for recurrent costs, staffing levels, skill needs and maintenance systems.

WHO is strongest in defining which health interventions should be delivered, with associated guidelines, standards and indicators for monitoring coverage. Most of this work is carried out on a programme-by-programme basis (e.g. for malaria, maternal or mental health). Increasingly, however, it is evident that there is a need to be sure that health systems in countries with differing levels of resources can accommodate the ideals that these norms imply. A further strength of many individual programmes is in exploring innovative models of service delivery, for example, involving private providers in the care of TB. Initiatives such as the Integrated Management of Child, or Adult, Illness (IMCI, IMAI) are responding to increasing interest in delivering packages of care.

Priorities

Building on the above, WHO will increase its attention to the challenges associated with delivering packages of care (prevention, promotion and treatment for acute and chronic conditions). The aim is to help develop mechanisms for integrated service delivery where possible, that is to say, mechanisms that encourage continuity of care for an individual where needed across health conditions and levels of care and over a lifetime. Priorities are as follows:

- **Integrated service delivery**
WHO will continue to produce and disseminate cost-effectiveness data for prevention and treatment, and define service standards and measurement strategies for tracking trends and inequities in service availability, coverage and quality. It will help define integrated packages of services, and the roles of primary and other levels of care in delivering the agreed packages, as part of its health policy development support.
- **Service delivery models**
WHO will increase efforts to capture experience with models for delivering personal and non-personal services in different settings, including fragile states. It will consider the whole network of public and private providers in order to enhance equitable access, quality and safety. It will synthesize and share experience of the costs, benefits and conditions for success of strategies to improve service delivery. These may include community health workers, task shifting, outreach, contracting, accreditation, social marketing, uses of new technologies such as telemedicine, hospital service organization and management, delegation to local health authorities, other forms of decentralization, etc. It will concentrate especially on lessons from those strategies that have been implemented on a large scale, and that have helped to improve services for the poor and other disadvantaged groups.
It will consider the stewardship and governance implications of different service delivery models, for example, legislation for non-communicable diseases, approaches to regulating private providers and the consequences for health services of decentralization to local government.
- **Leadership and management**
WHO will support Member States to improve management of health services, resources and partners by health authorities, as a means to expand coverage and quality. This will be done through: promoting tools for analysing barriers to care, and management weaknesses; generating and sharing knowledge on strategies to improve management, often in the context of decentralization; developing local resource institutions capacity to support local health managers; and developing methods to monitor progress.

- **Patient safety and quality of care**
WHO will continue its focus on patient safety, and systems and procedures that improve safety. Related work on quality will foster approaches that take account of the full spectrum of interventions needed: treatment protocols and clinical management schedules; supportive supervision and performance assessment; training and continuing education; procedures for registration, licensing and inspection; and fora for dialogue and motivating providers.
- **Infrastructure and logistics**
The challenge of how to handle major capital investment decisions, such as hospitals, deserves more attention by WHO. Currently the effectiveness of its contributions in, for example, complex emergencies is limited. WHO will review current work on infrastructure and logistics, both investment decisions and developing sustainable infrastructure and logistics systems, identifying the gaps, what other agencies are doing and how WHO should position itself.
- **Influencing demand for care**
WHO will communicate international agreements on rights and responsibilities of citizens with regard to their health, and support their incorporation into national policy and practice. It will encourage effective use of the media in promoting health and the engagement of civil society organizations in service delivery planning and oversight, as a means to provide all those who need care, especially the poor and other vulnerable groups, with the confidence that they will be treated decently, fairly and with dignity.

STRENGTHENING PRIMARY HEALTH CARE IN LAO PEOPLE'S DEMOCRATIC REPUBLIC

A comprehensive Primary Health Care programme has been in place in the remote Sayaboury province since 1991. It has achieved impressive results. Between 1996 and 2003 health facility utilization tripled, maternal mortality dropped 50%, and by 2003 infant and child mortality were less than one-third the national average. These impressive changes are the result of a suite of interventions, coupled with modest but sustained support. Key interventions included: provincial and district management strengthening (training; regular supervision and performance assessment); training

and regular supervision of dispensary staff village health volunteers and traditional birth attendants; construction and upgrading of dispensaries; staff development opportunities and incentives such as free medical treatment for volunteers; provision of essential equipment and seed capital for the revolving drug fund. Technical and financial support were provided throughout the 12 years. The external financial investment, roughly US\$4 million, was equivalent to US\$1 per person per year.

Source (see Annex 2, References): Perks C et al 2006.

2. HEALTH WORKFORCE

HEALTH WORKFORCE

Health workers are all people engaged in actions whose primary intent is to protect and improve health. A country's health workforce consists broadly of health service providers and health management and support workers. This includes: private as well as public sector health workers; unpaid and paid workers; lay and professional cadres. Countries have enormous variation in the level, skill and gender-mix in their health workforce. Overall, there is a strong positive correlation between health workforce density and service coverage and health outcomes.

In any country, a "well-performing" health workforce is one which is available, competent, responsive and productive. To achieve this, actions are needed to manage dynamic labour markets that address *entry* into and *exits* from the health workforce, and improve the distribution and performance of *existing health workers*. These actions address the following:

- How countries plan and, if needed, scale-up their workforce asking questions that include: What strategic information is required to monitor the availability, distribution and performance of health workers? What are the regulatory mechanisms needed to maintain

quality of education/training and practice. In countries with critical shortages of health workers, how can they scale-up numbers and skills of health workers, in ways that are relatively rapid and sustainable? Which stakeholders and sectors need to be engaged (e.g. training institutions, professional groups, civil service commissions, finance ministries)?

- How countries design training programmes so that they facilitate integration across service delivery and disease control programmes.
- How countries finance scaling-up of education programmes and of numbers of health workers in a realistic and sustainable manner and in different contexts.
- How countries organize their health workers for effective service delivery, at different levels of the system (primary, secondary, tertiary), and monitor and improve their performance.
- How countries retain an effective workforce, within dynamic local and international labour markets.

Traditionally, much of WHO's focus in countries has been on training, especially in-service training. More recently, WHO has mobilized greater international awareness of health workforce shortages and performance challenges, especially in Africa, and has been instrumental in creating the Global Health Workforce Alliance, a partnership intended to tackle them in a more coherent way. It has also shed light on the available but still limited knowledge base on workforce policy options through its World health report 2006.

Priorities

- **International norms, standards and databases**
WHO will maintain and strengthen the Global Atlas on the health workforce. It will facilitate the generation and exchange of information on health workforce availability, distribution and performance by supporting regional workforce observatories.
- **Realistic strategies**
WHO will increase its support for realistic national health workforce strategies and plans for workforce development. These will consider the range, skill-mix and gender balance of health workers (health service providers and management and support workers) needed to deliver the agreed package of services across priority programmes. They will address workforce education, recruitment, retention and performance and define regulatory options to improve quality of practice, such as licensing and accreditation.
- **Crisis countries**
In countries with a workforce crisis, WHO will act on the basis of agreed multi-stakeholder health workforce strategies (such as the Treat, Train, Retain Initiative) and best knowledge to take rapid action. Workforce strategies will be developed in collaboration with priority programmes and with key stakeholders in other sectors as needed.
- **Costing**
WHO will generate knowledge about the financial costs of scaling-up and then maintaining the expanded health workforce, as well as ways to address financial sustainability, and use this in dialogue with international financing institutions.
- **Training**
WHO will support the redesign of training programmes to produce the spectrum of health workers (service providers and management and support workers) to deliver health services. It will explore and document ways to maximise the use of priority programme training initiatives, and mechanisms such as accreditation to assure quality of training programmes.
- **Evidence**
WHO will synthesize and disseminate evidence on the following: ways to organize the health workforce for more effective service delivery and improved health worker performance;

strategies to better retain health workers that include attention to both salaries and working conditions and differential effects on male and female staff; and ways to monitor health worker performance.

- **Advocacy**
International and regional advocacy will focus on: developing strategies to manage migration, such as the International Code of Practice; promoting better understanding of the implications of international labour markets for developing countries; and ways to mobilize better technical support to countries. It will facilitate agreements between agencies on more effective financing mechanisms for workforce development.
- **Working with international health professional groups**
Such as the Internal Council of Nursing, the World Medical Association, the Federation of International Pharmacists and the World Federation of Medical Education, WHO will maintain its function in setting norms and standards for the health workforce, including the development of internationally agreed definitions, classification systems and indicators.

DEVELOPING NEW CADRES: LADY HEALTH WORKERS IN PAKISTAN

In 1994, the Government of Pakistan launched the National Family Planning and Primary Care Programme, to prevent and treat common ailments at the community level in a cost-effective manner. The lynch pin of this programme was the "Lady Health Worker" (LHW). These are salaried community health workers with eight years of schooling, who receive a 15-month training session followed by one year of field practice.

By the end of 2006, there were 96,000 LHWs, and another 14,000 LHWs will be deployed by end 2008. Each LHW serves a population of 1000-1500, of whom 75% live in rural areas. Each LHW is attached to a government health facility, from which they receive regular in-service training and medical supplies. They are supervised by LHW supervisors. Their annual salary is around US\$343. The cost of the programme for the first eight years

was US\$155 million, and the approved budget for 2003-2008 is US\$357 million. Government is the main funder, with 11% coming from external sources. The overall yearly cost of one LHW is approximately US\$745. This gives an average cost per person per year of less than 75 cents.

Evaluations of this programme have found significant impact on health knowledge and health service utilization, especially in rural areas. For example, in areas with LHWs, there are a higher proportion of births attended by a skilled attendant; more babies exclusively breast-fed; more mothers who know about oral rehydration, and who give it to children with diarrhoea; and more children fully vaccinated, compared with areas without LHWs.

Sources (see Annex 2, References): Oxford Policy Management, 2002; Arif GM Asian Development Bank, 2006. Desplats M, et al, Médecine Tropicale, 2004.

3. INFORMATION

INFORMATION

The generation and strategic use of information, intelligence and research on health and health systems is an integral part of the leadership and governance function (see 3.2.6). In addition, however, there is a significant body of work to support development of health information and surveillance systems, the development of standardized tools and instruments, and the collation and publication of international health statistics. These are the key components of the Information building block. This is increasingly more than just a national concern. As part of efforts to create a more secure world, countries need to be on the alert and ready to respond collectively to the threat of epidemics and other public health emergencies.

A well functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely health information by decision-makers at different levels of the health system, both on a regular basis and in emergencies. It involves three domains of health information: on health determinants; on health systems performance; and on health status. To achieve this, a health information system must:

- Generate population and facility based data: from censuses, household surveys, civil registration data, public health surveillance, medical records, data on health services and health system resources (e.g. human resources, health infrastructure and financing);
- Have the capacity to detect, investigate, communicate and contain events that threaten public health security at the place they occur, and as soon as they occur;
- Have the capacity to synthesize information and promote the availability and application of this knowledge.

WHO supports countries in developing and applying different data collection and data management tools, from personal medical records to population data records, and in analysing the data produced. It develops tools and standards, such as the International Classification of Diseases, maintains the global mortality and causes of death database, and produces regular reports on health statistics, disaggregated where appropriate by age and sex. It supports the development of strong public health surveillance systems, as part of an inter-connected global system to collectively reduce international vulnerability to public health threats.

Priorities

- **National information systems**
Support improved population and facility-based information systems, so that they can generate, analyse and use reliable information from multiple data sources, in collaboration with partners (e.g. UN, other agencies, the Health Metrics Network partnership, the Institute of Health Metrics and Evaluation).
- **Reporting**
Avoid parallel reporting systems where possible, and promote single reporting to development partners. WHO will support the use of new data collection and data management technologies where appropriate.
- **Stronger national surveillance and response capacity**
Public health systems that are equipped with up-to-date technologies and dedicated personnel and are able to detect, investigate, communicate and contain threats to public health security, and be part of an unbroken international line of defence against such threats.
- **Tracking performance**
Establish a set of core and additional health system metrics to track health system performance for use by countries and external agencies financing investments in health systems.
- **Standards, methods and tools**
These include the International Classification of Diseases, Global Burden of Disease updates, MDG monitoring tools; development and measurement of Health System Metrics; and standards for electronic medical records. A key role will be played by expert groups, including the Advisory Committee for Health Monitoring and Statistics.
- **Synthesis and analysis of country, regional and global data**
This includes comprehensive WHO databases populated with more uniform data, disaggregated as needed by age and sex; regular publication of World Health Statistics.

INFORMATION

HEALTH SYSTEM STRENGTHENING: MONITORING PROGRESS

Securing more investment in health system strengthening will depend on being able to demonstrate progress. Moreover, agreement on consistent ways of measuring change in key dimensions of the health system can guide resource allocation to where it is needed most and will improve accountability. A monitoring system for health systems strengthening needs to capture trends in health system inputs and outputs, supported by coverage data with a small set of indicators. Progress can be summarized with a country "dashboard"

that includes key indicators for these core areas and describes progress on an annual or bi-annual basis. The dashboard should also provide contextual information such as the country health situation in relation to its level of economic development or health expenditure. The potential contents of a dashboard are shown below, based on a international meeting organized by Health Metrics Network in September 2006. Proposed indicators and data collection strategies are in the meeting report.

http://www.who.int/healthinfo/health_system_metrics_glion_report.pdf

Source: Health systems strengthening: Monitoring progress: Proposed indicators and data collection strategies. T Boerma, WHO 2007.

4. MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES

MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES

A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.

To achieve these objectives, the following are needed:

- National policies, standards, guidelines and regulations that support policy;
- Information on prices, international trade agreements and capacity to set and negotiate prices;
- Reliable manufacturing practices and quality assessment of priority products;
- Procurement, supply, storage and distribution systems that minimize leakage and other waste;
- Support for rational use of essential medicines, commodities and equipment, through guidelines, strategies to assure adherence, reduce resistance, maximize patient safety and training.

WHO has a strong track record in helping countries frame national policies. It promotes evidence-based selection of medicines, vaccines and technologies by developing international standards, norms and guidelines through WHO's Expert Committees and consultation processes. WHO/UN pre-qualification programmes for priority vaccines, medicines and diagnostics will be boosted significantly by the establishment of UNITAID, the new international drug purchase facility. WHO provides information on medicine and vaccine prices and supports the development of systems for post-marketing surveillance. It promotes equitable access and rational use, for example, through essential medicines lists, clinical guidelines, strategies to assure adherence and safety, training and working with consumer organizations. It also supports technology assessments and policy development.

Priorities

- **Establish norms, standards and policy options**
Set, validate, monitor, promote and support implementation of international norms and standards to promote the quality of medical products, vaccines and technologies, and ethical, evidence-based policy options and advocacy.

- **Procurement**
Encourage reliable procurement to combat counterfeit and substandard medical products, vaccines and technologies, and to promote good governance and transparency in procurement and medicine pricing.
- **Access and use**
Promote equitable access, rational use of and adherence to quality products, vaccines and technologies through providing technical and policy support to health authorities, professional networks, consumer organizations and other stakeholders.
- **Quality and safety**
Monitor the quality and safety of medical products and technologies by generating, analysing and disseminating signals on access, quality, effectiveness, safety and use.
- **New products**
Stimulate development, testing and use of new products tools, standards and policy guidelines, emphasizing a public health approach to innovation, and on adapting successful interventions from high-income countries to the needs of lower-income countries, with a focus on essential medicines that are missing for children and for neglected diseases.

5. SUSTAINABLE FINANCING AND SOCIAL PROTECTION

A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. Health financing systems that achieve universal coverage in this way also encourage the provision and use of an effective and efficient mix of personal and non-personal services.⁵

Three interrelated functions are involved in order to achieve this: the collection of revenues – from households, companies or external agencies; the pooling of pre-paid revenues in ways that allow risks to be shared – including decisions on benefit coverage and entitlement; and purchasing, or the process by which interventions are selected and services are paid for or providers are paid. The interaction between all three functions determines the effectiveness, efficiency and equity of health financing systems.

Like all aspects of health system strengthening, changes in health financing must be tailored to the history, institutions and traditions of each country. Most systems involve a mix of public and private financing and public and private provision, and there is no one template for action. However, important principles to guide any country's approach to financing include:

- Raising additional funds where health needs are high, revenues insufficient, and where accountability mechanisms can ensure transparent and effective use of resources;
- Reducing reliance on out-of-pocket payments where they are high, by moving towards pre-payment systems involving pooling of financial risks across population groups (taxation and the various forms of health insurance are all forms of pre-payment);
- Taking additional steps, where needed, to improve social protection by ensuring the poor and other vulnerable groups have access to needed services, and that paying for care does not result in financial catastrophe;
- Improving efficiency of resource use by focusing on the appropriate mix of activities and interventions to fund and inputs to purchase, aligning provider payment methods with organizational arrangements for service providers and other incentives for efficient service provision and use including contracting, strengthening financial and other relationships

SUSTAINABLE FINANCING AND SOCIAL PROTECTION

⁵ Resolution WHA58.33 on «Sustainable health financing, universal coverage and social health insurance» defined universal coverage as ensuring that the population has access to needed services without the risk of financial catastrophe.

**SUSTAINABLE
FINANCING
AND SOCIAL
PROTECTION**

with the private sector and addressing fragmentation of financing arrangements for different types of services;

- Promoting transparency and accountability in health financing systems;
- Improving generation of information on the health financing system and its policy use.

The most pressing challenge is to provide technical advice to the large number of countries seeking support to develop their financing systems to move more quickly towards universal coverage. Key global public goods produced by WHO include standardized tools and guidelines, for example, for costing, cost-effectiveness analysis and national health accounts. In addition, WHO provides information to countries and works with them to improve their own data collection and to incorporate it into policy development, including analysis of health expenditures and catastrophic spending. Emerging issues relate to using debt relief and medium-term expenditure frameworks to raise more funds for health, and the need to collaborate with priority health programmes, many of which are seeking to develop sustainable financing plans for their particular country-level activities.

Priorities

- **Health financing policy option**
Assess and disseminate information about what works and what does not work in health financing strategies; facilitating the sharing of country experience in various types of health financing reforms; sharing of key information required by country policy makers; and the development of tools, norms and standards including those required to assist countries to generate and use information in their own settings.
- **Improve or develop pre-payment, risk pooling**
and other mechanisms to reduce the extent of financial catastrophe and impoverishment due to out-of-pocket payments, and to extend financial and social protection.
- **Ensure adequate funding from domestic sources**
In some countries, the ministry of health has the potential to attract a higher share of government funding. In others, the health sector can become engaged in debates about fiscal policies that directly affect health (e.g. taxes on products that are harmful to health), as well as by ensuring that health activities are included in poverty reduction strategy papers and medium-term expenditure frameworks. Funding might also be increased through financial arrangements between the government and non-government sectors. Various mixes of tax funding with social, community and private health insurance, provide the alternative institutional frameworks for such arrangements. WHO will support countries to make the case for health funding, as well as to develop new sources of finance.
- **Used funds**
Ensure available funds are used equitably and efficiently, by appropriate provider payment mechanisms, aligning financing and service delivery incentives; addressing fragmented financing systems; appropriate use of tools, such as contracting, to achieve appropriate balance between activities, programmes, inputs, capital versus recurrent expenditures, and ensuring protection of vulnerable population groups.
- **Promote international dialogue**
to increase funding for health in poor countries from domestic and external sources, ensure the predictability of funding, and ensure that new external sources contribute to the development of sustainable domestic financial institutions.
- **Increase availability of key information**
for use by country policy makers in areas such as how much is spent on health, by whom, whether it results in financial catastrophe and who benefits. This also requires information on the costs of scaling-up interventions and the impact on population health of doing so, as well as the costs and impact of reducing system constraints to scaling-up.

EXTENDING SOCIAL AND FINANCIAL PROTECTION IN COLOMBIA

Colombia's national health insurance scheme was part of a package of health reforms introduced nation-wide in 1993, with the aim of improving service access, efficiency and quality. Two insurance schemes were created that targeted different populations. First, a compulsory contributory regime that included all formal sector employees and independent workers able to pay, plus their families. This was largely financed from payroll taxes. Second, a subsidised regime targeted the poor by subsidising their insurance premiums using dedicated public resources and cross subsidies from the 'contributory regime'. The benefit package for the subsidized regime was initially limited to essential clinical services, a few surgeries plus the treatment of catastrophic diseases, but gradually made more generous as more resources became available. By 2004, the subsidized regime benefit package covered a wider

range of inpatient care, but was still smaller than that of the contributory regime.

The subsidized regime played a key role in increasing coverage for the poor and people living in rural areas. Insurance coverage rose from 3% to 57% for the poorest quintile between 1995 and 2005. In rural areas insurance coverage increased from 6% to 46%. Total impoverishment due to health spending (using Florez and Hernandez's comprehensive definition) declined from 18% to 8% over six years between 1997 and 2003. Access to and use of health services increased in rural areas over 15 years up to 2000: for example, there was a 49% increase in pre-natal care, and a 66% increase in assisted deliveries.

Sources (see Annex 2, References): Florez and Hernandez, 2005; Pinto D and Hsiao W, 2007.

6. LEADERSHIP AND GOVERNANCE

The leadership and governance of health systems, also called *stewardship*, is arguably the most complex but critical building block of any health system. It is about the role of the government in health and its relation to other actors whose activities impact on health. This involves overseeing and guiding the whole health system, private as well as public, in order to protect the public interest. It requires both political and technical action, because it involves reconciling competing demands for limited resources, in changing circumstances, for example, with rising expectations, more pluralistic societies, decentralization or a growing private sector. There is increased attention to corruption, and calls for a more human rights based approach to health. There is no blueprint for effective health leadership and governance. While ultimately it is the responsibility of government, this does not mean all leadership and governance functions have to be carried out by central Ministries of Health. Experience suggests that there are some key functions common to all health systems, irrespective of how these are organized.

LEADERSHIP AND GOVERNANCE

- Policy guidance. Formulating sector strategies and also specific technical policies; defining goals, directions and spending priorities across services; identifying the roles of public, private and voluntary actors and the role of civil society.
- Intelligence and oversight. Ensuring generation, analysis and use of intelligence on trends and differentials in inputs, service access, coverage, safety; on responsiveness, financial protection and health outcomes, especially for vulnerable groups; on the effects of policies and reforms; on the political environment and opportunities for action; and on policy options.
- Collaboration and coalition building. Across sectors in government and with actors outside government, including civil society, to influence action on key determinants of health and access to health services; to generate support for public policies, and to keep the different parts connected - so called 'joined up government'.
- Regulation. Designing regulations and incentives and ensuring they are fairly enforced.
- System design. Ensuring a fit between strategy and structure and reducing duplication and fragmentation.
- Accountability. Ensuring all health system actors are held publicly accountable. Transparency is required to achieve real accountability.

LEADERSHIP AND GOVERNANCE

An increasing range of instruments and institutions exist to carry out the range of functions required for effective leadership and governance. Instruments include sector policies and medium-term expenditure frameworks; standardised benefit packages; resource allocation formulae; performance-based contracts; Patient's Charters; explicit government commitments to non-discrimination and public participation; public fee schedules. Institutions involved may include other ministries, Parliaments and their committees, other levels of government, independent statutory bodies such as professional councils, inspectorates and audit commissions, NGO 'watch dogs' and a free media.

WHO's tendency at present is to focus on the development of specific technical health policies. This is important, but the added challenge for governments is to provide vision and direction for the whole health system, and oversee implementation of agreed health policies through systems that are faced with critical governance and stewardship challenges. These include: reconciling competing demands for resources; working across government to promote health outcomes; managing growing private sector provision; tackling corruption, responding to decentralization; engaging with an increasingly vocal civil society, and a growing array of international health agencies. This is an area in which WHO needs to enhance its capacity to support ministries of health.

Priorities

All governments are faced with the challenge of defining their role in health in relation to other actors. For many this is changing, for example, with decentralization. Any approach to leadership and governance must clearly be contingent on national circumstances. WHO will help governments as follows:

- **Develop health sector policies and frameworks**
that fit with broader national development policies and resource frameworks, and are underpinned by commitments to human rights, equity and gender equality. As part of this, it will promote international debate on the central but changing role of governments in health.
- **Regulatory framework**
Design, implement and monitor health related laws, regulations and standards, especially in the areas of International Health Regulations; regulation of medical products and technologies; regulation concerning occupational health and workplace safety. WHO will also engage in trade debates in areas affecting health systems.
- **Accountability**
Support greater accountability through the Organization's work on monitoring health system performance as set out in the building block on information.
- **Generate and interpret intelligence**
and research on policy options⁶. At the international level, it will facilitate access to knowledge on approaches to policy and systems development: by promoting a more systematic health systems research agenda; through the Alliance on Health Policy and Systems Research; by building capacity in regional observatories or their equivalent; and by increasing access to and use of new knowledge management technologies. It will work to strengthen national capacity in health policy analysis and links to policy decision-making.
- **Build coalitions**
across government ministries, with the private sector and with communities: to act on key determinants of health; to protect workers' health; to ensure the health needs of the most vulnerable are properly addressed; to anticipate and address the health impact of public and commercial investments.
- **Work with external partners**
to promote greater harmonization and alignment with national health policies.

6 Research for Health: a Position Paper on WHO's Roles and Responsibilities in Health Research. WHO 2006.

OECD-WHO REVIEW OF THE SWISS HEALTH SYSTEM

At the request of the Swiss Federal Office of Public Health, WHO and Organisation for Economic Co-operation and Development (OECD) jointly undertook an independent review of the Swiss health care system in 2005-6. The review assessed institutional arrangements and the performance of the health system against key policy goals of effectiveness and quality, access

and responsiveness, efficiency and financial sustainability. It discussed factors affecting performance, future system challenges, and potential areas for reform. Findings were discussed at a national seminar of Swiss health experts from the public and private sector.

STRENGTHENING INSTITUTIONAL CAPACITY FOR POLICY ANALYSIS IN KYRGYZSTAN

The WHO Health Policy Analysis Project was launched in Kyrgyzstan in 2000. It was designed to support the government's Manas Health Care Reform Programme, whose goal was to improve the sustainability, efficiency and quality of the Kyrgyz health system. The project had four types of activities: policy analysis; linking evidence to policy; capacity building for policy analysis and evidence based policy design; and dissemination of results.

Capacity building in monitoring and evaluation of health system performance, and in policy analysis more broadly, has been carried out in four ways. There were frequent interactions with senior policy makers to present findings and implications of studies, to demonstrate their political usefulness and stimulate demand. Round table discussions on key health policy topics were a way to inject technical input and build political consensus. The Ministry of Health (MOH) health management courses targeted at managers of primary

care and inpatient facilities were a crucial way to inform and engage health care managers in health policy issues. The health policy courses for Central Asia and Caucasus in collaboration with the World Bank Institute and WHO European Region allowed cross-country learning for a large number of Kyrgyz policy makers. Lastly, a group of young health policy analysts have been mentored through the six years to become independent researchers providing continuous support to the MOH.

These core activities have now been institutionalised through the creation of a Department of Strategic Planning and Reform Implementation within the MOH, which has taken on core health system performance monitoring, and a Centre for Health System Development, which is an autonomous public entity created by the MOH to support policy development and implementation through knowledge generation and training. Support to these two young institutions will continue until at least 2010.

Source: Box prepared by WHO/EURO, 2007, based on the Manas Health Care Reform Programme.

B. HEALTH SYSTEMS AND PROGRAMMES: GETTING RESULTS

WHO's involvement in all aspects of health and health systems constitutes a real comparative advantage. It is better placed than many other international agencies to identify competing demands across health priorities, and to understand how efforts to strengthen health systems affect services on the ground.

There is a growing body of experience with cross-departmental relationships that bring together 'programme' and 'system' expertise. Much existing collaboration focuses on 'normative' issues, such as costing of programme scale-up, estimates of disease burden or the dense network of relationships between those concerned with pharmaceutical policy and technical departments with a stake in essential drug lists, pre-qualification of manufacturers and treatment guidelines.

Collaboration on more operational aspects of health systems strengthening is less common. Many technical departments operate their own country support networks through which they provide independent advice on service delivery and systems issues. Sometimes, awareness of parallel efforts is lacking. This is beginning to change. Examples include the TTR initiative linking systems work on health service staffing with improving access to HIV/AIDS care and treatment; the Taskforce on TB control and health system strengthening; joint work on HIV/AIDS and TB scale-up in the Baltic countries, and work across WHO stimulated by the opening of the GAVI Health System Strengthening window.

Nevertheless it is clear that, in too many instances, WHO's support remains fragmented between advice focusing on particular health conditions (which may not always take account of systems or delivery issues) and advice on particular aspects of health systems provided in isolation. While there are good examples of how both streams can work together, the challenge is to develop a more systematic and sustained approach that responds better to the needs of Member States.

Improve and extend existing interactions

Learning from TTR, GAVI, etc., WHO will establish more systematic ways to work together to ensure priority programme policies and delivery strategies are designed in ways that can take account of a country's overall health system organization and resources that can identify whether appropriate solutions to barriers to care lie in or outside programme control, and that ensure gains in coverage do not occur at the expense of other health priorities. Much of this work has to happen at country level. However, there is room for more interaction at other levels of WHO. In this regard, there is interesting work as part of the new Stop TB Strategy. Guiding principles are being developed for national TB programmes and partners, to contribute to health system strengthening without losing gains made in TB control (known as the 'do's, don'ts and non-negotiables'). Work will also involve exploring how to build on packages of care such as the Integrated Management of Childhood Illness.

More pro-active engagement is needed across Strategic Objectives on approaches to service delivery (for example, to ensure continuing personal care for diabetes and HIV; service delivery in emergencies, or the delivery of non-personal services). These will help identify and exploit common systems requirements across interventions, and promote joint learning. Box 9 reflects emerging thinking in WHO Western Pacific Region on potential synergies in continuing care.

More active engagement is also needed in the area of health systems with global health partnerships concerned with HIV, TB, malaria and maternal, neonatal and child health.

Create better and more systematic communication

A pragmatic view of the basic relationship between systems and programmes is that outcome-oriented programmes / in WHO and in countries / will continue to exert a certain dominance because of their capacity to attract resources. This means that health system specialists have to be prepared to be responsive and act in advisory mode. They must also be opportunistic, and use

A 'DIAGONAL' APPROACH TO HEALTH SYSTEM STRENGTHENING

- Taking the desired health outcomes as the starting point for identifying health systems constraints that «stop» effective scaling up of services;
 - Addressing health systems bottlenecks in such a way that specific health outcomes are met while system-wide effects are achieved and other programmes also benefit;
 - Addressing primarily health systems policy and capacity issues;
 - Encouraging the development of national health sector strategies and plans, and reducing investment in isolated plans for specific aspects of health systems;
 - Robust monitoring and evaluation frameworks.
-

programme requests such as costing as entry points to identify issues such as financing policy that cannot be adequately addressed on a programme by programme basis. WHO needs a strong group of staff and consultants able to adapt the analytic approach to health systems for country support. Altogether, better communication is needed to think systematically about health system processes, constraints and what to do about them.

Achieve greater consistency, quality and efficiency

We must ensure greater consistency, quality and efficiency in the production of methods, tools and data reporting across WHO, building on current work in areas such as programme costing or the reporting of health statistics. This is covered further in the specific building blocks.

Other actions are listed here, and discussed further in the last section. For example, improved health system awareness among all WHO staff – in other words, a basic familiarity with health system issues – needs to be combined with improved 'outcome literacy' among systems staff, plus the establishment of a professional network for health systems staff in all parts of WHO. Better relationships also require careful thought about incentives, and top-level managerial support.

SELECTED SYSTEM CONSTRAINTS AND POSSIBLE DISEASE-SPECIFIC AND HEALTH-SYSTEM RESPONSES

Constraint	Possible disease-specific response	Possible health system response
Financial access difficult e.g inability to pay, informal fees	Payment exemptions for an individual, for a specific disease	Pooling pre-paid funds (from households, external agencies, companies) in ways that allow risks to be shared, and decrease individual payments when sick
Physical access difficult e.g. distance to facility	Out-reach for specific diseases; engage private providers	Revising plans for the location, construction or upgrading of health facilities
Knowledge and skills low (public and private providers)	Workshops and other continuing education for specific diseases	Revised pre-service training curricula; systems for licensing, accreditation, supervision
Staff are poorly motivated	Staff get financial incentives to deliver specific services	Clear job descriptions; performance and salary review; fair, transparent promotion procedures
Weak leadership and management	Workshops to develop skills in managing staff, budgets etc. (e.g. in public and NGO facilities)	Additional actions such as giving managers more control over resources; more accountability for results
Ineffective intersectoral action and partnership	Disease-specific cross-sectoral committees, usually national level	Building local government systems with cross-sector representation, and explicit procedures for public accountability

Source (see Annex 2, References): Adapted from Travis et al, 2004.

C. A MORE EFFECTIVE ROLE FOR WHO AT COUNTRY LEVEL

Countries at different levels of development look to engage with WHO as they seek to improve their health systems. Some countries are primarily interested in exchanging ideas and experiences in key aspects of policy (such as health worker migration), in getting wider international exposure for important domestic agendas (such as patient safety or the health of indigenous populations), or in the development of norms and standards for measuring performance. All countries look to WHO for comparative experience in relation to different aspects of reform in areas such as health financing, and for WHO's convening role where action may be needed across countries.

However, it is countries at a lower level of income – as evidenced increasingly in WHO CCS – that seek more direct involvement in overall policy and health systems development, often in conjunction with other partners such as the World Bank. This area, above others, requires improvement. In states recovering from emergencies or emerging from conflict, WHO may also be called on to act as the coordinator of the many organizations concerned with health work; to ensure that health remains central to the security and humanitarian agenda and to advise on reconstruction of the health system as a whole.

Improved capacity to diagnose and act on health system constraints

There are many different entry points to the analysis of health system weaknesses and barriers to improving service delivery. The purposes, depth and quality of analyses may vary widely. Some are done as part of broad sector review processes by Ministries and partners. Some are done as part of an external agency's individual strategy development⁷. Some are done for specific programmes or for specific aspects of the health system such as the health workforce. Programme-specific diagnostic tools are being developed by many agencies. Consultations suggest that WHO needs to improve capacity to diagnose and act on health system constraints.

- WHO will support the use of consistent approaches to identifying health system constraints, that incorporate a system-wide perspective, but are sufficiently flexible to be used by programme and systems groups with different entry points. These approaches need to be able to inform major planning exercises, medium-term expenditure frameworks, the health components of poverty reduction strategies, etc. WHO will work to ensure that core technical frameworks inform the assessment of health system challenges and priorities.
- To reduce duplication, WHO will undertake diagnostic exercises preferably through MOH-led reviews and, where appropriate, jointly with other development partners. It may also undertake independent reviews if requested.

More intensive engagement in sector policy processes and investment strategies

Helping a country decide on the best ways to invest in order to strengthen health systems requires two interconnected responses: having an over-arching vision and strategy for the health sector, and the development of more detailed policies and investment plans in specific technical areas.

As stated in the building block on leadership and governance, WHO's work at country level will be significantly enhanced if it engages more effectively with partners in overall policy processes. Many of WHO's senior interlocutors at country level (ministers, permanent secretaries, directors-general) seek support in assessing overall sectoral needs or on how to deal with varying advice on policy issues from different partners. This function – “helping to sort the wood from the trees” and putting technical advice in a political context – is an area of potentially great comparative advantage and influence.

In specific policy areas, demand from countries for WHO advice nearly always exceeds supply. For example, in health financing – one of the most common areas in which advice is sought

⁷ For example, the WHO CCS process provides some information on constraints but is not designed to do this in sufficient detail for national policy purposes.

– WHO has well-recognized strengths in costing, in national health accounts and in analysing financial catastrophe and impoverishment. It is less well equipped at present to support countries on domestic financing policy. The same is true in other specific areas.

WHO will increase its engagement in high level policy dialogue. It will:

- support the development of evidence-based health sector strategies and costed plans linked to the macro-economic framework. This will entail more active and consistent engagement in key policy events by all levels of the Organization;
- increase its capacity for policy advice in specific aspects of systems, such as health workforce strategies and investment plans, health financing policies, etc.;
- work with development partners, GHPs and funding agencies to improve harmonization and alignment with national health policies and systems, through harmonization plans, mutual accountability Memoranda of Understanding, institutional performance contracts, etc.
- assist governments in the implementation of International Health Regulations, international agreements on trade, human rights and gender, by identifying their implications for the national health system.

Build national capacity, especially in policy analysis and management

WHO will focus on building national capacity in health policy analysis and management, recognizing that the Organization itself needs greater capacity in these areas. Policy analysis involves analysing problems from several standpoints: the problem, and who is affected; possible solutions; and the political and institutional feasibility as well as technical desirability of implementing any of them. Management is about managing services, resources and partners. Aid management is a particularly important and difficult task in many poorer countries. It is about tracking aid flows and managing external partners - and the funds and technical assistance they provide - in ways that maximise their contribution to national strategies with minimum transaction costs.

WHO's focus will be on the development of *institutional* not just *individual* capacity. Actions will include:

- catalysing structured discussions by different stakeholders on key policy concerns, and making independent appraisals of experience with use of different tools for policy analysis and management available;
- sustained technical support to dedicated policy 'think-tanks' or 'observatories', to identify problems of national concern, gather intelligence, and generate policy options for debate. This includes promoting different forms of informal and formal 'experience-exchange' in managing specific policy challenges across countries.
- support national approaches to develop managerial capacity, through networks of resource institutions, a greater WHO role in harmonizing development partners support to management strengthening and linking activities to national instruments such as poverty reduction strategy papers. This includes helping managers tackle difficult management issues such as workforce productivity and performance, budgeting and procurement, and taking advantage of vehicles such as the Global Health Workforce Alliance and GAVI HSS.
- supporting national mechanisms for tracking aid flows and managing partners. In exceptional circumstances, such as countries emerging from conflict or health emergencies, it may involve temporarily taking on the role of co-ordinator of external health aid organizations.

Support countries' monitoring of trends in health systems and performance

The generation and use of information is at the heart of WHO's mandate. A major part of its work must be to support health ministries to track trends in their health systems' performance, in ways that are geared primarily to national decision-making, but also to enable them to make comparisons with, and learn from, other countries. For greatest positive effect, this requires

consistent approaches shared and supported by all levels of WHO. And it requires engagement with other international players, especially the Health Metrics Network. Priorities, below, here link with those in the information building block..

- Effective communication of internationally agreed concepts, language and metrics on health systems.
- Improved country data collection systems that capture health system inputs, services and outcomes, using validated tools, at national and sub-national level.
- Greater joint monitoring by external agencies, using nationally led processes and systems.

CAPACITY BUILDING: WHAT IS KNOWN ABOUT GOOD PRACTICE?

Capacity building in practical terms involves ensuring that a combination of the **tools, skills, staff and support systems** required for chosen functions are available and operational. There is no blueprint on how to build capacities in policy and strategy development, but there are some clear lessons from past efforts. The demand for tools for policy analysis is longstanding, with expectations of what they can achieve often exceeding experience on the ground. Available tools vary widely in purpose and scope; more are focused on assessing specific system components than on assisting political analysis. Key tools for aid management are credible policies and

costed plans. One important way of building skills in, for example, analysing how different interest groups are positioned, or brokering agreements between them, is through on-the-job practice coupled with exchanges of experience between individuals and institutions. Another lesson is that tools and skills alone are not enough to improve performance: attention to improving any required support systems (such as for tracking aid flows) may be needed. Lastly, attention to creating demand for staff with these capabilities may be needed, and a long-term view for any support provided is essential.

D. THE ROLE OF WHO IN THE INTERNATIONAL HEALTH SYSTEMS AGENDA

WHO's international work complements and supports its more direct engagement in countries, through the production of global public goods such as norms, standards, policies and guidance. In addition, WHO's international work has a value in its own right, through increasing the effectiveness of international systems such as the surveillance and response network, or through shaping international health aid architecture.

Produce global public goods: norms, standards, policies and guidance

WHO needs to respond to the consistent demand from countries and development partners for a common language to describe the components of health systems and the actions needed to make them function more effectively. Although there is progress, more remains to be done to simplify and communicate health systems terminology to a wider variety of audiences. The development of standardized methods and tools, such as for national health accounts in low and middle-income countries, will also continue to be core business of WHO.

There is a need for a more systematic approaches to research and learning. Evidence on effective strategies for health systems strengthening is scarcest where need is greatest.

Each reform and innovation constitutes a learning opportunity⁸. The question is how we best learn about what works and why. Broader social, political and institutional factors need to be taken into account as we amass evidence either from one-off case studies or in the ongoing work of emerging health systems observatories. Knowledge Networks of the Commission for Social Determinants on Health are amassing evidence on critical determinants and effective ways of influencing country policy and practice.

The 2008 World health report will draw on three decades of experience with PHC principles and practices and show how these may inform pathways to improve health in the 21st Century. Health systems will be prominent in the new health research agenda being prepared by WHO⁹. The Alliance for Health Policy and Systems Research has a new ten-year strategy that focuses on stimulating the generation, synthesis and use of policy relevant health systems knowledge. WHO will also support approaches to more informal learning and sharing tacit knowledge, taking advantage of progress in information technology, and leveraging e-health networks within and between countries.

To make the case that health systems strengthening merits greater investment, a key priority is to agree on a set of measurements that can capture the status of a health system and demonstrate whether its performance is improving (see box 13). The purpose of such health system metrics is twofold: for comparing systems one to another, but more importantly to enable decision makers and investors to track progress of their own health system over time and take action as needed.

It is also important to forecast trends and look ahead and consider the implications for health systems and health equity of aging populations, developments in medical therapies, information technologies, etc., and at how these changes will affect the interaction between health systems and human health security. An important part of WHO's global stewardship function is to generate awareness and informed debate on future policy challenges and options.

Coherent international systems for better health

A core function of WHO is to use its convening power effectively to work with global and regional systems for better health. Of growing importance in strengthening country support are the networks of regional institutions of which WHO is an integral part. In Africa, for example, WHO will work towards ensuring consistent health systems messages from the New Partnership for

8 Frenk J, Bridging the divide: global lessons from evidence-based health policy in Mexico. *Lancet*, 2006.

9 Research for Health: a Position Paper on WHO's Roles and Responsibilities in Health Research. WHO 2006.

Africa's Development (NEPAD) and the African Union (AU), the Regional Economic Commissions, and the newly reorganized African Development Bank.

There is also an important relationship between how aid for health is organized and how health systems develop. The principles agreed by countries and development partners at the High Level Forum on Aid Effectiveness in Paris (to which WHO was a signatory) aim for greater *ownership* by government, *alignment* with national priorities, and *harmonization* between development partners. Greater *predictability* in aid finance makes it more likely that finance ministries will budget for the long term recurrent costs that all functioning health systems need. WHO will continue to work with the OECD Development Assistance Committee and others to increase development partner accountability in health, focusing on ways in which applying the Paris Principles support health systems development.

WHO is also reviewing the way it works with GHPs, such as Stop TB and Roll Back Malaria, in order to bring the Paris 'best practice' Principles to bear, recognizing the importance of GHPs for strengthening health systems as well as accelerating achievement of health outcomes.

The development of systems for a more secure world includes, but is not limited to, systems for epidemic outbreak surveillance and response such as the Global Outbreak And Response Network (GOARN). It includes systems for predicting and preventing exposure to environmental health hazards. In addition, health systems contribute to human security, as poor health and the lack of health services can trigger instability (conversely, in many conflicts health facilities and health workers become the target of warring parties). A robust health system is a vital part of any governments' response, to avoid a vicious cycle of deteriorating health leading to deteriorating security. WHO's role in health security is addressed in the World health report 2007.

Work with partners

Given its critical role for health systems development, strengthened coordination with the World Bank is a priority. WHO will aim to leverage the capacity of other development banks and bilateral agencies to pursue health outcomes through investments in other sectors. WHO will also work with the Bretton Woods Institutions and finance ministries to ensure health is properly reflected in national development planning and expenditure frameworks.

The major health financing partnerships have recognized the need to engage in health systems strengthening and are doing so in different ways. The Global Fund currently requires systems strengthening activities to be built into disease specific proposals. GAVI has earmarked funds for a new health systems strengthening window. WHO is committed to working with GAVI and partners to operationalize the those opportunities in a way that will provide predictable financing for health systems development.

WHO will draw on the strengths of international NGOs with an interest in health systems. Two groups are of particular concern. First, the growing number of management consultancies responding to demands for technical support. WHO will seek to engage them to ensure consistency of approaches. Where appropriate, WHO can play a role in creating technical support networks and ensuring their quality through accreditation of individuals or institutions. A second emerging group is the international lobby for health systems development. Previously the province of a few international NGOs, a new Health Systems Action Network (HSAN) has been formed. Activist members are beginning to ensure that health systems messages are heard in major developmental fora. Their demand for clarity in messaging, costing and impact is something to which WHO will respond.

International agreements between governments impact on health systems. Prominent among these are interactions – both bilateral and through the World Trade Organization – that have influenced the price of and access to pharmaceuticals. Public health is an area in which innovation and Intellectual Property Rights will play an increasingly prominent role¹⁰. Other trade agreements

10 Public Health Innovation and Intellectual Property Rights. Report of the Commission on Intellectual Property Rights, Innovation and Public Health. World Health Organization, 2006.

likely to influence health systems, such as the General Agreement Trade in Services (GATS), have received less attention. Their potential impact, through liberalization of insurance markets and granting access to foreign private providers of health care, may be significant in many countries. International agreements will also influence the management of migration both of health workers and those seeking care. How these issues are handled between countries will have a lasting impact on health sector effectiveness.

Over the last three years, partly stimulated by having a UN Special Rapporteur of the Commission on Human Rights on the right to health, there has been increasing interest in how a focus on the realization of this right can be used to focus on the need for investment in health workers and health systems.

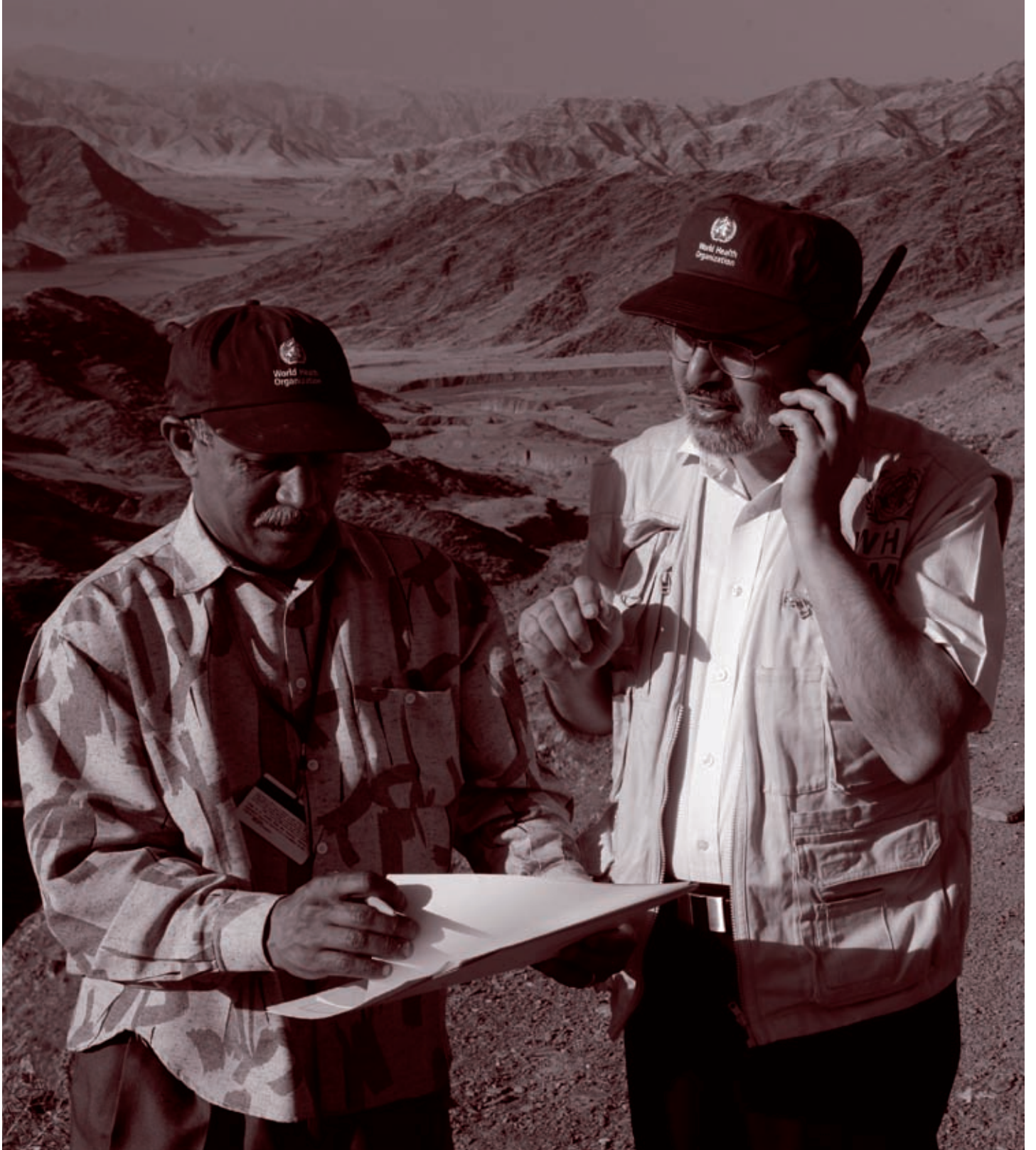
WHO will work to influence international agreements that impact on health and health systems. It will help in making linkages across governments (for instance between ministries of trade and health); and it will help ministries of health anticipate and act on changes that will come about as a result of international agreements.

GAVI AND HEALTH SYSTEM STRENGTHENING (GAVI-HSS)

Since the GAVI Board decision in December 2005 to earmark US\$500 million for health system strengthening (HSS), the GAVI-HSS window has developed rapidly. Applications for funds are expected to address health system barriers known to impede the demand for and delivery of immunization and other child and maternal health services. Three priority areas are identified,

focusing on the district level and below: health workforce mobilization, distribution and motivation; organization and management of health services; supply, distribution and maintenance systems for drugs, equipment and infrastructure. Three proposal rounds have now been completed, with a total of US\$266 million approved.





IMPLICATIONS FOR THE WAY WHO WORKS

HEALTH SYSTEM STRENGTHENING: WHO'S FRAMEWORK FOR ACTION

- **A single framework with six clearly defined building blocks**
- **Systems and programmes: getting results**
- **A more effective role on systems for WHO at country level**
- **The role of WHO in the international health systems agenda**

“Everybody’s Business” is a framework that signals directions and priorities in the health systems agenda for the whole of WHO, so that it can provide more effective support, directly and indirectly, to Member States. It is not a detailed implementation plan. Indeed an implementation plan in the conventional sense would not be appropriate, given that it has Organization-wide implications.

The Framework can be used in a number of ways, for example, as the basis for dialogue with partners, to inform internal staff development and learning, or as an input into operational planning at all levels. More detailed guidance on the ways in which it can be used will be ready by end 2007.

The Framework’s success will depend on how well WHO uses its institutional assets and instruments. Its translation into action will involve a wide range of WHO structures and processes, to ensure that planning, management, staff skill mix, etc. are geared to achieving the outcomes that are set out here.

This section outlines some of the implications of the Framework for Action for the way WHO works. It signals where innovation is already occurring, and where further, more detailed work is planned in the coming months to make the Framework operational. It focuses on three key areas.

New ways of working across the Organization

The previous section argued for the need to bridge the gap between programmes and systems departments, and the need for a more coherent approach to country support involving all levels of WHO. There are several ways of doing this. The first involves working within existing arrangements.

- Improved communication on what is meant by health system strengthening, better documentation of actual experience, convincing metrics for tracking improvements in health systems and clear deliverables will create greater confidence that health systems strengthening involves clear strategies, specific actions and gets results.
- Developing acceptable criteria for prioritizing country support: to strike the elusive ‘right balance’ between responding to demands from a large number of countries and ensuring impact through focusing on a few.
- Building on opportunities for collaboration, and ensuring a prompt response. There are already a number of examples. The cluster of Family and Child Health is involved in two major, well-resourced initiatives (GAVI and the Oslo Initiative to achieve MDGs 4 and 5).

These have recognized health systems constraints as major obstacles to scaling-up, and are prepared to commit significant funds to overcome them. By engaging early on, with several departments working together, WHO has been able to shape the new policies and funding windows these initiatives are developing. The volume of funds disbursed to countries for HIV/AIDS means that here, too, there are real opportunities to strengthen health systems, and collaboration needs to be intensified.

- Reappraisal of the use of expert guidance and external scrutiny, and experience with instruments such as expert advisory committees.

The second route involves organizational changes to create stronger incentives for joint work. Here, there are some interesting regional developments. WHO European Region has introduced significant changes to its country support planning and budgeting system, to make it more responsive to country needs. WHO African Region is introducing sub-regional offices, to bring technical support closer to the country level. WHO will review the organization-wide relevance of structural changes already happening in some regional offices.

Enhancing staff competencies and capacity

More analysis of WHO's health system workforce is needed but even without it, WHO will review how to do better with existing staff.

- **Strengthen capacity in health sector policy and strategy development**
As mentioned previously, much of the responsibility for sector policy dialogue with senior policy makers falls to WHO Representatives and Liaison Officers. The challenge is to ensure that they have adequate back-up support and advice from regional offices and headquarters, and to consider where such a function should be located and how it should be resourced. It also requires a more responsive approach to country requests for support (e.g. participation in joint health system reviews). This has implications for how WHO plans, as it runs counter to the current system of advance planning.
WHO will increase its capacity and skill base so that it has more staff equipped to respond to senior policy makers. Building on existing activities of WHO regional offices, and the WHO Learning Committee (including the Core Functions workshop), it will define the competencies required more precisely, decide what form of staff development is necessary and consider how staff with these capabilities can fit into WHO's strategic objective/departmental structure.
- **Develop a professional network of staff working on health systems**
The key change in recent years is that there are rising numbers of health system professionals in technical programmes.
WHO will work to build up a network of health system professionals across the Organization, to improve communication and share experience on health systems issues. The network will not replace independent work on specific issues. It will foster informal and more formal interactions, based on a review of existing staff, their level, distribution and skill-mix. Activities could include seminar series, cross-cluster groups or facilitated electronic debates on key topics, and possibly some form of health systems 'help desk'. It will build on past and current experience, such as the informal cross-cluster group on non-state providers that has been established.
- **Make a better match between supply and demand in specific areas.**
WHO is looking at ways to better respond to requests for specific policy advice. To expand its response capability, it will investigate the potential of WHO accredited support networks.

Strengthen WHO's convening role, and role in health system partnerships

- Maintain its convening role**
 WHO has immense convening power. A key role for WHO is to detect and raise visibility for neglected or critical health systems issues that affect many countries, or those which require a trans-national response. WHO will continue to do this through informal meetings or through expert committees.
- Address opportunities and challenges of health system partnerships**
 The various emerging partnerships referred in previous sections are giving prominence to a wide range of health systems issues that might not have been possible in other ways. WHO will work to leverage the benefits that these partnerships offer to countries and international partners. It will clearly define its roles on a case-by-case basis and negotiate ways for partnerships to support WHO in its core functions.
- Work with UN partners**
 As part of the UN family, WHO will be active in promoting a more coherent UN presence at country level. Working as part of the UN country team, WHO will seek to ensure a clear division of responsibilities among UN partners in responding to national needs for health systems support.

Next steps

The Framework for Action will be judged by the extent to which it is made operational. Based on the outline provided above, over the next months it will be complemented by additional documents to elaborate how this will be done.

Like all such documents, this Framework for Action is introduced into a complex and continually changing world. It should, therefore, be regarded as a 'living document' that sets direction but makes course corrections as needed.

In terms of judging results, this is a corporate Framework for Action. The Medium-term Strategic Plan defines specific results for WHO activities in health systems development and will be the main instrument used for tracking progress.

MATCHING SERVICES TO NEEDS: A NEW APPROACH TO COUNTRY SUPPORT

Work at country level throughout the European Region is characterized in terms of its influence on, or contribution to, four basic health systems functions. The Bi-ennial Collaborative Agreements between EURO and individual Member States contain the joint priorities for co-operation by the Ministry of Health and WHO. For each priority (or Strategic Objective), they identify expected

results, the products under each expected result and set out how the budget is allocated. Each product – regardless of which technical unit is responsible – is categorized according to one or more health system functions: health policy and stewardship; health system financing; health system resource generation; health service delivery.

 ANNEX 1

WHO Core Functions as defined in the 11th General Programme of Work

- **Providing leadership; engaging in partnerships where joint action is needed**
- **Stimulating knowledge generation, translation and dissemination**
- **Setting norms and standards**
- **Articulating ethical and evidence-based policy options**
- **Providing technical support; catalysing change; building sustainable institutional capacity**
- **Monitoring and assessment of trends**

WHO's Medium-term Strategic Objectives

- S01 To reduce the health, social and economic burden of communicable diseases
- S02 To combat HIV/AIDS, tuberculosis and malaria
- S03 To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries
- S04 To reduce morbidity and mortality and improve health during key stages of life, including pregnancy; childbirth; neonatal period; childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals
- S05 To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact
- S06 To promote health and development, and prevent or reduce risk factors for health conditions associated with tobacco, alcohol, drugs and other psychoactive substance use, unhealthy diets, physical activity and unsafe sex
- S07 To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive and human-rights based approaches
- S08 To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health
- S09 To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development
- S010 To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research
- S011 To ensure improved access, quality and use of medical products and technologies
- S012 To provide leadership, strengthen governance and foster partnership and collaboration in engagement with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the 11th General Programme of Work
- S013 To develop and sustain WHO as a flexible, learning Organization, enabling it to carry out its mandate more efficiently and effectively

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USEFUL WEBLINKS**Africa health workforce observatory:**

<http://www.afro.who.int/hrh-observatory>

European Observatory on health systems and policies

www.euro.who.int/observatory

Global Observatory for eHealth:

<http://www.who.int/goe>

Global atlas of the health workforce:

<http://www.who.int/globalatlas/default.asp>

The global health library:

<http://www.who.int/ghl>

GTZ-ILO-WHO Consortium on Social Health Protection in Developing Countries:

<http://www.socialhealthprotection.org/>

Health systems

www.who.int/healthsystems

Health Evidence Network:

<http://www.euro.who.int/HEN>

The health academy:

<http://www.who.int/healthacademy>

Health InterNetwork Access to Research Initiative:

<http://www.who.int/hinari>

Knowledge management for public health:

<http://www.who.int/km4ph>

Latin America and Caribbean Observatory of Human Resources:

<http://www.observatoriorh.org/eng/index.html>

Management for Health Services Delivery (MAKER):

<http://www.who.int/management/en>

Patient safety:

http://www.who.int/topics/patient_safety

Service Availability Mapping:

<http://www.who.int/healthinfo/systems/serviceavailabilitymapping/en>

WHO-CHOICE = CHOosing Interventions that are Cost-Effective:

<http://www.who.int/choice/en/>

WHO European Ministerial Conference on Health Systems 2008:

<http://www.euro.who.int/healthsystems2008>

World Health Statistics:

<http://www.who.int/healthinfo/statistics>

WHO Eastern Mediterranean Regional Health System Observatory:

<http://gis.emro.who.int/HealthSystemObservatory/Main/Forms/Main.aspx>

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