Unpacking Health System Strengthening

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Introduction

Health system strengthening (HSS) has recently been described as both “a new buzzword” and “a vague concept” (Marchal et al 2009). The purpose of this note is to help reduce this vagueness, at least by describing the range of meaning and content that various actors have drawn on when using this term. The intent is not to propose a single specific definition of health system strengthening as an activity – our sense is that the term doesn’t lend itself to a narrow operational definition. HSS is probably best “defined” in terms of a broad scope of activities. But describing that scope and encouraging HSS supporters to be more specific about their activities within that scope can help reduce the vagueness and provide a useful platform for partnership and collaboration.

The purpose of HSS bears frequent repetition. HSS is a means to improve national and local health system outcomes. However it is conceptualized, in practice the starting point is the countries’ situations and the purpose is to improve those situations in terms of better health system results. Clearer thinking is needed, but the usefulness of that thinking must be judged by whether it helps countries make their health systems better.

We begin with a brief review of how various global health agencies and initiatives (GHAIs) have used the term HSS and the value of “unpacking” this concept. The importance of a country perspective is highlighted. We then propose two dimensions along which actual HSS strategies and investments have been located. We conclude with some thoughts on how more clarity amongst agencies about where their activities are located along these dimensions could help develop mechanisms of collaboration and division of labor. Throughout this discussion we draw on the previous note on health systems prepared for this workshop.

What are global health initiatives saying about Health System Strengthening?

Most GHAIs accept as a starting point the broad World Health Organization (WHO) definition of a health system as “all organizations, people, and actions whose primary intent is to promote, restore, and maintain health” (WHO, 2000). As noted in the first paper for this workshop, WHO then proposed a descriptive framework of four components of health systems and later elaborated the notion of six health system “building blocks” (WHO, 2007a). The recent publication by WHO’s “Maximizing Positive Synergies Collaborative Group” (MPSCG) refers to “the WHO health systems framework” consisting of “service delivery; health workforce;
information; medical products, vaccines, and technologies; financing; and leadership and governance.” The paper notes that “these building blocks help to clarify the essential functions of health systems” and that “efforts to address health systems should recognize the interdependence of each part…” (WHO MPSCG, 2009)

The GAVI Alliance has proposed “Health system strengthening means improving critical components of health systems to effectively improve health outcomes.” (GAVI, 2008) GAVI then draws on the six building blocks to define these “critical components”: stewardship/governance/leadership; health financing; human resources; information and knowledge; technology and infrastructure; and service delivery. It supports HSS as a means to “achieve and sustain increased immunization coverage”. It cites a 2004 study which concludes that “health system issues beyond the immunization system alone constrained the majority of the developing partner countries trying to increase or maintain high immunization coverage” to explain the need for HSS to “go beyond immunization” and that HSS will also “improve access to other child and maternal health services.”

The Global Fund for AIDS, TB, and Malaria also cites the six building blocks as “basic functions” of health systems (GFATM, 2008), adding positive adjectives to their characterization – such as “good” health service delivery and health financing systems; “well-performing” health workforce; “well-functioning” health information system; “effective” leadership and governance – without defining what those terms mean specifically. It notes that “HSS refers to activities and initiatives that improve the underlying health systems of countries in any of the six areas…and/or manage interactions between them in ways that achieve more equitable and sustainable health services and health outcomes related to the three diseases.” The GFATM’s fact sheet notes that “health system weaknesses and gaps that impact achievement of improved HIV, tuberculosis, and malaria outcomes may be responded to through a disease specific program approach or a cross-disease approach that benefits more than one of the three diseases”, defining “cross-cutting health system constraints” for GFATM proposal purposes as those which are linked to the six building blocks and impact more than one of the three diseases.

The World Bank’s 2007 HNP Strategy cites “health system strengthening for improved HNP results” as one of its “comparative advantages” in the sector and one area in which it was not “tapping its full potential”. The HNP Strategy cites WHO’s earlier framework of four major health system functions. It notes that “governments and partners look to the Bank for systemic policy advice” on a wide range of questions and cites examples such as “how to ensure sustainable financing…; how to pay health service providers… how to strengthen the sector’s fiduciary and financial management systems; how to …ensure an intersectoral approach; how to design and implement health insurance; how to create the appropriate regulatory environment…; and how to reach the right balance between expanding “own” public health service infrastructure and contracting out with private providers. It identifies the following “functions and activities” for Bank focus, emphasizing the first five areas: health financing; fiduciary, logistical, and financial management arrangements of the system; system governance; positively influencing household demand for effective HNP interventions; stewardship (sector oversight); organization and management of providers; technical aspects of disease control; human resource training and creation of medical technologies and advances. It notes that HSS is “not an end in itself” and that “putting together the right chain of events” which improves results on the ground is the goal. The Bank also explicitly mentions both health and financial risk protection as key outcomes.
The World Bank Institute’s Flagship Program on Health Sector Reform and Sustainable Financing has disseminated a complementary view and has now been renamed the Flagship Program on Health System Strengthening. It relies on the health systems framework described in Roberts, et al (2003) Getting Health Reform Right: A Guide to Improving Performance and Equity (GHRR). This view also emphasizes HSS as a “means to an end” of better outcomes and equity, defined as health systems performance. It focuses on change strategies, bundled into five health system “control knobs”: financing, payment, organization, regulation, and behavior. It emphasizes the development of causal thinking about how HSS actions can bring about specific changes in performance and the importance of politics and implementation. Although the framework was not initially elaborated with any specific disease or health program in mind, its elements have been applied to specific interventions such as immunizations (Roberts and Jaganjac, 2004) and building blocks such as pharmaceuticals (Roberts and Reich, 2009).

While both GAVI and GFATM have been making grants through specific funding windows for HSS, the World Bank does not earmark funds with this classification. World Bank projects can be identified by the managing units as supporting “improving health system performance”, but the meaning of this term is different from the way HSS is defined by the other agencies.

WHO’s frameworks of health system functions (2000) and building blocks (2007a) have been used by other GHAI’s to frame their HSS activities. More recently WHO’s 2008 World Health Report, Primary Health Care: Now More Than Ever revived a commitment to that earlier initiative from 1978. Primary Health Care today emphasizes four sets of reforms: universal coverage reforms, service delivery reforms, public policy reforms, and leadership reforms. WHO proposes a set of PHC “core values” to guide health systems and health systems reforms.

The emerging agenda of Primary Health Care is being linked by WHO with HSS. In May 2009, at the 62nd World Health Assembly, a resolution on “Primary Health Care, Including Health System Strengthening” was passed. It speaks of “strengthening health systems based on the Primary Health Care approach”. While urging member states to commit to HSS based on this approach, the resolution also calls on the Director General to “prepare implementation plans for the four broad policy directions: (1) dealing with inequalities by moving towards universal coverage; (2) putting people at the centre of service delivery; (3) multisectoral action and health in all policies; (4) inclusive leadership and effective governors for health; to ensure that these plans span the work of the entire Organization…” Primary health care thus is appearing as another framework of objectives and mechanisms for HSS.

The Taskforce on Innovative International Financing for Health Systems (the Taskforce) issued its report in May 2009 with a focus on raising additional international funding for health systems strengthening (“more money for health”) but also improving the use of funding (“more health for the money”). The Taskforce defined health systems based on the Tallinn Charter (WHO Office for Europe, 2008), essentially along the lines of WHO, 2000 and 2007. Its report emphasizes “certain areas” requiring “targeted support to ensure essential capacities are in place for the health system to function properly, such as: public administration and accountability (or governance); financing; service delivery arrangements; and results-based financing. The taskforce also emphasized the importance of mobilizing the non-state sector across a range of
HSS areas. The report calls for a “health systems funding platform for the Global Fund, GAVI Alliance, the World Bank, and others to coordinate, mobilize, streamline, and channel the flow of existing and new international resources to support national health strategies” and for these three agencies to outline a joint mechanism for investment in health systems, with facilitation help from WHO. (Taskforce, 2009)

The Need for a Country-based Perspective

All of the references above have been to GHAI’s stated positions on HSS. But a critical perspective of central importance is that of the countries. Countries often accept and use the guidance of GHAI’s but also voice their own priorities and approaches.

A key point to keep in mind about health system strengthening is that it almost always means providing improvement to an existing health system – the national health system. As noted in others papers for this workshop, some health system frameworks have focused on describing the existing health system through how it carries out key functions (WHO, 2007a). Other efforts have emphasized assessing performance (WHO, 2000) and still others have highlight analysis of the causes of poor performance and development of reform strategies (Roberts, et al 2003). However conceptualized, actual HSS will take place in individual countries. Analysis, planning, funding, and action must be grounded in each country’s real situation.

To our knowledge there has not been any systematic or representative review of HSS in countries’ national health policies or plans although there are many examples of partial reviews, case studies, etc. (see for example, World Bank, 2008). This might be a useful step to give greater voice to the views of national authorities and experts on this topic, other than what takes place in global and regional meetings and fora. Of course, to carry out such a review we need a coherent definition of HSS, much as we need it to describe what GHAI’s are supporting. Certainly many countries express commitment to HSS in their domestic context and national strategies. There are also many examples of national initiatives in HSS which are not donor supported.

One recent initiative that links national plans with GHAIs is the International Health Partnership Plus (IHP+, http://www.internationalhealthpartnership.net). IHP+ fosters a process of national health plan development with collaborative efforts to assess plans, develop joint funding strategies, and common monitoring and evaluation efforts. The focus is on strengthening the technical basis of efforts to improve health and reducing transaction costs for countries of international partnerships. While IHP+ may not be an appropriate model is all settings, it does remind us that HSS is fundamentally about improving national (and local) health systems and that GHAIs’ work in this area is in support of national policies and strategies to achieve better outcomes.
Why unpack Health System Strengthening?

The preceding review suggests that the concept of HSS is not so much vague as it is broad and diverse. Most global actors make reference to some common concepts and categories, but with varying emphasis and focus in their application to different problems and interventions. These range from specific diseases and the diffusion of specific technologies to much broader “cross-cutting” aspects that span different levels of large, complex health systems.

The just-issued call of the Taskforce to GHAIs to create a common “health systems funding platform” suggests an urgent need to clarify the scope and range of potential HSS investments. A clearer delineation of HSS components can help:

- Clarify the different elements for funding and action in HSS strategies
- Classify the likely focal areas for different GHAIs within the broader scope of HSS
- Identify where are there likely to be synergies and complementarities between GHAIs and where there are likely to be separate programs of work
- Develop a clearer understanding of how donor-financed and supported HSS fits into larger national policies and plans
- Provide classifications and categories that can be used to measure efforts in terms of inputs, outputs, and outcomes for both GHAIs and countries.
- Develop better evaluation which can lead to improvement in HSS efforts.

The Scope of Health System Strengthening: Thinking Along Two Dimensions

The accusation that HSS is “vague” is elaborated in Marchal et al (2009) by their noting that HSS is becoming a “container concept that is used to label very different interventions.” This implies a lack of precise definitions and criteria to identify what is and what is not HSS. Without such criteria, there is a danger that almost any health investment or activity can be called HSS. At that point, the concept will lack any operational usefulness. As pointed out in the introduction, HSS may be best defined as containing a range of activities. But it is a range that should be specified. We attempt to do so below by offering two dimensions for thinking about HSS – one dimension lies along a range of different types of actions to strengthen health systems – using the shorthand terms of approaches providing more resources - better uses of resources through mainly existing channels - and approaches to better use of resources through newer channels. The second focuses on the types of services being addressed by HSS. It runs from single disease or health problem specific to non-disease specific cross-cutting elements.

To further illustrate the need for greater specification of HSS, imagine GAVI providing grants to a particular country. One part of GAVI’s financing supports the costs of purchasing essential vaccines for the national immunization program. Clearly an essential input and also included as one of the WHO’s health system “building blocks” – assuring access to drugs and supplies. A separate grant under GAVI’s HSS window supports incentive payments to immunization workers or perhaps strengthening the transport services that bring vaccines to the community. These are also “building blocks” – human resources productivity and logistics systems. Why is one grant classified as HSS and the other not? Couldn’t all expenditures on additional physical
inputs be termed HSS? Similarly, couldn’t all expenditures to improve the quality or productivity of immunization workers be termed HSS?

Take as another example a World Bank financed project to support a national tuberculosis control program. The Bank would classify this project as one supporting disease control efforts. But the project finances TB drugs, training for health workers, warehouses for supplies, and the hiring of program managers and evaluators. Why is this not classified as HSS? All of these investments are intended to improve health system performance.

**Dimension 1 – From Inputs to Processes and Reform: More, Better, New Approaches**

These examples illustrate that HSS investments and activities can take place at a variety of points along a continuum between supply of additional health system inputs and reform processes that change the way in which these inputs are used or function.

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<thead>
<tr>
<th>Additional health system inputs such as:</th>
<th>Reforms to health system processes leading to:</th>
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<tr>
<td>Health workers, drugs and supplies,</td>
<td>effective access, quality, demand, efficiency</td>
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<tr>
<td>buildings, vehicles, etc.</td>
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In many low-income countries there are clearly huge deficiencies in availability of basic essential inputs, such as human resources for health. Investing in additional health system inputs is necessary to achieve health-related MDGs. But what aid program does not finance additional inputs of some type to health systems? If we don’t make some distinctions, we will end up with the useless conclusion that all expenditures are HSS. How can we make a meaningful differentiation across input financing?

Paradoxically, simply increasing health system inputs may not be sufficient or may not give proportional returns in terms of results, without complementary reforms to health system processes. This is illustrated by the example on Human Resources for Health given below. HSS can be found anywhere along this continuum, but we should know, and be able to explain, where we are and why.

A more useful, and expanded version of this continuum is to characterize HSS strategies in terms of a range we could call “more”, “better”, and “new”. These categories capture three broad types of HSS investments.

- “More” captures the important additional investments in health system inputs such as additional health workers, drugs and supplies, transport, and physical facilities. It focuses mainly on public sector capacities to deliver services. “More” would also include investments in supporting systems in the public sector such as supply and logistics, information systems, financial management, etc. Much of what is captured in the “more” category is articulated in WHO’s six “health systems building blocks” for example, HRH, pharmaceutical supplies and logistics, information systems.
• “Better” refers to investments focused on improving the functioning of large public systems through such measures as strengthening management and public health skills, creating new incentives within public systems or better alignment of incentives with results, and reforming arrangements of authority and accountability such as decentralization, community involvement, etc. Some of what is being done through results-based financing initiatives (RBF) reflects mainly “better” strategies.

• “New” emphasizes focused efforts to engage new actors in HSS both in terms of financing and delivery. This would include new investment and funding vehicles, contracting out, partnerships with non-government actors, and other novel strategies (in the sense of novel to the traditional public sector finance and provision approaches). “New” need not be limited to service delivery. For example, contracting out supporting functions, such as supply chain and logistics, would be a “new” strategy approach to a part of HSS in contrast to the “more” strategy approach of building new warehouses and hiring more staff in the government logistics department.

<table>
<thead>
<tr>
<th>More</th>
<th>Better</th>
<th>New</th>
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<tbody>
<tr>
<td>(inputs)</td>
<td>(mainly</td>
<td>(mainly</td>
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<td></td>
<td>govt)</td>
<td>non-govt)</td>
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This formulation provides a richer field of action for process-changing strategies, giving an explicit focus on the non-government sector, which was also emphasized by the Taskforce. They are not mutually exclusive categories, in fact action in more than one, and possibly all three, might be needed to implement some change strategies. Or they may highlight alternative approaches to addressing the same problem – for example some government programs may face a choice between hiring more health workers as civil servants and contract with non-governmental organizations to deliver the same services.

**Dimension 2 – From a Single Disease to Cross-Cutting Health System Elements**

A second dimension for unpacking HSS is the continuum between strategies for strengthening systems elements related to a single disease or intervention (for example TB or immunization), strategies related to cluster of related interventions (for example, maternal and child health), and strategies directed to cross-cutting elements which affect many or all health services (for example, changing the way health workers are paid or decentralizing authority in public systems).

<table>
<thead>
<tr>
<th>Single disease or intervention</th>
<th>Related diseases or intervention</th>
<th>Cross-cutting elements not only related to a disease or intervention</th>
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For GHIAs like GAVI or GFATM, this dimension is particularly important. They recognize that sometimes addressing cross-cutting elements may be essential to improving health system functioning for the specific diseases, interventions, or outcomes that are their mandate. But they
are also concerned that they not be drawn into major investments not specifically in support of their primary mission.

**Putting the 2 Dimensions Together**

It may be helpful to use both dimensions to characterize specific HSS strategies.

For example, “A” could represent an HSS strategy to increase the availability of essential supplies, such as LLINs, to the national malaria control program. “B” could represent an HSS strategy to strengthen the government regulatory capacity to improve the quality of maternal care services in private maternity homes and clinics. A diagonal strategy, for example “C”, could be a strategy to introduce new “results-based” contracts for both district governments and NGOs to increase coverage with a package of maternal and child health and nutrition services.

**How do the different Health System Strengthening strategies relate to different health systems frameworks?**

The previous background paper for Theme 1 highlighted different purposes of health system frameworks, categorizing them as descriptive, analytical, and predictive, drawing on earlier writing by Hsiao and Siadat (2008). Because of the ways in which different frameworks describe and conceptualize health systems and their functioning, they sometimes lead to somewhat different policy prescriptions and strategies. Descriptive frameworks, such as the health systems “building blocks”, lend themselves to thinking about strategies for additional inputs – “More” strategies. Analytical/predictive frameworks, such as the health systems “control knobs”, lend themselves more to thinking about strategies to change processes – “Better” and “New” strategies.

The current approach to the human resources for health (HRH) area provides some illustration of this. HRH is one of the six health system building blocks. Much of the discussion has focused on the shortfalls in supply, which have been benchmarked against a norm of 2.3 or 2.5 health workers per 1,000 population, derived from a cross-country analysis of HRH supply relative to achievement of certain key health outputs such as immunization rates or attended deliveries (see for example, Figure 1 and Anand and Baernighausen, 2004). The policy strategies emphasized in this discussion include raising additional financing to pay for increased supply of health workers, creating education and training capacity (medical schools, nursing schools, paramedical schools), and ways to increase recruitment and retention.
One striking aspect of Figure 1 (and other similar analyses) is that at each level of HRH supply, there is a wide range of output reported from different countries – the vertical dispersion of the data points. For example, at about 1.8 health workers per 1,000 population coverage ranges from 20% to 100%. What accounts for this variability in performance in relation to health worker supply? Studies have pointed to other factors such as task-shifting and staff mix, health worker motivation, and high rates of absenteeism (WHO, 2007b, Chowdhury and Hammer, 2004). These are causal determinants of performance that are not mainly amenable to “more” strategies, but require complementary “better” or “new” strategies.

Figure 1:


The importance of these types of performance determinants is certainly well understood in the HRH community. But an emphasis on these determinants requires going beyond recognizing that HRH is an essential building block for a well-functioning health system or that HRH poses a “constraint” to achieving health outcomes (Hanson et al, 2003). It requires building up an analysis of the various HRH-related causes of poor performance and designing an HSS strategy that addresses those causes in a manner which is feasible and sufficient to bring about a change in performance.

The GHRR health systems framework emphasizes that type of analysis. It proposes a diagnostic method to decompose the causes of poor performance and link them analytically to specific outcomes as well as to HSS strategies – the control knobs. These strategies can fall anywhere along the dimensions already described above. This analytical approach has several advantages. It can highlight alternative strategies to address the same cause of poor performance – for
example hiring additional health workers compared with giving greater incentives to existing workers to increase their performance. Also, it emphasizes the need to coordinate across different elements of a strategy – for example increasing the supply of health workers could require changes in financing, payment, organization, and regulation to be effective. Bossert et al (2007) illustrate some of these issues in a guide on HRH prepared for WHO.

The place where these different strategies are most likely to be given expression is in the context of health sector plans – both national and sub-national. The International Health Partnership Plus (IHP+) has advocated a process in which national health plans, presumably also including HSS strategies, would be the basis for coordinated support from external agencies and common monitoring and evaluation frameworks. A key step towards sound HSS strategies will be the health systems analysis that precedes underpins those plans. A sound health systems analytical framework and a strong process of country-led and country-owned dialogue and decision-making are essential steps in that direction. A number of IHP+ countries are already advanced down that path.

Sound HSS requires that this job be done. But countries differ a great deal in their domestic capacities to analyze health systems performance and the causes of poor performance; as well as their capacities to design, implement, monitor, and evaluate reforms. The role of GHAIs will vary and depend on each country’s needs as well as the capacities of the different GHAIs.

How do different HSS strategies relate to the comparative advantages of different GHAIs?

Unpacking HSS along the two dimensions proposed also helps in thinking about how the GHAIs can move towards “a joint mechanism for investment in health systems” (Taskforce, 2009). Clearly different GHAIs and other partners focus on different areas of the two dimensions outlined and also are endowed with different skills and capacities that may be more and less applicable to different areas.

Some preliminary observations on this question include:

- Disease or problem specific GHAIs have a specific mandate to focus on their priority problems. They are more likely to have the capacities and skills to translate broader HSS strategies into specific measures related to their areas of focus.
- GHAIs that mobilize large grant funds, such as GFATM and GAVI, may be better suited to finance scale-up of the supply of essential inputs such as vaccines, ARVs, bed-nets – linking them more closely to “more” strategies.
- GHAIs with broader sector-wide or multi-sector mandates, such as the World Bank and WHO, are better suited to focus on cross-cutting HSS issues and strategies such as sector financing and sustainability, development of new strategies that reform financial and organizational relationship in health systems (such as risk-pooling or RBF), and governance reforms.
- Working with the non-government sector adds another dimension to consider in comparative advantage and capacity going forward. The World Bank Group has some specific experience with this through its private sector arm, the IFC, the recently launched “Health in Africa” program, and public-private partnership investment facilities, as well as the pilot program on
Results-Based Financing which is linked to IDA funding. Other GHAIs work more closely with civil society and non-governmental organizations, such as GFATM’s work through the Country Coordinating Committee mechanism or the long experience of the US government contracting with private sector organizations.

- GHAIs differ greatly in their presence in countries to provide ongoing technical support and assistance, as well as in their processes for support and review of projects during design and implementation. Some types of HSS support benefit more from in-country presence than others.
- GHAIs also differ in the extent of their partnership with countries at different levels of income and development.
- Capacities in key supporting areas such as capacity building in HSS-related skills and research are currently concentrated in organizations such as WHO and the World Bank Group (e.g. the World Bank Institute), but also in a wide range of academic and technical assistance organizations. How can these capacities be scaled-up and mobilized in a more coordinated way?

International agencies may want to consider how a matrix (Figure 2) describing their capacities and comparative advantages across the two HSS dimensions proposed would look – in which the cells also identified characteristics such as funding, analysis, technical support, capacity-building, focus on specific countries and regions, etc.

Figure 2: Possible Matrix to Outline Comparative Advantages of GHAIs

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<thead>
<tr>
<th></th>
<th>More (inputs)</th>
<th>Better (mainly govt)</th>
<th>New (mainly non-govt)</th>
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<tbody>
<tr>
<td>Single disease/intervention</td>
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<tr>
<td>Related diseases or intervention cluster</td>
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</tr>
<tr>
<td>Cross-cutting elements</td>
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Concluding thoughts

The current global focus on HSS reflects the problems of success in mobilizing national and international resources and commitment to scale up efforts to achieve the health-related MDGs. We are now challenged to find new ways to assist lower income countries to create effective, equitable, and sustainable health systems to realize these opportunities.
HSS is complex and multi-faceted, but not vague or intractable. The initial enthusiasm to engage more substantively in HSS often was, however, not clearly conceived. We are not groping completely in the dark. There is a significant body of sound conceptual thinking and solid empirical evidence to get us started – although certainly more needs to be done. We need to keep country needs, priorities, and capacities front and center in our thinking – national and local health systems are the focus of HSS. This note is offered as a contribution to help GHAI’s move forward on their commitment to scale-up HSS support in coordinated, effective, and efficient way.
References


