CHALLENGING INEQUITY THROUGH HEALTH SYSTEMS

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Acronyms

AIDS	Acquired Auto-immune Deficiency Syndrome
ART	Anti-retroviral therapy
CBO	Community-based organisation
CHWs	Community health workers
CSDH	Commission on the Social Determinants of Health
CSO	Civil society organisation
CWGH	Community Working Group on Health
DFID	Department for International Development (UK)
EU	European Union
EQUINET	Southern and East African network devoted to promoting health equity
GBS	General Budget Support
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHI	Global Health Initiative
HAZ	Health Action Zone
HIPC	Highly Indebted Poor Countries
HIV	Human Immuno-deficiency Virus
HSKN	Health Systems Knowledge Network
IAH	Intersectoral action for health
KN	Knowledge Network
LMICs	Low and middle-income countries
MAP	World Bank Multi-country Aids Programme
MDG	Millennium Development Goal
MOF	Ministry/Minister of Finance
MOH	Ministry/Minister of Health
NGO	Non-governmental organisation
NHI	National Health Insurance
NSMP	Nepal Safe Motherhood Programme
PAHO	Pan-American Health Organization
PEPFAR	The US President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PPP	Purchasing power parity
PRSP	Poverty Reduction Strategy Paper
SDH	Social determinants of health
SEAPACOH	Southern and East African Parliamentary Alliance of Committees of Health for Equity in Health
SWAp	Sector-wide approach
TB	Tuberculosis
UC	Universal coverage
UK	United Kingdom
UN	United Nations
US	United States
VAT	Value-added tax
WHO	World Health Organization

Glossary

autonomy: "The degree of … access to, and control over, material resources (including food, income, land and other forms of wealth) and to social resources (including knowledge, power and prestige) within the family, community and society at large" (Jejeebhoy 2000:205).

catastrophic (health care) payments: combined levels of health care payment (including, for example, fees, drug costs and transport costs) that are at such a high level they force households to reduce spending on other basic goods, sell assets or incur high levels of debt, ultimately risking impoverishment (McIntyre 2007) .

civil society: The common understanding is that civil society embraces the general public at large, representing the social domain that is not part of the State or the market. Lacking the coercive or regulatory power of the State and the economic power of market actors, civil society provides the social power of its networks of people. Its ideas, information, services and expertise are used to advance the interests of people by seeking to influence the State and the market. It is a sphere where people combine for their collective interests to engage in activities with public consequence' (WHO 2002).

civil society organisations (CSOs): CSOs are 'non-state, not-for-profit, voluntary organisations formed by people within the social sphere of civil society. These organisations draw from community, neighbourhood, work, social and other connections. CSOs have become an increasingly common channel through which people seek to exercise citizenship and contribute to social and economic change. They cover a variety of organisational interests and forms, ranging from formal organisations registered with authorities to informal social movements coming together around a common cause' (WHO 2002).

commercialisation: commercialisation within health systems encompasses: 'the provision of health care services through market relationships to those able to pay; investment in, and production of, those services, and of inputs to them, for cash income or profit, including private contracting and supply to publicly financed health care; and health care financing derived from individual payment and private insurance' (Mackintosh and Koivusalo 2005:3).

cross-subsidy: *income cross-subsidy*: whereby the wealthy make greater contributions to health care funding than the poor, but all have access to the same range of services; *risk cross-subsidy*: whereby people with a greater need for health care (i.e. high-risk individuals) are able to use more health services than those who are healthy (i.e. low-risk individuals), irrespective of the contribution made by each income group' (McIntyre 2007).

district health system: this is comprised of a well-defined population, living within a clearly delineated administrative and geographical area, and including all organisations and individuals promoting health or providing health care (WHO 1998).

health literacy: people's ability to access and understand basic health information and health systems, and to use such information and systems in ways that are health-enhancing and that support action on health.

health system: includes all actions whose primary purpose is to promote, restore, or maintain health (WHO 2000).

inequality reducing health care: systems of health care from which the poor receive a greater level of public expenditure (subsidy) than their share of market-generated income (but also, from which the rich may capture a larger share of public health care spending than the poor) (Mackintosh 2007).

institutions: the rules, laws, customs and norms that constrain and structure the actions of individuals, and show stability and legitimacy over time; they act as a barrier to change and have long-term often unpredictable effects (Hudson and Lowe 2004; Buse *et al.* 2005).

intersectoral action for health (IAH) is 'a recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone' (WHO 1997). This definition is interpreted to include collaborative action between different

departments and bodies within government, as well as between actors within and outside government, such as civil society organisations, for-profit private organisations and communities.

mandatory health insurance: 'a health insurance to which certain population groups or the entire population must belong by law' (and which imply income and risk cross-subsidies) (McIntyre 2007)

policy: broad statement of goals, objectives and means that create the framework for activity. Often takes the form of explicit written documents, but may also be implicit or unwritten (Buse *et al.* 2005).

policy process: the way in which policies are initiated, developed or formulated, negotiated, communicated, implemented and evaluated (Buse *et al.* 2005).

(policy) actor: individuals, organisations, or even the state and their actions that affect policy (Buse *et al.* 2005).

population health: not simply the sum of the health of individuals as it also entails consideration of the patterns of health distribution throughout the population, considering economic, social and cultural subgroups (Starfield 2001).

Primary Health Care is understood as a strategy for organising health systems to promote health. It encompasses essential health care made universally available to individuals and families by a means acceptable to them and at a cost that the society can afford, as well as intersectoral action for health. It is the nucleus of a country's health system and contributes to national socio-economic development. It is founded on recognition of the need for political action to address the social determinants of health inequity, taking account of the particular configuration of power relations within any society (PAHO 2007).

pro-poor health care: systems of health care in which the poor capture a larger share of public health care spending than the rich (Mackintosh 2007).

purchasing refers to the transfer of pooled funds to providers to pay for the health services used by the population (Kutzin 2001).

redistributive health care: see inequality reducing health care and pro-poor health care.

risk equalisation: 'a mechanism whereby revenue accruing from contributions to several health insurance schemes … is pooled and the individual schemes allocated an amount which reflects the expected costs of each scheme according to the overall ill-health risk profile of its membership' (calculated on the basis of the relative risk of incurring health expenditure) (McIntyre 2007:xii).

social empowerment: 'people's ability to act through collective participation by strengthening their organisational capacities, challenging power inequities and achieving outcomes on many reciprocal levels in different domains: psychological empowerment, household relations… transformed institutions, greater access to resources, open governance and increasingly equitable community conditions' (Wallerstein 1992).

social mobilisation: encompasses a range of activities aimed at increasing social awareness of health and health systems, strengthening health literacy and enhancing social capacities to take health actions. Social mobilisation can improve the performance of health systems and the health outcomes for communities, especially in relation to health promotion and public health activities.

universal coverage (UC): this is situation where the whole population of a country has access to good quality services according to needs and preferences, regardless of income level, social status, or residency. It is an absolute concept in relation to population coverage (100%) with the same scope of benefits extended to the whole population (but the range of benefits varies between contexts); and it incorporates the policy objectives of equity in payments (the rich should pay more than the poor), financial protection (the poor should not become poor as a result of using health care) and equity of access or utilisation (implying distribution according to need rather than ability to pay, and requiring equity in the distribution of spending and resources) (Kutzin 2001; Mills 2007).

Political Briefing: Report of the Health Systems Knowledge Network

This briefing note presents key messages of the final report of the *Health Systems Knowledge Network* established by the World Health Organization's Commission on the Social Determinants of Health. The messages have been formulated for the political executive, particularly Ministers of Health, and their senior advisors. They have been generated by Network members and are based on review of evidence and experience (members were drawn from a range of policy, civil society and academic bases across the world).

In the report, health systems are seen to include **all activities whose primary purpose is to improve health**. The report discusses important health system features and actions that can address health inequity. While it focuses on low- and middle-income countries, many of the recommendations may be appropriate to high-income countries. The messages are complementary to, and do not repeat, those in the reports of the *Women and Gender Equity* and *Globalisation Knowledge Networks.* More detailed messages on the role of public health programmes in addressing health inequity will be presented in the forthcoming report of the *Priority Public Health Conditions Knowledge Network*.

Why health systems matter to the social determinants of health inequity

1.   Health systems offer **general population benefits** that go beyond preventing and treating illness. Appropriately designed and managed, they:

  - o   provide a vehicle to improve people's lives, protecting them from the vulnerability of sickness, generating a sense of life security and building common purpose within society;
  - o   ensure that all population groups are included in the processes and benefits of socio-economic development; and
  - o   generate the political support needed to sustain them over time.

2.   Health systems **promote health equity** when their design and management specifically consider the circumstances and needs of socially disadvantaged and marginalized populations, including women, the poor and groups who experience stigma and discrimination, enabling social action by these groups and the civil society organisations supporting them.

3.   Health systems can, when appropriately designed and managed, **contribute to achieving the Millennium Development Goals**.

Critical health system features that address health inequity

4.   The key overarching features of heath systems that generate preferential health benefits for socially disadvantaged and marginalized groups, as well as general population gains, are:

  - •   the leadership, processes and mechanisms that **leverage intersectoral action** across government departments to promote population health;

  - •   organisational arrangements and practices that **involve population groups and civil society organisations**, particularly those working with socially disadvantaged and marginalized groups, in decisions and actions that identify, address and allocate resources to health needs;

  - •   health care financing and provision arrangements that **aim at universal coverage** and offer particular benefits for socially disadvantaged and marginalized groups (specifically: improved access to health care; better protection against the impoverishing costs of illness; and the redistribution of resources towards poorer groups with greater health needs); and

  - •   the **revitalization of the comprehensive primary health care approach**, as a strategy that reinforces and integrates the other health equity-promoting features identified above.

Actions to address health inequity

5.　To strengthen health systems and address health inequity, Ministers of Health and other government leaders must take action to:

- **secure political commitment** to social and economic policies that support equity, founded on social and economic rights and operationalised through the comprehensive primary health care approach, providing a basis for the social and institutional action necessary to promote health among socially disadvantaged and marginalized populations;

- **establish the legal provisions and policy frameworks** that, coordinated across sectors, enable and sustain equitable health system development, such as the frameworks governing:
  - the co-ordination of decision-making responsibilities and authorities between sectors and across levels of the health system;
  - opportunities to engage civil society in health system decision-making and action, especially at the local level;
  - the funding basis of the health system;
  - entitlements to health care;
  - regulation of the private sector; and
  - human resource development and management.

- **secure increases in government expenditure on the health sector**, for example, by re-prioritising health within the government budget, widening the tax base and improving tax collection, and securing international funding support;

- **re-allocate government resources** (in combination with other resources) between geographical areas, populations, levels of the system and forms of health care in response to the needs of population health and capacity development, rather than according to historical spending patterns;

- **remove user fees** for public services;

- **prioritise primary health care** in public health system investment strategies; and

- **empower and enable local level public sector managers** to re-orient the routine practices of health systems towards equity goals, by nurturing an ethic to sustain such action, providing them with skills and information tools, and securing authority and support to make decisions.

6.　The political leadership necessary to initiate and sustain these actions involves:

- **building coalitions of support** with like-minded actors based inside and outside government through:
  - looking for evidence on, and demanding investigation of, differentials in health status between areas and populations;
  - framing issues in terms that allow broad-based support for health equity to be built and support the specific actions needed to revitalize health systems, as well as to counter the values and norms that undermine equity goals;
  - engaging, motivating and leading those working within the public health sector in support of health equity goals and actions; and
  - identifying opponents and obstacles, working around them strategically and countering their influence.

- **establishing policy goals** that drive wider action by focusing on health inequities and on the investments, policies and institutions needed to tackle them, and **encouraging implementation processes** that stimulate innovation and learning in pursuit of health equity goals; and

- **demonstrating, by personal example, the values of integrity and transparency**.

Executive Summary: Report of the Health Systems Knowledge Network

Introduction

The World Health Organization's Commission on the Social Determinants of Health identifies health systems as a site for action to promote greater equity in health.   Accordingly, the Commission tasked its Health Systems Knowledge Network with synthesizing evidence to inform health system action against the root causes of health inequity. Health systems were seen as encompassing *'all the activities whose primary purpose is to promote, restore, or maintain health'* (WHO 2000) and as a vital part of the social fabric of any country, providing not only services and influencing health, but also reflecting the dominant social values.

The Commission directed the Network's attention to relevant features of national health systems that may be strengthened to address health inequity. This approach provided a broad focus but, to some extent, limited the range and depth of the issues addressed. Complementary work by other Knowledge Networks more fully addresses the connected issues of: the role of priority public health conditions; gender inequities in employment, management and health care delivery; and the influence of globalisation over health systems (specifically through international human resource migration, trade in heath services, intellectual property rights legislation and international assistance).

This executive summary presents the key conclusions and recommendations of the Health Systems Knowledge Network's final report and is primarily addressed to: Ministers of Health and senior government officials; civil society organisations at local, national and international level; and officials working within international health agencies. Our findings reflects two years of discussions and draws on: reviews of relevant literature generated over the past few decades; 30 specially commissioned peer-reviewed papers and case studies (available at www.wits.ac.za/chp/); and the policy, civil society and academic expertise of the 15 Knowledge Network members, as well as a wider circle of authors and reviewers.

We focus primarily on the situation in low- and middle-income countries, although there are lessons of relevance to high-income countries.   Our recommendations are underpinned by three understandings derived from our review of international experience:

- The experience of health systems **is always context-specific** and so contextual factors need to be considered when applying learning to other settings. However, health system development is not fully determined by context: equitable health systems have broad features in common that can be nurtured by context-sensitive strategies for health system transformation.
- Placing health equity as the central goal of health systems **requires substantial and co-ordinated re-orientation** through re-framing of policy and institutional transformation. This in turn requires active management of the policy development and implementation process and needs to be based on the wider political and policy commitment to social equity through which such action is enabled.

- Despite the increasingly plural nature of health systems (especially with respect to health care provision), **the public sector plays the primary role** in working towards health equity and should be strengthened to achieve this function.

Why do health systems matter?

Social determinants usually identified as influencing health and health equity include those such as housing, employment and education (the so-called 'upstream' factors). Growing evidence from a range of disciplinary perspectives shows, however, that health systems are themselves social determinants. They are seen more commonly as 'downstream' determinants (for example, in the extent to which they allow access by the disadvantaged to health care services), but this report shows how health systems have 'upstream' influence as well, extending even to impacts on the broader socio-political environment.

Overall, the evidence demonstrates that, when appropriately designed and managed, health systems can address health equity. They do this when they specifically address the circumstances of socially disadvantaged and marginalized populations, including women, the poor and other groups excluded through stigma and discrimination. They also generate wider benefits: a sense of life security, well-being, social cohesion and confident expectation of care in times of illness; and they may be influential in building societal and political support for governments that promote health equity. Health systems can, thus, contribute to achieving the Millennium Development Goals.

All too often, health systems fail to realise this positive potential. Opportunities to mitigate the harmful health and equity effects of social stratification are missed. In some instances, health systems actively perpetuate injustice and social stratification. There are examples of health systems that: fail to apply their expertise to address the social determinants of health; fail to contribute to social empowerment in the interests of health equity; institutionalise health care arrangements that create financial and geographic barriers to access for disadvantaged groups; alienate disadvantaged groups through culturally insensitive and sometimes antagonistic health worker and institutional practices; and impoverish the poor whilst allowing the rich to capture greater levels of public health care spending.

Such failures have been entrenched by the macro-economic policies and neo-liberal health sector reforms that have dominated health system development over the last decades. Commercialisation and globalisation have undermined the capacities of health systems in low- and middle-income countries to address health inequity. This can clearly be seen in the impoverishing cost burdens that result from charging fees for public health services (a neo-liberal reform associated with commercialisation), and the international migration of scarce human resources (a defining characteristic of globalisation). The norms and values that are commonly embedded within health systems also sustain practices that contribute to health inequity, such as gender discrimination in employment and care. Other ingrained approaches, such as the bio-medical, curative care orientation of service delivery, block initiatives to re-orient health systems to promote health and health equity.

Yet there are inspiring examples of health systems that choose to champion social justice, even in very low-income settings. A growing body of epidemiological, economic and other evidence, including both country-specific and cross-country investigations, also highlight what needs to be done within health systems to generate health and health equity gains. Although this evidence base has limitations, particularly evidence from low- and middle-income countries, and despite the fact that health system change is always complex, the diverse evidence we synthesize provides a surprisingly coherent and robust basis for action. Even where evidence is thinner, the challenges of inequity demand innovation and experimentation.

What are the overarching features of health systems that address the social determinants of health inequity?

The Health Systems Knowledge Network concludes that the main features of health systems oriented to population health and health equity are:

- leadership, processes and mechanisms that **leverage intersectoral action** across government departments to promote population health;
- organisational arrangements and practices that **involve population groups and civil society organisations** (particularly those working with socially disadvantaged and marginalized groups) in decisions and actions that identify, address and allocate resources to health needs;
- heath care financing and provision arrangements that **aim at universal coverage** and redistribute resources towards poorer groups with greater health needs; and
- the **revitalization of the comprehensive primary health care approach** as a strategy that reinforces and integrates other health equity-promoting features.

A range of epidemiological and other evidence demonstrates that intersectoral action for health and social empowerment both offer health and health equity gains. Intersectoral action for health offers particular benefits to the marginalized groups most affected by, and least empowered to take action on elements of the physical and social environment that produce illness. At a population level, meanwhile, social empowerment interventions generate these benefits either by addressing the structural causes of ill-health or by empowering low-income groups, women and others to take control of their health, for example, by changing risky environments and using available health care.

Universal coverage is achieved when the whole population of a country has access to the same range of quality services according to needs and preferences, regardless of income level, social status or residency. Such systems offer particular benefits to the poor by improving their access to health care, protecting them from financial impoverishment and ensuring that the rich pay a higher proportion of their income to support health care provision. Universal coverage approaches also generally require less administrative capacity and are more sustainable than targeted approaches.

Parallel bodies of cross-national epidemiological and economic evidence demonstrate that health care systems with universal coverage address economic inequality by re-distributing resources from the rich to the poor. Such systems tend to accord public funding a central role, charge no or very low fees for public services, offer a comprehensive set of services (with a clear role for primary level care in helping patients navigate the use of referral services) and regulate the private sector (including commercial providers and insurers and, in low-income contexts, informal providers) to protect equity gains. Additional strategies are also likely to be necessary fully to address the particular barriers to accessing care that disadvantaged and marginalized groups face.

Indeed, a growing body of epidemiological evidence demonstrates the health equity gains of strong primary health care systems that place families and communities at the heart of the health system, offering integrated services that emphasises health promotion and illness prevention. These systems most effectively address the types of health problems predominantly faced by socially disadvantaged groups, offer preferential gains to these groups by timely intervention which helps detect and prevent co-morbidity and limits the effects of illness severity, and makes services more accessible to them. Wider evidence also shows that strong primary health care systems lever and enable local-level intersectoral initiatives and social empowerment that addresses health needs, even in the face of wider constraints. For these reasons, this report sees the comprehensive primary health care strategy - an approach to health systems development that extends beyond the primary care level to the health system as a whole - as peculiarly suited to informing how health systems can address the social determinants of health.

What actions are needed to operationalise these features within health systems?

RECOMMENDATION 1:

Ministers of Health and health officials must mobilise intersectoral relationships

Intersectoral action for health (IAH) refers to relationships between sectors that are formed in order to take action on improving health outcomes in a way that has more potential than if the health sector acted on its own. IAH is a complex political process, involving diverse groups in wide-ranging activities. Contextual factors often act as obstacles, but can also stimulate opportunities for IAH. Although generally easier to implement at local levels, higher level action may better address some of the structural causes of ill-health that most affect socially disadvantaged groups. In sum, no single model fits all circumstances.

Country experiences show that Ministers of Health and health managers can play a central role in initiating and monitoring, if not also running, intersectoral projects in any setting, including low-income and conflict-affected countries; this is because of their explicit concern and understanding for population health. IAH is time-consuming and resource-intensive, however, and so health leaders and officials should make strategic choices about when and how to intervene to promote IAH. It is often possible to catalyse action by other sectors or take advantage of opportunities for intersectoral action which do not have equity as a stated goal. To leverage intersectoral action dynamic health leaders and officials at every level of the health system should:

- **make the case for intersectoral action**, using sound epidemiological and other evidence, to convince other sectors to participate;

- **take the strategic needs of other sectors into account**, framing objectives in ways that are commonly understood and sharing responsibilities and rewards (rather than taking prime responsibility for all the stages of developing, implementing and evaluating initiatives);

- **set explicit goals and objectives** that give a clear mandate, are clearly linked to activities and yield visible results that help build morale as well as provide a good basis for evaluation;

- **build trust-based teams**, drawn from actors in different sectors, levels of government and parts of civil society, who together combine the range of skills to develop, implement and evaluate IAH initiatives, and manage complex communication and negotiation processes; and

- **build relationships with local or national political leaders and media** to garner wider political and social support for particular IAH initiatives and for IAH in general.

Additional action at higher levels can enable and sustain local IAH initiatives. As first steps in any context, Ministers of Health and senior officials should strive to establish organisational arrangements that allow for on-going dialogue across sectors and secure dedicated budgets and performance incentives for participation in IAH, including appropriate accountability frameworks and relevant skills training. They may also be able to implement specific high-level interventions, such as alcohol or tobacco taxation. To achieve these steps they will, in particular, need to secure the support of central finance officials by making a persuasive case for how IAH can addresses the particular economic and budgetary policy concerns of Treasury. Health officials may also need to lead wider political action to offset opposition from powerful actors threatened by specific IAH initiatives, such as the opposition of tobacco companies to anti-smoking campaigns and legislation. In politically supportive contexts, Ministers of Health and senior officials should seek support for national policy frameworks that work towards institutionalising IAH by making health equity the central goal. Such frameworks should also place mandatory requirements on other government ministries to conduct health impact assessments or participate in intersectoral action. In these contexts, it may well become more appropriate for Cabinet or inter-Ministerial committees to drive IAH, although the Ministry of Health will always play an important role.

RECOMMENDATION 2:

Ministers of Health, health officials and civil society organisations must facilitate social empowerment

Strategies for social empowerment must be context-specific. In particular, they must take into account the nature of the relationships between the state and civil society and the values and norms that underpin policy. Stable, egalitarian socio-political contexts and social conditions that promote collective claims to social rights facilitate social participation. Also important are organised and capable social networks and civil society organisations (CSOs), sustained contact between population groups and health workers, an adequately resourced local health system and incentives for collective action.

International experience suggests measures that can facilitate social empowerment for health, especially for relatively powerless groups who also bear the burden of health problems in every society. Senior health officials and local public health system managers must, in broad terms, provide opportunities for such groups to engage in decisions on health and tap resources for health, ensuring that health systems respond to needs, and strengthening health worker-community relationships. At the same time, CSOs serving these groups must facilitate social processes and community-led action, including exposing and redressing power imbalances that harm opportunities for health in disadvantaged groups. Both sets of actions are enabled by government action to establish statutory rights to public information and to recognize, support and fund general mechanisms for direct participation by population groups.

More specifically, health officials can:

- **structure processes that bring professionals into roles that support social mobilisation** and support and reward these roles;
- **recognize, support and fund mechanisms for direct participation by communities**;
- **use participatory processes** in planning, and particularly in resource allocation, and make planning processes accessible to public monitoring;
- **establish a mix of legal, media, organisational and communication strategies** to monitor, report on and hold the health system accountable for its policies and commitments.

In parallel, CSOs can:

- **provide for the inclusion of population information and preferences** in monitoring, lobbying and planning;
- **monitor** the performance of health systems against social priorities;
- **draw attention to needs and inequities** in resource allocation;
- **provide special mechanisms to engage marginal groups**;
- **support the development of social capacities** for engaging with bureaucracies and authorities; and
- **engage with formal local and national political leaders** to strengthen political support for social action and participatory processes.

RECOMMENDATION 3:

Ministers of Health and senior health officials must gradually build up universal coverage

In low-income countries and post-conflict settings a vital first step towards universal coverage is to **mobilise extra resources for health care**: for example, by re-prioritising health care within government allocations, widening the tax base and improving tax collection, tackling corruption and securing increased international assistance.

The following five steps are then needed in all contexts, most even in post-conflict settings:

- **reduce out-of-pocket payments** by removing public sector user fees and developing innovative ways to limit other health care costs (such as drug and transport costs);

- **widen geographical access to comprehensive services** by investing in public primary and secondary services in currently under-served areas and strengthening referral linkages (strengthening maternal care will offer particular benefits for women);
- **re-allocate government resources between geographical areas** taking account of population health needs and all available funding sources;
- develop innovative strategies to **improve the acceptability and quality** of public sector health care; and
- **enhance technical efficiency** (especially in relation to pharmaceuticals).

Experience also suggests that, in low-income countries (and some transitional countries), it might be useful to test out two other strategies, but, given their limitations, only with adequate monitoring and evaluation:

- **working with non-state providers** in low-income populations to extend access and improve quality, providing that they complement strategies for universal coverage and do not reinforce inequity and stigmatisation; and
- **community-based health insurance** (or insurance schemes dedicated to particular population groups) as mechanisms for protecting poorer groups against catastrophic payment levels, learning from existing national and international experience about how to avoid the many pitfalls of such schemes and extend coverage, particularly to the most socially disadvantaged.

Finally, in the complex environments of middle-income countries (including some transitional countries), actions should be taken over time to:

- **expand pre-payment funding** through a combination of tax funding (used primarily to subsidise poor and hard-to-reach groups) and mandatory health insurance (ensuring income-related insurance contributions and limiting the tax deductibility of insurance contributions for higher income groups);
- **widen the benefit/service package** provided to poorer groups, over time, to minimise catastrophic cost burdens and impoverishment;
- **reduce fragmentation and segmentation** within the health care system by pooling funds and harmonising contribution levels and benefit packages between population groups;
- **where relevant, experiment cautiously with risk-equalisation mechanisms** to ensure equitable resource allocation between financing schemes;
- **consider carefully if and how to strengthen purchasing strategies,** such as contracting arrangements, to leverage performance improvements and cost containment, particularly in relation to private health care providers; and
- **regulate private insurance** to prevent distortions in the overall system that undermine equity, but allowing it to act primarily as top-up insurance for the more wealthy.

RECOMMENDATION 4:

Ministers of Health and health officials, working with civil society organisations, must revitalize PHC

Past experience around Primary Health Care (PHC) – as a combination of the promotion, prevention and care elements of health systems, as a strategy for organising the health system that covers the socio-political, economic, and biomedical dimensions of health and as a philosophy - has shown both promise and disappointment. Nonetheless, there is growing evidence of PHC's potential to deliver health and health equity gains and internationally there have been calls to revitalize the approach and its implementation. Building on the inspiration that PHC continues to generate among health personnel and the general public, the goal is to strengthen national capability to reduce health inequity as part of a human development agenda linked, for example, to the Millennium Development Goals.

The recommendations outlined above help to operationalised key actions on the social determinants of health inequity, namely, intersectoral action for health, social empowerment and re-distributive health care. These elements have historically been identified with comprehensive PHC. However, additional actions are necessary to revitalize PHC and so capture the health and health equity gains that it can deliver. Recognising the need for contextual variation in implementation, current experience indicates that the key steps in all contexts are to:

- **strengthen the local level** (sometimes called the District Health System) as the foundation of the health system and the focal point for the wider action needed to address the social determinants of health inequity;
- **adequately fund the local level and PHC**, within the framework of universal coverage;
- **recognize and tap local-level opportunities for partnership** between multi-disciplinary teams of local public health professionals, CSOs and local political and community leaders;
- **provide the primary care level with infrastructural and logistical support**, especially in terms of drugs, technology and transport systems;
- **ensure the availability of local health personnel** with the necessary resources, values base and skills to take action on health inequity and work with disadvantaged and marginalized populations;
- **strengthen local health management** by training and motivating managers and by establishing local information systems that support action on health inequity (see also recommendation 5.3);

What political and institutional processes are necessary to initiate and sustain health system transformation?

RECOMMENDATION 5:

Progressive policy actors working at national level must take action to strengthen the processes of developing and implementing policies

Addressing the social determinants of health inequity is not simply about making appropriate policy choices. Politics always matters. Governments with egalitarian ideologies are more likely to implement policies that promote social

equity than conservative governments. However, in every context policy choices are always subject to challenge, particularly from those with completely different agendas and those who fear a loss of power, status or income. Policies with health equity goals are particularly contested. Progressive policy actors who seek to bring about health system transformation must recognize these challenges and be strategic about the processes of developing and implementing new policies. They must also, sometimes, take action to address contextual factors (such as wider economic and social policy frameworks, features of the governance system or socio-cultural norms) that may block the development of such policies or their likelihood of effective implementation.

Recommendation 5.1:   Build coalitions of support for policy change

Policy actors seeking equity-promoting health system transformation may engage individuals working from a government base (such as Ministers of Health and senior officials), CSOs based outside government (such as groups with particular concerns e.g. women's issues or HIV/AIDS), researchers and academics, and progressive health profession organisations. Although such groups can advance policy change when working alone, experience shows that they are generally more effective when working in alliance. They also need to build wider coalitions of support for change that engage other potentially powerful actors who have their own circles of influence (such as the wider pool of public sector health managers and professionals and trade unions, other politicians and parliamentarians), as well as take action to offset policy opposition.

The first step in building such coalitions is to **map the key actors' positions** on, and concerns about, general and specific health equity issues and policies, and to consider the contextual influences over them. This mapping provides the basis for four further steps:

- **raising the public visibility** of inequities and the voice of the socially disadvantaged (using wide-ranging evidence to focus attention on a policy problem and legitimize a policy solution);
- **creating new supporters**, paying careful attention to the words and images used to introduce evidence into policy debates (so that problems and policies are brought alive in ways that other actors can understand and accept, mobilising popular support and support from important political constituencies or other actors);
- **tackling policy opposition** (by applying a broader range of strategies and tactics to counter opponents' positions or their power to oppose); and
- **building regional networks** to sustain coalitions and action.

Recommendation 5.2:   Strengthen policy implementation to address health inequity

Experience of policy change highlights the critical importance of strengthening public sector planning and management with an eye on health equity goals. More specifically, Ministers of Health and senior civil servants should seek to:

- **secure the legislative and funding base** of new policies, including constitutional rights to health or health care and more specific legislation linked to particular policies, and the processes to enable collective claims on these rights by marginalised groups;

- **establish clear health equity goals** to guide implementation and enable an equity-based evaluation;
- **implement new interventions first in disadvantaged areas** and with disadvantaged populations, taking care to strengthen their capacity to use and benefit from the programmes; and
- **learn through doing** by monitoring and evaluating the experiences of implementation.

Recommendation 5.3: **Empower public managers to lead sustained institutional change**

Policy implementation has to be sustained over time so that new policies become part of the taken-for-granted practices within the health system. To achieve this integration of policy and practice, the value basis, relationships and management of health systems (that is, their organisational culture) need to be re-framed to support health equity. Although the evidence is limited, experience suggests that public sector managers can be empowered to lead such change through:

- **mentoring processes** that nurture and develop the values and skills for such leadership;
- **policy frameworks that enable a balance of local autonomy and central direction** in particular areas of decision-making, such as human resource management, as well as engagement with actors outside government structures; and
- **supportive leadership** from senior officials and Ministers of Health.

Wider social processes initiated by CSOs, politicians or parliamentarians may also support public sector managers in this role. Such processes can hold them accountable to the principle of health equity, for example, or can challenge the wider socio-cultural norms embedded within health systems that act against health equity (such as gender norms and forms of prejudice).

RECOMMENDATION 6:

International actors must support national led health system transformation and action

International agents and interests have significant influence over the development paths of national health systems. In the last decades, their actions have often undermined health equity and impeded the health system development necessary to promote equity. They have fuelled health system commercialisation, supported vertical, disease-focussed approaches to health care provision, and sustained the international migration patterns propelling the human resource crisis facing low- and middle-income countries.

Given the past experience, a first principle for such agencies is to guard against interventions that result in unintended adverse consequences, to act on the basis of evidence and to make clear the values and principles that motivate action. In addition, international actors must make the case for providing international assistance to support national health system action on health inequity: for example, by linking such transformation to achievement of the Millennium Development Goals. Three other strategies for international action to support the national health system are to:

- **work with and respect national decision-making** and institutions;
- **provide support to strengthen the health equity orientation** of national health systems; and

- **increase funding flows** for health systems (especially to fragile states and low-income countries).

Conclusion

In conclusion, both technical analysis and political commitment are needed to strengthen health systems and address health inequity. The goal of such action must be to lever positive cycles of health system change that build their own momentum towards health equity. *Technical analysis* can help identify which features of health systems to nurture and protect. *Political action and commitment* is needed to confront again and again the powerful actors, institutional constraints and socio-cultural norms that act as brakes on health system development for health equity. Such action must also stimulate, reward and strengthen power to act within the groups, processes and mechanisms that support these virtuous changes.

The final report of the Health Systems Knowledge Network

Part 1:   Introduction

The World Health Organization's Commission on the Social Determinants of Health identifies health systems as one of nine areas that provide sites for action to promote greater equity in health. The Health Systems Knowledge Network (KN) was tasked with generating and synthesizing evidence to inform the large-scale health system action possible to address the root causes of health inequity (Annex 1). This report reflects two years of discussions and draws on: review of relevant literature from the last few decades; 10 commissioned papers and 20 case studies (Annex 4); and the wide-ranging policy, academic and civil society experience of the 15 KN members, as well as a wider circle of authors and reviewers (see acknowledgements page).

Evidence gathered through this work supports the argument that health systems matter in addressing health inequity. Health systems, defined as *'all the activities whose primary purpose is to promote, restore, or maintain health,'* (WHO 2000) can make a difference to health equity by: providing leadership for a social rights agenda; building intersectoral relationships to tackle other underlying social determinants of health and promote population health; enabling social action and engagement; and providing equitable access to decent, good quality care that is affordable even to those on the lowest incomes. A revitalized strategy of comprehensive primary health care supports these actions.

This KN also takes the view that health systems are a vital part of the social fabric of any society. They not only produce health and health care, but also shape wider societal norms and value (Freedman *et al.* 2005; Gilson 2003). The key value underlying the report's analysis is that health is a fundamental social right of all citizens, and this drives the ethical imperative to preserve and protect the population's health. The challenge is not to lift the health status of the poor through pro-poor initiatives, but to establish the conditions in which people can exercise their entitlement to health care and the living conditions that will enable them to protect and promote their health, participate in the decisions that affect their lives, and demand accountability from the people and institutions whose duty it is to take steps to fulfil those rights (Freedman *et al.* 2005). The KN is guided by a definition of health equity that encompasses the concept of a fair distribution of health outcomes, as well as a fair distribution of health care use and payment levels. Critically, our notion of health equity also includes redistribution of the power to make decisions that affect health and health care. This includes greater control over the resources for health. It implies building capabilities to tap and use these resources as well as to exercise greater influence over the distribution of resources.

Opportunities for action by health systems are therefore identified from a broad array of national health policy and systems issues, intersectoral action for health and civil society engagement. The focus is on low- and middle-income country experiences, with reference to some important high-income country experiences. We acknowledge that the broad focus established by our terms of reference has limited the range and depth of issues covered; pharmaceutical policy, for example, needs greater attention while the role of traditional healers is not addressed. We also

acknowledge that this report does not fully consider how to address the commercial actors and influences over national health system development that emanate from the global environment, or the social norms and values that underpin gender inequity. However, we have co-ordinated with other KNs on areas of overlap, drawing on some of their work but agreeing that some issues covered in greater detail by them are only cross-referenced in this report. In particular, we note the importance to health systems of the wider work of the Priority Public Health Conditions, Women and Gender Equity and Globalisation KNs.

The report is structured as follows. Part 2 clarifies the evidence base of the report as a sound basis for action, despite the complexities and the contested nature of evidence in this field. Part 3 addresses the question "Why do health systems matter?" and presents the evidence that supports the analytic framework of this report. However, the report's main focus is on the opportunities for action within and through health systems to address the social determinants of inequity and promote health equity. Part 4 is therefore a longer section that focuses on these opportunities considering how to: promote intersectoral action; enable social empowerment; strengthen redistribution through the health care system; and revitalize primary health care. Part 5, finally, considers the national level political and institutional actions necessary to sustain health system transformation and address health inequity, as well as key elements of the international support needed.

Part 2:   The evidence base of the report

Evidence demonstrating the health equity impacts of health system change is relatively hard to come by and synthesize. Health system change is highly complex, diffuse and made up of a myriad of 'sub-actions' across many organisations; it often has numerous goals, making it difficult to track and explain effects; health system enquiry is often cross-disciplinary and wide-ranging, making comprehensive reviews problematic and time-consuming; the study of health systems, their impacts and how to bring about change to achieve desired impacts, is a more recent and less documented discipline than, for example, studying the effects of clinical medicine; and the literature from low- and middle-income country settings (the focus of this KN) is under-represented and often difficult to access (for reasons of language, or because it is only documented in the grey literature).

To address these problems, the KN developed a multi-component strategy: considering existing reviews; commissioning 10 new reviews of key issues on which evidence has hitherto not been well collated; commissioning 20 case studies of relevant regional, national or sub-national experiences that have hitherto not been written up, at least with a health equity focus (Annex 4); holding two three-day workshops with KN members (who include policy-makers, members of civil society and academics) to tap their tacit knowledge of policy development in their own and other countries; submitting commissioned pieces for review by at least one internal and one external reviewer (so that, in the end, more than 100 people were involved in synthesizing and reviewing evidence) (see Annex 2 and list of contributors at front of report); and, finally, submitting this report for both internal and external review.[1]

There were consistent efforts to ensure diversity in the nature of evidence. Evidence was accessed from different geographic areas, different languages, different sources and methodological bases, and different perspectives (see Annex 2). The KN also developed a process to consider gender issues (Annex 2). The KN was relatively successful in achieving a degree of evidence diversity although English-language evidence still predominates. With respect to gender-based analyses the KN found that, despite their prominence in some areas of work (especially on sexual and reproductive health), in the main the evidence does not address gender equity adequately (or even disaggregate information on the health equity impacts of interventions by sex).

Importantly, the report draws on knowledge bases from a variety of research traditions: for example, different knowledge bases inform learning from intersectoral action for health (these tend to focus on enablers and constraints) compared to social empowerment (these tend to draw on case studies and are qualitative in nature). These varied sets of knowledge are necessary to address the range of questions raised in the report and are often complementary. However, they also pose challenges for establishing criteria that can be applied across the whole report to assess the quality of evidence and weight its use. In addition, the design and impact of most health system changes are highly context-specific which has implications for conventional understandings of generalizability. Throughout the report the

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[1] The justification for this approach appears in more detail in Doherty and Gilson (2007).

relevance of specific contextual evidence is made explicit to aid interpretation of the evidence (Annex 3 summarizes the broad enabling and disabling contextual factors identified from the evidence).

Evidence is most contested with regard to the role of the private sector in addressing health inequity and the potential of universal coverage policies within low-income countries. Where evidence is most tentative is in demonstrating associations between interventions and outcomes, effective human resource interventions to promote equity, and how to bring about institutional change in support of equity.

Despite limits and difficulties, this report contends that it is possible to learn from existing experience in order to act. Whereas on a few issues there is clear evidence of the kind conventionally accepted by public health practitioners as 'rigorous', on other issues action can be based on a combination of values and an assessment of how available evidence can be made useful in different contexts. In fact, the evidence collated here provides a surprisingly coherent set of messages on how health systems impact on health equity, what sorts of broad or macro-level interventions result in more positive impacts and, most importantly, what actions assist in designing and implementing these interventions effectively. Importantly, the KN feels that it is imperative to take action in the face of inequity, even where there is only limited evidence on appropriate, specific interventions.

In conclusion, this report's approach to the application of evidence draws on Rose's (2005) concept of 'policy learning': looking to the experience of other countries is not to copy but to understand under what circumstances and to what extent policies that are effective elsewhere might work in one's own context (learning what not to do is also important and lowers the political risk of change). As the report emphasises, in applying lessons from other settings it is always important to establish monitoring and evaluation processes that allow adjustment in response to the experience of implementation in a particular setting.

Part 3: The health system as a social determinant of health and health equity

3.1 <u>The health system as a social determinant of health</u>

A wide body of evidence conclusively demonstrates that health systems are a social determinant of health. Cross-national epidemiological and econometric analyses show that health systems, or particular elements within them, can and do promote population health, independent of other influences (Anand and Barnighausen 2004; Anand and Ravaillion 1993; Bokhari *et al*. 2007; Cutler *et al*. 2006; Mackenbach 1996; McKee 2002; Robinson and Wharrad 2000, 2001).

The positive impact on health is particularly clear where the primary health care (PHC) approach is applied as the health system's organisational strategy and underlying philosophy. Following the Pan-American Health Organization (PAHO 2007), we understand this strategy to be underpinned by recognition of the need to tackle the broader social and political determinants of health, and to involve wide-ranging action to promote health equity. Such action includes intersectoral action for health and mechanisms to enable collective action on health, as discussed below.

Within the health care delivery system, the PHC approach also requires the provision of comprehensive, integrated and appropriate health care that emphasises prevention and promotion, and places referral services within a framework that recognizes the key role of primary level care[2] in navigating their use by patients. While this approach to organising the delivery of health care captures only one dimension of the overall PHC approach, it nonetheless makes an important contribution to improving health. Thus, Starfield *et al*. (2005) identify three lines of evidence emerging from 25 studies (mainly from high-income countries) that demonstrate a progressively stronger association between primary level care and improved health: one line shows consistently that population health is better in geographic areas with more primary care physicians; the second line shows that individuals who receive care from primary care physicians are healthier (see also the experience of Spain, Annex 6); and the third line of evidence shows that there is an association between the special features of primary level care (e.g. preventive care) and improved health in the individuals who receive these services (this last point suggests that it may not only be improved access to curative care that renders primary level care effective, but also its embodiment of the principles of prevention and health promotion). In addition, three detailed international comparisons of industrialised countries show that countries with stronger primary level services have populations with better health, particularly when health policy is generally supportive of a primary level orientation (Starfield *et al.* 2005).

Data from low- and middle-income countries demonstrate similar successes. In Costa Rica, for example, a strengthened primary level of care (involving improved access and instituting multi-disciplinary health teams assigned

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[2]Primary level care, as distinct from the much broader primary care 'approach,' is: first-contact access to the health system; long-term, person-focused care; comprehensive care for most health care needs; and, having an orientation toward the family and community, in coordinated with other services (Starfield, 1998).
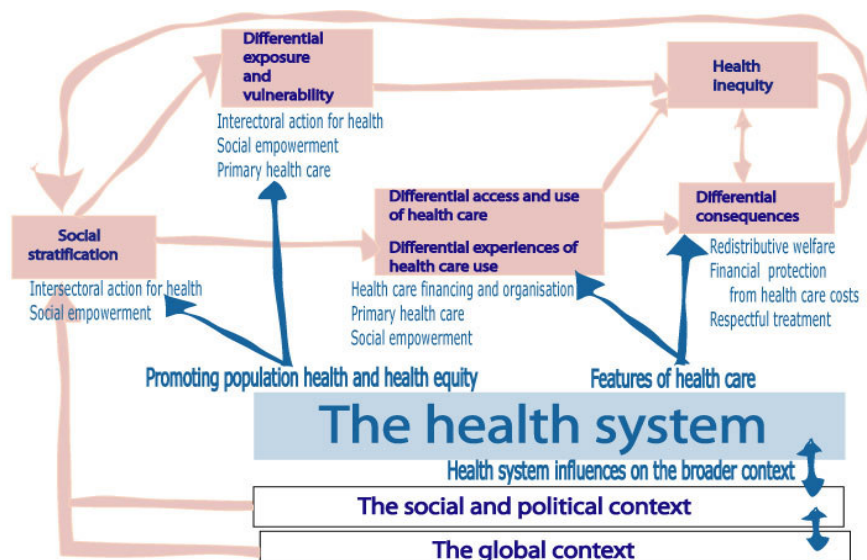
to populations within particular geographic areas) resulted in a reduction in the national infant mortality rate (from 60/1000 live births in 1970 to 19/1000 in 1985). For every five years after the reform, child mortality was reduced by 13% and adult mortality by 4%, independent of improvements in other health determinants (PAHO 2007; Starfield 2006a; Starfield *et al.* 2005). Broader evidence on the successes of primary level services is also available from Africa (for example, Liberia, Niger, Zaire), Asia (for example, China, the state of Kerala in India, Sri Lanka) and Latin America (for example, Brazil, Costa Rica, Cuba)) (De Maeseneer *et al.* 2007; Doherty and Govender 2004; Halstead *et al.*1985; Levine 2004; Macinko *et al.* 2006; Starfield *et al.* 2005). (Case studies on some of these countries are summarized in Annex 5 and Annex 6). As with high-income country work, these studies examine only one element of the PHC approach (namely, a focus on the primary level as key to the organisation of health care delivery). However, demonstration of its positive impact adds an important piece to the evidence 'jigsaw' on the benefits of the overarching PHC approach, given the difficulties associated with evaluating complex, system-wide interventions such as the PHC approach, as discussed by Doherty and Gilson (2007).

3.2   The health system as a social determinant of health equity

Apart from impacting on *health*, international evidence demonstrates that health systems can and do yield *health equity* gains. This role of health systems is the specific focus of this report.

Figure A builds on the Commission's own framework that describes how social stratification leads to health inequity (CSDH 2006). The figure highlights the potential of the health system to intervene in this vicious cycle, through particular features of the way it is designed and operated. Each of these features is outlined below, and ways of strengthening their influence on health equity are discussed in the following chapter, Part 4.

Figure A: The pathways of positive potential for health systems: points of intervention

Promoting population health and health equity

The PHC approach recognizes that, through intersectoral action and social empowerment, the health system can leverage 'upstream' impacts that influence social stratification and other social determinants of health as well as intervene in the pathways that lead to social inequities and ill-health. PHC integrates the promotion and prevention interventions that act on these determinants, whilst, in terms of the health care delivery system, the primary level of care also plays an important role in promoting health equity.

Intersectoral action for health (IAH) is *'a recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone'* (WHO 1997). IAH supports improved health and health equity by tackling the intermediate determinants of health, many of which are inter-related (see Early Childhood Development and Urban Settings Knowledge Networks). Reviews of the available empirical evidence (mostly from high-income countries) specifically conclude that policies directed at improving physical and social environments for populations will result in greater health equity because they do not require the individual behavioural changes that are themselves particularly influenced by material wealth, education or the social connectedness of individuals (Arblaster *et al.* 1996; Health Disparities Task Group 2004; Starfield 2006a).

The definition of IAH is interpreted to include collaborative action between different departments and bodies within government, as well as between actors within and outside government, such as civil society organisations, for-profit private organisations and communities. Sectors that have the potential to act together to affect health include agricultural, cultural, education, employment, environmental, financial, health, housing, information and communications, justice, manufacturing and technology, social and transport services. Thus, in Sri Lanka, for example, the Ministry of Health is supported in its efforts to control sexually transmitted and vector-borne diseases by the education and public broadcasting sectors (which provide health education at schools and on radio), the water and sanitation sectors (which reduce vector breeding through control of the environment), the tourism sector (which provides health education to tourists and workers in industry) and the transport sector (which provides an extensive road network and cheap public transport to ensure ready access to health care facilities) (Perera 2007; Sri Lankan case study, Annex 5). Both local government and CSOs are actively involved in these efforts.

Social empowerment is *'people's ability to act through collective participation by strengthening their organisational capacities, challenging power inequities and achieving outcomes on many reciprocal levels in different domains: including psychological empowerment, household relations… transformed institutions, greater access to resources, open governance and increasingly equitable community conditions'* (Wallerstein 1992). Social empowerment interventions take many forms but commonly engage people collectively through participatory processes in identifying health needs and strengthening capabilities to address them. They are important in promoting health equity because

the paths through which social stratification generates health inequity and differential consequences are underpinned by the powerlessness of socially disadvantaged and marginalized groups, including women, certain ethnic and indigenous groups, people with disabilities, people of different sexual orientation, the elderly and young people outside stable long-term partnerships (London 2003; Marmot 2006). A recent systematic narrative literature review of relevant empirical studies (Wallerstein 2006) concludes that interventions that strengthen empowerment:

- <u>promote better health</u> through individual empowerment outcomes and action on the structural determinants of health, or by encouraging greater health care use;
- can <u>address health inequity</u> by generating preferential gains for socially disadvantaged groups either by impacting on structural factors or by being implemented with these groups; and
- have, <u>for women specifically</u>, resulted in greater psychological empowerment and autonomy, and substantially affected a range of health outcomes, where most closely integrated with the economic, education and/or political sectors.

A growing range of epidemiological studies undertaken in low- and middle-income countries (LMICs), and using experimental or quasi-experimental study designs, also clearly demonstrate the potential of these interventions to generate health and health equity gains by supporting action on risk environments or encouraging access to health care (Eng *et al.* 1990; Loewenson *et al.* 2004; Malhotra *et al.* 2005; Mbonye *et al.* 2007; Pronyk *et al.* 2006). In Nepal, for example, a community-based case control intervention study in poor rural communities used participatory methods to identify local peri-natal problems and strategies to address them. Evaluation demonstrated that the intervention was associated with significant reductions in maternal mortality and birth outcomes and higher use of ante-natal care, institutional delivery and trained birth attendance (Manandhar *et al.* 2004). These outcomes are not inevitable. They depend on historical and socio-political contexts, the nature of social institutions and implementation practices (Rifkin 2003; Wallerstein 2006).

Epidemiological evidence shows that lower income groups not only have more illness but also more co-morbidity than richer groups, and suffer more from the consequences of illness severity. In addition, morbidity tends to cluster in particularly vulnerable groups rather than being randomly distributed in the population (Starfield 2006b). In principle, therefore, **primary level care** can offer health equity gains because it allows for the early detection and treatment of illness, offers person-focussed care for a range of illnesses and effectively addresses those illnesses that disproportionately affect poorer groups (Doherty and Govender 2004; Health Disparities Task Group 2004; Starfield 2006a). The emerging evidence confirms the health equity impacts of primary level care, especially when combined with other elements of the primary health care approach, as shown by studies from Bangladesh, Bolivia, Kerala (India), Mexico, the Netherlands, the UK and the US (Bhuiya *et al.* 2001; De Maeseneer *et al.* 2007; Doherty and Govender 2004; Mackenbach 2003; Perry *et al.* 1998; Reyes *et al.* 1997; Starfield 2006a; Starfield *et al.* 2005).

Relevant features of health care

Health care financing and provision strategies shape the patterns of **health care access, use and experience of care**, influencing its potential to intervene in the translation of differential exposure and vulnerability into health inequity. Health care features also influence the **differential consequences** resulting from health care use and ill health. Through both pathways health care can feed back into social stratification.

The importance of health care access to health care equity is well established (Gulliford *et al.* 2002). It can be defined as the 'degree of fit' between clients/patients and health care provision (Pechansky and Thomas 1981), emphasising the combined influence of supply and demand side factors over the extent of access achieved by any health system (Thiede *et al.* 2007). The three main dimensions of access are:

- *availability*, covering factors such as geographical location, transportation availability, as well as organisational factors such as opening hours or waiting time to appointment;
- *affordability*, combining concern for the costs of seeking care, households' ability to manage these costs and their impacts on household livelihoods; and
- *acceptability*, that is, the social and cultural distance between health care systems and their users, encompassing the fit between lay and professional health beliefs, patient-provider engagement and dialogue and the influence of health care organisational arrangements on patient responses to services (Gilson 2007a).

These access dimensions affect who uses and benefits from health care, and, together with the *quality* of service provision (Dahlgren and Whitehead 2007; Peabody *et al.* 2006), the impact of health care on health equity. Empirical evidence demonstrates that availability and affordability commonly influence whether and which population groups use health care, as well as when groups seek care in an illness episode, with implications for illness severity and treatment effectiveness (Dahlgren and Whitehead 2007; Dixon *et al.* 2003; Hausmann-Muela *et al.* 2003; Palmer 2007; Shaikh and Hatcher 2004). Acceptability also influences opportunities for effective diagnosis and treatment, patient adherence with advice or treatment, and self-reported health status (Gilson 2007a; Wallerstein 2006). Marginalized groups' experience of care, finally, has upstream consequences by influencing the broader value they derive from health care (Freedman *et al.* 2005; Gilson 2007a; Govender and Penn-Kekana 2007).

The level of fees charged to patients influences both access and whether or not health care offers financial protection against the cost burdens of ill-health. Empirical evidence demonstrates that these costs can influence poor households' poverty levels and, by affecting their ability to purchase other household needs, their living standards (McIntyre *et al.* 2006; Russell 2004, 2005; van Doorslaer *et al.* 2006; Wagstaff 2002) (see also, for example, the case study of Thailand in Annex 5).

Other approaches to health care financing can, in combination with health care provision strategies, allow a transfer of resources from better off to poorer groups - contributing to broad economic development goals by closing the relative

gap in living standards between the poor and rich (Mackintosh 2007). The redistributiveness of health care depends on how much richer and poorer population groups *pay for* health care relative to how much they *benefit from* it (that is, use it). To be redistributive, it is enough that the share of health care spending (subsidy) captured by the poor (through their use of public services) leaves the distribution of resources in the country less unequal that it would be without the health system. Under these circumstances, however, the rich may still use health services more than the poor (who arguably have greater needs). For health care systems to be actively pro-poor, therefore, the poor must use services to a greater extent than the rich and so capture the larger share of the health care subsidy (Mackintosh 2007). Cross-national analyses of health care financing and utilisation show that, in high-income countries, health care is generally redistributive (except for instances such as the USA, for example (Annex 5)). Within these countries, the rich either pay a higher proportion (or only slightly less) of their income for health care than the poor, whilst the poor generally use health services at least in proportion to their need (van Doorslaer and O'Donnell 2006; van Doorslaer *et al.* 2000).

As few detailed studies of both financing and provision are currently available for LMICs it is difficult to make comprehensive judgements about the level of redistribution achieved. However, an emerging range of analyses examine patterns of public health care spending and allow some assessment of subsidy patterns. For Asia, public spending was found to be inequality reducing (although the rich still captured a higher proportion of the subsidy) in ten out of eleven countries, whilst four achieved a pro-poor, or even, distributions of benefits (O'Donnell *et al.* 2007; O'Donnell *et al.* 2005a). Similarly, in five out of seven Latin American countries, public spending was either proportionally distributed across rich and poor groups or weighted towards the poor (PAHO 2001). Even in Africa, where most concern has been expressed about inequity of public health care expenditure, there is evidence that this expenditure is progressive. Public health care provision does reach poor groups (Kida and Mackintosh 2005) and can even offer greater levels of subsidy to them than richer groups (Chu *et al.* 2004). The potential for redistributive health care systems to offer health equity gains is, finally, suggested by evidence that public health care spending has a larger impact on mortality amongst the poor than the non-poor (Bidani and Ravaillon 1997; Gupta *et al.* 2003; Wagstaff 2003). Therefore, even where the poor get less of the public spending subsidy than the rich, they may still secure relatively greater health gains than richer groups (O'Donnell *et al.* 2005a).

Finally, <u>health systems that integrate the PHC strategy </u>offer particular access and redistribution gains for socially disadvantaged groups. Vega-Romero and Torres-Tovar (2007) use the systematically documented experience of a large PAHO initiative to illustrate the specific potential of PHC to promote an intercultural approach to health care and to enable indigenous health systems. General access gains through primary level care are noted by Starfield *et al.* (2005). In addition, data from Africa (Castro-Leal *et al.* 2000) and Asia (O'Donnell *et al.* 2007) show that higher income groups captured a lower proportion of public expenditure on primary health care than total public expenditure – in both cases because lower income groups had better access to primary care than other services.

Health system influences on the broader context

In Figure A, the bi-directional nature of the arrow between 'the social and political context' and the health system points to the potential for the health system to influence context and the way it functions. Thus, health systems both reflect existing patterns of social inequality and provide a site within and from which to contest them (Mackintosh 2001).

Every public health care system is, for example, a major employer: the UK's National Health System is amongst the five largest employers in the world, with around 1.3 million employees. New health workforce structures and practices could, in principle, offer personal gains for women and other socially marginalized groups within the health workforce and influence the broader societal context in ways that have important health equity consequences. Health system development could also, in principle, contribute to social cohesion by empowering socially disadvantaged groups and enabling dialogue between groups within society (De Maeseneer *et al.* 2007), an impact for which there is some evidence from fragile states (Ranson *et al.* 2007). Health systems may even be influential in building and sustaining societal and political support for governments that promote health equity (see the Mexico City and Sri Lankan case studies, Annex 5).

3.3 <u>The equity problems of health systems</u>

The common problems

Despite their potential to promote health equity, many health systems currently work to generate health inequity and entrench social stratification (see, for example, the China and US case studies, Annex 5). Efforts to strengthen health systems must, therefore, start by acknowledging four key problems.

<u>First</u>, most health systems have, at best, only a weak population health and health equity orientation. They make limited and often unsustained attempts to address differential exposure and vulnerability through IAH and social empowerment (Baez and Barron 2006; Wallerstein 2006); and only a few countries apply a strong primary health care orientation within their health systems (Vega-Romero and Torres-Tovar 2007). In addition, social action, including around health and health system issues, often excludes socially disadvantaged and marginalized population groups (Goetz and Gaventa 2001; Loewenson 2003a).

<u>Second</u>, despite the potential for redistribution discussed earlier, in many LMICs, and particularly the lowest income countries, health care is not pro-poor: higher income groups make greater use of public health care than poorer groups (Castro-Leal *et al.* 2000; Gwatkin *et al.* 2004; Haddad *et al.* 2004; O'Donnell *et al.* 2005a; Ouendo *et al.* 2005; Palmer 2007; Sahn and Younger 2000). Access problems are a key influence and, in general, disproportionately affect women and other groups suffering from discrimination. The main barriers to care include: the costs of seeking care; lack of information and knowledge; lack of voice or empowerment; inaccessible and poor quality services; and unresponsive service providers (Ashford *et al.* 2006; Gilson 2007a; McIntyre and Thiede 2007; Palmer 2007). For example, research on equity in anti-retroviral therapy access in Malawi specifically illustrates gender differences in:

the experience of stigma that influences health seeking and adherence; access to resources to pay for health care; experience of, and resources to cover, the opportunity costs of seeking care - food, transport; service quality and waiting times; and control over care decisions (Nyirenda *et al.* 2006). Women, in particular, can also face both physical and sexual abuse (Govender and Penn-Kekana 2007).

A third point is thus that, across settings, women and other socially marginalized groups often experience health care as demeaning and exclusionary, as a result of poor quality interpersonal care (Gilson 2007a; Govender and Penn-Kekana 2007). There is also a little evidence that these problems increase the probability of worse outcomes, particularly in relation to chronic care, lower self-reported health status and the denial of dignity and patients' rights (Gilson 2007a).

Finally, the differential consequences of illness and health care can increase social disparities. Illness and out-of-pocket payments for health care, separately and combined, push poor people into poverty or worsen their existing poverty (McIntyre *et al.* 2006; Russell 2004). A recent study of the effects of paying out-of-pocket for health care in Asia concluded that health care payments pushed 2.7 per cent of the total population of eleven low- to middle-income countries below the very low poverty threshold of $1 per day (van Doorslaer *et al.* 2006; see also Xu *et al.* 2005; Xu *et al.* 2003). Other studies show the particular burden such payments impose on poorer groups (McIntyre *et al.* 2006; Russell 2007; WHO 2006a). Not surprisingly, high levels of private spending (including out-of-pocket spending) undermine the redistributive impact of health care in many LMICs (Mackintosh 2007; see China case study, Annex 5). High levels of out-of-pocket spending are linked partly to user fees, although the cost of drugs is often particularly important (McIntyre *et al.* 2006; van Doorslaer *et al.* 2006).

The forces driving health system inequity

Over the last few decades health systems worldwide have been assaulted by economic, political and social forces that underpin the equity problems they currently face. Three key forces are: commercialisation and globalisation; the health policy choices made by international and national health system leaders; and the bureaucratic culture of the public sector health system, including the social and gender power differentials embedded within it (Freedman *et al.* 2005; Global Health Watch 2005).

Commercialisation: Commercialisation within health systems encompasses: *'the provision of health care through market relationships to those able to pay; investment in, and production of, those services, and of inputs to them, for cash income or profit, including private contracting and supply to publicly financed health care; and health care financing derived from individual payment and private insurance'* (Mackintosh and Koivusalo 2005:3). It has been driven by the broader neo-liberal economic agenda that includes trade liberalisation (see Globalisation KN*)*, macro-economic policy change, and the deliberate encouragement of a particular set of health policies (that includes user fees, performance-related pay, separation of the provider and purchaser functions, determination of a cost-effective package of interventions to offer through the public sector, and a stronger role for private sector agents).

A limited body of cross-national evidence suggests that higher levels of health system commercialisation are associated with worse and more unequal health access and outcomes. In addition to the equity problems generated by out-of-pocket spending there is some cross-national evidence that greater overall reliance on private providers is associated with inequity in treatment rates between socio-economic groups (Mackintosh 2007; Mackintosh and Koivusalo 2005). Commercialisation has also had effects on key aspects of health system functioning. In a wider context of declining salary levels, it appears to have encouraged unethical and abusive behaviours to become the new norm of practice in some health system settings (Owusu 2005; Van Leberghe *et al.* 2002). Another consequence has been the growing levels of international migration in health human resources that generally undermine LMIC health systems and exacerbate access inequities (Padarath *et. al.* 2003). Finally, commercialisation has closed down space within health systems for the engagement with civil society important to social empowerment, and made it more difficult for civil society organisations (CSOs) to work for public rather than self interest (Cardelle 1998; Clayton *et al.* 2000; Embuldeniya 2001).

Health policy choices: Implementation of neo-liberal health reforms has been driven strongly by a combination of international agencies, commercial actors and the higher income and medical groups whose power they enhance (Bond and Dor 2003a; Homedes and Ugalde 2005; Lister 2007). The influence of international agencies, in particular, over national policy development was also demonstrated in an earlier period by the narrowing down of the primary health care approach to a limited set of health care interventions of proven cost-effectiveness offered through vertically managed programmes, that is, 'selective primary health care' (De Maeseneer *et al.* 2007). As with more recent policies, concern for efficiency was a key driver of selective primary health care, and the result was a medical and technical focus in analysis, as well as policies that undermined the development of comprehensive primary health care systems that could address the social determinants of health inequity (Rifkin and Walt 1986; Ravindran and de Pinho 2005). A range of new Global Health Initiatives have once again brought the debates about selective vs. comprehensive approaches to health system development to the policy agenda (Hanefeld *et al.* 2007). Although these initiatives have brought enormous new levels of funding to health systems within LMICs (US$8.9 billion in 2006 for HIV/AIDS alone (Hanefeld *et al.* 2007)), there is a concern that their vertically managed programmes have potential to undermine the population health orientation of health systems and exacerbate health inequity (Garret 2007).

Actors in international agencies can influence national policy-making through the generation of globally accepted policy ideas, through the provision of more specific advice and policy guidelines or, more forcefully, by attaching conditionalities to funding flows (Lee and Goodman 2002; Walt *et al.* 2004; Hanefeld *et al.* 2007). However, experience also suggests that where public sector capacity is weaker, as in Africa, there is a greater likelihood that local policy-makers will be unduly influenced by external interest groups, than where public bureaucracies are stronger, as, for example in India and Sri Lanka (Mills *et al.* 2001).

Public sector organisational capacity and culture: Public sector problems of weak organisational capacity (Mills *et al.* 2001) are, from a health equity perspective, compounded by organisational culture (that is, the basic patterns of assumptions that drive the behaviour and practices of those working within any particular organisation (Schein 1992)). Empirical investigation shows that public sector organisations are characterised by hierarchical, rigid and rule-bound cultures that encourage an authoritarian management style, commonly impeding the innovative action, such as IAH, needed to promote health equity (Gilson 2007b, 2007c). Furthermore, power often lies with the doctor, trained to provide individualised, curative care, rather than the nurse or the multi-disciplinary team responsible for primary health care at a local level.

Public sector norms and practices may also promote inequity; such as the norms encouraging informal payments (see the situation in transitional states, Annex 5). Within the health workforce women are generally in less powerful positions, earn less than male counterparts, are seen as problematic because of their different needs as workers (including security needs), may be subject to managerial abuse and even sexual harassment, are given roles that have less credibility in the community's eyes (such as preventive outreach care) and are not acknowledged or supported in the vital informal domestic roles they play in health care (George 2007). The results are widespread gender inequities: gaps in the services needed by women, failure to support the critically important community-based activities undertaken by women, and demeaning interpersonal interactions that challenge patient dignity and autonomy (George 2007; Govender and Penn-Kekana 2007).

3.4   Conclusion

Given the range of existing problems, both technical analysis and political commitment are needed to strengthen health systems and address health inequity. The goal of such action must be to lever positive cycles of health system change that build their own momentum towards health equity. ***Technical analysis*** can help identify which features of health systems to nurture and protect. ***Political action and commitment*** is needed to confront again and again the powerful actors, institutional constraints and socio-cultural norms that act as breaks on health system development for health equity. Such action must also stimulate, reward and strengthen power to act within the groups, processes and mechanisms that support these virtuous changes. The following sections outline the actions needed on both fronts, and the associated evidence base.

Part 4:   Strengthening health systems to address health inequity

4.1   Revitalise intersectoral action for health

Part 3 has already identified the importance of intersectoral action for health (IAH) and its close association with the PHC approach. As already explained, IAH is *'a recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone'* (WHO 1997).

Many components of the Commission consider the value of IAH: it is the focus of much of the work of the Country and Civil Society streams of the Commission; most of the Knowledge Networks identify the need for IAH; and the Priority Public Health Conditions KN specifically discusses the importance of strengthening public health programmes to address differential exposure and vulnerability as well as health inequity. The Health Systems KN, therefore, confines itself here primarily to strategies that Ministries of Health can adopt to leverage action in the rest of government.   Ideally, however, IAH should be a collective endeavour of government as a whole. It is greatly facilitated when, backed up a political commitment to social equity, it is adopted as an over-arching strategy by Cabinet (as in the UK and Sweden, for example; see Annex 6).

Approaches to mobilising IAH

A systematic review of IAH experience (Public Health Agency of Canada and Health Systems Knowledge Network 2007), on which this section is based, roughly categorises IAH initiatives into four broad approaches.

1. **Targeted approaches** focus efforts on a specific population or issue (such as a disease or risk factor), especially when there are resource constraints and a desire for visible and timely results (for example, intersectoral approaches are used to address the poor health status of indigenous peoples in Australia, Canada and New Zealand, while in Canada, the National Tobacco Strategy involves all levels of government, is led by the health sector and includes partners from justice, taxation and border service agencies). A drawback of targeted approaches is a narrow focus on more 'downstream' issues, and the potential to duplicate efforts.

2. **Place-based or settings approaches** involve broad-based implementation at the local level. They provide a shared platform for action by different sectoral actors within a defined community, thereby facilitating horizontal engagement and offering tangible results (for example, the UK Labour Government's Health Action Zones in the early years of this decade were built on WHO's Healthy Cities movement, and identified disadvantaged communities for concerted action, see Annex 6). These approaches are complex and require sustained support by a wide range of actors.

3. **Incremental approaches** arise on a larger scale when there is recognition of the need to act across sectors to address shared challenges. Evidence is often used to review all sectoral policies and inform choices on where and when to act collaboratively, yielding a diverse set of actions (for example, at the global level, the Water, Sanitation and Health Protection of the Human Environment initiative has followed a five-year process in which government and non-government actors have been involved in joint policy development). Incremental approaches tend to develop interventions over a longer timescale that makes them vulnerable to vagaries in political support.

4. **Broad policy frameworks** can be adopted by governments as a whole to guide policy-making within and between sectors (at a global level, the Millennium Development Goals, and at a regional level, Europe's National Environment and Health Action Plan, provide a framework within which governments and sectors are obliged to work collectively towards shared goals).

Contextual influences

IAH is a complex, political process, involving diverse groups in wide-ranging sets of activities. Consequently, *how* IAH interventions are developed and implemented matters as much as *what* is done. The evidence base is quite strong on factors that constrain and facilitate IAH in a range of contexts (Public Health Agency of Canada and Health Systems Knowledge Network, 2007; see also Ranson *et al*, 2007; Sri Lanka (Perera 2007) , Mexico City (Laurell 2007) and Chile (Infante 2007) case studies in Annex 5, and Sweden and UK, Annex 6). Some factors relate to features of the social, political and economic environment that can limit or promote IAH, while others relate to the institutional features of government.

Social, economic and political environment

The ideological and political context: IAH is difficult to implement in divided societies, especially those suffering under oppressive governments or where government capabilities have disintegrated. Even in stable democracies IAH poses challenges if health concerns are low on the political agenda, as has been a problem in many European countries. Societal values that support equity, solidarity and action on social determinants of health can prompt government to embark on, and sustain, IAH – this has been the case in Sri Lanka for more than half a century. Such action is particularly effective where government as a whole (rather than just the Ministry of Health) embraces the concept of social determinants of health, as shown by the UK and Sweden experiences.

The economic environment. IAH can be expensive and time-consuming. It is often difficult to initiate when there is poor economic growth and government is experiencing budget cuts. However, budget cuts can sometimes act as a stimulus for innovative collaboration on long-standing problems as different sectors appreciate the need to join forces for the sake of efficiency.

Electoral cycles. IAH projects need to be responsive to local needs and take time to build a political consensus. They may only yield benefits in the long-term and therefore not be attractive to politicians seeking to gain favour with the electorate in the short term (thus, in the UK, the Health Action Zones initiative suffered from undue pressure to

deliver short-term gains during the first term of office of the 1997 Labour government). On the other hand, the election of a new party can galvanize action on IAH, as was the case for Mexico City in 2000 when a new government with social equity goals came to power and implemented an intersectoral social programme including housing and neighbourhood renewal, scholarships for children of single mothers and for job training, breakfasts in public schools, compensation for the increased milk price, micro-credit for households, funds for peasants to protection of remaining rural areas, a pension for senior citizens and free health services and drugs for residents of poor areas.

Institutional features of government

Government decision-making processes. Many features of decision-making within government restrict opportunities for IAH which depends on integration both horizontally (between sectors) and vertically (between levels of government). Government departments have limited mandates, tend to compete with other departments, and have their own language and culture that hinders communication between sectors and can lead to conflict. Funding structures tend to reinforce these 'organisational silos' of separation, as sometimes does the way in which international funding is channelled (see section 5.2). However, 'new' money in times of budget expansion, as well as dedicated budgetary support, provide ways to get around the barrier posed to IAH by these 'silos'.

Institutional structures. A common vision for IAH is not sufficient to ensure that IAH activities materialize. Experience shows that very few states institutionalize IAH by integrating it into daily administrative structures and processes. This means that 'ownership' of IAH projects tends to remain at the level of committed individuals, rather than of organisations as a whole. This makes IAH projects vulnerable when key individuals leave (as was the case with the Health Action Zones in the UK and many Health Cities Projects). At a high level, national policy and legislation can create an obligation for government sectors to work together (as is emerging in the European Union). A number of other mechanisms are detailed below.

Capacity for IAH. IAH requires dynamic leaders who are able to work across sectors, draw in communities and manage different interests. The skills required to manage and sustain intersectoral action are often very different from those required for work within the sector. Many health sector workers have not received training or practice in these types of skills. This can be aggravated by a high turnover of skilled staff.

How can Ministries of Health achieve better leverage for IAH?

IAH is facilitated when it becomes an over-arching strategy of government as a whole: under such circumstances it may not be necessary for the Ministry of Health (MOH) to play an unusually prominent role in IAH. In conflict-affected countries, moreover, humanitarian assistance agencies may lead IAH efforts (Ranson *et al.* 2007).

Nonetheless, the WHO definition of IAH quoted above**,** implies a central role for MOHs in at least initiating and monitoring, if not also running, IAH projects. This is because Ministries' explicit concern for population health and understanding of the multi-factoral determinants of ill-health, give them a clear mandate and the necessary skills to participate in IAH. The responsibilities of Ministers of Health in this regard become particularly important when their Cabinet's support for IAH is lacklustre. IAH is time-consuming and resource intensive, however, which means that the

Minister and MOH officials need to make strategic choices about when and how the Ministry intervenes. IAH is also usually a highly political endeavour, challenging powerful interest groups that can mount campaigns against initiatives (witness the response of the tobacco lobby to campaigns to reduce smoking) or generating conflict between sectors. Particular attention, therefore, has to be given to managing concerned and interested actors. Several steps are outlined below: while many of these are drawn from the experience of high-income countries, they resonate with the more limited evidence of LMICs, and are applicable across a wide range of contexts.

Level of action

IAH becomes more complex and harder to achieve at higher levels of government, given territorial competitiveness and the growing numbers of actors involved. More success stories of IAH at the community or local level are documented: the smaller, more human scale allows for closer ties among participants in local projects; policy-makers live where they work so they are more accountable for their decisions; and bureaucratic structures are smaller and relatively more accessible. In turn, successful local action can promote effective higher-level action with wider and longer-term impacts on population health by addressing the structural causes of ill health - such as fiscal interventions like tobacco and alcohol taxation. Higher level intersectoral action is also often necessary to support other equity-promoting actions within health systems (Wagstaff 2002). Collaboration is needed, for example, between the health and education sectors in training new cadres of health workers for under-served rural areas, or between the health and transport sectors to improve people's access to health facilities in remote areas.

Making the case for IAH

Experience demonstrates that strategically-used evidence facilitates a shared vision of the importance of health equity and IAH. For example, Sweden's National Public Health Strategy was underpinned by nineteen background papers, commissioned from expert groups, which provided credibility for an IAH-centred strategy. It also mobilised the research community in an intersectoral way and allowed for a multi-disciplinary research approach to health determinants (Annex 6). In Chile, epidemiological information was used effectively to emphasises the social determinants of health, thereby encouraging intersectoral solutions to health problems (around family violence and housing for poor families, for example) as well as strengthening support for the PHC approach (Annex 5). In Europe, Health Impact Assessments of sectoral policies are becoming more commonplace, raising awareness of the social determinants of health (Public Health Agency of Canada and Health Systems Knowledge Network 2007). Such periodic assessments could be complemented by information from public health surveillance systems. These are vital to resource allocation and planning of health interventions within the health sector, but can also serve to monitor determinants and interventions emanating from other sectors. Developing a strong evidence base on IAH is particularly useful in sustaining political commitment and alliances (see below).

Governments' commitments to international conventions provide another opportunity to make the case for collaborative alliances around priority areas. For example, conventions on the rights of the child require intersectoral action to develop national action plans for children, setting up multisectoral task forces, and agreed areas for policy, legal review, programmes, and budget reform (see Early Child Development Knowledge Network).

Clarifying the role of MOH officials

It is neither feasible nor necessary for MOH officials to be involved in all stages of all IAH initiatives. They need to maximise windows of opportunity and focus on a catalytic rather than an implementing role. This requires particular skills, as the role of the Ministry of Health *'is no longer straightforward – it must be able to shift and adapt, knowing when to lead and what kind of input is required. It must also be vigilant to ensure that the health aspect of complex files* [i.e. initiatives] *led by other sectors are flagged and addressed. It must be sensitive to timing, able to distinguish between short, medium and long-term gains, and prepared to make decisions on appropriate entry points and strategies'* (Public Health Agency of Canada and Health Systems Knowledge Network 2007:31). Health officials also need to anticipate and respond to opportunities to advance health equity through broader social and economic policies which may involve intersectoral action but where health equity is not a stated goal.

Balancing the contribution of health with other sectors

The roles of policy development, implementation and evaluation must be shared between the different sectoral actors, particularly given the common experience of competitiveness between government departments. Explanations of IAH's value in addressing policy challenges, will strongly influence the roles the respective actors will be willing to play. The systematic review of IAH experience suggests that *'successful collaboration depends on shared interest and mutual trust, and there is careful balancing of power for these relationships to work. In addition, these relationships are sometimes enhanced if the focus of intersectoral work is cast in broader societal terms (such as social equity), rather than narrowly as health-centred initiatives'* (Public Health Agency of Canada and Health Systems Knowledge Network 2007:19). To initiate and sustain IAH it is, therefore, particularly important for the Ministry of Health to look beyond its own goals and to take account of other sectors' objectives. At the same time, it needs to uphold equity principles in the way it organises and delivers care within the confines of its own sector.

Actively building alliances

Successful alliances involve appropriate actors at appropriate points in the process and ensure that partners share leadership, accountability and rewards. As shown in Sweden in the 1990s, an inclusive engagement with interested and concerned actors can build momentum in support of IAH and prevent the strategy from being undermined. Within government this means building connections between sectors (especially through the health focal points of other Ministries) as well as different levels of government. While local government is an important locus of action, sub-national and national level buy-in and support are necessary for sustainable, wide-scale initiatives. The Treasury or Finance Ministry, in its funding and performance assessment role, is a critical actor in supporting joint initiatives across organisational and sectoral boundaries and lines of accountability. Connections between IAH programme staff and local political leaders or administrators, and the media, are also important in garnering support for an IAH perspective. Engagement with the community is equally important to highlight equity concerns and to facilitate action and uptake of interventions.

Sustaining IAH initiatives

A major challenge is how to maintain commitment to IAH initiatives over time (beyond the electoral lifetime of

individual political leaders and despite the turnover of staff that is common in government programmes). Experience shows the value of setting clear goals and articulating the benefits to all actors, promoting initiatives so that they become high profile, involving public health professionals in identifying priorities and planning action, and ensuring that decision-making authority rests with those responsible for implementing such action. In addition, the teams of government staff involved in IAH initiatives must, between them, possess the range of skills to develop policy, implement and assess initiatives, and manage complex communication and negotiation processes. Skilled leadership builds the inter-personal trust necessary to bind these teams together, despite the many institutional obstacles to collaborative action. Finally, generating visible results also helps to build morale to continue IAH efforts.

Institutionalising IAH

Whilst highly motivated individuals often drive IAH processes, long-term stability requires institutionalized structures and processes that offset contextual challenges and resist the vagaries of time. Most important among these are: creating a mandatory requirement to participate in IAH as well as conduct health impact assessments (through legislation); institutional arrangements that allow for on-going dialogue between colleagues (such as committees made up of related sectoral 'clusters,' including both routine inter-Ministerial committees and those set up specifically for IAH projects); dedicated budgets and performance incentives for participation in IAH, including accountability frameworks; and government budget, planning and audit processes that track IAH. Institutionalizing Health Impact Assessment as part of routine decision-making within government can, in particular, maintain awareness of the social determinants of health: the MOH can play a role in ensuring that at least some form of assessment is performed and monitored, even in low-income countries where complex, data-intensive assessments are not possible.

4.2 Promote social empowerment

Part 3 concluded that social empowerment can impact positively on health and health equity. This section draws on international experience to suggest strategies that promote social empowerment for health equity within health systems. These strategies are largely led by public-public partnerships between actors at various levels of government and the social networks within communities, as well as their formal organisations (that is, civil society organisations (CSOs) which include non-state, non-profit, voluntary organisations such as formally managed non-government organisations, professional membership bodies (e.g. health profession associations), and more informal groups of people who come together on the basis of neighbourhood, work or social connections). The strategies encourage: grounding the practice of government in social dialogue and accountability; a more horizontal relationship between public authorities, experts and social actors; a move from simple representative to participatory democracy, and an emphasis on local-level management, all of which are included within the comprehensive PHC approach (Vega-Romero and Torres-Tovar 2007).

Context matters

Social action strategies are context-specific and involve diverse actors who may be organised differently in relation to one another over time. Social action in Brazil under authoritarian military rule was different, for example, to the role

now played by civil society under the universal health system established within the subsequent democracy (Becker 2003; Oliveira 2003). State welfare policies that are grounded in obligations towards citizen rights focus social action on community engagement with local and central government around state performance in meeting these obligations. In contrast, commercialised social service delivery often leads to consumer and interest lobbies around the performance of private providers, involving less direct engagement with the state. In some countries, moreover, social services provided privately are controlled by corporate interests in other countries, complicating social action; but in other instances social action has contested commercialisation and reclaimed the role of the state in fulfilling its obligations towards the health of its citizens (Vega-Romero and Torres-Tovar 2007).

All in all, stable, egalitarian socio-political contexts and social conditions that enable collective claims to social rights, facilitate social empowerment (Wallerstein 2006; see, for example, the case of Mexico City in Annex 5). Organised and capable social networks are also important, for example, a media that is not entirely controlled by the state or big business, and a judiciary that functions independently (Murthy *et al.* 2005). In relation to health, government-community partnerships and social action are stronger where: communities are locally organised and geographically concentrated; there is sustained interaction and communication between population groups and health workers (such as through committees and other mechanisms for joint community-health system planning); the local health system is adequately resourced; user charges and other forms of commercialisation do not create barriers to access; and donor demands do not outweigh local inputs (Baez and Barron 2006; EQUINET *et al.* 2005; Goetz and Gaventa 2001; Loewenson 2000; Loewenson *et al.* 2004; Macwan'gi and Ngwengwe, 2004; Ngulube *et al*, 2004; Vega-Romero and Torres-Tovar 2007). Importantly, though, poverty and lack of power may exclude disadvantaged and marginalized population groups from social action, making social empowerment strategies vulnerable to capture by higher income and more powerful groups.

Social mobilisation

As a first step towards social empowerment, social mobilisation strategies encompass a range of activities aimed at increasing social awareness of health and health systems, strengthening health literacy, and enhancing social capacities to take health actions. Social mobilisation can improve the performance of health systems and population health outcomes, especially in relation to health promotion and public health activities.

The international evidence suggests a number of strategies, all founded on increased social awareness and collective reflection (Goetz and Gaventa 2001; Loewenson 2003a; Vega-Romero and Torres-Tovar 2007). These strategies include:

- increasing citizen's access to information and resources and raising the visibility of previously ignored health issues, such as was achieved by the Panchayat Waves community radio programme in India and the participatory research and advocacy campaign on breast cancer in the United Kingdom (Goetz and Gaventa 2001; see also the case study in Annex 5 of the Community Working Group on Health in Zimbabwe which ran information campaigns around levels of government expenditure on health care, gender issues and the

quality of health services, and calculated a 'health basket' which made visible the costs of maintaining health for Zimbabwean households (Rusike 2007);

- developing the consciousness, self-identity and cohesion that underlies social action, such as was shown by a South African study of a combined micro-finance and training intervention for poor rural women which led to a dramatic reduction in intimate-partner violence (Pronyk *et al.* 2006, see Annex 6);

- involving population groups in priority-setting for planning, such as was the experience of a theatre programme used by some local authorities in the United Kingdom to tap residents' opinions and identify alternative policy solutions for local authority Health Improvement Plans (Goetz and Gaventa 2001); and

- involving disadvantaged and marginalized groups in health promotion, prevention and care, such as was done in a community-based intervention in Nepal that involved mothers in an action-learning cycle to identify local perinatal problems and devise strategies to solve them (this was associated with significant reductions in maternal mortality and adverse birth outcomes as well as increased health service utilisation (Manandhar *et al.* 2004), see Annex 6)).

Accountability

Social mobilisation may also be linked to efforts to hold health authorities accountable. Accountability involves *answerability* (that is, the obligation to inform and explain) and *enforceability* (that is, the holding of authorities to task over commitments of obligating a review of practice). Table A provides examples of accountability strategies. Murthy *et al.* (2005) note that these strategies are more successful when initiated by population groups (rather than authorities) and have had less impact on contested, new or low priority areas of health services (such as adolescent reproductive health). George (2003) also notes that health workers can become frustrated when they do not have the authority to respond to issues raised at local level.

Table A: Accountability strategies

Accountability mechanisms initiated within health systems	Accountability mechanisms initiated within civil society or by other sectors
To build answerability	
• Consultations with stakeholders on specific policies • Permanent or time-bound stakeholder fora for policy formulation and monitoring of implementation • Placing adverts in the media and holding public hearings • Target-setting	• Right-to-information campaigns • Right-to-information laws • Citizen monitoring of health expenditure and quality • Mortality audits • Joint health information surveys
To strengthen enforceability	
• Institutionalising access to decision-making through, for example, clinic committees • Local-level management • Service charters • Health system quality assurance and monitoring systems • Professional self-regulation	• Creation of task forces, user groups and community lobbies • Consumer protection laws, consumer fora and public interest litigation • Women's health groups supporting enforcement of women-friendly health services • Patients' rights charters promoting rights and responsibility • Ombudsman centres

Sources: George *et al.* 2003; Murthy *et al.* 2005

From social mobilisation and accountability to social empowerment

While *social mobilisation* and *accountability* can support equity-oriented health systems and improve health outcomes, strategies to address the social determinants of health call for more direct forms of participation in decision-making, and greater control over the resources for health, particularly by relatively powerless groups who also bear the burden of health problems in every society. Thus, for example, accountability strategies are more likely to strengthen *social empowerment* when directed towards health policy and management decisions, and when disadvantaged and marginalized groups participate in decision-making (Murthy *et al.* 2005).

For social empowerment to be equity-promoting, central and local government structures, including Ministries of Health, must provide opportunities for disadvantaged and marginalized groups to engage in decisions on health, facilitate such input by making health systems more responsive to need (rather than demand), and enhance relationships and communication between health workers and the population. CSOs, on the other hand, need to facilitate social processes and population-led action, including those which expose and redress power imbalances that harm opportunities for health in disadvantaged groups. Above all, social empowerment takes time, needs resources and must be sensitive to local contexts (EQUINET *et al.* 2005; Loewenson 2003a; Vega-Romero and Torres-Tovar 2007). The range of relevant actions are outlined in detail below, based on wide-ranging literature reviews (Baez and Barron 2006; Goetz and Gaventa 2001; Loewenson 2003a, 2007; Murthy *et al.* 2005; Musuka and Chingombe 2007; Pollard and Court 2005; van Dam 1992; Wallerstein 2006), as well as various small-scale studies (Chebundo 2007a, 2007b; Cuevas 2007; Gonzales *et al.* 1998; Health Systems Trust 2007; Helling *et al.* 2005; Loewenson *et al.* 2004; London 2003; Macwan'gi and Ngwengwe 2004; Mbombo and Marmorato 2007; Mugisha 2007; Musuka 2007; Nazarit

2007; Ngulube *et al.* 2004; Ngulube *et al.* 2005; Ochoa and Visual 2007; Peren 2007; Rusike 2007; University of Namibia Ontevrede community 2006).

Strategies for central and local government

- *Provide statutory rights to information to the public.*

- *Recognize, support and fund mechanisms for direct participation by population groups,* through local government structures generally and with links to specific structures for health (see, for example, the case of Cuba which holds regular assemblies at municipal level during which members of the public engage with elected representatives and discuss and propose answers to health problems (Ochoa and Visbal 2007; see Annex 5) and Brazil where six thousand health councils exercise oversight on health policy (Labra and Giovanela 2007; see Annex 6)).

Strategies for Ministries of Health

- *Structure processes that bring health professionals into roles that support social mobilisation, and encourage and reward these roles*, including: valuing community roles and improved community competencies; recognising the demands of social engagement on health workers, including alterations in their power and control over the health system; replacing bureaucratic and hierarchical ways of working with approaches that demand innovation and flexibility; and providing formal rewards and support systems to incentivise these changes.

- *Recognize, support and fund mechanisms for direct participation by communities*, such as district and clinic boards or committees (these should be formalised in law or guidelines, and should receive support in the form of resources, planning tools and training).

- *Use participatory processes in planning (particularly resource allocation) and make planning processes accessible to public monitoring* by, for example: basing plans on information that is accessible to communities; using funding benchmarks that are linked to specific health goals to facilitate public understanding; and establishing mechanisms that allow public input on budget reviews (see, for example, participatory municipal budget analysis in Brazil (Goetz and Gaventa 2001; the experience of parliamentary engagement with communities in East and Southern Africa, Annex 5 (Musuka and Chingombe 2007)).

- *Establish a mix of legal, media, organisational and communication strategies* so that partnerships between Ministries of Health and CSOs: are governed by clear agreements; benefit from uninterrupted financing and staffing; and are subject to regular and timely monitoring and evaluation by implementing partners.

Strategies for civil society organisations and population groups

- *Provide for the inclusion of population information and preferences in monitoring, lobbying and planning* (such as was the case with the participatory municipal budget analysis in Brazil, the successes of the women's movement in the same country and the experience of Chiapas state in Mexico where the

Zapatista movement was integrally involved in planning and delivering health services in the area under its control (Cuevas 2007; see Annex 5)), recognising that civil society organisations are able to: generate information relatively quickly; direct it to where it will have impact; and draw on symbols and stories, as well as popular vocabulary, to great effect (as for example in the Access to Treatment campaigns in east and southern Africa, particularly South Africa).

- *Monitor the performance of health systems against social priorities* such as was the case with the report cards on client satisfaction with public services used in Mumbai, Bangalore and Calcutta, India, carried out through large surveys by a CSO).

- *Draw attention to needs and inequities in resource allocation*, including proposing alternative budget allocation priorities (e.g. youth, child and gender 'friendly' budgets).

- *Provide special mechanisms to engage marginal groups* (such as the 'citizen juries' and participatory 'well-being assessments' in the United Kingdom which engage local residents who do not normally participate in local government;), recognizing that rights-based approaches can also become drivers of equity when they are used to strengthen the collective agency of the most vulnerable groups.

- *Support the development of social capacities for engaging with bureaucracies and authorities* through popular education work, skills building in lobbying and negotiation and support for publications (see, for example, the Community Working Group on Health in Zimbabwe, or the work of organisations in the Health Civil Society Network in East and Southern Africa, Annex 5).

- *Engage with formal local and national political leaders* to strengthen political support for social action and participatory processes and offset disabling power relations within communities (see Mexico City case study (Laurell (2007), Annex 5) and the Zimbabwean parliamentary experience where links and dialogue with civil society was a key factor in strengthening the budget work of Parliament (Chebundo 2007b, Annex 5)).

Many of these strategies tend to be implemented in local settings, but there is some evidence that strategies can be scaled up beyond the specific context in which they were first developed. For example, a project in Bolivia was carried out in 50 communities in one province through a participatory action cycle relating to maternal services, then scaled up to 500 communities and further extended to Peru (Gonzales *et al.* 1998). Scaling up is also facilitated by: establishing shared health goals between civil society and government actors; providing legal frameworks for participation (such as the Bolivian Law on Popular Participation 1994); and involving local government and support from public resources (Loewenson 2007; Vega-Romero and Torres-Tovar 2007).

 Such strategies should not, therefore, be reduced to a set of 'tools' that can be applied independent of context (EQUINET *et al.* 2005; Loewenson 2003a; Vega-Romero and Torres-Tovar 2007). They are always applied within a specific context: encompassing a political system, societal values and norms and the structural factors that underlie social exclusion. These influence their operation. For example, social empowerment approaches that are premised on individual rights (like patient charters) and consumer lobbying to claim service entitlements do not acknowledge the power imbalances between health care workers and low-income communities or the limits of purchasing power in poor

communities. They ignore the more collective ways in which societies seek to resolve problems in access and quality of care through social and economic rights, and through social networking and dialogue. Similarly, approaches that seek to empower women through micro-credit schemes may fail if they do not recognize the factors affecting control over those loans, or the ways in which this subjugates them to new systems over which they have little control. Ultimately, there are six imperatives to create enabling environments that allow for wider-scale social empowerment:

1. **recognize and make explicit the links to political values, systems and leadership** needed for social empowerment;
2. **make the linkages across sectors**, and particularly with local government and civil society, to facilitate social roles in health;
3. **promote rights approaches that recognize social entitlements** and strengthen and provide mechanisms for active collective roles in claiming those entitlements for disadvantaged groups (rather than focusing on procedures and mechanisms for individual claims);
4. **make explicit goals, policies and legal frameworks, and resource plans and mechanisms** for participatory approaches to health systems development;
5. **orient, train and reward health workers** for facilitating social action through participatory approaches; and
6. **monitor, report on and hold the health system accountable** for its policies, targets and commitments.

4.3   Strengthen the redistributive role of health care

Key features of redistributive health care systems

Part 3 provided evidence that health care systems can be redistributive and that public spending, even where pro-rich, may offer gains in relative living standards, and possibly even health, to poorer groups. The international evidence suggests some overarching policy recommendations for strengthening the re-distributive role of health care, although the appropriate set of design elements will inevitably differ between settings. This evidence is largely derived from cross-national and country level health economic analyses, as synthesized in five recent reviews (Mackintosh 2007; McIntyre 2007; McIntyre *et al.* 2005; Mills 2007; WHO 2006a). However, the robustness of the policy recommendations is demonstrated by their consistency with recommendations drawn from international comparisons of primary care (Starfield and Shi 2002).

Overall, experience suggests that redistributive health care systems share five common features, which are described below. Together these features re-affirm the central role of public health care in addressing inequity. Rather than abandoning the public sector in the face of current problems in LMICs (Part 3), dedicated efforts are needed to strengthen the equity of public funding and provision.

The policy goal of universal coverage

The goal of universal coverage guides the development of re-distributive health care systems. It also makes transparent the entitlements and obligations of the population, and provides the basis by which citizens can hold the State accountable for this promise of universal coverage (WHO 2006a).

Universal coverage requires that everyone within a country can access the same range of services on the basis of need and pays for these services on the basis of their income (see definition in Box A). Within such systems, redistribution is achieved because the rich (and relatively healthy) cross-subsidise the use of health care by the poor (and relatively sick). In practice, this requires that individuals and households share the financing of their health care costs by making regular contributions, according to their income level, into a pooled fund. By sharing the financing burden in this way, individuals are protected from the unpredictability and impoverishing effects of illness-related costs, and are more likely to have access to care when they need it. As the rich pay a higher proportion of their income than the poor into the pooled fund, there is also cross-subsidisation (Carrin and James 2005; McIntyre *et al.* 2006). The larger the number of people pre-paying into the fund, the more the risks of being ill are spread among contributors, and the greater the protection provided against health care costs.

Box A: Defining universal coverage (UC)

- a situation where the whole population of a country has access to good quality services according to needs and preferences, regardless of income level, social status, or residency
- an absolute concept in relation to population coverage (100%) with the same scope of benefits extended to the whole population (but the range of benefits varying between contexts)
- incorporates policy objectives of equity in payments (the rich should pay more than the poor), financial protection (the poor should not become poor as a result of using health care) and equity of access or utilisation (implying distribution according to need rather than ability to pay, and requiring equity in the distribution of spending and resources)

Importantly, within systems of universal coverage, specific actions are needed to avoid richer groups using health care considerably more, or being offered considerably better quality care, than poorer groups. Such action includes addressing the particular barriers to health care access faced by socially disadvantaged and marginalized groups and placing referral services within a framework that recognizes the key role of primary care services in navigating their use by patients.

Source: Adapted from Mills, 2007; Kutzin, 2001

In low-income countries, however, as public funding is limited and public spending commonly pro-rich, some argue that universal coverage is unlikely ever to be achieved and, as a policy goal, distracts attention from the critical need to experiment with other ways of extending health care coverage to poorer groups (Gwatkin *et al.* 2004). Yet experience shows that it is difficult to expand small-scale innovative projects designed preferentially to benefit the poor into national-scale action to address inequity (Ranson *et al.* 2003; Simmons and Shiffman 2006). A large body of international evidence also shows that programmes targeted at poorer groups suffer sustainability and equity problems. They require high levels of administrative capacity and have high administrative costs, often stigmatise

users, do not achieve adequate coverage of the target group and their benefits are often captured by more powerful groups (Mkandawire 2005). In contrast, Asian evidence clearly indicates that universal systems can protect the poor and transfer resources to them from the rich, even if the rich continue to use services more and so the public subsidy is not strictly pro-poor (as discussed in section 3.2) (O'Donnell *et al.* 2005a; O'Donnell *et al.* 2007). Although less common, Sri Lankan experience shows that universal coverage is possible in low-income settings, whilst new Ghanaian policies are working within policy framework of universal coverage to strengthen the redistributiveness of health care (Annex 6).

This report asserts, therefore, that universal coverage provides the central policy framework within which to build re-distributive health care systems – noting the priority of deliberate efforts to ensure that socially disadvantaged and marginalized groups really do have access to effective health services (see definition, Box A). With the reduction of inequity as the central goal, efforts must still be made to ensure a pro-poor distribution of benefits from some interventions and services.

Public funding plays a central role

The available cross-national empirical evidence clearly suggests that publicly provided care can be redistributive in countries of all income levels (as discussed in Part 3). The evidence is particularly clear that the core foundation of such redistribution is tax-based and mandatory health insurance funding, as through these financing systems the rich pay a higher proportion of their income towards health care than the poor (Mackintosh 2007; Wagstaff *et.al.* 1999). In Asia, therefore, increases in the tax-funded share of health care funding are associated with reductions in the pro-rich bias within the subsidy, and are achieved even in the low-income setting of Sri Lanka (O'Donnell *et al.* 2007). Also, in Latin America increases in public health expenditure are consistently redistributive (Mackintosh 2007). Despite recent interest in social health insurance, tax-based funding offers particular advantages (Mills 2007; Wagstaff 2007). In some situations, such as falling employment levels, it may be difficult to extend mandatory insurance; and even within insurance systems tax-funding must be used fully or partially to subsidise the costs of care provided to groups who are hard to reach through insurance, such as the informally or self-employed (see the case studies from Costa Rica and Thailand, Annex 6).

No or very low fees are charged for public services

Systematic reviews of available evidence clearly show that the introduction of user fees in LMICs has led to overall reductions in utilisation levels (Lagarde and Palmer 2006; Palmer *et al.* 2004). Although there is less evidence on the relative impact of fees on poorer versus richer groups in LMICs, the wider experience of out-of-pocket payments presented in Part 3 shows the particular burdens borne by lower income groups (see also the China case study (Meng 2007), Annex 5). Out-of-pocket payments, including user fees, generate utilisation inequities and impoverish women, lower income and socially marginalized groups. Asian evidence also specifically shows that in three of the four (out of eleven) more re-distributive health care systems only minimal fees for public services are charged to anyone, whilst in Thailand an unusually effective mechanism protected the poor from payment (O'Donnell *et al.* 2005b). The common

ineffectiveness of exemption mechanisms, however, only adds to the inequitable impact of public sector fees (Bitrán and Giedion 2003).

They offer a set of comprehensive services

The services provided to achieve universal coverage must be determined, first, by considering which are important in improving access and offering financial protection to poorer groups and enhancing redistribution overall. Cost-effectiveness should be a secondary consideration. Analysis suggests, therefore, that a fairly comprehensive range of services should be made available everywhere (McIntyre 2007), even if it is quite narrow initially and expanded over time as budget resources allow (e.g. Thailand and Mexico City case studies, Annexes 5 and 6). Not only are the costs associated with in-patient and higher level care, including delivery care, clearly impoverishing for poor households, but so also are repeated small payments for ambulatory chronic care (Borghi *et al.* 2006; McIntyre *et al.* 2006; Perera *et al.* 2007; Russell 2007). Asian experience also suggests that, although hospital services are used more by the rich than the poor, redistribution through health care is greater where there is better access to a range of levels of care. Good geographic access even to small and not necessarily very well equipped public hospitals in Malaysia, Sri Lanka and Thailand, thus, helps explain the wide distribution of benefits in these countries (O'Donnell *et al.* 2007). Nonetheless, as emphasised in Box A, it is important that service delivery is re-oriented through a primary health care approach that encourages re-allocation of resources to, and significant strengthening of, primary care provision (McIntyre 2007; Mills 2007), as well as strengthening hospital services in ways that enhance their benefits for poorer groups (de Maeseneer *et al.* 2007; Figueras *et al.* 2004; O'Donnell *et al.* 2007).

The private sector complements the public sector

Public provision dominates in more redistributive health care systems, and should be strengthened better to achieve universal coverage. Nonetheless, experience from higher income settings indicates that for-profit private providers can sometimes play important roles within the overall health system, where adequate managerial capacity allows effective contracting arrangements (Palmer 2000; Siddiqi *et al.* 2006). In addition, private insurance may service the extra demands of rich groups, for example by allowing the voluntary purchase of additional care, including amenity facilities and relieving the public sector of this pressure (Carrin and James 2005; Mackintosh 2007; O'Donnell *et al.* 2005a; A Wagstaff 2007; see also Sri Lanka and Thailand experience, Annex 6). In low-income settings, meanwhile, a range of informal and non-profit private providers, including traditional healers, are likely to continue to play important roles (Palmer 2007). In both cases, however, it is essential to identify the policy and regulatory action needed to ensure that the private sector contributes to, rather than undermines, the redistributiveness of health care (WHO 2006a).

The steps towards universal coverage in different contexts

The set of feasible policy actions needed to move towards universal coverage will vary between settings according to contextual differences. In high-income countries, for example, policy-makers face the challenge of securing

redistributive goals whilst simultaneously containing the costs associated with ageing populations and rapid technological development (WHO 2006a). Other contextual factors influencing policy choices in all settings are:

- current economic growth rates and structures, particularly the proportion of the population formally employed;
- macroeconomic and social policy frameworks;
- the population distribution between rural and urban areas;
- the existing pattern of health care funding, provision and organisation, and payment and access inequities within this;
- the available level of managerial and organisational capacity within the system; and
- the configuration of political and institutional forces (Carrin and James 2005; Mackintosh 2007; Mills 2007; see also Annex 3).

Experience from higher income countries suggests that achieving universal coverage is a long-term goal (Carrin and James 2005). However, policy-makers in different contexts face a core set of policy choices and can draw on the available evidence in beginning to work towards universal coverage (Box 1, Annex 7).

Shorter-term actions

Mobilise increased public resources for health care

Given the enormous resource constraints faced by health care systems in lower income settings (Jha and Mills 2002), additional resource mobilisation is essential to support the other actions needed to enhance health care redistributiveness. Even in middle-income settings, additional resources are likely to be needed to improve geographic access and the acceptability of public services. Three policy options that can be considered everywhere are: 1) re-prioritising health care relative to, for example, spending on defence or debt servicing in government budget allocations; 2) widening the tax base and improving tax collection; and 3) combating corruption to generate resources for health care (Mexico City, Annex 5). Clearly, in low-income settings domestic resource mobilisation must also be complemented by international action, including channelling funding through mechanisms that allow the alignment of donor resources with national health priorities (section 5.2).

On the first option, the existing African government commitment to allocate at least 15% of the government budget to health care provides a rallying cry for action and a possible example for other regions. Although unfashionable, the feasibility of the second option, even in lower income countries, is also demonstrated by a range of experiences. New dedicated health taxes have been introduced or are being considered in several countries, such as Ghana's VAT levy of 2.5%, Zimbabwe's 3% personnel and income tax levy for HIV/AIDS (McIntyre *et al.* 2006), and tobacco and alcohol taxes in Thailand. In addition, tax collection efficiency has been substantially improved in South Africa (McIntyre *et al.* 2006) and, in Bolivia, overall tax system reform increased revenue collection by nearly six times in the middle 1980s (Wagstaff 2007). From resource mobilisation and equity perspectives, middle-income countries must also take action to maintain income tax progressivity and limit the tax deductability of insurance contributions for higher income groups (McIntyre *et al.* 2006).

<u>Remove public sector fees and reduce total out-of-pocket payment levels</u>

Wherever possible, public sector user fees should be removed in all LMICs, including post-conflict fragile states (Ranson *et al.* 2007), taking care to limit unintended negative impacts (Gilson and McIntyre 2005; see also Uganda case study, Annex 6) and to introduce wider policy action to reduce drug and transport costs. Unofficial payments deserve as much attention as official fees (Balabanova 2007; O'Donnell *et al.* 2007). For example, in Kyrgyzstan, careful implementation of formalised fees, accompanied by a range of sanctions, information and benefits to the facility under a new health financing system, helped to reduce informal charging, but only while a supportive and coherent policy environment was maintained (Balabanova 2007). Action on drug expenditure, meanwhile, must combine efforts to improve supply systems and prescribing practices, as well as adherence and compliance, in both public and private sectors. However, a systematic review of interventions to improve adherence, notes that their effectiveness depended on how well they were designed to meet the needs of the patients, given the particular characteristics of the health problem and socio-cultural context (Homedes and Ugalde 2001).

<u>Strengthen public provision by improving geographical access</u>

In lower income countries, it is particularly important to strengthen the public service infrastructure in rural and peri-urban areas. This provided a critical foundation for implementing universal coverage policies in Costa Rica, Sri Lanka, Mexico City and Thailand (Annexes 5 and 6). Three key requirements for all countries are to: widen geographic access by investing in public primary and secondary level infrastructure in under-served areas (McIntyre and Thiede 2007; Mills 2007); reduce transport cost barriers, for example, by providing subsidies to beneficiaries as was done in the UK (Dixon *et al.* 2003) and is being tested in Nepal (Borghi *et al.* 2006); and improve the referral linkages between primary and secondary levels (Mills 2007).

<u>Implement mechanisms to ensure equitable resource allocation between geographical areas</u>

To expand geographic coverage in under-served areas and sustain comprehensive service availability in all countries, it is important to implement mechanisms that allocate available tax funding between populations and areas relative to need (for example, allocating budgets between geographic areas on the basis of formulae that weight population numbers according to need rather on the basis of historical expenditure patterns). Experience shows the real potential of such mechanisms even in low-income contexts, despite informational and political challenges (McIntyre *et al.* 2006). Where, as in many low-income countries, a patchwork of financing sources exists (including, for example, international funding and community-based health insurance revenue), the resource allocation mechanism should take account of all sources of funding to ensure an overall distribution that is equitable (McIntyre *et al.* 2005). However, to have real effect, allocation mechanisms will need to be complemented by procedures to support effective spending of the resources (Goudge *et al.* 2003; Thomas *et al.* 2007 forthcoming).

<u>Strengthen public provision by improving acceptability</u>

Action is also needed to make public services more acceptable, particularly for women and other marginalized groups. Building on the strategies to strengthen linkages between communities and the health system discussed under the section on social empowerment, existing experience suggests interventions to encourage a greater client-centred

approach to service delivery (for example, provider training to improve communication skills and sensitivity, employing members of socially marginalized groups as health workers, and providing interpreters and signage in different languages) and to enable patient and social empowerment (Gilson 2007a; Govender and Penn-Kekana 2007; Nepal case study (Manandhar *et al.* 2004), Annex 6; see also section 4.2). Despite the dearth of impact evaluations for these types of interventions (Anderson *et al.* 2003), the existing problems demand experimentation (Gwatkin *et al.* 2004) and new interventions will need to be backed up by wider health system support, such as accountability mechanisms and dedicated funding (Gilson 2007a).

Work with non-state providers in low-income populations

In recent years, public contracts with non-government providers have become particularly popular because of the potential for access gains (Hanson *et al.* 2007), including in post-conflict settings (Ranson *et al.* 2007). In sub-Saharan Africa, for example, such organisations already provide a large proportion of primary and secondary care, are often located in under-served areas and may base their work on values that motivate them to empower socially disadvantaged groups. In some cases they have also received government funding for many years for the services they provide (Bennett *et al.* 1997). In Afghanistan, moreover, the use of contracting by three major donors has increased access to basic health services from 5% in 2002 to an estimated 77% in 2006 (Newbrander 2006). A second reason for government to work with formal and informal private primary care providers (including drug sellers of various types) is because they often add to the cost burdens these groups bear by providing low-quality care to low-income populations (Bennett *et al.* 2005; Patouillard *et al.* 2007). Relevant interventions include pre-packing drugs, vouchers, regulation, training, franchising, accreditation, contracting and social marketing.

However, the available evidence on interventions is limited and intervention benefits are not clearly demonstrated. For contracting, Lagarde and Palmer (2006) note that CSOs may not have the capacity to scale up rapidly in post-conflict settings, and, where donors are involved, the arrangements may undermine the role of the government in driving health care development. However, in terms of improving quality, Patouillard *et al.* (2007), suggest that there is evidence of potential gains as many interventions worked reasonably well in poor communities and some improved the care offered by providers used by poor people. Overall, Bennett *et al.* (2005) and Palmer (2006) suggest that the priorities for action include: developing a comprehensive regulatory framework; strengthening regulatory functions; building government capacity to regulate and work with non-state providers and provider capacity to organise themselves; and strengthening the generation and synthesis of information.

Medium- to longer-term actions

Pool funds from various sources and harmonise contributions and benefit packages over time

Patchwork financing systems are common in LMICs. In the lowest income countries, a range of financing mechanisms may cover different groups of the population whilst mandatory insurance is generally implemented by first covering only the formally employed (Dussault *et al.* 2006). Within patchwork systems there is strong potential for some people to receive no financial protection (for example, US case study, Annex 5). Fragmentation and segmentation also limits the size of the population amongst whom risks are shared and the possibilities for cross-

subsidising health care costs, whilst inequity in utilisation is generated by allowing the better off to access a wider range of better quality health care than poorer groups (McIntyre 2007; Mills 2007).

In lower income countries, the first step in addressing the problems of patchwork funding is to use tax funding to improve and extend coverage for hard-to-reach groups, whilst ensuring these groups do not have to pay for care (Mills 2007); see also the example in Annex 5 of Mexico City which has extended free health services and drugs to poor areas of the city). Other options for extending coverage include *community-based health insurance schemes* or, in middle-income countries, separate programmes to reach *specific groups*, such as was the case for school children in Egypt (Nandakumar *et al.* 2000)) or *the currently uninsured*, as was the case in Mexico (Frenk 2006).

Community-based insurance schemes played an important role in the evolution of universal coverage in Europe and Japan (Ogawa *et al.* 2003), as well as in Thailand (Annex 5) and are currently important in China (case study, Annex 5) some African (Carrin *et al.* 2005) and transitional countries (Balabanova 2007). Although such schemes may offer financial protection benefits to some amongst the poor, existing cross-national evidence suggests that limited coverage, frequent exclusion of the very poorest, and weak capacity can limit the impact they have on equity and undermine their sustainability (Lagarde and Palmer 2006; Mills 2007). Separate insurance programmes may also face difficulties in achieving high coverage of the target population (Mills 2007). Either arrangement should only be implemented with caution, therefore, and particular efforts must be made to safeguard access for socially disadvantaged groups.

In middle-income countries, it is also important to reduce fragmentation and segmentation by pooling funds across schemes, perhaps managed by a new organisation, and to harmonise contributions and benefit packages, as was the case in Thailand (Annex 5; see also WHO 2006a). Specific efforts will be needed to ensure income-related contributions. To avoid entrenching segmentation, richer groups should not be allowed to opt out of the mandatory insurance environment, as happened in Chile following the health reforms of the 1980s (McIntyre *et al.* 2006; Mills 2007).

Within fragmented insurance environments, regulation may force integration of insurance funds and increase risk pool size, as was implemented in South Africa (Chetty 2007, Annex 5). In addition, risk-equalisation mechanisms - that allow the transfer of funds between different schemes on the basis of the relative health risks faced by their members - may also be needed to consolidate risk pools and support cross-subsidisation between schemes. However, there is little reported experience of these mechanisms and the capacity demands seem to be considerable (Mills 2007). Although pooling and harmonisation are longer-term tasks for low-income countries, the Ghanaian experience of bringing different financing schemes together under the umbrella of a mandatory insurance scheme offers an important experience from which low-income countries could learn (Annex 6).

<u>Strengthen purchasing strategies carefully</u>

Purchasing refers to the transfer of pooled funds to providers to pay for the health services used by the population (Kutzin 2001). New organisations established to manage pooled funds, as in Thailand (Annexes 5 and 6) or Kyrgyzstan (Jakab *et al.* 2005), also have responsibility for purchasing care from public or private providers.

Strategic purchasing by a few larger purchasing organisations may enable performance and efficiency improvements and contain costs, influencing the speed with which universal coverage can be achieved (Mackintosh 2007; Mills 2007; WHO 2006a). Specifically, the introduction of contracts between a powerful new purchasing organisation and private providers allows, in principle, the introduction of new provider payment mechanisms, which, by changing the incentives providers face, may offer tools for, cost containment (McIntyre 2007; Mills 2007; see Thai case studies, Annex 5 and 7). However, a recent systematic review concludes that evidence of the positive effects of financial incentives on the performance of providers is weak and closely related to the broader organisational structure of the health system (Chopra *et al.* 2006). Active purchasing strategies also pose implementation challenges in middle-income settings as they demand significant administrative capacity and commonly generate political resistance (Mills 2007). Emerging experience from Colombia, for example, which introduced a purchaser-provider split as a central element within the insurance reform it initiated in 1993, highlights the dangers of such arrangements (especially where private agents are allowed to manage pooled funds). Cost escalation has been considerable and access problems have resulted from both hospital and service closures in low-demand areas (Arbelaez *et al.* 2004; Velandia Salazar 2006).

<u>Enhance technical efficiency</u>

Finally, as there are fiscal pressures within every health care system, it is always necessary to improve the efficiency of resource use within systems (WHO 2006a). The actions required inevitably vary between contexts but are commonly likely to include ensuring rational and cost-effective use of drugs (Mexico City, Annex 5).

4.4   **Revitalise primary health care**

As noted in Part 3, we draw on PAHO (2007) in outlining the understanding of Primary Health Care that underpins this report: *'We define a PHC-based health system as an overarching approach to the organisation and operation of health systems that makes the right to the highest attainable level of health its main goal while maximising equity and solidarity. Such a system is guided by the PHC principles of responsiveness to people's health needs, quality orientation, government accountability, social justice, sustainability, participation and intersectorality'* (PAHO 2007: p8). More specifically, a PHC-based health system is composed of functional and structural elements that place families and communities at the heart of planning and action, and are equity-enhancing. These elements include intersectoral action to address the social determinants of health and health equity as well as mechanisms to enable collective and individual participation in health, and are organised in ways that guarantee universal coverage and service acceptability. A PHC-based health system also provides comprehensive, integrated, and appropriate care that emphasises prevention and promotion and assures first contact care. Organisational and management practices

assure quality, efficiency and effectiveness, based on a sound legal, institutional and organisational base and adequate human, financial and technological resources.

Sections 4.1, 4.2 and 4.3 outlined the actions needed to operationalise the key features of health systems that enhance action on the social determinants of health inequity, namely, intersectoral action for health, social empowerment and re-distributive health care. As these elements are themselves integral components of a PHC-based health system, their operationalisation helps build such systems. However, additional action is necessary to revitalize PHC and so capture the health and health equity gains that, as outlined in Part 3, it can deliver. This section outlines six additional actions to revitalize PHC. In parallel, the Priority Public Health Conditions KN considers how to operationalise this transformation from the viewpoint of specific programmes.

Strengthen the local level as the foundation of the health system

The local level should be the central location of action in PHC-based health systems: it is a focal point for wider action to address the social determinants of health inequity, as well as the entry point to any health system. There are more documented success stories of IAH, for example, at the local level than at higher levels of government (as noted in section 4.1) because of the greater possibilities of closer ties amongst participants and for holding local policy-makers and managers accountable. One review of experience notes that *'linking public health agencies to their communities is like plugging intersectoral action into an electrical outlet. These connections provide the energy to make IAH for health happen'* (Rachlis 1999: 21). Social empowerment for health is also facilitated at the local level because there is sustained interaction between the population and health professionals (see section 4.2). A wide body of experience suggests, in turn, that PHC approaches can enable local initiative and empowerment in response to needs identified by the population, even in the face of restrictive local power relations, resource constraints and limited support from higher levels of the health system (Baez and Barron 2006; Goetz and Gaventa 2001; Lopez *et al.* 2007; Vega-Romero and Torres-Tovar 2007). In Africa, in particular, therefore, the District Health System has often been seen as the organisational basis for PHC (Grodos and Tonglet 2002). It is comprised of a well-defined population, living within a clearly delineated administrative and geographical area, and including all organisations and individuals promoting health or providing health care (World Health Organization 1998).

Adequately fund local level PHC

Despite evidence that PHC services contribute to health and health equity (see Part 3), achieving coverage, range and quality of these services, as well as wider local action to promote health, are constrained by resource limitations. The need for resource support for IAH and social empowerment initiatives, particularly at local level, was highlighted in sections 4.1 and 4.2. In section 4.3, the importance of resource mobilisation for health care was also noted – to support primary and community level services and interventions, as well as to enable supportive referral services at higher levels, including secondary hospitals. In the most resource-constrained situations, political choices to invest at the primary care rather than tertiary service level are likely to confront powerful clinical and high-income interests.

Recognise and tap local opportunities for partnership with civil society

As identified in sections 4.1 and 4.2, IAH and social empowerment initiatives are more likely to be implemented when constructive partnerships are formed between public sector health professionals and managers on the one hand, and, on the other hand, local politicians and community leaders and CSOs that support local populations, and particularly socially disadvantaged and marginalized groups. Such partnerships can, in particular, tap the experience, expertise and information within CSOs, their approaches to people-centred and participatory development, and their experience in generating formal and informal networks of trust and co-operation within PHC programmes (Clayton *et al.* 2000; Embuldeniya, 2001; Kahssay and Baum, 1996; Klugman, 2003). Evidence is limited, but an evaluation of a large-scale contracting experience in Brazil (focusing on HIV/AIDS services) identified four features that contributed to its widely accepted success: it was part of a larger national strategy, built on existing CSO and health ministry capacity to implement contracts, involved the CSOs in its design, and was supported by a dedicated unit based in the health system and staffed by two people from the CSO sector. This unit was careful to maximise transparency and facilitate communication with CSOs and also provided technical assistance in proposal preparation, accounting, monitoring and evaluation (Connor 2000).

Community Health Workers (CHWs) can also sometimes play a role in relationships between public sector managers and professionals and the populations they serve, supporting intersectoral action and social mobilisation, extending services to socially disadvantaged groups and providing effective care for simple health problems (Juraci *et al.* 1998; Lewin *et al.* 2005). However, the evidence base is limited and experience mixed (Lewin *et al.* 2005; Mason *et al.* 2006; Walt 1988, 1990). Local power relations can be a significant obstacle.

The known implementation challenges suggest ways that local health managers can support CHWs, for example, through stronger selection criteria, training approaches and supervision, and through wider engagement with local populations, such as health committee structures (Kahssay *et al.*1998; Walt 1990).

Provide the primary care level with infrastructural and logistical support

To build up the primary care level as a means to support IAH, engage communities and achieve universal coverage and responsiveness, it must be supported by improved infrastructure (such as health facilities and equipment, roads, water and electricity supplies and telecommunications) and logistical support (such as the supply and distribution of affordable pharmaceuticals based on an Essential Drugs List, appropriate laboratory services and transport for outreach services to extend coverage of core interventions to socially marginalized or geographically inaccessible populations). The importance of these pro-equity features is widely recognised, as is the need to move towards integration of vertical services whenever possible (see, for example, (de Maeseneer *et al.* 2007; Mills *et al.* 2006; PAHO 2007; Victora *et al.* 2006).

Ensure and support health workers at the local level

Adequate numbers of appropriately skilled health workers at the local level is fundamental to extending coverage, improving the quality of care and developing successful partnerships with the community and other sectors (Kurowski *et al.* 2007). There are also three key equity-related challenges. First, there are *skills imbalances* in almost all countries, with too much dependency on expensive, curative care-oriented doctors and specialists, and too few auxiliary workers. Public health skills are commonly neglected and an orientation to primary health care is not fully adopted. Second, there is a severe *geographic maldistribution* of human resources that is worsened by unplanned migration from rural to urban areas, from the public sector to the private sector or to donor-funded vertical programmes, and from the developing to the developed world. This leaves rural and marginalized communities worst off (EQUINET *et al.* 2005; Padarath *et al.* 2003). Third, there are *poor working environments* in many public sectors, especially in poorer areas: these include poor management, inadequate supplies and facilities, and weak monetary and other incentives to retain and motivate health workers. Lastly, there is *weak information on the health workforce* which hampers policy-making, planning and management.

To address these equity challenges, multi-faceted, long-term action is needed. This section highlights three areas of action, while acknowledging that the evidence base in this field is thin. Complementary actions not covered by this report include: addressing international inequity in human resource distribution, including national actions to address the 'push' factors fuelling the brain drain (see Globalisation KN); increasing human resource production through better human resource planning (Hongoro and Normand 2006); providing incentives for strengthening all aspects of human resource performance (Peabody *et al.* 2006; Rowe *et al.* 2005; WHO 2006b); and addressing gender inequities within the workforce (see Women and Gender Equity KN).

Developing a skills mix appropriate for health equity will require review of what types of personnel are needed to promote health equity, as well as the skills and values they need to sustain their work. The Brazilian Family Health programme, for example, relies on multi-disciplinary teams comprised of a family health physician, a nurse, two auxiliary nurses and four to six community health agents who provide public health and health care services to a population within a defined geographic area. Although overall evaluation shows the health gains that have resulted from this programme, implementation experience demonstrates that a particular challenge is to re-orient health workers' attitudes towards a model of preventive and promotive care, without losing sight of curative care needs (Macinko *et al.* 2006; Peres *et al.* 2006). Actions to address these types of problems are likely to include reform of training curriculae, although there is little reported experience from which to draw clear conclusions (Govender and Penn-Kekana 2007). In-service training is another option, and there is some experience of innovative approaches to in-service training and mentoring that may enable the changes in personnel attitudes and practices necessary to sustain an equity orientation within health systems (Gilson 2007b; Govender and Penn-Kekana 2007; see also Box 2 in Annex 7 and Nepal case study, Annex 6). However, the evidence also emphasises the need to sustain attitudinal changes by backing up training with wider organisational and policy developments (see also section 5.1.3).

<u>More equitable distribution of the health workforce</u> is likely to require national measures to improve overall human resource availability, as well as differential implementation between geographical areas to address the particular needs of under-served areas. However, the Thai experience highlights that securing more equitable human resource distribution in contexts that are changing rapidly, needs careful planning (see Box 3 in Annex 7; Wibulpolprasert *et al.* 2004; Wibulpolprasert and Pengpaibon, 2003). From review of existing evidence, the 2006 World Health Report (WHO 2006b) concludes that the actions with the most potential to improve personnel availability are those related to salaries and payment mechanisms, combined with ensuring availability of the materials and equipment needed to do one's job, and flexibility and autonomy to manage work. However, as new payment mechanisms can have either significantly negative or significantly positive effects, their implementation needs to be closely monitored and should include opportunities for timely strategic review. Experience in east and southern Africa also suggests that non-financial incentives (e.g. training, welfare provision, career paths, support and supervision) may play a significant role in motivating health workers' choice of whether to work and stay at particular levels of services, and may have a more sustained effect in situations of high inflation and economic instability (Caffery and Frelick 2006; Dambisya *et al.* 2005).

<u>Strengthening interpersonal relations</u> between providers and patients and community groups is essential to improve the acceptability of care (see section 4.3): the Women and Gender Equity KN emphasises that where health workers feel valued, cared for and respected, they are more likely to provide client-centred and better quality services. Such action is also particularly important in tackling the gender discrimination that affects women as patients (Govender and Penn-Kekana 2007). Relevant policy interventions include: norms and codes of conduct for health workers; supervision (with quality improvements) and basic amenities such as privacy during consultation; and, possibly, team-based interventions that allow health workers to innovate and make them feel valued (Rowe *et al.* 2005; WHO 2006b). In-service training and mentoring programmes may be another strategy (Gilson 2007c; Govender and Penn-Kekana 2007). However, to tackle gender discrimination, it is also important to acknowledge the gender context in which health workers - the majority of whom are women - live and work, including problems of sexual harassment at work and workplace and domestic violence (George 2007; WHO 2006b).

Strengthen local health management

Local public sector health managers play vital roles in taking action on the social determinants of health inequity. Low-cost investments in strengthening local level management and supervision can also improve the performance of a much larger number of staff (Rowe *et al.* 2005). However, to perform their roles, managers, like other staff, need relevant skills (Box 4, Annex 7 outlines the key features of effective learning programmes), as well as incentives to sustain their motivation.

In addition, local managers and other local actors need information to take informed decisions, including setting and reviewing local public health and clinical care priorities. To support health equity such information should reflect social differences and highlight entry points for addressing these differences. From a review of African experience, Baez

and Barron (2006:27) conclude that local information systems are *'one of the most important tools for enabling programmes to maintain core principles of accessibility, relevance, directed at major public health burdens, involving communities and so on.'* There is also clear evidence that combined investments in management skills development and local information systems can deliver health status gains, even in difficult circumstances (De Savigny *et al.* 2004; Perks *et al.* 2006; Rhyne *et al.* 1998). This feature underlies influential pilot work – at times referred to as 'community-oriented primary care' (COPC) – that emerged in the first half of the 20th century. The COPC process involves interaction between the community and the local primary health care team, using qualitative information and epidemiological data to identify community health problems, set priorities and monitor interventions (de Maeseneer *et al.* 2007).

Conclusion

Ultimately, PHC is a philosophy and strategy that should guide all actions performed within a health system. The evidence presented in Part 3 and Part 4 of this report provides the basis for supporting the widening call for a renewal of PHC. First made by the Pan American Health Organization in 2006 (PAHO 2007), this call has now also been made by African health ministers in the Africa Health Strategy 2007-2015 (African Union Health Ministers 2007). As PAHO proposes, a renewed PHC can build on the inspiration and hope the approach continues to generate among health personnel and the general public in order to strengthen countries' ability to reduce health inequity, even whilst addressing the challenges and problems faced in its implementation until now.

Part 5: Initiating and sustaining health system transformation

5.1 <u>National processes to institutionalise change</u>

The political and institutional influences over policy change

Addressing the social determinants of health equity is not simply about making appropriate policy choices. Politics always matters to health. Recent cross-country analysis of political, economic, social and health variables over a 50-year period for a set of wealthy countries concludes that political parties with egalitarian ideologies tend to implement redistributive social policies, including public health expenditure, and that these policies are positively associated with health outcomes (Navarro *et al.* 2006).

However, the policies implemented within countries do not always reflect the ideology of the dominant political regime. Even in egalitarian states, as discussed in Part 3, social and health policies likely to slow or reverse progress towards health equity have often been implemented. Good intentions and government policies are also not necessarily enough to promote health equity even within a supportive political context (South Africa case study, Annex 5). Yet committed leaders who marshal their political and technical resources effectively can support the development of social welfare policies even in antagonistic contexts such as authoritarian or fragile states (Atkinson *et al.* 2000; Ranson *et al.* 2007; Weyland, 1995; see Annex 5). Experience shows, moreover, that political action is always needed to introduce and sustain the range of health system changes discussed in this report (Mackintosh 2007; Mills 2007; PAHO 2007; WHO 2006b).

More specific evidence about relevant political strategies is limited but growing, based primarily on detailed case studies of national experiences of policy change applying policy analysis theory. Reviews specifically undertaken for this KN (Gilson 2007b, 2007c; Mackintosh 2007; Mills 2007), specific case studies (such as Nepal, Mexico City and Thailand, Annex 5) as well as wider examinations of health and social policy change in LMICs (for example, Buse *et al.* 2006; Grindle and Thomas 1991; PAHO 2007; Stein *et al.* 2006) highlight the three processes necessary to support implementation of health system policies that address health inequity, as described below. Although contextual factors do not fully determine whether or not such actions are taken, they do influence their feasibility. Political instability, for example, has made policy change difficult in some transitional countries (Figueras *et al.* 2004), whilst broader political change has opened space for transformation in a range of other settings (Gilson *et al.* 2003; Kwon and Reich 2005; Tangcharoensathien and Jongudomsuk 2004).

Building coalitions of support for policy change

Strong political leaders with a clear values-base can lead policy change to address health inequity (as shown in Mexico City and Thailand, Annex 5). Yet, however important personal leadership, alliances of progressive actors often also play critical roles (as in Thailand), and a range of actors always influence policy change - bargaining, negotiating and contesting new policy ideas (Stein *et al.* 2006). A critical step of political action is, therefore, to build a

coalition for change (PAHO 2007). This, in turn, involves *identifying other likely supporters* of particular policies or policy positions, as well as the potential opponents and those who are currently neutral. Coalition leaders must then act to *strengthen their support base and offset policy opposition*. Both actions must, moreover, be rooted in a clear understanding of contextual factors that shape actors' influence and power (such as characteristics of the political system) and their concerns (such as societal and group values or interests). A range of analytical tools are available to support such actions (Hardee *et al.* 2004; Klugman and Hlatshwayo 2001; see also Annex 7).

Identifying supporters and opponents

Supporters of the types of policies recommended in this report are likely to include some politicians, senior government managers, and CSOs, possibly with varying agendas. CSOs commonly active in policy work include groups with particular concerns (such as women's issues or HIV/AIDS), researchers and academics, and progressive health professional groups, based at national and international levels. Although unlikely to have enough political power to bring about policy change by themselves, such groups have, played critical advocacy roles and strengthened the voice and agency of poor people within political processes (Loewenson 2003b; Pollard and Court 2005). Sometimes they work from outside the political system, lobbying and advocating for policy change, and sometimes they work within the political or health system (Klugman 2003). In Korea and Thailand, for example, progressive researchers and health professionals played key roles in bringing about change in financing policy to strengthen the re-distributive role of health care (Kwon and Tchoe 2005; Tangcharoensathien and Jongudomsuk 2004)

The main opponents to the policy changes recommended in this report are likely to include those with completely different agendas (such as commercial actors, including health insurers, hospital groups, pharmaceutical companies (Homedes and Ugalde 2005; PAHO 2007; Reich 1995)), and some government bureaucrats and health professionals (such as medical specialists), who fear a loss of power, status or income (Glassman *et al.* 1999; Jeppson *et al.* 2003; Kwon 2003; PAHO 2007). Past experience also indicates the influence of international funding agencies (see Part 3 and section 5.2).

A third, and vital group, are neutral actors who may only take an active position once they determine the likely consequences of a policy on their primary concerns. Amongst them, the key potential supporters of the policies called for in this report are:

- the pool of health managers and providers working within the public sector – who implement, and therefore have influence on, policy and whose attitudes and practices always influence how equity-promoting policies are experienced by communities and households;
- trade unions – who may be particularly important allies in fighting for health equity given their orientation towards worker needs, and who can have strong policy influence where they have a large membership base, including health workers, or hold positions within governance structures (as has been the case in some Latin American countries, and in South Africa);

- Ministers of Finance – who are commonly more powerful within the political executive than Ministers of Health and whose leading role in economic policy often gives them (and their officials) a significant influence over which policies are implemented; and

- parliamentarians – who are elected to work in the public interest and might be able to exercise some policy influence through their public profile, legislative role, and as watchdogs of the executive (recent experience in southern and eastern Africa, for example, shows that following parliamentary reforms that opened up policy space, parliamentarians were able, in South Africa, Zimbabwe and other countries in the region, to raise the importance of equity goals when debating budget allocations and, in Kenya, to lever support for reproductive health policies and support implementation of rational drug procurement policies (Chebundo 2007b; Mugisha 2007)).

However, experience shows that the support of these actors cannot be taken for granted, and may be hard to win. Health workers and local managers have often resisted the implementation of new policies in various African settings by failing to take the action expected of them (Gilson *et al.* 2006; Kaler and Cotts Watkins 2001) or by taking their workplace frustrations out on patients and community members, thereby exacerbating the acceptability problems of health care delivery (Walker and Gilson 2004).   Trade unions have also stalled or delayed policies they thought would negatively affect their members in Latin America (Gonzales-Rosetti and Bossert 2000; Homedes and Ugalde 2005; see also Mexico City case study, Annex 5) and South Africa (Thomas and Gilson 2004). Ministers of Finance and their officials may oppose new health care financing policies they judge may have unacceptable macro-economic policy implications (Gilson *et al.* 2003). Finally, the influence of parliamentarians is strongly shaped by broader constitutional and political environments, as well as resource constraints (Musuka and Chingombe 2007).

Building support for, and offsetting opposition to, policy action on health inequity

Given the actor positions outlined above, the potential leaders of coalitions seeking policy action on health inequity are clearly likely to involve some combination of politicians, senior civil servants and CSOs. In some instances, one of these groups may lead the drive for policy change, but at some point (or on some tasks) an alliance is likely to be necessary to move change forward – and particularly to tackle policy opposition. Reviews of experience specifically suggest that policy actors seeking to re-frame health systems in order to tackle health inequity must, together or separately, take the following actions.

Raise the visibility of inequity and the voice of the socially disadvantaged and marginalized

Evidence often focuses policy actors' attention on a policy problem and legitimises a potential policy solution, enabling broad-based agreement on the need for action (Hardee *et al.* 2004). The Women and Gender Equity KN, thus, strongly emphasises the importance of disaggregating data by sex to make gender inequity visible. Thai (Tangcharoensathien and Jongudomsuk 2004) and Mexican (Frenk 2006) experience also show how evidence and information can support policy change. In both countries, research alliances between researchers and politicians

identified the existing equity problems of health care financing and possible policy solutions, which then generated changes in financing policy.

To generate wider public support it is also valuable to solicit the public's views and present evidence in ways that stimulate citizens and community groups to analyse and discuss (PAHO 2007). CSOs play particularly important roles in making inequity visible, because they work at community level, often using participatory approaches to bring evidence and views from socially marginalized groups to the policy process (Box 5, Annex 7; see also section 4.2). In this way, they increase the chances that policy action will build on these groups' capacities and address their needs (Goudge *et al.* 2003; Pollard and Court 2005). Renewed PHC systems, therefore, need the capacity to generate evidence that can prompt policy action (section 4.4).

Create new supporters, paying careful attention to language and imagery and actor concerns
Building new supporters for a policy requires changing how the problem and solutions are perceived amongst potentially interested actors. Evidence must be presented and used in ways that bring problems and policies alive, mobilise popular support, and engage the support of important political constituencies (Hardee *et al.* 2004; PAHO 2007; Theobald *et al.* 2005; see also report of Women and Gender Equity KN). In particular, the language and images used should link policies addressing health inequity to relevant social values, encouraging debate about how such values are articulated in policy (PAHO 2007; Ridde 2006).

The language used to frame new policies can also build support for them by linking them to wider political developments. For example, pharmaceutical policy reforms in Bangladesh in the 1980s were framed within a vision of fostering self-reliance and providing for basic needs; this appealed directly to the country's rural poor population and, through a stance of economic nationalism, to a wider popular audience (Reich 1995). Similarly, the popularity of the 2001 Thai universal coverage policy was sustained by framing it as a policy that responded to the needs of the rural population and to calls for greater protection for the rural poor from the costs of health care access, especially after the financial crises of the 1990s (Tangcharoensathien and Jongudomsuk 2004). PAHO (2006) specifically suggests that new supporters for the renewal of PHC can be generated by emphasising that the Millennium Development Goals and PHC are complementary strategies, both aiming at broad based societal development.

In generating new supporters it is also vital to pay attention to the specific concerns and experiences of different actors. Trade unionists must see the benefits for their members and the wider working population. Ministers of Finance will either need persuasion that health sector investments are necessary to achieve broader economic and development goals (see also Box 6, Annex 7) or that proposed policies are feasible within the current fiscal context (WHO 2006a). Parliamentarians, meanwhile, can be supported by CSOs to conceptualise and propose action on health equity problems (Musuka and Chingombe, 2007). Persuading public sector health workers and managers to support and accept new policies must, moreover, begin by taking better account of their views and concerns. Their resistance to new policies is often a response to the perceived imposition of new policies without any form of consultation (Kamuzora and Gilson 2007; Ridde 2007; Walker and Gilson 2004) as well as wider workplace concerns.

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Greater efforts must, therefore, be made to draw these groups and their experience into policy development processes, as well as to address the wider factors influencing their motivation and performance (see Boxes 7 and 8 in Annex 7). To sustain support for equity-promoting policies additional action will also be required to institutionalise new attitudes and practices (as elaborated below).

<u>Tackle policy opposition</u>

Stakeholder analysis provides a basis for identifying strategies to manage policy opposition by allowing careful consideration of different actors' interests, power and concerns on particular policy issues (Glassman *et al.* 1999; Varavasovszky and Brugha 2000). Implementing relevant strategies will again involve the use of evidence, language and imagery. The broader range of strategies and tactics include: careful strategic engagement with opponents, actor alliances that challenge the power of particular actors; establishing new organisations that undercut the power of existing organisational actors; and making policy concessions to generate support (Reich 1995; Tangcharoensathien and Jongudomsuk 2004; see Box 9 and 10, Annex 7). Particular care should, however, be taken when making policy concessions as they may undermine the potential to achieve overall policy goals (Gonzales-Rosetti and Bossert 2000). It may anyway be possible to disarm potential opposition by identifying win-win actions, where an action can have the twin objectives of promoting equity (e.g. extending coverage to the poor) and generating benefits for potential opponents to such action (e.g. addressing health care problems experienced by richer groups) (see Box 11, Annex 7; Mills 2007).

Finally, timing and speed of implementation can contain opposition. There may be a greater possibility of implementing major or controversial policy changes, such as those discussed here, in the post-election honeymoon period, compared to later in a government's life (Reich 1995). Experiences in gender mainstreaming within development programmes suggest that windows of opportunity are provided when new policies or programmes are developed, or at times of large scale health policy change (see Women and Gender Equity Knowledge Network report). It is also necessary to think carefully about whether to adopt radical or incremental strategies. Speedy and radical approaches might be more appropriate when there is the potential of significant interest group opposition to certain policies (Figueras *et al.* 2004; Kwon and Reich 2005). Incremental approaches might, however, be more appropriate for policy changes likely to have quite strong impacts on patients and providers, where gradual implementation can allow the preparation and learning necessary to sustain implementation (as with user fee removal in Uganda, Annex 6; Figueras *et al.* 2005).

<u>Build regional networks</u>

Co-operation between policy actors working within the same region has a number of potential gains. Regional networks can build national actors' capacity and motivation to drive forward necessary policy changes. Regional cooperation among state and non-state actors in southern and eastern Africa has, for example, allowed experiences to be shared and has supported national action on a range of policies (see for example the work with parliamentarians (Chebundo 2007a), and more widely with other actors (EQUINET, 2000, 2004)). Regional networks, alliances, collaborating centres and research could also mobilise and sustain resources for PHC regionally and nationally,

including in relation to health worker training (PAHO 2007). Regional co-operation can also enable the development of regional policy frameworks that support national action to address existing problems. Packer *et al.* (2007), for example, recommend developing cross-border public health care agreements based on evolving European Union arrangements to minimise human resource flows to the private sector within countries and to other countries that result from medical tourism. Finally, in both ways, regional co-operation might also strengthen action to realign international cooperation strategies towards the needs of the region.

Strengthening policy implementation to address health inequity

Experience also highlights the critical importance of complementing political action by taking steps to strengthen planning and management as the basis for improved policy implementation (Figueras *et al.* 2004; Mexico City and Thailand case studies, Annex 5). Below are described four key principles of action, to be used primarily by Ministers of Health and their civil servants, for strengthening national-level policy implementation in ways that` increase the likelihood of positive equity impacts.

Secure the legislative and funding base of new policies

Well-conceived enabling legislation can provide a strong base for action (Figueras *et al.* 2004). Constitutional rights to health care or equitable health care access have, thus, been an important foundation for equity-promoting policy changes in some countries (see Mexico City, South Africa and Thailand case studies: Annex 5). More specific legislation may also help secure particular reforms, such as the 2000 Korean law integrating health insurance funds. Wider action will, however, be necessary to establish the processes enabling collective claims on these rights by marginalized groups (section 4.2), and may also be needed to generate sustained public financing for reforms (Hardee *et al.* 2004; Mills 2007).

Establish clear health equity goals

Goals established as population averages do not encourage or require the policy action needed to address the problems of socially disadvantaged groups. On these grounds, Gwatkin *et al.* (2004) make a strong case for establishing goals in terms of the progress needed to benefit specifically the poor. For example, instead of a generic policy target for attended deliveries of 'raising coverage of women in the entire population to 80% in 2010 from 50% in 2000,' an equity target could be framed as, 'raising coverage of women in the 48% of the population below the national poverty line to 80% in 2010 from 37% in 1999.' The Women and Gender Equity Knowledge Network*,* moreover, argues that gender-specific goals and indicators serve as a critical *'signal to all actors involved in the interventions, a constant reminder during the life of the intervention, as a measure of performance in the achievement of gender aware goals and objectives and as a tool for analysing shortfalls'* (Kabeer and Subrahmanian 1999:352). The Network also recommends the establishment of goals and indicators around the multiple levels of political and institutional action needed to tackle gender inequity: investments, policies and institutions; service and programme delivery; and conceptual frameworks that foreground the human rights of women and girls.

Implement first in disadvantaged areas and with disadvantaged populations

To generate early gains for socially disadvantaged groups, new equity-promoting policies might be implemented first in poorer communities, as with the Brazilian Family Health Programme (Barros *et al.* 2005), and directed towards the populations intended preferentially to benefit from the service (Kabeer and Subrahmanian 1999; Mooney and Houston 2004; Mexico City case study, Annex 5). However, to secure such gains, capacity building in these areas and with these populations is essential to ensure that they can use and benefit from the programmes, and to avoid implementation ultimately favouring richer areas and populations (Hardee *et al.* 2004). Building capacity requires not only attracting and retaining skilled managerial staff and basic management systems, but also the leadership and mechanisms necessary to sustain social mobilisation (section 4.2; Thomas *et al.* 2007 forthcoming). Clear central guidance is important, balanced by strengthened local level management (section 4.4; Goudge *et al.* 2003).

Learning by doing (monitoring and evaluation)

Finally, local and national processes of innovation and learning through implementation must be established to meet the particular needs of socially disadvantaged groups (Gilson 2007c; WHO 2006a). Gwatkin *et al.* (2004), for example, recommend that ideas about interventions tailored to reach the poor can be drawn from other settings, adapted to a new setting, tested in large populations, and monitored to identify how to strengthen implementation. Scaling up experience (Simmons and Shiffman 2006) also emphasises the need to consider scaling-up requirements right at the start of an innovation, engage multiple actors, adapt interventions to local contexts and build local capacities for innovation. Building information systems that support monitoring and evaluation is therefore vital to sustain implementation, as well as to raise the visibility of health inequity (section 4.4; Box 12, Annex 7). They must, however, be embedded in processes that allow their effective use.

Empowering public managers to lead institutional change

Sustaining the implementation of policies aimed at transforming health systems also requires action at a deeper level: in particular, to challenge the institutions (the assumptions, values and taken-for-granted practices embedded in organisational culture) that underpin public sector actors' resistance to such policies (as discussed in Part 3). A community health worker programme, which was successfully implemented in under-served communities in Ceara State, Brazil, sustained policy change by combining centralised and decentralised decision-making to offset political opposition and build popular support; and creating collective responsibility among health workers and clients through building the programme's mission and status (Tendler and Freedheim 1994; see Box 11, Annex 7). To institutionalise policies addressing health inequity, Ministers of Health, senior civil servants and CSOs must, specifically, continue to encourage the re-framing of public sector organisational culture in ways that build and consolidate the foundation of norms and values that sustain such action (Grindle 1997).

Solidarity and reciprocity are, for example, recognized as essential foundations of European health systems (Mills 2007; Mackintosh 2007) and are considered vital to nurture in institutionalising equity-promoting health care financing policies in LMICs (Goudge *et al.* 2003). Earlier sections have also shown that within health systems it is particularly

important to build the norms that can sustain intersectoral action, engagement with social actors, improvements in the acceptability of care and preventive and promotive care, whilst undercutting those that sustain the existing hierarchical and medically dominated decision-making practices (see Part 3). One such norm is that of trustworthiness (Freedman *et al.* 2005; Global Health Watch 2005; Mackintosh 2007; WHO 2006b). Trusting relations support the collaboration between actors that facilitate the range of actions recommended here, and sustain the respectful relationships essential for fair treatment of others, that is, for ethical and equitable practice (Gilson 2003).

Although evidence on how to re-frame organisational norms, values and culture remains limited, existing experience points to the influence of managers and leaders. Middle managers (such as local and hospital managers) model organisational values and norms and shape the ways in which employees experience their organisational environment (Ruppel and Harrington 2000; Watson and Papamarcos 2002). Their influence over other health staff has already been mentioned, and their human resource management role is particularly important (Grindle 1997; Mannion *et al.* 2005; Mathauer and Imhoff 2006). There is, therefore, some evidence to suggest that, by demonstrating caring management, trust-based human resource management practices have the potential to engender positive employee (that is, health worker) attitudes towards clients (Nyhan 2000; see also Box 13, Annex 7). Public sector middle managers also play wider roles in addressing health inequity, such as managing IAH and relationships with CSOs and sustaining innovative interventions (Simmons and Shiffman 2006).

Enabling middle managers to lead change in organisational culture will, however, require multi-faceted action at personal, organisational and policy levels, and a process of learning through doing (Women and Gender Knowledge Network report; NHMC 2005; see also Box 14, Annex 7). Managers may themselves need to be sensitised to equity concerns, and supported to develop the communication and inter-personal skills necessary to work with other actors, articulate a vision and persuade people to support it (Performance and Innovation Unit no date; Sanders and Timsina 2004; Simmons and Shiffman 2006); see also Nepal case study, Annex 6. Implementing trust-based human resource management is also likely to require new public sector policy frameworks and some organisational autonomy in human resource management decision-making. The flexibility to reward good performance and invest in capacity development initiatives, allowing fairness in their decision-making, are likely to be important (Grindle 1997; Morgan *et al.* 2005). Wider decentralisation of some decision-making power is also necessary for managers to develop innovative, equity-promoting responses to local needs and circumstances (Simmons and Shiffman 2006). Local engagement can, in turn, encourage and support the necessary transformation of health system practices (see section 4.2).

However, decentralisation is a complex policy deserving of more consideration than possible here. Subversion and problems in implementation are common (Bennett 2007; Homedes and Ugalde 2005). International evidence on its potential for positive health equity impacts is both limited and equivocal (Bennett *et al.* 2005; Peckham *et al.* 2005). Decentralisation has clear potential to increase geographical inequities unless there is some central control (of resource re-allocation or human resource management policies) that limits practice variations (for example, in salary

levels) between areas. Encouraging change in organisational culture is, thus, likely to require a balance of local and central decision-making in specific functions (as in the Ceara State example, Box 11, Annex 7).

Middle managers must also be backed up by senior public sector health managers and Ministers of Health. The leadership style and practices of such individuals (such as their personal behaviours and the way they communicate with others) are vital influences over all public sector employees, and strongly influence the general public's perception of the health system (Moore 1995). A competent public sector leader guides change within organisations by generating and hearing multiple perspectives, exposing and dealing with uncertainty and previously hidden or unspoken concerns, translating demands from the outside into roles for the organisation, and communicating what the organisation is doing to the external world (Performance and Innovation Unit no date; see also Box 15, Annex 7).

Finally, institutionalising new ways of working will require action to challenge the social forces that permeate organisational culture and block equity-promoting action (Women and Gender Knowledge Network report; Nepal case study, Annex 6). Examples of these forces are cultural acceptance of women's subordination, prejudice against other stigmatised population groups, or religious discourse against abortion. Local level engagement between public sector managers and CSOs may help to institutionalise new ways of working within the health system (see section 4.2). At the same time, political leaders and parliamentarians can seek to influence societal perspectives by demonstrating new norms and values through public statements and personal action, for example around HIV/AIDS (Musuka and Chingombe 2007; Parkhurst and Lush 2004; Putzel 2004). CSOs, meanwhile, can influence social norms by working with population groups to challenge existing views (such as demonstrating the problem of women's subordination as a contributory factor to HIV/AIDS), or by forming alliances with other groups that can challenge dominant perceptions (Klugman 2003).

5.2   International support for transformation

International influences over LMIC health systems, as outlined in Part 3, give rise to the question: what key strategies can international actors apply in supporting national actors to transform health systems? Although this KN did not address this question in detail, it recognizes that tackling inequities within countries also requires international action on global forces. Its consideration of what national actions are needed points to some tentative lessons for international actors (also drawing on the work of the Globalisation KN).

As a starting point, international agencies (multilateral and bilateral donors, disease-specific Global Health Initiatives (GHIs), and new funders such as the Gates and Clinton Foundations) should be cautious about encouraging substantial policy and system change, recognising the problems of past experience (Part 3). There is also clearly a need for innovation and experimentation rooted in national contexts. Lister (2007) specifically argues that international agencies and actors should establish the evidence that policies they propose achieve their stated goals before requiring or encouraging their implementation, and support analysis of positive experiences to generate wider lessons for national and international policy-makers. At the same time, as in national settings (see section 5.1),

international actors must make the case for providing international assistance to support national health system action on health inequity. They must persuade powerful actors of its importance. Freeman *et al.* (2005), for example, recommend building an argument around the impoverishing effect of ill-health on the majority of the population in the absence of an equitable, well-financed and well managed health system; this could also be linked to the MDGs. Past and emerging experience within countries suggests three other strategies that international actors might consider: these are described below.

Work with and respect national decision-making and institutions

As the actions required to transform health systems to address health inequity vary between countries, health system change must be led by national actors taking due consideration of their particular context. There is also growing agreement that new ways of channelling international funds to LMICs should give more power to national governments to determine how to use available resources to meet national needs. This offers the possibility of containing donor influence as well as encouraging longer-term financial commitments for improved budget stability and planning (Hecht and Shah 2006). Mechanisms to achieve this include:

- Sector Wide Approaches (SWAps) as the basis for deciding, through consultation with all stakeholders, how best to use the total available pool of funds to meet health and health system needs;

- General Budget Support (GBS) which channels donor funds via the central Ministry of Finance for distribution through public sector budget allocation procedures on the basis of nationally-defined priorities (although have some potential to weaken Ministry of Health influence over health system development, the potential gains include: increased domestic ownership; alignment of external funds with the national budget process; improved policy dialogue; increased harmonisation of donor activities and requirements; increased predictability of donor funding; and greater transparency in the budgeting and planning system (DFID 2004 quoted in McIntyre *et al.* 2005); and

- Poverty Reduction Strategy Paper (PRSP) preparation by governments, which is a key step in qualifying for debt relief under the Highly Indebted Poor Countries (HIPC) initiative. The process may allow for donor coordination and has the potential to improve participatory, outcome-focussed, comprehensive national planning and priority setting to better serve poor and marginalized groups, including through the health system, although there is some critique of past PRSP processes for the extent to which they have in fact achieved this (Bond and Dor 2003b; Verheul and Cooper 2001).

Experience suggests that these approaches may not empower national actors relative to international agencies (Ravindran and Maceira 2005). Nonetheless, Freeman *et al.* (2005) argue that sector-wide approaches, specifically, are the only model of sector coordination that directly promotes government ownership and alignment of donor support with national sector priorities and processes (see, for example, Bangladesh, Annex 6).

Experience so far with the new Global Heath Initiatives suggests mixed possibilities (Hanefeld *et al.* 2007). Within the World Bank Multi-country Aids Programme (MAP) and the Global Fund to Fight AIDS, Tuberculosis and Malaria

(GFATM), country actors define strategies that are then funded or supported if successful in technical review processes. The Global Fund planning framework also highlights the need to link with SWAps and PRSP processes. In contrast, PEPFAR (the US President's Emergency Plan for AIDS Relief) is a bilateral initiative and adopts a top-down and quite prescriptive approach to its programme development.

Finally, harmonisation between donors and alignment of priorities between donors and national governments is particularly crucial in post-conflict periods. From their review of conflict-affected fragile states, Ranson *et al*, (2007) conclude that when government structures are dysfunctional, international agencies might work through non-state mechanisms or offer leadership themselves. In both cases, however, they need to work from a position of neutrality, proceeding cautiously to avoid exacerbating conflict and adopting a long-term vision of support for state-building through building capacity, legitimacy and accountability (see Annex 5).

Strengthen the capacity of national health systems to take action on the social determinants of health inequity

Experience suggests that the existing approaches to channelling international funds to LMICs suffer problems that constrain national action on health inequity. First, they may not open up national policy space to the range of actors who together can form pro-equity alliances (Foster *et al.* 2000 quoted in McIntyre *et al.* 2000; Freedman *et al.* 2005), although the Global Fund's Country Coordinating Mechanisms appear to hold some promise, including in opening up space for women's involvement in decision-making (Hanefeld *et al.* 2007). Second, experience is mixed regarding whether the allocation of funding responds to population health needs; there is specific concern that GBS approaches may strengthen Ministries of Finance relative to Ministries of Health and so limit action to transform health systems (McIntyre *et al.* 2005; Ravindran and Maceira 2005). Third, there is little evidence that the approaches have improved health service delivery or the health status of poor and marginalized groups (Toole *et al.* 2003 quoted in Freeman *et al.* 2005).

GHIs have recently been specifically criticised for programming that can harm health equity. Although it should be noted that PEPFAR emphasises its success in encouraging gender equity in ART access (in March 2006, 61% of those accessing ART supported through PEPFAR funding were women), Hanefeld *et al.*'s (2007) review of potential GHI impacts on gender equity highlight potential problems. These include PEPFAR's moral stance on sex workers, extra marital sexual activity and abortion which restrict support to comprehensive sexual and reproductive health services, MAP's limited focus on gender equity in planning and programming, and the effects on health workforce distribution resulting from the Global Fund and PEPFAR offering salaries above government rates.

Nonetheless, GHI experience also provides insights into how international agencies could in general better support health system development and address health inequity (Hanefeld *et al.* 2007):

- to promote IAH, work synergistically with other development agencies in addressing health inequity and develop equity-oriented monitoring and evaluation frameworks;

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- to support social mobilisation**,** create political spaces for public debate, participation and empowerment, ensuring equitable representation and funding for capacity building that enables that participation;

- to build health-equity promoting health systems, address the social and gender inequities (and the underlying causes) that determine access to health services, avoiding distortion of health systems and maldistribution of human resources, and paying particular attention to the impact of support to HIV/AIDS programmes on reproductive health services; and

- to strengthen equity-oriented planning and monitoring processes**,** assess interventions' longer-term impacts on social inequity; establish gender and equity sensitive planning targets across a range of measurements (e.g. participation, outcomes, services provided, quality of care, dignity and discrimination) and, where possible, integrate these targets into existing goals, such as the MDGs; and collect gender and other disaggregated data to allow equity monitoring, including indicators to assess GHI effects on wider social inequities and the influence of these inequities on GHI implementation.

In post-conflict states, coordinated approaches among actors to address health inequity are particularly important, and non-state mechanisms might advocate or co-ordinate policy for marginalized groups such as internally displaced persons (Ranson *et al.* 2007). In addition, flexible and intersectoral approaches should be developed to support improved monitoring and evaluation capacity.

In relation, specifically, to the international migration in human resources, coordinated action by international agencies and source and recipient country governments will be needed to encourage staff retention by improving pay and working conditions. Action should also be taken to re-examine the macroeconomic conditionalities that limit employment and salary increases, and to support international monitoring of progress in taking action (see Globalisation KN report). International agencies can also play a role in strengthening national technical capacity in a way that does not reinforce dependency or lead to undue donor influence.

Increase funding flows, especially to fragile states and low-income countries

While this report argues for greater commitment by governments, the scale of resource mobilisation required (Jha and Mills 2002) also implies massive increases in donor commitments. Long-term and sustained funding commitments are especially needed in conflict-affected states (Ranson *et al.* 2007).

Rich countries continue to fall well short of the target of allocating 0.7% of GDP to official development assistance, and currently only reach 0.36% (Oxfam International 2006). Simply reaching this target would bring immense new resources to low-income countries, if not directly for health.

Other proposals for greater investment in fragile and low-income countries have been floated and include taxes on airline tickets, currency transactions, and carbon use, sales of International Monetary Fund gold stocks and a new system of special drawing rights (Lister 2007 quoting Gottret and Schieber 2006). It may also be possible for

countries to tap into, or continue to tap into, the GHI funding pool for action in priority public health programmes. GHIs could, moreover, earmark a proportion of their funding to develop local primary health care (de Maeseneer *et al.* 2007).

Whether debt relief programmes, including HIPC and, more recently, the G8 proposals, are able to deliver increasing resources for health is, however, contested (Rowson 2007). In addition, although improved trade opportunities may offer scope for national economic growth, caution is needed. Trade commitments should not lock countries into policy choices that are detrimental to health outcomes, such as commercialising health care (see Globalisation KN).

Part 6: Conclusions

This report outlines the pathways through which health systems address the social determinants of health inequity and presents evidence that justifies the role of health systems in promoting health equity. Through their operations, health systems can also offer wider benefits to society: a sense of life security, social cohesion, well-being, and confident expectation of care in times of illness. They may be influential in building and sustaining societal and political support for governments that promote health equity.

Although in many settings health systems have yet to fulfil this potential, there are inspiring country examples where health systems promote social justice, including in low-income settings. Wider experience, including multi-country analyses and in-depth case studies, add to the evidence from which we can draw conclusions about how to strengthen health systems to tackle health inequity.

The following recommendations are primarily addressed to: Ministers of Health and senior government officials; civil society organisations at local, national and international level; and officials working within international health agencies.

The recommendations are underpinned by three understandings derived from review of international experience:
1. The experience of health systems is always context-specific. However, equitable health systems have broad features in common that can be nurtured by context-sensitive strategies of health system transformation.
2. Placing health equity as the central goal of health systems requires substantial transformation through the re-framing of policy, phased and managed institutional transformation, and wider political and policy commitment to social equity.
3. Despite the increasingly plural nature of health systems (especially with respect to health care provision), the public sector plays the primary role in working towards health equity and should be strengthened to achieve this function.

Overall, the Health Systems KN concludes that the main features of health systems oriented to population health and health equity are:
- leadership, processes and mechanisms that leverage intersectoral action across government departments to promote population health;
- organisational arrangements and practices that involve population groups and civil society organisations, and particularly those working with socially disadvantaged and marginalized groups, in decisions and actions that identify, address and allocate resources to health needs;
- health care financing and provision arrangements that aim at universal coverage and redistribute resources towards poorer groups with greater health needs, and

- the revitalization of the primary health care approach, as a strategy that reinforces and integrates the other health equity-promoting features identified above.

Re-distributive health care systems, specifically, share the following features:

1. Their goal is universal coverage.
2. Public funding plays a central role.
3. No or very low fees are charged for public services.
4. They offer a set of comprehensive services.
5. The private sector complements the public sector.

In order to operationalise these features within health systems, the following actions are needed.

RECOMMENDATION 1:

Ministers of Health and health officials must mobilise intersectoral relationships

This is enabled by wider government support for social equity, but IAH initiatives can be developed in other contexts, particularly at the local level. The key steps include:

1. making the case for intersectoral action, using sound epidemiological and other evidence, to convince other sectors to participate;
2. taking the strategic needs of other sectors into account, framing objectives in ways that are commonly understood and sharing responsibilities and rewards (rather than taking prime responsibility for all the stages of developing, implementing and evaluating initiatives);
3. setting explicit goals and objectives that give a clear mandate, are clearly linked to activities and yield visible results that help build morale as well as provide a good basis for evaluation;
4. building trust-based teams, drawn from actors in different sectors, levels of government and parts of civil society, who together possess the range of skills to develop, implement and evaluate IAH initiatives, and manage complex communication and negotiation processes; and
5. building relationships with local or national political leaders and media to garner wider political and social support for particular IAH initiatives and for IAH in general.

RECOMMENDATION 2:

Ministers of Health, health officials and civil society organisations must facilitate social empowerment.

Government action can establish statutory rights to public information and recognize, support and fund general mechanisms for direct participation by population groups. In addition, *health officials* can: bring health professionals into supportive roles; recognize, support and fund mechanisms for direct participation in health; use transparent processes in planning; and establish legal, media, organisational and communication strategies to monitor, report on and hold the health system accountable for its policies and commitments. In parallel, *CSOs* can: include population information and preferences in monitoring, lobbying and planning; monitor the performance of health systems against social priorities; draw attention to needs and inequities in resource allocation; provide mechanisms to engage marginal

groups; and develop social capacities for engaging with bureaucracies and authorities; and engage with political leaders to strengthen political support of social action and participatory processes.

RECOMMENDATION 3:

Ministers of Health and senior health officials must gradually build up universal coverage

In low-income countries and post-conflict settings, a vital first step is to mobilise extra resources for health care: for example, by re-prioritising health care, widening the tax base and improving tax collection, tackling corruption and securing increased international assistance. Greater government resources may also be the basis of universal coverage in middle-income countries.

Five further steps for moving towards universal coverage in **all contexts**, most even post-conflict settings are:

1. reduce out-of-pocket payments by removing public sector user fees and developing innovative ways to limit other health care costs (such as drug and transport costs);

2. widen geographical access to comprehensive services by investing in public primary and secondary services in under-served areas, and strengthening referral linkages (strengthening maternal care will offer particular benefits for women);

3. re-allocate government resources between geographical areas taking account of population health needs and the availability of other resources;

4. develop innovative strategies to improve the acceptability and quality of public sector health care; and

5. enhance technical efficiency (especially in relation to pharmaceuticals).

Two further strategies to test in **low-income and some transitional countries**, but only with the support of policy monitoring and evaluation, are:

1. working with non-state providers in low-income populations to extend access and quality of care, provided that they do not reinforce inequity and stigmatisation;

2. community-based health insurance (or insurance schemes dedicated to particular population groups) to protect poorer groups against catastrophic costs, learning from existing national and international experience about how to avoid the many pitfalls of such schemes and extend coverage, particularly to the most socially disadvantaged.

Finally, in **middle-income countries** (including some transitional countries) action should be taken to:

1. expand pre-payment funding through a combination of tax funding (used preferentially to subsidise poor and hard-to-reach groups) and mandatory health insurance (ensuring income-related insurance contributions and limiting the tax deductability of insurance contributions for higher income groups);

2. widen the benefit/service package provided to poorer groups over time to minimise catastrophic payments and impoverishment;

3. reduce fragmentation and segmentation within the health care system by pooling funds and harmonising contribution levels and benefit packages between population groups, perhaps linked to a new funding organisation;

4. where needed, experiment cautiously with risk-equalisation mechanisms to ensure equitable resource allocation between financing schemes;

5. consider carefully if and how to strengthen purchasing strategies, such as contracting, to leverage performance improvements and cost containment, particularly in relation to private health care providers; and

6. regulate private insurance and let it act primarily as top-up insurance for the more wealthy.

RECOMMENDATION 4:

Ministers of Health and health officials, working with CSOs, must revitalize Primary Health Care

The previous recommendations outline the actions needed to operationalise the key features of health systems that impact on the social determinants of health inequity. As these elements are themselves integral components of a PHC-based health system, their operationalisation also helps build such systems. However, additional actions are necessary to revitalize PHC and so capture the health and health equity gains that it can deliver. These are:

- strengthening the local level (sometimes called the District health System) as the foundation of the health system and the focal point for the wider action needed to address the social determinants of health inequity;

- adequately funding the local level and PHC, within the framework of universal coverage;

- recognising and tapping local opportunities for partnership between multi-disciplinary teams of local public health professionals and CSOs, and local political and community leaders;

- provide the primary level with infrastructural and logistical support, especially in terms of drugs, technology and transport systems;

- ensuring the availability of local health personnel with the necessary resource base, skills and values base to take action on health inequity and to work with socially disadvantaged and marginalized populations;

- strengthening local health management by training and motivating managers and by establishing local information systems that support action on health inequity.

Finally, in order to initiate and institutionalise this health system transformation the following actions are needed.

RECOMMENDATION 5:

Progressive policy actors working at national level must take action to:

Build coalitions of support for policy change by:

- raising the public visibility of inequities and the voice of the socially disadvantaged and marginalized;

- creating new supporters, including through framing evidence in language and imagery that bring problems and policies alive, build understanding and mobilise support from the population and important political constituencies;

- tackling policy opposition; and

- building regional networks to sustain coalitions and action.

Strengthen policy implementation to address health inequity by:

- securing the legislative and funding base of new policies, including constitutional rights to health or health care, and the processes to enable collective claims on these rights by marginalized groups, as well as establishing health equity goals to guide implementation and enable an equity-based evaluation;

- implementing new interventions first in disadvantaged areas and with marginalized populations, taking care to strengthen their capacity to use and benefit from the programmes; and

- learning through doing by monitoring and evaluating the experiences of implementation.

Empower public managers to lead sustained institutional change by:

- mentoring that nurtures and develops the values and skills for such leadership;

- policy frameworks that enable a balance of local autonomy and central direction in particular areas of decision-making, such as human resource management, as well as engagement with actors outside government structures; and

- supportive leadership from senior officials and Ministers of Health.

RECOMMENDATION 6:

International actors must support national led health system transformation and action

These actors should always be cautious about proposing specific health system changes in LMICs, and have a responsibility to make the international case for supporting health system development. More specifically, they should:

- work with and respect national decision-making and institutions;

- provide support to strengthen the health equity orientation of national health systems;

- increase funding flows for health systems (especially to fragile states and low-income countries);

In conclusion, both technical analysis and political commitment are needed to strengthen health systems and address health inequity. The goal of such action must be the leverage of positive cycles of health system change that build their own momentum towards health equity.

References

African Union Ministers of Health. (2007). Africa Health Strategy 2007-2015. Third Session of The African Union Conference of Ministers of Health, Johannesburg, South Africa, 9 – 13 April 2007. CAMH/MIN/5(III)

Anand, S., and Barnighausen, T. (2004). Human resources and health outcomes: cross country econometric study. *Lancet,* 364(9445), 1603-1609.

Anand, S., and Ravaillion, M. (1993). Human development in poor countries: on the role of private incomes and public services. *Journal of Economic Perspectives,* 7, 133-150.

Anderson, L., Scrimshaw, S., Fullilove, M., Fielding, J., Normand, J., and Task Force on Community Preventive Services (2003). Culturally competent healthcare systems: systematic review. *American Journal of Preventive Medicine,* 24, 68-79.

Arbelaez, M., Gavira, M., Franco, A., Restrepo, R., Hincapie, D., and Blas, E. (2004). Tuberculosis control and managed competition in Colombia. *International Journal of Health Planning and Management,* 19(S25-S43).

Arblaster, L., Lambert, M., Entwhistle, V., Forster, M., Fullerton, D., Sheldon, T., et al. (1996). A systematic review of the effectiveness of health service interventions aimed at reducing inequalities in health. *Journal of Health Services Research and Policy,* 1, 93-103.

Ashford, L., Gwatkin, D., and Yazbeck, A. (2006). *Designing health and population programs to reach the poor.* Washington DC: Population Reference Bureau.

Atkinson, S., Medeiros, R. L., Oliveira, P. H., and de Almeida, R. D. (2000). Going down to the local: incorporating social organization and political culture into assessments of decentralised health care. *Social Science and Medicine,* 51(4), 619-636.

Baez, C., and Barron, P. (2006). Community voice and role in district health systems in east and southern Africa: A literature review. Discussion paper 39. In Regional Network for Equity in Health in East and Southern Africa (EQUINET).

Balabanova, D. (2007). Health sector reform and equity in transition. Prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Barros, A., Victoria, C., Cesar, J., Neumann, N., and Bertoldi, A. (2005). Brazil: are health and nutrition programmes reaching the neediest? Ch 13 In D. Gwatkin, A. Wagstaff and A. Yazbeck (Eds.), *Reaching the poor with health, nutrition and population services: what works, what doesn't and why.* Washington: World Bank.

Becker, D. (2003). Orgainzaoes da sociedade civil e politicas publicas em salud. pp117-134. In J. García, L. Landim and H. Dahmer (Eds.), *Sociedade e políticas – novos debates entre ONGs e universidades.* Rio de Janeiro: Editora Revan. http://www.cedaps.org.br (accessed 27 June 2007).

Bennett, S. (2007). Alternative approaches to extending health services to the poorest. In S. Bennett, L. Gilson and A. Mills (Eds.), *Health, Economic Development and Household Poverty.* London: Routledge.

Bennett, S., Hanson, K., Kadama, P., and Montagu, D. (2005). Working with the non-state sector to achieve public health goals. Making Health Systems Work: Working Paper No.2. WHO/EIP/healthsystems/200.5.2. Geneva: World Health Organization.

Bennett, S., McPake, B., and Mills, A. (Eds.) (1997). *Private health care providers in developing countries: service the public interest?* London: Zed Press.

Bhuiya, A., Chowdhury, M., Ahmed, F., and Adams, A. (2001). Bangladesh: an intervention study of factors underlying increased equity in child survival. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya and M. Wirth (Eds.), *Challenging inequalities in health: from ethics to action.* New York: Oxford University Press.

Bidani, B., and Ravaillon, M. (1997). Decomposing social indicators using distributional data. *Journal of Econometrics,* 77, 125-139.

Bitrán, R., and Giedion, U. (2003). Waivers and exemptions for health services in developing countries. Social Protection Discussion Paper Series No. 0308. Washington, D.C: The World Bank.

Bokhari, F., Gai, Y., and Gottret, P. (2007). Government health expenditures and health outcomes. *Health Economics,* 16(3), 257-273.

Bond, P., and Dor, G. (2003a). A critique of uneven health outcomes and neoliberalism in Africa, EQUINET Discussion Paper 2. Johannesburg: EQUINET. Available at: http://www.equinetafrica.org/bibl/docs/DIS2trade.pdf (accessed 26 March 2007).

Bond, P., and Dor, G. (2003b). Neoliberalism and poverty reduction strategies in Africa, Equinet Discussion Paper 3. Johannesburg: EQUINET. Available at: http://www.equinetafrica.org/bibl/docs/DIS4trade.pdf (accessed 26 March 2007).

Borghi, J., Ensor, T., Somanathan, A., Lissner, C., Mills, A., and on behalf of the Lancet Maternal Survival Series steering group (2006). Mobilising financial resources for maternal health. *Lancet,* 368, 1457-1465.

Buse, K., Martin-Hilber, A., Widyantoro, N., and Hawkes, S. J. (2006). Management of the politics of evidence-based sexual and reproductive health policy. *Lancet,* 368(9552), 2101-2103.

Buse, K., Mays, N., and Walt, G. (2005). *Making health policy*. Milton Keynes: Open University Press.

Caffery, M., and Frelick, G. (2006). Attracting and Retaining Nurse Tutors in Malawi. Health Workforce "Innovative Approaches and Promising Practices" Study: The Capacity Project. Available at: http://www.interchurch.org/resources/uploads/files/242Malawi_Prompractices_Report_First_Official_Draft.doc (accessed 8 February 2007).

Cardelle, A. (1998). Democratisation, health care reform, and NGO-government collaboration: catalyst or constraint? North South Agenda papers pp. 1-22.

Carrin, G., and James, C. (2005). Social health insurance: key factors affecting the transition towards universal coverage. *International Social Security Review,* 58(1), 45-64.

Carrin, G., Waelkens, M.P., and Criel, B. (2005). Community-based health insurance in developing countries: a study of its contribution to the performance of health financing systems. *Tropical Medicine and International Health*. 10(8), 799-811.

Castro-Leal, F., Dayton, J., Demery, L., and Mehra, K. (2000). Public spending on health care in Africa: do the poor benefit? *Bulletin of the World Health Organization,* 78(1), 66-74.

Chebundo, B. (2007a). The way parliamentary committees on health have overcome obstacles in creating sustained and co-ordinated pressures for health through regional networking in Southern and Eastern Africa: A case study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health.

Chebundo, B. (2007b). The Zimbabwe re-engineered budget process and the impact if its all-stakeholder inclusiveness approach, and how the involvement of EQUINET and other stakeholders contributes towards achieving equitable distribution of health resources. A case study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health.

Chetty, K. (2007). Equity promoting health care policies in South Africa. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Chopra, M., Oxman, A., Lavis, J., Bennett, S., Munro, S., and Gunn, V. (2006). Evidence from systematic reviews of effects to inform policy making about optimizing the supply, improving the distribution, increasing the efficiency and enhancing the performance of health workers. A policy brief prepared for the International Dialogue on Evidence-informed action to achieve health goals in developing countries (IDEAHealth). Khon Kaen Thailand: Alliance for Health Policy and Systems Research.

Chu, K.Y., Davoodi, H., and Gupta, S. (2004). Income distribution and tax and government spending policies in developing countries. In Cornia, GA (Ed.), *Inequality, Growth and Poverty in an Era of Liberalisation and Structural Adjustment.* Oxford: Oxford University Press.

Clayton, A., Oakley, P., and Taylor, J. (2000). Civil society organizations and service provision. *Civil Society and Social Movements Programme,* 2, 1-25.

Commission on the Social Determinants of Health. (2006). A conceptual framework for action on the social determinants of health: A discussion paper for the Commission on the Social Determinants of Health. Geneva: Commission on the Social Determinants of Health, World Health Organization.

Connor, C. (2000). Contracting Non-governmental organizations for HIV/AIDS: Brazil Case Study. Special Initiative Report No. 30. Bethesda, Maryland: Partnerships for Health Reform, Abt Associates Inc.

Cuevas, J. H. (2007). Health and autonomy: the case of Chiapas (in Mexico). Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Cutler, D., Deaton, A., and Lieras-Muney, A. (2006). The determinants of mortality. *Journal of Economic Perspectives,* 20(3), 97-120.

Dahlgren, G., and Whitehead, M. (2007). A framework for assessing health systems from the public's perspective: the ALPS approach. *International Journal of Health Services*. 37(2), 363-378.

Dambisya, Y., Modipa, S., and Legodi, M. (2005). The Distribution of Pharmacists Trained at the University of the North, South Africa. EQUINET Discussion Paper 31: EQUINET. Available at: http://www.equinetafrica.org/bibl/docs/Dis31HRdambisya.pdf. (accessed 27 June 2007)

De Maeseneer, J., Willems, S, De Sutter, A., Van de Geuchte, I. and Billings M. (2007). Primary health care as a strategy for achieving equitable care. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

De Savigny, D., Kasale, H., Mbuya, C., and Reid, G. (2004). *Fixing Health Systems*. Ottawa: International Development Research Centre.

DFID. (2004). Poverty reduction budget support: a DFID policy paper. London: DFID.

Dixon, A., le Grand, J., Henderson, J., Murray, R., and Poteliakhoff, E. (2003). Is the NHS equitable? A review of the evidence. London School of Economics Health and Social Care Discussion Paper Number 11. London: London School of Economics and Political Science.

Doherty, J., and Govender, R. (2004). The cost-effectiveness of primary care services in developing countries: a review of the international literature. A background paper commissioned by the Disease Control Priorities Project.

Doherty, J. and Gilson, L. (2007). The approach guiding the development of the evidence base for the Health Systems Knowledge Network. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Dubowitz, T., Anthony, R., Bird, C., Cohen, D., and Lurie, N. (2007). The experience of the USA: health inequity within a high-income setting. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Dussault, G., Fournier, P., and Letourmy, A. (eds.) (2006). L'Assurance maladie en Afrique francophone: Ameliorer l'access aux soins et lutter contre la pauvrete. Washington: Banque Mondiale.

Embuldeniya, D. (2001). Exploring the Health, Strength and Impact of Canada's Civil Society. Canada: Canadian Centre for Philanthropy.

Eng, E., Briscoe, J., and Cunningham, A. (1990). Participation effect from water projects on EPI. *Social Science and Medicine,* 30(12), 1349-1358.

EQUINET. (2000). Equity in Health in Southern Africa: Turning Values into Practice. EQUINET Regional Conference on Building Alliances for Equity in Health. South Africa: EQUINET Series Editor R Loewenson. Available at: http://www.equinetafrica.org/bibl/docs/POL7rights.pdf (accessed 27 March 2007).

EQUINET. (2004). Reclaiming the State: advancing people's health; challenging injustice. EQUINET Policy Series number 15: EQUINET. Available at: http://www.equinetafrica.org/bibl/docs/POL15equity.pdf (accessed 27 March 2007).

EQUINET, TARSC, and CHESSORE. (2005). Meeting Report: Strengthening community voice and agency in health, Zambia, 26-28 January 2005. Available at: http://www.equinetafrica.org/bibl/docs/REP26012005gov.pdf (accessed 27 March 2007).

Figueras, J., McKee, M., Cain, J., and Lessof, S. (Eds.) (2004). Health systems in transition: learning from experience. Geneva: WHO on behalf of European Observatory on Health Systems and Policies. Available at: http://www.euro.who.int/document/E83108.pdf (accessed 27 March 2007).

Foster, M., Brown, A., and Conway, T. (2000). Sector wide approaches for health development: a review of experience. Geneva: WHO and Overseas Development Institute.

Freedman, L., Waldman, R., De Pinho, H., and Wirth, M. (2005). *Who's got the power? Transforming Health Systems for Women and Children*. UN Millennium Project Task Force on Child Health and Maternal Health. London: Earthscan. Available at: http://www.unmillenniumproject.org/documents/TF4Childandmaternalhealth.pdf.

Frenk, J. (2006). Bridging the divide: global lessons from evidence-based health policy in Mexico. *Lancet,* 368, 954-961.

Garret, L. (2007). The Challenge of Global Health. *Foreign Affairs*, (online) 86(1), Available from: http://www.foreignaffairs.org/20070101faessay86103-p0/laurie-garrett/the-challenge-of-global-health.html (accessed 27 June 2007).

George, A. (2003). Accountability in Health Services: Transforming Relationships and Contexts. In V. Working Paper No. 1 (Ed.), No. 1, Vol 13: Harvard Center for Population and Development Studies.

George, A. (2007). Human resources for health: A gender analysis. Paper prepared for the Women and Gender Equity Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Gilson, L. (2003). Trust and the development of health care as a social institution. *Social Science and Medicine,* 56(7), 1453-1468.

Gilson, L. (2007a). Acceptability, Trust and Equity. In G. Mooney and D. McIntyre (Eds.), *The economics of health equity*. Cambridge: Cambridge University Press.

Gilson, L. (2007b). The political management needs of health policy change intended to promote equity. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Gilson, L. (2007c). What sort of stewardship and health system management is needed to tackle health inequity, and how can it be developed and sustained? Paper prepared for the Knowledge Network on Health Systems of the Commission on the Social Determinants of Health.

Gilson, L., Doherty, J., Lake, S., McIntyre, D., Mwikisa, C., and Thomas, S. (2003). The SAZA study: Implementing financing reform in South Africa and Zambia. *Health Policy and Planning,* 18(1), 31-46.

Gilson, L., Erasmus, E., Kamuzora, P., Mathews, V., Ngulube, T., and Scott, V. (2006). Applying health policy analysis in tackling health equity related implementation gaps. EQUINET discussion paper No. 28: EQUINET.

Gilson, L., and McIntyre, D. (2005). Removing user fees for primary care in Africa: the need for careful action. *British Medical Journal,* 331, 762-765.

Glassman, A., Reich, M., Laserson, K. and Rojas, F. (1999). Political analysis of the health reform in the Dominican Republic. *Health Policy and Planning* 14(2), 115-126.

Global Health Watch. (2005). *Global Health Watch 2005-2006: An alternative World Health Report.* London: Zed Books.

Goetz, A., and Gaventa, J. (2001). Bringing citizen voice and client focus into service delivery. IDS Working Papers - 138. UK: Institute of Development Studies. Available at: http://www.ids.ac.uk/ids/bookshop/wp/wp138.pdf (accessed 27 June 2007)

Gonzales, F., Arteaga, E., and Howard-Grabman, L. (1998). *Scaling up the Warmi project: Lessons learned, mobilising Bolivian community around reproductive health.* Washington DC: Save the Children.

Gonzales-Rosetti, A., and Bossert, T. (2000). Enhancing the political feasibility of health reform: A comparative analysis of Chile, Columbia and Mexico. LAC HSR Health Sector Reform Initiative Paper no. 36 Available from http://www.hsph.harvard.edu/ihsp/publications/pdf/lac/PolicyProcessSynEng2.PDF (Accessed 27 June 2007).

Gottret, P., and Schieber, G. (2006). Health financing revisited. Washington DC: The World Bank. Available at: http://siteresources.worldbank.org/INTHSD/Resources/topics/Health-Financing/HFRFull.pdf

Goudge, J., Khumalo, N., and Gilson, L. (2003). Policy options to improve the access of low income households to state-provided health care. Commissioned by the Affordability Ladder Programme. mimeo.

Govender, V., and Penn-Kekana, L. (2007). Gender Biases and Discrimination: a review of health care interpersonal interactions. Paper prepared for the Women and Gender Equity Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

Grindle, M. (1997). Divergent Cultures? When Public Organizations perform well in developing countries. *World Development,* 25(4), 481-495.

Grindle, M., and Thomas, J. (1991). *Public choices and policy change: the political economy of reform in developing countries.* Baltimore and London: Johns Hopkins Press.

Grodos, D. and Tonglet, R. (2002) Developing a coherent functional sanitary setting in sub-Saharan African cities: proof of the health district. *Tropical Medicine and International Health* 7(11), 977-92.

Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., and Hudson, M. (2002). What does 'access to health care' mean? *Journal of Health Services Research and Policy,* 7(3), 186-188.

Gupta, S., Verhoeven, M., and Tiongson, E. R. (2003). Public spending on health care and the poor. *Health Economics,* 12(8), 685-696.

Gwatkin, D., Bhuiya, A., and Victoria, C. (2004). Making health systems more equitable. *Lancet,* 364, 1272-1280.

Haddad, S.A., Nougtara, A., and Ridde V. (2004) Les inegalites d'access aux services de sante et leurs determinants au Burkina Faso. *Sante, Societe et Solidarite,* 2, 199-210.

Halstead, S., Walsh, J., and Warren, K. (1985). *Good health at low cost.* New York: Rockefeller Foundation.

Hanefeld, J., Spicer, N., Brugha, R., and Walt, G. (2007). How have global health initiatives impacted on health equity? Prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Hanson, K., Worrall, E., and Wiseman, V. (2007). Targeting services towards the poor: a review of targeting mechanisms and their effectiveness. In S. Bennett, L. Gilson and A. Mills (Eds.), *Health, Economic Development and Household Poverty.* London: Routledge.

Hardee, K., Feranil, I., Boezwinkle, J., and Clarke, B. (2004). The Policy Circle: A framework for analyzing the components of Family Planning, Reproductive health, maternal health and HIV/AIDS policies. Policy working paper series No. 11. Policy working paper series No. 11: The Policy Project. Available from http://www.policyproject.com/pubs/workingpapers/wps-11.pdf (accessed 27 June 2007).

Hausmann-Muela, S., Muela Ribera, J., and Nyamongo, I. (2003). Health seeking behaviour and the health system response. Disease Control Priorities Project Working Paper No.14. Available at: http://www.dcp2.org/file/29/wp14.pdf (accessed 27 June 2007).

Health Disparities Task Group. (2004). Reducing health disparities – roles of the health sector: Discussion paper. Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security. The Ministry of Health, Canada.

Health Systems Trust. (2007). Manner in which parliamentarians have been able to use the budget process to make visible inequalities in health and to promote equitable distribution in South Africa. A case study commissioned by the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

Hecht, R., and Shah, R. (2006). Recent trends and innovations in development assistance for health. Chapter 13 In D.T. Jamison, *et al.* (Eds.), *Disease control priorities in developing countries (*2nd edition): The World Bank and Oxford University Press.

Helling, L., Serano, L., and Warren, D. (2005). *Linking community empowerment, decentralised governance and public service provision through local development framework.* New York: World Bank.

Homedes, N., and Ugalde, A. (2001). Improving the use of pharmaceuticals through patient and community level interventions. *Social Science and Medicine,* 52, 99-134.

Homedes, N., and Ugalde, A. (2005). Why neoliberal health reforms have failed in Latin America. *Health Policy,* 71(1), 83-96.

Hongoro, C., and Normand, C. (2006). Health workers: building and motivating the workforce. In D. Jamison, J. Breman, A. Measham, G. Alleyne, M. Claeson, D. Evans, P. Jha, A. Mills and P. Musgrove (Eds.), *Disease Control Priorities in Developing Countries.* Washington: Oxford University Press and The World Bank.

Hudson, J., and Lowe, S. (2004). *Understanding the policy process: analysing welfare policy and practice.* Bristol: The Policy Press.

Infante, A. (2007). The post military government reforms to the Chilean Health System. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Jakab, M., Kutzin, J., Chakraborty, S., O'Dougherty, S., Temirov, A., and Manjieva, R. (2005). Evaluating the Manas Health Sector Reform (1996-2005) - Focus on Health Financing, Manas Health Policy Analysis Project Policy Research Paper No. 31.

Jejeebhoy, S. (2000). Women's Autonomy in Rural India: Its dimensions, determinants and the influence of the context. In G. Sen, H.B Presser, (eds). *Women's Empowerment and Demographic Processes.* Oxford: Oxford University Press.

Jeppson, A., Ostergren, P., and Hagstrom, B. (2003). Restructuring a ministry of health: an issue of structure and process. *Health Policy and Planning,* 18(1), 68-73.

Jha, P. and Mills, A. 2002. Improving health outcomes of the poor: the report of Working Group 5 of the Commission on Macroeconomics and Health. Geneva: World Health Organization.

Juraci, A., César Gustavo, S., de Lima R, and Houthausen, S. (1998). Evaluating the Impact and Cost of Interventions with Community Health Workers on Child Health: A Brazilian Experience. Research Paper No. 152. Boston: Takemi Program in International Health Harvard School of Public Health

Kabeer, N., and Subrahmanian, R. (1999). Following the process: implementation, monitoring and evaluation. In N. Kabeer and R. Subrahmanian (Eds.), *Institutions, relations and outcomes: a framework and case studies for gender aware planning.* New Delhi: Kali for Women.

Kahssay, H., and Baum, F. (1996). *The role of civil society in district health systems: hidden resources.* Division of Analysis, Research and Assessment. WHO:1-80.

Kahssay, H. M., Taylor, M., and Berman, P. (1998). *Community Health Workers: The Way Forward.* Public Health in Action, No 4: World Health Organization.

Kaler, A., and Cotts Watkins, S. (2001). Disobedient Distributors: Street level bureaucrats and would-be patrons in community-based family planning programmes in rural Kenya. *Studies in Family Planning* 32(3), 254-269.

Kamuzora, P., and Gilson, L. (2007). Factors influencing implementation of the Community Health Fund in Tanzania. *Health Policy and Planning,* 22(2), 95-102.

Kida, T., and Mackintosh, M. (2005). Public expenditure allocation and incidence under health care market liberalization: a Tanzanian case study. Ch 17. In M. Mackintosh, and M. Koivusalo, eds., *Commercialisation of health care: global and local dynamics and policy responses.* Basingstoke: Palgrave Macmillan.

Klugman, B. (2003). The value of policy analysis in the assessment of "post Cairo" policy processes. Johannesburg: PhD Thesis. University of the Witwatersand.

Klugman, B., and Hlatshwayo, Z. (2001). Strategy and action for abortion access: a comparative analysis. In B. Klugman and D. Budlender. *Advocating for abortion access: eleven country studies.* The Johannesburg Initiative, Women's Health Project, School of Public Health, University of the Witwatersrand.

Kurowski, C., Wyss, K., and Abdulla, S. (2007). Scaling up priority health interventions in Tanzania - the human resources challenge. *Health Policy and Planning.* 22(3), 113-127.

Kutzin, J. (2001). A descriptive framework for country-level analysis of health care financing arrangements *Health Policy,* 56, 171-204.

Kwon, H., and Tchoe, B. (2005). The political economy of national health insurance in Korea. Ch 15 in M. Mackintosh and M. Koivusalo, eds. *The commercialisation of health care: global and local dynamics and policy responses.* Basingstoke: Palgrave Macmillan.

Kwon, S. (2003). Pharmaceutical reform and physician strikes in Korea: separation of drug prescribing and dispensing. *Social Science and Medicine,* 57, 529-539.

Kwon, S., and Reich, M. (2005). The changing process and politics of health policy in Korea *Journal of Health Policy, Politics and Law,* 30(6), 1003-1025.

Labra, M.E. & Giovanela, L. (2007). Brazil: Building the unified national health system and civil society participation. Case study commissioned for the Civil Society stream of the WHO Commission on the Social Determinants of Health.

Lagarde, M., and Palmer, P. (2006). *Health Financing. Evidence from systematic reviews to inform decision making regarding financing mechanisms that improve access for poor people.* Alliance for Health Policy and Systems Research Khon Kaen, Thailand.

Laurell, A. (2007). Granting universal access to health care: The experience of the Mexico City Government. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Lee, K., and Goodman, H. (2002). Global policy networks: the propagation of health care financing reform since the 1980's. In K. Lee, K. Buse and S. Fustukian, eds., *Health policy in a globalising world.* Cambridge: University Press.

Levine, R. (2004). *What's worked? Accounting for success in global health.* Washington DC: Centre for Global Development.

Lewin, S., Dick, J., Pond, P., Zwarenstein, M., Aja, G., van Wyk, B., et al. (2005). Lay health workers in primary and community health care. *Cochrane Database of Systematic Reviews* Art No: CD004015. DOI: 10.1002/14651858.CD004015.pub2 (1).

Lister, J. (2007). Globalisation and health systems change. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Loewenson, R. (2000). Public participation in health systems in Zimbabwe. *IDS Bulletin,* 31(1), 14-20.

Loewenson, R. (2003a). Civil Society – State interactions in national health systems. Annotated Bibliography on Civil Society and Health. WHO/TARSC. Available from: http://www.tarsc.org/WHOCSI/ (accessed 26th June 2007).

Loewenson, R. (2003b). Civil Society contributions to pro-poor, health equity policies. Annotated Bibliography on Civil Society and Health. WHO/TARSC. Available from: http://www.tarsc.org/WHOCSI/ (accessed 26th June 2007).

Loewenson, R. (2007). Building voice and agency in health: public action within health systems. In S. Bennett, L. Gilson and A. Mills eds., *Health, Economic Development and Household Poverty.* London: Routledge.

Loewenson, R., Rusike, I., and Zulu, M. (2004). Assessing the impact of health centre committees on health system performance and resource allocation. EQUINET discussion paper 18. Available at: http://www.equinetafrica.org/bibl/docs/DIS18%20res.pdf. (accessed 27 June 2007).

London, L. (2003). Can human rights serve as a tool for equity? EQUINET Policy Paper 14. South Africa: Ideas studio. Available at: http://www.equinetafrica.org/bibl/docs/POL14rights.pdf (accessed 07 November 2006).

Lopez, L., Margweva, F., and Mpofu, E. (2007). A review of the district health system in east and Southern Africa: facilitators and barriers to participation in health. EQUINET discussion paper No. 40. Zimbabwe: EQUINET. Available from: http://www.equinetafrica.org/bibl/docs/Dis40ehsLOPEZ.pdf. (accessed 07 November 2006)

Macinko, J., Guanais, F. C., de Fatima, M., and de Souza, M. (2006). Evaluation of the impact of the Family Health Program on infant mortality in Brazil, 1990-2002. *Journal of Epidemiology and Community Health,* 60(1), 13-19.

Mackenbach, J. (1996). The contribution of medical care to mortality decline: McKeown revisited. *Journal of Clinical Epidemiology,* 49(11), 1207-1213.

Mackenbach, J. (2003). An analysis of the role of health care in reducing socio-economic inequalities in health: the case of the Netherlands. *International Journal of Health Services,* 33, 523-541.

Mackintosh, M. (2001). Do health care systems contribute to inequalities? . In D. Leon and G. Walt, eds. *Poverty, inequality and health: An international perspective.* Oxford: Oxford University Press.

Mackintosh, M. (2007). Planning and market regulation: strengths, weaknesses and interactions in the provision of less inequitable and better quality health care. Prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Mackintosh, M., and Koivusalo, M. (2005). *The commercialisation of health care: global and local dynamics and policy responses*. Basingstoke: Palgrave Macmillan.

Macwan'gi, M., and Ngwengwe, A. (2004). Effectiveness of district health boards in interceding for the community, Discussion paper 19. Harare: EQUINET. Available at: http://www.equinetafrica.org/bibl/docs/DIS40ehsLOPEZ.pdf (accessed 27 June 2007).

Malhotra, A., Mathur, S., Pande, R., and Roca, E. (2005). Nepal: The impact of participatory approaches on reproductive health for disadvantaged youths. In D. Gwatkin, A. Wagstaff and A. Yazbeck, eds., *Reaching the poor with health, nutrition and population services: what works, what doesn't and why?* Washington: World Bank.

Manandhar, D., Osrin, D., Shrestha, B., Mesko, N., Morrison, J., Tumbahangphe, K., et al. (2004). Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial. *Lancet,* 364(9438), 970-979.

Mannion, R., Davies, H., and Marshall, M. (2005). *Cultures for performance in health care*. Maidenhead: Open University Press.

Marmot, M. (2006). Harveian Oration. Health in an unequal world. *Lancet,* 368, 2081-2094.

Mason, J., Sanders, D., Musgrove, P., Soekirman, and Galloway, R. (2006). Community Health and Nutrition Programmes. In D. Jamison, J. Breman, A. Measham, G. Alleyne, M. Claeson, D. Evans, P. Jha, A. Mills and P. Musgrove. eds. *Disease Control Priorities in Developing Countries.* Washington: Oxford University Press and World Bank.

Mathauer, I., and Imhoff, I. (2006). Health worker motivation in Africa: the role of non-financial incentives and human resource management tools. *Human Resources for Health* 4:24 (Online) 29 August, 2006. (accessed 27 June 2007).

Mbombo, N., and Marmorato, S. (2007). Building and maintaining the capacity, representativeness, and informed engagement: the case of SIZAKUYENZA Community-based Organisation in South Africa: Case study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health.

Mbonye, A. K., Bygbjerg, I., and Magnussen, P. (2007). Intermittent preventive treatment of malaria in pregnancy: Evaluation of a new delivery approach and the policy implications for malaria control in Uganda. *Health Policy*. 81(2-3), 228-241.

McIntyre, D. (2007). *Learning from experience: Health care financing in low- and middle-income countries.* Geneva: Global Forum for Health Research. Available from: http://www.globalforumhealth.org/Site/000__Home.php (accessed 26 June 2007).

McIntyre, D., Gilson, L., and Mutyambizi, V. (2005). Promoting equitable health care financing in the African context: Current challenges and future prospects. EQUINET discussion paper 27. Harare: Regional Network for Equity in Health in Southern Africa EQUINET. Available at: http://www.equinetafrica.org/bibl/docs/DIS27fin.pdf (accessed 27 June 2007).

McIntyre, D., and Thiede, M. (2007). Illness, health service costs and their consequences for households. In S. Bennett, L. Gilson and A. Mills, eds. *Health, Economic Development and Household Poverty.* London: Routledge.

McIntyre, D., Thiede, M., Dahlgren, G., and Whitehead, M. (2006). What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts? *Social Science and Medicine,* 62(4), 858-865.

McKee, M. (2002). What can health services contribute to the reduction of inequalities in health? *Scandanavian Journal of Public Health,* 20 (suppl. 59), 54-58.

Meng, Q. (2007). Developing and implementing equity-promoting health care policies in China. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Mills, A. (2007). Strategies to achieve universal coverage. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Mills, A., Bennett, S., and Russell, S. (2001). *The challenge of health sector reform: What must governments do?* Basingstoke: Palgrave.

Mills, A., Rasheed, F., and Tollman, S. (2006). Strengthening health systems. In D. Jamison, J. Breman, A. Measham, G. Alleyne, M. Claeson, D. Evans, P. Jha, A. Mills and P. Musgrove, eds. *Disease Control Priorities in Developing Countries.* Washington: Oxford University Press and the World Bank.

Mkandawire, T. (2005). Targeting and universalism in poverty reduction. Social policy and development programme paper. Geneva: United Nations Research Institute for Social Development. Available from: www.unrisd.org (accessed 9 March 2007).

Mooney, G., and Houston, S. (2004). Alternative approach to resource allocation: weighted capacity to benefit plus MESH infrastructure. *Applied Health Economics and Health Policy,* 3(1), 29:23.

Moore, M. (1995). *Creating Public Value: Strategic management in government.* Cambridge: Harvard University Press.

Morgan, P., Land, T., and Baser, H. (2005). Study on capacity, change and performance. (ECDPM Discussion paper 59A). Maastricht: ECDPM. Available from: http://www.ecdpm.org/dp59A (accessed 22 September 2006).

Mugisha, F. (2007). The Nairobi Gauge work with parliaments. A case study prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Murthy, R., Klugma, B., and Weller, S. (2005). Service accountability and community participation. In T. Ravindran & H. de Pinho, eds. *The right reforms? Health sector reforms and sexual and reproductive health.* Johannesburg: Women's Health Project.

Musuka, G. (2007). Civil society participation in programme implementation for the intersectoral action on health equity and intersectoral action for health: a case study of the Health Civil Society Network in East and Southern Africa. A case study prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Musuka, G., and Chingombe, I. (2007). Building equitable people-centred national health systems: the role of parliament and parliamentary committees on health in East and Southern Africa: Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Nandakumar, A., Reich, M., Chawla, M., Berman, P., and Yip, W. (2000). Health reform for children: the Egyptian experience with school health insurance. *Health Policy,* 50, 155-170.

Navarro, V., Muntaner, C., Borrell, C., Benach, J., Quiroga, A., Rodriguez-Sanz, M., et al. (2006). Politics and health outcomes. *Lancet,* 368(9540), 1033-1037.

Nazarit, P. S. (2007). The contribution made by women's and feminist movements to equity in health: the Chilean experience. A case study prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Newbrander, W. (2006). Providing Health Services in Fragile States. Draft prepared for the DAC Fragile States Group Service Delivery Workstream, Sub Team for Health Services.

Ngulube, T., Loewenson, R., and Rusike, I. (2004). Governance, equity and health: impact of participatory mechanisms and structures in equity and quality of health systems. A research paper presented at the EQUINET conference. Durban. South Africa.

Ngulube, T., Mdhuli, L., and Gondwe, K. (2005). Planning and Budgeting for Primary Health Care in Zambia. A policy analysis. Discussion paper 29. Harare: EQUINET. Available at: http://www.equinetafrica.org/bibl/docs/DIS29ngulube.pdf (accessed 27 June 2007).

Nyhan, R. (2000). Changing the paradigm: trust and its role in public sector organizations. *American Review of Public Administration,* 30(10), 87-109.

Nyirenda, L., Makwiza, I., Bongololo, G., and Theobald, S. (2006). A gender perspective on HIV treatment in Malawi : A multi-method approach. *Gender and Development,* 14(1), 10.

Ochoa, F., and Visbal, L. (2007). Civil society and the health system in Cuba. Prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

O'Donnell, O., van Doorslaer, E., Rannan-Eliya, R., Somanathan, A., Adhikiri, S., Harbianto, D., et al. Garg, C.C., Hanvoravongchai, P., Huq, M.N., Karan, A., Leung, G.M., Ng, C.W., Pande, B.R., Tin, K., Tisayaticom, K., Trisnantoro, L., Zhang, Y., and Zhao Y. (2007). The incidence of public spending on healthcare: comparative evidence from Asia. *World Bank Economic Review,* (Online) 2007 21(1):93-123; doi:10.1093/wber/lhl009 (accessed 27 June, 2007).

O'Donnell, O., Van Doorslaer, E., Rannan-Eliya, R., Somanathan, A., and et al. (2005a). Who benefits from public spending on health care in Asia? EQUITAP Project Working Paper. Rotterdam and Colombo: Erasmus University and IPS. Available from: http://www.equitap.org/publications/wps/EquitapWP3.pd. (accessed 12 October 2006).

O'Donnell, O., Van Doorslaer, E., Rannan-Eliya, R., Somanathan, A., and et al. (2005b). Who pays for health care in Asia. EQUITAP Project Working Paper Number 1. Rotterdam and Colombo: Erasmus University and IPS. Available from: http://www.equitap.org/publications/wps/EquitapWP1.pd (accessed 12 October 2006).

Ochoa, F., and Visual, L. (2007). Civil society and the health system in Cuba. Prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Ogawa, S., Hasegawa, T., and Carrin, G. (2003). Scaling up community health insurance: Japan's experience with the 19th century Jyorei scheme. *Health Policy and Planning,* 18(3), 270-278.

Oliveira, M. (2003). A parceria Estado – Sociedad: amplinando recursos e competencies. Available from: Home page da RITS (Rede de Informacoes do terceiro sector. http://www.rits.org.br/idacs.rits.org.br/ongs) (accessed 27 June 2007).

Ouendo, E.M., Makoutode M., Paraiso, M.N., Wilmet-Dramaix, M., and Dujardin B. (2005). Itineraire therapeutique des maladies indigents au Benin (pauvrete et soins de sante). *Tropical Medicine and International Health,* 10(2), 179-186.

Owusu, F. (2005). Livelihood strategies and performance of Ghana's health and education sectors: exploring the connections. *Public Administration and Development,* 25, 17.

Oxfam International. (2006). *In the public interest: health, education and water sanitation for all.* Oxford: Oxfam. Available from: http://www.oxfam.org/en/policy/briefingpapers/bp_public_internest (accessed 27 March 2007).

Packer, C., Labonte, R., and Spitzer, D. (2007). Globalisation and the health worker migration crisis. Paper prepared for the Globalization Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Padarath, A., Chamberlain, C., McCoy, D., Ntuli, D., Rowson, M., and Loewenson, R. (2003). Health personnel in Southern Africa: Confronting maldistribution and brain drain. EQUINET discussion paper 3. EQUINET Available from: www.equinetafrica.org (accessed 27 March 2007).

PAHO. (2001). Investment in Health: Social and Economic Returns Scientific and Technical Publication No.582. Washington: Pan American Health Organization.

PAHO. (2007). Renewing Primary Health Care in the Americas. A position paper of the Pan American Health Organization. Available at: http://www.paho.org/English/AD/THS/primaryHealthCare.pdf (accessed 27 June 2007)

Palmer, N. (2000). The use of private-sector contracts for primary health care: theory, evidence and lessons for low-income and middle-income countries. *Bulletin of the World Health Organization,* 78(6), 821-829.

Palmer, N. (2007). Access and Equity: evidence on the extent to which health services address the needs of the poor. In S. Bennett, L. Gilson and A. Mills, eds. *Health, Economic Development and Household Poverty.* London: Routledge.

Palmer, N., Mueller, D., Gilson, L., Mills, A., and Haines, A. (2004). Health financing to promote access in low income settings – how much do we know? *The Lancet,* 364, 1365-1370.

Parkhurst, J., and Lush, L. (2004). The political environment of HIV: lessons from a comparison of Uganda and South Africa. *Social Science and Medicine.* 59(9), 1913-1924.

Patouillard, E., Goodman, C., Hanson, K., and Mills, A. (2007). Can working with the private sector improve utilisation of quality health services by the poor? A systematic review of the literature. Paper submitted to the International Journal for Equity in Health.

Peabody, J., Taguiwalo, M., Robalino, D., and Frenk, J. (2006). Improving the quality of care in developing countries. In D. Jamison, J. Breman, A. Measham, G. Alleyne, M. Claeson, D. Evans, P. Jha, A. Mills and P. Musgrove, eds. *Disease Control Priorities in Developing Countries.* Washington: Oxford University Press and the World Bank.

Pechansky, R., and Thomas, W. (1981). The concept of access. *Medical Care,* 19, 127-140.

Peckham, S., Exworthy, M., Powell, M., and Greener, I. (2005). Decentralisation, Centralisation and Devolution in publicly funded health services: decentralisation as an organisational model for health care in England. Report for the National Co-ordinating Centre for NHS Service Delivery and Organization R & D (NCCSDO).

Peren, H. (2007). Revivial of Maya medicine and impact for its social and political recognition (in Guatemala). Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Perera, M. (2007). Intersectoral Action for Health in Sri Lanka. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Perera, M., Gunatilleke, G., and Bird, P. (2007). Falling into the medical poverty trap in Sri Lanka: what can be done? . *International Journal of Health Services.* 37(2), 379-398

Peres, E., Andrade, A., Dal Poz, M., and Grande, N. (2006). The practice of physicians and nurses in the Brazilian Family Health Programme – evidence of changes in the delivery health care model. *Human Resources for Health*. 4:25 (online) Available from: http://www.human-resources-health.com/ (accessed 15 November 2006).

Performance and Innovation Unit. (no date). Strengthening leadership in the public sector: A research study by the PIU. Cabinet office: UK Government. Available at: http://www.cabinetoffice.gov.uk/strategy/downloads/su/leadership/piu-leadership.pdf. (accessed 27 June 2007).

Perks, C., Toole, M., and Phouthonsy, K. (2006). District health programmes and health sector reform: case study in the Lao People's Democratic Republic. *Bulletin of the World Health Organization,* 84(2), 132-138.

Perry, H., Robison, N., Chavez, D., Taja, O., Hilari, C., Shanklin, D., et al. (1998). The census-based, impact-oriented approach: its effectiveness in promoting child health in Bolivia. *Health Policy and Planning,* 13(2), 140-151.

Pollard, A., and Court, J. (2005). How civil society organizations use evidence to influence policy processes. A literature review. ODI Working Paper 249. Available at: http://www.odi.org.uk/RAPID/Publications/Documents/WP249.pdf (accessed 26 June 2007).

Pronyk, P., Hargreaves, J., Kim, J., Morison, L., Phetla, G., Watts, C., et al. (2006). Effect of structural intervention for the prevention of intimate partner violence and HIV in rural South Africa: a cluster randomised trial. *Lancet,* 368(9551), 1973-1983.

Public Health Agency of Canada and Health Systems Knowledge Network. (2007). Crossing sectors: experiences in intersectoral action, public policy and health. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Putzel, J. (2004). The politics of action on AIDS: a case study of Uganda. *Public Administration and Development,* 24(1), 19-30.

Rachlis, M. (1999). A paper prepared for a workshop on intersectoral action and health: sponsored by Health Canada (Alberta and NWT) in partnership with Alberta Health and Alberta Community Development. Available from: www.michaelrachlis.com/publications/php (accessed 28th June 2007).

Ranson, K., Poletti, T., Bornemisza, O., and Sondorp, E. (2007). Promoting Health Equity in Conflict-affected Fragile States. Prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Ranson, M., Hanson, K., and Oliveira Cruz, V. (2003). Constraints to expanding access to health interventions: an empirical analysis and country typology. *Journal of International Development,* 15, 15-39.

Ravindran, T., and de Pinho, H., eds. (2005). *The right reforms? Health sector reforms and sexual and reproductive health*. Johannesburg: The Initiative for Sexual and Reproductive Rights and Health Reforms. Available from: www.wits.ac.za/whp/rightsandreforms/globalvolume.htm (accessed 27 March 2007).

Ravindran, T., and Maceira, D. (2005). The impact of health financing reforms in developing countries on reproductive and sexual health services: A review. In T. Ravindran and H. de Pinho, eds. *The right reforms? Health sector reforms and sexual and reproductive health.* Johannesburg: The Initiative for Sexual and Reproductive Rights and Health Reforms. Available from: www.wits.ac.za/whp/rightsandreforms/globalvolume.htm (accessed March 2007).

Reich, M. (1995). The politics of health sector reform in developing countries: three cases of pharmaceutical policy. Ch 3 In P.C. Berman, ed. *Health sector reform in developing countries: making health development sustainable.* Boston: Harvard University Press.

Reyes, H., Perez-Cuevas, R., Salmeron, J., Tome, P., Guiscafre, H., and Gutierrez, G. (1997). Infant Mortality Due to Acute Respiratory Infections: The Influence of Primary Care Processes. *Health Policy and Planning,* 12, 214-223.

Rhyne, R., Bogue, R., Kukulka, G., and Fulmer, H. eds. (1998). *Community Oriented Primary Care: health care for the 21st century.* Washington: American Public Health Association.

Ridde, V. (2006). Apprehender les conceptions locales de l'equite pour forumler les politiques publiques de sante au Burkina Faso. *Promotion and Education,* XIII(4), 252-256.

Ridde, V. (2007). *Equite et mise en oeuvre des politiques de sante au Burkina Faso.* Paris: Editions L'Harmattan.

Rifkin, S. (2003). A framework linking community empowerment and health equity: It's a matter of CHOICE. *Journal of Health and Population Nutrition* 21(3), 168-180.

Rifkin, S., and Walt, G. (1986). Why health improves: defining the issues concerning "comprehensive primary health care" and "selective primary health care. *Social Science and Medicine.* 23(6), 559-66

Robinson, J., and Wharrad, H. (2000). Invisible nursing: exploring health outcomes at a global level. Relationships between infant and under 5 mortality rates and the distribution of health professionals, GNP per capita, and female literacy. *Journal of Advanced Nursing,* 32(1), 28-40.

Robinson, J., and Wharrad, H. (2001). The relationship between attendance at birth and maternal mortality rates: an exploration of United Nations data sets including the ratio of physicians and nurses to population, GNP per capita and female literacy. *Journal of Advanced Nursing,* 34(4), 445-455.

Rose, R. (2005). *Learning from comparative public policy: A practical guide.* Abingdon: Routledge.

Rowe, A., de Savigny, D., Lanata, C., and Victora, C. (2005). How can we achieve and maintain high-quality performance of health workers in low resource settings. *Lancet,* 366, 1026-1035.

Rowson, M. (2007). Globalization, debt and poverty reduction strategies. Paper prepared for the Globalization Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Ruppel, C. P., and Harrington, S. J. (2000). The relationship of communication, ethical work climate, and trust to innovation. *Journal of Business Ethics,* 25(4), 313-328.

Rusike, I. (2007). Civil society promotion of equity and the social determinants of health through involvement in the governance of health systems: the case of the Community Working Group on Health in Zimbabwe. A case study prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Russell, S. (2004). The economic burden of illness for households in developing countries: A review of studies focusing on malaria, tuberculosis and human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome. *American Journal of Tropical Medicine and Hygiene,* 7(Suppl 2), 147-155.

Russell, S. (2005). Treatment-seeking behaviour in urban Sri Lanka: trusting the state, trusting private providers. *Social Science and Medicine,* 61(7), 1396-1407.

Russell, S. (2007 forthcoming). Coping with the costs of illness: vulnerability and resilience among poor urban households in Sri Lanka. In S. Bennett, L. Gilson and A. Mills, eds. *Health Economic Development and Household Poverty.* London: Routledge.

Sahn, D., and Younger, S. (2000). Expenditure incidence in Africa: microeconomic evidence. *Fiscal Studies,* 21(3), 31-48.

Sanders, J., and Timsina, T. (2004). Decentralised transformative leadership approaches to HIV/AIDS in Nepal, 2002-2004. *Development in Practice,* 14(6), 761-767.

Schein, E. (1992). *Organizational culture and leadership* (2nd ed). San Francisco: Jossey-Bass.

Shaikh, B., and Hatcher, J. (2004). Health seeking behaviour and health service utilisation in Pakistan: challenging the policy makers. *Journal of Public Health Management,* 27, 49-54.

Siddiqi, S., Masud, T.I., and Sabri, B. (2006). Contracting but not without caution: experience with outsourcing of health services in countries of the Eastern Mediterranean Region. *Bulletin of the World Health Organization* 64(11), 867-875

Simmons, R., and Shiffman, J. (2006). Scaling up health service innovations: a framework for action. Ch 2. In R. Simmons, P. Fajans & L. Ghiron, eds. *Scaling up health services delivery: from pilot innovations to policies and programmes.* Geneva: World Health Organization. Available from: http://www.expandnet.net/volume.htm (accessed 26th June 2007)

Starfield, B. (1998). *Primary health care: Balancing health needs, services and technology.* New York: Oxford University Press.

Starfield, B. (2001). Basic concepts in population health and health care. *Journal of Epidemiology and Community Health,* 55(7), 452-454.

Starfield, B. (2006a). State of the art research on equity in health. *Journal of Health Politics Policy Law,* 31(1), 11-32.

Starfield, B. (2006b). Threads and yarns: weaving the tapestry of comorbidity. *Annals of Family Medicine,* 4(2), 101-103.

Starfield, B., and Shi, L. (2002). Policy relevant determinants of health: an international perspective. *Health Policy* 60(3), 201-218.

Starfield, B., Shi, L., and Macinko, J. (2005). Contribution of primary care to health systems and health. *Milbank Quarterly,* 83(3), 457-502.

Stein, E., Tommasi, M., Echebarria, K., Lova, E., and Payne, M. (2006). *The politics of policies: Economic and social progress in Latin America.* Washington: Inter-American Development Bank.

Tangcharoensathien, V., and Jongudomsuk, P. eds. (2004). *From policy to implementation: historical events during 2001-2004 of Universal Coverage in Thailand.* Bangkok: National Health Security Office.

Tendler, J., and Freedheim, S. (1994). Trust in a rent-seeking world: health and government transformed in Northeastern Brazil. *World Development,* 22(12), 1771-1791.

Theobald, S., Tolhurst, R., Elsey, H., and Standing, H. (2005). Engendering the bureaucracy? Challenges and opportunities for mainstreaming gender in Ministries of Health under sector-wide approaches. *Health Policy and Planning,* 20(3), 141-149.

Thiede, M., Akweongo, P., and McIntyre, D. (2007). Exploring the dimensions of access. In D. McIntyre and G. Mooney, eds.*The Economics of Health Equity*. Cambridge: Cambridge University Press.

Thomas, S., Mooney, G., and Mbatsha, G. (2007 (in press)). The MESH approach: Strengthening public health systems for the MDGs. *Health Policy*, (Online) 7 February 2007, Available at: http://journals.elsevierhealth.com/periodicals/heap/ (accessed 27 June 2007).

Toole, M., Snell, B., Holmes, W., Malau, C., Perera, C., Vaughan, C., et al. (2003). Harnessing the New Global health Resources to Build Sustainable Health Systems. Melbourne: Background paper commissioned by the UN Millennium Project Task Force on Child Health and Maternal Health. Centre for International Health, Burnet Institute.

University of Namibia Ontevrede community. (2006). Creating nurse student awareness on community knowledge on health in "Ontevrede" (unsatisfied) informal settlement, Namibia. EQUINET PRA Project report. Available at: http://www.equinetafrica.org/bibl/docs/PRAhofne.pdf (accessed 27 June 2007).

van Dam, A. (1992). Popular education in Latin America Synthesis of the discussion Themes Verhandelingen no 50. The Hague: Centre for the Study of Education on Developing countries.

Van Doorslaer, E., and O'Donnell, O. (2006). Measurement and explanation of inequality in health and health care in low-income settings. UNU-WIDER Conference on Advancing Health Equity. Helsinki.

van Doorslaer, E., O'Donnell, O., Rannan-Eliya, R. P., Somanathan, A., Adhikari, S., Garg, C., et al. (2006). Effects of payments for health care on poverty estimates in 11 countries in Asia: an analysis of household survey data. *Lancet,* 368(9544), 1357-1364.

van Doorslaer, E., Wagstaff, A., van der Burg, H., Christiansen, T., De Graeve, D., Duchesne, I., et al. (2000). Equity in the delivery of health care in Europe and the US. *Journal of Health Economics,* 19(5), 553-583.

Varavasovszky, A., and Brugha, R. (2000). How to do (or not to do)… A stakeholder analysis. . *Health Policy and Planning* 15(3), 338-345.

Vega-Romero, R., and Torres-Tovar, M. (2007). The role of civil society in building an equitable health system. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Velandia Salazar, F., ArdonCenteno, N.R., Jara Navarro, M.I., Cardona, J.F. (2006). *Estructura, estado y modification de la calidad y de la oportunidad de la Atencion Medica en Colombia.* Bogota: Pontifica Universidad Javeriana.

Verheul, E., and Cooper, G. (2001). Poverty Reduction Strategy Papers (PRSP): What is at Stake for Health? Amsterdam: Wemos.

Victora, C., Adam, T., Bryce, J., and Evans, D. (2006). Integrated management of the sick child. In D. Jamison, J. Breman, A. Measham, G. Alleyne, M. Claeson, D. Evans, P. Jha, A. Mills and P. Musgrove (Eds.), *Disease Control Priorities in Developing Countries.* Washington: Oxford University Press and World Bank.

Wagstaff, A. (2002). Poverty and health sector inequalities. *Bulletin of the World Health Organization,* 80(2), 97-105.

Wagstaff, A. (2003). Child health on a dollar a day: some tentative cross-country comparisons. *Social Science and Medicine,* 57(9), 1529-1538.

Wagstaff, A. (2007). Social Health Insurance Reexamined. World Bank Policy Research Working Paper 4111 WPS4111 Available from http://www-wds.worldbank.org/. (accesssed 27 June 2007).

Wagstaff, A., van Doorslaer, E., van der Burg, H., Calonge, S., and Christiansen, T. (1999). Redistributive effect, progressivity and differential tax treatment: personal income taxes in twelve OECD countries. *Journal of Public Economics* 72, 25.

Walker, L., and Gilson, L. (2004). We are bitter but we are satisfied: Nurses as street level bureaucrats in South Africa. *Social Science and Medicine,* 59(6), 125-1261.

Wallerstein, N. (1992). Powerlessness, empowerment, and health: implications for health promotion programs. *American Journal of Health Promotion,* 6(3), 197-205.

Wallerstein, N. (2006). What is the evidence on effectiveness of empowerment to improve health? Copenhagen: WHO Regional Office for Europe (Health Evidence Network).

Walt, G. (1988). CHWs: are national programmes in crisis? *Health Policy and Planning,* 3(10), 1-21.

Walt, G., ed. (1990). *Community health workers in national programmes: just another pair of hands?* Milton Keynes: Open University Press.

Walt, G., Lush, L., and Ogden, J. (2004). International organisations in policy transfer: iterative loops of adoption, adaptation and marketing in infectious diseases *Governance,* 17(2), 189-210.

Watson, G., and Papamarcos, S. (2002). Social Capital and Organizational Commitment. *Journal of Business and Psychology 16(4): 537-552,* 16(4), 537-552.

Weyland, K. (1995). Social movements and the state: The politics of health reform in Brazil. *World Development,* 23(10), 1699.

WHO. (1997). Intersectoral Action for Health: A Cornerstone for Health-for-All in the Twenty-First Century. International Conference on Intersectoral Action for Health. Halifax: World Health Organization.

WHO. (1998). T*he challenge of implementation: District health systems for primary health care.* Geneva: WHO.

WHO. (2000). *World Health Report: Health Systems Improving Performance.* Geneva: World Health Organization.

WHO. (2002). Understanding Civil Society Issues for the WHO. Civil Society Initiative. In: *External Relations and Governing Bodies* Geneva: WHO. Available at:
http://www.who.int/civilsociety/documents/en/understanding_en.pdf. (accessed 27 June 2007)

WHO. (2006a). Approaching health financing policy in the WHO European Region. The Regional Committee for Europe 56th Session. Copenhagen: Paper prepared for the Regional Committee for Europe 56th Session.

WHO. (2006b). *Working together for health: the World Health Report.* Geneva: World Health Organization.

Wibulpolprasert, S., Pachnanee, C., Pitayanrangsarit, S., and Hempisut, P. (2004). International service trade and its implications for human resources for health: a case study of Thailand. *Human resources for health 2, 10.*

Wibulpolprasert, S., and Pengpaibon, P. (2003). Integrated strategies to tackle the inequitable distribution of doctors in Thailand: four decades of experience*. Human Resources for Health* (Online) 2003, Nov 25; 1-12. Available from: http://info.worldbank.org/etools/docs/library/206766/suwit%204%20decades.pdf (accessed 27 June 2007).

Xu, K., Evans, D., Carrin, G., and Aguilar-Rivera, A. (2005). Designing health financing systems to reduce catastrophic health expenditure. Technical Briefs for Policy-Makers. Number 2. WHO/EIP/HSF/PB/05.02. Geneva: World Health Organization.

Xu, K., Evans, D., Kawabata, K., Zeramdini, R., Kalvus, J., and Murray, C. (2003). Household catastrophic health expenditure: a multicountry analysis. *Lancet,* 362 (9378):111-7.

List of annexes

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Annex 1: Terms of reference

As agreed between the Secretariat for the CSDH, the Commissioners and the Health Systems KN hub, **the scope of the Health Systems KN** is the following:

> The way health systems are designed, operated and financed act as a powerful determinant of health. They modify the effects of other upstream determinants on health and thus by design should be sensitive to overcoming these barriers to access to health care. Evidence on the effectiveness of different models for health systems to improve health equity outcomes will be reviewed. In an effort to gather and subsequently mainstream knowledge and action on how to overcome social barriers to health, the focus will be on innovative approaches that effectively incorporate action on social determinants of health (e.g. integrated goal setting and budgeting, intersectoral programming and financing, etc) and on strategies of policy development and implementation. The recommendations of this group will be highly relevant in those resource scarce country contexts where budgets are allocated vertically to a variety of government bodies, which forces them to compete fiercely for funds.

Knowledge Network Objectives

> The purpose of the Knowledge Networks (KN) is to synthesise knowledge to inform the Commission of opportunities for improved action on SDH by fostering the leadership, policy, action and advocacy needed to create change. The Health Systems KN will use the CSDH conceptual framework to organise knowledge:
> 1. on priority associations between health systems and the social determinants of health and health inequities across different country contexts with attention to widespread cross-cutting determinants such as gender inequality;
> 2. on the extent to which prioritised social determinants of health in relation to Health Systems can be acted upon, exemplified through successful national and global policies, programmes and institutional arrangements;
> 3. to stimulate societal debate on the opportunities for acting on health systems and the social determinants of health; and
> 4. to inform the application and evaluation of policy proposals and programmes in relation to health systems nationally, across regions and globally, assessing implications for both women and men.

Knowledge Network tasks

The KN work is essential to the success of the entire CSDH. The focus of the KNs is to:
1. Analyse evidence on the robustness of the associations between SDH and health/ health equity across different country contexts.
2. Evaluate evidence and suggest national and global policies, programs and institutional arrangements that modify the association between SDH and health equity and enhance opportunities for greater health equity, taking into consideration women's as well as men's concerns and experiences.
3. Document and assess the processes and mechanisms to mainstream and scale-up successful examples of incorporating social determinants (SDH) into health programs and policies.
4. Propose approaches for using the evidence on integrating the SDH and health equity goals into national and global policy and planning.
5. Identify and engage institutions and actors to contribute to the production, dissemination and use of knowledge for the proposed policies and programs across different regions.
6. Engage with the Commission components (country work, civil society organisations and global initiatives) to exchange knowledge and learning and the WHO technical liaison for your respective KN.

Annex 2: Sources of evidence

This annex supplements Part 2 of the report, providing more information on the evidence base.

Table (a):   Analysis of profile of KN members, authors and reviewers (excluding Commissioners, Commission secretariat members and WHO link people who tended to provide anonymous combined reviews)

Demographic feature	Hub members	Other authors and reviewers	Total
Sex			
Male	**10**	**40**	**50**
Female	**5**	**38**	**43**
Geographic base			
Africa	**3**	**23**	**26**
E. Mediterranean	**0**	**1**	**1**
Europe	**4**	**23**	**27**
Latin America	**3**	**12**	**15**
North America	**1**	**14**	**15**
South-East Asia	**3**	**5**	**8**
Western Pacific	**1**	**0**	**1**
Institutional base			
Academic/consultant*	**5**	**51**	**56**
Civil society	**4**	**18**	**22**
Policy-maker/manager	**6**	**2**	**8**
International agency/funder	**0**	**7**	**7**
TOTAL	15	78	93

* Many of these were also actively involved in civil society organisations

Table (b):   Ensuring diversity of the evidence base

Type	Approach of the Health Systems Knowledge Network
Geographic diversity	In the main, the KN drew on evidence from low- and middle-income countries (including transitional and fragile states): this is because these countries tend to be under-represented in the mainstream literature whilst also suffering from the greatest health inequities. Where relevant, lessons are drawn from the experience of high-income countries.
Language diversity	The KN includes members from a range of regions and language groups (including Latin America and South-East Asia). In addition, criteria for including evidence in review papers urged reviewers to access adequate geographic and language representation. These two features attempted to guard against an over-emphasis on evidence from English-speaking countries or the English literature although this was not entirely successful.
Different types of evidence	In order to assemble an 'evidence jigsaw,' the KN tapped knowledge from formal research (both qualitative and quantitative), practice (including case studies) and experiential knowledge (from key informants, including KN members who were policy-makers). These last two forms of knowledge are an important supplement to formal research given that so much of the contemporary experience of how to change health systems is not yet written up in a formal way.

Type	Approach of the Health Systems Knowledge Network
Different sources of evidence	Sources used included: electronic databases; reference lists from studies already identified; the internet; conference proceedings; reports by governments, civil society groupings, donors, academics and consultants; and personal communications with policy-makers and researchers in the field to elicit 'tacit' knowledge. These sources were accessed through 1) electronic searches of data bases and web sites, 2) hand searching of reference lists and specialist journals, 3) requesting experts and key actors involved in transformation to identify relevant material and 4) commissioning specific case studies of positive country experiences.
Different perspectives on evidence	Fundamental to the approach of the KN is the adoption of a critical approach to all evidence, acknowledgement of the contestation between different research traditions and appreciation of differences in perspective and interpretation. The avoidance of bias is one of the rationales for combining data from different research sources through a process of triangulation. This was assisted by the process of peer review whereby each commissioned literature review or case study was reviewed by at least one member of the KN as well as external reviewer. Reviewers were selected on the basis that they were likely to have different interpretations or additional knowledge to the authors: this was particularly important for case studies written by authors who had been personally involved in the changes they were describing. Policy-makers and civil society members were involved in the collection and analysis of evidence, to introduce a perspective different from that of academics. The final report was also reviewed by three external reviewers.
Different method-ological bases of evidence	The KN derived its evidence from a wide array of studies based on the full range of research methods, as well as from non-research sources. The complementarity of different research methods and traditions serves to enrich understanding of what policy designs are appropriate in different contexts, how policies can be developed and implemented within complex health systems, and what makes certain actions work.

Box (a):   Ensuring that gender issues are represented in the evidence base

- A gender expert (who was approved by the Women and Gender KN) sat on the KN and was charged with ensuring that the theme was reflected across all areas of the KN's work.
- A gender balance was reflected in the composition of the KN (see front inside page of report).
- The need to reflect gender issues was incorporated in the terms of reference of commissioned papers.
- Consideration of gender issues was incorporated into the terms of reference for the peer review process.
- A joint paper on gender-related issues was commissioned with the Women and Gender Equity KN.

Annex 3:   Contextual factors influencing pro-equity health system development

Numbers in first column refer to features relevant to:
   1) policy making; 2) civil society role; 3) implementation; and 4) health system design.

Brackets indicate partial relevance.

Contextual factor	Enabling/Favourable	Disabling/Unfavourable
Political environment 1, 2, 3 (4)	• Constitutional rights • Capable local government • Opportunities for democratic influence over decision-making (responsiveness) • Democratic civil society • Some level of trust in government • Strong government legitimacy in population's eyes • Donors responsive to national processes and priorities	• Elite capture • Personalised politics and systems • Higher levels reversing lower level decision-making and reverse of enabling/favourable column
Economic /social welfare environment 1, 3, 4	• High income + pro-social policy frameworks • Low income + pro social policy frameworks • Balance corporate and social interests	• High income without pro-social policy frameworks • Low income without pro social policy frameworks • Corporate interests dominating
Situational 1, 2, 3	• Literacy	• Illiteracy
Cultural and societal norms 1,2,3	• Gender equity • Solidarity • Acceptance of other cultural systems	• Gender inequity • Individualism • Not accepting other cultural systems
Health system 3, 4	• Strong public sector role • Strong stewardship • Low % private financing • Strong PHC systems	• Reverse
Inter-government relations 2, 3 (4)	• Balanced forms of decentralisation and centralisation allowing effective government • Coordination between tiers of government • Treasury responsive to social needs • Strong local government	• Over-centralised, too decentralised and/or weak coordination between tiers of government • Treasury has conservative position on investment in health
Resource Allocation 4	• Needs-based resource allocation in health system and generally • Opportunities for local control over decision-making	• Reverse
Human and technical capacity (1,2) 3, 4	• High • Strong community roles	• Low • Weak community roles
Bureaucracy 3 (4)	• Empowering/enabling • Lack of corruption • Participatory planning • Clear guidelines	• Strong hierarchies • Corruption • Weak guidance • Rigid, controlling

Contextual factor	Enabling/Favourable	Disabling/Unfavourable
Power of policy actors 1	• Supportive alliances and/or good actor management of potential opponents • Forums and platforms for discussion and dialogue • Information flow • Social and institutional power enabling dialogue and debate	• Weak alliances • Clear opposition

Annex 4: List of commissioned reviews and case studies

10 systematic literature reviews and 20 case studies were commissioned by the Health Systems KN as part of its process of collecting and synthesising evidence.

Systematic literature reviews

1. De Maeseneer J, Willems S, De Sutter A, Van de Geuchte I, Billings M. (2007). Primary health care as a strategy for achieving equitable care.
2. George A. (2007). Human resources for health: a gender analysis.
3. Gilson, L. (2007). What sort of stewardship and health system management is needed to tackle health inequity, and how can it be developed and sustained?
4. Gilson, L. (2007). The political management needs of health policy change intended to promote equity.
5. Hanefeld J, Spicer N, Brugha R, Walt G. (2007). How have global health initiatives impacted on health equity? What strategies can be put in place to enhance their positive impact and mitigate against negative impacts?
6. Mackintosh, M. (2007). Planning and market regulation: strengths, weaknesses and interactions in the provision of less inequitable and better quality health care.
7. Mills, A. (2007). Strategies to achieve universal coverage: are there lessons from middle-income countries?
8. Musuka G, Chingombe I. (2007). Building equitable people-centred national health systems: the role of parliament and parliamentary committees on health in East and Southern Africa.
9. Public Health Agency of Canada and Health Systems KN. (2007). Crossing sectors: experiences in intersectoral action, public policy and health.
10. Vega-Romero, R., Torres-Tovar, M. (2007). The role of civil society in building an equitable health system.

Country and regional case studies

1. Balabanova, D. (2007). Health sector reform and equity in transition.
2. Chetty K. (2007) Equity promoting health care policies in South Africa.
3. Dubowitz, T., Anthony, R., Bird, C., Cohen, D., Lurie, N. (2007) The experience of the USA: health inequity within a high-income setting.
4. Infante, A. (2007) The post military government reforms to the Chilean Health System .
5. Laurell, A.C. (2007). Granting Universal Access to Health Care. The experience of the Mexico City Government.
6. Meng, Q. Developing and implementing equity-promoting health care policies in China (2007)
7. Perera, M.A.L.R. (2007). Intersectoral Action for Health in Sri Lanka
8. Ranson K, Poletti T, Bornemisza O, Sondorp E. (2007). Promoting health equity in conflict-affected fragile states
9. Tangcharoensathien, V, Prakongsai, P, Limwattananon, S, Patcharanarumol, W, and Jongudomsuk, P. (2007). Achieving universal coverage in Thailand: what lessons do we learn?

Case studies on the role of civil society in promoting health equity

10. Cuevas, JH. (2007) Health and autonomy: the case of Chiapas (in Mexico).
11. Mbombo N. (2007). Building and maintaining the capacity, representativeness, legitimacy, diversity and voice of civil society in order to allow for authentic, bottom up, effective and informed engagement: The case study of a community based organisation (CBO) at a Black informal settlement area, South Africa Case study commissioned by the Health Systems Knowledge Network.
12. Musuka G, Chingombe I. (2007). Civil society participation in programme implementation for intersectoral action on health equity and intersectoral action for health: a case study of the Health Civil Society Network in East and Southern Africa. Case study commissioned by the Health Systems Knowledge Network.

13. Nazarit P.S. (2007). The contribution made by women's and feminist movements to equity in health: the Chilean experience. Case study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health.

14. Ochoa FR, Visbal LA. (2007). Civil society and health system in Cuba. Case study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health.

15. Peren HI. (2007) Revivial of Maya medicine and impact for its social and political recognition (in Guatemala)

16. Rusike I. (2007). Civil society promotion of equity and the social determinants of health through involvement in the governance of health systems: the case of the Community Working Group on Health in Zimbabwe. Case study commissioned by the Health Systems Knowledge Network.

Case studies on the role of parliamentarians in promoting health equity

17. Chebundo B. (2007). The Zimbabwe re-engineered budget process and the impact of its all-stakeholder inclusiveness approach, and how the involvement of EQUINET and other stakeholders contributes towards achieving equitable distribution of health resources. Case study commissioned by the Health Systems Knowledge Network.

18. Chebundo B. (2007). The way parliamentary committees on health have overcome obstacles in creating sustained and co-ordinated pressures for health through regional networking in Southern and Eastern Africa. Case study commissioned by the Health Systems Knowledge Network.

19. Health Systems Trust. (2007). Manner in which parliamentarians have been able to use the budget process to make visible inequalities in health and to promote equitable distribution in South Africa. Case study commissioned by the Health Systems Knowledge Network.

20. Mugisha F. (2007). The Nairobi Equity Gauge work with parliaments. Case study commissioned by the Health Systems Knowledge Network.

Annex 5: Summaries of commissioned case studies

Brief summaries of case studies commissioned by the Health Systems KN are presented below, organised into:
- country case studies (by country in alphabetical order);
- regional case studies (on transitional and fragile states);
- case studies on the role of civil society in promoting health equity (in Africa and Latin America); and
- case studies on the role of parliamentarians in promoting health equity in Africa.

The full versions of these case studies are available on www.wits.ac.za/chp/, some in both Spanish and English.

COUNTRY CASE STUDIES

Chile

Infante, A. (2007). The post military government reforms to the Chilean Health System. Paper commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health (Infante, 2007).

The Chilean health system has experienced several changes in the last 30 years. During the dictatorship, the role of the state was seen as subsidiary and the regime proceeded with privatisation. The National Health Service withstood some of these changes because of its historical strength and its good performance in terms of health indicators. It managed to maintain a structure with national coverage that gave some access to health care to all the population.

The arrival of democracy in 1990 led to a number of sustained efforts to strengthen the health system and improve equity. Important strategies included:
1. investment in health infrastructure and human resources;
2. strengthening of primary health care as the foundation of the health system, together with the strengthening of referral systems;
3. strengthening of public health policy through the separation in the Ministry of Health of the health provision area and the health policy and regulation area;
4. and, importantly, the promulgation of a law that aims to reduce the equity gap (this law guarantees access, opportunity of care and financial protection for the most prevalent health problems, representing 70% of the disease burden).

China

Meng, Q. (2007). Developing and implementing equity-promoting health care policies in China. Paper commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health (Meng, 2007).

This paper examines disparities in health and health care between rural and urban areas, regions, and population groups, and analyzes recent equity-promoting health policies in China. China has experienced radical socio-economic transitions and changes in its health care system since the late 1970s. Disparities in health and health care have increased over the past two and a half decades, with the rural population, the population in western provinces, and the low-income population suffering heavier disease burdens and utilizing health care services the least. User fees are one of the major barriers to health care in a system based mainly on out-of-pocket payment in the absence of adequate provision of social health insurance and medical assistance.

From the beginning of the 21st century, the Chinese government has adjusted its development policy from "GDP-led" to "people-centred." Health is recognised as a human right and the top Chinese leaders have promised to establish a health care system with universal coverage of essential health care services.   A number of equity-promoting policy interventions have been initiated:
1. establishment of a new rural cooperative medical scheme;

2. operation of medical assistance programs;
3. free provision of selected public health programs;
4. and development of a community health care system.

These policies have to some extent achieved a positive impact on health care utilization and a reduction of the financial burden of diseases for the poor. However, lots of challenges remain to improve the design and implementation of the policies. Enforcement of regulations and strengthening of intersectoral coordination are essential for making the existing equity-promoting health policies more effective.

Mexico

Laurell, A. (2007). Granting universal access to health care: The experience of the Mexico City Government. Paper commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health (Laurell, 2007).

Although the right to health protection is a constitutional right in all of Mexico, it is not clearly stated that the state is obliged to grant it universally to all. This has led to tiering of the health care system with different income groups having access to different services.   By way of contrast, since the election of the Progressive Party in 2000, the Mexico City government sees health care as an entitlement of all citizens that should be granted by the state. It sees any kind of discrimination as unacceptable. This led the Mexico City Government to adopt five main strategies to grant access for the uninsured to all available government health care services that, together with those provided by social security, would achieve universal coverage in the city:

1. the removal of financial barriers to access through the Program of Free Health Services and Drugs;
2. the enlargement and institutional strengthening of health care services based on criteria of health needs;
3. a new health care model with an emphasis on health education, promotion, prevention, early detection and control of chronic diseases;
4. a substantial and sustained increase in the health budget through additional fiscal resources; and
5. the intensification of popular participation and social control over health care services.

This health policy is based on the city government's broader social policy that favours universalism but with an initial territorial targeting on the poor areas of the city and progressive income re-distribution. The reasons for territorial targeting are: using incontrovertible criteria; avoiding individual means-testing to diminish stigma and administrative expenditures; eliminating discretional decisions that facilitate political patronage and; avoiding a division in the community.

The fact that a local government could grant the universal right to health even within a segmented national health care system was facilitated by decentralisation of health services to the federal states and the capacity to mobilize sufficient financial and technical resources to develop and implement an autonomous policy. The policy enjoys growing popular support since citizens have obtained real benefits in their daily life as well as an enhanced sense of 'life security.' The redirection of public resources from the expenditure on privileges of high government officials towards social programmes, and the sustained fight against corruption, have created a new credibility in the government and increased popular support. This progress was achieved through the following political and institutional actions:

Political actions
- Early action taken to tackle government 'luxury spending' by limiting government privileges, and re-allocating funds to social programmes
- Anti-corruption programme a central part of the health sector programme, including facilitating personal access to senior government officials and Ministers in order to lay complaints
- Health minister engages Trade Unions in seeking their support for new policies, which they worry will threaten their existing benefits
- The Party implements new health and social policies and on basis of resulting political support is able to secure legislation underwriting the free health programme

Institutional actions
- Value base of new government clearly signalled by range of actions (e.g. action on luxury spending and corruption, efforts to improve health workplace conditions)

- Social mobilisation around health care encouraged through establishment of structures through which community needs-assessment conducted, and engagement with health system enabled
- Improvements made to physical infrastructure of public facilities and to availability of drugs, in part by tackling corruption in procurement systems, to re-establish conditions of dignity in health workplaces
- Workshops for health staff conducted to discuss human rights and the rights and responsibilities of users and health staff in the context of the reform

South Africa

Chetty, K. (2007). Equity promoting health care policies in South Africa. Paper commissioned by the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health (Chetty, 2007).

Whilst South Africa faces major challenges in addressing inequities, equity is high on the health and social policy agenda and a range of specific policies and programmes have been developed to effect the equity goal. These include re-distributing public sector health care resources between and within provinces, improving access to primary care services and addressing the public/private mix (by making resources currently located in the private sector accessible to a broader section of the population, and/or by redistributing resources from the private to the public sector). Although the public health sector has received greater budgetary protection than other sectors and does have additional financing options open to it, it faces large and growing demands. Improvements in geographic access and the quality of health services have proved difficult to achieve rapidly, despite the policy imperatives, and progress in addressing the inequities in health care financing within and between the public and private sectors has been limited. Fiscal constraints will certainly slow progress towards desired goals.

There are a number of lessons that can be learnt from the South African experience:
1. The constitutional entitlement to health services is important in establishing a clear goal for policy action.
2. Political advocacy for the importance of health equity gains has been critical. One of the key reasons that health strategies have received support from a wide range of politicians is that the health sector was seen by the new government as an area where rapid equity gains could be achieved.
3. A key obstacle is the issue of human resources. Thus, whilst investment in infrastructure is of paramount importance, the capacity to spend and to maintain quality services depends on the quantity and quality of human resources

Finally, the South African experience indicates that good intentions on the part of government and even some good government policies are simply not enough to promote equity. The promotion of equity requires buy-in from a number of stakeholders, to prevent obstacles and challenges arising. In addition, effective policy action also requires the strengthening of health systems, as good policies cannot be implemented without the appropriate vehicle.

Sri Lanka[3]

Perera, M. (2007). Intersectoral Action for Health in Sri Lanka Paper commissioned by the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health (Perera, 2007).

Sri Lanka has proven to be fertile territory for intersectoral action for health. In 1980, the Charter for Health Development was signed by the Prime Minister and the World Health Organization. The Government of Sri Lanka committed to attaining acceptable levels of health for all its citizens by 2000, and embraced primary health care as the key approach. The National Health Development Network, driven by the National Health Council (chaired by the Prime Minister), was established to ensure political commitment to intersectoral action for health. The Council sets government policies regarding health care and mobilization of non-health sectors, coordinates intersectoral action, and encourages participation in health care. Ministers of Health, Agriculture Development and Research, Higher Education, Finance and Planning, Local Government, Housing and Construction, Home Affairs, Labour and Rural Development serve on the Council.

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[3] This summary of Perera (2007) was extracted from Public Health Agency of Canada and Health Systems Knowledge Network (2007).

Decentralization provided a strong impetus for intersectoral action. District Health Councils were established in 1981 to promote intersectoral action and coordination in 24 administrative districts in Sri Lanka. Four key interventions had an impact on equity during these years: investment in human development, through access to education, health services and food supplements; development of health infrastructure; access to essential medicines; and, continued provision of medical supplies and food during periods of armed conflict.

Key developments related to health and equity have included the first poverty elimination program (1989), social marketing for leprosy elimination (1990), the establishment of Divisional Directorates for Health (1992), a population and reproductive health policy (1998), and an intersectoral implementation approach for policy for the aged. A National Commission on Macroeconomics and Health (2002) was established to reinforce national-level commitments to sustainable investment in health, particularly for the poor.

In 2002, a ten-year master plan for health development was initiated. Five strategic objectives were established: to ensure delivery of comprehensive health services to reduce disease burden and promotion; to empower communities toward more active participation in maintaining their health; to strengthen stewardship and management functions of the health system; to improve human resources for health development and management; and, to improve health financing, resource allocation and utilization. Although the plan lacks a specific strategic objective on intersectoral action, it is expected that IA will be explored under the second and third objectives. Plans include enhancing the participation of civil society and non-governmental organisations in promoting behavioural and lifestyle changes. To strengthen health stewardship, enhanced coordination and partnerships with other sectors is envisioned. The Health Sector Development Project, established in 2004, aims to strengthen the health sector's capacity to fulfil this stewardship role.

Sri Lanka's significant improvements in health indicators have stemmed from performance within the health sector itself, as well as major socio-economic developments in education, agriculture and other sectors. Education is now universally accessible and heavily promoted, and there are strong links with the health sector. Government (both national and local), the community, and non-governmental organisations play consistently strong roles in promoting intersectoral action for health and equity.

Strong political leadership and positive intersectoral synergies between health and other sectors appear to be key features of intersectoral action in Sri Lanka. Free education since 1945, leading to high levels of female literacy, have promoted attitudinal changes and created a knowledge base that has weathered periods of economic decline. Nutritional status of poor families, mortality rates, and a host of social services (including water and sanitation systems) have improved dramatically in tandem with the health system.

There are multiple challenges associated with further improvements to health equity and intersectoral action. Conflict in the North East (the 20-Year War) led to a deterioration of health status, infrastructure and human resources in the region. As a nation, the epidemiological transition to non-communicable diseases has taken place, with associated challenges for the quality of health services. While Sri Lanka is currently a low HIV-prevalence country, many of the risk factors are present. Intersectoral responses are included in a draft HIV/AIDS policy.

Thailand

Tangcharoensathien, V., Prakongsai, P., Limwattananon, S., Patcharanarumol, W., and Jongudomsuk, P. (2007). Achieving universal coverage in Thailand: what lessons do we learn? Prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health (Tangcharoensathien *et al.*, 2007).

This paper reviews the policy process of achieving universal coverage of health care in Thailand and critically assesses how the reform achieved the policy objectives of improving equity and efficiency of the health care system with sustainable health care finance.

Several lessons are drawn from this experience:
1. The strength of health care infrastructure and the geographical distribution of well-functioning primary health care services in rural and urban areas served as a strong basis for success in the smooth implementation of the universal coverage policy. The availability of qualified human resources for health at district and provincial health

facilities was also a key factor enabling the health care system to cope with the increasing demand for health care and allowing the provision of essential health care services to the whole population.

2. Thailand was able to deal with the financial implications of universal coverage because it had experienced a long period of internal peace as well as economic growth. The universal coverage scheme made use of appropriate health financing arrangements which fostered better access to health care and effective financial risk protection through a comprehensive benefit package.

3. Relevant knowledge and evidence for policy formulation and implementation, and skills in the estimation of budget requirements, were acquired through the establishment of effective knowledge-management mechanisms and sufficient long-term investment in human resources in health systems research. Strong international linkages enabled Thailand to keep abreast of new developments. Also, the national capacity to coordinate data producers (i.e. the National Statistical Office) and data users (i.e. the Ministry of Public Health), and ability of researchers to communicate with health care reformists and policy-makers, supported the process of translating research into policy and practice , known as the concept of "The triangle that moves the mountain".

4. Government was responsive to the concerns of stakeholders and other influential partners who actively participated in the process of policy formulation and implementation.

In conclusion, evidence indicates that bureaucrat-led reformists played an important bridging role between researchers and policy-makers. While agenda-setting was vested in the political leadership, the systems design and monitoring and evaluation were guided by researchers. Successful policy implementation was based on the health systems capacity. Evidence played a strong foundation of the health sector reform.

USA

Dubowitz, T., Anthony, R., Bird, C., Cohen, D., and Lurie, N. (2007). The experience of the USA: health inequity within a high-income setting. Commissioned by the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health (Dubowitz, Anthony, Bird, Cohen, and Lurie, 2007).

The U.S. boasts one of the most technologically developed health systems in the world, yet disparities in both health and health care associated with race/ethnicity and socioeconomic status are profound. Despite the well-established and strong positive associations of income, wealth, education, and housing conditions with health, there exist few social policies with the specific aim of improving health and reducing health disparities in the U.S. Most of the national efforts directed toward health disparities have been focused on forming organisational infrastructures for coordination and oversight of activities designed to address health disparities across a broad range of issues (such as housing choice vouchers, tax credits for low-income families and food stamps). Policies emanating from the health sector itself have almost entirely centred on health insurance coverage, specifically programs of Medicaid and Medicare.

In reviewing these policies, the paper concludes that it is important to:
1. increase resources devoted towards collecting and using national data to appropriately understand and identify high risk populations and their social and physical environment;
2. increase efforts to understand health care and social services, the residential environments of the patients as well as the environment of the providers/services in order to bridge gaps between structural determinants (availability and accessibility to services), individual determinants (cultural, individual preference), use of services and health outcome;
3. improve the physical and socioeconomic environment;
4. formally encourage the integration of policies, including social, land development and transportation, environmental, public health and educational policy;
5. design and implement demonstration projects in defined areas and among defined populations specifically addressed at issues around health disparities in order to better understand policies that work and their overall impacts; and
6. increase efforts toward monitoring and evaluation on a more regional level (i.e. states) to better gauge who benefits from different initiatives.

<u>REGIONAL CASE STUDIES</u>

Health sector reform and equity in transition

Balabanova, D. (2007). Health sector reform and equity in transition. Prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health (Balabanova, 2007).

Transitional states are those that, prior to 1989, formed part of central and Eastern Europe and the former Soviet Union, and shared considerable similarities in health systems based on a common ideology. Prior to transition, the health care systems of these countries were based on public financing, ownership and delivery of care. Access to care was free at the point of use for the whole population with limited private contributions (mainly for pharmaceuticals and supplies). This 'Semashko' model – named after an influential Soviet policy-maker – had a number of advantages, achieving good access and affordability as well as a high degree of equity: this was the outcome of a society with low levels of social polarisation and governments that assumed a strongly redistributive function. However, even during the communist era access to good quality care began to deteriorate, mainly due to resource constraints and structural problems, while inequities began to widen. Political, military and intellectual elites had privileged access to superior facilities at the expense of ethnic minorities (such as the Roma) and other marginalized populations (such as the disabled or poorly educated), and informal payments began to creep into the system.

The fall of communism led to fundamental political, economic and social change across the region, including market liberalization and privatization as well as, in some cases, ethnic conflict and political unrest. Income differentials grew rapidly and vulnerability and marginalisation increased. Public health systems deteriorated and suffered from poor governance and loss of effective stewardship.

Within this overall context, health system reform trajectories have differed dramatically in the region, exposing considerable diversity between countries. This paper discusses the various types of financing reform, as well as initiatives to reduce informal payments and promote primary health care. Lessons from this experience are:

- Transitional countries provide a scenario where extensive infrastructure and the presence of trained staff and beds is insufficient in itself to guarantee access to care for all, pointing to the importance of putting well-functioning systems in place and improving efficiency.
- The poorer areas of the region offer examples of seeking to promote universal coverage and build delivery systems, starting from low levels of resource (e.g. community financing in the Caucasus). The example of Armenia illustrates the complexity of scaling up locally successful donor-funded schemes, and integrating them with national financing and delivery health systems.
- Social insurance is costlier to operate than tax-based systems, and relies on significant in-country capacity. It may also have some unexpected negative consequences for equity.
- Policy transfer in the region has had a tendency to transfer whole packages of reform, without taking into account local context or capacity.
- Reform should include a pro-poor monitoring from the start.

Promoting health equity in conflict-affected fragile states

Ranson, K., Poletti, T., Bornemisza, O., and Sondorp, E. (2007). Promoting Health Equity in Conflict-affected Fragile States. Prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health (Ranson, Poletti, Bornemisza, and Sondorp, 2007).

Fragile states have governments that cannot or will not deliver core functions to the majority of its people. They lack the capacity to manage public resources, deliver basic services and are unable to protect and support poor and vulnerable groups. There are 46 fragile states, and of these 23 are conflict-affected.

The literature recognizes that fragile states are significantly worse off than non-fragile states in terms of key health – and social determinant of health – indicators. Amongst fragile states, those affected by conflict are significantly worse off. Within conflict-affected states, some sub-populations experience worse inequity, for example: people

discriminated against in the course of conflict, such as women and children; people displaced from their homes because of conflict, including refugees and internally displaced persons; and people living in areas that experience worse conflict.

Health inequity resulting from differential exposure, vulnerability and consequences of ill-health increases under conflict because: there is little political commitment to the concept of equity, especially where marginalized populations are the target of violence; the destruction of institutions leads to reduced capacity for policy-making, planning and implementation (including the flood of frontline health workers out of the system and most especially from rural areas); there is widespread destruction of infrastructure, resulting in the reduced availability of potable water and sanitation systems (leading to disease outbreaks) and decreased geographic access (this is aggravated by deteriorating security); the economy collapses, impacting on food security and livelihoods and leading to a collapse of the financial protection function of the health system, charging of user fees by health care services and reduced financial access; there is predatory behaviour by combatants (this is often targeted especially at women, in the form of assault and rape; however, men experience more violence due to fighting); and there is transmission of disease through migration and over-crowding.

To a large extent, conflict and state fragility must be addressed before other interventions can be effective. However, there are ways to promote health equity despite ongoing instability. In fact, improved and impartial service delivery may even reduce conflict and contribute to increased stability, especially where conflict has resulted from marginalization of certain groups. The post-conflict period in particular may represent a unique opportunity for setting up effective health systems that create conditions in which it becomes significantly easier to address health inequities, and through which confidence in government can be restored and the social contract re-created.

If service delivery strategies are to be equity-promoting they need to be highly context-specific and, in the main, differentiated between situations with high levels of persisting conflict and post-conflict settings. Strategies need to focus on three elements: strengthening pro-equity policy and planning functions; building provider capacity to provide health services; and reducing access and participation barriers for excluded groups.

CASE STUDIES ON CIVIL SOCIETY'S ROLE IN PROMOTING HEALTH EQUITY

Africa

Civil society promotion of equity and the social determinants of health through involvement in the governance of health systems: the case of the Community Working Group on Health in Zimbabwe

Rusike, I. (2007). Civil society promotion of equity and the social determinants of health through involvement in the governance of health systems: the case of the Community Working Group on Health in Zimbabwe. A case study commissioned by the Health Systems Knowledge Network of the WHO Commission on Social Determinants of Health (Rusike, 2007).

In 1998, a network of membership-based civic organisations was formed in Zimbabwe that focused on advocacy, action and networking around health issues, called the Community Working Group on Health (CWGH). The story of the CWGH is one of increasing and widening confidence within civil society of the right to act and the issues on which to act. This has begun to generate some tangible health gains for communities in a situation of economic decline and a general decline in health.

Amongst CWGH's actions have been lobbying campaigns (around levels of government expenditure on health care, gender issues and the quality of health services), revitalization of health centre committees, motivating for the re-instatement of the village health worker concept, and calculation of a 'health basket' which made visible the costs of maintaining health for Zimbabwean households.

The CWGH builds on the lessons learned from the exceptional health gains based on primary health care and community mobilization in Zimbabwe in the 1980s. Given the erosion of those gains in the 1990s, it adds the new

understanding that these gains are not a privilege but a right, one that demands active community organisation, advocacy and control within health systems.

The case study of a community based organisation (CBO) at a Black informal settlement area, South Africa

Mbombo, N., and Marmorato, S. (2007). Building and maintaining the capacity, representativeness, legitimacy, diversity and voice of civil society in order to allow for authentic, bottom up, effective and informed engagement: The case study of a community based organisation (CBO) at a Black informal settlement area, South Africa: Case study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health (Mbombo and Marmorato, 2007).

This case study reports on progress made by a group of volunteer women who subsequently formed a formal community-based organisation that is mainly active in Cape Town but also has activities in the other provinces of South Africa (through, for example, the orphan care project).

In Cape Town, the women advocated for, and successfully achieved, their own clinic which was staffed by themselves as peer educators and HIV/AIDS counselors, as well as a professional nurse and a medical doctor who would look at the medical/ nursing aspect in the management of sexually transmitted infections and common AIDS-opportunistic infections. Previously, the community used to travel quite a distance to the local municipality clinics. Because of the long waiting hours, the housing projects in which they were involved had been stalled. Now, their clinic is no longer benefiting the members of the organisation, but all women and children residing in their community.

The case study shows that the CBO was able to build and maintain its identity with low-income women as representatives of the organisation. In addition, civil society was able to build an equitable health system to address the needs of women and children.

The Health Civil Society Network in East and Southern Africa

Musuka, G. (2007). Civil society participation in programme implementation for the intersectoral action on health equity and intersectoral action for health: a case study of the Health Civil Society Network in East and Southern Africa.: A case study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health (Musuka, 2007).

The Health Civil Society Network is a coalition of seventeen organisations operating in the southern and east African region that are united around the common objective of advancing an agenda and action for people's health, equity and justice. Despite being a relatively young organisation, the network's achievements - in terms of knowledge dissemination and lobbying - provide evidence of impact around its five main strategic areas of collaboration, namely: revitalizing and building National People's Health Systems; organizing People's Power for Health; ensuring adequate and fair financing of national health systems; ensuring our health systems have adequate, available and motivated health workers; and challenging trade liberalization and encroachment on health.

Challenges facing the network include developing appropriate mechanisms for information exchange and communication, ensuring accountability and achieving adequate feedback between members of the steering committee and those assigned particular roles on specific areas of work.

Latin America[4]

Chile

Nazarit, P. S. (2007). The contribution made by women's and feminist movements to equity in health: the Chilean experience. A case study commissioned by the Health Systems Knowledge Network of the WHO Commission on Social Determinants of Health (Nazarit, 2007).

This case study provides an overview, from the final years of the military dictatorship in the late 1980s to the present, of the action by Chilean women's and feminist movements on behalf of health. During the years of the military dictatorship, the women's movement was noteworthy for its capacity to resist repression and poverty, as well as for putting forward gender-specific demands denouncing the violence and discrimination practised by the military regime against women. With the transition to democracy, thematic networks grouped civil society organisations and individuals around issues such as sexual health and reproductive rights as well as gender violence. These networks based their political and technical action on the knowledge and experience that had already been gained, as well as a belief in health as a human right and the importance of comprehensive care.

Noteworthy milestones and strategies include:
1. A National Convention on Women's Health intended to produce a diagnosis of, and proposals for, women's health using a participatory approach, which highlighted the importance of quality care, led subsequently to the convening of four women's health 'parliaments' with the support of PAHO, and resulted in transformation of the Ministry of Health's traditional Maternal and Perinatal Health Programme into a Women's Health Programme.
2. Interventions by the Open Health and Reproductive Rights Forum to halt unethical experimental research into sterilisation of women with quinacrine, a drug with potential carcinogenic risks.
3. Actions to establish sexual and reproductive health rights, including the drafting of a legal framework (which has not yet been adopted) as well as the publication of national standards on the regulation of fertility.
4. Actions by the Chilean Network against Domestic and Sexual Violence that contributed to the promulgation of a new law on domestic violence.
5. Campaigning for the provision of emergency contraception which is now available in some primary health care facilities.
6. Campaigns aimed at disseminating information amongst women and developing gender-sensitive proposals to influence the health reforms of government,

There is no doubt that two decades of mobilisation by this sector of civil society has had an impact in terms of gaining recognition for women's rights in the sphere of health and brought about changes in attitude both within Chilean society and its institutions. This has been achieved despite cultural constraints and the distortion of some policy proposals as they pass through the policy process. However, the strength of conservative groupings, the disorganisation of the women's movement, the lack of alliances with other social sectors (including organisations of health workers), and a shortage of resources all pose challenges. Currently there is debate over political strategies: should the women's movement work independently of other institutions or should it influence public policy from within universities and NGOs or via direct participation in the state?

Cuba

Ochoa, F., and Visbal, L. (2007). Civil society and the health system in Cuba. Paper commissioned by the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health (Ochoa and Visbal, 2007)

Cuba is known for its achievements in improving health indicators despite adverse economic conditions. This paper looks at the contribution of Cuban civil society to health improvement and the relationship between civil society and the state.

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[4] These case studies were written in Spanish and subsequently translated into English.

The paper characterises the ties between civil society and the health sector as harmoniously integrated and cooperative. Apart from the involvement of the population in epidemic control programmes, the Federation of Cuban Women has been influential in developing programmes on sex education, family planning and reproductive health. This example shows how a civil society group gave rise to an initiative that led to a national health programme involving government Ministries as well as members of civil society. Another example is committees made up of government officials and civil society members to respond to natural disasters. Lastly, regular assemblies are held at the municipal level during which members of the public engage with elected representatives and discuss and propose answers to health problems.

Guatemala

Peren, H. I. Revival of Maya medicine and impact for its social and political recognition (in Guatemala). Paper commissioned by the Health Systems Knowledge Network of The World Health Organization's Commission on the Social Determinants of Health (Peren, 2007)

This paper reports on the experience gained from two interactive studies with six ethnic groups representative of the Mayan people who make up more than half the Guatemalan population. These formed part of efforts to restore and advance indigenous Mayan medicine and to promote a health system with inter-cultural relevance. At present, the official health system in Guatemala is rooted in Western medicine and tends to exclude alternative systems of healing.

The studies revealed an organised system of Mayan physicians whose general or specialised functions respond to a differentiated epidemiological profile. Their knowledge base has its foundations in the Mayan people's world view. The Mayan health system has social application in the dimensions of prevention, promotion and care, and it is well-accepted by the community because it is effective.

Advocacy work based on these studies has made it possible to incorporate the theme of Mayan medicine in the programmes of the Guatemalan Association of Community Health Services. It has also led to the creation in the Ministry of Health of a national traditional and alternative medicine programme and an education programme for health centres and posts. The subject of Mayan medicine has also been incorporated in the curricula of nurse training schools and undergraduate and postgraduate public health programmes at the San Carlos de Guatemala University.

Mexico

Cuevas, J. H. (2007). Health and autonomy: the case of Chiapas (in Mexico). Paper commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health (Cuevas, 2007).

Chiapas is the Mexican state with the highest poverty and marginalisation figures, particularly in those administrative areas with the highest indigenous Indian populations. It was from these areas that various social movements developed in the 1970s and 1980s in response to harsh social conditions. In 1994 the Zapatista movement took up arms, subsequently declaring its decision to develop autonomous government in the areas it controlled.

The Zapatista Autonomous Health System is part of this project, and is based on the principles of health as a human right and a strong emphasis on quality and responsiveness. The health system is founded on preventive and curative care delivered through the primary care level at no charge (although a shortage of resources means that patients have to pay for medicines), with patients being referred to the national health system for higher-level care. Other interaction with the national health system includes access to vaccines and co-ordinated action on epidemics. Communities are involved in the appointment of staff and civil society, including NGOs and universities, are involved in the development and monitoring of the system. Zapatista facilities have been able to extend the coverage of facilities and there is some evidence of impact on health indicators, such as maternal mortality. A challenge facing the health system is its failure to develop itself on the basis of traditional health practices which historically were a key element in the survival of the community.

CASE STUDIES ON THE ROLE OF PARLIAMENTARIANS IN PROMOTING HEALTH EQUITY

Kenya

Mugisha, F. (2007). The Nairobi Gauge work with parliaments. A case study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health (Mugisha, 2007).

The Nairobi Equity Gauge is a partnership between the African Population and Health Research Center, the National Coordinating Agency for Population and Development and the City Council of Nairobi. The mandates of the three institutions are, respectively, to conduct high quality policy relevant research in population and health, to provide leadership in defining and streamlining the role of population in Kenya's development, and to provide services and facilitate the provision of such services to the Nairobi population.

Each of the institutions was charged with a specific pillar to which they had a comparative advantage to contribute. The policy advocacy pillar focused on the role of parliamentarians in responding to the growing inequities in family planning and reproductive health in Kenya. The community empowerment pillar focused on two slum communities where a demographic surveillance system improves understanding of the background forces that support and undermine equity. The assessment and monitoring pillar focused on generating scientific evidence from a combination of national representative surveys and the demographic surveillance system.

The partnership works relatively well and no major problems were encountered. However, the process is very time consuming and sometimes without clear outputs. Several lessons were learnt in the process. First, identify common interests that cut across different stakeholders. In this case, all stakeholders were keen to re-position family planning and reproductive health. Second, identify influential people amongst the actors you intend to target. In this case, key people through whom the Gauge could interact with members of parliament were Assistant Clerks in Parliament and Personal Assistants. Third, be prepared to assemble the necessary evidence quickly in order to allow deliberation on the issues at hand.

South Africa

Health Systems Trust. (2007). Manner in which parliamentarians have been able to use the budget process to make visible inequalities in health and to promote equitable distribution in South Africa. A case study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health (Health Systems Trust, 2007).

Over a period of years the Health Systems Trust worked with the South African National Assembly. The intention was to support Parliamentary budget analysis with a view to strengthening approaches to providing more equitable access to heath care services. This case study reflects on that project and its impact.

Systems of proportional representation would seem to limit democracy given the foregrounding of party as opposed to constituency relationships that they potentially foster. For example in South Africa parliamentary hearings were limited by the lack of grass roots engagement. Thus, health systems would do well to put in place structures that enable bottom-up processes to interact with parliamentary processes. Appropriate levels of financial support to Parliaments, although not sufficient are certainly a necessary prerequisite for enabling community engagement to take place in a meaningful way.

Time restraints and multiple demands on parliamentarians also limit their ability to undertake policy analysis and to motivate for and support policy shifts. Structured mechanisms to enable committees to draw upon appropriate technical support are essential if Committees are to intervene effectively. Committee clerks play a critical role in the functioning of committees and also in continuity. They can potentially assist and guide committees in accessing technical support that will be of high quality and real assistance to their work.

If Parliaments are to fulfil their function as representatives of the people they need to be well informed and equipped with compelling facts and arguments. The need to build the capacity of Parliamentarians and especially of those participating in relatively new structures, as was the case in South Africa, is easily overlooked. In the experience of this project, Parliamentarians needed support to understand and analyse equity issues and to identify possible useful

policy trajectories, as well as to interrogate plans and reports from the Executive. This project utilised a range of interventions designed to strengthen the Health Committee. The combination of first hand experience, through site visits, supplemented with ongoing and accessible technical support is a minimum if Health Committees are to be effective role players in moving beyond rhetoric to make a real impact on inequitable health care provision.

Southern and Eastern Africa

Chebundo, B. (2007). The way parliamentary committees on health have overcome obstacles in creating sustained and co-ordinated pressures for health through regional networking in Southern and Eastern Africa.: A case study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health (Chebundo, 2007a).

This paper provides insights into the way parliament and parliamentarians in Southern and East Africa are working to create opportunities and overcome challenges to maintain and coordinate collective activities on good health policies and practices for the people. The case study highlights the effectiveness of the networking by Parliamentary Committees on Health at both the national and regional level, and demonstrates how this helps to remove obstacles and facilitates continuous pressure on authorities for sustainable health policies. In particular, networking at a regional level is one of the checks and balances on governance and health. The study also shows that parliamentary networking cannot be successful on its own: parliamentarians need to collaborate with civil society and health professionals for technical and other inputs.

Lessons for other countries include: to be effective and to avoid activities remaining very much ad hoc, regional parliamentary networks need to have a permanent secretariat; a particular emphasis in regional networks must be placed on influencing and creating clearly-defined budget processes for health; and networks for parliamentary committees and civil society organisations should work towards the development of resources allocation formulae that could be agreed to, with the Ministry of Health, and used consistently to address equity in health.

Zimbabwe

Chebundo, B. (2007). The Zimbabwe re-engineered budget process and the impact if its all-stakeholder inclusiveness approach, and how the involvement of EQUINET and other stakeholders contributes towards achieving equitable distribution of health resources. A case study commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health .(Chebundo, 2007b)

In response to the growing demands for better governance, the fifth Parliament of Zimbabwe, beginning in 2000, saw the implementation of parliamentary reforms that changed the course of parliamentary processes in its legislative functions, oversight over executive programs and policy implementation, representational approaches and budgetary process. With respect to the country's re-engineered budget process, a number of positive lessons have been drawn:

- parliamentary links and dialogue with civil society is a key factor in strengthening the budget work of Parliament, through utilization of the wealth of information available amongst civil society organisations ("equity needs are easily recognized when working with those who are constantly in touch with the ordinary people");
- Parliament and the Ministry of Health benefit from research provided by stakeholders on the impact of the budget on the general populace so that they understand what are public priorities;
- government tries as much as possible to remain within its health budget tracks when they are aware that their expenditures will be scrutinized by the public.

In conclusion, the re-engineered budget process has enabled the Health Committee of the Parliament of Zimbabwe, through the involvement of civil society and professional bodies, to be more focused on a needs-based approach, rather than the previous incremental approach. The process can however be strengthened by increasing the capacity of parliamentarians to appreciate equity principles in budget processes. Time and resource constraints need to be alleviated to ensure a thorough and undisrupted process.

Annex 6:   Selected case studies from the literature

Bangladesh

Experience of SWAp in Bangladesh
A SWAp approach was introduced with the 1998 Health and Population Sector Program (HPSP) in Bangladesh. The HPSP was developed in consultation with key donors active in the health sector in Bangladesh, and the SWAp was formalised through a Memorandum of Understanding.

Key achievements relating to the SWAp include:
- Government 'ownership' increased under the SWAp, with the HPSP strategy explicitly noting that with the move to a SWAp, greater responsibility was placed on government for strategic planning budgeting and monitoring.
- The SWAp was seen as important in promoting key institutional reforms, particularly the restructuring of directorates in the Ministry of Health and Family Welfare.
- The SWAp improved coordination across donors and reduced duplicative activities and projects. While not all donors participate in pooled funding arrangements, the majority have agreed to work within framework of the HPSP.

However, the SWAp has not removed the potential for conflict between the government and donors on key policy decisions. For example, in 2003 the Ministry of Health took a policy decision (not to pursue the integration of family planning with other health services) without consulting its donor partners. This dramatically comprised donor trust in government, with some donors partially suspending their contributions to the health pooled fund as a result. This funding was only restored when the government presented a comprehensive plan for implementing reforms agreed in the HPSP. Despite the quite interventionist approach of some donors, many of the donor partners indicated that their priority was to continue to support the SWAp and work closely with the government. This incident highlights the need to develop strong working relationships between SWAp partners, and to reach a common understanding of what concepts such as 'government ownership' mean.

Sources: Extracted from McIntyre 2006 who used (Sundewall, Forsberg, and Tomson, 2006; Sundewall and Sahlin-Andersson, 2006; Walford, 1998)

Brazil

'In the 1980s, following two decades of military dictatorship, Brazil entered the drawn-out process of its return to democracy, culminating in the proclamation of the 1988 Federal Constitution. Of crucial historical importance, the new Constitution enshrines unprecedented individual and collective rights, particularly the universal right to health and the duty of the State to assure that right by means of a new institution – the Unified National Health System (SUS - Sistema Único de Saúde) - to be set up on the basis of the principles of universality, equity, decentralization, and participation. With implementation of the SUS from 1990 onwards, the former unjust, chaotic health care system began to undergo a radical transformation through an extremely difficult process which has entailed combining or reconciling very diverse dimensions: the high complexity inherent to medical and health care; the vast organizational and techno-scientific structure they involve; the considerable population to be served; the continental proportions of Brazil's territory; the political and administrative organization of the Brazilian Federation, comprising the Union, 27 states, 5,561 municipalities, and the Federal District; and, no less important, the nation's relatively slow economic development, combined with the enormous regional inequalities and serious social inequities that plague Brazil. The Constitution also provided for indirect and direct forms of citizen participation in the nation's destinies. The former include elections of representatives, while the latter comprise particularly citizen participation in social policymaking. This development opened up ample opportunities for representation of civil society organizations in the formal decision-making arenas of the Executive, starting with the Health Councils (Conselhos de Saúde), which are deliberative institutional bodies that form an integral part of the Nation Health System's political and institutional design. At present, the Health Councils – of which there are some 6,000 throughout the country and whose activities involve more than 100,000 volunteer citizens – have two central features: (a) parity representation shared between user organizations, on the one hand, and health sector authorities, service providers, and workers, on the other and, (b) their prime object is to exercise social oversight of public decisions in the health sector, meaning that they are to

intervene in the formulation and implementation of policies and programs, participate in budgeting, and monitor financial execution.

Throughout the vast movement for the return to democracy and for the right to health, civil society was always present on all fronts. It also played a decisive role in the creation and implementation of the SUS and continues to do so in that the institutionalization of participation has yielded a series of virtuous effects on politicization of the health field, advocacy of the principles of the SUS, increasing formal association-building, accumulation of social capital, and greater institutional accountability, all of which adds substantial value to democracy.'

Source: Extracted from Labra and Giovanela (2007)

Costa Rica

The impact of primary care reform in Costa Rica
'The Costa Rican primary care reforms … were instituted first in the most socially deprived areas … These reforms included transferring the responsibility for providing health care from the Ministry of Health to the Costa Rican Social Security Fund, expanding the number of primary care facilities … and re-organising primary care into "integrated primary care teams" … which consist of teams of health professionals assigned to a geographic region … By 1985, Costa Rica's life expectancy reached 74 years, and infant mortality rates fell from 60 per 1,000 live births in 1970 to 19 per 1,000 live births, levels comparable to those in more developed countries. The improvements in primary health care were estimated to have reduced infant mortality by between 40 percent and 75 percent, depending on the particular study …'

Source: Starfield, Shi, and Macinko (2005:472)

Mandatory insurance in Costa Rica
Costa Rica is regarded as one of the health sector success stories in that it has achieved remarkable health status indicators despite its relatively low level of economic development. It is a middle-income country, with a per capita GDP of less than PPP US$10,000 in 2003, an infant morality rate of 8 per 1,000 live births and an average life expectancy at birth of over 78 years. Its success is attributed to a range of factors, including an extensive rural primary health care program (that preceded Alma Ata), strong government commitment to funding of social services (health care, social security and a compulsory, free education system) and relatively low levels of income inequality. The tax-funded rural PHC program included the building and staffing of 218 health centres and deployment of auxiliary health workers with six months of training, who regularly visit each household in their area to vaccinate children, monitor the growth and nutritional status of children, provide health education, undertake malaria and TB surveillance and refer household members for treatment of acute and chronic illness.

Costa Rica has achieved near universal coverage through a combination of mandatory health insurance and tax funding. Mandatory insurance was first introduced in late 1941, when the Caja Costarricense de Seguro Social (CCSS) was established. It initially only covered sickness and maternity care for low-income workers living in the national and provincial capitals. Coverage was gradually extended to workers in rural areas and the income threshold for membership was raised. By 1961, 18% of the population was covered by CCSS. In 1961, legislation was introduced to make membership of CCSS compulsory for all, with the intention that universal coverage would be achieved within 10 years. Progress to universal coverage was slower than anticipated with 45% of the population covered by 1971, 75% by 1981 and 90% at present. The ownership of all health facilities was transferred to CCSS in the mid-1970s.

For formal sector workers, the total contribution is equivalent to 15% of their salary, with the employer contributing 9.25%, the employee contributing 5.5% and government making a 0.25% contribution. The government pays the full CCSS contribution on behalf of the poor, handicapped and elderly from general tax funds. In addition, the CCSS receives revenue from the national lottery and from 'sin taxes' (indirect taxes on cigarettes). Thus, almost all Costa Ricans are covered under a single mandatory insurance system, with revenue being obtained both from payroll contributions and substantial tax revenue contributions. Although there are no empirical data available on the relative progressivity of overall health care funding in Costa Rica, the lack of a maximum cap on payroll contributions, inability to 'opt out' of CCSS, and the full tax funding for vulnerable groups through a unitary funding system suggests strong

progressivity (wealthy to poor cross-subsidy) in the Costa Rican health system. In addition, risk pooling (healthy to ill cross-subsidy) is maximised and, very importantly, all Costa Ricans use the same health facilities and receive the same package of services (although the very wealthy have recently begun to use the services of the growing private sector for general and specialist practitioner ambulatory services). The poor benefit disproportionately from public sector expenditure with 28% of the benefit from public health care expenditure accruing to the poorest 20% of households and only 11% to the richest 20%.

Source: Extracted from McIntyre (2006) who drew on Birdsall and Hecht (1995), Carrin and James (2004), Casas and Vargas (1980), McGuire (2001) and Morgan (1987)

Cuba

Primary health care in Cuba
'Health is considered as the principal component for the quality of life and the strategic aim in the development of the society. The health system in Cuba is based in the sense of the value as a human right and the appropriation of the community. The pillars of the system are: multi-sectoral approach …; multidisciplinary approach; participation of the population. This system shows success in access of care and in health outcomes. The infant mortality rate, life expectancy, and other health indicators in Cuba match those in the world's richest countries. A study shows that while secondary and tertiary care suffered in the early years of the crisis because of interruptions in access to medical technologies, primary care services expanded everywhere, resulting in improved health outcomes. Cuba's people reported equal access to health care services or resources and were particularly happy with their primary care services. These findings are consistent with official health care statistics.'

Source: Summarised by De Maeseneer *et al.* (2007)

Ghana

Mandatory health insurance as the basis for universal coverage – the case of Ghana
While a growing number of African countries are considering or are in the early phases of introducing mandatory health insurance, the Ghanaian government has made the boldest moves in this direction of any African country to date. The government has made an explicit commitment to achieving universal coverage under the National Health Insurance (NHI), but recognises that coverage will have to be gradually extended and the aim is to achieve enrolment levels of about 60% of residents in Ghana within 10 years of starting mandatory health insurance. There are two very important aspects of the NHI design that make the commitment to universal NHI coverage more than just 'political speak'. Firstly, unlike other countries which have focused only on formal sector workers initially, the Ghana NHI explicitly includes both those in the formal and informal sectors from the outset. Secondly, although there are different sources of funding for the formal and informal sectors, they will belong to one, unified scheme.
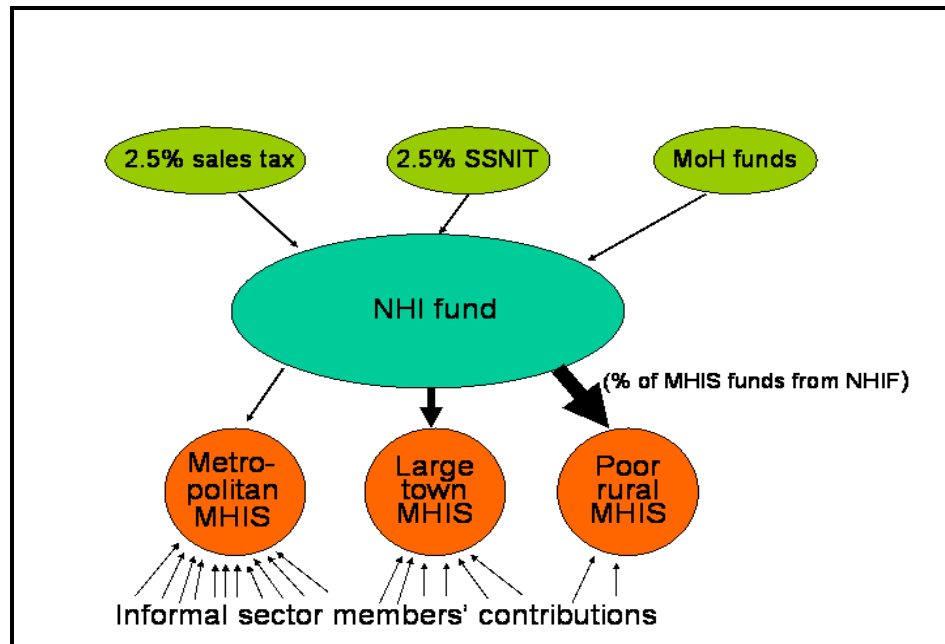
The basis of the NHI system will be district-wide 'Mutual Health Insurance Schemes' (MHIS) – a form of CBHI – in each district. The NHI Act, introduced in 2003, requires every Ghanaian citizen to join either a district-wide MHIS or a private mutual or commercial insurance scheme. However, government subsidies will only be provided to district-wide MHIS, thus creating a strong incentive for people not to 'opt-out' of the integrated NHI system by purchasing coverage through private insurance organisations. Those employed in the formal sector will be covered through payroll-deducted contributions to the Social Security and National Insurance Trust (SSNIT) Fund. Those outside the formal sector are expected to make direct contributions to their district MHIS, which are set at approximately $8 per adult per annum for the poor, $20 per annum for middle-income groups and $53 per annum for high-income groups. Each adult in a household is expected to become a MHIS member in their own right and pay the necessary contribution, which will cover themselves and dependent children under the age of 18. The National Health Insurance Fund (NHIF) will fully subsidise the contributions of the indigent.

The NHIF will be funded mainly by a NHI levy of 2.5% sales tax on almost all goods and services, a 2.5% payroll deduction for formal sector employees as part of their contribution to the SSNIT Fund and government allocations (including both general tax revenue and donor funding). The NHIF will allocate funds to each district MHIS in order to transfer the contributions of formal sector workers secured from the SSNIT payroll contributions, partially subsidise

contributions for low-income households, fully subsidise contributions for the indigent and serve a risk equalisation and reinsurance function. The figure below illustrates how the flow of funds within the NHI would function. It highlights that it is likely that a relatively high proportion of funds for MHIS in poor rural areas will be attributable to the NHIF given that most of their members would require partially or fully subsidised membership.

A factor that will facilitate the implementation of the NHI is that it builds on the well-established tradition of CBHI schemes in Ghana. There are several hundred of these schemes in Ghana, which has ensured that many Ghanaians are familiar with health insurance principles and the operation of MHIS. However, the district-wide MHIS have a different benefit package and contribution structure to the previous community level schemes and there have been concerns within the older MHIS about these changes and about their future role.

Another facilitatory factor is that there is considerable government and donor support to promote successful implementation of the NHI. The NHI was announced as an election promise and it is a promise that the government is committed to fulfilling. While many donors were initially concerned about the feasibility of such a major and ambitious health care financing restructuring initiative, they have now also committed themselves to providing all possible support for its implementation.

Source: McIntyre, Gilson, and Mutyambizi (2005a, 2005b)

Source: Extracted from McIntyre *et al.* (2005b) who drew on Atim, Grey, and Apoya (2002), Government of Ghana (2003), McIntyre *et al.* (2005a), Ministerial Task Team (2002) and National Health Insurance Secretariat (2004)

Niger

Primary care successes in Niger
'Magnani *et al.* (1996) show, using data from a national survey in Niger, that children living in villages near to health dispensaries were 32 percent less likely to die than children without access to modern primary care services (differential access was due to the phased implementation of services which represented a natural quasi-experiment). The use of multi-variate and other analyses suggest that these results were not due to the location of dispensaries in villages that were predisposed to lower mortality. Magnani *et al.* (1996:574) conclude that 'packages of basic primary

health care services can be effectively mounted at the national level so as to have a significant impact on infant-child mortality over a fairly short period of time.,.' but acknowledge that the impact of services may have been exaggerated by the high initial level of mortality, as well as the occurrence of famine and a severe measles outbreak during the study period. However, these sorts of conditions are not uncommon in many developing countries.'

Source: Summarised by Doherty and Govender (2004:11)

Liberia and Zaire

Primary care successes in Liberia and Zaire
'Ewbank (1993:S64,S71) states that the results of surveys in Zaire and Liberia 'suggest that child survival programmes in Africa can reduce mortality substantially in populations living in different environments at very different initial levels of child mortality … In both countries, it appears that the programme reduced mortality under age 5 by about 20% or more.' The author assesses these findings as robust because of their constancy under differing circumstances, as well as their consistency with other studies. In addition, this study improved on earlier surveys because it examined a longer follow-up period, assessed routine rather than special programmes, and was not limited simply to immunization activities (including, as it does, oral rehydration services and treatment with anti-malarial drugs).'

Source: Summarised by Doherty and Govender (2004:12)

Nepal

The Nepal Safe Motherhood Programme (NSMP)
The Nepalese government's safe motherhood programme was launched in 1997. The project goal was to contribute to mortality reduction by generating sustained increases in the utilisation of quality midwifery and obstetric services through action to support policy and programme development, strengthen the provision of good quality services and address the social context for and access to midwifery and obstetric services within NSMP supported districts. No data are available on project impacts, but some data are available on utilisation and quality of care improvements. Although overall coverage remains low, national data show that the proportion of deliveries attend by health care providers had increased from 7.4% in 1991, to 10.8% in 2001 and, using routine health information system data (HMIS), to 16.1% in 2002/3. Moreover, in the project districts the average annual increase in met need for emergency obstetric care was 1.3% for phase 1 districts over 7 years, and 1.2% for phase 2 districts over 4 years, although the proportion of all births occurring in a facility remained well below the UN recommended level of 15%. At the same time, national HMIS data show an increase in deliveries at home attended by health workers rising from 4.3% in 2001/2 to 5.7% in 2002/3 nationally. Assessment of the project's impact on quality of care also shows improvements over time in structure and process including, specifically, in staff confidence and motivation. Overall, however, project evaluations also report continuing implementation challenges and constraints associated particularly with the broader weaknesses of the health system, prevailing power structures within communities and the broader context of conflict within the country.

Yet despite these challenges, the NSMP applied innovative approaches in its efforts to strengthen maternal care, which offer particularly important insights for equity-promoting health system strengthening efforts. The change process applied within NSMP and its current challenges are summarised below and then discussed in more detail.

NSMP activities were founded on recognition of the diverse social barriers to health care access and differences in these barriers between areas of the country. Working within a newly decentralised system (the Local Self-Governance Act of 1999 devolved decision-making power to district development committees, municipalities and village development committees), the NSMP sought to address barriers within the community by adopting a district partnership approach, involving work with local structures and: social mobilisation efforts to strengthen community awareness around safe motherhood practices; the development of community based emergency funds and transport schemes to offset the financial and transport barriers to accessing care; efforts to reduce the social and cultural distance that included staff training activities to strengthen their confidence and motivation so that they would offer better treatment to patients; and district level advocacy to build political and institutional support within districts.

The parallel actions taken to strengthen quality of care combined a range of hardware and software interventions, to strengthen equipment and infrastructure as well as staff skills, behaviours and motivation levels, and those of hospital managers. Together the synergies resulting from this combination are judged to have been particularly important in supporting quality-of-care improvements; for example allowing effective use of newly acquired skills by ensuring supplies and equipment, as well as enhancing provider confidence and motivation.

In the initial phase of implementation, intensive support for an iterative learning and quality improvement process was provided by NMSP human resource development officers, but in phase two these officers then worked with and through locally identified change agents (a staff member expected to lead change from within the facility). The quality of care improvement process also applied two specific capacity strengthening approaches. First, an adapted version of the COPE tool (client-oriented provider efficiency) was used to initiate and support quality of care change. Second, the Appreciative Inquiry approach to generating change was used within a training programme called Foundations for Change (FFC), with participants from hospitals, district stakeholders and village development committees. The FFC programme aimed to bring about changes in motivation and attitudes of people towards each other, changes in the way they take responsibility and increases in their skills to organize, manage and lead. Indeed, Clapham et al (2004) specifically comment that an integral element of quality of care improvements efforts 'was the adoption of methods to encourage accountability, respect and desire to provide service among staff members that will result in both a greater self-respect and a respect for clients' (p.92). An evaluation of the FFC process found, based on respondents perceptions of the experience and their subsequent work, that the training had enabled hospital staff to develop positive and committed attitudes to life and work, strong team work, better management of their tasks and positive client relations. It also helped district stakeholders work together, and across political lines, to promote safe motherhood awareness among village development committees.

Overall, however, these quality of care improvement approaches are judged both to have enabled improvements by challenging existing organisational culture, and yet to have been constrained by other cultural factors. The FFC approach specifically tackled the culture of *'ke garne'*, characterised by a sense of disempowerment and apathy where the individual feels no responsibility to work hard or change things, by empowering service providers to improve service quality. It fostered a team approach to address gender dynamics and the social exclusion of certain groups within health organisations. The synergies resulting from a multi-faceted intervention package were also important in sustaining this motivation. However, these gains are challenged by the continued frequent and inappropriate transfer of staff within the public sector, and the failure to institutionalise the FFC approach, to train new staff and renew the motivation of remaining staff. Quality of care is also undermined by the continuing expectations and practices of patronage (service providers treating their own family and friends better than others) and the continuing lack of power experienced by poor patients, so that the relationship is still provider dominated. Wider cultural change will be required to offset these barriers.

Source: Aitken and Thomas (2004), Clapham *et al.* (2004), Gilson (2007), Hodgson *et al.* (2003) and ODC (2004)

Spain

The impact of primary care reform in Spain
'Spain passed a law in the mid-1980s that strengthened primary care by reorganising services to better achieve the main features of primary care, which led to the establishment of a national programme of primary health care centres. The impact of this reform was evaluated after ten years by examining mortality rates for some major causes of death (Villalbi *et al.,* 1999). Death rates associated with hypertension and stroke fell most in those areas in which the reform was first implemented. There were even fewer deaths from lung cancer in those areas with primary care reform than in other areas. Health outcomes that could not be expected to be influenced by primary care, for example, perinatal mortality, did not differ across the areas.'

Source: Starfield *et al.* (2005:464)

Sri Lanka

General tax funding as a basis for universal coverage – the case of Sri Lanka
Sri Lanka has long been held up as an excellent example of a country that has achieved remarkably good health status indicators given its relatively low income levels. For example, life expectancy improved from 43.9 years for men and 41.6 years for women in 1946, to 64.8 and 66.9 years respectively in 1967 and to 70.7 and 75.4 in 2001. These levels are more comparable to high-income countries than low-income countries. While there are a range of factors outside the health sector that contribute to this achievement, such as relatively good gender equality and high levels of female literacy, the universal tax-funded health system is seen as an important contributor.

Sri Lanka explicitly adopted a policy of sustained and relatively high levels of government expenditure on social services as a means of promoting equity within the country. It also explicitly rejected user fees as a mechanism of financing public sector health (and education) services. In 1953, all public sector health services were made available for the entire population, without any payment by patients at the time of using a service. A private health sector (for outpatient care) does exist in Sri Lanka, with its growth starting in earnest in the 1960s. The majority of private provision relates to public sector staff undertaking private practice outside of official working hours. Only 15% of all outpatient consultations are provided by full-time private doctors while limited private practice by public sector doctors accounts for slightly more than 30%. The remaining half of outpatient services is provided in the public sector. Higher income groups use private providers for outpatient care considerably more than low-income groups, with lower waiting times being the main reason cited for this preference. Universal access to tax funded health care is particularly important at the hospital level, with 94% of inpatients being treated in public sector hospitals.

Sri Lanka has a well distributed public health facility infrastructure, with most rural residents being within 5-10 kilometres of a peripheral health facility. The technical quality of care within public facilities, particularly hospitals, is very highly rated. There also appears to be considerable efficiency within the Sri Lankan system, with only 2-2.5% of GDP being devoted to public sector health care yet this sector caters for the vast majority of its population's health care needs. High levels of productivity are partly attributable to a culture among health workers of dedicated service to citizens.

Sri Lanka has achieved universal cover through tax funding in the sense that *all* citizens have access to *adequate* health care at an *affordable* cost. The protection offered by this tax funded system against the potentially catastrophic costs of hospitalisation has been particularly important. While some concerns have recently been expressed about declining tax funding of health care (down to approximately 1.2% of GDP) and a possible deterioration in the provider-patient interaction aspect of quality of care, Sri Lanka has registered remarkable health status achievements on the basis of a universal tax funded health system.

Source: Extracted from McNay, Keith, and Penrose (2004), Russel (2005) and Withanachchi and Uchida (2006)

Sweden

During the 1980s, Swedish citizens enjoyed not just a modern medical system, but an exemplary record on many key indicators - lowest infant mortality in the world (3.2 deaths per 1000 live births), low poverty rates (4%), good housing standards and solid employment numbers. When the United Kingdom's Black Report (1980) highlighted considerable health inequalities in that country, Sweden was prompted to look inward. A cross-national comparison revealed similar - if less pronounced – challenges at home.

Intersectoral action for health linked to social determinants by a proactive government
Intersectoral approaches have been used by national and local governments in Sweden well before the release of the Black Report. Sweden's current national public health strategy has emerged out of a social welfare model and recognition of health inequities identified in the 1980s. Significant research into the nature of these inequities and intervention approaches provided evidence to support broad-based public health objectives. Ultimately, this focus was linked to a social determinants framework, with an overarching intersectoral action component.

Contextual factors that contributed to the development of national public health goals included: a long history of social democratic government; a strong relationship with the labour movement; a highly developed welfare system; a call from municipalities for national public health goals; involvement of politicians from across the political spectrum; strong civic literacy; a highly democratic process; political commitment to equity; a high level oversight body; intersectoral goal setting; a strong evidence base; and, strategies concerning lifestyle factors emphasizing collective and systematic versus individual responsibility.

A comprehensive national strategy

Sweden's *Health on Equal Terms* public health goals and strategy provided a philosophical and practical framework for the interaction of multiple sectors and actors in relation to major health determinants. The goals identified roles of other sectors, were developed in a democratic process, established targets related to determinants of health and were based on strong scientific evidence.

The national policy governs intersectoral actions at the county council and municipal levels, which makes public health a shared responsibility among several central agencies, Sweden's 21 county councils and its 290 municipalities. In addition, the policy embraces non-government organisations, trade unions and universities. This breadth of approach offers a unique model for governing intersectoral action for health and equity.

Barriers overcome through solid research, consultation and inclusion

Initially, the greatest barrier was lack of a long-term comprehensive strategy to overcome health inequities and, social and economic policies of the time tended to increase rather than reduce the gaps. The process of goal development included three key steps: framework development and discussion; ethical values, scientific facts and priority setting; and finalising the strategy. Experts were commissioned to provide scientific data pinpointing needs. Multidisciplinary research into health determinants was undertaken and analysed, and active participation of all seven political parties was a critical element in shaping policy directions.

Public consultation heightened citizen awareness and involvement. Key documents were available to the public in low literacy formats and Braille. The three step public health goals process initiated in 1998 led to the adoption by Parliament of *The Public Health Objectives Act (2003)*, Sweden's first formal public health policy. It also represents one of the world's first formalized approaches to health using a health determinants approach.

Through this act, Parliament endorsed the broad goal "to provide societal conditions for good health on equal terms for the entire population" (Public Health Objectives Act). Eleven public health goals across the following three categories support the broad goal:
- societal structures and living conditions;
- settings and environments: and,
- lifestyles and health behaviours.

Specific measurable targets were established for each of the 11 goals. Of note, the goals related to employment and social supports from other sectors were integrated into public health goals, rather than imposing new goals on other sectors.

Health took the lead, others joined in

The health sector played an initial driving role, and facilitated the process throughout, by at first calling for research into the health inequities present in the country, and by providing the expertise in producing the hard data needed by the political sphere to lead the process. Other sectors also played roles: intersectoral and multi-disciplinary research into the issues highlighted the inequities present in the system. The involvement of government, non-government actors, experts and the public throughout the process was instrumental in the approval and early implementation of the public health goals and strategy.

A Steering Committee - chaired by the Minister of Public Health, with Ministers from other sectors - oversees the ongoing implementation of public health goals that fall outside the health sector.

Monitoring and evaluation techniques under development

Because it is new, the impact of the policy is difficult to ascertain. The Swedish National Institute of Public Health is tasked with monitoring and evaluation on behalf of the Steering Committee. Developing the methodology to monitor and evaluate the intersectoral components of Sweden's public health policy is at best challenging.

Source: Extracted from Public Health Agency of Canada and Health Systems Knowledge Network (2007)
Thailand

Equitable distribution of health care benefits in Thailand
Thailand has been engaged in a process of extending health insurance coverage of the population over a 25 year period. Formal sector workers were covered by the Civil Servant Medical Benefit Scheme (CSMBS) for government employees (initiated in 1978) and the Social Security Scheme (SSS) for employees of private firms (introduced in 1990). The poorest households were covered through a publicly funded Low-Income Card (LIC) scheme introduced in 1975 while the publicly subsidised Voluntary Health Card (VHC) scheme covered those in the informal sector who were not classified as poor from 1981. In 2001, the 30% of the population who were uninsured at that point were covered under a tax funded public Universal Coverage (UC) scheme, into which the previous LIC and VHC schemes were integrated. Together, the UC, CSMBS and SSS now cover the entire population. While the CSMSS and SSS operate as insurance schemes, the UC scheme is similar to direct tax funding.   UC members must register with a local primary care facility (usually public sector, but sometimes an accredited private provider) which is paid a capitation fee from tax funds to provide primary care to UC members. Public hospitals are funded by a global budget based on Diagnosis Related Group estimates. The UC scheme is also known as the '30 Baht scheme', given that members are expected to make a nominal payment of 30 Baht (less than US$1) per outpatient visit and per hospital admission (except for the poor who were previously part of the LIC scheme, who are not required to pay anything). All schemes have a relatively comprehensive benefit package, with a 'negative list' that excludes very high cost services (e.g. dialysis for end-stage renal disease, cosmetic surgery, drug addiction treatment, organ transplantation and infertility treatment).

In Thailand, the poor benefit from public subsidies (through their use of health services) considerably more than the rich. This is particularly the case for health centre ambulatory services and outpatient and inpatient services at district hospitals. This highlights the important role of district level services, which are generally more physically accessible (and hence also financially accessible in terms of limiting transport costs) to the poorest population groups. The degree of inequality between socio-economic groups in the use of health care and in public subsidy benefits has reduced since the introduction of UC. Even though the poor benefit more from the public subsidy than the rich, UC has been shown to also provide important protection against catastrophic inpatient costs for the better off – the occurrence of catastrophic levels of out-of-pocket payments has declined for all socio-economic groups, but particularly for the poorest groups. While 2% of the population was impoverished (pushed below the poverty line) as a result of out-of-pocket payments before UC, 0.5% was impoverished in this way after UC was introduced. The combination of universal coverage, a relatively comprehensive health service benefit package and relatively high levels of tax funding to support the provision of good quality public sector health services have led to a distribution of health service benefits that preferentially advantage the poorest in Thailand.

Sources: Limwattananon, Tangcharoensathien, and Prakongsai (2005) and Suraratdecha, Saithanu, and
        Tangcharoensathien (2005)

Uganda

Removal of user fees in Uganda
Uganda introduced user fees on a universal basis in 1993. Although revenue generation was relatively low (generally less than 5% of expenditure), it was an important source of funds for supplementing health worker salaries, maintaining facilities and purchasing additional drugs. However, there was a dramatic decline in the utilisation of health care services and there were growing concerns about the impact on the poor, given that 46% of the Ugandan population live on less than $1 per day.

User fees at public sector facilities were abolished in March 2001, with the exception of private wards. Various studies have shown that utilisation of health services increased immediately and dramatically. One study of 78 health facilities in 10 districts, using data for 8 months before and 12 months after the removal of fees, found that the mean monthly number of new visits increased by 53%, while repeat visits increased by 24%. Two years after the abolition of fees, sustained utilisation increases of 77% were recorded.

An extensive study using the first and second Ugandan National Household Surveys (conducted in 1999/2000 and 2002/03 respectively) and data from the Health Management Information System highlighted that the poor had particularly benefited from the removal of fees. Although the incidence of reported illness in the previous 30 days was similar in the two surveys (of slightly less than 30%), the percentage of those who were sick who sought professional care increased from 69% to 79% and the number of days when the sick person was unable to work declined from 8.3 to 7 days on average. In addition, only 30% of those who did not seek care cited inability to afford health care as the reason in 2002/03 compared to 50% in 1999/2000. The poor benefited most from the abolition of fees; utilisation of health services when ill increased from 58% to 70% in the case of the poorest quintile and from 80% to 85% for those in the richest quintile.

A number of the studies have highlighted that these sustained utilisation increases, and related positive outcomes such as national immunisation coverage increases from 41% in 1999/2000 to 84% in 2002/03, could not have been achieved without an increase in the resources available for public sector health services. Of particular importance was the pro-active provision of a $5.5 million buffer fund by the Ministry of Health to offset the potential impact on availability of drugs arising from the loss of fee revenue and utilisation increases. In addition, the move away from project donor funds to provision of Sector-Wide Approach (SWAp) support to the Ministry of Health by donors resulted in the Ministry budget doubling in real terms between 1999/2000 and 2002/03. The Ministry has control over the allocation of these SWAp resources and has directed the additional resources preferentially to primary health care services; district budgets have increased seven-fold since 1999/2000.

While there is overwhelming evidence of the substantial positive impact of fee removal in Uganda, particularly for the poorest, there have been some negative consequences. Of particular concern is the decline in staff morale. This is related to the loss of fee revenue which had previously been used to supplement staff salaries as well as the fact that workload had increased by about 47%. Health workers and members of the health facility management committees also indicated that maintenance of health facilities and cleanliness had declined. This highlights the need for careful planning and implementation of fee removal.

Sources: McIntyre (2006) who drew on Burnham *et al.* (2004), Deininger and Mpuga (2004), Kipp *et al.* (2001) and Yates (2004)

United Kingdom

In 1980, *The Black Report* identified health inequalities in the UK population. This ignited debate on the extent of the inequalities and contributing determinants. Other important drivers included the Wanless Report, a cross-cutting review of national policy and evaluation reports on inequalities exploring child poverty and transportation.

A new government prompted action on inequalities
However, despite acknowledgment of, and ongoing discussion about the situation, it wasn't until the Labour Party formed government in 1997 that the UK produced a dedicated national policy on addressing health inequities. Until 2005 it remained the only country to take such an approach.

Joined-up government adopts IAH as a key strategy
The policy places the responsibility for dealing with health on government as a whole, with IAH a key strategy for addressing health inequity within that framework. Further, the concept of "joined up government" emerged as a mechanism to facilitate the implementation of IA. "Joined up government" is defined as the bringing together of a number of public, private and voluntary sector bodies to work across organisational boundaries towards a common goal. Importantly, the push toward IA was seen as part of the process of modernizing government. The Cabinet Office and Treasury were made responsible for promotion and monitoring. Related national policies on children and neighbourhood renewal were introduced during the same time frame. At the national level, a Social Exclusion Unit promotes multi-agency approaches for Health Action Zones, Education Action Zones and Young Offender teams

Numerous challenges impeded progress

Clearly the greatest barrier to achieving IAH in the UK was politics. Until a Labour government was in place, IAH was not a priority. The establishment of Health Action Zones is one of the most well-documented IA of the new government. Twenty-six Health Action Zones (HAZ) were established to organise area-based action around the social determinants of health. Intended to foster inter-agency and intersectoral collaboration, as well as harness community-based resources and experience, these Zones were planned to operate for at least seven years. After a high profile start accompanied by considerable enthusiasm for the concept, most of the Zones were wound down after three years, due to shifting government priorities.

Evaluations of the HAZ experience yield two observations: the experience of each Zone was highly context-specific and there is evidence of long-lasting befit in terms of learning around intersectoral working. In short they made a "good start in difficult circumstances". The difficult circumstances noted include: unrealistic objectives; inadequate funding; constantly shifting objectives and partnership arrangements; performance management systems that provided little rewards for IA; shortfalls in organisational capacity; and a tension between achieving change at the local level while attempting to identify structural causes of inequity at the national level.

Despite obstacles, some positive outcomes

Most Health Action Zones were wound down before their impact could be properly evaluated. However, some evaluators, while acknowledging the equivocal nature of the data gathered from the Zones, nonetheless contend that there is evidence of long-lasting benefit in terms of learning around intersectoral work. These include new models of service provision to previously poorly serviced group of the population and in creating a context in which those with organisational boundary spanning skills were supported to develop new ways of working. Additionally, the Zones raised the profile of health inequalities on the political agenda, at least at a local level.

While cross-departmental working groups have emerged on thematic issues, and ministers for different departments jointly sign strategy documents, there is evidence that departments often continue to work in individual 'silos' and do not always feel sufficient ownership over intersectoral policies. The UK government appears to remain dedicated to the concepts of joined-up government and intersectoral action, seeking to build on past experience to enhance intersectoral and interagency working at both the national and local levels.

Lessons from experience

Documented lessons from experiences of intersectoral action under the Labour government in the UK include:
- design the most appropriate form of joint working once it has been decided that joint working is necessary;
  - reinforce with a statutory duty to collaborate, where appropriate;
  - ensure that partner organisations align their vision and policy objectives, and that while providing appropriate guidance, central government avoid undue interference in partnerships;
  - provide incentives for joint working, e.g. financial incentives, flexibility around joint decision making, appropriate performance assessment;
  - minimise administrative burden on departments and local partnerships;
  - set realistic timescales (it is commonly observed that IA requires several years to materialise;
  - develop strong leaders and build organisational capacity;
  - put in place monitoring and evaluation systems;
  - ensure that there are clear lines of redress for citizens; and
  - ensure that there is a clear accountability framework.

Source: Extracted from Public Health Agency of Canada and Health Systems Knowledge Network (2007)

Annex 7: Policy experience and guidance

Box 1: Moving towards universal coverage - policy choices and questions

Financing sources:
- what is the most desirable and feasible way of increasing mobilisation of compulsory revenues for health services? what is the preferred mix of general tax or compulsory insurance?
- does increased funding require greater mobilisation of funds or is the taxation system raising adequate funds and there is a case for a greater share to be allocated to health services?
- how can the role of direct payments in the overall financing mix be minimised?
- should either or both private insurance and community-based insurance play a role in the financing system?

Fund pooling:
- how widely can funds be pooled, to minimise inequities in payment and benefits between pools?

Purchasing:
- how can the purchasing role be strengthened, in order to improve equitable and efficient access to health services?
- what are the relative roles advantages of targeting subsidies to specific individuals, funding a local purchasing agency or channelling funding direct to providers?

Provision of care:
- should countries provide a choice between public and private providers (assuming payment methods can be put in place to control utilisation and costs)?
- should benefits be comprehensive, or focussed on services most likely to be financially catastrophic to households packages or on the most cost-effective set of services?
- what should be the balance between breadth of coverage (including as high as proportion as possible of the population) and depth of coverage (a large benefit package)?
- is one single benefit package feasible or is it better to aim at a basic package and additional elements for well-off groups?
- how can a benefit package be specified and applied?
- how can the needs of especially disadvantaged groups be met?

Structure of arrangements:
- Should countries gradually expand a single scheme or develop multiple arrangements and seek to harmonise them over time?
- Is the introduction of competition desirable either in terms of insurer or choice of provider?

Source: Mills (2007)

Box 2: Leading organisational culture change through training

A Latin American training programme supporting implementation of the Cairo reproductive health rights agenda (Diaz and Cabral, 2006):
- seeks both to empower participants and to create an enabling environment in which they can become agents of change
- provides opportunities for personal reflection and also empowers participants by providing technical knowledge relevant to new clinical practices, developing their capacity to conduct organisational development activities and providing insights into the socio-cultural factors and

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power relations that shape policies supplemented by wider efforts to build an enabling environment, such as training an intersectoral team from each municipality that includes managers, getting political commitment through formal agreements for the training programme and continuing support through coaching and electronic networking

- has adopted a training of trainers approach, involving locally-based mentoring for participants backed up by the training organisation.

The Health Workers for Change training intervention (Special edition of Health Policy and Planning vol 16, supplement 1, 2001):

- is a workshop series that provides participants with opportunities for critical reflection on their practices, their patients, the obstacles to providing good quality of care in their facilities and ways of addressing these obstacles;
- has been evaluated using a common protocol across seven countries (6 in Africa and 1 in Latin America), generating the conclusion that it had a 'positive impact on the relationship between providers and clients, creating teamwork within a facility, creating a supportive environment for health facility staff to take more initiative and, to some extent, demand more responsiveness from system level' (Onyango-Ouma *et al.*, 2001: 30)
- subsequent application of the package in Pakistan also showed that the process was able to generate a renewed commitment to work among participants, with greater willingness to examine their own practices and improve quality of care (Shaikh, Rabbani, and Rahim, 2006).
- however, reflecting wider experience, both the multiple country evaluation and the Pakistan study noted that the workshop package is not enough by itself, and that it is also vital to establish an enabling environment that supports the changes initiated at local level - higher level commitment for the programme was identified as a key influence over its potential for positive impacts, as well as an environment of communication and participatory management practices (Vlassoff and Fonn, 2001).

Box 3: Reversing the internal brain drain in Thailand

- policy: incentives for working in rural areas combined financial incentives with non-financial incentives that included: changing physicians' status from civil servants to contracted public employees; housing; introducing a system of peer review and recognition
- supported by: wider programme of sustained rural development
- impacts: the difference in the availability of doctors between the rural North East and Bangkok fell from a level of 21 in 1979 to 8.6 in 1986
- context influences: but as the economy grew, the private health sector grew and attracted health professionals, leading to growing inequity between areas; which was only reversed after the economic crisis of 1997

Sources: Wibulpolprasert *et al.* (2004) and Wibulpolprasert and Pengpaibon (2003)

Box 4: Effective learning programmes

- adopt approaches to learning that are most suited to particular leadership qualities (such as self-directed learning and assessment, observation and supported experimentation, coaching and performance management systems to develop leadership style and behaviours, and taught programmes on the job training to develop relevant technical skills);
- balance taught courses with opportunities for experiential learning (such as through secondments and work exchanges);
- structure taught programmes to allow for action-oriented, hands-on learning, with time to reflect

and absorb new ideas;
- establish informal peer support networks to support continuing personal development, as well as encouraging it through performance management agreements, for example.

Source: Egger *et al. (*2005) and Performance and Innovation Unit (no date)

Box 5: Civil society organisation (CSO) roles in influencing agenda setting

From a comprehensive and detailed review of South African experience on women's health issues, CSOs were shown to support problem identification and solution development by:
- developing and using methodologies for participatory problem identification among: those affected and potential beneficiaries of action; managers and service providers; diverse organisations and individuals, to build a shared problem analysis and a wide basis from which to lobby;
- gathering research findings or doing research to identify: the nature and extent of the problem (including an analysis of current policies, the extent and nature of implementation and their impacts); perspectives of politicians and senior decision-makers on the issue;
- conducting ongoing assessments of problems, even after a particular policy option has been agreed upon and while implementation is underway; since these processes often generate new obstacles and problems around which CSOs will want to mobilise for further policy change;
- drawing on and packaging evidence in ways appropriate for different actors so that it supports them in shaping solutions

As well as:
- identifying resources, institutional requirements, likely responses from different levels of the bureaucracy and other factors necessary for effective implementation;
- empowering managers, providers and clients: building their confidence to identify solutions so that these are appropriate to specific institutional contexts;
- building alliances with diverse interest groups in order to gain legitimacy for a specific solution;
- drawing on a human rights approach provided by international consensus agreements (e.g. the programme of action of the Cairo conference) to bring added legitimacy to locally identified problems.

Source: Klugman (2003)

Box 6: Persuading Ministers of Finance (MOF) to address health inequities by investing in health systems

- Use media shocks to raise profile of issues (comparison stories are good stories)
- Make issues public through consultations and public statements
- Mobilise social support and secure community views as inputs into policy debates, so that it is not only the Ministry of Health lobbying
- Generate good quality research that addresses health inequities
- Provide clear evidence of impact and relationship of impacts which benefit people
- Combine data and personal stories, as each works on different audiences
- Talk about equity in health and not just aggregate health gain
- Use language familiar and compelling for MOFs - make clear the benefits and efficiencies of health equity gains, and the costs of not securing these benefits
- Make the case for the action as part of the Minister of Finance's legacy
- Encourage decision making within Cabinet, rather than in bilateral negotiations between

MOF and MOH
- Build up wider political influence and base

Source: reflection on experience by Health System KN members

Box 7: Principles for health systems managers to use in working with front line staff

1. Be clear about the purpose of the policy (focus on outcomes, not process and outputs to gain commitment)
2. Recognise that input from front line staff is an essential element of evidence-based policy-making
3. Identify who is at the front line of any policy, how they can be reached and when and where to involve them
4. Maximise opportunities to make the most of the front-line contribution by engaging with them before policy details are set in stone and by providing contexts of engagement which encourage free thinking and innovation
5. Recognise the value of synergy by bringing policy makers and front line staff together to share knowledge
6. Plan the engagement process to ensure that it is undertaken at appropriate times within the overall policy process, expectations of implementers are clearly stated and that there is sufficient time for feedback to the implementers before policy finalisation
7. Allocate enough time to involve front line, and provide resources to enable their involvement
8. Establish processes of implementation that enable frontline providers' active engagement in developing policies in response to experience of their implementation (see below also)

Source: Cabinet Office (no date)

Box 8: Principles for health system managers to use in engaging health workers in supporting health equity-promoting policy change

- Establish new values and an orientation towards equity
- Provide information on equity gaps to motive their support
- Tackle the basic problems impacting on health workers
- Reward health worker action to promote health equity rather than bureaucratic and curative work e.g. improve social recognition, establish career structures and pathways that support equity such as rewards for location in rural areas
- Strengthen training programmes using problem based learning and including social accountability, inclusive programmes
- Work with health worker Trade Unions
- Share power with communities (see section 4.1)

Source: reflection on experience by Health System KN members

Box 9: Strategies to counter opposition

- Pharmaceutical reform in Asian countries in the 1970s and 80s provides several concrete examples of the types of strategies that can be used to manage interests and interest groups in such reform (Reich, 1995). In Sri Lanka, for example, technical expertise was used to counter criticisms. In Bangladesh, the coercive power of government was used to quash some opposition whilst policy concessions offset other opposition and rewards to local manufacturers turned them into supporters of the policy.
- In Thailand, bureaucrats' potential to resist the universal coverage policy was undermined both by the growing influence of competing business interests in government and by the establishment, as part of the policy change, of a new organisation to implement the new policy, located outside the existing bureaucratic structures and led by a committed leader (Tangcharoensathien and Jongudomsuk, 2004) .
- In South Africa, government officials and technical analysts working to develop proposals for the re-regulation of the medical insurance industry conducted low profile negotiations with industry representatives around their proposals. They initially put forward what they knew to be an unrealistic set of proposals, and after initial discussion moved towards a middle ground on some issues, whilst holding on to elements of the original set of proposals that were key to their overall goals. They also took advantage of an emerging split within the industry to work with some industry actors but not others, so splitting the opposition (Gilson and Thomas, 2003).

Box 10: Nineteen possible strategies for working with actors

1. Create Common Ground[1]:
- seek common ground with other organisations, identify common interests, link different interests – invent new options, make decisions for opponents easier.

2. Create a Common Vision[1]:
- keeping in mind that the principal obstacles to reform are not only technical: create an atmosphere of shared values, unified leadership, articulate a common vision of equity and the respective roles of the public and private sectors

3. Define the Decision Making Process (around a particular reform)[1]:
- formalise who does what in making a decision and who approves what type of decision, legalise formal processes if relevant

4. Mobilize and Prepare Key Actors for their Roles in Reforms Debates[1]:
- identify who can take leadership positions and provide them with appropriate information, who can influence support/opposition by taking a strong and clear position and provide them with appropriate information, the most critical issues for discussion and focus debate on them.

5. Meet with Political Parties[1]:
- meet with politicians and their technical staff, attempt to integrate health reform policies and specific policy ideas into political debate and discourse, identify their specific concerns on reforms and seek to offset them through technical argument and debate

6. Initiate Strategic Communications[1]:
- initiate strategic contacts with the press, respond to attacks on reforms immediately, feed information and technical findings to the press, place key decision-makers in the media

7. Initiate Pilot Studies[1]:
- select pilot study sites according to technical and political exigencies, focus pilot study work on issues critical to technical understanding and/or political support, preserve neutrality of those involved in pilot study to maintain integrity of findings

8. Manage the Bureaucracy[1]:

- involve different groups in designing reforms, and in developing implementation strategies

9. Strengthen Alliances with International Organisations[1]:
- request technical-political assistance from international financial institutions and other donors in order to respond to criticisms of reforms, work together with supportive donors in some areas, ask for donor support for vision of reform and define their active participation in influencing key actors in the health sector

10. Involve 'Friends' in Planning[1]:
- hold informal consultations with 'friends' of the reform on the sequencing of actions and political strategy, bring together key 'friends' to formulate specific agendas in some reform areas

11. Create Strategic Alliances[1]:
- create alliances with key actors not usually involved in health sector policy debate (e.g. unions, NGOs etc)

12. Use Backdoor Channels[2]:
- by-pass formal procedures and meet with those in power to try and influence the development of reforms and/or gain useful information about the future course of events for use in their own activities.

13. Establish Independent Commission of Inquiry To Create Support[2]:
- identify relevant 'experts' whose opinions and views will be valued publicly to sit on Commission, establish balance between declared supporters and opponents of reform in Commission membership to maintain neutrality and independence of Commission, provide technical support to Commission to gather additional ideas and/or generate additional analysis, create link between Commission and 'policy champion' within government

14. Establish Independent Commission of Inquiry To Block Opposition[2]:
- establish balance between declared opponents and supporters of reform in Commission, delay consideration of Commission report/findings after publication until no longer newsworthy

15. Establish Parallel Processes During Formal Commissions[2]:
- use informal parallel processes to gain guidance from constituencies on positions to take in debates, and/or to generate information to feed into debates

16. Use Technical Information to Offset Opposition[2]:
- identify key arguments of opponents to reform, undertake technical analysis to offset their arguments
- use technical analysis to support alternative line of policy development, feed technical analysis into relevant decision-making processes, make technical analysis widely available to policy-makers, media etc.

17. Divide and Rule[2]:
- put 'high bid' policy document forward for debate, through reactions to 'high bid' document, identify lukewarm opponents and hard core opponents, isolate hard core opponents by developing a detailed policy design that offsets the concerns of lukewarm opponents, proceed with policy implementation with support of previously lukewarm opponents

18. Mobilising a Third Party[2]:
- seek to bring a potentially powerful but as yet unmotivated actor into the debates to support own position

19. Create Tailored Information for the Public and Policy Leaders[2]:
- tailor policy information to different target audiences to seek their support and to influence their understanding

Source: Gilson *et al.* (1999) using (1) Glassman *et al.* (1999) and (2) original research

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Box 11: Strengthening a community health worker programme, Ceara State, Brazil

Introduced in 1987 within a broader programme of public management strengthening, and during the tenure in office of two reformist governors of a centre left party (1987-1994), this programme contributed to a 36% reduction in infant deaths by 1992, tripled vaccine coverage for measles and polio (from 25% to 90%), expanded its operations from 30% of the state's counties to nearly all within five years and by 1993 was visiting around 65% of the state's populations in their homes. In ?year, programme costs averaged US$2 per capita served, around US$7-8 million per year, 80% of which supported the employment of health agents who visited every household offering preventive and promotive health advice, and who were, in turn, managed by nurse-supervisors.

In examining the reasons for success in this programme, the analysts suggest both that much of what occurred was unintentional and that four sets of issues help explain the successes:

A combination of centralised and decentralised control contained opposition and built popular support .Whilst a dedicated group of state-level officials was responsible for hiring and paying all health agents, the agents worked for nurse supervisors hired by local municipalities and were only employed after the local mayor expressed support. This balance of control prevented the use of the programme as a source of patronage by mayors, and yet developed sufficient popular support for the programme that mayors were encouraged to accept it; whilst also allowing the supervisors to exercise considerable discretion in their control of the programme.

The creation of a sense of mission and status for the programme . This was achieved, despite employment on a contract-only basis, through a state-led and rigorous process of meritocratic selection and training, wide publicity efforts and repeated public prizes for good performance by agents – together generating a sense of collective responsibility for the programme among agents, supervisors and clients, and empowering all three groups.

The voluntary enlargement of work tasks by health agents supported relations of trust with clients Watched over by supervisors but balanced by monitoring by community members (newly informed by public information campaigns about health agents' jobs), agents responded to client preferences by taking on additional tasks (both curative and community level action to tackle public health hazards), and so created relations of trust with their clients that sustained their motivation and job satisfaction.

The state was also able to offset resistance to the programme above other actions offset resistance from mayors (who gained no patronage opportunities from the programme but instead came to see it as something from which they could get credit as well as being subject to popular pressure to implement it) and from nurses and doctors (nurses were offered professional opportunities through the programme without threatening the accepted territory of doctors).

Sources: Tendler and Freedheim (1994) and Tendler (1997)

Box 12: Equity monitoring in Thailand

Conceptual framework for monitoring
The available data sets are used to monitor inequities in health financing (at national and household level), coverage, health care utilisation, quality and responsiveness, health status and health risk by geographic area (province, urban vs. rural), demographic group (gender, age group), social status (education, occupation) and economic status (using wealth, income and consumption indexes)

Main data bases and uses
- National health accounts and household socio-economic surveys are used to monitor equity in health care finance
- National household health and welfare survey and unit costs for government services are used to monitor equity in health care use and public subsidy to health care
- National household health and welfare survey is used to assess the distribution of health risks across socio-economic groups, and of chronic illness and health-related quality of life
- Special surveys have been applied to identify the perspectives on health equity of Thai health policy-makers – both in terms of key problems and in terms of the UC equity achievements

Source*:* Tangcharoensathien, Limwattananon, and Prakongsai (2007)

Box 13: Trust-based management practices

Personal behaviours of supervisor:
- consistency and fairness
- taking action to tackle abuse or breakdown of trust
- explaining reasons for decisions

- treating those affected by decisions with dignity and respect

Management systems and procedures

- whether recruitment procedures ensure that new recruits have skills and values that match organisational goals and tasks
- relevance of in-service training to tasks assigned to workers
- fairness and consistency of selection process for in-service training, and link to organisational goals
- fairness and consistency of appraisal and reward system, communication and link to organisational goals
- whether reward people who share organisational values and goals
- job allocation allow multi-tasking, how narrowly jobs specified
- workers allowed to adapt and expand job definitions in response to understanding of client needs
- workers encouraged to debate and discussion about organisational goals and activities
- ways in which worker performance measured and monitored

Source: Gilson, Palmer, and Schneider (2005)

Box 14: Developing culturally competent health care systems

Four guiding principles:

- engaging consumers and communities and sustaining reciprocal relationships
- using leadership and accountability for sustained change
- building on the strengths of the system by engaging the community
- shared responsibility through partnerships.

Four dimensions of action:

- systemic: involving effective policies and procedures
- organisational: including putting the necessary skills and resources in place, creating a culture in which cultural competence is valued as integral to core business and there is management committed to diversity at all levels
- professional: recognising the influence of professional organisations over professional development
- individual: so that knowledge, attitudes and behaviours are strengthened within a supportive environment and health professionals feels supported to work with communities.

Source: NHMC (2005) which developed guidelines based on: a wide-ranging review of existing experience (involving a literature search, specially commissioned qualitative research, and national consultations and focus group discussions)

Box 15: The competencies of a public sector leader

- leaders must be able to think carefully about their roles, know when and how to give responsibility to others, communicate well visions, values and priorities, bring out the best in people and be willing to learn
- leaders must be able to adopt a range of leadership styles, responding to the needs of particular circumstances
- leadership of organisations (and of change within organisations) requires being able to generate and hear multiple perspectives, exposing and dealing with uncertainty and previously hidden or unspoken concerns, translating demands from the outside into roles for the organisation and communication what the organisation is doing to the external world

- enabling others means that leaders have to accept the limits on their own power and create a climate for others to lead through clear communication and information dissemination within the organisation and articulating the organisational values expected to govern behaviours
- partnership working with other private and non-government organisations requires the building of trusting relationships based on recognising the legitimate roles of others, effective negotiation to protect organisational interests and shape common goals and taking some responsibility for the overall outcome.

Source: Performance and Innovation Unit (no date)

References for the Annexes

Aitken, J., and Thomas, D. (2004). Synthesis of Final Evaluation Findings from the Nepal Safe Motherhood Project Report to His Majesty's Government of Nepal, DFID, Options. Available from: http://www.nsmp.org/publications_reports/index.html (accesssed 19 July 2006).

Atim, C., Grey, S., and Apoya, P. (2002). *A Survey of Mutual Health Organisations in Ghana.* Bethesda: PHRplus.

Balabanova, D. (2007). Health sector reform and equity in transition. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Birdsall, N., and Hecht, R. (1995). *Swimming against the tide: Strategies for improving equity in health.* Washington D.C.: Inter-American Development Bank.

Burnham, G., Pariyo, G., Galiwango, E., and Wabwire-Mangen, F. (2004). Discontinuation of cost sharing in Uganda. *Bulletin of the World Health Organization,* 82, 187-195.

Buse, K., Mays, N., and Walt, G. (2005). *Making health policy*. Milton Keynes: Open University Press.

Cabinet Office. (no date). Involving the front line in policy-making: T*ransforming public services: A Civil Service that delivers*. The Cabinet Office. Available from: http://www.policyhub.gov.uk/docs/Front_line-staff2.pdf (accessed 3 February 2007).

Carrin, G., and James, C. (2004). Reaching universal coverage via social health insurance: key design features in the transiation period. Discussion Paper Number 2 - 2004. Geneva: World Health Organization.

Casas, A., and Vargas, H. (1980). The health system in Costa Rica: Toward a National Health Service. *Journal of Public Health Policy,* 1(3), 258-279.

Chebundo, B. (2007a). The way parliamentary committees on health have overcome obstacles in creating sustained and co-ordinated pressures for health through regional networking in Southern and Eastern Africa. A case study prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Chebundo, B. (2007b). The Zimbabwe re-engineered budget process and the impact if its all-stakeholder inclusiveness approach, and how the involvement of EQUINET and other stakeholders contributes towards achieving equitable distribution of health resources. A case study prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Chetty, K. (2007). Equity promoting health care policies in South Africa. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

Clapham, S., Basnet, I., Pathal, L., and McCall, M. (2004). The evolution of a quality of care approach for improving emergency obstetric care in rural hospital in Nepal. *International Journal of Gynaecolgy and Obstetrics,* 84, 86-97.

Cuevas, J. H. (2007). Health and autonomy: the case of Chiapas (in Mexico). Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

De Maeseneer, J., Willems, A., De Sutter, A., and Van de Geuchte, I., Billings M. (2007). Primary health care as a strategy for achieving equitable care. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

Deininger, K., and Mpuga, P. (2004). Economic and Welfare effects of the abolition of health user fees: Evidence from Uganda. World Bank Policy Research Working Paper 3276. Washington, D.C.: World Bank.

Diaz, M., and Cabral, F. (2006). An innovative approach facilitates capacity building and scaling up to address the Cairo agenda in Latin America. In R. Simmons, P. Fajans and L. Ghiron (Eds.), *Scaling up health services delivery: from pilot innovations to policies and programmes.* Geneva: World Health Organization.

Doherty, J., and Govender, R. (2004). The cost-effectiveness of primary care services in developing countries: a review of the international literature. A background paper commissioned by the Disease Control Priorities Project.

Dubowitz, T., Anthony, R., Bird, C., Cohen, D., and Lurie, N. (2007). The experience of the USA: health inequity within a high-income setting. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

Egger, D., Travis, P., Dovlo, D., and Hawken, L. (2005). Strengthening management in low income countries. Making health systems work. Working Paper No.1. WHO/EIP/healthsystems/2005.1. Geneva: World Health Organization.

Gilson, L. (2007). What sort of stewardship and health system management is needed to tackle health inequity, and how can it be developed and sustained? Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

Gilson, L., Doherty, J., McIntyre, D., Thomas, S., Brijlal, V., Bowa, C., et al. (1999). The Dynamics of Policy Change: Health Care Financing in South Africa, 1994-1999. Monograph No, 66. Johannesburg and Cape Town: Centre for Health Policy, University of the Witwatersrand, Health Economics Unit, University of Cape Town.

Gilson, L., Palmer, N., and Schneider, H. (2005). Trust and health worker performance: exploring a conceptual framework using South African evidence. *Social Science and Medicine,* 61(7), 1418-1429.

Gilson, L., and Thomas, S. (2003). Introduction: Intervening in the public/private mix. In N. Soderlund, P. Mendoza-Arana and J. Goudge, eds. The new public private mix in health care: exploring the changing landscape pp. 1-12. Geneva: Alliance for Health Systems and Policy Research.

Glassman, A., Reich, M., Laserson, K. and Rojas, F. (1999). Political analysis of the health reform in the Dominican Republic. *Health Policy and Planning* 14(2), 115-126.

Government of Ghana. (2003). National Health Insurance Act (Act 650). Accra: Government of Ghana.

Health Systems Trust. (2007). Manner in which parliamentarians have been able to use the budget process to make visible inequalities in health an to promote equitable distribution in South Africa. A case study prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

Hodgson, R., Badu, K., Kati, C., and Parajuli, M. (2003). Artistry of the invisible. Evaluation of 'Foundation for Change' - a change management process. Report prepared for Report to His Majesty's Government of Nepal, DFID, Options. Available from: http://www.nsmp.org/publications_reports/index.html (accessed 19 July 2006).

Hudson, J., and Lowe, S. (2004). *Understanding the policy process: analysing welfare policy and practice. Bristol:* The Policy Press.

Infante, A. (2007). The post military government reforms to the Chilean Health System. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

Kipp, W., Kamugisha, J., Jacobs, P., Burnham, G., and Rubaale, T. (2001). User fees, health staff incentives and service utilization in Kabarole District, Uganda. *Bulletin of the World Health Organization,* 79(1), 1032-1037.

Klugman, B. (2003). The value of policy analysis in the assessment of "post Cairo" policy processes. Johannesburg: PhD Thesis University of the Witwatersand.

Kutzin, J. (2001). A descriptive framework for country-level analysis of health care financing arrangements. *Health Policy,* 56, 171-204.

Labra, M.E. & Giovanela, L. (2007). Brazil: Building the unified national health system and civil society participation. Case study commissioned for the Civil Society stream of the WHO Commission on the Social Determinants of Health.

Laurell, A. (2007). Granting universal access to health care: The experience of the Mexico City Government. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

Limwattananon, S., Tangcharoensathien, V., and Prakongsai, P. (2005). Equity in financing healthcare: impact of universal access to healthcare in Thailand. EQUITAP Project: Working Paper #16. Nonthaburi: International Health Policy Program.

Mackintosh, M., and Koivusalo, M. (2005). *The commercialisation of health care: global and local dynamics and policy responses.* Basingstoke: Palgrave Macmillan.

Magnani, R., Rice, J., Mock, N., Abdoh, A., Mercer, D., and Tankari, K. (1996). The impact of primary health care services on under-five mortality in rural Niger. *International Journal of Epidemiology,* 25(3), 568-577.

Mbombo, N. (2007). Building and maintaining the capacity, representativeness, and informed engagement: the case of SIZAKUYENZA Community-based Organization in South Africa. Case study prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

McGuire, J. (2001). Social policy and mortality decline in East Asia and Latin America. *World Development,* 29(10), 1673-1697.

McIntyre, D. (2007). *Learning from experience: Health care financing in low- and middle-income countries.* Geneva: Global Forum for Health Research. Available from: http://www.globalforumhealth.org/Site/000__Home.php (accessed 26 June 2007)

McIntyre, D., Gilson, L., and Mutyambizi, V. (2005a). Promoting equitable health care financing in the African context: Current challenges and future prospects. Harare: Regional Network for Equity in Health in Southern Africa (EQUINET).

McIntyre, D., Gilson, L., and Mutyambizi, V. (2005b). Promoting equitable health care financing in the African context: Current challenges and future prospects. EQUINET discussion paper 27. Harare: Regional Network for Equity in Health in Southern Africa EQUINET.

McNay, K., Keith, R., and Penrose, A. (2004). *Bucking the trend: How Sri Lanka has achieved good health at low cost - challenges and policy lessons for the 21st century*. London: Save the Children.

Meng, Q. (2007). Developing and implementing equity-promoting health care policies in China. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

Mills, A. (2007). Strategies to achieve universal coverage. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

Ministerial Task Team. (2002). Policy Framework for Establishment of Health Insurance in Ghana. Accra: Ministry of Health.

Morgan, L. (1987). Health without wealth? Costa Rica's health system under economic crisis. *Journal of Public Health Policy,* 8(1), 86-105.

Mugisha, F. (2007). The Nairobi Gauge work with parliaments. Case study prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

Musuka, G. (2007). Civil society participation in programme implementation for the intersectoral action on health equity and intersectoral action for health: a case study of the Health Civil Society Network in East and Southern Africa. Case study prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

National Health Insurance Secretariat. (2004). National Health Insurance Scheme: Proposed minimum benefit package. Daily Graphic. Accra.

Nazarit, P. S. (2007). The contribution made by women's and feminist movements to equity in health: the Chilean experience. Case study prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

NHMC (2005). *Cultural competency in Health: A guide for policy, partnerships and participation*. Canberra: Commonwealth of Australia.

Ochoa, F., and Visbal, L. (2007). Civil society and the health system in Cuba. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health.

ODC. (2004). Study on Quality of Care approach in selected health facilities of Nepal. Prepared for Nepal Safe Motherhood Project, Nepal. Available from: http://www.nsmp.org/publications_reports/index.html, (ccessed 19 July 2006).

Onyango-Ouma, W., Laisser, R., Mbilima, M., Araoye, M., Pittman, P., Agyepong, I., et al. (2001). An evaluation of health workes for change in seven settings: a useful managment and health system development tool. *Health Policy and Planning,* 16(suppl.1), 24-32.

PAHO. (2007). Renewing Primary Health Care in the Americas. A position paper of the Pan American Health Organization. Available at: http://www.paho.org/English/AD/THS/primaryHealthCare.pdf (accessed 27 June 2007)

Peren, H. (2007). Revivial of Maya medicine and impact for its social and political recognition (in Guatemala). Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Perera, M. (2007). Intersectoral Action for Health in Sri Lanka. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Performance and Innovation Unit. (no date). Strengthening leadership in the public sector: A rearch study by the PIU. Cabinet office: UK Government. Available from:
http://www.cabinetoffice.gov.uk/strategy/downloads/su/leadership/piu-leadership.pdf. (accessed 27 March 2007).

Public Health Agency of Canada and Health Systems Knowledge Network. (2007). Intersectoral action for health: a synthesis of country and regional experiences. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Ranson, K., Poletti, T., Bornemisza, O., and Sondorp, E. (2007). Promoting Health Equity in Conflict-affected Fragile States. Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Reich, M. (1995). The politics of health sector reform in developing countries: three cases of pharmaceutical policy. Ch 3 In P.C. Berman ed. *Health sector reform in developing countries: making health development sustainable*. Boston: Harvard University Press.

Rusike, I. (2007). Civil society promotion of equity and the social determinants of health through involvement in the governance of health systems: the case of the Community Working Group on Health in Zimbabwe. Case study prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Russell, S. (2005). Treatment-seeking behaviour in urban Sri Lanka: Trusting the state, trusting private providers. *Social Science and Medicine,* 61, 1396-1407.

Shaikh, B., Rabbani, F., and Rahim, M. (2006). Health workers for change: a tool for promoting behaviour change among providers. *Eastern Mediterranean Health Journal,* 12(3/4), 331-339.

Starfield, B. (2001). Basic concepts in population health and health care. *Journal of Epidemiology and Community Health,* 55(7), 452-454.

Starfield, B., Shi, L., and Macinko, J. (2005). Contribution of primary care to health systems and health. *Milbank Quarterly,* 83(3), 457-502.

Sundewall, J., Forsberg, B., and Tomson, G. (2006). Theory and practice - a case study of coordination and ownership in the Bangladesh health SWAp. *Health Policy and Systems,* 4, 5.

Sundewall, J., and Sahlin-Andersson, K. (2006). Translations of health sector SWAps - A comparative study of health sector development cooperation in Uganda, Zambia and Bangladesh. *Health Policy,* 76, 277-287.

Suraratdecha, C., Saithanu, S., and Tangcharoensathien, V. (2005). Is universal coverage a solution for disparities in health care? Findings from three low-income provinces of Thailand. *Heatlh Policy,* 73, 272-284.

Tangcharoensathien, V., and Jongudomsuk, P. eds. (2004). From policy to implementation: historical events during 2001-2004 of Universal Coverage in Thailand. Bangkok: National Health Security Office.

Tangcharoensathien, V., Limwattananon, S., and Prakongsai, P. (2007). Improving health-related information systems to monitor equity in health: lessons from Thailand. In D. McIntyre and G. Mooney G eds. *The economics of health equity.* Cambridge: Cambridge University Press.

Tangcharoensathien, V., Prakongsai, P., Limwattananon, S., Patcharanarumol, W., and Jongudomsuk, P. (2007). Achieving universal coverage in Thailand: what lessons do we learn? Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health.

Tendler, J. (1997). Good government in the tropics. Baltimore: Johns Hopkins Press.

Tendler, J., and Freedheim, S. (1994). Trust in a rent-seeking world: health and government transformed in Northeastern Brazil. *World Development,* 22(12), 1771-1791.

Villalbi, J., Guarga, A., Pasarin, M., Gil, M., Borrell, C., Ferran, M., et al. (1999). An evaluation of the impact of primary care reformo on health. *Atencion Primaria,* 24, 468-474.

Vlassoff, C., and Fonn, S. (2001). Health workers for change as a health systems management and development tool. *Health Policy and Planning,* 16(suppl.1), 47-52.

Walford, V. (1998). Developing Sector Wide Approaches in the health sector: An issues paper for DFID advisers and field managers. London: Institute for Health Sector Development.

Wallerstein, N. (1992). Powerlessness, empowerment, and health: implications for health promotion programs. *American Journal of Health Promotion,* 6(3), 197-205.

WHO. (1997). Intersectoral Action for Health: A Cornerstone for Health-for-All in the Twenty-First Century. International Conference on Intersectoral Action for Health. Halifax: World Health Organization.

WHO. (2000). *The World Health Report 2000 Health Systems: improving performance.* Geneva: World Health Organization.

Wibulpolprasert, S., Pachnanee, C., Pitayanrangsarit, S., and Hempisut, P. (2004). International service trade and its implications for human resources for health: a case study of Thailand *Human resources for health 2, 10*.

Wibulpolprasert, S., and Pengpaibon, P. (2003). Integrated strategies to tackle the inequitable distribution of doctors in Thailand: four decades of experience. *Human Resources for Health* (Online) 2003, Nov 25; 1-12. Available from: http://info.worldbank.org/etools/docs/library/206766/suwit%204%20decades.pdf (accessed 27 June 2007).

Withanachchi, N., and Uchida, Y. (2006). Healthcare rationing: A guide to policy directions in Sri Lanka. *Health Policy,* 78(1), 17-25.

Yates, R. (2004). Voting with their feet: What lessons can be learnt from increased consumption of public services in Uganda? *Health Policy and Development,* 2(1), 48-51.