The mixed health systems syndrome

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Global health appears to be undergoing a gradual shift in focus away from diseases towards systems. This is partly a response to the difficulties that disease-specific global health initiatives have experienced in meeting individual programme targets and internationally agreed benchmarks, in spite of significant increases in development assistance over the past decade.[1] It is also a response to the fiscal constraints caused by the global financial crisis, which has created an environment in which governments and development partners are not only striving to secure resources for development but are also focusing attention on improving returns on spending by strengthening poorly functioning public systems. As a result, there has been increased attention on health systems by major global health initiatives, the governments of the Group of Eight (G8) high-income countries, private foundations, new international partnerships and the World Health Organization (WHO). The latter is demonstrated in particular by its recent resurrection of primary health care.[2]

The diversity in design of health systems around the world, complicated by the interconnectedness of health systems with the country's body politic, must be considered in any effort to strengthen health systems. Notwithstanding the many differences, health care in a majority of low- and middle-income countries is delivered by a mixed health system – defined as a health system in which out-of-pocket payments and market provision of services predominate as a means of financing and providing services in an environment where publicly-financed government health delivery coexists with privately-financed market delivery.[3] This perspective hypothesizes that poor performance is due to interplay between three factors in the mixed health system: (i) insufficient state funding for health; (ii) a regulatory environment that enables the private sector to deliver social services without an appropriate regulatory framework; and (iii) lack of transparency in governance. This triad of determinants acts together to compromise the quality of public services and defeat the equity objective in several ways (see figure at: http://heartfile.org/mhhs1.htm).

Most low- and low middle-income countries spend less than US$ 34 per capita annually on health, the amount considered essential by WHO to secure basic health services. All of the 42 low-income countries (as defined by The World Bank) spend less than US$ 34 per capita on health, except Zambia which spends US$ 35 (see figure at: http://heartfile.org/mhhs2.htm). Among the low to middle-income countries, the following spend less than the benchmark: Azerbaijan, Cameroon, the Congo, Côte d'Ivoire, Georgia, India, Indonesia, Lesotho, Morocco, Nigeria, Pakistan, Papua New Guinea, the Philippines, Sri Lanka, the Sudan and the Syrian Arab Republic. Of these, India, Indonesia, Nigeria and Pakistan have populations greater than 100 million.

Low levels of public financing mean that public health workers are seldom paid at current market rates. Better incentives in the private system lead to workers holding dual jobs, reported to be widespread in mixed health systems. In remote areas, where supervision cannot always be maintained, absenteeism and the "ghost worker" phenomenon is common. Limited public resources result in poorly maintained infrastructure and force users to pay for their care, which can lead to inequity if there is no assistance for the disadvantaged. Private services flourish in such environments where the public system cannot cater to demand. In a weak regulatory environment, which is often the case in developing countries, the private sector can charge very high fees for poor quality service. Weaknesses in governance and transparency can further compromise scarce resources by allowing collusion in procurement and theft from the supply chain. Patronage, tolerance to circumventing procedures and state capture by the elite cannot only cause misappropriation of talent but also bias laws and policies of the country towards issues to obtain selective benefits, which can be detrimental to the equity objective.

When a public and private mix of health-care delivery shows "symptoms" of compromised quality and equity, it can be "diagnosed" as having mixed health systems syndrome. Characteristics of this syndrome are identified using key indicators of poor health systems performance. Failure to achieve "fairness in financing" is shown in the dominance of out-of-pocket payments.[4] When care is predominantly provided by the private sector, management and performance problems are manifest in the public system and are hence reflective of poor "responsiveness". In addition, inability to achieve "equity in outcomes" is endemic to these systems.

The public-private mix is not necessarily a guarantee of poor performance. Locally relevant public policies can use private providers in a positive way. As private markets are unlikely to go away in the short-term, it is important to consider their possible impact on health systems goals. Developing countries with mixed health systems should draw on the experiences of many high- and some middle-income countries, which have developed ways to regulate private providers. This involves a major effort to build technical capacity of stewardship and regulatory agencies in developing countries. Such measures should be paralleled with major efforts to broaden the base of public financing for health.

Reform of mixed health systems needs to include measures both within and outside the health-care system. The

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first priority is to address broader constraints of the political and economic systems that are manifest in inequities of power, money and resources, one of the strongest determinants of health status achievement. Debt limitation, fiscal responsibility and measures to broaden the tax base are necessary to create the needed fiscal space in the developing countries for the health sector; macroeconomic reform is critical for economic growth that benefits the poor and for bridging broader social inequities. Reform of public service and financial management to promote transparency in governance can deeply impact performance of a health system (see figure at: http://heartfile.org/mhhs3.htm).

Second, an increase in public sources of financing for health is critical. Measures can include incremental increases in revenues earmarked for health to support essential services, broadening the base of social protection for the informally employed sector and maximizing pooling through insurance for the formally employed sector. Increased funding, coupled with strategic approaches to reform public service delivery, can help achieve two results: retaining the workforce in the public sector (with appropriate incentives and accountability arrangements) and improving availability of essential medicines and supplies and improving infrastructure (through transparency in management, procurement and supply chains). Public facilities can be better managed through directly managed services, by granting greater autonomy with appropriate supervision or by contracting out, albeit with appropriate safeguards.

Third, regulatory approaches can enable the use of private providers to broaden primary health-care services and achieve greater equity overall. These changes in service delivery and financing arrangements require government health agencies in developing countries to enhance their normative and supervisory role to oversee provision of services, ideally with institutional separation of policy-making, implementation and regulatory functions. With appropriate stewardship of mixed health systems, "health for all" objectives can be pursued by augmenting public financing and harnessing private providers.

Global health initiatives can catalyse change in countries. It is presently not within the remit of most of these initiatives to invest in prepayment mechanisms, address broader health inequities and build capacity of health systems in pre-service education nor to lend impetus to broad-based health systems reform, which appears to be needed in most countries to bridge some of the critical gaps. Expanding the mandate of these initiatives, possibly through a new health systems financing platform, could permit them to engage in countries with a broader set of issues to boost public financing, maximize the work of a broad range of providers, consolidate health information systems at large, work towards building a sustainable workforce and lobby for workforce retention regulation.[5]

This broad agenda for reforming a mixed health system can be phased in stages, with the first step being the creation of appropriate laws, policies and frameworks, the next step restructuring in pilot settings, before scaling up across the system.[6] Implementation of this kind of broad reform requires political will, perseverance, consistency of policy and the resolve and capacity to implement these changes into policies, laws and institutional arrangements. Limited capacity, the short-term outlook of governments in most developing countries and lack of transparency in governance create impediments and so need to be addressed in tandem with health system reform. ■

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