

IV. SERVICE PROVISION FUNCTION

1. WHR 2000

WHR 2000 described four functions of the health system – financing, resource generation, service provision, and stewardship – and summarized the available evidence about their links to outcomes and health-system performance. In the text of the Report, service provision was defined as the way inputs are combined to allow the delivery of a series of interventions or health actions.

Three main aspects of health-service provision were identified:

- Priority setting – choosing the appropriate mix of interventions;
- Organization of service delivery – choosing the appropriate level for delivering interventions and the degree of integration;
- Aligning provider incentives to ensure that performance is optimized.

Coverage was seen as an intermediate goal, something that was valuable because it contributed to the intrinsic goals. No attempt was made to define and measure indicators of how this function was being performed, or to assess the coverage of key interventions.

2. Main commentaries and criticisms

Assessing service provision attracts attention because it is directly related to the daily management of the health system, and impacts are immediate and visible. WHR 2000 focused mainly on the measurement of intrinsic goals. As with the other functions, Member States and policy makers expressed a desire for practical applications of the assessment exercise. During the regional and technical consultations on HSPA, the development of instrumental goals has been consistently emphasized as a way of allowing policy makers to 'drill down' to find practical ways of improving system performance. At all regional consultations coverage was recognized as one of the key intermediate goals that should be routinely monitored.

3. WHO responses and proposals

WHO proposed three focus areas for health-service provision: (i) health-system inputs, (ii) organizational structure and processes, and (iii) the

quantity and quality of personal and non-personal health services in relation to the health-care needs of the population (Adams et al. 2000).

Nine domains are proposed for these areas in order to assess and monitor the management and development of the health system. Health-system inputs are measured through: (i) recurrent costs of service provision; (ii) physical availability of inputs; (iii) skill mix of health-care personnel; and (iv) utilization of medical equipment and structures. The organizational structure of the system and the process of health-service delivery are assessed through: (i) the level and type of autonomy and integration; and (ii) incentive structures. The outcomes of the service-provision function will be reflected in the intrinsic goals of health and responsiveness, both in terms of overall level and distribution. Two concepts – effective coverage and provider performance – are proposed as instrumental goals.

The concept of effective coverage was developed at a technical consultation in Brazil in August 2001. WHO subsequently proposed that it should incorporate the traditional concepts of access, utilization, and effectiveness (Shengelia et al. 2001). Coverage is an integrated concept using these three traditional elements, and is defined as the probability of receiving a necessary health intervention conditional on the presence of a certain health problem or health-care need. WHO further proposes five domains of coverage – availability, accessibility, affordability, acceptability and effective coverage.

Effective coverage can be estimated at the population level or at the individual level. WHO recommends estimation at the individual level, allowing the estimation of inter-individual inequality in (the probability of) coverage. Effective coverage at individual level can be measured by five steps using data on: prevalence and incidence of diseases; occurrence of interventions in the population; individual observable and unobservable characteristics; health-system characteristics; and effectiveness of intervention (Murray et al. 2001). The Secretariat further proposes that reducing inequality of effective coverage should be an instrumental goal, measured using methods developed previously.

Eight areas and 19 indicators are proposed for regular measurement using the criteria suggested by experts at the technical consultation.

4. SPRG comments and recommendations

The conceptual frame that WHO proposes for considering the service-provision function, consisting of three focus areas and nine measurement domains, seems to be useful. But the relationship between personal and non-personal health services needs further development, particularly in respect of the instrumental goals proposed by WHO for this function, i.e.,

effective coverage and provider performance. In the domain for management of service provision, management-oriented concepts such as autonomy, integration and incentives should be more clearly delineated.

Because targets for intermediate goals of the health system are more manageable in the short term than targets for intrinsic goals, outcome-related process indicators such as effective coverage will be very useful for policy makers and field workers. The assembly of a parsimonious set of indicators of the intermediate goals is an essential step towards enhancing the policy relevance of HSPA.

SPRG agrees that it is highly desirable for WHO to develop indicators of service provision. The categories of inputs, organizational structure, and health services appear to be conceptually sound. However, considerable further work is needed to develop operational indicators. WHO should develop a set of criteria for evaluating such indicators. The indicators should be clear, appropriate, understandable, measurable, and where necessary country-specific.

The process of indicator selection is important, and must involve relevant specialists and field workers. In presenting these indicators, their relationship to other functions such as resource generation – and to the intrinsic goals of health and responsiveness – has to be spelt out. To enhance policy relevance, it would be useful in some settings to measure these indicators at the sub-national level or even at the level of health institutions.

There has recently been a worldwide concern for improvement in the quality of health care, and in several countries quality of care has been redefined to include patient safety (IOM/NAS 2001). SPRG endorses the proposal to develop the notion of provider performance as an instrumental goal, including the concepts of quality and safety.

The analytical framework being developed by WHO for the other instrumental goal of effective coverage holds great promise, but needs to be exposed to detailed peer scrutiny and to incorporate feedback from external experts.

The concept of effective coverage can be important in quantifying the gap between efficacy and effectiveness of many interventions. However, the way that the proposed components of coverage – availability, accessibility, affordability, acceptability and effective coverage – relate to the more traditional concepts of access, utilization and effectiveness, needs to be explained clearly to policy makers.

SPRG endorses the development of carefully chosen measures of coverage that can be shown from research evidence to be linked to the achievement of the intrinsic goals. The use of such indicators is an important step in addressing the difficulty that some outcome indicators relate not only to the current period but reflect the results of health-system activity in the past.

The choice of the type of interventions that are routinely monitored for coverage should be guided by the criterion that these interventions are expected to be significant determinants of population health. (HALE).

The development of indicators of coverage not yet linked through research to the achievement of the intrinsic goals should be approached with caution. Use of such indicators may encourage some nations to introduce interventions that are subsequently shown to be ineffective. We suggest instead that appropriate research be commissioned to identify effective interventions.

Some care is needed in the presentation of coverage data. Interventions that are cost-effective in some countries may not be so in others, and crude rankings will be inappropriate.

Measuring inequality in effective coverage is useful because it is directly amenable to policy and is a determinant of inequality in health outcomes. But the method of measurement should be carefully developed and different alternatives explored.

Finally, in keeping with the general approach of WHO to examine both inequality and deprivation in the intrinsic goals (e.g., fairness in household financial contributions), SPRG recommends that deprivation in coverage should be measured alongside inequality. This will require specifying a minimum threshold level of coverage and estimating the percentage of individuals who fall below it. Identifying individuals with a low probability of coverage of key interventions would be very useful for policy purposes.

5. References

Adams, O., B. Shengelia, B. Stilwell, I. Larizgoitia, A. Issakov, S. Kwankam, and F. Jam (2000): Provision of personal and non-personal health services: Proposal for monitoring. Global Programme on Evidence for Health Policy Discussion Papers, No. 25. Geneva, Switzerland: World Health Organization.

IOM/NAS (2001): Crossing the Quality Chasm: A New Health System for the 21st Century.

Murray, C. J. L., B. Shengelia, N. Gupta, and O. Adams (2001): Inequality in coverage: concepts and measurement strategies. Global Programme on Evidence for Health Policy, mimeo. Geneva, Switzerland: World Health Organization.

Shengelia, B., O. Adams, M. Thieren, Y. Berchmans, Y. Kwankam, and C. J. L. Murray (2001): Measuring the coverage of critical interventions through household surveys. Global Programme on Evidence for Health Policy, mimeo. Geneva, Switzerland: World Health Organization.

