

HEALTH SYSTEM DEVELOPMENT (HSD)

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HSD 01 – Understanding of the Health Systems

Pages 1 – 3 (3 pages)

Time Allow – 2 Hours

Objectives

At the end of the session, the learners should be able to

Explain four basic models of health care systems

Explain health systems framework and building blocks

Describe National Health Plan in Myanmar

Teaching methods

Lecture and Discussion

Health System

A health system consists of all the organizations, institutions, resources and people whose primary purpose is to improve health. This includes efforts to influence determinants of health as well as more direct health-improvement activities. The health system delivers preventive, promotive, curative and rehabilitative interventions through a combination of public health actions and the pyramid of health care facilities that deliver personal health care — by both State and non-State actors.

The actions of the health system should be responsive and financially fair, while treating people respectfully. A health system needs staff, funds, information, supplies, transport, communications and overall guidance and direction to function. Strengthening health systems thus means addressing key constraints in each of these areas.

The World Health Organization (WHO), the directing and coordinating authority for health within the United Nations system, is promoting a goal of universal health care: to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. According to WHO, healthcare system goals are good health for the citizens, responsiveness to the expectations of the population, and fair means of funding operations. Progress towards them depends on how systems carry out vital functions: provision of health care services, resource generation, financing, and stewardship. Other dimensions for the evaluation of health systems include quality, efficiency, acceptability, and equity.

Health Care Systems

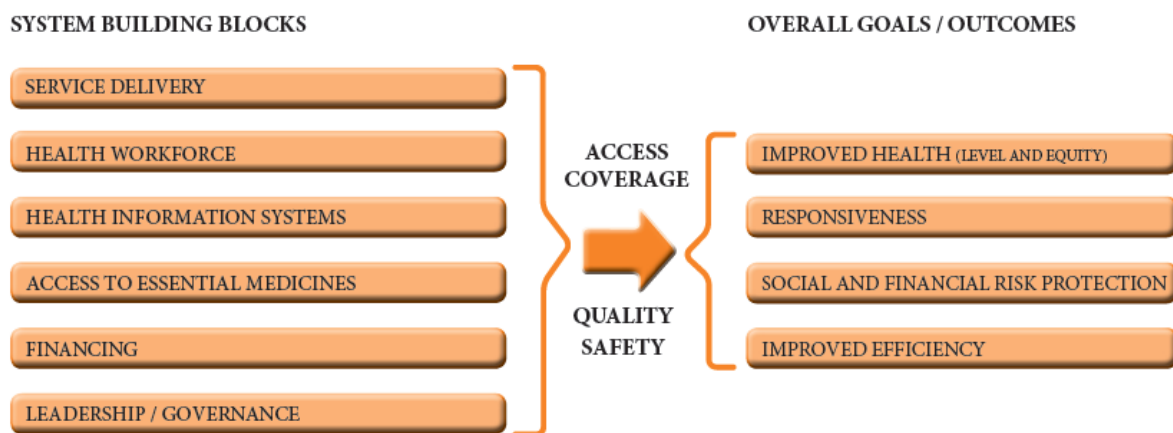
Four Basic Models

1. Beveridge model: state financed system – example Great Britain
2. Semashko model: completely state-controlled system – example Poland
3. Bismarck model: the system is financed by contributions to a social security or insurance system – example Germany
4. Market-oriented model: example USA

Health Systems Framework and Building Blocks

WHO framework describes health systems in terms of six core components or “building blocks”: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance.

The six building blocks contribute to the strengthening of health systems in different ways. Some cross-cutting components, such as leadership/governance and health information systems, provide the basis for the overall policy and regulation of all the other health system blocks. Key input components to the health system include specifically, financing and the health workforce. A third group, namely medical products and technologies and service delivery reflects the immediate outputs of the health system, i.e. the availability and distribution of care.



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

MYANMAR NATIONAL HEALTH PLAN (2017 – 2021)

Context

The health status of the Myanmar population still does not compare favorably with other countries in the region. Life expectancy at birth, for example, is 64.7 years in Myanmar, the lowest among ASEAN countries. Moreover, hidden behind the national averages are wide geographic, ethnic and socio-economic disparities.

The Myanmar health system currently faces many challenges. These relate to the availability and distribution of inputs (e.g. human resources, physical infrastructure, essential medicines and supplies, financial resources) and to weaknesses in key functions such as supportive supervision, referral, supply chain, health management information system, and public financial management. Limited oversight, leadership and accountability further exacerbate these challenges.

Myanmar currently allocates only 3.65 percent of its total budget on health, which is extremely low by global and regional standards. As a result, out-of-pocket (OOP) spending by households remains the dominant source of financing for health. It can push or keep households in poverty, and it prevents many from seeking necessary health care.

Universal Health Coverage (UHC) is defined as all people having access to needed health services of quality without experiencing financial hardship. Myanmar's political leadership has expressed a strong commitment to accelerating progress towards UHC, which has also become a global priority. The National Health Plan (NHP) aims to strengthen the country's health system and pave the way towards UHC, choosing a path that is explicitly pro-poor. The main goal of NHP 2017-2021 is to extend access to a Basic Essential Package of Health Services (EPHS) to the entire population by 2020 while increasing financial protection.

References:

1. World health report 2000. Health systems performance assessment. Geneva, World Health Organization, 2000 ([http:// www.who.int/whr/2000/en/index.html](http://www.who.int/whr/2000/en/index.html)).
2. Roberts MJ, Hsiao W, Berman P, Reich MR. Getting health reform right: a guide to improving performance and equity. New York, Oxford University Press, 2008.

HSD 02 – Health Service Delivery

Pages 4 – 8 (5 pages)

Time allow 2 hours

Objectives

At the end of this session, the learners should be able to:

Describe characteristics of good health service delivery

Explain sources of information on health service delivery

Teaching Methods

Lecture and Discussion

Characteristics of Good Health Service Delivery

Good service delivery is a vital element of any health system. Service delivery is a **fundamental input to population health status**, along with other factors, including social determinants of health. The precise organization and content of health services will differ from one country to another, but in any well-functioning health system, the network of service delivery should have the following **key characteristics**.

- 1. Comprehensiveness:** A **comprehensive range** of health services is provided, appropriate to the needs of the target population, including **preventative, curative, palliative** and **rehabilitative** services and **health promotion** activities.
- 2. Accessibility:** Services are directly and permanently accessible with no undue barriers of cost, language, culture, or geography. Health services are **close to the people, with a routine point of entry to the service network at primary care level** (not at the specialist or hospital level). Services may be provided in the home, the community, the workplace, or health facilities as appropriate.
- 3. Coverage:** Service delivery is designed so that all people in a **defined target population** are covered, i.e. the sick and the healthy, all income groups and all social groups.
- 4. Continuity:** Service delivery is organized to provide an individual with **continuity of care across the network of services, health conditions, levels of care, and over the lifecycle**.
- 5. Quality:** Health services are of high quality, i.e. they are **effective, safe, centred on the patient's needs** and given in a **timely** fashion.
- 6. Person-centredness:** Services are **organized around the person, not the disease** or the financing. Users perceive health services to be responsive and acceptable to them. There is **participation** from

the target population in service delivery design and assessment. People are partners in their own health care.

7. Coordination: Local area health service networks are actively coordinated, across types of provider, types of care, levels of service delivery, and for both routine and emergency preparedness. The patient's primary care provider facilitates the route through the needed services and works in collaboration with other levels and types of provider. Coordination also takes place with other sectors (e.g. social services) and partners (e.g. community organizations).

8. Accountability and efficiency: Health services are **well managed** so as to achieve the core elements described above with a **minimum wastage** of resources. Managers are allocated the necessary authority to achieve planned objectives and held **accountable for overall performance and results**. Assessment includes appropriate mechanisms for the participation of the target population and civil society.

Sources of Information on Health Service Delivery

There are multiple sources of data on health service delivery. These include routine facility reporting systems, health facility assessments (both facility censuses and surveys), and other special studies. No single method provides all the information required to assess service delivery, and multiple methods are needed to understand it completely.

Routine Health Facility Reporting System

A routine facility reporting system, often referred to as a Health Management Information System (HMIS), is generally used to monitor service delivery. Service data are generated at the facility level and include key outputs from routine reporting on the services and care offered and the treatments administered. Reporting may include supervisory or clinic-reported data on medicine stock-outs in a defined reference period (e.g. during the last month), functioning of outreach services and availability of health workers. Because the data are routinely collected (often monthly or quarterly), it provides information on a continuous basis for time and seasonal trend analyses.

The problems associated with developing service coverage estimates from facility data relate to completeness and accuracy of recording and reporting as well as biases arising from differences in use of services by different populations. In general, routine facility reporting systems give only limited information on the status of service delivery. In many settings, the HMIS often covers only public sector facilities (which may include private hospitals or clinics).

Health Facility Census

A facility census includes visits to *all* public and private health facilities in a defined area (can be national in scope or sub-national, covering one or more provinces, regions or districts). It is designed to form the basis for a national and sub-national monitoring system of service delivery. The key output

is a national database, and where possible, district databases of health facilities. The database should be updated on a regular basis, e.g. every 3–4 years.

The World Health Organization (WHO) service availability and readiness assessment methodology provides a standard health facility assessment questionnaire to assess, map and monitor service availability and readiness. It is designed to support a health facility census with a focus on the core functional capacities and availability of services. The instrument can be further adapted at the country level to respond to specific country contexts. If resources are limited and do not allow for visiting all health facilities in a country (or sub-nationally in a township, region, or state), a census can be implemented in sentinel townships with additional townships added each year, to achieve a full census over a longer time period.

The key topic areas and core functional capacities of a facility census of service availability and readiness include:

- Identification, location and managing authority of health facility (public and private)
- Facility infrastructure and amenities, such as availability of water supply, telecommunications and electricity
- Basic medical equipment, such as weighing scales, thermometer and stethoscope
- Availability of health workforce (e.g. cadre of human resources, staff training and guidelines)
- Drugs and commodities — availability of general medicines
- Diagnostic facilities — availability of laboratory tests (e.g. HIV, malaria, tuberculosis (TB), others)
- Standard precautions on prevention of infections — availability of general injection and sterilization, disposal and hygiene practices
- Specialized services, such as family planning, maternal and newborn care, child health, HIV/AIDS, tuberculosis, malaria and chronic diseases.

Facility censuses also serve as an independent source for numbers of health workers, which may be compared with those from other sources and analyzed in conjunction with them. Additional particulars, such as the presence of workers on the day of the visit, can also be gathered. Comparisons between districts and regions provide valuable evidence about the distribution of services within a country. Information on minimum standards can be used for key services to provide feedback to programme planners.

The identification of all facilities, however, is a major challenge. Small private facilities are more likely to be missed, and special efforts have to be made to include them, especially in urban areas. Completeness is likely to improve with subsequent rounds of censuses. Other sources, such as household surveys in which respondents are asked which facilities they utilize, may be used to identify more centres. Obtaining access to private facilities for the brief interview can pose another challenge.

Health Facility Surveys

A general facility survey usually focuses on a wide range of key health services and collects information on facility infrastructure, equipment and supplies, support systems, management systems and providers' adherence to standards.

Facility surveys may also measure the quality of specific services and whether all required elements are present to provide routine care; for example, immunization and diarrhoea treatment in the survey of child health services. The core questionnaire reflects generally accepted standards for health-care services, including United Nations Children's Fund (UNICEF) immunization guidelines and standards set by the Safe Motherhood initiative, with local adaptations as necessary.

The objective of a facility survey is not to provide information on the strengths and weaknesses for specific facilities, but to identify the strengths and weaknesses in health systems. The findings can be used to measure changes in the systems put in place to support quality services and adherence to standards. The facility survey presents information not only on the availability of services, but also on measures of quality. One of the disadvantages of the facility survey, however, is the cost of obtaining extensive information whose relevance is only at the national level. The extensive data collection efforts in each facility provide a wealth of information on hundreds of indicators, but a much smaller number of indicators matter for policymaking.

Data Collection Method	Description	Strengths	Limitations
Routine health facility reporting system	Regular facility data reported to regional and national levels by service providers	Mandated practice at the facility level with standard reporting formats and cycles	Limited data on service provision; often incomplete, covers public sector only, and with time lags in reporting; biases due to variation in population use of services
Health facility census	Periodic census of all public and private health-care facilities within a country	Provides information useful to planners at all levels, such as basic characteristics (ownership, facility type, coordinates), availability and functionality of basic infrastructure, staffing, service provision and general status	Time-consuming and can become costly, if not well integrated; difficult to identify all health-care facilities, particularly in urban centres where smaller private practices may be more common; access to all facilities may be problematic
Health facility survey	Periodic survey of a representative sample of public and private health-care facilities within a country	More detailed information than in facility census with verification of information in many cases; quality of care	Time-consuming and costly; information most useful at national level; requires a complete facility listing for sampling to be done correctly; long intervals between surveys

HSD 03 – Health Workforce and Human Resource Management

Pages 9 -22 (14 pages)

Time Allow – 3 hrs

Objectives

At the end of this session, the learners should be able to

define human resource and staffing

define human resource management

goals of human resource management

describe importance of human resource management

enumerate the factors that affect human resource management

list human resource management problem areas

describe job description

List the role and functions of Basic Health Staff

Teaching Methods

Lecture and Discussion

Definition of Human Resources

Human resources for health can be defined as the different kinds of clinical and non-clinical staff responsible for public and individual health interventions.

Definition of Staffing

Staffing can be defined as filling and keeping filled, positions in the organization structure. This includes identifying workforce requirement, inventorying the people available, and recruiting, selecting, placing, promoting, appraising, planning the careers of, compensating and training or otherwise developing both candidates and current jobholders to accomplish their tasks effectively and efficiently.

What is Human Resource Management (HRM)?

A way of management that links people-related activities to the strategy of a business or organization.

Human resource management includes entire range of management activities from planning to the mobilization and motivation of the workforce.

HRM is the study of activities regarding people working in an organization. It is a managerial function that tries to match an organization's needs to the skills and abilities of its employees.

Goals of Human Resource Management

- To meet the needs of the organization and management
- To link human resources policies/strategies to the goals and objectives of an organization
- To find ways for human resources to "add values" to organization
- To help organization gain the commitment of workers to its values, goals and objectives

Why Human Resources Management is important?

- The performance and the benefits the system can deliver depend largely upon the knowledge, skills and motivation of those individuals responsible for delivering health services
- Essential to maintain an appropriate mix between the different types of health promoters and caregivers to ensure the system's success
- Handled and managed very differently from physical capital
- Very complex as managing people is more difficult than managing things.
- People like to feel useful and appreciated and may and may become discouraged when they are ignored or unjustly criticized. When people are helped and their work problems are understood, the quality of their work improves.

There is no best way to manage people and no manager has formulated how people can be managed effectively, because people are complex beings with complex needs. Effective HRM depends very much on the causes and conditions that an organizational setting would provide.

Since all Health Care is ultimately delivered by and to people, a strong understanding of the human resources issue is required to ensure the success of

Important Issues of HRM

- The size, composition and distribution of the health care workforce
- Workforce training
- The migration of health care workers
- Country's level of economic development
- Socio-demographic elements such as age distribution of the population
- cultural and geographical factors

In 2004 World Health Organization states that "Without improvements to the human resources situation, the health-related Millennium Development Goal cannot be achieved".

In many countries, the effect of insufficient capacity development in the health system is aggravated by migration and a mounting burden of diseases.

From the perspective of health professional, the challenges include

- Lack of equipment
- Frequent shortage of supplies
- A mounting workload

Despite decentralization efforts, key functions of human resource management (recruitment, overall staff distribution, remuneration, promotion and transfer) remain highly centralized.

One of the challenges of the organization is low motivation of health workers. Comprehensive strategy to maximize health worker motivation in a developing country context has to involve a mix of financial and non-financial incentives.

Low motivation has a negative impact on the performance of individual health workers, facilities and the health system as a whole.

Factors that affect HRM

- Management philosophy
- Organizational goals
- Integrating people and technology
- Human resource planning
- Recruitment
- Compensation plans
- Appraisal system
- Education and training
- Channels of self-development
- Motivation
- Employee relations
- Organizational discipline
- Quality of work life

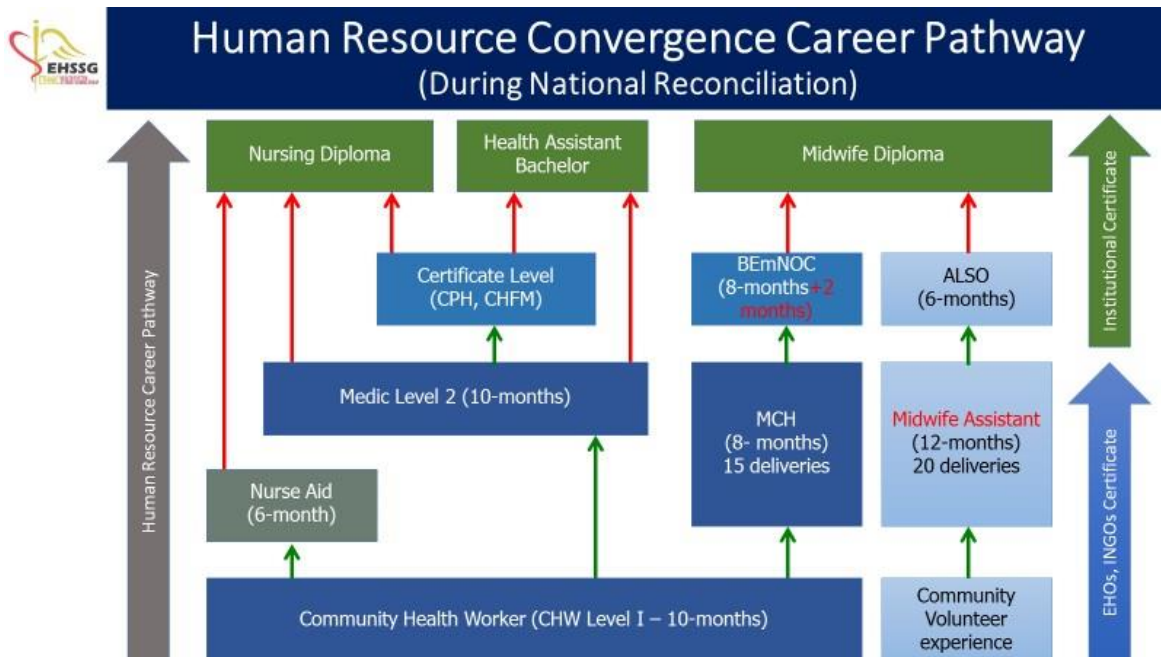
Human Resource Problem Areas

- Maldistribution of personnel (shortage of manpower in one department and excess/surplus in others)
- Inefficient use of personnel
- Low productivity
- Low motivation
- Lack of good relations between management and staff

Principles of Human Resource Management

There are many principles for human resource management. The followings are some of the important principles:

- Review, train or form and provide the requirements according to the job description
- Provide continuous training
- Recruit, select and orientate to the needs of organization
- Conduct personal assessment, physical energy and mental stress of the human resources
- Motivate workers
- Protect workers from the risk of illness and accidents as well as from the social risk
- Allow integration, cooperation and participation of workers in decision making
- Form union or association for workers



Job Description

Job description is a useful tool for the organization of work. It describes clearly what each health worker must do and expected to achieve. Job description assists managers in recruiting, interviewing, and evaluating employees. Job description is also vehicle for employees to learn the expectations as well as comprehend the ramification of their jobs.

Job description states:

The objectives, activities and programs of the holder of the post concerned

The authority of the health worker, i.e. the decisions that the health worker is expected to make and has a right to make.

E.g. Health Assistant is the immediate authorized person of PHS II.

The responsibility of the health worker, i.e. the expected degree of achievement of tasks and functions

Uses of job description

- helps prevent arguments between people about who should do what
 - Therefore, no overlapping and no gaps in work
- helps distribution of equipment needed to do the work
- shows the need for training
- provides basis for evaluating performance of health worker

Level of Health Care

There are three levels of health care and these levels represent different types of care involving varying degree of complexity.

A. Primary Care Level

It is the first level of contact of individuals, families and community with the National Health System.

It is close to the people and most of the health problems can be dealt with and resolved.

Primary health care will be most effective within the context of the area's needs and limitations.

Health care is provided by Rural Health Center, Sub-Rural Health Center and Station Hospitals.

B. Secondary Care level

Also called intermediate health care level.

More complex health problems are dealt at this level.

This level of health care is given by township/district hospitals.

C. Tertiary Care Level

It is more specialized level and require specific facilities and attentions of highly specialized health workers.

This health care is provided by State/Regional level or central level institutions such as State/Regional Hospitals, Teaching Hospitals, Specialized Hospitals etc.

Levels of Organization

- Policy making Level - National Health Committee, Ministry of Health, Board (Technical committee)
- Administrative Level - Department of Health (Central)
- State and Region (Intermediate)
- District/Township /Rural Health Center (Peripheral)
 - Functional Level - Hospital, Disease control units, Campaign, Urban Health Center, Maternal and Child Health, School Health, Station Hospital

Health Administration at Central Level

Authority rested on Ministry of Health.

Policy decision's transformed to Ministry's activities.

All these departments are divided according to their functions and responsibilities.

The Ministry of Health has taken responsibilities of raising the health status of people through providing comprehensive health care.

Department of Health (Department of Public Health and Medical Care)

Responsible for providing Health care services to the entire population of country.

The Basic Health Staff (BHS) down to the grass level are providing comprehensive health care through PHC approach.

Health infrastructure of Myanmar is based upon sub rural health center and rural health center where Midwives (MW), Lady Health Visitors (LHV), Public Health Supervisors and Health Assistant (HA) are the responsible person for rural community.

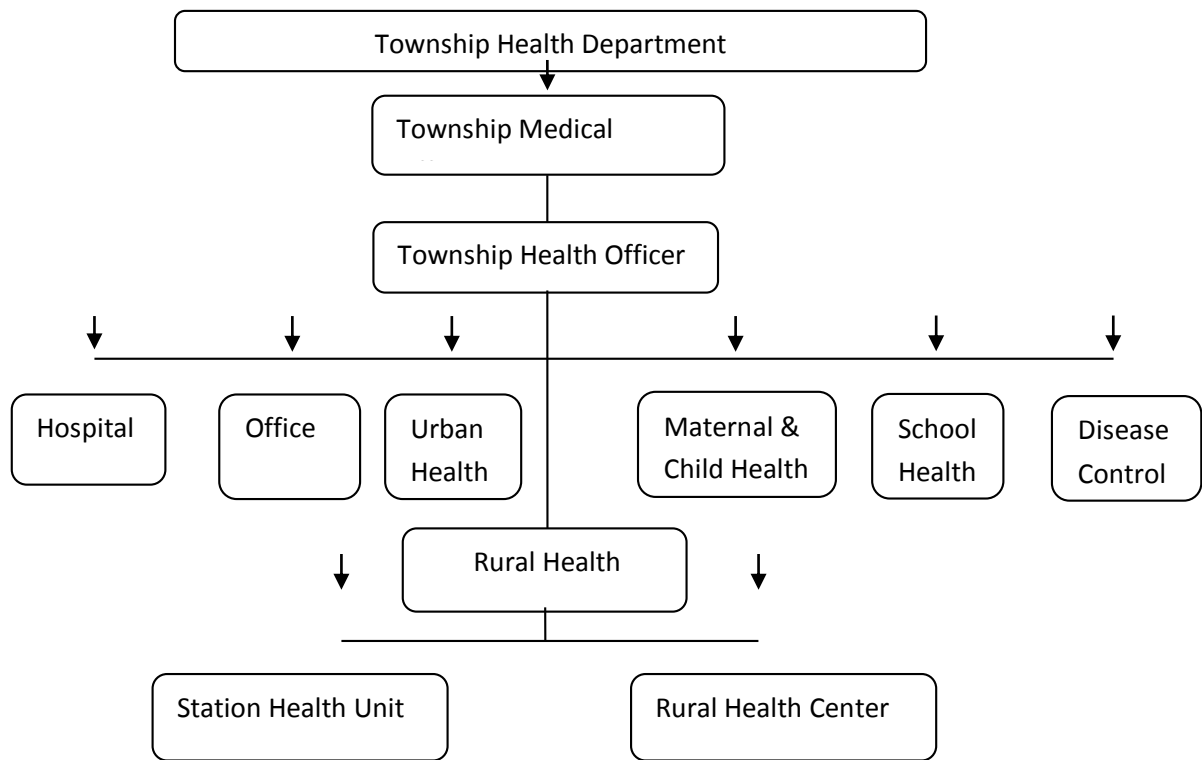
Primary medical care is provided at the grass root level by these staffs and those who need special care are being referred to Station hospital, Township hospital and to the specialist hospital successively.

At State and Region Level – The State and Region Health department is responsible for planning, coordinating, training and technical support, close supervision, monitoring and evaluation of District and township health department.

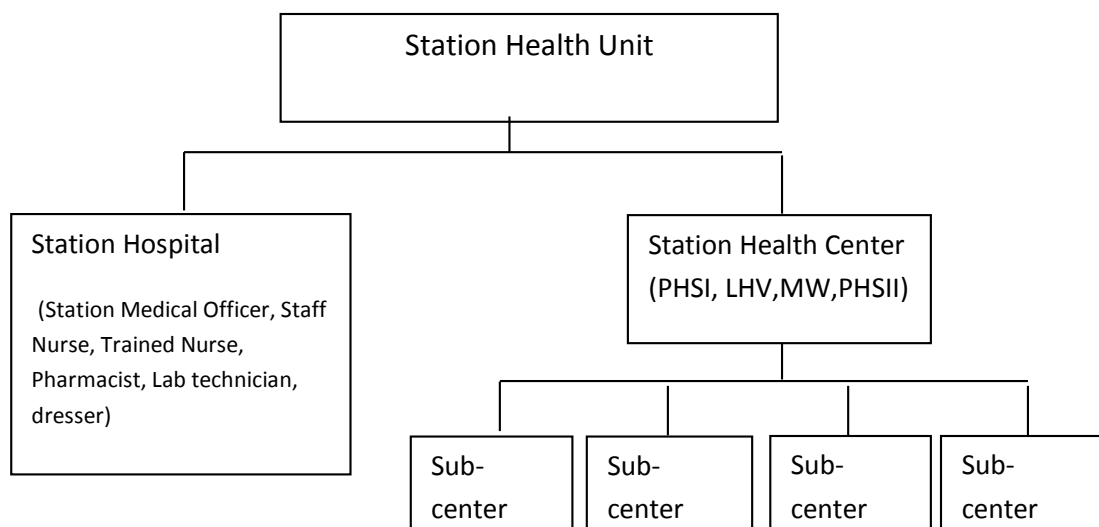
At the peripheral level, the Township level actual implementation of health services to the community is undertaken. The Township Medical Officer (TMO) is responsible for all centers and voluntary village health posts providing health care at rural level.

In each township, there is a township hospital which may be 16/25/ or 50 bedded depending on the population of the township. Each township has at least one or two Station Hospitals and 4-7 RHCs under its jurisdiction. Each RHC has 4 sub-centers covered by MW and Public Health Supervisor II (PHSII) at the village level. In addition, there are VHW (CHW, AMW) in outreach villages providing the community with PHC.

Organization Set up of Township Health Department



Organization Set up of Station Health Unit



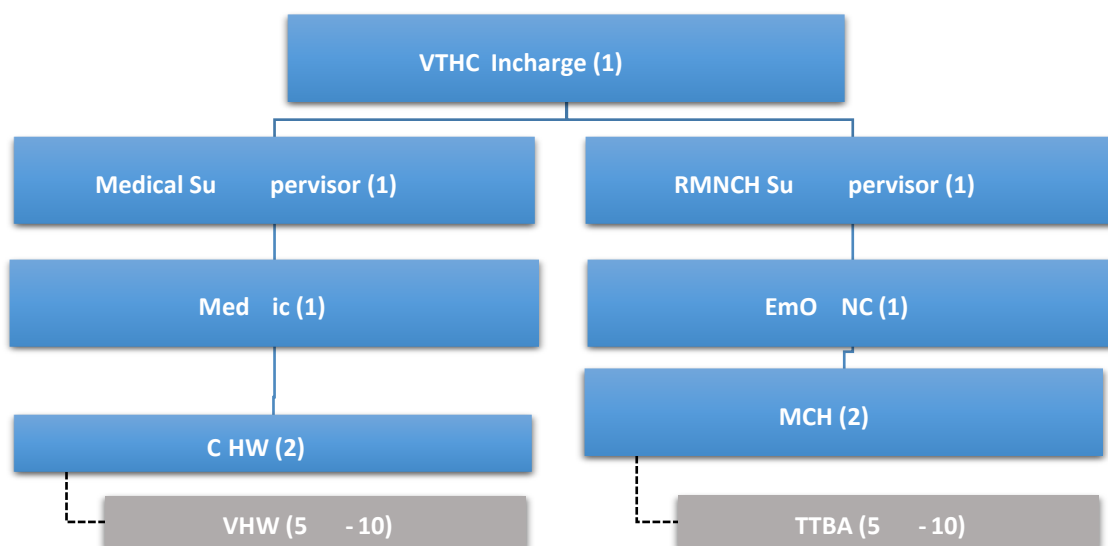
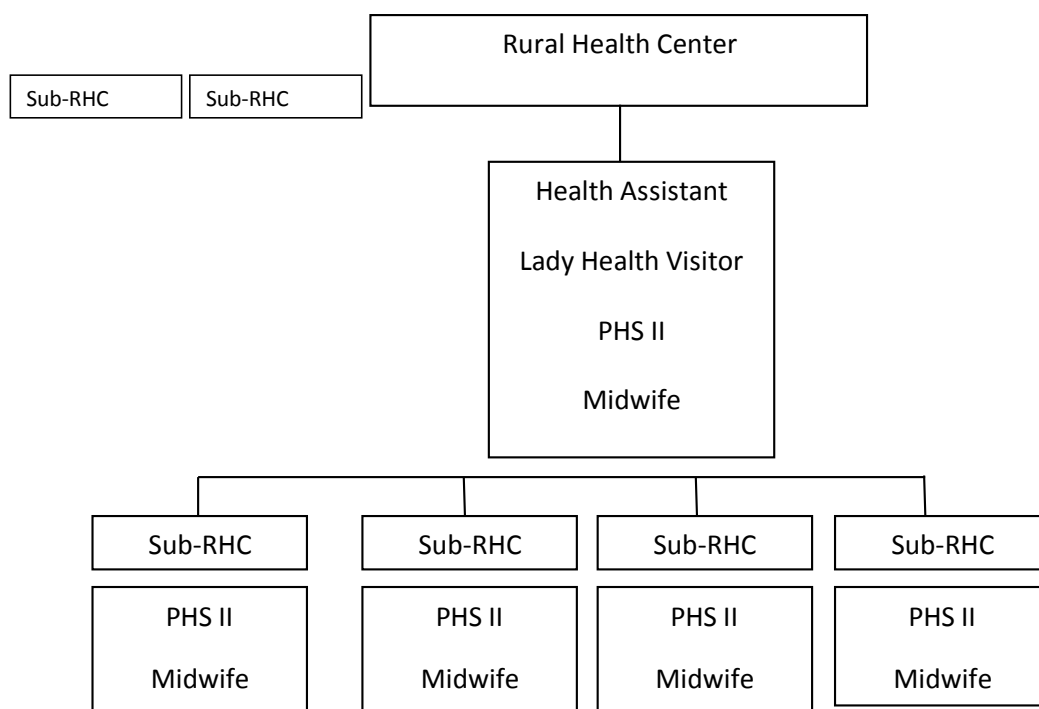
Organization Set Up of Rural Health Center

Rural health Center (RHC)

At least 4-5 RHCs in each township

One RHC is supposed to serve at least 20,000 rural population.

Organization and staffing pattern of RHC is as follow:



Functions of Health Care Facilities

A. Functions of Township Health Department

All the functions as determined by National Health Plan are carried out in township health department.

3 major functions are (a) Medical care

(b) Public Health care

(c) Disease control

(a) Medical care

Inpatient and outpatient care, Laboratory services, X ray services are carried out at Township and station hospital.

Outpatient care at Urban Health center, Primary Health center, Secondary health center, rural health center and sub center and MCH center.

Domiciliary and field visit by Basic Health Staff (mainly MCH care and treatment of minor ailment).

Dental care – Township, SH services, UHC.

Referral services

(b) Public Health care

Provided through Health care centers Institutional type of care and in the Field (Home, work, place, School, Villages)

Public Health care activities:

Medical care -Treatment of minor ailment and campaign diseases.

Health education

Immunization – UCI/EPI

MCH, Family planning, Birth spacing

SH services

Nutrition promotion, Nutrition rehabilitation

Occupational Health services

Sanitary disposal of excreta, refuse

Sanitation of Water, Food, Slaughter House, Public places

Management of Fair and festivals and emergency situation,

Community development program.

(c) Disease control activities

Communicable disease control – TB, STD, Leprosy, VBDC etc.

NCD control such as Hypertension, Diabetes, Mental health etc.

EPI/UCI program

Epidemiological surveillance

B. Function of RHC

Medical care – Treatment of minor ailments, outpatient care, clinic days = (3) times / week,
Domiciliary care during field visits

Communicable disease prevention and control

MCH/SH/(family planning) /Nutrition promotion

Environmental sanitation including Drilling of tube wells and Latrine program.

Training and supervision of Voluntary Health Workers.

Role of Health Workers

A. Duties and responsibilities of TMO

TMO is the leader of the THD. He is responsible for carrying out the functions of THD. His roles in township are:

A technical professional specialist providing medical care, public health care and disease control.

An administration: He is responsible for Management and administration of THD which include:

a. General administration

Office work

Coordination, Collaboration and attend the meeting with community leaders and other departments.

Supervision of station health units and disease control staff.

b. Hospital administration

Work allocation for staff in hospital

Maintenance of equipment, drugs, building and medical store.

Issuing instructions as required.

Reports and returns.

c. Field administration

Supervised field workers, Station Health Units and RHC.

Cooperation and coordination with other department and NGOs.

Duties and responsibilities of THO and SMO are quite similar to that of TMO except they have less responsibilities in Administration and Management functions.

B. Function of HA and PHS (I)

Public health care – Health education, Environmental sanitation, Nutrition, School health services, Community development.

Disease control – Immunization, Surveillance, VBDC, Epidemic control.

Medical care – Treatment of minor ailments at clinic and during tour, Referral services.

Administrative management

- Supervise RHC staff and VHW
- Administration and management of all RHC function
- Training of VWH
- Coordinate and collaborate with other departments
- Birth and Death registration
- Reports and return to higher authority.

C. Function of Midwife

Antenatal care – identification of high-risk pregnancy

Intra natal care – safe and aseptic delivery

Postnatal care

Family planning and birth spacing

Nutrition promotion of mother and child, Growth monitoring

Immunization

Health education, Environmental sanitation

Assist in disease control program (DOTS/ MDT)

Birth and death registration, Reports and return

Training and supervision of AMW.

D. Functions of LHV (lady Health Visitor)

Mother and child care (at clinic / at home)

Nutrition promotion / School health services

Health education

Supervision of MW, AMW

Training of VHW

Assist in disease control

Birth and death registration

E. Functions of PHS (II)

Environmental sanitation

Health education

Assist in disease control program, Disease surveillance

Treatment of minor ailments

Supervise CHW

Birth and death registration

Community development program

F. Voluntary Health workers (VHW)

Community Health Worker (CHW), Auxiliary Midwife (AMW), Ten Household Health Worker (THHW), Traditional Birth Attendance (TTBA) – All these categories are included in VHW.

VHWs assist the basic health staffs in rural and urban area.

VHWs are recruited and trained to assist BHS in their respective village or quarter.

The administrative purposes are managed by local authority concerned, only to be supervised technically under BHS.

CHWs are trained for 21 days.

AMWs are trained for 6 months (3 months at township hospital, 3 months at RHC – supervised by LHV and MW).

THHW are trained for 1 month.

TTBA are trained only 80 hours.

Duties of CHW

Health education

Assist in NHP program: immunization, CD control, Environmental sanitation.

Treatments of minor ailments and minor injury.

Births and Death register, reports and return.

Duties of THHW

Community development program

Health education

Assist in Immunization, E.S, CDC, Births and death registration.

Duties of AMW

MCH care – AN care, domiciliary delivery, PN care.

Assist in immunization, Nutrition promotion, ES.

Births and death registration, Report and return

Treatment of minor ailment

Duties of TTBA

Mother care, domiciliary delivery, PN care

Infant care

Referral of high risk

References:

Harold Koontz and Heinz Weihrich (2001). "Essentials of Management". Fifth Edition, Tata McGraw-Hill Publishing Company Limited, New Delhi.

Tabish, S.A. (2005). "Hospital and Health Service Administration: Principles and Practices" - Oxford University Press.

World Health Organization (1992). "On Being Incharge". Second Edition, Geneva.

HSD 04 – Health Information System

Pages – 23 to 27 (5 pages)

Time allow - 3 hrs

Objectives

At the end of this session, the learners should be able to

Explain HIS data from different levels and sources

Describe indicators for health information system performance

Define HIS performance core indicators

Teaching Methods

Lecture and Discussion

Introduction

The health information system provides the underpinnings for decision-making and has four key functions: data generation, compilation, analysis and synthesis, and communication and use. The health information system collects data from the health sector and other relevant sectors, analyses the data and ensures their overall quality, relevance and timeliness, and converts data into information for health-related decision-making.

Health planners and decision-makers need different kinds of information including:

health determinants (socioeconomic, environmental, behavioural and genetic factors) and the contextual environments within which the health system operates);

inputs to the health system and related processes (policy and organization, health infrastructure, facilities and equipment, costs, human and financial resources and health information systems);

the performance or outputs of the health system (availability, accessibility, quality and use of health information and services, responsiveness of the system to user needs, and financial risk protection);

health outcomes (mortality, morbidity, disease outbreaks, health status, disability and wellbeing); and

health inequities (determinants, coverage of use of services, and health outcomes, and including key stratifiers such as sex, socioeconomic status, ethnic group and geographical location).

A good health information system brings together all relevant partners to ensure that users of health information have access to reliable, authoritative, usable, understandable and comparative data.

Data from Different Levels and Sources

Individual level data about the patient's profile, healthcare needs and treatment serve as the basis for clinical decision-making. Health-care records provide the basis for sound individual clinical care. Problems can arise when health workers are overburdened by excessive data and reporting demands from multiple and poorly coordinated subsystems.

Health facility level data, both from aggregated facility level records and from administrative sources, such as drug procurement records, enable health-care managers to determine resource needs, guide purchasing decisions for drugs, equipment and supplies, and develop community outreach. Data from health facilities can provide immediate and ongoing information relevant to public health decision-making, but only if certain conditions are met. The data must be of high quality, relate to all facilities (public and private), and be representative of the services available to the population as a whole.

Population level data are essential for public health decision-making and generate information not only about those who use the services but also, crucially, about those who do not use them. Household surveys have become a primary source of data in developing countries where facility-based statistics are of limited quality. Household surveys are needed everywhere, however, because they are the only good source of information on individual beliefs, behaviours and practices that are critical determinants of health-care use and health status.

Public health surveillance brings together information from facilities and communities with a main focus on defining problems and providing a timely basis for action. This is especially important when responses need to be urgent, as for epidemic diseases. The need for timeliness of reporting and response and the requirement for effective linkages, to those in authority with the responsibility for disease control, impose additional requirements on health information systems.

Indicators for Health Information System Performance

Indicators of country health information system performance can be grouped into two broad types, namely:

Indicators related to data generation using core sources and methods (health surveys, civil registration, census, facility reporting, health system resource tracking),

Indicators related to country capacities for synthesis, analysis and validation of data.

Health Surveys

Country has a 10-year costed survey plan that covers all priority health topics and takes into account other relevant data source

Two or more data points available for child mortality in the past 5 years

Two or more population-based data points for maternal mortality in the last 10 years

Two or more data points for coverage of key health interventions in the last 5 years

One or more data point on smoking and adult nutritional status in the last 5 years

Birth and Death Registration
Percentage of births registered
Percentage of deaths registered
IDC 10 used in district hospitals and causes of death reported to national level
Census
Census completed within past 10 years
Population projections for districts and smaller administrative areas available in print and electronically, well documented

Definitions of Some Core Indicators

Indicator	Definition
Country has a 10-year costed survey plan that covers all priority health topics and takes into account other relevant data source	Survey plan comprises modular contents with periodicity for specific indicators calibrated to achieve maximum sensitivity and efficiency. Includes data collection related to health-related behaviours and bio-clinical measurements.
Two or more data points for coverage of key health interventions in the last 5 years	Comprising coverage of key maternal and child health care interventions, risk behaviours, care seeking
One or more data point on smoking and adult nutritional status in the last 5 years	Nutritional status clinically measured
Percentage of births registered	<i>Numerator:</i> Number of births registered, as reported by civil or sample registration systems, hospitals and community-based reporting systems. <i>Denominator:</i> Total births for the same time period and geographic region. Where information on total births is not available because of incomplete civil registration, total births can be estimated by extrapolating from the census or on the basis of information about natality rates derived from population surveys.
Percentage of deaths registered	<i>Numerator:</i> Number of deaths registered as reported by civil or sample registration systems, hospitals and community-based reporting systems. <i>Denominator:</i> Total deaths for the same time period and geographic region. Where information on total deaths is not available because of incomplete civil registration, total deaths can be estimated by extrapolating from the census or on the basis of information about mortality rates derived from population surveys.
ICD10 used in hospitals and causes of death reported to national level	<i>Numerator:</i> Number of hospitals using ICD–10 to certify cause of death <i>Denominator:</i> Total hospitals
Number of institutional deliveries available, by township, and published within 12 months of preceding year	Includes deliveries in public, private and NGO Facilities

Percentage of townships that submit timely, complete, accurate reports to national level	<i>Numerator:</i> Number of health townships with timely and complete reporting of key data series. <i>Denominator:</i> Total townships. Countries should define core data series that should be reported by all facilities and reported to townships and compare reports against this list.
Data quality assessments carried out and published within last 3 years	Assessment should cover routine all administrative data sources (e.g. civil registration, facility reports)
International Health Regulations implemented according to international standards	Compliant with IHR monitoring and evaluation Framework
National database with public and private sector health facilities, and geocoding, available and updated within last 3 years	Database should separately distinguish public, private and non-profit facilities; should also include key infrastructure, human resources, medicines, equipment and supplies, and service availability
National database with health workers by township and main cadres updated within last 2 years	Database comprises data from multiple sources, including census, labour force surveys, professional registers, training institutions, facility assessments
Annual data on availability of tracer medicines and commodities in public and private health facilities	Aligned to national essential medicines list
There is a designated and functioning institutional mechanism charged with analysis of health statistics, synthesis of data from different sources and validation of data from population and facility sources	Ideally, the body should be quasi autonomous or independent and should adhere to Fundamental Principles of Official Statistics
There is a national set of indicators with targets and annual reporting to inform annual health sector reviews and other planning cycles	Indicators cover key issues including health determinants, health system inputs, processes and outputs, use of health care services, mortality, morbidity, health system responsiveness etc.
Survey data are used to assess and adjust routine reports from health facility on vaccinations with the results published within 12 months of the preceding year	Validation by an independent reviewer would be needed to ascertain the extent of analysis and validation.
There is national commitment to transparency in data dissemination and acknowledgement of uncertainty.	Published health data include meta data descriptors, margins of uncertainty, methodologies

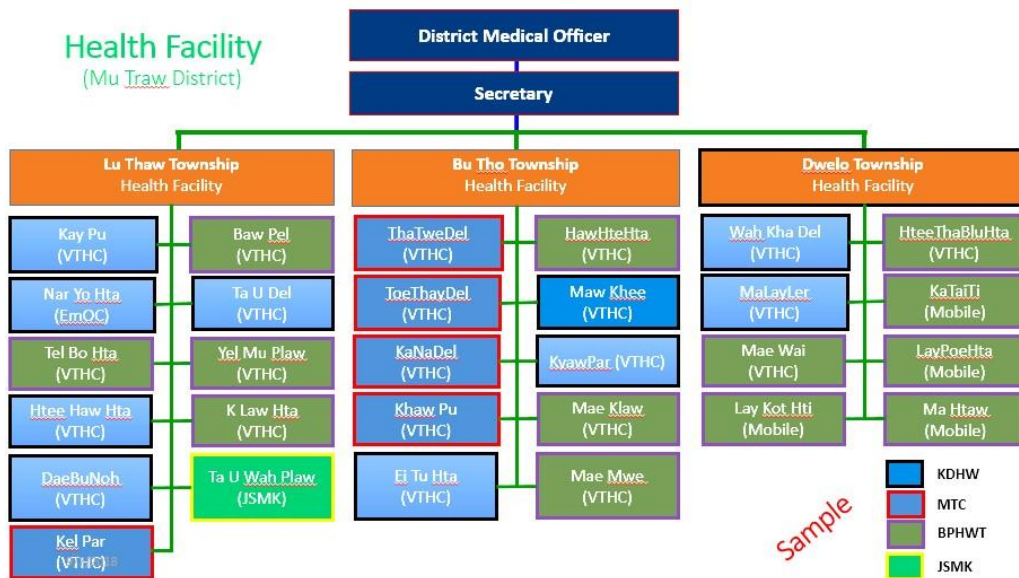


Figure Health Information System (Sample of Mutraw District)

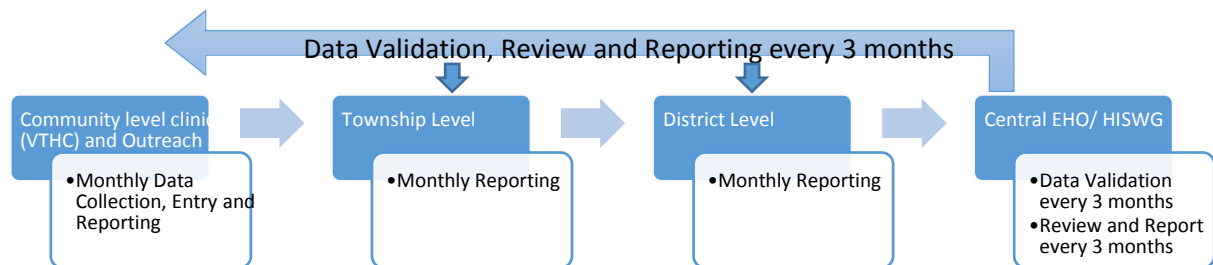


Figure 6 Data Flow of EHO clinics

References:

World Health Organization. (2010). Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies.

HSD 05 – Access to Medicines, Vaccines and Other Health Products

Pages – 28 to 30 (3 pages)

Time allow 3hrs

Objectives

At the end of this session, the learners should be able to

Describe information on access to essential medicines

Explain WHO Framework for Thirteenth General Programme WHO work, 2019-2023

Teaching Methods

Lecture and Discussion

Brain storming

Introduction

Equitable access to health products is a global priority, and the availability, accessibility, acceptability, and affordability of health products of assured quality need to be addressed in order to achieve the Sustainable Development Goals, in particular target 3.8.1 Every disease management strategy requires access to health products for prevention, diagnosis, treatment, palliative care and rehabilitation.

According to the WHO framework for health systems, 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, the status of international trade agreements and the capacity to set and negotiate prices;

reliable manufacturing practices when they exist in-country and quality assessment of priority products;

procurement, supply and storage, and distribution systems that minimize leakage and other waste; and

support for rational use of medicines, commodities and equipment, through guidelines and strategies to assure adherence, reduce resistance, maximize patient safety and training.

Information on Access to Essential Medicines

A general facility survey usually focuses on a wide range of key health services and collects information on facility infrastructure, equipment and supplies, support systems, management systems and providers' adherence to standards. The collection of data on the availability of essential medicines and commodities and on the use of these medicines is an essential part of such surveys.

In addition to the availability and price of medicines, it is also important to assess the quality of use aspects, such as appropriate prescription practices, rational medicine use and user adherence. This requires a more extensive assessment of practices in facilities, including record reviews, exit interviews and observation of patients and providers. There are three categories of indicators for which data are collected.

prescribing indicators (average number of medicines prescribed per encounter, percentage of medicines prescribed by a generic name, percentage of encounters with an antibiotic prescribed, percentage of encounters with an injection prescribed, percentage of medicines prescribed from essential medicines list);

patient care indicators (average consultation time, average dispensing time, percentage of medicines actually dispensed, percentage of medicines adequately labelled, the patient's knowledge of correct dosage);

facility indicators (availability of a copy of essential medicines list of formulary, availability of key medicines).

WHO has developed a set of facility-level indicators to measure key outcomes of these structures and processes in the areas of access, product quality and rational use.

Access is measured in terms of the availability and affordability of essential medicines.

Quality is represented by the absence of expired stock on pharmacy shelves and adequate handling and conservation conditions.

Rational use is measured by examining prescribing and dispensing practices and the implementation of strategies that have been shown to support rational use, such as standard treatment guidelines and the essential medicines list.

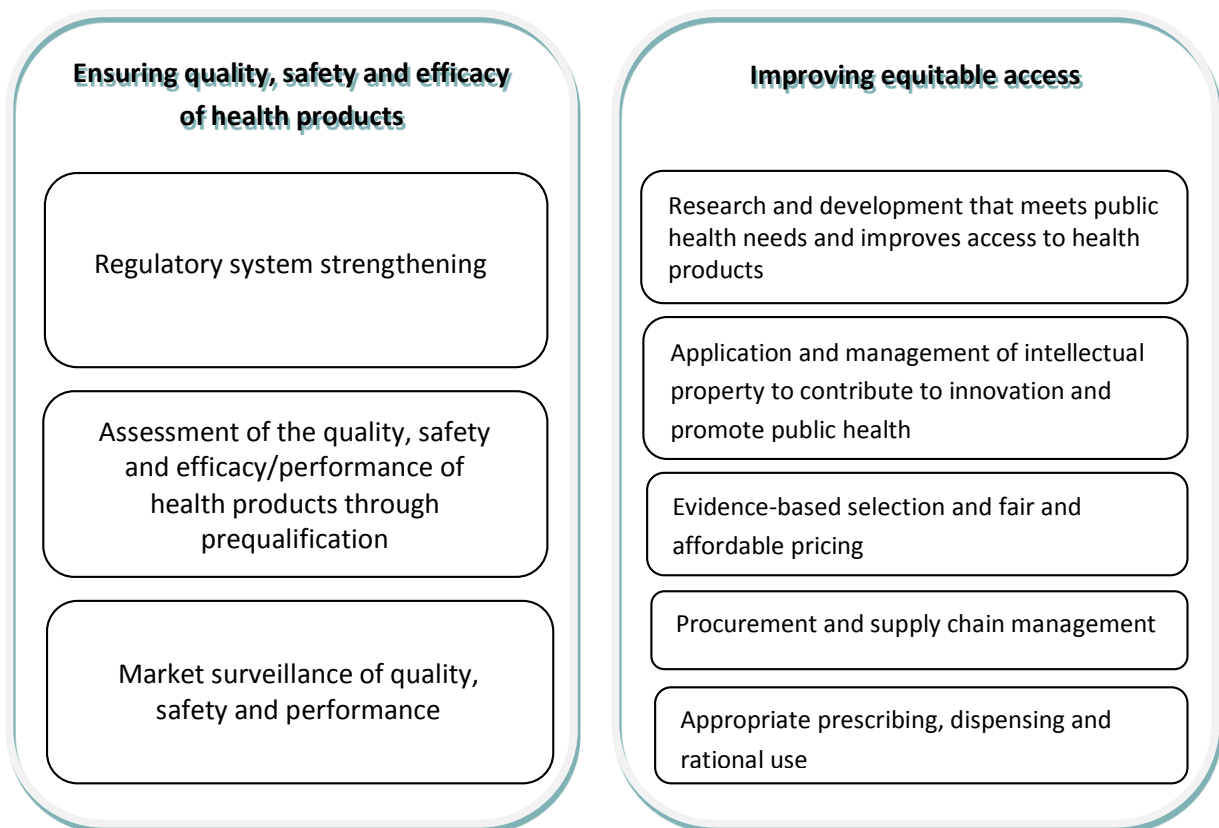
WHO Framework for the Thirteenth General Programme of Work, 2019-2023

The Thirteenth General Programme of Work, 2019–2023¹ sets out three strategic priorities for ensuring healthy lives and well-being for all at all ages: achieving universal health coverage, addressing health emergencies and promoting healthier populations. These strategic priorities are supported by three strategic shifts: stepping up leadership; driving public health impact in every country; and focusing global public goods on impact.

The planning framework for the Thirteenth General Programme of Work provides a structure for identifying priorities at the country level and for the planning and budgeting of the work of WHO. It

will ensure that the programme budget reflects the needs of the countries and that work at all three levels of the Organization is geared towards delivering country impact. This road map for access to medicines, vaccines and other health products, 2019–2023, aligns with improved access to essential medicines, vaccines, diagnostics and devices for primary health care.

The principles of WHO’s work on access to health products, including essential health system components, consist of two interlinked strategic areas that are necessary to support access to health products: ensuring the quality, safety and efficacy of health products and improving equitable access to health products. Under each strategic area, the road map describes activities and puts forward the specific actions and deliverables for the period 2019–2023.



References:

World Health Organization. (2010). Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies.

World Health Organization. (2019). Seventy-Second World Health Assembly. Provisional Agenda item 11.7. Access to medicines and vaccines. Report by the Director-General.

HSD 06 – Health Systems Financing

Pages 31 to 35 (5 pages)

Time allow 3 hrs

Objectives

At the end of this session, the learners should be able to

Explain national health accounts

Describe core indicators for health financing

Understand institutionalizing collection of data for monitoring finance indicators

Understand using financial indicators for health systems strengthening

Teaching Methods

Lecture and Discussion

Introduction

Health financing is fundamental to the ability of health systems to maintain and improve human welfare. At the extreme, without the necessary funds no health workers would be employed, no medicines would be available, and no health promotion or prevention would take place.

Health financing refers to the “function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system... the purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care”.

In most low-income and many middle-income countries, revenue collection derives from a mix of domestic and external sources. Despite the substantial increases in external assistance for health since 2000, the available resources are still insufficient in most low-income settings to assure universal coverage with even a very basic set of needed interventions. The adjustment of Commission on Macroeconomics and Health estimates of the cost of a core package to current prices reveals a need for around US\$ 40 per person per year. This is an underestimate for many reasons, but even then, almost a third of the 193 member countries of WHO did not have access to even this level of funding in 2005, and 33 spend less than US\$ 25 per person per year despite increased external inflows.

National Health Accounts

The best source of health expenditure data is from NHA, which combines expenditure data from all sources and through all types of financial agents. The System of Health Accounts (SHA) developed by

the OECD for its countries has become the international classification standard although some country analysts prefer to use variations on this theme, including an approach called ‘national account sub-accounts’. In general, it is possible to modify the figures emerging from one method to make them consistent with the other. Recently, the WHO, World Bank and USAID jointly developed a guide to undertake NHA in low-income countries based on SHA, adapted to meet the needs of low-income countries. Application of the methods in a variety of settings has resulted in a group effort between the OECD, Eurostat and WHO to revise the SHA with the goal of making it more appropriate to countries at all income levels.

National Health Accounts studies vary among countries — some countries have undertaken regular NHA studies, some have undertaken one or two studies but not regularly, while still others have yet to undertake a full NHA exercise. In the last case, data on health expenditures need to be collated from various sources. WHO works with countries to collate information from these sources, which combined with the information provided by countries who have undertaken NHA studies, allows annual reports of selected health expenditure aggregates for 192 of its 193 member countries.

Core Indicators for Health Financing

Total Expenditure on Health

This indicator provides information on the overall availability of funds. Sufficiency must be considered as a second step, in relation to country-specific estimates of the funds needed to ensure access to the desired level of services, or in terms of comparisons with other countries with similar levels of gross domestic product (GDP) per head. Some countries also seek to compare their total expenditure on health as a proportion of GDP with those in other countries.

Definition

Numerator: The sum of all health expenditures (ideally from NHA and including all sources of funds — external, government, and non-government including household out-of-pocket payments).

Denominator: Total population.

Data Collection Methodology

Data collection is through country-specific reporting by the ministry of finance/ministry of health/other relevant ministries (for government expenditures), donors (for funding that is not channelled through the ministry of finance/ministry of health), insurance fund managers (for third-party funding) and household surveys (for out-of-pocket expenditures) using NHA methodology. Population numbers should ideally be de facto rather than de jure population, with the most complete cross-country source being the United Nations Population Division.

Periodicity

Health expenditures should ideally be calculated on an annual basis. Full surveys of household expenditure are expensive and could be done less frequently, with extrapolations in the inter-survey years.

General Government Expenditure on Health as a Proportion of General Government Expenditure (GGHE/GGE)

This indicator is related to how much funding is raised for health and reflects government commitment. African heads of state committed to ensuring that 15% of overall government expenditure goes to health in the Abuja Declaration of 2001. This can be taken as an aspirational goal, which even a few of the richer countries in the world have yet to achieve. While it is difficult to justify why 15% is the ideal cut point, many countries still devote less than 4% of GGE to health, suggesting low levels of government commitment.

The Ratio of Household Out-of-Pocket Payments for Health to Total Expenditure on Health

The ideal indicator of financial risk protection is the proportion of the population incurring catastrophic health expenditure due to out-of-pocket payments. A variation is the percentage that is impoverished as a result of out-of-pocket payments.

WHO has defined financial catastrophe for the past eight years as direct out-of-pocket payment exceeding 40% of household income net of subsistence needs. Subsistence needs are taken to be the median of household food expenditure in the country. Expenditures in excess of the 40% cut point generally require reallocation of household expenditures from basic needs, sometimes even from children's education. The World Bank now has a simpler definition of financial catastrophe, i.e. occurring when out-of-pocket payment exceeds 10% of a household's total income. While this does not incorporate the progressivity allowed by the deduction of basic subsistence needs, it is probably simpler to estimate and similar to those derived by the WHO method.

Definition

The number of households in each region where direct out-of-pocket payments to providers for health during the past 12 months was more than 40% of their household income net of subsistence, or 10% of their total income.

Numerator: Household out-of-pocket expenditure for health during the past 12 months.

Denominator: Household income. As argued above, in most developing countries it is accepted that self-reported total expenditure on health is a more reliable indicator of household purchasing power than self-reported income, so this should be used as the denominator in those settings.

Data collection methodology

Household interview surveys.

Periodicity

The ratio is not likely to change dramatically over time unless substantial health financing reforms are done. In most countries, measurements done every five years would be adequate.

Institutionalizing Collection of Data for Monitoring Finance Indicators

Since total expenditure on health is currently being reported for 192 of the 193 WHO member countries, the primary need is to improve the quality of information that is already being collected, and to strengthen the institutionalization of the generation and utilization of this information. This requires regular and accurate reporting of government expenditures at all levels of the government, regular household expenditure surveys, and some method of routinely tracking expenditures by NGOs, faith-based organizations, philanthropies and the private sector.

WHO has identified four steps essential to the institutionalization process of NHA. These are: (i) creating a demand on the part of policymakers for institutionalization; (ii) determining a location where NHA is housed; (iii) establishing standards for data collection and analysis; and (iv) instituting data reporting requirements.

The institutionalizing process of NHA also requires an assessment of existing infrastructure and systems and should include the following critical information.

Government and stakeholder commitment to NHA as indicated by such steps as delegation of responsibility for generating NHA to a specified body and allocation of a budget for implementation.

An assessment of existing human resources numbers and capacity, and infrastructure for generating NHA data.

Clarity of health financing mechanisms related to funding sources, processes for channelling funds, and knowledge on where information on external health funding and third-party funding is available including if it is provided to any central or coordinating body. An assessment of the process currently used by WHO for NHA estimates for the country and identification of which data are weakest or least reliable should help obtain this information.

Identification of problems with regards to transparency in national or donor health funding, and the need for policy changes or advocacy to improve this.

Development of an audit function within the NHA to periodically assess the completeness and accuracy of the submitted or collected information, with a systematic strategy for feedback to the data sources to improve availability and quality of needed information.

Using Financial Indicators for Health Systems Strengthening

In general, total expenditure on health should be increasing both in absolute terms and as a proportion of GDP in low-income countries, while the proportion of households facing financial catastrophe as a result of out-of-pocket payments should be decreasing. Financial indicators could be used to answer the questions listed below.

1. Is the total expenditure on health per capita, within the range defined internationally, enough to allow universal coverage of key health interventions (e.g. at least US\$ 40 per capita)?

Is the percentage of the national budget for health reasonable given the national situation? Does it reflect a strong government commitment to health?

What proportion of total expenditure on health is dependent on external funding, and may not be sustainable in the long run? What steps can be taken domestically to raise additional funds for health?

Does a high total expenditure on health get reflected in health outcomes? If not, the efficiency and quality of service, and possibly transparency and corruption issues need to be reviewed.

2. What policies or implementation practices are needed to decrease catastrophic expenditures?

What does the assessment of out-of-pocket catastrophic expenditure show in terms of health finance mechanisms that contribute to, or hurt, equity in financing health? What other options are available to improve equity?

Are the existing health finance policies being implemented in a transparent manner (e.g. are the households receiving exemptions or subsidized services and medicines if they are eligible?).

Are there regional disparities that need to be addressed separately?

References:

World Health Organization. (2010). Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies.

HSD 07 –Governance in Health

Pages 36 to 41 (6 pages)

Time allow 3 hours

Objectives

At the end of this session, the learners should be able to

Understand importance of good governance in health system

Describe indicators for health system governance

Understand decentralization in health care

Teaching Methods

Lecture and Discussion

Introduction

Governance in health is a cross-cutting theme, connected with issues surrounding accountability. In the context of health systems strengthening, it is an integral part of the health system components. Governance in health is being increasingly regarded as a salient theme on the development agenda. Leadership and governance in building a health system involve ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability. The need for greater accountability arises both from increased funding and a growing demand to demonstrate results.

Accountability is a crucial aspect of governance that concerns the management of relationships between various stakeholders in health, including individuals, households, communities, firms, governments, nongovernmental organizations, private firms and other entities that have the responsibility to finance, monitor, deliver and use health services. Accountability involves, in particular:

delegation or an understanding (either implicit or explicit) of how services are supplied;

financing to ensure that adequate resources are available to deliver essential services;

performance around the actual supply of services;

receipt of relevant information to evaluate or monitor performance;

enforcement, such as imposition of sanctions or the provision of rewards for performance.

Indicators for Health System Governance

Two types of indicators have been proposed for measuring governance: rules-based and outcome-based.

Rules-based indicators measure whether countries have appropriate policies, strategies and codified approaches for health system governance. In the health systems context, these indicators include the existence, for example, of a national essential medicines list or a national policy on malaria control. They are part of a larger class of indicators called governance determinants. In addition to the existence of rules (called “formal procedures”), the determinants of health-care-provision governance include four other broad categories: ownership arrangements, decentralization, stakeholder participation, and contextual factors. In this framework, determinants of governance are contrasted with governance performance.

Outcome-based indicators measure whether rules and procedures are being effectively implemented or enforced, based on the experience of relevant stakeholders. For health systems, examples may include the availability of essential medicines in health facilities or the absenteeism of health workers. Since the outcome-based indicators relate directly to the functioning of other health system “building blocks”, only the rules-based indicators for measuring health system governance are discussed in this section.

Existence of an Up-to-Date National Health Strategy

Formulating national policies and strategies is a basic function of governments, and the task of formulating and implementing a health policy falls within the remit of the health ministry. An explicit health strategy defines the vision for the future, and outlines how objectives will be achieved. National health policies should outline priorities and the expected roles of different actors, inform and build consensus, and estimate the resources required to achieve goals and priorities. A recommended core indicator, therefore, is the existence of effective national health strategies and policies that reflect national needs and priorities, as opposed to factional political or financial interests, to foster broad-based political support and ownership of policies.

Existence of policies on procurement of medicines and other products

Expenditures on pharmaceuticals are highly susceptible to various forms of corruption. The pharmaceutical sector, with a global market value of over US\$ 600 billion, is particularly vulnerable in the area of procurement. Procurement involves inventory management, aggregate purchasing, public bidding contests, technical analysis of offers, proper allocation of resources, payments, receipts of drugs purchased and quality control checks. These processes are often poorly documented and are thus a vulnerable target for corruption and fraud. Therefore, to mitigate this threat, and to promote good governance, open bidding processes, good technical specifications and consistent and transparent procedures are essential.

Maternal Health – Existence of a Comprehensive Reproductive Health Policy

The 1994 International Conference on Population and Development (ICPD) articulated a vision of the relationships between population, development and individual well-being. At the Conference, 179 governments adopted a 20-year plan of action, including reproductive health and rights, as well as women's empowerment and gender equality as the cornerstone of population and development programmes. This indicator monitors whether reproductive health policies are both comprehensive and consistent with the ICPD plan of action.

Child health—existence of an updated comprehensive, multiyear plan for childhood immunization

Immunization programmes are often based on past achievements and trends, with separate initiatives for each targeted disease, and too often seek to respond to specific global goals rather than to country needs and priorities. A comprehensive, multiyear plan for childhood immunization would face up to these challenges by proposing strategies that are all-inclusive and integrated with other health interventions. A comprehensive multiyear plan would evaluate the costs and financing options to ensure the financial sustainability of the programme and create linkages to broader health sector planning and budgeting processes. Such efforts would help to strengthen the capacity of countries to deliver immunization and child health services.

Existence of key health sector documents that are disseminated regularly

The publication and dissemination of key health sector documents and reports, including annual budgets and performance reviews, promote accountability and transparency in the health sector. Such documentation helps to create an informed public and serves to improve government accountability to the population. A core indicator relating to the annual publication and dissemination of such materials seeks to create an environment that is responsive to public needs and concerns.

Existence of mechanisms for obtaining community input on appropriate, timely and effective access to health services

Surveys of patient satisfaction and utilization of health services are useful tools for obtaining information on the quality and responsiveness of health services. Such surveys may measure inputs (including whether facilities are properly equipped with essential medicines), processes (including whether waiting times are reasonable and treatment protocols are followed) and outcomes (including whether medical interventions reduce morbidity and mortality). Hence, an indicator that measures whether consumer satisfaction is taken into account in the assessment of health services reflects the responsiveness of health systems.

Decentralization in Health Care

Health systems decentralization involves moving decision making away from centralized control and closer to the users of health services. Many countries have embarked on a process to decentralize their health systems as a means to improve their responsiveness and performance. In practice, decentralization involves the transfer of authority and power from: Higher to lower levels of government or from national to sub national levels of government, E.g. Government to legally independent autonomous state organizations, Government to the private sector (whether “for profit” or “not for profit”).

Types of decentralization

There are **four main types** of decentralization: **1. Political, 2. administrative, 3. fiscal, and 4. market decentralization.**

Political decentralization

Political decentralization aims to give citizens or their elected representatives more power in public decision-making. Its goal is to introduce more participatory forms of governance by giving citizens, or their representatives, more influence in the formulation and implementation of health policies and plans. Political decentralization often requires constitutional law reform as well as changes to other laws.

Administrative decentralization

Administrative decentralization involves redistributing authority, responsibility and financial resources for providing public services from the national government to local units of government agencies, sub national government or semi-autonomous public authorities or corporation.

There are **three major forms** of administrative decentralization: **deconcentration, delegation, and devolution.**

Deconcentration involves redistributing decision making authority and financial and management responsibilities among different levels of a national government. For example, it may involve shifting responsibilities from government officials working in the head office of a health ministry, to ministry staff working in regions, provinces or districts. Deconcentration does not usually involve any changes to existing laws. Though in some countries, changes to who may exercise a legal power have to follow a specific legal procedure.

Delegation involves a national government transferring responsibility for decision-making and administration of public functions to semi-autonomous public sector organizations such as hospital corporations. These organizations usually have separate legal status and have a great deal of discretion and autonomy around management decision-making. Delegation usually involves extensive legal changes including passing laws to establish the new public sector organizations and specify their duties, powers, accountabilities and relationship to national government. It also may involve introducing new regulatory controls. This is because independent decision making may generate a need for state regulation to ensure that decisions made by autonomous bodies are made in line with government's broader health policy objectives.

Devolution is where national governments devolve functions to sub national government. In a devolved system, sub national governments often have clear and legally recognized geographical boundaries over which they exercise authority and within which they perform these functions. Devolution may involve constitutional law reform as well as law reform to formalize the devolution of powers, roles and accountabilities.

Fiscal decentralization

Financial responsibility is a core component of decentralization. If sub national governments and private organizations are to carry out decentralized functions effectively, they must have an adequate level of revenues either raised locally or transferred from the national government– as well as the authority to make decisions about expenditure.

Law changes are likely be required to give effect to the fiscal devolution, to authorize the transfer of revenue and to authorize local decision making and revenue raising.

Market decentralization

Market decentralization involves shifting responsibility for health functions from the public to the private sector including businesses and non-government organizations.

Market decentralization may involve constitutional law reform as well as the passage of new laws to: allow the private sector to perform functions that had previously been performed by government; and to regulate the performance of those functions.

Working on decentralization - the importance of legal and institutional reform

Key legal and institutional issues for countries working on health system decentralization include:

Settling the objectives of the decentralization process. The objectives of the process and the context in which it will take place, are the key factors for designing and implementing appropriate legal and institutional frameworks to implement decentralization.

Ensuring that relevant laws are amended to specify the core functions, roles and responsibilities necessary for the effective operation of a decentralized health system and to support the relevant health policy objectives of government.

Identifying existing laws and regulations that regulate the health system, including those that affect it indirectly, such as civil service laws and local government laws. These laws need to be assessed and modified as necessary to implement the desired decentralization reforms.

Ensuring that appropriate institutional arrangements for the process are in place, including the assignment of functions, responsibilities and resources necessary for the effective operation of the desired decentralized system.

Ensuring that appropriate accountability obligations, mechanisms and process are introduced consistent with the roles and responsibilities of the various organizations which form part of the decentralized system. This may include introducing specific legal requirements to facilitate the participation of local communities in decision making.

Determining the sequencing for the making of necessary law changes; estimating the time and resources needed for implementing each step and the phases of the transition to the new system.

References:

Smith, B. C (1997). "The Decentralization of Health Care in Developing Countries: Organizational Options". *Public Administration and Development* Vol 17, 399-412.

Bossert, T . "Decentralization of health system, decision space, Innovation and Performance".

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<http://www.who.int/health-laws/topics/governance-decentralisation/en/> (retrieved on 6 Jul 2017)

4. *World development report 2004 – Making services work for poor people*. Washington, DC, The World Bank and Oxford University Press, 2004.

5. Kaufmann D, Kraay A. Governance indicators: where are we, where should we be going? *The World Bank Research Observer*, 2008, 23:1.

6. Savedoff W. Governance in the Health Sector: A Strategy for Measuring Determinants and Performance. *World Bank*, 2011.

7. Devarajan S. Comment on Governance indicators: where are we, where should we be going? *The World Bank Research Observer*, 2008, 23:1.