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Working Paper

Towards an Ideal African Health System: Paper #2

An affordable and sustainable health service for Africa in the 21st century

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This paper is one in a series of speculative working papers examining past, current and future African health system directions – from the theoretical to the practical, from blue skies to the ground perspective. Seven different authors responded to our question of, "What might an affordable and sustainable 21st century sub-Saharan African health system look like?" For the other papers – including a short synthesis document highlighting the best of each – visit *www.research-matters.net*.

Introduction

In most African countries today health systems are the source of catastrophic costs, humiliating treatment, and deepening social exclusion[1]. Common diseases go largely untreated, epidemics flourish, and preventable child and maternal deaths remain appalling high. Malaria kills over 1 million African children a year[2] despite easy diagnostics, effective treatment (artemisin-based) and cheap prevention (bed nets and spraying). Health systems should be about solidarity in provision of health care, and about investing resources wisely, but instead they are seriously under-funded, buffeted by external programmes, and buried in bureaucracy. Health systems cover not only acute illness, but prevention and care of the chronically ill: the guiding principles of Alma Ata's Health For All (HFA)[3] are as relevant today as they were in 1978: universal access, inter-sectoral collaboration, essential drugs, appropriate health technology, and strong and effective people's participation.

Macintosh and Koivuslao[4] suggest four basic functions of health systems (Box 1) on which this paper will be based. It will discuss background, based on personal experience and the literature, followed by highlighted practical suggestions on how a sustainable and affordable health system might be developed.

Box 1: Functions of a health system[4]

- Protection and promotion of population health and the provision of preventative services, inter-sectoral action (***"public health functions"***)
- The provision of health service and the care of all according to need and financing according to ability to pay ***("health services***")
- Training, surveillance and research on the maintenance and improvement of population health and health services and availability of skilled work force ***("human resources and knowledge***")
- Ensuring ethical integrity and professionalism, policy planning and public accountability, citizens rights and participation and involvement of users and respect of confidentiality, and dignity in the provision of services ***("ethics, accountability and policy***")

1. Public health functions

1.1 How might collaboration with donors be improved?

Health care is under-funded in most African countries and heavily reliant on donor funds, amounting to one quarter of health care funding in 35% of African countries. More money is needed; it has been estimated that aid contributions of about 23% of GDPs are

required between 2004–2015 to achieve the Millennium Development Goals and Targets[5] . But donor funds can skew or fragment health planning especially if vertical programmes (with specialised management, logistics and delivery mechanisms) demand recipient governments dance to the tune of international agendas rather than develop their own plans, polices and targets, at their own pace. Although not inherently bad, vertical programmes and disease-specific initiatives should be used with caution as a biomedical, technological bias towards health improvement distracts from prevention and comprehensive care.

International donors may focus on different diseases, may insist on different drugs or delivery approaches (as with AIDS drugs), may fail to deliver their funding pledges[6], or fund short-term (5 years or less). New financing instruments, like the Global Fund to Fight AIDS, TB and Malaria (GAFTM), put pressure on governments to apply for and disburse resources quickly. WHO's "3 by 5" initiative[7] has scaled up access to anti-retroviral therapy (ART) at a dizzying speed before countries have the personnel or technology in place to cope. In the author's experience, clinical officers and nurses are sucked from Zambian wards full of undernourished sick children to service AIDS clinics because free ART has swollen client demand to unmanageable levels.

Global Public Private Initiatives – of which there are approximately eighty – mainly focus on a specific disease, offer technical solutions, and fund through public private donations. Examples include the Stop TB and Roll Back Malaria initiatives as well as the Global Fund for AIDS, TB, and Malaria (GFATM). Though they may be successful in the short term (or longer if reducing morbidity from vector diseases with biological stability and no drug resistance[8]) history shows that international interest and long-term benefits are not always maintained e.g. the child survival revolution of the 1980s[9]. Countries often lack the power or the communication channels to communicate or control donor activities[10]. In contrast, the UN Millennium Task Force on Child Health and Maternal Health[11] gives an example of collaborative thinking: "In today's environment of disease-specific initiatives, cross-disease planning, implementation and monitoring are hard to establish and maintain. Enhanced integration between programmes would mean neonatal health would link with maternal health, pregnancy spacing, and child survival"[12]. Unger et al. offer a code of best practice to ensure that vertical programmes do not damage health services[13].

Action: **To be sustainable, a health service must recognise the primacy of the long-term goal of strengthening its whole health system. This needs innovative thinking on how to use the benefits of external expertise and funds, and to blend these, in an incremental way, with its own home-grown national plans, at its own pace, and include human resource planning in the equation. Aid should be pledged for 10 years or longer to help this process. Donors must be explicit about how their disease specific approach would interact with other programmes and show how the totality of this would benefit the health system[14]. If this cannot be achieved, then the aid programme should not be accepted until country conditions are met.**

1.2 Can ministries work together to improve health?

Achieving good health services goes beyond traditional government boundaries and is closely linked to poverty reduction. "Intersectoral collaboration" has been fashionable jargon since Alma Ata and difficult to put in practice as government ministries are essentially territories and are reluctant to promote each other's programme. This is because, in a resource poor situation, the overarching entity (be it family planning or HIV control) simply externalizes deep political conflicts of funding and priorities[15]. One tension is that "pro-poor health programmes" do not necessarily equate with increasing the health sector's funding: for example, road transport may be important to improve maternal health; effective ART programmes may depend on food provision and clean water; and a girl's ability to read and write (dubbed the "social vaccine") may protect her from HIV/AIDS. Similarly, ensuring women's legal and property rights by cross-ministry working could make a significant contribution to health. Recent examples of collaborative working exist: National AIDS Councils are broad-based corporate bodies which include government, private sector and civil society. They aim to develop, monitor, and evaluate a multi-sectoral response to the AIDS epidemic. Although their success has been patchy, the model could be used to integrate a disease-specific focus with a health plan.

Action: **In order to achieve sustainable health improvement, co-operative dialogue between ministries is essential. This needs strong altruistic national leadership focussed on health and poverty reduction. Line ministry arrangement may be what works best, as long as the ministers understand that they are leaders of networks and not of fiefdoms. The control of elites over resource management is an issue for public accountability and therefore ministry budgets in all sectors must be transparent. An independent media has an important role in discussing priorities and in highlighting inefficiency or inequity in resource allocation.**

1.3 What are the main diseases and how can evidence be used to treat them?

Three quarters of the deaths of the 4 million babies who die in developing countries every year could be prevented with well-known, low technology interventions costing less than US$1 per head[11]. 17 African countries still have a maternal mortality ratio of 1000 per 100,000 births (or more) and in 12 countries the maternal mortality ratio worsened between 1994 and 2004[16] despite well-known causes and global initiatives. Moreover, it has been calculated that, by making 15 preventive interventions and eight treatment interventions universally available in 42 counties, this would achieve the MDG child mortality target[17] (figure 1). But translating evidence into practice, estimating resource needs, prioritising and scaling up programmes can over-stretch a country's planning capacity, especially if many programmes are competing for attention. Evidence has to be translated into clear guidelines but these do not always reach the intended implementers, and rarely are they available to the public. The author has frequently heard staff in rural health facilities say they do not know what current health plans or treatment policies are.

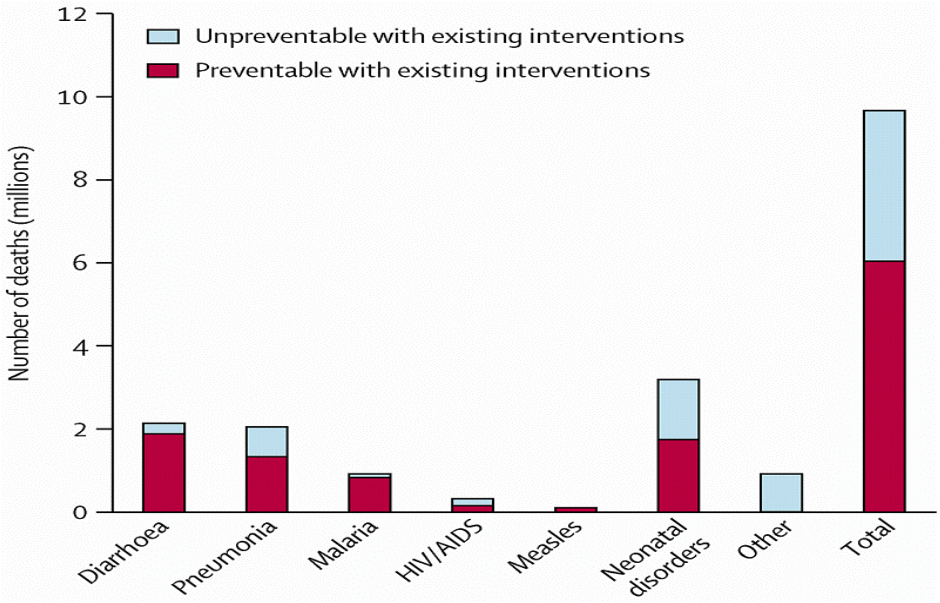

Figure 1. Child deaths in relation to use of existing interventions. Printed from reference [1] with permission of World Bank

The Millennium Development Goals and a plethora of other initiatives have focused on the control of HIV/AIDS, tuberculosis and malaria while neglecting other infectious diseases (viral, bacterial, parasitic and vector-borne plus respiratory infection and diarrhoeas

in children). Non-communicable diseases are now epidemic and to a large extent have been neglected.

Action: **In order to create a sustainable and integrated health plan a situational analysis of essential interventions for each country should be published, based on the baseline mortality rates of the most important diseases. Cost-effectiveness will be only one consideration, as it does not always address public concerns. Prioritisation of programmes should be made in a flexible system of rationing by a process known as "dilution" [18] as distinct from blanket exclusion or "denial" of some diseases as with World Bank "basic care packages". The plan should include evidence based interventions, and specify the manner by which coverage will be achieved, and include hard-to-reach groups. This will need extra money and political will. The plan should then seek funding, set time limits, and have a monitoring mechanism. It should be developed in a public forum.**

Evidence, translated into guidelines, must be widely disseminated, updated regularly, and monitored, in an iterative process which includes feedback from implementers, plus training and support.

1.4 Health Prevention

Some poor countries (e.g. Thailand, Sri Lanka, Cuba and Cost Rica) have improved their health status despite low budgets by promoting inter-sectoral policy linked to strong prevention programmes[19]. Health prevention (and education) is usually the poor relation of treatment programmes, and lacks funding, as the number of lives/illnesses prevented is difficult to quantify. Risk reduction is often reduced to exhortations about personal action (e.g. safe sex) whereas reducing unfair, unjust, avoidable inequalities (e.g. exposure to unfavourable living or working conditions) cannot be changed by individual effort. The ability to apply preventative practices, as well as accessing help early is likely to be concentrated among the better off[20].

Action: **Sustaining good health means recognising the importance of preventing disease and contextualising risk in people's lives by elucidating barriers to change (e.g. through village health committees). Knowledge about health must be made available, accessible, and understandable to the whole population, especially the illiterate, youths, and other excluded groups (e.g. prisoners). This will be challenging but much more use could be made of community radio and other media outlets. The increasing numbers of orphans will require special targeting to prevent psychological and physical problems.**

The rising epidemic of non-communicable disease (hypertension, heart disease, lung disease, epilepsy, diabetes, mental health) needs urgent preventative action including secondary prevention to detect early disease e.g. blood pressure monitoring or cervical cytology checks. If funds are short, prevention targeted at high risk groups (e.g. sex workers) will bear most fruit. Government policy, (challenging food industry, taxing alcohol and tobacco, preventing road accidents) is important to health improvement in rich countries and should be copied.

1.5 Addressing vulnerability and inequalities.

In every country, it is the poor and disenfranchised (as a result of gender, ethnicity, location, age) who bear the brunt of premature ill health in a vicious circle which includes lack of health services, education, opportunities, and increased exposure to pollution, accidents and violence, all of which may interact synergistically. In Zambia the vast majority of rural dwellers (97%) consider themselves to be poor[21]. Although the highest deaths rates at every stage of life are found among the most marginalised, research has shown[22] that efforts to reach disadvantaged groups do not always reach their intended beneficiaries and that it is the very poor who miss out.

Measuring inequalities is important, but crude or composite rates like Disability Adjusted Life Years (DALYS) fail to disaggregate layers of poverty. Wagstaff[23] suggests an "equity analogue" (the equity equivalent of the cost-effectiveness analysis) to measure how well health programmes reach the different levels of poor. He describes a wealth-based investigation of fever in 22 malarious African countries where treatment failed to reach the very poor although it did reach the moderately poor. Relative poverty plays as an important part as absolute poverty. A "marginality index" [24] has been suggested to calculate comparative poverty where the parameters include: illiteracy, incomplete elementary education, wage, no running water, electricity, no sewage facilitates, a proper floor, overcrowded accommodation.

Action: **attention must be given to equity analyses and disaggregation of data. Without this, essential information may be obscured and pro-poor health targeting may fail to reach the very poor. Health indices in a country may appear to be improving while disaggregated data may show significant and widening gaps in health outcomes in some communities, thus increasing inequity[25].**

1.6 Research and knowledge exchange.

Inequities in health research translate into inequalities in health**.** The Mexico summit on health research in poor countries identified failing health systems as an obstacle to achieving the MDGs and called for more reliable evidence on which to base service delivery[26]. They also called for 2% of national health budgets to be used for health research. Collaboration across regions, and with universities in the north, should be encouraged and is beginning to happen[27]. A novel idea, based on mobile phones to collect and exchange information, is described (Box 1).

Action: **Academic institutions must change the biomedical focus of research to include a role in strengthening health systems. This means using field research and qualitative methods to monitor delivery, effect and quality of programmes, including equity analyses. Information dissemination channels must be revolutionised to meet Africa's needs and made cheaper by greater use of (subsidised) satellite technology. Dissemination of knowledge must extend to district level**. D**onors and research institutions should train decision-makers in research-literacy. Twinning and exchange between research facilities must be genuine partnerships: research with, rather than about Africa, is the goal. Patient participation should have a voice in a country's research priorities and governance.**

Box 1. By-Cell mobile phone use and health statistics[28]

A good health surveillance system would increase knowledge of community health, and track changes. Mobile phone use in Africa is ubiquitous and could be used to collect and synchronise data. By-Cell Health Care Network is an independent mobile phone platform. Started as a WHO initiative it has already been used successfully in micro-finance and can operate in a confidential setting. Individuals in the community would be rewarded to collect and transmit data using their ordinary phones linked to By-Cell. Routine data collected might include pregnancies, complications of pregnancy, family planning, births, childhood diseases, infections or institutional data: availability of drugs, medical supplies, and transport. Rewards for collection could be in the form of health insurance, micro-finance payments or saving deposits. The extent and detail of the information gathered would alter in different circumstances but could be collected by community health volunteers. The system has been used successfully in India.

2. Providing health services

2.1 Affordable health care

How to finance health care in Africa is challenging as the tax base is low, unemployment high, illness ubiquitous, and inequity of access huge. Annual health budgets of $20 per capita, or less, constrain planning: Sachs has calculated that a trebling of annual budgets is needed in order to provide *basic* essential care[29].

In many countries the tax base could be increased in a progressive way to raise revenue to at least 20% of GDP and, from that base, to increase public health expenditure (Box 2). No African country has reached the target of 15% of government budget for health recommended by the African Heads of State at Abuja[30]. There is controversy on whether to increase private or public providers, but there is some evidence to show that the larger the role of the public sector in health care systems the better the health outcomes as judged by healthy life expectancy and child mortality[4]. The important aspect of private care is that it should not overwhelm government planning of the health service as a whole.

Pooling of recurrent donor aid has been encouraged to support "basket funding", through a sector-wide approach (SWAp). A SWAp has the advantage of shifting the dialogue between government and donors up a level: from the planning and management of projects to overall policy, institutional and financial frameworks. Sub-Saharan Africa health services receive only $12 of effective drugs for every $100 many taxpayers spend on them[31].

Action: **The tax base could be raised by additional taxing of foreign industry or of the very rich (who often escape paying). There is scope for increased indirect taxation hypothecated to health from alcohol or tobacco, a retrogressive tax but one with significant public health benefits. Countries must also work towards complying with the Abuja targets. Money could be saved by tightened efficiency in procurement of drugs and equipment. People should have a say on how their taxes are spent (democracy). For example, Uganda's military budget is high while health infrastructure is poor.**

WHO should document and promote a regular appraisal of health care financing systems on a country-by-country basis, making it easier for civil society to gauge where their money is spent. Resource allocation and delivery of better health should be part of the poverty reduction process (PRSP) and *should* enable public debate but so far PRSPs have been dominated by discussion on economic growth, as the solution to poverty reduction, with little focus on health[32].

Box 2
Millennium Development Goals for financing health care systems: some targets suggested by Global Health Watch 2005-6[33]

- Government expenditure on health should be at least 15% of GDP.
- Direct-out-of pocket payments should be less than 20% of total health care.
- Spending on district health services (up to and including Level 1 hospital services) to be at least 50% of total public health expenditure, of which half (25% of total) should be on primary health care.
- Expenditure on district health services to be at least 40% of total public and private health expenditure.
- A ratio of total expenditure on district health services in the highest spending district to that of the lowest spending district of not more than 1.5.

2.2 Which methods of financing should be used?

a) Out-of pocket fees have been one of the largest sources of financing exceeding 25% of total health expenditure in more than three-quarters of SSA countries[34]. These fees include user charges (amounting to about 5% of health spending) at public health facilities, as well as direct payments to private providers including traditional healers and informal drug sellers. User fees mean payment at the time of illness and are retrogressive as the poor pay a larger percentage of their income than the rich. Concern about the adverse equity impact of user fees has grown throughout the 1990s. Such fees modify illness perception (the phenomenon of ignoring early disease) and encourage households to sell assets or borrow money. They also have an adverse impact on the purchase of food, education; clothes and fuel[35]. When indirect costs are included, like transport, studies have found that costs to the poor can be as high as 10% of household income[36]. One study in Tanzania showed that a fatal illness like AIDS cost 64% of household income over a 6-month period[37]. Most countries do not have the administrative capacity to implement a reliable exemption scheme[38]. The World Bank and Commission for Africa now acknowledge that user fees can make the difference between a household being poor or not and that alternative financing is preferable. Ghana, South Africa, Uganda, and most recently Zambia, have abolished user fees (using funds from cancelled debt repayment).

b) Compulsory social health insurance pools risk but demands good administrative skills. There are drawbacks when a large part of the population works in the informal sector. Selective insurance (cream-skimming) may exclude the seriously ill. Payments are usually income related (though not always) and therefore progressive (the rich contribute more than

the poor) but if a flat rate is charged the opposite is true. These schemes have several cost and equity benefits over private health insurance. Ideally, social insurance schemes should cover preventative and curative service but more often they only deal with curative, and acting through a fee-for- service, may increase over-prescribing.

c) Community co-financing with or without government or donor subsidies is the term used for regular predetermined contribution by the local community towards specific health services (pre-payment schemes). Often however the very poor are left out[39] and if the population coverage is low, the scope for cross-subsidy is limited. The initiative in Bamako[40] in Mali, where a revolving fund was used to purchase new drugs and subsidise the provision of other elements of health care at a local level, raised standards greatly. However it was a "model scheme" with much support and dependent on fees remaining locally. In China's rural cooperative medical scheme, developed in the 1960 and 70s, communes raised welfare funds which reimbursed part or all of health costs but as the scheme covered 90% of the population, "pooling" was very wide. Co-financing community schemes can be supplemented by donor or central government cross-subsidies**.** Pooling is attractive in rural areas as it evens out seasonal availability of money. The package of health care benefits may need to be explicit to control over-use and achieve value for money.

Action: **Financing mechanisms will differ in each country and there is no "one size fits all" model. But if governments spend more resources on their health sector, out-of-pocket spending should be lower. User fees do not improve allocative efficiency and there is much evidence that they should be gradually and cautiously phased out and the results monitored. It is recommended that the money saved from debt relief be used for this. If there is no other option (or as part of co-funded community financed services) fees should be as low as possible and health centre staff and their relatives should not be exempt.**

If pooling of funds is sufficiently large and if donors or government act as guarantor for the community[41] and help create the necessary organisational and institutional capacity, community financing could be one option for financing health, linked to some form of social insurance scheme for those in work. Critical evaluation of the different options is one of the most needed health service research priorities[42].

2.3. Delivery of care

Devolution of health care to provincial and district health directorates, and sharing administrative boundaries with other sectors, allows integration of policy at a local level. The

district should be able to co-ordinate primary care, 1st level hospitals and private providers and tailor their health resources accordingly. But, to do so, they need demographic information and epidemiology profiles. They also need adequate staffing, and communication with the populations they serve and with the policy makers to whom they are responsible. They often don't do, or have, any of these things. As well as being under-funded, they tend to be weak in managerial capacity, often hierarchical, and suffer from the time-consuming demands of a multiplicity donor programmes. If interlinking projects were in place, they could have a synergistic health effect e.g. micro-credit opportunities for women can improve health and family nutrition. Women's Health Action Research in Nigeria provides small-business skills, training, and reproductive health information to poor women, linking to credit programmes[43]. Multi-sectoral district HIV/AIDS Task Forces are examples of joined up working but they struggle because of under-funding.

Action: **Donors should be asked to increase their investment at district level to ensure district managerial and institutional competence and to support epidemiological and human resource planning. The synergistic hunger-poverty-disease nexus should be addressed at this level by linking voluntary, NGO and community organisations (Box 3). The district should facilitate the involvement of all service users (health centre staff, NGOs, private providers, and patient groups) to inform health planning, monitor standards, disseminate information and empower communities. District management should be backed by District Health Boards with a significant degree of public representation to monitor the quality, responsiveness, and standards of the local heath service. Lay members of Boards need training.**

2.4 Primary health care (PHC), rural care and care of the chronically ill.

If you have ever walked, cycled or driven 40 kilometres on a rough track in the rainy season to reach a rural health centre only to find it un-staffed (because mobile phones don't work) and empty of drugs, you begin to understand the reality of health care delivery in Africa. A nurse may be the only trained health worker and, if absent, a cleaner may be in charge. Rural health centres are usually inadequately equipped (though staff may be very committed) because, traditionally, hospitals have absorbed the major costs at district level. Well-functioning primary care, working in conjunction with first-referral hospitals, has the capacity to manage 90% of health demands[44] including safer maternity services.

Three categories of lay workers are under-acknowledged by health planners. Local chiefs exert a huge influence over often-large rural populations and can encourage drug

adherence, modify or change risky cultural practices and communicate knowledge to the (often illiterate) communities they serve. Traditional healers are very widely consulted and may be the only source of health care: half the rural population of Uganda only use healers. Volunteer home based care workers (usually women) have done much to support the sick and dying, but there is a danger of volunteerism being a cheap option, unsupported, and exploited.

With the arrival of ART, HIV/AIDS is now a chronic disease, requiring long-term monitoring. This has greatly increased the burden on health staff and resources. It has been shown that mobile VCT and ART clinics using lay support workers (often HIV positive) can offer adherence, prevention and defaulter tracing[45].

The universally poor access to pain relief throughout Africa could be improved if the example of Uganda were followed (scaling up of nurse prescribing and community access to cheap oral morphine[46]). Not only would this enhance the quality of home-based care, but prevent enormous suffering.

Action: **A sustainable health sector will creatively use different cadres of staff, including trained lay workers, to support and monitor the chronically ill as near to the patient's home as possible. A re-assessment of the balance between primary and secondary care and an examination of the function of each, with reallocation of funds to district purchasers, will improve equity and help to achieve the MDGs.**

Evaluation of contracts and services within primary care by cross sectional surveys, utilisation rates, patients' satisfaction and quality measures are recommended to ensure user-friendly services and adequate drugs and equipment. Staff can be motivated by a positive management style which uses comparative audit, targets, and incentives. Staff must be paid regularly and kept "in the loop" of policy and guideline production. Communication and referral between primary and secondary care should be smooth and two-way. Government regulation may be necessary to persuade health workers to work in rural areas: incentives (housing, education grants, and sabbatical leave) may minimise isolation.

Enlisting the support, and regulating, traditional healers and community volunteers would assist care in rural areas. Local chiefs have great influence on their populations and are currently under-used by health planners. Voluntary community workers should be valued and given incentives (through a local regulatory scheme) plus supervision and support.

Dialogue with decision-makers, and health professional training, should challenge the legalistic, attitudinal and cultural barriers which prevent access to adequate pain relief in the community.

2.5 Private providers and mission hospitals

Throughout Africa, the bulk of health care provision is carried out by the private sector, much of it in the form of small-scale, disorganized private dispensaries and clinics. Private health providers can fragment and commodify health care, as it is easier to market tangible health interventions than prevention or public health measures. Governments usually do not have the capacity either to regulate the sector or to improve the quality and safety of care provided. Mission hospitals provide a significant proportion of rural health services (about 50% in Zambia) and usually give good quality, dedicated service but, with comparatively generous funding, they can be reluctant to share information with district services and have not been well incorporate into planning strategies. Because mission hospitals and health NGOs are randomly sited, they may not contribute to overall rural equity and their presence may make planning even more complex. Community mapping is a tool to increase collaboration and avoid duplication (Box 3).

Action: **Private health services should be kept to a minimum as, even when entirely financed by private means, they can suck resources from the public health system, and equity is a serious issue. District management must evaluate contracts with private providers (NGOs, faith-based facilities and private providers) to co-ordinate planning. Measurements of quality and coverage are essential and achieving this will require disciplines on all providers in the health system and will be time-consuming. By linking all providers, a synergy of effort may be achieved which also covers employment options, nutrition etc.**

Box 3. Community mapping for HIV/AIDS treatment, support and prevention in rural Zambia. (Simbeya D, Logie D 2006 unpublished)

19 organisations (NGOs: community based support groups (CBSGs): home-based care (hbc), government departments: faith based organisations) were mapped using the following indicators: catchment: activities: objectives: time frames: target groups: capacity: and sustainability.

Observations:

- Only two programmes had long-term funding.
- 80% of organisations were concentrated along the Great East Road (the only tarred road)
- Only one programme (hbc) covered whole district and linked with the 19 rural health centres.

- Several organisations offered the same service in a village, while the next village had none.
- The volunteer dropout rates were high (especially in the rains but also because of lack of interest and competitive incentives)
- There was no incentive regulatory policy in the District.
- Some volunteers were serving more than 1organisation.
- Most of the CBSGs did not have any form of transport.
- Programme sustainability was based on community capacity building.
- Very little funding was available for income generation which, in turn, was slow to generate reasonable profits.
- Seven organisations were aware of similar programmes but did not make an effort to collaborate.

3. Human Resources, planning and knowledge

3.1 Staffing

The serious short-fall in health personnel is a significant factor limiting the ability of countries to deliver better health services. Zambia has lost all but 400 of its 1,600 doctors trained in recent years[6]. It is not uncommon in secondary or tertiary level hospitals to have a single trained nurse looking after a busy ward. Staff shortages cause disillusionment, which may be a factor in the counter-productive behaviour of remaining staff, absenteeism, moonlighting, pilfering of public property, poor treatment of patients, under the counter fee charging, and the sale of free drugs. Recruitment by aid agencies offering higher salaries contributes to the attrition rate. **I**nternational health service labour markets pull staff from rural to urban settings and from poor to richer countries. This "global conveyor belt" has been speeded up by aggressive recruitment by rich countries ("pull factors"). While "push factors" are low remuneration, work associated disease risk, unrealistic workloads, poor human resource support, poor infrastructure, isolation, and sub-optimal living conditions.

Public sector wages in many African countries are low because, in order to reach HIPC completion point and to stabilise inflation, Ministries of Finance, under the auspices of the IMF, placed a ceiling on public sector wages. In Zambia total heath sector wage spending was capped at 8% of GDP. This has contributed not only to poor remuneration but unemployment of health workers. The Lusaka District health management said that "unless annual wages are at a level equivalent to US$3,300 for doctors and $1500 for nurses, migration of health staff will continue to be a chronic problem for Zambia"[47].

Action: **The Commission for Africa suggests that the workforce should be tripled through the training of one million extra health workers over a decade, and their pay significantly increased [5]. Migration of health workers should be controlled by a health service which values skills and commitment: bonuses, incentives, public praise (e.g. quality assurance, site certification, site-comparisons) would help. Policy on migration should not be limitation of movement but equity of health care as soon as possible[48]. Appeals should be made to the Finance Ministries to exclude essential health workers from public sector wage ceilings.**

It is important that human resource planning be incorporated into the highest level of strategic health planning, and also be influential at district level. Inventories of key health workers, geographical distribution, types of skills, and the balance between public and private sector resources should be compiled by MOHs to better manage workers education, migration, and attrition. Each factor contributing to attrition needs to be addressed by the country involved, and working conditions improved. Rich countries should review their recruitment polices.

4. How can a health service become more accountable?

Ways of achieving accountability have been mentioned frequently above, underlining its importance. For public sector bureaucracies to work effectively, efficiently and fairly, they need to be held accountable– internally through rules and codes of ethical conduct but, equally importantly, externally by the public. All too often, the role of civil society organizations within health care systems is given inadequate attention, or is used to cover up other agendas such as transferring responsibility to communities (like unfunded home based care) or rubberstamping central decisions.

Action: **Community mobilization at all levels is important in order to assert rights to health, challenge policies and present alternatives, to monitor services and be involved in planning and decision-making. What is missing in the PRSP processes are practical linkages to health and to the MDGs. Public advocacy should be an instrument of influence over policy.**

5. Conclusions. How can the strengths and deficiencies of a health system be addressed and "refined".

Although it is generally agreed that African health sectors need significantly increased funding and support, attitudes have to change too. Planners have neglected to listen to the

majority of users, the poor, female, marginalised and the rural, and have omitted to take into account their diverse, complex responses to ill health. Addressing equity, quality and coverage simultaneously is a big challenge. Programme implementation has often failed when trade-offs between competing demands are ill-balanced. For example, Integrated Management of Childhood Infections (IMCI) was introduced in rural Tanzania successfully by diligent training of health workers and resulted in good child survival outcomes[49]. As a result, many governments, including Uganda committed themselves to the IMCI strategy but, working under pressure, district health managers took short cuts in case management training, supervision and district-level management, which curtailed expected outcomes[50].

A wise choice of delivery systems are the key to the success of programmes e.g. via rural health centres, or by "piggybacking" on other interventions (like adding micronutrient distribution at time of immunisation), or by using community workers (as in DOTS). The delivery system can influence quality, coverage, cost, sustainability and equity of a programme[50]. Effectiveness studies often fail to take this into account. NGOs have greater mobility to reach excluded groups and might be encouraged to expand their services to improve rural coverage, but co-ordination, funding and resources are issues. The Commission for Macroeconomics and Health has developed a framework[51] to review constraints to scaling up and suggest ways of overcoming them, depending on a county's capacity.

An "African health systems observatory" has been suggested[6] to share good practice. Such an organisation would also help Africa's capacity for drug development, regulation, and bulk buying and help manage trade related intellect property rights at a regional level. Much more needs to be done to support exchange of knowledge, by meta-institutional efforts, and regional cooperation. Partnerships with other health services and academia should be encouraged.

Recent debt relief in HIPC countries should be directed towards health or education and the international community should monitor this. The Commission for Africa calls for additional overseas development assistance of $25 billion a year to 2010, and subject to review, till 2015, under African Union/ NEPAD's Health Strategy and Initial Programme of Action[6] which will coordinate donors, track initiatives, harmonise aid and support governments own priorities. African countries too must play their part to reach the Abuja target of 15% of budget expenditure for health[29].

If health systems could achieve improved quality, coverage, equity, and effectiveness of care, plus meaningful public accountability, plus gain significant additional funding wisely-directed, then health systems could be a vehicle for improving human rights, encouraging active citizenship, and reducing poverty.

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