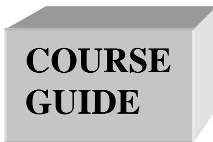
NATIONAL OPEN UNIVERSITY OF NIGERIA

COURSE CODE : HEM710

COURSE TITLE:
HEALTH SYSTEMS MANAGEMENT



HEM710
HEALTH SYSTEMS MANAGEMENT

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CONTENTS **PAGE**

Introduction………………………………………………………….…….. 1
What You Will Learn in this Course……………………………….. 1
Course Aims…………………………………………………………….. 2
Course Objectives……………………………………………………. 2
Working through the Course……………………………………… 2
Course Materials……………………………………………………… 3
Study Units……………………………………………………………… 3
Textbooks and References…….…………………………………. 4
Assignment File………………………………………………………. 4
Presentation Schedule……………………………………………… 5
Assessment……………………………………………………………. 5
Tutor-Marked Assignments (TMAs)……………………………… 5
Final Examination and Grading…………………………………… 5
Course Marking Scheme………………………………………….. 6
Course Overview…………………………………………………….. 6
How to Get the Most out of this Course………………………….. 7
Facilitators/Tutors and Tutorials…………………….………………… 9

Introduction

HEM710: Health Systems Management is a 2-credit course for PGD HIV/AID Education and Management and related disciplines.

The course is broken into 4 modules and 14 study units. At the end of this course, you are expected to be conversant with the following terms: health (definitions and levels); types and level of health care providers/specialty care; health care (definitions and levels), goals, element, typologies and evaluation of health care. This course will also present briefly the elements and levels of Nigerian health care system as well as the evolution of the global health system. This course further provides an overview of management and its theoretical scope namely: planning, organising, leading, coordinating, controlling and staffing; and further dwells more on specific health management terms like structure and functions of health system management; dimensions of health organisations as well as human resources management. This course further looks at specific terms like physical resources management; financial management; community involvement in health system, health systems reform and qualities of a good manager/health care worker.

The course guide, therefore, tells you briefly what you are expected to do, in other words, how best to get the best from this course. Specifically, you will have information on tests for further readings, what you are expected to know in each unit, and how to work through the course material. It suggests the general guidelines and also emphasises the need for self assessment and tutor-marked assignments. There are also tutorial classes that are linked to this course and students are advised to attend.

What You Will Learn in this Course

The overall aim of this course, HEM710, is to introduce students to the basic variables associated with health systems management. During this course, you will be equipped with definitions of health, health care and system as well as different types and levels of care in the health system. More specifically, you will encounter terms like financial management, human resource management, physical management etc., and all associated variables of health systems management. The role of the state in health care delivery as well as the import of community involvement in health care will be briefly analysed. Finally, this course will give a brief presentation of the qualities of a good health care worker/manager.

Course Aim

This course aims to give students an in-dept understanding of health systems management. Basic management variables such as financial management, human resource management, physical management etc, are discussed. It is hoped that the knowledge would equip students with the conceptual issues of health, health care and health systems management.

Course Objectives

Note that each unit has specific objectives. Students should read them carefully before going through the unit. You may want to refer to them during your study of the unit to check on your progress. You should always look at the unit objectives after completing a unit. In this way, you can be sure that you have done what is required of you by the unit.

However, below are the overall objectives of this course. On successful completion of this course, you should be able to:

- define health and health care
- illustrate levels of health care
- identify health care providers and specialty care
- explain health care system and associated variables
- explain the historical development of health care systems
- describe the Nigerian health care system
- define management and management theories
- identify the functions of health management
- illustrate health management collaborations
- explain human resources management in the health system
- explain physical resource management in the health system
- explain financial management in the health system
- identify the role of community in health care management
- identify the need for health system reform

Working through the Course

To complete this course, you are required to read the units, the recommended text books, and other relevant materials. Each unit contains some self assessment exercises and tutor-marked assignments, and at some point in this course, you are required to submit the tutor-marked assignments. There is also a final examination at the end of this course. Stated below are the components of this course and what you have to do.

Course Materials

The major components of the course are:

1. Course Guide
2. Study Units
3. Text Books
4. Assignment File
5. Presentation Schedule

Study Units

There are 14 study units and 4 modules in this course. They are:

Module 1 Understanding Health and Health Care

Unit 1 Understanding Health
Unit 2 Understanding Levels of Health Care
Unit 3 Health Care Providers and Specialty Care

Module 2 Understanding Health Care System

Unit 1 Understanding Health Care System
Unit 2 Historical Development of Health Care Systems
Unit 3 Nigerian Health Care System

Module 3 Introduction to Health System Management

Unit 1 Defining Management
Unit 2 Health Management: Functions
Unit 3 Health Organisation/Institution Management and Collaborations
Unit 4 Managing Human Resources in the Health System

Module 4 Managing Physical/Financial Resources – Community Involvement and Health System Reform

Unit 1 Physical Resources Management
Unit 2 Financial Management
Unit 3 Health System Management: Community Involvement
Unit 4 Health System Reform

Textbooks and References

These texts will be of immense benefit to this course:

Campbell, C. (2007). *Essentials of Health Management Planning and Policy*. Lagos: University of Lagos press.

Davies, C. & Bullman, A. (1999). *Changing Practice in Health and Social Care*. SAGE.

Encyclopedia of Public Health; Social Health. Answers.com Retrieved from ://www.answers.com/topic/social-health.

Karonne, B. J. (2002). *Medical Office Procedure*. NY: McGraw Hill Pub.

Merson, M. H. Black R. E. and Mills, A. J. (eds.). *International Public Health: Disease, Programmes, Systems and Policies*. Maryland: Aspen Publishers.

Melia, K. M. (2004). *Health Care Ethic*. SAGE

Mitchell, J. & Haroun, L. (2001). *Introduction to Health Care*. Canada: Delmar.

Mills, A. J. & Ranson, M. K. (2001). The Design of the Health System. *In*: M.H. Merson, R.E. Black & A.J. Mills (eds.). *International Public Health, Disease, Programmes, Systems and Policies*. Maryland: Aspen Publishers.

Parker, R. (2006). *Global Public Health.* Routledge.

Reike, W. A. (2001). Health Systems Management. *In*: M. H. Merson, R. E. Black, and A.J. Mill, (eds.). *International Public Health: Disease, Programmes*.

Assignment File

The assignment file will be given to you in due course. In this file, you will find all the details of the work you must submit to your tutor for marking. The marks you obtain for these assignments will count towards the final mark for the course.

Presentation Schedule

The presentation schedule included in this course guide provides you with important dates for completion of each tutor-marked assignment. You should therefore try to meet the deadlines.

Assessment

There are two aspects to the assessment of this course. First, there are tutor-marked assignments; and second, the written examination.

You are thus expected to apply knowledge, comprehension, information and problem solving gathered during the course. The tutor-marked assignments must be submitted to your tutor for formal assessment, in accordance to the deadline given. The work submitted will count for 30% of your total course mark.

At the end of the course, you will need to sit for a final written examination. This examination will account for 70% of your total score.

Tutor-Marked Assignment (TMAs)

There are 14 TMAs in this course. You will need to submit the required TMAs. The best 4 will be counted. When you have completed each assignment, send them to your tutor as soon as possible and make sure that it gets to your tutor on or before the stated deadline. If for any reason you cannot complete your assignment on time, contact your tutor before the assignment is due to discuss the possibility of extension. Extension will not be granted after the deadline, unless in exceptional cases.

Final Examination and Grading

The final examination for HEM710 will be of 2 hours duration and have a value of 70% of the total course grade. The examination will consist of questions which reflect the self assessment exercise and tutor-marked assignments that you have previously encountered. Furthermore, all areas of the course will be examined. It is also better to use the time between finishing the last unit and sitting for the examination to revise the entire course. You might find it useful to review your TMAs and comment on them before the examination. The final examination covers information from all parts of the course.

Course Marking Scheme

The following table includes the course marking scheme

Table 1: Course Marking Scheme

Assessment	Marks
Assignments (4 TMAs)	30% for the best 3 Total = 10% X 3 = 30%
Final Examination	70% of overall course marks
Total	100% of Course Marks

Course Overview

This table indicates the units, the number of weeks required to complete them and the assignments.

Table 2: Course Organiser

Unit	Title of Work	Weeks Activity	Assessment (End of Unit)
	Course Guide		
	Module 1 Understanding Health and Health Care		
1	Defining Health	Week 1	Assignment 1
2	Understanding Levels of Health Care	Week 2	Assignment 2
3	Health Care Providers and Specialty Care	Week 3	Assignment 3
	Module 2 Understanding Health Care System		
1	Understanding Health Care System	Week 4	Assignment 4
2	Historical Development of Health Care Systems	Week 5	Assignment 5
3	Nigerian Health Care System	Week 6	Assignment 6
	Module 3 Introduction to Health Care Management		
1	Defining Management	Week 7	Assignment 7
2	Health Management: Functions	Week 8	Assignment 8
3	Health Organisation/ Institution Management and Collaborations	Week 9	Assignment 9
4	Managing Human Resources in the Health System	Week 10	Assignment 10

Module 4	Managing Physical/Financial Resources; Community involvement and Health System Reform		
1	Physical Resources Management	Week 11	Assignment 11
2	Financial Management	Week 12	Assignment 12
3	Health System Management: Community Involvement	Week 13	Assignment 13
4	Health System Reform	Week 14	Assignment 14

How to Get the most out of this Course

In distance learning, the study units replace the university lecturer. This is one of the huge advantages of distance learning mode. You can read and work through specially designed study materials at your own pace and at a time and place that suit you best. Think of it as reading from the teacher, the study guide tells you what to read, when to read and the relevant texts to consult. You are provided exercises at appropriate points, just as a lecturer might give you an in-class exercise.

Each of the study units follows a common format. The first item is an introduction to the subject matter of the unit and how a particular unit is integrated with the other units and the course as a whole. Next to this is a set of learning objectives. These learning objectives are meant to guide your studies. The moment a unit is finished, you must go back and check whether you have achieved the objectives. If this is made a habit, then you will significantly improve your chances of passing the course. The main body of the units also guides you through the required readings from other sources. This will usually be either from a set book or from other sources.

Self assessment exercises are provided throughout the unit, to aid personal studies and answers are provided at the end of the unit. Working through these self tests will help you to achieve the objectives of the unit and also prepare you for tutor-marked assignments and examinations. You should attempt each self test as you encounter them in the units.

The following are practical strategies for working through this course

1. Read the course guide thoroughly.

2. Organise a study schedule. Refer to the course overview for more details. Note the time you are expected to spend on each unit and how the assignment relates to the units. Important details, e.g. details of your tutorials and the date of the first day of the

semester are available. You need to gather together all these information in one place such as a diary, a wall chart calendar or an organizer. Whatever method you choose, you should decide on and write in your own dates for working on each unit.

3. Once you have created your own study schedule, do everything you can to stick to it. The major reason that students fail is that they get behind with their course works. If you get into difficulties with your schedule, please let your tutor know before it is too late for help.

4. Turn to Unit 1 and read the introduction and the objectives for the unit.

5. Assemble the study materials. Information about what you need for a unit is given in the table of content at the beginning of each unit. You will almost always need both the study unit you are working on and one of the materials recommended for further readings, on your desk at the same time.

6. Work through the unit, the content of the unit itself has been arranged to provide a sequence for you to follow. As you work through the unit, you will be encouraged to read from your set books.

7. Keep in mind that you will learn a lot by doing all your assignments carefully. They have been designed to help you meet the objectives of the course and will help you pass the examination.

8. Review the objectives of each study unit to confirm that you have achieved them. If you are not certain about any of the objectives, review the study material and consult your tutor.

9. When you are confident that you have achieved a unit's objectives, you can start on the next unit. Proceed unit by unit through the course and try to pace your study so that you can keep yourself on schedule.

10. When you have submitted an assignment to your tutor for marking, do not wait for its return before starting on the next unit. Keep to your schedule. When the assignment is returned, pay particular attention to your tutor's comments, both on the tutor-marked assignment form and also written on the assignment. Consult your tutor as soon as possible if you have any questions or problems.

11. After completing the last unit, review the course and prepare yourself for the final examination. Check that you have achieved the unit objectives (listed at the beginning of each unit) and the course objectives (listed in this course guide).

Facilitators/Tutors and Tutorials

There are 8 hours of tutorial provided in support of this course. You will be notified of the dates, time and location together with the name and phone number of your tutor as soon as you are allocated a tutorial group.

Your tutor will mark and comment on your assignments, keep a close watch on your progress and on any difficulties you might encounter and provide assistance to you during the course. You must mail your tutor-marked assignment to your tutor well before the due date. At least two working days are required for this purpose. They will be marked by your tutor and returned to you as soon as possible.

Do not hesitate to contact your tutor by telephone, e-mail or discussion board if you need help. The following might be circumstances in which you would find help necessary: contact your tutor if:

- You do not understand any part of the study units or the assigned readings.
- You have difficulty with the self test or exercise.
- You have questions or problems with an assignment, with your tutor's comments on an assignment or with the grading of an assignment.

You should try your best to attend the tutorials. This is the only chance to have face to face contact with your tutor and ask questions which are answered instantly. You can raise any problem encountered in the course of your study. To gain the maximum benefit from the course tutorials, prepare a question list before attending them. You will learn a lot from participating in discussion actively. GOODLUCK!

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CONTENTS **PAGE**

Module 1 Understanding Health and Health Care ……….. 1

Unit 1 Understanding Health.. 1
Unit 2 Understanding Levels of Health Care........................ 11
Unit 3 Health Care Providers and Specialty Care................. 18

Module 2 Understanding the Health System ……………….. 26

Unit 1 Understanding the Health System.............................. 26
Unit 2 Historical Development of Health Care System.......... 35
Unit 3 Nigerian Health Care System...................................... 42

Module 3 Introduction to Health System Management …….. 49

Unit 1 Defining Management... 49
Unit 2 Health Management Functions................................... 58
Unit 3 Health Organisation/Institution Management and Collaborations.. 65
Unit 4 Managing Human Resources in the Health System...... 74

Module 4 Managing Physical/Financial Resources: Community Involvement and Health System Reform ………………………………………………. 83

Unit 1 Physical Resources Management................................ 83
Unit 2 Financial Management.. 91
Unit 3 Health System Management: Community Involvement 100
Unit 4 Health System Reform... 108

MODULE 1 UNDERSTANDING HEALTH AND HEALTH CARE

Unit 1 Understanding Health
Unit 2 Understanding Levels of Health Care
Unit 3 Health Care Providers and Specialty Care

UNIT 1 UNDERSTANDING HEALTH

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Defining Health
    3.2 The Health Triangle
        3.2.1 Physical Health
        3.2.2 Mental Health
        3.2.3 Social Health
    3.3 Determinants of Health
    3.4 Strategies for Maintaining Good Health
        3.4.1 Social Activities
        3.4.2 Sports/Nutrition
        3.4.3 Hygiene
        3.4.4 Stress Management
        3.4.5 Health Care
        3.4.6 Workplace Wellness
        3.4.7 Public Health
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

Welcome to the course: Health Systems Management! I am sure you will find this course interesting and insightful. Health system is defined as a "combination of resources, organisation, financing and management that culminate in the delivery of health services to the population" (Roemer, 1991). Health systems vary greatly from country to country. Unlike the study of disease, there is little standardised terminology or methodology for studying and understanding the health system. Each country's health system is a product of a complex range of factors: historical, social, economical, etc. Gro Harlem Brundtland of World Health Organisation emphasised that 'in many parts of the world, health

systems are ill-equipped to cope with the present demands, e.g., poverty, advent of new diseases, bloated population, etc., let alone those they will face in the future, and there is the need to develop a more effective health system" (WHO, 1999).

In this section, we will start with the basics: 'defining health' because of the obvious need for a firm grasp of health and its associated variables. Enjoy your studies.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define health
- identify and describe the health triangle
- explain the determinants of health
- identify strategies for maintaining good health.

3.0 MAIN CONTENT

3.1 Defining Health

At the time of the creation of the World Health Organisation (WHO) in 1948, ***Health*** was defined as being "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, 1948; WHO, 2006).

This definition invited nations to expand the conceptual framework of their health systems beyond issues related to the physical condition of individuals and their diseases, and it motivated us to focus our attention on what we now call the social determinants of health. Consequently, WHO challenged political, academic, community, and professional organisations devoted to improving or preserving health to make the scope of their work explicit, including their rationale for allocating resources. This opened the door for public accountability (WHO, 2005).

Only a handful of publications have focused specifically on the definition of health and its evolution in the first 6 decades. Some of them highlight its lack of operational value and the problem created by use of the word "complete." Others declare the definition, which has not been modified since 1948, "simply a bad one" (LaLonde, 1974). More recently, Smith suggested that it is "a ludicrous definition that would leave most of us unhealthy most of the time" (The UN, Basic Needs).

In 1986, the WHO, in the Ottawa Charter for Health Promotion, said that health is "a resource for everyday life, not the objective of living.

Health is a positive concept emphasising social and personal resources, as well as physical capacities." Classification systems such as the WHO Family of International Classifications (WHO-FIC) which is composed of the International Classification of Functioning, Disability, and Health (ICF) and the International Classification of Diseases (ICD) also define health. Overall health is achieved through a combination of physical, mental, emotional, and social well-being, which, together is commonly referred to as the Health Triangle.

3.2 The Health Triangle

Health is achieved through a combination of physical, mental, and social health, which, together is commonly referred to as the Health Triangle.

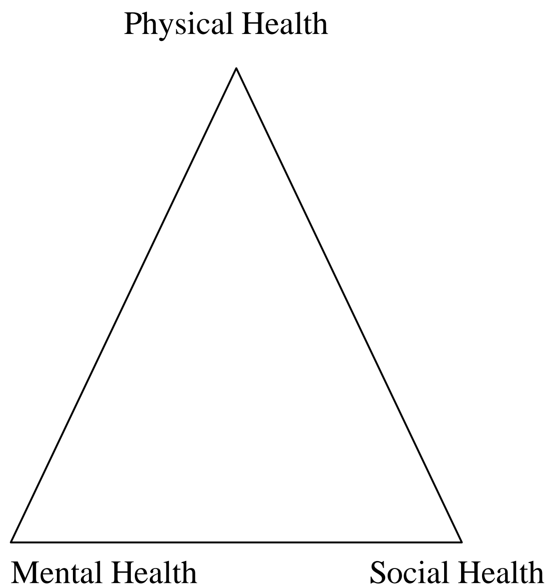

Figure 1: The Health Triangle

3.2.1 Physical Health

Physical fitness is good bodily health, and is the result of regular exercise, proper diet and nutrition, and proper rest for physical recovery.

Physical health is also the overall condition of a living organism at a given time, the soundness of the body, freedom from disease or abnormality, and the condition of optimal well-being. People want to function as designed, but environmental forces can attack the body or the person may have genetic malfunctions. The main concern in health is preventing injury and healing damage caused by injuries and biological attacks (Kurtus, 2002).

3.2.2 Mental Health

Mental health refers to an individual's emotional and psychological well-being. Merriam-Webster (1828) defines mental health as "A state of emotional and psychological well-being in which an individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life."

According to the World Health Organisation, there is no single "official" definition of mental health. Cultural differences, subjective assessments, and competing professional theories all affect how "mental health" is defined. In general, most experts agree that "mental health" and "mental illness" are not opposites. In other words, the absence of a recognised mental disorder is not necessarily an indicator of sound mental health.

One way to think about mental health is by looking at how effectively and successfully a person functions. Feeling capable and competent; being able to handle normal levels of stress, maintain satisfying relationships, and lead an independent life; and being able to "bounce back," or recover from difficult situations, are all signs of mental health.

3.2.3 Social Health

The concept of social health is less intuitively familiar than that of physical or mental health, and yet, along with physical and mental health, it forms one of the three pillars of most definitions of health. This is partly because social health can refer both to a characteristic of a society, and of individuals. "A society is healthy when there is equal opportunity for all and access by all to the goods and services essential to full functioning as a citizen" (Russell ,1973). Indicators of the health of a society might include the existence of the rule of law, equality in the distribution of wealth, public accessibility of the decision-making process, and the level of social capital.

The social health of individuals refers to "that dimension of an individual's well-being that concerns how he gets along with other people, how other people react to him and how he interacts with social institutions and societal mores" (Russell, 1973). This definition is broad—it incorporates elements of personality and social skills, reflects social norms, and bears a close relationship to concepts such as "well-being," "adjustment," and "social functioning."

Formal consideration of social health was stimulated in 1947 by its inclusion in the World Health Organisation's definition of health, and by the resulting emphasis on treating patients as social beings who live in a complex social context. Social health has also become relevant with the

increasing evidence that those who are well integrated into their communities tend to live longer and recover faster from disease. Conversely, social isolation has been shown to be a risk factor for illness. Hence, social health may be defined in terms of social adjustment and social support—or the ability to perform normal roles in society.

Definitions of social health in terms of adjustment derive from sociology and psychiatry. Poor social adjustment forms a common indicator of neurotic illness, and adjustment may be used to record the outcome of care, especially for psychotherapy. Adjustment may be rated subjectively, or it may be judged in terms of a person's fulfillment of social roles—how adequately a person is functioning compared to normal social expectations. Role performance can also indicate the impact of disability, bringing the concept of social health close to that of handicap, which refers to the social disadvantage resulting from impairments or disabilities (WHO, 1980). As norms vary greatly between cultures, however, a challenge lies in selecting an appropriate standard against which to evaluate roles.

Mutual social support is also commonly viewed as an aspect of social health. Support attenuates the effects of stress and reduces the incidence of disease. Social support also contributes to positive adjustment in children and adults, and encourages personal growth. The concept of support underlines the theme of social health as an attribute of a society: a sense of community—or the currently fashionable concept of social capital, which refers to the extent to which there is a feeling of mutual trust and reciprocity in a community—is an important indicator of social health.

A combination of physical, mental and social health is necessary to achieve overall health.

SELF ASSESSMENT EXERCISE

Physical health is defined as ……………..

3.3 Determinants of Health

The LaLonde report (LaLonde, 1974) suggests that there are four general determinants of health including ***human biology, environment, lifestyle***, and ***healthcare services***. Thus, health is maintained and improved not only through the advancement and application of health science, but also through the efforts and intelligent lifestyle choices of the individual and society. A major environmental factor is water

quality, especially for the health of infants and children in developing countries (UN, Basic Needs).

Studies show that in developed countries, the lack of neighborhood recreational space that includes the natural environment leads to lower levels of neighborhood satisfaction and higher levels of obesity; therefore, lower overall well-being (Bjork, *et al*, 2008). Therefore, the positive psychological benefits of natural space in urban neighborhoods should be taken into account in public policy and land use.

3.4 Strategies for Maintaining Health

Achieving health and remaining healthy is an ongoing process. Effective strategies for staying healthy and improving one's health include the following elements:

3.4.1 Social Activity

Personal health depends partially on the social structure of one's life. The maintenance of strong social relationships is linked to good health conditions, longevity, productivity, and a positive attitude. This is due to the fact that positive social interaction as viewed by the participant increases many chemical levels in the brain which are linked to personality and intelligence traits.

3.4.2 Sports/Nutrition

Sports/nutrition focuses on the link between dietary supplements and athletic performance. One goal of sports nutrition is to maintain glycogen levels and prevent glycogen depletion. Another is to optimise energy levels and muscle tone. An athlete’s strategy for winning an event may include a schedule for the entire season of what to eat, when to eat it, and in what precise quantities (before, during, after, and between workouts and events).

3.4.3 Hygiene

Hygiene is the practice of keeping the body clean to prevent infection and illness, and the avoidance of contact with infectious agents. Hygiene practices include bathing, brushing and flossing teeth, washing hands especially before eating, washing food before it is eaten, cleaning food preparation utensils and surfaces before and after preparing meals, and many others. This may help prevent infection and illness. By cleaning the body, dead skin cells are washed away with the germs, reducing their chance of entering the body.

3.4.4 Stress Management

Prolonged psychological stress may negatively impact health, such as by weakening the immune system and mind. Stress management is the application of methods to either reduce stress or increase tolerance to stress. Relaxation techniques are physical methods used to relieve stress. Psychological methods include cognitive therapy, meditation, and positive thinking which work by reducing response to stress. Improving relevant skills and abilities builds confidence, which also reduces the stress reaction to situations where those skills are applicable.

Reducing uncertainty, by increasing knowledge and experience related to stress-causing situations, has the same effect. Learning to cope with problems better, such as improving problem solving and time management skills, may also reduce stressful reaction to problems. Repeatedly facing an object of one's fears may also desensitize the fight-or-flight response with respect to that stimulus—e.g., facing bullies may reduce fear of bullies.

A prolonged hour of surfing on the Internet is a major concern that can affect the eyes significantly. A white background on computer screens with a viewing distance of less than 14 inches is known to increase strain, mental fatigue and temporary di-chromatic visions in a normal healthy human being. Trying to opt for black or any non-white backgrounds can help in reducing eye strain in front of personal computers.

3.4.5 Health Care

Health care is the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical, nursing, and allied health professions.

3.4.6 Workplace Wellness Programmes

Workplace wellness programs are recognised by an increasingly large number of companies for their value in improving the health and well-being of their employees, and for increasing morale, loyalty, and productivity. Workplace wellness programmes can include things like on-site fitness centres, health presentations, wellness newsletters, access to health coaching, tobacco cessation programmes and training related to nutrition, weight and stress management. Other programmes may include health risk assessments, health screenings and body mass index monitoring.

3.4.7 Public Health

Public health is "the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individual. It is concerned with threats to the overall health of a community based on population health analysis. The population in question can be as small as a handful of people or as large as all the inhabitants of several continents (for instance, in the case of a pandemic). Public health has many sub-fields, but is typically divided into the categories of epidemiology, biostatistics and health services. Environmental, social and behavioral and occupational health, are also important fields in public health.

The focus of public health intervention is to prevent rather than treat a disease through surveillance of cases and the promotion of healthy behaviours. In addition to these activities and in many cases, treating a disease can be vital to preventing it in others, such as during an outbreak of an infectious disease. Vaccination programmes and distribution of condoms are examples of public health measures.

4.0 CONCLUSION

We observed that at the time of the creation of the World Health Organisation (WHO), in 1948, ***Health*** was defined as being "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, 1948; WHO, 2006). However, more recently, it was observed that such definition would leave most of us unhealthy most of the time. Thus, in 1986, the WHO, in the Ottawa Charter for Health Promotion, added that health is "a resource for everyday life, not the objective of living. We have also seen in this unit that total health involves physical, mental and social well-being; thus these variables formed the health triangle. We briefly identified some determinants of health: biological, lifestyle choices, environmental and above all health care services. We also identified basic strategies for maintaining and sustaining good health, such as social activities, good hygiene, stress management, health care and public health. The thrust of this course is health systems management, so we will focus more on health care in subsequent units.

5.0 SUMMARY

In this unit, we have learnt the:

- definition of Health
- the health triangle
- determinants of health
- strategies for maintaining good health.

ANSWER TO SELF ASSESSMENT EXERCISE

Physical fitness is good bodily health, and is the result of regular exercise, proper diet and nutrition, and proper rest for physical recovery. Physical health is also the overall condition of a living organism at a given time, the soundness of the body, freedom from disease or abnormality, and the condition of optimal well-being.

6.0 TUTOR-MARKED ASSIGNMENT

1. Health is not just the absence of disease and infirmity, but also the resource for everyday life. Do you agree?
2. How true is this statement in your country?
3. Describe strategies for maintaining good health

7.0 REFERENCES/FURTHER READING

Björk. J.; Albin, M.; Grahn, P.; Jacobsson, H.; Ardo, J.; Wadbro, J.; Östergren, P. and Skärbäck, E. (2008). Recreational Values of the Natural Environment in Relation to Neighbourhood Satisfaction, Physical Activity, Obesity and Wellbeing. *Journal of Epidemiology and Community Health* 2008; 62:e2; doi:10.1136/jech.2007.062414.

Campbell, C. (2007). *Essentials of Health Management Planning and Policy*. Lagos: University of Lagos Press.

Encyclopedia of Public Health; Social Health. Answers.com Retrieved from ://www.answers.com/topic/social-health. Site Accessed on 26th October 2008.

Kurtis, R. (2002). What is Physical Health? School for Champions.

Karonne, B. J. (2002). *Medical Office Procedure.* NY: McGraw Hill Pub.

Merson, M. H.; Black, R. E and Mill, A. J. (2001). *International Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

Mitchell, J. and Haroun, L. (2001). *Introduction to Health Care*. Canada: Delmar.

LaLonde, Marc. (1974). "A New Perspective on the Health of Canadians." Ottawa: Minister of Supply and Services.

Russell, R. D. (1973). "Social Health: An Attempt to Clarify this Dimension of Well-Being." *International Journal of Health Education* 16:74–82.

United Nations. (1995). *Basic Facts*. Geneva: United Nations.

WHO (1948). Preamble to the Constitution of the World Health Organisation *(Official Records of the World Health Organisation, no. 2, p. 100)*; and entered into force on 7 April 1948.

WHO. (1994a) *Basic Documents.* Geneva: WHO.

WHO, (1980). *International Classification of Impairments, Disabilities, and Handicaps.* Geneva: Author.

WHO (2005). Constitution of the World Health Organisation: Promoting Mental Health: Concepts, Emerging evidence, Practice: A Report of the World Health Organisation, Department of Mental Health and Substance Abuse in Collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. World Health Organisation. Geneva.

WHO, (2006). Constitution of the World Health Organisation. *Basic Documents*, (44th ed.). Supplement, October 2006.

Wikipedia (2009). Primary Health Care. Wikipedia Foundation Inc. Page Last Modified 16th July 2009.

Wikipedia, (2009). Health. Wikipedia Foundation Inc. Page last Modified on 14th July 2009. Page accessed on 14th July 2009.

UNIT 2 UNDERSTANDING LEVELS OF HEALTH CARE

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
 3.1 What is Health Care?
 3.2 Levels of Health Care
  3.2.1 Primary Health Care
   3.2.1.1 Essentials of Primary Health Care
   3.2.1.2 Four Cornerstones of Primary Health Care
  3.2.2 Secondary Health Care
  3.2.3 Tertiary Health Care
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

It is the view of the World Health Organisation that health care should embrace all the goods and services designed to promote health, including “preventive, curative and palliative interventions. In this unit, we will attempt a definition of the health care as well as its levels. Enjoy your studies.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define health care
- identify the levels of health care
- illustrate the cornerstones of primary health care.

3.0 MAIN CONTENT

3.1 What is Health Care?

Health care is the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical, nursing, and allied health professions. According to the World Health Organisation, health care embraces all the goods and services designed to promote health, including “preventive, curative and palliative interventions, whether directed to individuals or to

populations" (Wikipedia, 2009). The organised provision of such services may constitute a health care system.

Since health is influenced by a number of factors such as adequate food, housing, basic sanitation, healthy lifestyles, protection against environmental hazards and communicable diseases, the frontiers of health extend beyond the narrow limits of medical care. It is thus clear that "health care" implies more than "medical care." It embraces a multitude of "services provided to individuals or communities by agents of the health services or professions, for the purpose of promoting, maintaining, monitoring, or restoring health.

The term "medical care" is not synonymous with "health care." It refers chiefly to those personal services that are provided directly by physicians or rendered as the result of physicians' instructions. It ranges from domiciliary care to resident hospital care. Medical care is a subset of health care system (Wikipedia, 2007).

3.2 Levels of Health Care

The delivery of health care differs from region to region, but the basic approaches are somewhat similar. Levels of health care include:

3.2.1 Primary Health Care

This is the medical care a patient receives upon first contact with the health care system, before referral elsewhere within the system. This is often abbreviated as PHC (Primary Health Care) and it is "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination" (McGilvary, 1981); (Alma Ata international conference definition).

The concept of primary health care was defined by the World Health Organisation in 1978 as both a level of health service delivery and an approach to health care practice. Primary care, as the provision of essential health care, is the basis of a health care system. It provides both the initial and the majority of health care services of a person or population. This is in contrast to secondary health care, which is consultative, short term, and disease-oriented for the purpose of assisting the primary care practitioner. Tertiary care is for patients with unusual illness requiring highly specialised services. Primary care clinicians may be physicians, nurses, or various other health workers trained for the

purpose. Countries with better provision of primary health care have greater patient satisfaction at lower costs and better health indicators.

While there are many definitions of primary care, the principles of accessible, comprehensive, continuous, and coordinated personal care in the context of family and community are consistent. Primary health care should be available to all people without the barriers of geography, cost, language, or culture. In primary care, all types of problems, at all ages and for both genders, are considered, including care for acute self-limited problems or injuries, the care of chronic diseases such as diabetes or AIDS (acquired immunodeficiency syndrome), the provision of preventive care services such as immunisations and family planning, and health education. Because primary health care is broad, it is information-rich. Primary care clinicians coordinate care for patients among different service providers and for different patient concerns, responding to the fact that most patients have multiple problems. Continuity of care refers to the ongoing relationship between individual patients and primary care clinicians who are committed to the person, not a specific disease, body of knowledge, or specialised technique, and who recognise that physical, mental, emotional, and social concerns are related. Primary care clinicians, interested in the meaning of illness to the particular person, must negotiate care with that individual. A person's health is greatly influenced by the individual's family, culture, and community. Thus, the delivery of primary health care may be different for each individual and in different areas of the world (Encyclopedia of Public Health).

3.2.1.1 Essential Components of Primary Health Care

The Declaration of Alma Ata outlined the following essential components of primary health care such as principles of:

- **Equitable Distribution**

Health services must be shared equally by all people irrespective of their ability to pay and all (rich or poor, urban or rural) must have access to health services. Primary health care aims to address the current imbalance in health care by shifting the centre of gravity from cities where a majority of the health budget is spent to rural areas where a majority of people live in most countries.

- **Community Participation**

There must be a continuing effort to secure meaningful involvement of the community in the planning, implementation and maintenance of

health services, beside maximum reliance on local resources such as manpower, money and materials.

- **Intersectoral Coordination**

Primary health care involves in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communication and other sectors.

3.2.1.2 The Four Cornerstones of Primary Health Care

1. Active community participation
2. Intra and inter-sectoral linkages
3. Use of appropriate technology
4. Support mechanism made available (Wikipedia, 2009).

SELF ASSESSMENT EXERCISE

What is primary health care?

3.2.2 Secondary Health Care

The term secondary care is a service provided by medical specialists who generally do not have first contact with patients, for example, cardiologists, urologists and dermatologists. A physician might voluntarily limit his or her practice to secondary care by refusing patients who have not seen a primary care provider first, or a physician may be required, usually by various payment agreements, to limit the practice this way.

Some areas of secondary care are also managed by allied health professions who work to co-manage that aspect of health care with physicians, such as occupational therapists and orthoptists.

Secondary health care is also the intermediate level of health care, which is the responsibility of the state government. It provides mutually supportive referral sub-system to the primary health care. It is involved in curative as well as promotive services. Health institutions under the secondary level include: general hospitals, cottage hospitals and comprehensive health centres. Providers of services here are doctors, nurses, midwives, pharmacists, laboratory staff, x-ray technologists/technicians, etc.

3.2.3 Tertiary Health Care

In medicine, tertiary health care is specialised consultative care, usually on referral from primary or secondary medical care personnel, by specialists working in a centre that has personnel and facilities for special investigation and treatment. Specialist cancer care, neurosurgery (brain surgery), burns care and plastic surgery are examples of tertiary care services. In comparison, secondary medical care is the medical care provided by a physician who acts as a consultant at the request of the primary physician.

Also as the name implies, tertiary health care is the top most level of health care, which provides referral base for all cases sent from primary and secondary levels. Health institutions involved here are: specialist and teaching hospitals. This level also provides the mutually supportive referral sub-systems to the secondary care level and specialists with rehabilitation care as well as training for capacity building.

The tertiary level care is the responsibility of the federal government in Nigeria. This is because of the high financial commitment of the activities involved, such as specialist services, huge technology, advanced diagnostic procedures and counselling. The federal government therefore controls the tertiary level of health care in Nigeria through:

- legislation
- policy making
- standard setting
- health manpower training
- provision of teaching committee
- providing assistance to state and local government

4.0 CONCLUSION

In this unit, we noted that health care is the prevention, treatment, and management of illness and the preservation of mental, social and physical well-being through the services offered by the medical, nursing, and allied health professions. WHO also affirms that health care embraces all the goods and services designed to promote health, including “preventive, curative and palliative interventions, whether directed to individuals or to populations”. This unit also looked at levels of health care which include: primary, secondary and tertiary health care. Thus, primary health care is the medical care a patient receives upon first contact with the health care system, before referral elsewhere within the system. Secondary care is a service provided by medical specialists who generally do not have first contact with patients while

tertiary health care is specialised consultative care, usually on referral from primary or secondary medical care personnel.

5.0 SUMMARY

This unit presented the following concepts:

- health care and its definition
- levels of health care
- essential components of primary health care

We hope you enjoyed your studies. Now let us attempt the questions below.

ANSWER TO SELF ASSESSMENT EXERCISE

The concept of primary health care was defined by the World Health Organisation in 1978 as both a level of health service delivery and an approach to health care practice. Primary care, as the provision of essential health care, is the basis of a health care system. It provides both the initial and the majority of health care services of a person or population. This is in contrast to secondary health care, which is consultative, short term, and disease-oriented for the purpose of assisting the primary care practitioner. Tertiary care is for patients with unusual illness requiring highly specialised services. Primary care clinicians may be physicians, nurses, or various other health workers trained for the purpose. Countries with better provision of primary health care have greater patient satisfaction at lower costs and better health indicators.

6.0 TUTOR-MARKED ASSIGNMENT

1. Distinguish primary, secondary and tertiary health care
2. Identify the essential components of primary health care

7.0 REFERENCES/FURTHER READING

Campbell, C. (2007). *Essentials of Health Management Planning and Policy*. Lagos: University of Lagos Press.

Encyclopedia of Public Health; Social Health. Answers.com Retrieved from ://www.answers.com/topic/social-health. Site Accessed on 20th July 2009.

McGilvray, J. C. (1981). *The Quest for Health and Wholeness*. Tübingen: German Institute for Medical Missions.

Merson, M. H.; Black, R. E and Mill, A. J. (2001). *International Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

Mitchell, J. and Haroun, L. (2001). *Introduction to Health Care*. Canada: Delmar.

WHO (1978). "Alma Ata 1978: *Primary Health Care*". *HFA Sr.* (1).

Wikipedia (2009) Primary Health care. Retrieved from ://en.wikipedia.org/wiki/Primary_health_care. Site visited on 20th July 2009.

UNIT 3 HEALTH CARE PROVIDERS AND SPECIALTY CARE

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
 3.1 Primary Care Provider
 3.2 Nursing Care
 3.3 Drug Therapy
 3.4 Specialty Care
 3.5 Complementary and Alternative Care
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

Welcome to unit 3 of this course. Remember this course is about health system management, but we need to have a firm knowledge of basic health concepts and determinants. In previous units, we presented definitions of health as well as levels of health care. In this unit, we will look at different health care providers, specifically, health care professionals as well as specialty care available in health care. Enjoy your studies.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- identify primary health care providers/professional
- explain the features of nursing care
- identify features of drug therapy
- illustrate various specialty cares obtainable in health care
- explain complementary and alternative medicine.

3.0 MAIN CONTENT

3.1 Primary Care Provider

A primary care provider (PCP) is the person a patient sees first for checkups and health problems. The following is a review of practitioners that can serve as PCP.

- The term "generalist" often refers to medical doctors (MDs) and doctors of osteopathic medicine (DOs) who specialise in internal medicine, family practice, or pediatrics.
- OB/GYNs are doctors who specialise in obstetrics and gynaecology, including women's health care, wellness, and prenatal care. Many women use an OB/GYN as their primary care provider.
- Nurse practitioners (NPs) are nurses with graduate training. They can serve as a primary care provider in family medicine (FNP), pediatrics (PNP), adult care (ANP), or geriatrics (GNP). Others are trained to address women's health care (common concerns and routine screenings) and family planning. In some countries, NPs can prescribe medications.
- A physician assistant (PA) can provide a wide range of services in collaboration with a Doctor of Medicine (MD) or Osteopathy (DO) (Medical Encyclopedia, 2006).

3.2 Nursing Care

- Provided by registered nurses (RNs) that have graduated from a nursing programme, have passed a state board examination, and are licensed by the state.
- Advanced practice nurse training with education and experience beyond the basic training and licensing is required of all RNs. This includes nurse practitioners (NPs) and the following:
- Clinical nurse specialists (CNSs) with training in a field such as cardiac, psychiatric, or community health.
- Certified nurse midwives (CNMs) with training in women's health care needs, including prenatal care, labour and delivery, and care of a woman who has given birth.
- Certified registered nurse anaesthetists (CRNAs) with training in the field of anaesthesia. Anaesthesia is the process of putting a patient into a painless sleep, and keeping the patient's body working, so surgeries or special tests can be done (Medical Encyclopedia, 2006).

3.3 Drug Therapy

This is provided by licensed pharmacists with graduate training from a college of pharmacy.

Your pharmacist prepares and processes drug prescriptions that were written by your primary or specialty care provider. Pharmacists provide information to patients about medications, while also consulting with health care providers about dosages, interactions, and side effects of medicines.

Your pharmacist may also follow your progress to check the safe and effective use of your medication (Medical Encyclopedia, 2006).

3.4 Specialty Care

Your primary care provider may refer you to professionals in various specialties when necessary, such as:

- Allergy and asthma
- Anesthesiology -- general anesthesia or spinal block for surgeries and some forms of pain control
- Cardiology -- heart disorders
- Dermatology -- skin disorders
- Endocrinology -- hormonal and metabolic disorders, including diabetes
- Gastroenterology -- digestive system disorders
- General surgery -- common surgeries involving any part of the body
- Haematology -- blood disorders
- Immunology -- disorders of the immune system
- Infectious disease -- infections affecting the tissues of any part of the body
- Nephrology -- kidney disorders
- Neurology -- nervous system disorders
- Obstetrics/gynaecology -- pregnancy and women's reproductive disorders
- Oncology – cancer treatment
- Ophthalmology -- eye disorders and surgery
- Orthopaedics -- bone and connective tissue disorders
- Otorhinolaryngology -- ear, nose, and throat (ENT) disorders
- Physical therapy and rehabilitative medicine -- for disorders such as low back injury, spinal cord injuries, and stroke
- Psychiatry -- emotional or mental disorders
- Pulmonary (lung) -- respiratory tract disorders

- Radiology -- X-rays and related procedures (such as ultrasound, CT, and MRI)
- Rheumatology -- pain and other symptoms related to joints and other parts of the musculoskeletal system
- Urology -- disorders of the male reproductive and urinary tracts and the female urinary tract (Medical Encyclopedia)

SELF ASSESSMENT EXERCISE

1. Identify the three health practitioners available in the modern health care
2. Identify10 specialisations available in the modern health care.

3.5 Complementary and Alternative Medicine

Complementary and Alternative Medicine (CAM) is the use of treatments that are not commonly practised by the medical profession. CAM includes visits to:

Faith Healing

This is the use of suggestions, power and faith in God to achieve healing. According to Denton (1978), two basic beliefs are prevalent in religious healing. They are:

1. The idea that healing occurs through psychological processes and is effective only with psychophysiological disorders.
2. The other idea is that healing is accomplished only through the intervention of God. This, thus, constitutes the present day miracle.

Denton (1978) also offers 5 general categories of faith healing. They are:

1. self-treatment through prayer
2. treatment by a lay person thought to be able to communicate with God
3. treatment by an official church leader for whom healing is only one of many tasks
4. healing obtained from a person or group of persons who practise healing fulltime without affiliation with a major religious organisation
5. healing obtained from religious leaders who practise full time and are affiliated with a major religious group.

A common theme running through each of these categories is an appeal to God to change a person's physical and mental conditions for the better (Denton, 1978).

Folk Healing

Folk medicine is often regarded as a residue of health measures leftover from pre-scientific historical periods (Bakx, 1991). Yet, folk healing has persisted in modern scientific society, and major reasons appear to be dissatisfaction with professional medicine and a cultural gap between biomedical practitioners and particular patients (Bear, 2001; Bakx, 1991; Madsen, 1973). These patients, typically low income persons, may view folk medicine as a resource because it represents a body of knowledge about how to treat illness that has grown out of historical experiences of the family and ethnic group (Thorogood, 1990). Common ingredients in folk remedies are such substances as ginger tea, honey, whisky, lemon juice, garlic, pepper, salt, etc.

Aromatherapy

Aromatherapy is the use of aromatic oils for relaxation.

Acupuncture

Acupuncture is an ancient Chinese technique of inserting fine needles into specific points in the body to ease pain and stimulate bodily functions.

Homeopathy

Homeopathy is the use of micro doses of natural substances to booster immunity.

Naturopathy

Naturopathy is based on the idea that diseases arise from blockages in a person's life force in the body and treatments like acupuncture and homeopathy are needed to restore the energy flow.

Aryuveda

This is an Indian technique of using oil and massage to treat sleeplessness, hypertension and indigestion.

Shiatsu

Japanese therapeutic massage

Crystal Healing

This is based on the idea that healing energy can be obtained from quartz and other minerals.

Biofeedback

This is the use of machines to train people to control involuntary bodily functions.

Use of Dietary Supplements

Use of supplements like garlic to prevent blood clot, ginger, fish oil capsules to reduce the threat of heart attack

4.0 CONCLUSION

As you can see, there are quite a number of options available for medical care/self care. The usage of one or more available options depends on one's orientation, experience and socialisation. The list of healing options provided in this unit is of course not exhaustive.

5.0 SUMMARY

In this unit, we looked at several healing options available in modern health care and complementary or alternative health care. New let us attempt this exercise.

ANSWER TO SELF ASSESSMENT EXERCISE

1. Primary care provider, nursing care and the pharmacist
2. 10 specialisations available in modern health care are:

- Cardiology -- heart disorders
- Dermatology -- skin disorders
- Endocrinology -- hormonal and metabolic disorders, including diabetes
- Gastroenterology -- digestive system disorders
- General surgery -- common surgeries involving any part of the body
- Haematology -- blood disorders
- Immunology -- disorders of the immune system

- Infectious disease -- infections affecting the tissues of any part of the body
- Nephrology -- kidney disorders
- Neurology -- nervous system disorders

6.0 TUTOR-MARKED ASSIGNMENT

Identify and discuss at least 8 healing options obtainable in the complementary/ alternative medicine.

7.0 REFERENCES/FURTHER READING

Ajala, J.A (2005). *Health Education in Wellness and Sickness: This day, This Age; an Inaugural Lecture Delivered at the University of Ibadan*, on Thursday, 24th November, 2005.

Bakx, K. (1991). The 'Eclipse' of Folk Medicine in Western Society. *Sociology of Health and Illness*, 13: 20-38.

Bear, H. A. (2001). *Biomedicine and Alternative Healing System in America: Issues of Class, Race, Ethnicity and Gender. Madison*, WI: Univ. of Wisconsin.

Cockerham, W. C. (2003). *Medical Sociology*, 9th edition. NY: Prentice Hall.

Cole, R. M. (1970), *Sociology of Medicine*. New York: McGraw-Hill Book Co.

Denton, J. A. (1978). *Medical Sociology*. Boston: Houghton Mifflin.

Encyclopedia of Public Health; Social Health. Answers.com Retrieved from ://www.answers.com/topic/social-health. Site Accessed on 26th October 2008.

Hawe, P. and Shiell, A. (2000). "Social Capital and Health Promotion: A Review." *Social Science and Medicine* 51:871–885.

Kurtis, R (2002). What is Physical Health? School for Champions

Kendell, R. E. (1975). *The Role of Diagnosis in Psychiatry*. Oxford: Blackwell Scientific Pub:

LaLonde, Marc. "A New Perspective on the Health of Canadians." Ottawa: Minister of Supply and Services; 1974.

Merrian-Webster (1828). An American Dictionary of English Language. Springfield Massachusetts: G & C Merian Co.

Marinker, M. Why make people Patients? *Journal of Medical Ethics* 1975:I:81–4.

Medical Encyclopedia – Types of Healthcare Providers. Update on 10/24/2006 by Daniel R. Alexander. *Retrieved from Medline Plus Online*. Site visited on 22 march 2007.

Medsen, W. (1973). *The Mexican-American of South Texas*, (2nd ed.). NY: Holt, Rinehart and Winston.

Russell, R. D. (1973). "Social Health: An Attempt to Clarify this Dimension of Well-Being." *International Journal of Health Education* 16:74–82.

Szasz, T. S. (1987). *Insanity – The Idea and its Consequences*. New York: John Wiley and Sons.

Taylor, S. E. (2006). *Health Psychology*, (6th ed.). Los Angeles: McGraw Hill.

Thorogood, N. (1990). Caribbean Home Remedies and the Importance for Black's Health Care in Britain, pp 140-152. *In*: P. Abbott and G. Payne (eds.). *New Directions in the Sociology of Health*. London: Taylor and Francis.

The British Journal of Psychiatry (2001) 178: 490-49 © 2001 Royal College of Psychiatrists.

United Nations. (1995) *Basic Facts*. Geneva: United Nations.

WHO. (1994a) *Basic Documents*. Geneva: WHO.

World Health Organisation (1980). *International Classification of Impairments, Disabilities, and Handicaps*. Geneva: Author.

Wikipedia (2008). Health. Wikipedia Foundation Inc. Page last modified 27th October 2008. Page accessed on 27th October 2008.

Wikipedia (2008). *Primary Health Care*. Wikipedia Foundation Inc. Page Last Modified 16th September 2008. Page accessed 27th October 2008.

Weiss, L. G. and Lonnquist, L. E. (2005). *The Sociology of Health, Healing and Illness,* (5th ed.). Safari book online. Retrived from http//www.safarix.com/0131928406/ch07iev1sec3. Accessed on 10th July, 2007.

MODULE 2 UNDERSTANDING THE HEALTH SYSTEM

Unit 1 Understanding the Health System
Unit 2 Historical Development of Health Care System
Unit 3 Nigerian Health Care System

UNIT 1 UNDERSTANDING THE HEALTH SYSTEM

CONTENTS

1.0 Introduction
2.0 Objectives
4.0 Main Content
- 4.1 What is Health System?
- 4.2 Goals of Health System
- 4.3 Elements of Health System
- 4.4 Typologies of Health System
- 4.5 Evaluation of Health System
  - 4.5.1 Efficiency
  - 3.5.2 Equity

4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

In module 2 of this course, we will learn about specific terms and variables related to health system. Remember the previous module dwelt on defining health, determinants of health, understanding health care and levels, as well as specialty care. Specifically, this unit provides us with definitions of health system, its goals, elements, typologies and evaluations. Enjoy your studies.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define the health system
- explain the goals of the health system
- identify the elements of the health system
- explain the typologies of health system
- evaluate the health system.

3.0 MAIN CONTENT

3.1 What is Health System?

The term “health system” refers to a country’s system of delivering services for the prevention and treatment of disease and for the promotion of physical and mental well-being.

A health system has also been defined as “the combination or resources, organisation, financing and management that culminates in the delivery of health services to the population” (Roemer, 1991). The system includes all actors, institutions and resources that undertake health actions. Although the defining goal of a health system is to improve population health, other intrinsic goals are to be responsive to the population they serve, determined by the way and the environment in which people are treated, and to ensure that the financial burden of paying for health is fairly distributed across households. Four key functions determine the way inputs are transformed into outcomes that people value – *resource generation, financing, service provision and stewardship.* Of particular interest to a health care system is how medical care is:

- organised
- financed
- delivered

The *organisation* of care refers to such issues as who gives care (for example, primary care physicians, specialist physicians, nurses, and alternative practitioners) and whether they are practising as individuals, in small groups, in large groups, or in massive corporate organisations.

The *financing* of care involves who pays for medical services (for example, self-pay, private insurance, medicare, or medicaid) and how much money is spent on medical care.

The *delivery* of care refers to how and where medical services are provided (for example, in hospitals, doctors’ offices, or various types of outpatient clinics; and in rural, urban, or suburban locations).

Health systems, like medical knowledge and medical practice, are not fixed but are continually evolving. In part, health systems reflect the changing scientific and technologic nature of medical practice. Further, a country’s health system also reflects in part the culture and values of that society.

3.2 Goal of Health System

The goals for health systems, according to the *World Health Report 2000 - Health systems: improving performance* (WHO, 2000), are good health, responsiveness to the expectations of the population, and fair financial contribution. Duckett (2004) proposed a two-dimensional approach to evaluation of health care systems: quality, efficiency and acceptability on one dimension and equity on the other (Brody, 2008).

Providers: Health care providers are trained professional people working as self-employed or as an employee in an organisation, whether a for-profit company, a not-for profit company, a government entity, or a charity. Organisations employing people providing health care are also known as health care providers. Examples are doctors and nurses, dentists, medical laboratory staff, specialist therapists, psychologists, pharmacists, chiropractors, and optometrists.

SELF ASSESSMENT EXERCISE

Of particular interest to a health system is how medical care is: organised, financed and delivered. Explain.

3.3 Elements of Health Systems

Since the seminal study of Kohn and White 1976, an expanding body of literature has been attempting to both systemise the discussion of various *elements of health system* and to categorise health system into a limited number of *different types* (Roemer, 1991).

Roemer (1991) identifies five major categories that enable a comprehensive description of a country's health system to be made:

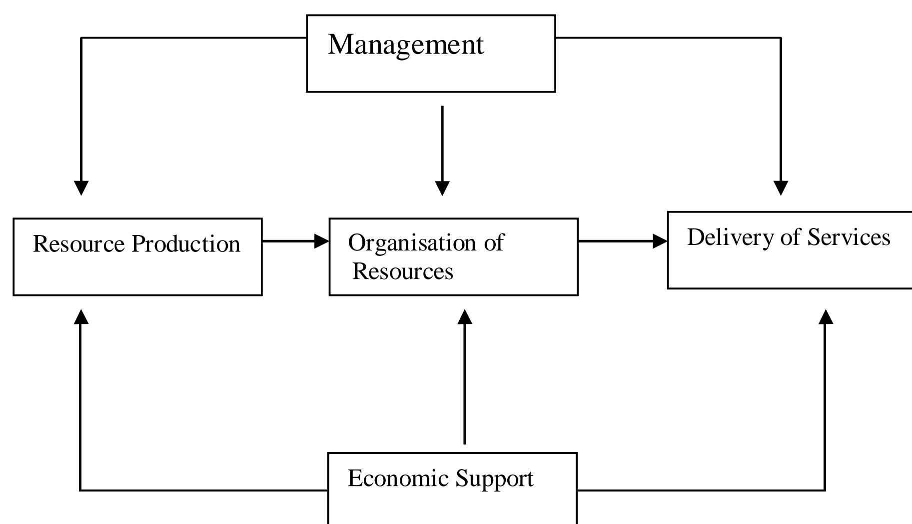

Fig. 2: The Elements of Health System
(Culled from Roemer, 1991)

Management and Methods: this entails planning, administration, regulation, legislation.

Production of Resources involves the contributions of trained staff; and commodities such as drugs; facilities; knowledge.

Organisation of Resources is the duty of the government, ministries, private providers, voluntary agencies.

Delivery of Services: includes: preventive and curative personal health services; primary, secondary and tertiary services; services for specific population groups, such as children, or for specific conditions, such as mental illness.

Economic Support Mechanisms include sources of funds such as tax, insurance, user fees.

This categorisation is helpful for describing the health system; indeed Roemer (1991, 1993) applies it in his books to a very large number of countries. However it is not helpful in understanding how health system behaves in terms of efficiency and equity. This would require much more detailed subcategories and greater elaboration of the relationships not just within each category, but particularly between categories (for example, between economic support mechanisms and organisation of programmes).

The Organisation of Economic Cooperation and Development (OECD) has developed a categorisation that is helpful for understanding not only the economic dimensions in OECD countries, but also the directions that reforms are taking them in (OECD, 1992). The key yardsticks of such economic directions and reforms are:

- Whether the prime funding source consists of payments that are made voluntarily (as in private insurance or payment of user fees) or are compulsory (as in taxation or social insurance)
- Whether services are provided by direct ownership (termed the integrated pattern, where a Ministry of Health or social insurance agency provides services itself), by contractual arrangements (where a Ministry of Health or social insurance agency contracts with providers to deliver services), or simply by private providers (paid by direct out-of-pocket payment).
- How services are paid for (prospectively---where financial risk is transferred to providers, or retrospective—where the cost of care is reimbursed).

3.4 Typologies of Health System

In order to make comparisons of how different types of health systems perform, it is necessary to group countries into manageable number of types. There have been various attempts to do this. Countries can be classified according to:

- The dominant method of health care financing (for example, tax, social insurance, private insurance, out-of-pocket payment)
- The underlying political philosophy (for example, capitalism, socialism)
- The nature of state intervention (for example, to cover the whole population, or only the poor and vulnerable)
- The level of Gross National Product (GNP) (for example, low, medium, high)
- Historical or cultural attributes (for example, industrialised, non-industrialised (Merson *et al.*, 2001).

A key difficulty is that countries do not nearly fit into these categories. Roemer (1991), for example, uses two dimensions:

Economic level (with 4 categories)

1. Affluent and industrialised
2. Developing and transnational
3. Very poor
4. Very rich

Health system policies (with 4 categories)

1. Entrepreneurial and permissive
2. Welfare-oriented
3. Universal and comprehensive
4. Socialist and centrally planned.

While some of these categories are less relevant than they were at the time (for example, centrally planned), it is also the case that the second dimension does not classify well the, health systems of low and middle income countries. Since a typology suitable for low and medium income countries is yet to be worked out, the content of the next section is based on simple framework (shown in figure 3, map of the health system) that identifies 4 key actors:

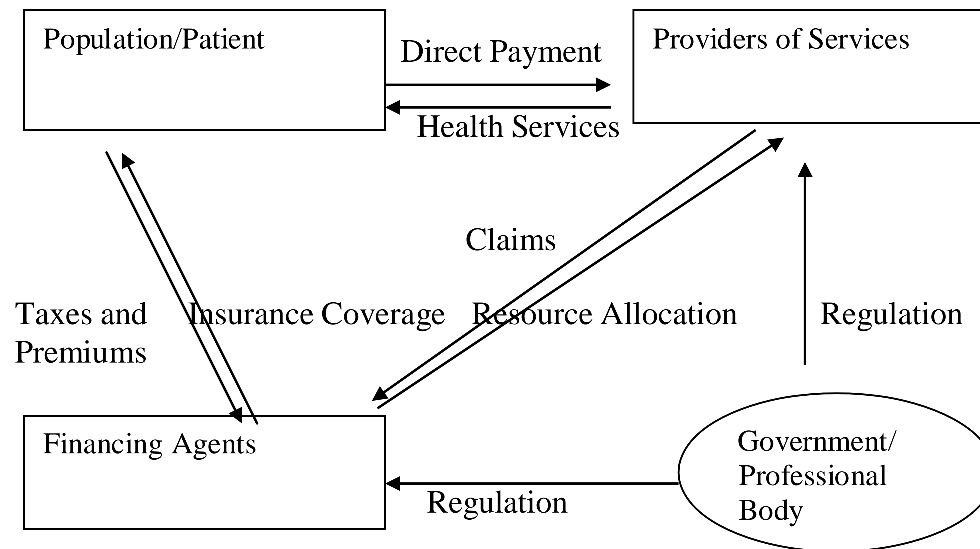

Fig. 3: A Map of the Health System (Merson, *et al*, 2001)

1. The government or professional body that structures and regulates the system
2. The population, including patients, who as individuals and households ultimately pay for the health system and receive services.
3. Financial agents, who collect funds and allocate them to providers or purchase services at national or lower levels
4. The providers of services who themselves can be categorised in various ways, such as by level (primary, secondary and tertiary), function (curative, preventive); ownership (public, private), degree of organisation (formal, informal); or medical system (allopathic, ayurvedic).

3.5 Evaluation of Health System

Criteria often used to evaluate health systems are:

1. efficiency and
2. equity

3.5.1 Efficiency

Efficiency has a number of different dimensions:

1. Macroeconomic efficiency: This refers to total cost of the health system in relation to overall health system status. Countries differ

in how efficiently their health systems convert resources used into health gains.

2. Microeconomic efficiency: This refers to the scope for achieving greater efficiency from existing resources. It is of 2 types:

- **Allocative Efficiency:** devoting resources to the mix of activities that will have greatest impact on health (i.e., most cost effective).
- **Technical Efficiency:** using only the minimum necessary resources to finance, purchase and deliver a particular activity or a set of activities (i.e., avoiding waste).

3.5.2 Equity

Equity can be expressed in 2 different ways, namely:

1. horizontal and
2. vertical equity.

Horizontal equity refers to the equal treatment of equals. This implies that the charge levied by all agents or providers for a particular good and service should be the same for households with equal ability to pay regardless of gender, marital status and so on.

Vertical equity is based on the principle that individuals who are unequal in society should be treated differently (Donaldson and Gerard, 1993).

4.0 CONCLUSION

We hope you enjoyed your studies. In this unit, we learnt that "health system" is a country's system of delivering services for the prevention and treatment of disease and for the promotion of physical and mental well-being. A health system was also defined as "the combination or resources, organisation, financing and management that culminates in the delivery of health services to the population" (Roemer, 1991). Four key functions determine the way inputs are transformed into outcomes that people value. They include: resource generation, financing, service provision and stewardship. Goals of the health system thus include: health, responsiveness to the expectations of the population, and fair financial contribution. We also observed five major categories that enable a comprehensive description of a country's health system and they include: management, resource production, organisation of resources, delivery of services and economic support. For the evaluation of health system, we observed 2 important variables: efficiency and equity.

5.0 SUMMARY

In this unit, we illustrated the following:

- defining health system
- goals of health system
- element of health system
- typologies of the health system
- evaluation of the health system

We hope you enjoyed your studies. Now let us respond to the assignment below.

ANSWER TO SELF ASSESSMENT EXERCISE

Of particular interest to a health care system is how medical care is: organised, financed and delivered.

The *organisation* of care refers to such issues as who gives care (for example, primary care physicians, specialist physicians, nurses, and alternative practitioners) and whether they are practising as individuals, in small groups, in large groups, or in massive corporate organisations.

The *financing* of care involves who pays for medical services (for example, self-pay, private insurance, Medicare, or Medicaid) and how much money is spent on medical care.

The *delivery* of care refers to how and where medical services are provided (for example, in hospitals, doctors' offices, or various types of outpatient clinics; and in rural, urban, or suburban locations).

6.0 TUTOR-MARKED ASSIGNMENT

1. With diagrammatic presentation, illustrate the elements of health system?
2. Draw a map of the health system and identify the roles of the 4 key actors.

7.0 REFERENCES/FURTHER READING

Brody, (2008). Criteria for Evaluating the US Health Systems: Cost, Coverage, Consistency, Complexity and Chronic Illness.

Campbell, C. (2007). *Essentials of Health Management Planning and Policy*. Lagos: University of Lagos Press.

Donaldson, C. and Gerard, K. (1993). *Economics of Health Care financing: The Visible Hand*. London: McMillan.

Encyclopedia of Public Health; Social Health. Answers.com Retrieved from ://www.answers.com/topic/social-health. Site Accessed on 20th July 2009.

Merson, M. H., Black, R. E and Mill, A. J. (2001). *International Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

Mitchell, J. and Haroun, L. (2001). *Introduction to Health Care*. Canada: Delmar.

Organisation of Economic Cooperation and Development (OECD), (1992). Sub-Systems of Financing and Delivery of Health Care. *In:* OECD. The Reform of Health Care (pp. 9-29). Paris: Author.

Reinke, W. A. (2001). Health Systems Management. *In*: M. H. Merson, R. E. Black, and A. J. Mill, (eds.). *International Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

Roemer, M. I. (1991). *National Health Systems of the World* (Vol: The Countries). Oxford, England: Oxford Univ. Press.

Roemer, M. I. (1993). *National Health Systems of the World*. (Vol 2: The issues). Oxford England: Oxford Univ. Press.

UNIT 2 HISTORICAL DEVELOPMENT OF HEALTH SYSTEMS

CONTENTS

1.0 Introduction
2.0 Objectives
3.3 Main Content
 3.1 Global Health System: Historical Development
 3.2 Nigerian Health System: Historical Development
 3.3 Evolution of Health System in Nigeria
  3.3.1 Pre-Colonial Period
  3.3.2 Colonial Period
  3.3.3 Post Independence Period
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

Remember that in the previous unit, we tried to define the health system, its goals, elements, typologies and evaluative components. This unit continues with the historical development of health system, both globally and locally (Nigeria).

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- explain the history of global health system
- describe the historical development of the Nigerian health system
- identify the evolution of the Nigerian health system.

4.0 MAIN CONTENT

3.1 Global Health System: Historical Development

As indicated by archeological evidence, medicine has had its role in all cultures and civilisations (for example, in ancient Mesopotamia and Egypt). The Romans built hospitals for domestic slaves and soldiers in permanent forts in occupied territories such as England. However, the real development of the hospital derived from the spread of Christianity and the ideas of Christian charity and caring for all who might be in need for conversion. Hospitals developed in the main cities of the Christian world are often associated with churches and monasteries. The

Islamic world also developed hospitals and by the 11th century, there were large hospitals in every major Muslim town. Hospitals were for the sick who lacked families, or servants who care for them – the poor, travelers and those working away from home (Abel-Smith, 1994).

In Europe, by the middle Ages, a multiplicity of institutions and organisations had developed with pretensions to authority over medicine: the church, guilds, medical colleges, town councils and powerful individuals. In Brussels, for example, a board of clergy, doctors and midwives licensed midwives in the 15th century. The arrival of the plague-the Black Death-which in its first wave killed about 25% of Europe's population stimulated growing state involvement to protect health through measures such as imposing quarantine and isolating the sick (Abel-Smith, 1994).

From the early 19th century, the scientific basis of medicine was increasingly established, with scientific training becoming essential for the practice of medicine (Porter, 1996b). The strong development of discipline of public health in the 19th century was also a response to the disease hazards of the urban environment. Over the 18th and 19th centuries, modern forms of medical regulation developed. Countries in which medicine was dominated by free market (such as USA) converged with countries in Europe with strong state control (such as Germany) to produce closely regulated medical markets that exist today. However, the degree of state involvement in the provision of health services varied enormously between countries, as it still does (Merson *et al*, 2001).

A key development was the increase in collective arrangement for funding health services. State services developed in all Western countries to provide health services for those who could not afford to purchase it themselves. In addition, mutual insurance schemes developed in Europe and United States to protect workers against financial losses, and this often included medical care (Abel-Smith, 1994).

Another key development in the creation of modern health system was the development of organised systems of medical care, as opposed to fragmented and competing individual doctors and hospitals. World War 1 marked a turning point in Europe, when the need to organise medical care on a massive scale, highlighted the advantages of a large, coordinated system (WHO, 1999).

In the late 19th century, Western medicine spread around the world, often as part of colonial expansion (Zwi & Mills, 1995). Medicine acted in part as agency of Western imperialism, and organised health services

were a component of British, French, German and Belgian colonisation. These were initially intended for the military, settler and civil service communities, but it rapidly became apparent that protecting the health of expatriates required addressing health needs among the colonised (Merson, *et al.* 2001).

As in Africa, the earliest Western health services were developed by the colonists, especially for the armed forces and the police. Major employers provided health services especially where enterprises were remote from urban centres. Some religious hospitals were built to care for the poor (Abel-Smith, 2001). These hospitals were later supplemented by government hospitals and clinics, especially in areas without charitable hospitals. A key difference with most of Africa and Asia was the development of compulsory insurance arrangement for workers in the formal sector. Since medical infrastructure was lacking, the insurance agencies often built and ran their services, thus contributing to parallel health systems.

The historical development of health services in many countries resulted in a health infrastructure that was biased towards hospitals. Attempts to re-orientate services culminated in 1978, in the Alma Ata Declaration, which emphasised the importance of primary health care.

However, a marked development in recent years is that low and middle-income countries have increasingly questioned government's role in health care. In countries where market forces are allowed to influence health services, governments are advised to step in and cushion the cost and effect of health care for a better living condition and well-being of the citizens.

3.2 Nigerian Health System: Historical Development

Historically, Nigeria had no formalised planned health services. Provision of medical services was by the British Army Medical Services to its colonies and protectorates. The birth of the colonial medical service was marked with the integration of the army and the colonial government. Free medical services were limited to the army and the colonial service officers. Non-officers in the environment benefited only as an incidental service. However, dispensaries and other health care services were provided through mission and private hospitals, dispensaries and maternity centres were sparsely scattered in the country.

After the Second World War in 1946, a formalised health plan was born through an integrated Ten-year National Development and Welfare Plan (1946 – 1956). This plan was integrated to include all aspects of

activities of the government. Subsequently, the Second and Third National Development plans were developed in 1970 – 1974, 1975 – 1980, respectively after the civil war. Each dealt with issues of deficiencies in the health services, health manpower development, the provision of comprehensive health care services based on the Basic Health Service Scheme (BHSS), disease control, health management and planning (Campbell, 2006).

SELF ASSESSMENT EXERCISE

Identify 4 historical features of the Nigerian health care system

3.3 Evolution of Health Care System in Nigeria

Evolution of health care system in Nigeria covers three main periods namely:

- pre-colonial Period
- colonial Period
- post-independence Period

3.3.1 Pre-Colonial Period

This is the period before the advent of colonial government in Nigeria. This period was dominated by traditional health care providers. Examples include:

- *dibia*- In the Igbo region
- *gozan* – In the Nupe region
- *wombai* – In the Hausa region
- *babalawo* – In the Yoruba region
- *abia ibok* – In Efik and Ibibio region

3.3.2 Colonial Period

This period started around mid 17th century to Nigerian independence from colonial rule. This period was characterised by infiltration of western-oriented (modern) health care, traceable to the arrival of European missionaries and traders.

Here, health care was provided by British colonial government to their expatriates and privileged few.

The period also gave rise to missionary hospitals that sought to provide health care services to the grassroots and less privileged. Also with the

integration of the army with the colonial government, public health services originated and government offered to treat the local civil servants and the relatives.

3.3.3 Post-Independence Period

This period started after the independence in 1960, till date. Highlights of this period were:

- basic Health Services Scheme (BHSS) designed to provide community based comprehensive health care, with emphases on disease prevention and health promotion
- development of health manpower to man the existing health care facilities
- schools of health technology established to train and retrain personnel
- establishment of primary, secondary and tertiary levels of health care
- zoning of the country into six geo-political areas for the implementation of primary health care
- establishment of teaching hospitals for training and retraining medical personnel
- providing more licenses for qualified medical personnel to man private hospitals
- establishment of National Health Insurance Scheme
- research and orientation into new disease burden (example, HIV/AIDS).

4.0 CONCLUSION

As indicated in this unit, medicine has had its role in all cultures and civilisations. However, the real development of the hospital derived from the spread of Christianity and the ideas of Christian charity and caring for all who might be in need for conversion. The Islamic world also developed hospitals and by the 11th century, there were large hospitals in every major Muslim town. In Nigeria, provision of medical services was first introduced by the colonial masters, specifically by the British Army Medical Services to its colonies and protectorates.

Also, the evolution of health system in Nigeria covered three main periods namely: Pre-colonial Period, Colonial Period and Post-independence Period, each with peculiar features and characteristics.

5.0 SUMMARY

In this unit, we provided information on the following:

- the global health system: historical development
- nigerian health system: historical development
- the evolution of health care in Nigeria

We hope you enjoyed your studies. Now let us attempt the question below.

ANSWER TO SELF ASSESSMENT EXERCISE

- Historically, Nigeria had no formalised planned health services. Provision of medical services was by the British Army Medical Services to its colonies and protectorates.
- The birth of the colonial medical service was marked with the integration of the army and the colonial government. Free medical services were limited to the army and the colonial service officers.
- Non-officers in the environment benefited only as an incidental service.
- Dispensaries and other health care services were provided through the mission/missionaries.

6.0 TUTOR-MARKED ASSIGNMENT

Give a detailed presentation of the historical development of the global health system.

7.0 REFERENCES/FURTHER READING

Abel-Smith, B. (1994). *An Introduction to Health: Policy, Planning and Financing*. London: Addison Wesley Longman Ltd.

Campbell, C. (2007). *Essentials of Health Management Planning and Policy*. Lagos: University of Lagos Press.

Donaldson, C. & Gerard, K. (1993). *Economics of Health Care Financing: The Visible Hand*. London: McMillan.

Encyclopedia of Public Health; Social Health. Answers.com Retrieved from ://www.answers.com/topic/social-health. Site Accessed on 20th July 2009.

Merson, M. H.; Black, R. E and Mill, A. J. (2001). *International Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

Mitchell, J. and Haroun, L. (2001). *Introduction to Health Care*. Canada: Delmar.

Porter, R. (1996b). Hospital and Surgery. *In*: R. Porter. *The Cambridge Illustrated History of Medicine.* Cambridge, England: Cambridge University Press.

Reinke, W. A. (2001). Health Systems Management. *In*: M. H. Merson, R. E. Black, and A. J. Mill, (eds.). International *Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

WHO (1999). *The World Health Report, 1999: Making a Difference*. Geneva, Switzerland: Author.

Zwi, A. & Mills, A. (1995). Health Policy in Less Developed Countries. Past Trends and Future Direction. *Journal of International Development, 7 (3),* 299 – 328.

UNIT 3 THE NIGERIAN HEALTH SYSTEM

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
 3.1 Nigerian Demographic and Health Indicators
 3.2 The Health Tier System in Nigeria
 3.3 National Health Strategy
 3.4 Implementation
 3.5 Role of the State in Health Care
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

Nigeria has a population of 140 million (2006 population census), and it is the most populous black nation in the world. As a mono-cultural economy, Nigeria depends on crude oil as a single major export commodity for foreign exchange earnings. Thus, the low level of resources committed to health and education is responsible for poor health status and health system management. This unit starts with an introduction of Nigerian demographic and health indicators. This is very helpful in health system planning and management.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- describe the Nigerian demographic and health indicators
- discuss the health tier system in Nigeria
- identify Nigerian health strategies
- discuss the role of government in health systems management.

3.0 MAIN CONTENT

3.1 Nigerian Demographic and Health Indicators

Nigerian Demographic and Health Indicators

Area

Total area in square kilometres --- ------ 923,768

Demographic Indicators

Total population in millions – 1991	---------	88.9
Estimated population for 2001 in million	----------	118
Per cent annual population growth rate	---------	2.9%
Per cent rural population – 2000	----------	60
Per cent urban population – 2000	----------	39
Life expectancy at birth in years – 1999	---------	53.2
Life expectancy – 2006	---------	46.6
Total fertility rate – 1999	----------	5.2
Young people aged 10 – 24 years – 1991	----------	32%
Young people less than 15 years – 1991	---------	44%
Dependency ratio (15 – 64 years)	---------	89/100

Health Indicators

Contraceptive prevalence rate – 1999	--------	8.6%
Unmet need for family planning – 1999	-------	18.0%
Teenage pregnancy – 1999	-------	22.0%
Crude birth rate per 1,000 – 2000	-------	40
Crude birth rate per 1,000 – 2000	-------	14
Antenatal attendance (at least once) – 1999	-------	64.0%
Supervised delivery – 1999	-------	42%
Maternal mortality rate per 1,000 live birth – 1999	-------	704
Infant mortality rate per 1,000 – 1999	---------	75
Under 5 mortality rate per 1,000 – 1999	-------	140
Children under 3 years who show wasting - 1999	--------	12%
Children under 3 years who are stunted - 1999	--------	46%
Children under weight – 1999	--------	27%

Literacy

Male adult literacy rate	-------	40.7%
Female adult literacy rate	-------	58.0%
Adult literacy rate (ages 15 +) – 2006	-------	71.0

Sources:
NDHS 1999; Population Reference Bureau, 001; National Population Census Report, 1999. UNFPA, 1999 MICS 1999, NPP, 2001.

Human Development Report, 2008 Statistical Update. Nigeria. The Human Development Index - going beyond income

3.2 The Health Tier System in Nigeria

The Nigerian health system has its origin from the British Army Medical Services. The health system has evolved through a series of historical developments, health policies and plans. Nigeria has a three-tier system of government: Federal, State and Local.

The local tier consists of 776 Local Government Areas. Therefore, PHC implementation is diverse. Some states have PHC departments, others have divisions. Some states have all the components of PHC housed in one department, while in some others, PHC components are divided among several departments.

For an effective implementation of PHC, the National Health Policy has adopted a strategy, which identified roles and responsibilities of the different levels of government as a health strategy (Campbell, 2007).

3.3 National Health Strategy

The three tiers of government have their roles described:

- Federal Government Level: Tertiary Health Care (Teaching and Specialist Hospital)
- State Government Level: Secondary Health Care (General Hospitals)
- Local Government Level: Primary Health Care

Federal Level

The Federal Ministry of Health formulates and reviews policy guidelines and maintains standards. This level of the health system has the control machinery and advocacy. It acts as the coordinating body of the overall health system. It monitors and evaluates the implementation of the national health policies.

State Level

This is the operational body. The Commissioner of Health translates all health policies and implements them through adequate supports and ancillary services. It acts as a coordinating body within and outside the health system. Secondly, from the state, health care is delivered to the local community at secondary level, and referred cases from PHC level.

Local Level

This is the first point of contact with the health care delivery system, under the close supervision of the state level. The Medical Officer for Health (MOH) is responsible for the:

- provision and maintenance of health infrastructure
- planning and implementation of strategies to meet community health needs
- provision of PHC components to the community
- training of personnel and logistic support for community mobilisation and participation, and management of information system

SELF ASSESSMENT EXERCISE

Identify the roles of the 3 levels of health system in Nigeria.

3.4 Healthcare Implementation

Local Government Areas (LGAs) are comparable to the districts of other developing countries. Their population size ranges from 150,000 to over 500,000. The Model Local Government Approach was designed to meet the national health policy goal of Health for All. LGAs are selected and all the necessary steps taken in setting up the system and building infrastructure for promotive, protective, preventive, restorative and rehabilitative services delivery to every citizen as required. In 1986, 52 Model LGAs were selected and technical support given by identified institutions.

Each College of Medicine sets up PHC system at nearby local governments. These systems play dual roles; service provision to the community and training centres for students. Schools of Health Technology provide expertise to set up the service in their choice LGAs as practice areas to train health workers.

All State Ministries of Education develop PHC services in their chosen LGAs.

The LGA with the support of the State Ministry of Health has the following roles:

- to deliver community organised health and related services
- to provide and maintain infrastructure to health services, and
- to involve local communities in support of primary health care (Campbell, 2007).

3.5 The Role of the State in Health Care: Economic Justifications

One argument in favor of state involvement in health services is the belief that some type of health services are '*merit goods*', that is, goods that society believes should be provided, but that individuals, if left to themselves, might under consume because they are not the best judge of what is their own or the public interest. This argument is the strongest for health services for children and mentally ill.

The other argument is founded on *equity principles*: that even with perfectly operating private markets for health services and health insurance, there will be individuals too poor to afford to access them. Although, it could be argued that this problem could be taken care of by income redistribution policies, equitable access to health services is of concern, and hence it can be argued that providing benefits in kind is appropriate.

Although these are the standard arguments used to explore the appropriate role of the state in health services, the judgment on their significance differs enormously between economists, leading to radically different policy prescriptions. Underlying this debate are alternative views on the ethical basis of a health system. One view sees access to health services as similar to access to other goods and services so survival of the fittest applies. The other sees access to health services as a right of citizenship that should not depend on individual income or wealth.

4.0 CONCLUSION

In this unit, we observed that life expectancy in Nigeria in 1999 was recorded as 53.2%. Alarmingly, 2006 report indicates a massive drop to 46.6%. This further buttressed the importance of a well established and efficient health system. We also looked at different levels of health care delivery system in Nigeria as well as their characteristics. Health being the right of every citizen thus justifies the role of the state in health care delivery.

5.0 SUMMARY

The following topics formed part of this unit:

- Nigerian demographic and health indicators
- The health tier system in Nigeria
- Nigerian health strategies
- The role of government in health care system

We hope you found this unit interesting. Ok, let us attempt the question below.

ANSWER TO SELF ASSESSMENT EXERCISE

Federal Level

The Federal Ministry of Health is the consultative in Nigeria. It formulates and reviews policy guidelines and maintains standards. This level of the health system has the control machinery and advocacy.

State Level

This is the operational body. The Commissioner of Health translates all health policies and implements them through adequate supports and ancillary services. It acts as a coordinating body within and outside the health system.

Local Level

This is the first point of contact with the health care delivery system, under the close supervision of the state level.

6.0 TUTOR-MARKED ASSIGNMENT

Discuss the role of the state in health care system

7.0 REFERENCES/FURTHER READING

Abel-Smith, B. (1994). *An Introduction to Health: Policy, Planning and Financing.* London: Addison Wesley Longman Ltd.

Campbell, C. (2007). *Essentials of Health Management Planning and Policy*. Lagos: University of Lagos press.

Donaldson, C. & Gerard, K. (1993). *Economics of Health Care Financing: The Visible Hand*. London: McMillan.

Encyclopedia of Public Health; Social Health. Answers.com Retrieved from ://www.answers.com/topic/social-health. Site Accessed on 20th July 2009.

Merson, M. H., Black, R. E and Mill, A. J. (2001). *International Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

Mills, A. J. & Ranson, M. K. (2001). The Design of the Health System. *In*: M. H. Merson, R. E. Black & A. J. Mills (eds.). *International Public Health, Disease, Programmes, Systems and Policies*. Maryland: Aspen Publishers.

Mitchell, J. and Haroun, L. (2001). *Introduction to Health Care*. Canada: Delmar.

Porter, R. (1996b). Hospital and Surgery. *In*: R. Porter. *The Cambridge Illustrated History of Medicine.* Cambridge, England: Cambridge University Press.

Reinke, W. A. (2001). Health Systems Management. *In*: M. H. Merson, R. E. Black, and A. J. Mill, (eds.). International *Public Health: Disease, Programmes.*

WHO (1999). *The World Health Report, 1999: Making a Difference*. Geneva, Switzerland: Author.

Zwi, A. & Mills, A. (1995). Health Policy in Less Developed Countries. Past Trends and Future Direction. *Journal of International Development, 7 (3),* 299 – 328.

MODULE 3 INTRODUCTION TO HEALTH SYSTEM MANAGEMENT

Unit 1 Defining Management
Unit 2 Health Management Functions
Unit 3 Health Organisation/Institution Management and Collaborations
Unit 4 Managing Human Resources in the Health System

UNIT 1 UNDERSTANDING THE HEALTH SYSTEM

CONTENTS

1.0 Introduction
2.0 Objectives
5.0 Main Content
  5.1 Defining Management?
  5.2 Management: Theoretical Scope
  5.3 Overview of Contemporary Theories in Management
    5.3.1 Contingency Theory
    5.3.2 Systems Theory
    5.3.3 Chaos Theory
  3.4 Central Principles of Management
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

An efficient and effective health system is a well managed one. Here, we are going to introduce theoretical scope of management as well as an overview of contemporary theories in management. Enjoy your studies.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define management
- identify and explain the theoretical scope of management
- describe some contemporary theories in management
- explain the central principles of management.

3.0 MAIN CONTENT

3.1 Defining Management

Should management be classified as art or science? Some observers have taken the position, implicitly at least, that managers are essentially problem solvers who face a series of unique challenges that cannot be easily codified and met through the use of ready-made management techniques. Rather, these challenges must be attacked one by one, through the application of common sense molded by years of experience. Support for this position is weakening as management methods covering a wide array of circumstances have been developed, successfully applied, and incorporated into the formalised body of knowledge known as management science. Truly, management is both art and science, and competent managers are noted for their skillful blending of technical knowledge, common sense, and experience.

A carpenter without tools is helpless. At the same time, those who won an expensive toolkit but do not know how to use its contents can hardly be called carpenters. Possession of the tools, as well as knowledge of how and when to use them, is needed. Although the truth of the statement regarding carpentry is readily accepted, its applicability to the field of management is less clear, especially in the health sector where advanced medical knowledge and skills seem paramount. Our task is to provide understanding of important management concepts, principles, and methods, to cite requisites and instance of their successful application, and thereby provide convincing evidence of the value of the "management toolkit." The common sense and experience needed to select appropriate tools and use them successfully, however, must remain with the manager (Wikipedia, 2009).

As multipurpose and multidisciplinary endeavours, health service enterprises require coordinated efforts among numerous individuals and units, making efficient and effective systems of management essential. Increasingly, the effort involves collaboration with external bodies. Private hospitals and public health departments must deal with health sector regulatory agencies, government officials in other sectors, social security and insurance offices, professional organisations, community groups, media organisation, and a host of other interests. This broadened perspective emphasised the importance of collaborative relationships in contrast to direct control (Korten, 1979). The notion that management involves simply the hierarchical directive and controlling relationship between managers and subordinates is certainly unrealistic in the present climate if, indeed, it ever was relevant.

Specifically, the verb *manage* comes from the Italian word *maneggiare* (to handle — especially a horse), which in turn derives from the Latin *manus* (hand). The French word *mesnagement* (later *ménagement*) influenced the development in meaning of the English word *management* in the 17th and 18th centuries (Oxford English Dictionary).

Some definitions of management are:

- Management is defined as organisation and coordination of the activities of an enterprise in accordance with certain policies and in achievement of clearly defined objectives. Management is often included as a factor of production along with machines, materials, and money. According to the management guru Peter Drucker (1909–2005), the basic task of a manager is two-fold: *marketing and innovation.* Practice of modern manager owes its origin to the 16th century enquiry into low-efficiency and failures of certain enterprises, conducted by the English statesman Sir Thomas More (1478–1535), (Wikipedia, 2009).

- Management is also perceived as directors and managers who have the power and responsibility to make decisions to manage an enterprise. As a discipline, management comprises the interlocking functions of formulating corporate policy and organising, planning, controlling, and directing the firm's resources to achieve the policy's objectives. The size of management can range from one person in a small firm to hundreds or thousands of managers in multinational companies. In large firms, the board of directors formulates the policy which is implemented by the chief executive officer (Wikipedia, 2009).

3.2 Management: Theoretical Scope

Mary Parker Follett (1868–1933), who wrote on the topic in the early 20th century, defined management as "the art of getting things done through people". She also described management as philosophy (Barrel, 2003). One can also think of management functionally, as the action of measuring quantity on a regular basis and of adjusting some initial plan; or as the actions taken to reach one's intended goal. This applies even in situations where planning does not take place. From this perspective, Frenchman Henri Fayol (Dunord, 1966), considers management to consist of six functions:

1. planning
2. organising
3. leading
4. coordinating
5. controlling
6. staffing

- **Planning** in organisations and public policy is both the organisational process of creating and maintaining a plan; and the psychological process of thinking about the activities required to create a desired goal on some scale. As such, it is a fundamental property of intelligent behaviour. This thought process is essential to the creation and refinement of a plan, or integration of it with other plans, that is, it combines forecasting of developments with the preparation of scenarios of how to react to them.

The term is also used to describe the formal procedures used in such an endeavour, such as the creation of documents, diagrams, or meetings to discuss the important issues to be addressed, the objectives to be met, and the strategy to be followed. Beyond this, planning has a different meaning depending on the political or economic context in which it is used.

- **Organising:** Organising is the act of rearranging elements following one or more rules. Anything is commonly considered organised when it looks like everything has a correct order of placement. But it is only ultimately organised if any element has no difference on time taken to find it. In that sense, organising can also be defined as - *to place different objects in logical arrangement for better searching*.

- **Leading**: The word leadership can refer to:

- Those entities that perform one or more acts of leading
- The ability to affect human behaviour so as to accomplish a mission
- Influencing a group of people to move towards its goal setting or goal achievement (Stogdill, 1950).

Leadership has a formal aspect (as in most political or business leadership) or an informal one (as in most friendships). Speaking of "leadership" (the abstract term) rather than of "leading" (the action) usually it implies that the entities doing the leading have some "leadership skills" or competencies.

- **Coordinating**: Coordination is the act of coordinating, making different people or things work together for a goal or effect.

- **Controlling:** Control is one of the managerial functions like *planning*, *organising*, *staffing* and *directing*. It is an important function because it helps to check the errors and to take the corrective action so that deviation from standards are minimised

and stated goals of the organisation are achieved in a desired manner.

According to modern concepts, control is a foreseeing action whereas earlier concept of control was used only when errors were detected. Control in management means *setting standards, measuring actual performance and taking corrective action*. Thus, control comprises these three main activities (Johnson, 1976).

- **Staffing:** Human resources are terms with which many organisations describe the combination of traditionally administrative personnel functions with performance, Employee relations and resource planning.

SELF ASSESSMENT EXERCISE

Management is defined as ……………………

3.3 Overview of Contemporary Theories in Management

Contemporary theories of management, (McNamara, 2005), tend to account for and help interpret the rapidly changing nature of today's organisational environments. As before in management history, these theories are prevalent in other sciences as well.

3.3.1 Contingency Theory

Basically, contingency theory asserts that when managers make a decision, they must take into account all aspects of the current situation and act on those aspects that are key to the situation at hand. Basically, it is the approach that "it depends." For example, the continuing effort to identify the best leadership or management style might now conclude that the best style depends on the situation. If one is leading troops in the Persian Gulf, an autocratic style is probably best (of course, many might argue here, too). If one is leading a hospital or university, a more participative and facilitative leadership style is probably best.

3.3.2 Systems Theory

Systems theory has had a significant effect on management science and understanding organisations. First, let us look at "what is a system?" *A system is a collection of parts unified to accomplish an overall goal.* If one part of the system is removed, the nature of the system is changed as well. For example, a pile of sand is not a system. If one removes a sand particle, you have still got a pile of sand. However, a functioning car is a system. Remove the carburetor and you have no longer got a working

car. A system can be looked at as having inputs, processes, outputs and outcomes. Systems share feedback among each of these four aspects of the systems.

Let us look at an organisation. Inputs would include resources such as raw materials, money, technologies and people. These inputs go through a process where they are planned, organised, motivated and controlled, ultimately to meet the organisation's goals. Outputs would be products or services to a market. Outcomes would be, e.g., enhanced quality of life or productivity for customers/clients, productivity. Feedback would be information from human resources carrying out the process, customers/clients using the products, etc. Feedback also comes from the larger environment of the organisation, e.g., influences from government, society, economics, and technologies. This overall system framework applies to any system, including subsystems (departments, programmes, etc.) in the overall organisation.

Systems theory may seem quite basic. Yet, decades of management training and practices in the workplace have not followed this theory. Only recently, with tremendous changes facing organisations and how they operate, have educators and managers come to face this new way of looking at things. This interpretation has brought about a significant change (or paradigm shift) in the way management studies and approaches organisations.

The effect of systems theory on management is that writers, educators, consultants, etc. are helping managers to look at the organisation from a broader perspective. Systems theory has brought a new perspective for managers to interpret patterns and events in the workplace. They recognise the various parts of the organisation, and, in particular, the interrelations of the parts, e.g., the coordination of central administration with its programmes, engineering with manufacturing, supervisors with workers, etc. This is a major development. In the past, managers typically took one part and focused on that. Then they moved all attention to another part. The problem was that an organisation could, e.g., have a wonderful central administration and wonderful set of teachers, but the departments did not synchronise at all (McNamara, 2005).

3.3.3 Chaos Theory

As chaotic and random as world events seem today, they seem as chaotic in organisations too. Yet for decades, managers have acted on the basis that organisational events can always be controlled. A new theory (or some say "science"), chaos theory, recognises that events indeed are rarely controlled. Many chaos theorists (as do systems

theorists) refer to biological systems when explaining their theory. They suggest that systems naturally go to more complexity, and as they do so, these systems become more volatile (or susceptible to cataclysmic events) and must expend more energy to maintain that complexity. As they expend more energy, they seek more structure to maintain stability. This trend continues until the system splits, combines with another complex system or falls apart entirely. This trend is what many see as the trend in life, in organisations and the world in general (McNamara, 2005).

3.4 Central Principles of Management

Two basic principles of management practice provide the foundation for carrying out the functions described.

The first principle is: ***management by objectives***. This requires that the organisation defines its aims clearly and explicitly. Recent management thinking further emphasises the importance of a democratic process in which those who are to be responsible for achieving the objectives are involved in setting them in the first place (Drucker, 1974). It is thought that as a consequence the objectives will be realistic and widely understood. In addition, members of the organisation who gain a sense of ownership and function as a team are expected to be more highly motivated and productive (Merson *et al*, 2001).

The second principle, ***management by exception***, recognises that management effort is too valuable to be squandered on oversight of routine activities; attention should be focused instead on areas of exceptional concern, such as an individual worker or health unit that has an especially high absentee rate. Obviously, application of the management by exception principle requires advance specification of objectives and standards if meaningful departures from expected levels of conduct are to be identified. This in turn requires a reliable information system to signal the emergence of problems (Merson *et al*, 2001).

4.0 CONCLUSION

In this unit, we outlined different facets of management. By definition, management was viewed as the organisation and coordination of the activities of an enterprise in accordance with certain policies and in achievement of clearly defined objectives. Theoretical scope of management identified include: planning, organising, leading, coordinating, controlling and staffing. This indicates that management, no matter how it is perceived, is inclusive of all aforementioned variables. Some contemporary theories of management such as chaos

theory, systems theory and contingency theory, as well as basic principles of management, management by objectives and management by exception, all served to broaden our understanding of this concept.

5.0 SUMMARY

The following were examined in this unit:

- definition of management
- theoretical scope of management
- contemporary theories of management
- central principles of management

Hope you enjoyed your studies. Now let us attempt the questions below.

ANSWER TO SELF ASSESSMENT EXERCISE

Management is defined as: the organisation and coordination of the activities of an enterprise in accordance with certain policies and in achievement of clearly defined objectives. As a discipline, management comprises the interlocking functions of formulating corporate policy and organising, planning, controlling, and directing the firm's resources to achieve the policy objectives. The size of management can range from one person in a small firm to hundreds or thousands of managers in multinational companies. In large firms, the board of directors formulates the policy which is implemented by the chief executive officer (Wikipedia, 2009).

6.0 TUTOR-MARKED ASSIGNMENT

1. Explain the theoretical scope of management
2. What are the central principles of management?

7.0 REFERENCES/FURTHER READING

Abel-Smith, B. (1994). *An Introduction to Health: Policy, Planning and Financing*. London: Addison Wesley Longman Ltd.

Arvid, R. J. (1976). *Management, Systems, and Society: An Introduction*. Pacific Palisades, Calif.: Goodyear Pub. Co.

Barrett, R. (2003). *Vocational Business: Training, Developing and Motivating People*. Business & Economics. - Page 51.

Campbell, C. (2007). *Essentials of Health Management Planning and Policy*. Lagos: University of Lagos press.

Donaldson, C. & Gerard, K. (1993). *Economics of Health Care Financing: The Visible Hand*. London: McMillan.

Druker, P. F. (1974). *Management: Tasks, Responsibilities and Practices*. NY: Harper and Row.

Dunod, (1966). *Administration Industrielle et générale - prévoyance organisation – commandement, coordination – contrôle,* Paris

Encyclopedia of Public Health; Social Health. Answers.com Retrieved from http://www.answers.com/topic/social-health. Site Accessed on 20th July 2009.

Gomez-Mejia, Luis R.; David B. Balkin and Robert L. Cardy (2008). *Management: People, Performance, Change,* (3rd ed.). New York USA: McGraw-Hill.

Korten, D. C. (1979). Toward a Technology for Managing Social Development. *In*: D. C. Korten (ed.). Population and Social development Management. Caracas: Population and Social Development Centre.

McNamara, C. (2005). *Contemporary Theories in Management*. Free Management Library.

Merson, M. H.; Black, R. E and Mill, A. J. (2001). *International Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

Mills, A. J. & Ranson, M. K. (2001). The Design of the Health System. *In*: M. H. Merson, R. E. Black & A. J. Mills (eds.). *International public health, Disease, Programmes, Systems and Policies*. Maryland: Aspen Publishers.

Mitchell, J. and Haroun, L. (2001). *Introduction to Health Care*. Canada: Delmar Oxford English Dictionary

Reinke, W. A. (2001). Health Systems Management. In M. H. Merson, R. E. Black, and A. J. Mill, (eds.). *International Public Health: Disease, Programmes Systems and Policies. Maryland: Aspen Pub.*

Stogdill, R.M. (1950) 'Leadership, Membership and Organisation', Psychological Bulletin, 47: 1-14.

Wikipedia (2009). *Management.* Site visited on 22nd July, 2009. Page was Last Modified on 19 July 2009 at 15:00.

UNIT 2 HEALTH MANAGEMENT: FUNCTIONS

CONTENTS

1.0 Introduction
2.0 Objectives
3.4 Main Content
- 3.1 Health Management Functions
  - 3.1.1 Statement of Mission
  - 3.1.2 Policy Setting
  - 3.1.3 Planning
  - 3.1.4 Scheduling and Budgeting within the Plan Framework
  - 3.1.5 Decision Analysis
  - 3.1.6 Problem Solving and Process Involvement
  - 3.1.7 Development and Use of Information System
  - 3.1.8 Organised Coordination
  - 31.9 Implementation Function
  - 3.1.10 Monitoring and Evaluation

4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

Although it is essential that we maintain the perspective of the entire health system, the main focus in this unit will be on management functions of the individual health institution, or in some cases a unified network of organisations, such as primary care and referral activities. The health institution must be prepared to respond to external influences and seek to influence and collaborate with other interests appropriately.

Within this context, management is defined as the organised effort to achieve the entity's purpose(s) in an effective, efficient, equitable, and sustainable manner. The effort involves the development and use of *human resources* within an *organizational framework* of appropriate authority and responsibility relationships; provision of adequate physical support (for example, equipment, drugs, and supplies) that allows personnel to use fully their knowledge and skills; making available financial resources in a timely manner; and operation of an information system that permits effective oversight of the services operation and support activities (Merson, *et al,* 2001).

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- explain management functions
- explain policy setting in management
- define planning and management
- explain the role of problem solving and process information in management
- illustrate the influence of monitoring and evaluation in management.

5.0 MAIN CONTENT

3.1 Health Management Functions

Management functions are most easily described as logical sequences of activities, although in practice they are carried out in whatever order is appropriate (McMahon, Barton, & Piot, 1992). Thus, managers may shift attention from planning to implementation and monitoring, then back to planning. Below are the management functions.

3.1.1 Statement of Mission

The initial function of management is to establish the organisation's (health enterprises), basic mission and direction. For example, should the organisation provide specialised care in certain areas, e.g., ophthalmology in which it has acknowledged expertise, e.g., ophthalmologist, or should its mission be to provide comprehensive services to a defined population? e.g. primary health care.

3.1.2 Policy Setting

In order to move expeditiously in the desired direction, the entity/health care institution should be able to function in as favorable a climate as possible. Policy setting encompasses efforts to create a favorable climate for pursuing organisational goals. Organisational sub-units should be encouraged to act in ways that enhance the mission and prohibited from actions that might detract from the basic purposes that have been set forth. To improve coverage of antenatal care, for example, a policy may be adopted to provide these services on demand, rather than at clinic sessions held only on Tuesday afternoons. Or, to ensure that health care decisions are made at the appropriate level, patients going directly to a specialty clinic might be charged a higher fee than is assessed for those who are referred appropriately from a primary care centre.

3.1.3 Planning

Planning is a third important function of management in which alternative courses of action are formulated and evaluated, often requiring management to shift attention back and forth among various management functions. The aim here is to identify the most cost-effective means of achieving desired objective. To illustrate, the cost and expected coverage of a clinic-based immunisation programme might be compared with a programme based upon outreach through mobile units and another that relies upon annual National Immunisation Days. In the course of planning, management sometimes finds that resources are inadequate to achieve initially desired objective by any means. In this case, more modest objectives might have to be set, or existing policy altered to place higher priority on the programme of interest and to assign more funds to it.

SELF ASSESSMENT EXERCISE

1. Health management functions can be described as ....
2. Planning enables an organisation to ....

3.1.4 Scheduling and Budgeting within the Plan Framework

Planning is essentially strategic. Tactical considerations relate to the scheduling of personnel effort in the form of a work plan and the budgeting of requisite funds. Planning and scheduling are clearly interconnected; indeed three interrelated levels of health planning are worth noting:

- long term
- lntermediate
- short term.

Intermediate-range plans, which look forward 5 to 7 years, are most common, but the timeframe is of limited relevance. Basic changes in the design of services and the consequent mix of facilities and personnel require many years to implement; therefore, documents that present broad visions of the future, known as perspective plans, with time horizons of 15 to 20 years, are recommended, Intermediate-range plans can then be formulated with the longer-term goals in mind. Even 5-year plans are not adequately operational, however, unless accompanied by annual work plans and budgets. Because those documents reflect actual resources made available, they tend to determine where principal effort is in fact placed. Too often, 5-year plans considerations, because intermediate-range plans are little more than unrealistic “wish-lists,” and perspective plans provide only a broad vision of the future. Proper

integration of planning time horizons is therefore an important function of management (Merson, *et al*, 2001; Reinke, 2001).

3.1.5 Decision Analysis

Plan implementation requires sound decision making every step of the way. Future uncertainties inevitably make the task more difficult, and decisions in the health field are further complicated by the need for making value judgments regarding intangible “quality of life” outcomes, along with more tangible economic considerations of resource use and cost.

3.1.6 Problem Solving and Process Improvement

Decision making is closely associated with problem solving, which has long been recognised as a key function of management. A more dynamic view in recent years, however, has shifted emphasis from problem solving to process improvement (Berwick, Godfrey, & Roessner, 1991). The view is, in effect, that if all workers could become 10% more productive, the overall gain would be greater than if the few laggards who are only half as productive as they should be were identified and removed or brought up to standard. This revision in management thinking has brought about substantial changes in management practice. In place of the vision of the boss charged with the responsibility for controlling and disciplining weak subordinates, we now envision the work team itself as best able to identify areas where improvements can be made and jointly to devise appropriate courses of action. Of course team members must see a clear link between organisational interests and personal needs for recognition and fulfillment. The poor motivational climate in many bureaucracies make this understanding difficult, a factor that deserves further attention in considering the execution of management functions in practice (Reinke, 2001).

3.1.7 Development and Use of Information Systems

Sound decision making requires the application of reasoned judgment to both quantitative and qualitative information that has been made available in a timely manner. A well functioning Health Management Information System (HMIS) is therefore essential to effective management. Vitally important is integration of the “health” and “management” elements. Health information systems that report morbidity and mortality rates, hospital admission rates, and other indicators of health status are common place. Likewise, management system for tracking staff disposition and vacancies, budgets and cash flow, and drug inventories are in use. But information regarding the

availability and use of resources must be directly related to the epidemiologic data, so that a determination can be made of the extent to which health needs are being met effectively, efficiently, and equitably.

3.1.8 Organised Coordination

The conversion of sound decisions into effective action requires the coordinated efforts of numerous participants in the organisation. Some organisational unit generates information and advice that form the basis for decisions made by those same units or others; the decisions are then transmitted to still other units for action. Thus, the separate roles of data gathering, standard setting, information dissemination, decision making, implementation, monitoring and evaluation must be smoothly coordinated.

3.1.9 Implementation Functions

To many, the essence of management is in the oversight of planned activities in the course of programme implementation, clearly the supervision and training functions of personnel management, cost accounting and control in financial management, and logical considerations associated with stock control and transport management are critically important.

3.1.10 Monitoring and Evaluation

Although it is cited as the final function, the monitoring and evaluation function represents a set of tasks to be carried out continuously throughout the process of managing. Ongoing monitoring of progress is at least as important as end stage retrospective evaluation. After all, travelers driving from Abuja to Lagos would refer frequently to a map or road signs to make sure they were following the desired route, rather than waiting until the end of their journey to determine whether they recognised the Lagos skyline in the distance.

4.0 CONCLUSION

In this unit, health management was defined as the organised effort to achieve the entity/health organisations purpose(s) in an effective, efficient, equitable, and sustainable manner. To achieve this, it must follow logical and coherent activities known as health management functions. Such functions include: mission statement, policy setting, planning, decision analysis, organised coordination, monitoring and evaluation, etc.

5.0 SUMMARY

Specifically, this unit looked at the following: health management functions, which involve: policy setting, mission statement, planning, scheduling and budgeting with the framework, decision analysis, problem solving and process improvement, organised coordination, monitoring and evaluation, etc. We hope you enjoyed your studies. Now let us attempt the questions below.

ANSWER TO SELF ASSESSMENT EXERCISE

1. Health management functions are most easily described as logical sequences of activities in organisation/health enterprises.
2. Planning enables an organisation to identify the most cost-effective means of achieving desired objectives.

6.0 TUTOR-MARKED ASSIGNMENT

An efficient and effective health system must adhere to logical sequence of activities. Identify and briefly explain each of the functions.

7.0 REFERENCES/FURTHER READING

Abel-Smith, B. (1994). *An Introduction to Health: Policy, Planning and Financing*. London: Addison Wesley Longman Ltd.

Arvid, R. J. (1976). *Management, Systems, and Society: An Introduction*. Pacific Palisades, Calif.: Goodyear Pub. Co.

Berwick, D. M.; Godfery, A. B. & Roessner, J. (1991). *Curing Health Care*. San Francisco: Jossey-Bass Pub.

Campbell, C. (2007). *Essentials of Health Management Planning and Policy*. Lagos: University of Lagos press.

Druker, B. F. (1974). *Management: Tasks, Responsibilities, Practices*. NY: Harper and Row.

Donaldson, C. & Gerard, K. (1993). *Economics of Health Care Financing: The Visible Hand*. London: McMillan.

Encyclopedia of Public Health; Social Health. Answers.com Retrieved from ://www.answers.com/topic/social-health. Site Accessed on 20th July 2009.

Gomez-Mejia, Luis R.; David B. Balkin and Robert L. Cardy (2008). *Management: People, Performance, Change,* (3rd ed.). New York USA: McGraw-Hill.

Mcmahon, R., Barton, E. & Piot, M. (1992). On Being in Charge. Geneva, Switzerland:WHO.

Merson, M. H., Black, R. E and Mill, A. J. (2001). *International Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

Mills, A. J. & Ranson, M. K. (2001). The Design of the Health System. *In*: M. H. Merson, R. E. Black & A. J. Mills (eds.). *International Public Hhealth, Disease, Programmes, Systems and Policies*. Maryland: Aspen Publishers

Mitchell, J. and Haroun, L. (2001). *Introduction to Health Care*. Canada: Delmar

Reinke, W. A. (2001). Health Systems Management. In M. H. Merson, R. E. Black, and A. J. Mill, (eds.). *International Public Health: Disease, Programmes Systems and Policies. Maryland: Aspen Pub.*

Ryan, T. P (1989). Statistical Methods for Quality Improvement. NY: John Wiley and sons.

Suchman, E. A. (1967). *Evaluative Research*. NY: Russel Sage Foundation.

UNIT 3 HEALTH ORGANISATION/INSTITUTION MANAGEMENT AND COLLABORATIONS

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
 3.1 Health Organisation: Definition of Term
 3.2 Effective External Collaboration
 3.3 Internal Organisation and Control
  3.3.1 Pursuit of Multiple Objectives
  3.3.2 Unity of Command
  3.3.3 Span of Control
  3.3.4 Services Integration
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

In the previous unit, we looked at the following: health management functions: policy setting, mission statement, planning, scheduling and budgeting with the framework, decision analysis, problem solving and process improvement, organised coordination, monitoring and evaluation, etc. The focus of this unit will be on health care organisation, structure and relations. We will present a brief definition of organisation as well as related terms that would broaden our understanding of this course. Enjoy your studies.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define health care/system organisation and its characteristics
- illustrate the role of effective external collaboration on organisational dynamics
- identify internal organisational control mechanism.

3.0 MAIN CONTENT

3.1 Health Organisation: Definition of Term

Organisations are independent, lifelike entities that have defined purposes, functional capabilities and unique personalities. Young organisations, like newer health institutions, for example, tend to be vigorous and oriented to change, much like youthful individuals. As organisations mature they are prone to conservatism and protection of the resources and authority they have acquired, much like persons who reach middle age. Thus, a significant management concern is how to remain dynamic and innovative through continuous infusion of "new blood" and ideas without sacrificing hard work prior accomplishments (Merson, *et al*, 2001).

The individuals comprising an organisation have their own interests, ideals, aims, capabilities and personalities. Effective organisations are sensitive to these characteristics and strive to establish congruence between organisational and individual goals and motivations.

While the organisation/health institutions/hospitals are independent, purposeful entity composed of individuals, it is not a closed system; it must relate effectively to its external environment. The enterprise is sometimes called upon to respond appropriately to externally imposed changes; for example, the introduction of fee schedules where services were formerly free requires action to ensure that high levels of use are maintained, and those with low-incomes are not denied access to needed health services. In other circumstances, change brings new opportunities to be seized. Managers and policy makers must constantly strive to maintain a proper balance between reactive and proactive postures or between effective external collaboration and internal control.

3.2 Effective External Collaboration

Some organisations have a tendency to look inward and disregard external agencies until forced to deal with them in their day to day affairs. A more useful approach is to acknowledge explicitly the presence of significant outside "actors", and to determine their interests and agenda. The list will undoubtedly include other formal public and private service agencies, as well as the informal sector comprised of indigenous healers and others that may be important to the public, though largely ignored by other professions. Financial interests will also be noted as reflected in ministries of finance, social security agencies, and other funding bodies within government, along with international donors and private insurers.

National and international non-governmental organisations often represent significant sources of financial support for services and may be direct providers of care as well. They are frequently considered to offer the advantage of innovative flexibility independent of government bureaucratic procedures and regulations. This advantage, however, must be weighed against the feasibility of later replication on a wider scale where conformity to usual practices is required.

Professional organisations are in many respects part of the system, but they may have particular interests that differ from those of other "actors" in the system. Health departments have been thwarted in the introduction of less expensive paramedical providers of primary care by professional associations fearful of the loss of authority, status and revenue.

Finally, community groups form increasingly vocal and organised sources of discontent and cooperation. Providers must clearly distinguish between genuine partnerships with community resources. Too often, individuals selected and trained to work in their own communities serve in effect as poorly paid government workers but without the usual civil service benefits. Such arrangements are convenient in the short run but do not foster the sense of local ownership and participation required for long term sustainability (Merson, *et al*, 2001; Reinke, 2001).

When an organisation identifies significant external players, it must assess their role in relation to its own interests. Which agencies are likely to oppose a particular programme of interest to the subject organisation? What is the force and nature of the opposition? How can it be overcome? At what cost, tangible and otherwise? Which agencies are mutually supportive of subject organisation endeavours? How can coalitions be formed to strengthen the mutuality of interests?

One practical means of dealing with the outside world is through members of the organisation's governing board. Enterprises in which most board members are appointed from within tend to focus on the maintenance and possible improvement in efficiency of existing operations, whereas a large representation of outside interests on the board is more likely to lead to a search for innovation in recognition of a dynamic climate for change (Morlock, Nathanson, & Alexander, 1988).

SELF ASSESSMENT EXERCISE

1. Health organisations are dependent lifelike entities with defined purposes and capabilities, True or False.
2. Identify one major difference between the younger and older health organisations.

3.3 Internal Organisation and Control

The following are discussed under this section:

- pursuit of multiple objectives
- unity of command
- span of control
- services integration

3.3.1 Pursuit of Multiple Objectives

Organisational arrangement and decision processes within organisation should accommodate the inevitable multiplicity of objectives and interests. Some are widely accepted, though not necessarily mutually compatible. There may be a desire to improve overall service coverage in a defined target population, to ensure that the services are equitably distributed according to need, and to provide them cost effectively. Other possibly conflicting aims may reflect more parochial interests. Physician providers may stress the importance of beneficial care to all comers, whereas hospital trustees may exhibit greater concern over coverage of costs incurred in providing services and avoidance of deficit. Yet a third perspective may be offered by the ombudsman who focuses attention on patient satisfaction in general and length of waiting time in particular. Obviously, the organisation structure should contain provisions for prompt and acceptable resolution of conflicting aims.

3.3.2 Unity of Command

In addition to providing assurance that the organisation adheres to a unified set of objectives, the principle of unity of command should be followed (Szilagyi, 1988). In its simplest form this means that each employee should have a single “boss”. While acknowledging the acceptability of arrangement whereby a worker receives technical guidance from other sources, the unity of command principle calls for administrative authority to be clearly vested in a single line supervisor (WHO, 1998).

3.3.3 Span of Control

Just as job descriptions should reflect a reasonable scope of work, supervisory arrangements should provide a realistic span of control in terms of the number of individuals for whom one supervisor has responsibility. The rule of thumb is that one manager can oversee not more than five to seven persons, but this number can vary according to individual circumstances (Szilagyi, 1988). Because individuals performing routine, repetitive work require relatively little supervisory support, the span of control over their performance can be increased. Likewise, managers of departments employing highly skilled professional or technical staff may be able to supervise large numbers of personnel because of their ability to function quite independently. The span of control in other cases may depend upon the experience and stability of the work force, but apart from these exceptional circumstances, the 'five to seven' rule usually works quite well.

3.3.4 Services Integration

Efforts to improve primary health care have produced the vision of a neatly packaged mix of basic health services available to all communities, including the most remote. Current practice, in which categorical programmes are centrally mandated, funded, and controlled despite local differences in needs and capabilities, is considered to be contrary to this vision. Therefore, the strongest recommendations in recent years regarding organisational matters have called for further integration of services and greater decentralisation of authority and responsibility (Araujo, 1997; Janovsky, 1988; Tarimo, 1991).

Health service operations include health promotion and disease prevention, as well as curative care, which have management implications. Curative care at district level in some countries is organised separately from other health services. Typically, the district hospital superintendent or another physician manages curative care, whereas a health inspector or other non-physician is placed in charge of preventive services. While preventive services thereby receive explicit attention, often they are assigned relatively low priority, partly because of a general lack of appreciation of their importance, and partly because they are the responsibility of a manager with lower status than the principal physician of the district.

3.3.5 Decentralisation

There are obvious advantages to the decentralisation of authority and responsibility, so that resource allocation decisions are adjusted to local needs, and partnerships with local communities are fostered. Consequent

demands on management to make decentralisation work are less evident but no less real (Cassels & Janovsky, 1996). In the first place, not all functions need to be decentralised. Most training is best carried out at provincial or national levels. Nationally established uniform standards of care also make sense, allowing for minor adaptations to local circumstances. Thus, the first management issue is to determine which function to decentralise. The optimum balance is likely to be a combination of top-down support coupled with bottom-up initiatives systematically introduced, strengthened, expanded, and sustained (Taylor-Ide & Taylor, 1995).

However, decentralisation of funding can be difficult even when the will to decentralise exists, because revenue is principally generated at the national level. In Indonesia, for example, the move toward decentralisation, prompted by the existence of large differences in population density and health needs among provinces on Java and the other islands, has been hampered by the fact that three-fourths of the funds available to local health departments come from the national treasury (Bosset, Soebeku, & Rai, 1991; Reinke, 1988a). Although block grants not earmarked for specific purposes are possible, decisions must be demanded by national authorities in order to ensure the legitimacy of local fund allocations.

4.0 CONCLUSION

In this unit, we described health enterprises/organisations as independent, lifelike entities that have defined purposes, functional capabilities and unique personalities. While health organisation is an independent, purposeful entity composed of individuals, it is not a closed system; it must relate effectively to its external environment. The enterprise is sometimes called upon to respond appropriately to externally imposed changes. Also effective and efficient organisation should involve certain external mechanisms as well as internal organisational mechanisms such as span of control, unity of command, and pursuit of multiple objectives and services integration.

5.0 SUMMARY

In this unit, we have been able to discuss the following:

- health organisation and its dynamics.
- the role of effective external collaboration on organisational dynamics.
- internal organisational control mechanism.

ANSWER TO SELF ASSESSMENT EXERCISE

False. Health organisations are independent, lifelike entities that have defined purposes, functional capabilities and unique personalities.

Young organisations, for example, tend to be vigorous and oriented to change, much like youthful individuals. As organisations mature, they are prone to conservatism and protection of the resources and authority they have acquired, much like persons who reach middle age. Thus, a significant health management concern is how to remain dynamic and innovative through continuous infusion of "new blood" and ideas without sacrificing hard work and prior accomplishments (Merson, *et al*, 2001).

6.0 TUTOR-MARKED ASSIGNMENT

External collaboration and monitoring are effective tools in health management. Discuss.

7.0 REFERENCES/FURTHER READING

Abel-Smith, B. (1994). *An Introduction to Health: Policy, Planning and Financing.* London: Addison Wesley Longman Ltd.

Araujo, O. (1997). Attempt to decentralize in recent Brazil Health Policy: Issues and Problems, 1988 – 1994. *International Journal of Health Services, 27* (1), 109 – 124.

Arvid, R. J. (1976). *Management, Systems, and Society: An Introduction*. Pacific Palisades, Calif.: Goodyear Pub. Co.

Bossert, T. J.; Soebekti, R. & Rai, N. K. (1991). Bottom-up Planning in Indonesia: Decentralization in the Ministry of Health. *Health Policy and Planning, 6*(1), 55.63.

Campbell, C. (2007). *Essentials of Health Management Planning and Policy*. Lagos: University of Lagos Press.

Cassel, A. & Janovsky, K. (1996). *Strengthening Health Management in District and Provinces. Handbook for Facilitators*. Geneva: Switzerland: WHO.

Druker, B. F. (1974). *Management: Tasks, Responsibilities, Practices.* NY: Harper and Row.

Donaldson, C. & Gerard, K. (1993). *Economics of Health Care Financing: The Visible Hand*. London: McMillan.

Encyclopedia of Public Health; Social Health. Answers.com Retrieved from ://www.answers.com/topic/social-health. Site Accessed on 20th July 2009.

Gomez-Mejia, Luis R.; David B. Balkin and Robert L. Cardy (2008). *Management: People, Performance, Change, 3rd edition*. New York, New York USA: -Hill,

Janovsky, K. (1988). *The Challenge of Implementation: District Health Services for Primary Health Care*. Geneva: WHO.

Mcmahon, R.; Barton, E. & Piot, M. (1992). On Being in Charge. Geneva, Switzerland: WHO.

Merson, M. H., Black, R. E and Mill, A. J. (2001). *International Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

Mitchell, J. and Haroun, L. (2001). *Introduction to Health Care*. Canada: Delmar.

Mills, A. J. & Ranson, M. K. (2001). The Design of the Health System. In M. H. Merson, R. E. Black & A. J. Mills (eds.). *International Public Health, Disease, Programmes, Systems and Policies*. Maryland: Aspen Publishers.

Mitchell, J. and Haroun, L. (2001). *Introduction to Health Care*. Canada: Delmar.

Morlock, L. L., Nathanson, C. A. & Alexander, J. A. (1988). Authority, Power and Influence. In S. M. Shortell and A. D. Kaluzny, *Health Care Management*. NY: John Wiley and Sons.

Reinke, W. A. (1988a). Health Care in Indonesia: Dealing with Diversity. *In*: Sirageldin (ed.). *Public Health and Development*. Greenwish, CT: Jai Press.

Reinke, W. A. (2001). Health Systems Management. In M. H. Merson, R. E. Black, and A. J. Mill, (eds.). International *Public Health: Disease, Programmes Systems and Policies. Maryland: Aspen Pub.*

Szilagyi, A. D. (1988). *Management and Performance*, (3rd ed.). Glenview, IL: Scott Foresman and Co.

Taromi, E. (1991). *Toward a Healthy District: Organising and Managing District Health Systems Based on Primary Health Care*. Geneva: WHO.

Taylor, D. & Taylor, C. E. (1995). *Community Based Sustainable Human Development: Going to Scale with Self-Reliant Human Development*. NY: UNICEF Environmental Section.

WHO (1988). *Training Manual of Health Manpower Management*. Geneva: Author.

UNIT 4 MANAGING HUMAN RESOURCES IN THE HEALTH SYSTEM

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Human Resources Management: Definition of Term
    3.2 Functions of Human Resources Management
    3.3 Managing Human Resources in the Health System
    3.4 Shifting Emphases in Personnel Management
    3.5 Framework for Functional Analysis
    3.6 Human Resources Performance and Evaluation
        3.6.1 Selective Evaluation
        3.6.2 Continuing Education
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

In the previous unit, we dealt with health institution/organisation and its dynamics, the role of effective external collaboration on organisational dynamics as well as internal organisational control mechanism. This unit focuses on human resources management in the health system, its functions, functional analysis, performance and evaluation. Enjoy your studies.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define the concept of 'human resources'
- identify the functions of human resources
- illustrate shifting emphases in personnel management
- illustrate framework for functional analysis
- identify the need for performance evaluation in human resources.

3.0 MAIN CONTENT

3.1 Human Resources Management: Definition of Term

Human Resources Management (HRM) is the strategic and coherent approach to the management of an organisation's most valued assets - the people working there who individually and collectively contribute to the achievement of the objectives of the business (Michael, 2006). Human Resource Management (HRM) is also the function within an organisation that focuses on recruitment of, management of, and providing direction for the people who work in the organisation. Human Resource Management is further defined as the organisational function that deals with issues related to people such as compensation, hiring, performance management, organisation development, safety, wellness, benefits, employee motivation, communication, administration, and training (Heathfield, 2000).

The terms "human resource management" and "human resources" (HR) have largely replaced the term "personnel management" as a description of the processes involved in managing people in organisations (Michael, 2006). In simple sense, and as applied to health system management, HRM means employing health professionals, developing their resources, utilising, maintaining and compensating their services in tune with the job and organisational requirement.

3.2 Functions of Human Resources Management

The Human Resources Management (HRM) functions include a variety of activities, and key among them are:

- deciding what staffing needs are and whether to use independent contractors or hire employees to fill these needs
- recruiting and training the best employees (health professionals)
- ensuring that employees are high performers
- dealing with performance issues
- ensuring that personnel and management practices conform to various regulations
- managing the approach to employee benefits and compensation
- managing employee records and personnel policies. Usually small businesses (for-profit or nonprofit) have to carry out these activities themselves because they cannot yet afford part- or full-time help. However, they should always ensure that employees have -- and are aware of -- personnel policies which conform to current regulations. These policies are often in the form of employee manuals, which all employees must have (McNamara, 2009).

3.3 Managing Human Resources in the Health System

The most important resources in the labour intensive health sector are its personnel; they account for up to two-thirds of total expenditures, and even then remuneration is often inadequate because of budget limitations. But to function effectively, personnel and organisational units must have access to drugs and supplies, medical equipment, transport, and other physical resources (WHO, 1990). These in turn require adequate funding. Problems occur when countries are forced to curtail public health budgets during periods of economic decline. When budgets were severely reduced in Nigeria, for example, it was not feasible politically to reduce staffing levels correspondingly (World Bank, 1991). Instead, non personnel expenditures on such things as drugs and maintenance were drastically curtailed, becoming less than 20% of the limited budget. Patients, who soon realised that they would not find necessary drugs and laboratory services at the health centres, stopped using those facilities, which in turn became increasingly inefficient as a result of enforced staff idleness. Because of the separate and combined importance of human, physical, and financial resources, the management of each is taken up in turn, in subsequent units.

SELF ASSESSMENT EXERCISE

1. Human resource management is defined as---?
2. What are the aims of human resource management?

3.4 Shifting Emphases in Personnel Management

In the early years following World War II, principal attention was focused on training increased numbers of doctors, nurses, pharmacists, and other health personnel. This emphasis was especially evident in countries that had recently achieved independence and were bent upon making health care widely available as an essential human right (Fulop & Roerner, 1982). By the 1970s it was becoming apparent that a mere increase in the number of personnel was not sufficient to guarantee health improvement. It was also essential that personnel be used effectively, especially in view of the increasing cost of supporting fully staffed facilities.

Thus, attention shifted to the content of training and its relevance to subsequent practice in addressing community health needs. Two divergent studies of national health manpower needs in the 1960s reflect the needed change in emphases. One study found that Turkey had twice as many doctors as nurses and two-third of the physicians were practising in three urban centres (Taylor, Dirican & Deuschile, 1968). By contrast, another study found that Nigeria had approximately 10

times as many nurses and midwives as doctors, especially in rural areas. It seems unlikely that conditions in the two countries were so different that the manpower situation in each was optimal. Undoubtedly, urban doctors in Turkey were performing "nursing" tasks, and Nigerian nurse/midwives were acting as doctors, even though they were not trained to fill this role. Although Turkey evidently needed more nurses and Nigeria needed more doctors, the desired content of the training was unclear in view of existing role differences and ill-defined unmet needs (Merson, *et al*, 2001).

Methods of functional analysis (elaborated below) for assessing job content will be very informative here, (The Functional Analysis of Health Needs and Services, 1976).

3.5 Framework for Functional Analysis

The conceptual framework for functional analysis is depicted in Figure 4. On the one hand, we have a target population with its defined demographic characteristic, health needs, and demands for care. On the other hand, human, physical, and financial resources are available or can be mobilised to meet population needs. The needs are usually defined demographically and epidemiologically in terms of birth rates, disease incidence rates, and similar indicators, whereas resource levels are described in economic terms, such as health expenditures per capita, or in administrative units, such as doctor-population or bed-population ratios. One is left with the question. What is the relation between 20 doctors, 50 midwives, 200 Community Health Workers, 10,000 cases of diarrhea and 1,500 pregnancies per year? The first task of functional analysis is the development of mutually compatible measures that link needs and resources.

Service units and associated standards of service and productivity form this link. Using the example above, if qualified midwives are expected to be present at 80% of all deliveries, this service standard calls for 1,200 units of service in the form of deliveries by qualified personnel. If 1 midwife working full time assisting deliveries (or, more realistically, 10 midwives each devoting 10% of the time to the task) can handle 200 deliveries per year, this productivity standard translates into a need for 6 Full-Time Equivalent (FTE) midwives to assist in deliveries.

The mobilisation of resources to provide needed service capacity requires development of personnel competencies and the provision of support for the appropriate use of those competencies. Services programmes designed to improve health status and thereby reduce the level of need can fail because:

- persons with health needs do not seek care
- resources to meet service needs are inadequate
- available resources are not organised most efficiently and effectively to address those needs; or
- workers are not motivated or otherwise prepared to use available resources properly.

Below is a presentation of the link between health needs and resources.

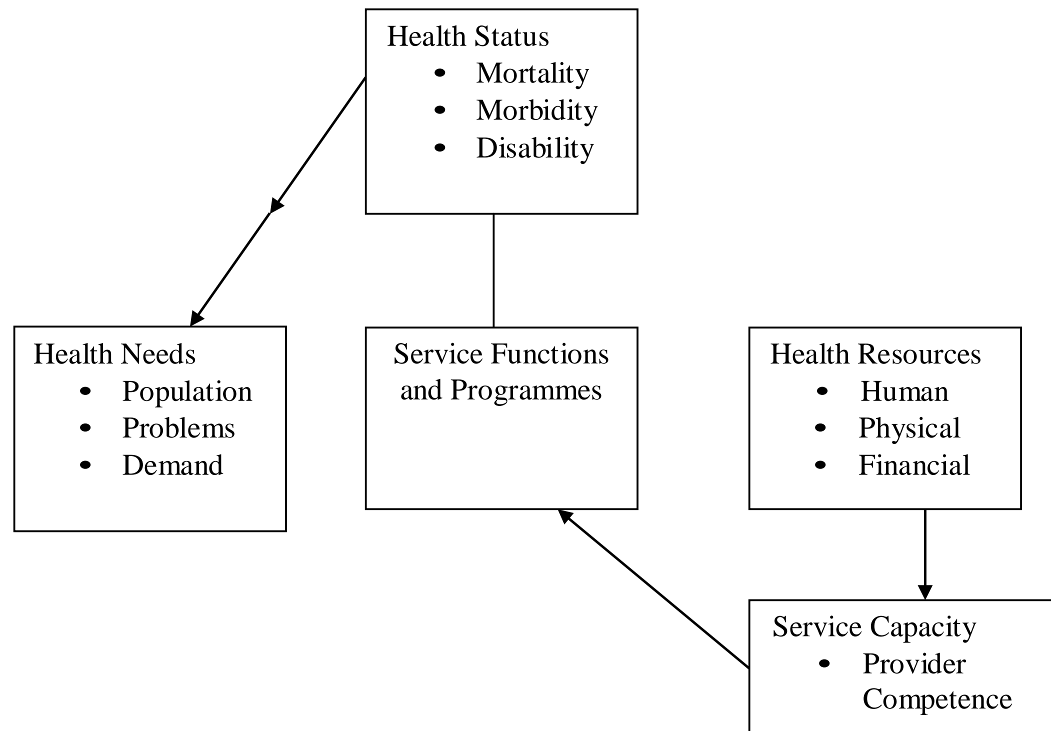

Figure 4: Link between Health Needs and Resources (Merson, *et al*, 2001)

From the presentation above, mortality, morbidity and disability rates of a given country influences its health needs, which in turn influences the health service functions and programmes. Sustainable and effective health system is also a product of competent human resources and service capacity.

3.6 Human Resources Performance Monitoring and Evaluation

A number of evaluative comments have appeared throughout the discussion of personnel management. Rather than treating evaluation as a separate endeavour, it is important to perform ongoing monitoring in the interest of process improvement. Thus, evaluation is a forward looking endeavour, not a periodic backward reflection to cast blame for past failures. Consonant with this view are the two important concepts associated with evaluation of performance: *selective supervision and continuing education.*

3.6.1 Selective Supervision

Selective supervision is based upon the principle of management by exception. Because individuals and work units inevitably experience differing degrees of difficulty in performing their tasks, supervisory attention should be focused on those units in greatest need of support. This is contrary to the conventional wisdom that declares all field units should be visited at the same regular intervals.

3.6.2 Continuing Education

Continuing education often received little systematic attention despite changing circumstances in which health workers are continually called upon to perform unanticipated tasks for which they have received little or no training. When training courses or workshops are conducted, the subject is often based upon the specialised interests of a particular health officer or the availability of funds for a specified training purpose. It was also observed that the most important resource in the health system is its personnel, thus to function effectively, personnel and organisational units must have access to drugs and supplies, medical equipment, transport, and other physical resources (WHO, 1990).

4.0 CONCLUSION

In this unit, Human Resources Management (HRM) in the health system was viewed as the strategic and coherent approach to the management of an organisation’s most valued assets - the people (health professionals), working there who individually and collectively contribute to the achievement of the objectives of the business (Michael, 2006). Several functions were identified among which are: deciding what staffing needs are and whether to use independent contractors or hire employees to fill these needs and recruiting and training the best employees.

5.0 SUMMARY

The following were discussed in this unit:

- human resources: definition of term
- aims of human resources management
- shifting emphases in personnel management
- framework for functional analysis
- performance evaluation in human resources.

ANSWER TO SELF ASSESSMENT EXERCISE

Human Resource Management (HRM) is the function within an organisation that focuses on recruitment of, management of, and providing direction for the people who work in the organisation.

Aims

The Human Resources Management (HRM) functions include a variety of activities, and key among them are:

a. deciding what staffing needs are and whether to use independent contractors or hire employees to fill these needs
b. recruiting and training the best employees
c. ensuring that employees are high performers
d. dealing with performance issues
e. ensuring that personnel and management practices conform to various regulations
f. managing the approach to employee benefits and compensation
g. managing employee records and personnel policies. (McNamara, 2009).

6.0 TUTOR-MARKED ASSIGNMENT

Is HIV/AIDS effectively managed in your country or community? Discuss in line with the following:

a. health status
b. health needs
c. service functions
d. health resources
e. service capacity

7.0 REFERENCES/FURTHER READING

Abel-Smith, B. (1994). *An Introduction to Health: Policy, Planning and Financing*. London: Addison Wesley Longman Ltd.

Arvid, R. J. (1976). *Management, Systems, and Society: An Introduction*. Pacific Palisades, Calif.: Goodyear Pub. Co.

Campbell, C. (2007). *Essentials of Health Management Planning and Policy*. Lagos: University of Lagos press.

Cassel, A. & Janovsky, K. (1996). *Strengthening Health Management in District and Provinces. Handbook for Facilitators*. Geneva: Switzerland: WHO.

Druker, B. F. (1974). *Management: Tasks, Responsibilities, Practices.* NY: Harper and Row.

Donaldson, C. & Gerard, K. (1993). *Economics of Health Care Financing: The Visible Hand*. London: McMillan.

Encyclopedia of Public Health; Social Health. Answers.com Retrieved from ://www.answers.com/topic/social-health. Site Accessed on 20th July 2009.

Fulop, T. & Roemer, M. I. (1982). *International Development of Health Manpower Management*. Geneva: WHO.

Gomez-Mejia, Luis R.; David B. Balkin and Robert L. Cardy (2008). *Management: People, Performance, Change,* (3rd ed.). New York, New York USA: McGraw-Hill.

Heathfield, S. M. (2000). *What is Human Resource Management?* About.com.

Janovsky, K. (1988). *The Challenge of Implementation: District Health Services for Primary Health Care*. Geneva: WHO.

McNamara, C. (2009). *Human Resources Management*. Retrieved from **://managementhelp.org/hr_mgmnt/hr_mgmnt.htm**.Site visited on 24th July 2009.

Merson, M. H., Black, R. E and Mill, A. J. (2001). *International Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

Merson, M. H., Black, R. E and Mill, A. J. (2001). *International Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

Michael, A. (2006). *A Handbook of Human Resources Management Practice* (10th ed.). London: Kogan.

Mitchell, J. and Haroun, L. (2001). *Introduction to Health Care*. Canada: Delmar.

Reinke, W. A. (2001). Health Systems Management. *In*: M. H. Merson, R. E. Black, and A. J. Mill, (eds.). International *Public Health: Disease, Programmes Systems and Policies. Maryland: Aspen Pub.*

Taylor, C. E.; Dirican, R. & Deuschle, K. W. (1968). *Health Manpower Planning in Turkey*. Baltimore: The John Hopkins Univ. Press.

World Bank (1991). *Federal Republic of Nigeria: Health Care Cost, Financing and Utilization.* (Report No. 8382-UNI), Washington DC: Author.

WHO (1990). *Coordinated Health and Human Resources Development* (Technical Report Series, No. 801), Geneva: WHO.

MODULE 4 MANAGING PHYSICAL/FINANCIAL RESOURCES; COMMUNITY INVOLVEMENT AND HEALTH SYSTEM REFORM

Unit 1 Physical Resources Management
Unit 2 Financial Management
Unit 3 Health System Management: Community Involvement
Unit 4 Health System Reform

UNIT 1 PHYSICAL RESOURCES MANAGEMENT

CONTENTS

1.0 Introduction
2.0 Objectives
6.0 Main Content
    6.1 Transport Equipment Use and Maintenance
    6.2 The Logistics Cycle
    3.3 Stock Replenishment and Decision Rules
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

The provision of quality health care is increasingly demanding on the physical infrastructure. The way in which physical resources such as buildings, equipment and supply systems are managed largely affects the lifetime of investments and the performance of the health system as a whole. Appropriate buildings and equipment are a major motivation factor for health workers. Yet, in many countries the physical assets are in a poor functional condition or not appropriate for the interventions to be delivered. Engineering support services have frequently been neglected which explains in part the poor performance of health services. Well performing systems require an array of technical support services including i.e. strategic technology planning, procurement and logistics as well as efficient clinical equipment maintenance. This unit thus elaborates more on the role of physical resource management in health system management.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- identify the need for physical resource management in the health systems
- illustrate the techniques of transport management and maintenance
- explain the logistics cycle
- discuss the rudiments of stock replenishment and decision rules.

3.0 MAIN CONTENT

3.1 Transport Equipment Use and Maintenance

Much has been said about methods for developing work force capabilities and for motivating individuals to use their capabilities fully. All is for naught, however, if staff do not have the drugs and supplies, functioning equipment, and transport needed to perform their jobs satisfactorily. Because the cost of drugs and supplies is usually second only to personnel costs, it deserves particular management attention and discussion, but first some observations are offered on the subjects of transport and equipment use and maintenance.

The classic example of overcentralised management is in the control of transport. Procedures that require headquarters approval to purchase fuel and spare parts increase administrative costs and result in excessive and costly downtime for ambulances and other vehicles. On the other hand, authorised private use of vehicles under local control is, unfortunately, commonplace. What is needed, of course, is a set of locally relevant rules and procedures that are competently enforced. It is hard to generalise how to achieve this management structure but decentralised authority coupled with strict rules of accountability is paramount, along with a large measure of good will (Reinke, 2001).

As community outreach efforts expand in an effort to satisfy the needs of underserved areas, travel time and costs mount, unnecessary costs of a different sort are incurred when inoperative vehicles make impossible the transport of emergency cases from the periphery to the district hospital. These two considerations draw attention to the use of appropriate modes of transport. Motorised vehicles used in place of bicycles save travel time of field personnel; hence they might be justified despite their higher cost. The benefits are lost, however, when spare parts are not locally available or mechanics familiar with the particular vehicle are not present. Again, it is difficult to generalise, but

clearly, considerations of appropriate technology must receive the attention they deserve (Merson, 2001; Reinke, 2001).

In the usual situation where funds are severely limited, there is a temptation to postpone needed maintenance in order to satisfy more immediate budgetary demands, despite the clear implication for increased costs in the long run. It is often more rational to move in the opposite direction by performing early preventive maintenance. Because of the potential cost savings in this regard (not unlike the benefits from preventive health care), mathematical models have been developed to determine optimum preventive maintenance policies. The models themselves are beyond the scope of concern here, but the principle behind them is worth noting (Morse, 1958).

Take the classic case of light bulb replacement. When a bulb failure is reported, maintenance personnel must make a special trip to the failure site. Once there, they can replace other bulbs that are about to fail at relatively little additional cost. The question is: which ones are about to fail? The answer cannot be determined precisely, but appropriate record keeping can yield a probability distribution of survival times from which the cost of early replacement can be ascertained. Specifically, one must weigh the added cost of light bulb purchases due to more frequent replacement against the reduction in personnel costs obtained from the simultaneous replacement of multiple units (Morse, 1958).

SELF ASSESSMENT EXERCISE

Why is it necessary to de-centralise transport and equipment maintenance?

3.2 The Logistics Cycle

An even richer potential for gain is available from the mathematical modeling of drug usage because of the costs involved. Before elaborating on this point, however, the ***four basic elements of the logistics cycle*** must be outlined:

- selection of items to stock
- procurement of those items
- distribution to the sites of use
- disbursement and replenishment (Management Sciences for Health, 1997).

With regard to ***selection,*** the value of a limited list of essential drugs is well established. Considering price and efficacy, the list should contain only materials shown to be cost effective. Where several varieties serve

essentially the same purpose and are similarly cost effective the choice of a single item can result in a price advantage gained from large volume purchase and can simplify administrative stock control procedures as well.

Procurement decisions are important, but may be beyond the control of local institutions and agencies. The decision might be made to:

- manufacture drugs domestically
- import raw materials and process them domestically, or,
- purchase the finished product in the international market.

Although the decisions are sometimes made on political grounds they should be based on considerations of manufacturing capacity, price, quality control, and foreign exchange requirements (Merson, 2001; Reinke, 2001).

Procurement decisions at the district or institutional level can relate to purchase locally in the open market versus procurement through the national depot system. This issue is them closely tied to questions of distribution. To secure price advantages and other controls from volume purchasing, items are often procured at the national level, then distributed to regional warehouses and on to local institutions such as hospitals for further reallocations. The longer the chain of distribution, the more opportunity there is for bottlenecks and shortages to develop. For this reason, the flexibility of local purchase is sometimes preferred even at the expense of higher prices.

The increasing number of drug revolving funds (DRFs) further complicates the matter. The funds are designed to broaden the distribution base by making commodities available for sale to all patients, even those at the periphery, and using the revenues thus generated to replenish the initial supply. If the DRF serves to extend the national network to one lower level, the shortage problems described above can be made worse. If on the other hand, the DRF is strictly a local enterprise, difference concerns arise with respect to price, availability, control, and corruption. These funds have enjoyed considerable success and have served a useful purpose, but their management is a matter of continuing concern (Merson, 2001; Reinke, 2001).

3.3 Stock Replenishment and Decision Rules

Effective procedures are essential for the selection, procurement, and distribution of drugs and supplies, but drug availability ultimately depends upon stock control procedures employed at the point of usage. Shortages can cause costly interruptions in service delivery, but excessively high inventory levels can also be costly, especially when the items stocked are perishable. Because of these cost implications in the industry, mathematical models prescribing optimal stock replenishment decision rules were among the earliest contributions of operations research to management practice (Morse, 1958). Inventory cost -saving rules are available in the health field as well.

The simplest model recognises two conflicting costs requiring trade-offs, as shown in Figure 5 below.

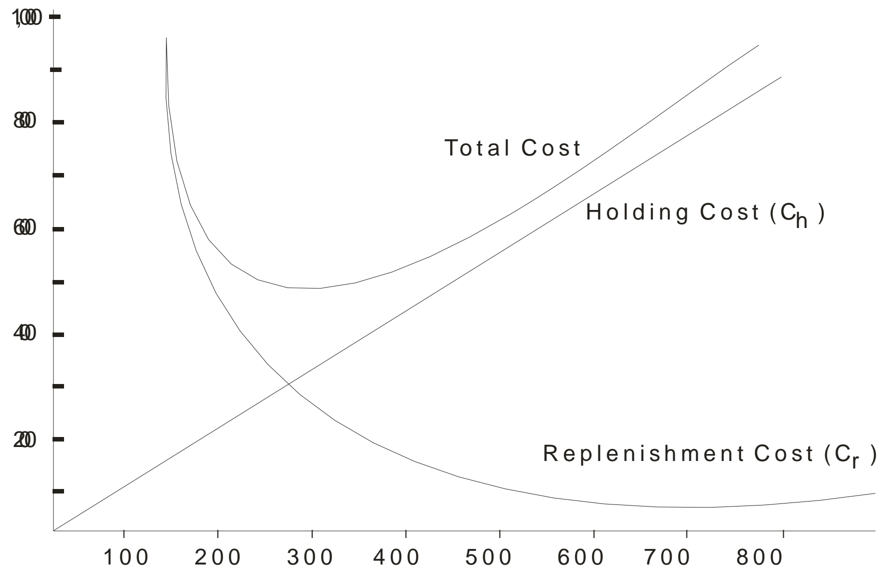

Figure 5: Economic Order Quantity (Reinke, 2001)

First, a restocking cost, C_r, is incurred every time replenishment takes place. Because the cost of placing the order and transporting the stock to the site where it is dispensed is essentially the same regardless of the amount ordered, restocking costs can be minimised if orders are placed infrequently, say annually. Such a decision, however, requires a large investment in inventory and storage facilities and increase the risk and cost of pilferage and spoilage. These holding costs, C_h, must be weighed against the restocking costs, C_r. the optimal balance depends on the ratio

of these costs and usage levels, U. specifically, and the optimal economic order quantity is determined to be the square root of the expression $2UC_r/C_h$.

In the typical case where many items with different usage rates are stocked, there are obvious advantages to joint replenishment regardless of the reorder frequency dictated by the above formula. The mathematically derived S,s decision rule achieve these advantages without loss of the benefits from the single item replenishment model.

The rule specifies that stock levels be reviewed periodically (say monthly) in order to identify items that have fallen below their individually determined minimum (order trigger) values, s. orders are placed for these items to bring their stock levels up to the maximum value S established for each. Minimum and maximum values are determined by frequency of review, lead time needed between placement of the order and actual replenishment, average usage during the lead time, variation in usage, and economic order quantity considerations.

4.0 CONCLUSION

We saw in this unit, that the provision of quality health care is increasingly demanding on the physical infrastructure. The way in which physical resources such as buildings, equipment and supply systems are managed largely affects the lifetime of investments and the performance of the health system as a whole. Thus, appropriate buildings and equipment are a major motivation factor for health workers.

5.0 SUMMARY

This unit has outlined the following:

- physical management in the health systems
- transport and equipment use and maintenance
- the logistics cycle
- stock replenishment and decision rules

We hope this unit was not too complicated for you. For test of understanding, let us attempt the question below.

ANSWER TO SELF ASSESSMENT EXERCISE

It is necessary to decentralise transport and equipment use and maintenance because procedures that require headquarters approval to purchase fuel and spare parts increase administrative costs and result in time-wasting and inefficiency.

6.0 TUTOR-MARKED ASSIGNMENT

Describe the 4 basic elements of the Logistic Cycle.

7.0 REFERENCES/FURTHER READING

Abel-Smith, B. (1994). *An Introduction to Health: Policy, Planning and Financing*. London: Addison Wesley Longman Ltd.

Arvid, R. J. (1976). *Management, Systems, and Society: An Introduction*. Pacific Palisades, Calif.: Goodyear Pub. Co.

Campbell, C. (2007). *Essentials of Health Management Planning and Policy*. Lagos: University of Lagos Press.

Encyclopedia of Public Health; Social Health. Answers.com Retrieved from http://www.answers.com/topic/social-health. Site Accessed on 20th July 2009.

Gomez-Mejia, Luis R.; David B. Balkin and Robert L. Cardy (2008). *Management: People, Performance, Change,* (3rd ed.). New York USA: McGraw-Hill.

Management Science for Health (1997). *Managing Drug Supply: The Selection, Procurement and Distribution Use of Pharmaceuticals* (2nd ed.). West Hartford, Ct: Kumarian Press.

Merson, M. H., Black, R. E and Mill, A. J. (2001). *International Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

Michael, A. (2006). *A Handbook of Human Resources Management Practice* (10th ed.). London: Kogan.

Mitchell, J. and Haroun, L. (2001). *Introduction to Health Care*. Canada: Delmar Oxford English Dictionary.

Morse, P. M. (1958). *Queues, Inventories and Maintenance*. NY: John Wiley and Sons.

Reinke, W. A. (2001). Health Systems Management. *In*: M. H. Merson, R. E. Black, and A. J. Mill, (eds.). *International Public Health: Disease, Programmes Systems and Policies. Maryland: Aspen Pub.*

WHO (1990). *Coordinated Health and Human Resources Development* (Technical Report Series, No. 801), Geneva: WHO.

UNIT 2 FINANCIAL MANAGEMENT

CONTENTS

1.0 Introduction
2.0 Objectives
3.5 Main Content
    3.1 Financial Management: Definition of Term
    3.2 Objectives of Financial Management
    3.3 Elements of Financial Management
    3.4 Financial Management Levels
    3.5 The Practice of Financial Management
        3.5.1 Resource Allocation Decisions
        3.5.2 Performance Budgeting
        3.5.3 Cost Analysis
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

No system or institution can run optimally without a logical and systematic management of its personnel, its physical resources as well as its finances. The management of the finances of a business/organisation in order to achieve financial objectives is very crucial. Financial management in health entails planning for the future of a health enterprise to ensure a positive cash flow. This will be elaborated on in this unit.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define financial management
- list the objectives of financial management
- illustrate the elements of financial management
- explain the levels of financial management
- describe specific terms associated with financial management.

6.0 MAIN CONTENT

3.1 Financial Management: Definition of Term

Financial management can be defined as: the management of the finances of a business/organisation (health institution) in order to achieve financial objectives (Tutor2u, 2009). Financial management entails planning for the future of a person or a business enterprise to ensure a positive cash flow. It includes the administration and maintenance of financial assets. Besides, financial management covers the process of identifying and managing risks.

The primary concern of financial management is the *assessment* rather than the *techniques* of financial quantification. A financial manager looks at the available data to judge the performance of enterprises. Managerial finance is an interdisciplinary approach that borrows from both managerial accounting and corporate finance.

Some experts refer to financial management as the science of money management. The primary usage of this term is in the world of financing business activities. However, financial management is important at all levels of human existence because every entity needs to look after its finances (Tutor2u, 2009).

3.2 Objectives of Financial Management

Taking a health enterprise as the most common organisational structure, the key objectives of financial management would be to:

- create wealth for the business
- generate cash, and
- provide an adequate return on investment bearing in mind the risks that the business is taking and the resources invested.

3.3 Elements of Financial Management

There are three key elements in the process of financial management:

(1) Financial Planning

Management needs to ensure that enough funding is available at the right time to meet the needs of the business. In the short term, funding may be needed to invest in equipment and stocks, pay employees and fund sales made on credit.

In the medium and long term, funding may be required for significant additions to the productive capacity of the business or to make acquisitions.

(2) Financial Control

Financial control is a critically important activity to help ensure that the business is meeting its objectives. Financial control addresses questions such as:

- are assets being used efficiently?
- are the businesses assets secure?
- does management act in the best interest of shareholders and in accordance with business rules?

(3) Financial Decision-making

The key aspects of financial decision-making relate to investment, financing and dividends:

- investments must be financed in some way – however, there are always financing alternatives that can be considered. For example, it is possible to raise finance from selling new shares, borrowing from banks or taking credit from suppliers
- a key financing decision is whether profits earned by the business should be retained rather than distributed to shareholders via dividends. If dividends are too high, the business may be starved of funding to reinvest in growing revenues and profits further.

SELF ASSESSMENT EXERCISE

1. Define financial management
2. What are the objectives of financial management?

3.4 Financial Management Levels

Broadly speaking, the process of financial management takes place at two levels. At the ***individual level***, financial management involves tailoring expenses according to the financial resources of an individual. Individuals with surplus cash or access to funding invest their money to make up for the impact of taxation and inflation. Else, they spend it on discretionary items. They need to be able to take the financial decisions that are intended to benefit them in the long run and help them achieve their financial goals.

From an ***organisational point*** of view, the process of financial management is associated with financial planning and financial control. Financial planning seeks to quantify various financial resources available and plan the size and timing of expenditures. Financial control refers to monitoring cash flow. Inflow is the amount of money coming into a particular company, while outflow is a record of the expenditure being made by the company. Managing this movement of funds in relation to the budget is essential for a business (Economy watch, 2009).

3.5 Financial Management Practice

The financial management of an enterprise first requires appraisal of alternative strategies for allocating the limited resources available. Once a preferred strategy is identified, a detailed budget is prepared to carry it out. Then in the course of implementation, expenditures are monitored in relation to budgeted levels (Mills, 1990a, 1990b). Financial management practice, therefore, is discussed under three headings:

- resource allocation decisions
- performance budgeting
- cost analysis

3.5.1 Resource Allocation Decisions

The fundamental aim of the design of health programmes is to achieve desired results at minimum cost. This is the essence of Cost Effectiveness Analysis (CEA) (Reynolds & Gaspari, 1985). In recognition of the special importance of intangible benefits in connection with health and other social services, the economic orientation of CEA has been broadened to form Cost Utility Analysis (CUA) (Gold, Russell, Siegel, & Weinstein, 1996; Torrance, 1986). The notion of health for all has further directed attention to the distribution of benefits along with overall levels of achievement. Thus, equity has become a prime concern (Musgrove, 1986). More recently, we have come to appreciate the labour intensive nature of health care and its effect on recurrent costs. One-time development costs incurred with donor support to improve service coverage leads to an ongoing recurrent cost commitment normally borne by the host country government to maintain the capability that has been developed. Issues of programme sustainability and affordability have, therefore, come to the forefront (Abel-Smith & Creese, 1989, Bossert, 1990; Lafond, 1995; Olsen, 1998; Prescott & De Ferranti, 1985). This interest has been heightened by growing concern over quality issues which can be costly. The question is raised whether improved quality, achieved at a cost, carries with it a level of client satisfaction that results in a willingness to pay for the

added costs. Thus, issues of cost recovery enter the equation (Creese & Kutzin, 1995; Kanji, 1989; Knippenberg, Reinke, & Hopwood, 1997).

These multiple desires are not necessarily mutually compatible. For example, the most cost effective strategy in a given situation might focus on a readily accessible urban population, but this approach would be unlikely to satisfy even minimum criteria of equity. Sound and reliable appraisals of the trade-off between cost-effectiveness and equity require explicit comparisons of each evaluative indicator. Although cost-effectiveness measures have been well defined, the meanings of equity, quality, and sustainability are still somewhat vague. Financial analysis methods must be defined to clarify the various evaluative measures and lastly, facilitate integrated analysis of the trade-offs required among them (Reinke, 2001).

3.5.2 Performance Budgeting

Too often, budgeting is merely an exercise in which planners take last year's allocation and project a certain percentage increase this year as reasonable or feasible. Or perhaps, a 15% increase in the personnel budgets is considered necessary, while a 10% increase in the transport budget would be satisfactory. Budgets based upon line item inputs like personnel, transport, drugs, and maintenance, apart from the outputs expected, are necessarily arbitrary and not easily justified.

Programme budgets are somewhat more satisfactory because the inputs are related to areas of activity. Thus, the judgment might be made to give higher priority to family planning and increase that programme budget by 20% while holding the budget for communicable disease control to last year's level. Still, as a budget of resources only, albeit for selected purposes, the programme budget is of limited value to programme managers for tracking performance during the budget year, family planning expenditures have consumed 40% of budgeted funds for family planning, or 80% (40/50) of expected levels for the period. Perhaps cost savings have accrued as a result of efficient use of resources, but what if only 30% of planned contacts for the year have been made during the first 6 months. This presents a picture of relative inefficiency, in which 40% of budgeted resources were consumed in providing 30% of intended services. For management action purposes, it is clearly preferable to relate inputs and outputs explicitly (Reinke, 1988b).

3.5.3 Cost Analysis

Although cost analysis techniques comparing actual experiences with budgeted expectations have been introduced, further elaboration of costing methods is needed. First, it is necessary to understand how costs are interpreted differently at various stages of budgeting and cost accounting (Creese & Parker, 1994). To illustrate, consider a presently used piece of equipment that is to be replaced by a more automatic labour-saving instrument. Specifically, the old equipment was purchased 2 years ago for N48, 000 and was expected to last for 6 years, and the new instrument costs N70, 000 and is expected to remain serviceable for 5 years.

In the resource allocation decision to purchase, the capital cost of the new equipment enters into the calculation, but not the initial cost of the existing instrument, as this expenditure has already been expended and is not subject to reversal. An issue in the allocation decision is whether the superior performance of the new instrument justifies its purchase.

If purchase of the new equipment requires full payment in advance, the next budget must include the entire cost of the new equipment, but nothing for the old. In contrast, the accounting records will show entries for both instruments. One-sixth (N8,000) of the original cost of the old equipment is to be accounted for during each year of its expected life, and now N14,000 will be added during each of the 5 years that the new instrument is expected to be in use. The thinking behind this procedure is that because the equipment is anticipated to produce service benefits over time, its cost should be similarly allocated in order to permit determination of cost per unit of service. Cost calculations, then, must suit the purpose for which the determination of cost is being made. In particular, accounting records are of limited value in analysis of cost effectiveness.

4.0 CONCLUSION

It is hoped that you have gained a better understanding of financial management which was defined as: the management of the finances of a business/organisation in order to achieve financial objectives. Its objectives among many include: creating wealth for the business, generating cash and providing an adequate return on investment. Financial planning, control and decision were also recognised as key elements of financial management. Also, the level of financial management can be at the individual or organisational levels. This unit concluded with descriptions of the following: financial management practices: resource allocation decision, performance budgeting and cost analysis.

5.0 SUMMARY

This unit outlined the following:

- financial management: definition of term
- objectives of financial management
- elements of financial management
- financial management: levels
- the practice of financial management

ANSWER TO SELF ASSESSMENT EXERCISE

Financial management can be defined as: the management of the finances of a business/organisation in order to achieve financial objectives (Tutor2u, 2009). Financial management entails planning for the future of a person or a business enterprise to ensure a positive cash flow. It includes the administration and maintenance of financial assets. Besides, financial management covers the process of identifying and managing risks.

Objectives of Financial Management:

- create wealth for the business
- generate cash, and
- provide an adequate return on investment bearing in mind the risks that the business is taking and the resources invested

6.0 TUTOR-MARKED ASSIGNMENT

1. Define financial management
2. What is the role of the following in financial management?

a. Resource allocation decisions
b. Performance budgeting
c. Cost analysis

7.0 REFERENCES/FURTHER READING

Abel-Smith, B. & Creese, A. (eds.). (1989). *Recurrent Costs in the Health Sector: Problems and Policy Options in three Countries.* Geneva: WHO.

Abel-Smith, B. (1994). *An Introduction to Health: Policy, Planning and Financing*. London: Addison Wesley Longman Ltd.

Arvid, R. J. (1976). *Management, Systems, and Society: An Introduction*. Pacific Palisades, Calif.: Goodyear Pub. Co.

Bossert, T. J. (1990). Can they get along without us? *Social Science and Medicine*, 30(90), 105-1032.

Campbell, C. (2007). *Essentials of Health Management Planning and Policy*. Lagos: University of Lagos press.

Creese, A. & Parker, D. (1994). Cost *Analysis in Primary Health Care: A Training Manual for Programme Managers.* Geneva: WHO.

Creese, A. & Kutzin, J. (1995). *Lessons from cost Recovery in Health.* Discussion paper No. 2. Geneva: WHO.

Economy watch, 2009. *Financial management.* Retrieved from: ://www.economywatch.com/finance/financial-management.html. Site visited on 27th July, 2009.

Encyclopedia of Public Health; Social Health. Answers.com Retrieved from ://www.answers.com/topic/social-health. Site Accessed on 20th July 2009.

Gold, M. R., Russell, L. B., Siegel, J. E. & Weinstein, M. C. (1996). *Cost-effective in Health and Medicine.* NY: Oxford Univ. Press.

Kanji, N. (1989). Charging for Drugs in Africa. *UNICEF's "Bamako Initiative". Health Policy and Planning,* 4(2), 110-120.

Knippennberg, R., Reinke, W. A. & Hopwood, I. (1997). Sustanability of Primary Health Care including Immunisation in Bamako Initiative Programmes in West Africa. *Health Planning and Management*, 12 (suppl.1).

Lafond, A. K. (1995). Research on Sustainability in the Health Sector. *Health Policy and Planning*, 10 (suppl), 1-7.

Merson, M. H., Black, R. E and Mill, A. J. (2001). *International Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

Mitchell, J. and Haroun, L. (2002). *Introduction to Health Care*. Canada: Delmar.

Mills, A. (1990a). The Economics of Hospitals in Developing Countries, Part 1: Expenditure Pattern. *Health, Policy and Planning,* 5(2), 107-117.

Mills A. (1990b). The Economics of Health in Developing Countries, Part 11: Costs and Resources of Income. *Health, Policy and Planning*, 5(3), 203-218.

Musgrove, P. (1986). Measurement of Equity in Health. *World Health Statistics Quarterly,* 39(4), 325-335.

Olsen, I. T. (1998). Sustainability of Health Care: A Framework for Analysis. *Health Policy and Planning,* 13(3), 287-295.

Prescott, N. & Ferranti, D. (1985). The Analysis and Assessment of Health programmes. *Social Science and Medicine*, 20(12), 1235-1240.

Reynolds, J. & Gaspari, K. C. (1985*). Cost-Effective Analysis.* Chevy Chase, MD: Center for Human Services.

Reinke, W. A. (1988). *Health Planning for Effective Management.* NY: Oxford Univ. Press.

Reinke, W. A. (1995). Quality Management in Managed Care. *In*: H. Jolt (eds), State *of the Art Reviews* (Vol, 2, No. 1). Philadelphia: Hanley and Belfus.

Reinke, W. A. (1999). A Multidimensional Programme Evaluation Model: Consideration of cost Effectiveness, Equity, Quality and Sustainability. *The Canadian Journal of Programme Evaluation,* 14(2), 145-160.

Reinke, W. A. (2001). Health Systems Management. *In*: M. H. Merson, R. E. Black, and A. J. Mill, (eds.). *International Public Health: Disease, Programmes Systems and Policies. Maryland: Aspen Pub.*

Tutor2U (2009). *What is Financial Management*? Retrieved from ://tutor2u.net/business/accounts/finance_management_intro.htm. Site visited on 27th July 2009.

UNIT 3 HEALTH SYSTEM MANAGEMENT: COMMUNITY INVOLVEMENT

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
3.1 Meaning of Community
3.2 Meaning of Participation
3.3 Specific Activities in a Community
3.4 Why Community Participation in Health System
3.5 Guidelines for Overcoming Obstacles
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

The rationale for decentralisation in health system management logically extends to consideration of community involvement. If decentralised decision making makes locally relevant actions more likely, participation of the communities themselves should offer further assurance of relevance. Because both terms: community and participation are ambiguous, the subject deserves separate attention. These and more will be discussed in this unit.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define a community
- define community participation
- identify the specific activities in community participation
- illustrate the need for community participation in health system
- describe the guidelines for overcoming obstacles in community participation in health system.

3.0 MAIN CONTENT

3.1 Meaning of Community

It is misleading to think of community in strictly geographical terms, for those living within defined boundaries are often divided into several factions with conflicting goals. It is more useful, therefore, to define communities in terms of common culture, traditions, interests, and needs (Madan, 1987). In this sense, an association of geographically dispersed nurses/doctors is a community. Although community considerations in health services management often have a geographic base, we must bear in mind that separate community interests exist within the geographic area of concern. Leadership questions arise within this framework because designated leaders may reflect the interests of a single influential faction that is not prepared to support broader reforms. In this case, the central authority that fails to serve local needs is simply replaced by an equally unrepresentative local authority (Reinke, 2001).

3.2 Meaning of Participation

The initiative for community collaboration usually comes from outside the community. This raises the question: Is the aim to enlist community support in order to satisfy project objectives? Or is project support sought to satisfy community wants and needs? Whereas the latter approach is usually specified or implied, it seems that the former is more practised. The meaning of partnership is coloured accordingly.

Communities can contribute *physical resources (*as when a room in a village home is used as a health post), *funds* (for example, establishment of a drug revolving fund), or personnel. The latter can offer ideas and advice, be empowered to make decisions, or take actions, as in providing care or conducting surveys of health needs. The appropriate form of involvement depends upon what decisions are to be made and what action is to be taken, at what level, and when. These activities run the gamut from policy analysis to planning, implementation, and evaluation. If a policy of charging for drugs dispensed by community health workers (CHWs) is under consideration, should the fee scheduled be established by a village health committee (VHC) with community membership (in part or exclusively), or should the CHWs merely collect the fees that have been set by district health authorities? In any case, the presence of truly functional VHC decision-making bodies and respected CHW service providers has been found to be crucial to effective community participation.

3.3 Specific Activities in a Community

Nine specific sets of activity have been identified for which community roles should be defined (Taylor, 1988). They are as follows:

1. establishing community representation
2. setting community organisation objectives
3. determining community organisations strategies and functions
4. determining community structures
5. identifying appropriate incentives for participation
6. managing the community organisation
7. providing supervision and support
8. implementing community organisation activities
9. monitoring and evaluating community performance

SELF ASSESSMENT EXERCISE

1. A community is defined as………………………….
2. The phrase community participation in health system implies…………………..

3.4 Why Community Participation in Health System

Community participation is beneficial to the extent that it contributes to usual health service objectives of effectiveness, efficiency, equity, and sustainability (Newell, 1975). One of the most successful community-based efforts, the Jamkhed Project in India (Arole & Arole, 1994), illustrates community participation in numerous ways. For example, a 40-bed hospital set up under project auspices provides quality care at low cost because village people take care of all non-technical hotel functions, and project professional staff focus limited resources on the technical aspects of care. Functioning at the grassroots level, the project also has been able to achieve equity by, for example, concentrating the funding of water sources in low caste residential areas, thereby making advantaged segments of the population dependent upon the disadvantaged for an important contribution to well-being.

Also, a village health project in Somalia provides striking evidence of sustainability. According to informal reports from WHO staff closely associated with the project, community "ownership" of the enterprise was so well established when armed conflict escalated and most government services of all types were curtailed, that health care in the project villages continued virtually uninterrupted. Although the circumstances make it impossible to document the experience in detail, the anecdotal evidence in informative.

The value of community health projects is not limited to the health sector. More generally, they encourage community cohesion and empowerment. The theology of liberation movements in Latin America has been especially notable in emphasising *conscientisation*, whereby traditionally subservient individuals and groups are emboldened to demand their rightful place in society.

3.5 Guidelines for Overcoming Obstacles

Numerous roadblocks to effective community participation in health system must be overcome (Korten, 1981). Even in the absence of overt threats to success, certain actions can be taken to make the partnership more rewarding. Several of the more important considerations are summarised below.

Official Commitment: Official commitment is needed at all levels to provide a favorable climate for collaboration. Because community-level decisions and actions cannot be carried out in isolation, support throughout the health system is important and takes the form of stated policy at central and district levels, as well as consequent evidence of willingness to relinquish control as necessary.

Positive Leadership: Much care is required in the formation of effective community links. Although external change agents can provide the needed initial stimulus, they must not be dictatorial. This approach requires exceptional sensitivity on their part. Leadership within the community must be established to fit the circumstances. Does the community role require democratically determined representation? Or should the leader be someone chosen because of specialised technical competence or community respect? All these are very important.

Good Partnership between Community Representatives and Health Experts: The evolving partnership between staff and community representative should provide mutual learning opportunities that establish common terms of reference. Staff members should become sensitive to community needs and priorities. Community participants should become acquainted with local epidemiologic conditions and intervention possibilities. When a survey of health professional and residents of certain area in Nepal enumerated local health problems, it was found that half of the problems were independently recognised by both professionals and community, indicating substantial congruence in perspective (De Sweemer, Parker, Taylor, & Renike, 1979). Equally revealing was that, among the items initially identified by only one of the parties and later accepted by the other, the number of items contributed by the community exceeded that put forward by the professionals, making clear the value of exchange of views.

Broad Perspective to Health Management: Individuals tend not to place their problems into neat categories; moreover, the usual priorities involving food, shelter, employment, and education are not seen to have direct health implications. Health workers therefore face a challenge in entering into a dialogue with the community (Flavier, 1970). The Jamkhed project began the effort by organising volleyball contests. These were followed by chat sessions that eventually led to formation of women's clubs and Young Farmers Clubs for men. When health-related projects were initiated with community support, they usually dealt at first with broad issues of safe water and nutrition. Only later were specific problems like immunisation and contraception tackled. In contrast, others have found advantage in launching clearly targeted immunisation or diarrhea diseases control programme capable of producing visible results in a relatively short period of time (Taylor & Waldman, 1998).

Democratisation of the Selection and Training of Community Health Workers: The CHW is the critical link in providing services. Much of the programme success therefore hinges upon CHW selection and, training recruitment decisions made solely by the community can lead to the nomination of unqualified members of the headman's family. Selection by health staff, on the other hand, is contrary to the notion of community participation. A workable solution allows the community to nominate three acceptable candidates, one of whom is chosen by the health team having responsibility for the training (Were, 1982). *Competency-based training* then mixes considerable practice with essential theory in preparing candidates to carry out at most five or six priority tasks. Once these are consistently and satisfactorily carried out, other tasks can be added. Too often, in an attempt to improve coverage, CHWs are assigned responsibility for an overwhelming array of activities that they have neither the time nor the competence to undertake.

Detailed Data Gathering Technique: While limiting the number of activities, the importance of data gathering in the CHW job description should not be underestimated, as village-based workers are in an excellent position to track their neighbours' problems. The Jamkhed found, for example, that whereas health centre workers typically identified two or three leprosy cases in community surveys, the CHWs were able to uncover 10 times as many.

Full Support of CHWs: Once trained, CHWs should be fully supported in their daily activities. An attractive work site and adequate levels of supportive supervision should be provided. Although some programmes try to rely on volunteer effort, experience suggests that some form of remuneration in money or in kind is highly recommended. Funding may

come from the community directly, or from fees collected. If funds come directly from the government, the community loses control, and CHWs become in effect government workers co-opted from the community. Remuneration through collection of fees for drugs dispensed has the disadvantage of encouraging curative care at the expense of health promotion and disease prevention activities. Regardless of the financial arrangements, the risk of corruption exists. Under decentralisation, special care must be taken to prevent past corrupt practices at the central level from multiplying across communities, where they can be especially damaging (Reinke, 2001).

4.0 CONCLUSION

It is obvious that a community is much more than strictly a geographical entity, for those living within defined boundaries are often divided into several factions with conflicting goals. It is thus more useful to define communities in terms of common culture, traditions, interests, and needs. Community participation in health care and management can be in the area of *physical resources, funds* or *personnel.* This unit also observed ways of surmounting obstacles to community participation in health care namely: positive leadership, flexibility, support of community health workers and full participation in health care.

5.0 SUMMARY

This unit outlined the following:

- definition of community
- illustration of the meaning of community participation
- specific activities in community participation
- need for community participation in health system
- guidelines for overcoming obstacles in community participation.

ANSWER TO SELF ASSESSMENT EXERCISE

Community is defined as an entity comprising common culture, traditions, interests, and needs. Although community considerations in health services management often have a geographic base, we must bear in mind that separate community interests exist within the geographic area of concern.

Community participation can entail contribution of *physical resources (*as when a room in a village home is used as a health post), *funds* (for example, establishment of a drug revolving fund), or personnel. The latter can offer ideas and advice, be empowered to make decisions, or take actions, as in providing care or conducting surveys of health needs.

6.0 TUTOR-MARKED ASSIGNMENT

1. List specific activities in a community
2. Obstacles to active community participation in health system management can be overcome. Discuss

7.0 REFERENCES/FURTHER READING

Abel-smith, B. & Creese, A. (eds.). (1989). *Recurrent Costs in the Health Sector: Problems and Policy Options in three Countries.* Geneva: WHO.

Abel-Smith, B. (1994). *An Introduction to Health: Policy, Planning and Financing*. London: Addison Wesley Longman Ltd.

Arole, J. L. & Arole, R. (1994). *Jamkhed*. Bombay: Archana Art Printers.

Arvid, R. J. (1976). *Management, Systems, and Society: An Introduction*. Pacific Palisades, Calif.: Goodyear Pub. Co.

Campbell, C. (2007). *Essentials of Health Management Planning and Policy*. Lagos: University of Lagos press.

DeSweener, C., Parker, R. L., Taylor, C. E. & Reinke, W. A. (1979). Unresolved Issues in Primary Care in the Developing World. *In:* K. L. White & P. J. Bullock (eds.). *The Health of Population: a Report of two Rockefeller Conferences*. NY: Rockerfeller Foundation.

Encyclopedia of Public Health; Social Health. Answers.com Retrieved from ://www.answers.com/topic/social-health. Site Accessed on 20th July 2009.

Flavier, J. M. (1970). *Doctor to the Barrios*. Quezon City: New Day Pub.

Korten, F. J. (1981). Community Participation: a Management Perspective on Obstacle and Options. In D. C. Korten & F. B. Alonso (eds.). *Bureaucracy and the Poor: Closing the gap*. Singapore: McGraw-Hill.

Madan, T. N. (1987). Community Involvement in Health Policy: Socio-Structural and Dynamic aspects of Health Beliefs. *Social Science and Medicine*: 25(6), 615-620.

Merson, M. H., Black, R. E and Mill, A. J. (2001). *International Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

Mitchell, J. and Haroun, L. (2001). *Introduction to Health Care*. Canada: Delmar

Newell, K. (1975). *Health by the People*. Geneva: WHO.

Reinke, W. A. (1988). *Health Planning for Effective Management.* NY: Oxford Univ. Press.

Reinke, W. A. (2001). Health Systems Management. *In*: M. H. Merson, R. E. Black, and A. J. Mill, (eds.). International *Public Health: Disease, Programmes Systems and Policies. Maryland: Aspen Pub.*

Taylor, C. E. (1988). Community Involvement. *In*: W. A. Reinke (Ed), *Health Planning for Effective Managemen*t. NY: Oxford Univ. Press.

Taylor, C. E. & Waldman, R. J. (1998). Designing Eradication Programme to Strengthen PHC. *In*: R. Dowdle & D. R. Hopkins (eds.). *The Eradication of Infectious Diseases*. NY: John Wiley and Sons.

Were, M. (1982). *Organization and Management of Community-Based Health Care*. Kenya: UNICEF.

UNIT 4 HEALTH SYSTEM REFORM

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
  3.1 Health System Reform: Definition of Term
  3.2 Health System Reform: Key Areas
  3.3 Goals of Health System Reform
  3.4 Role of the State in Health System Reform
  3.5 Qualities of a Good Manager
  3.6 Qualities of a Good Health Care Worker
4.0 Conclusion
5.0 Summary
6.0 Tutor-Marked Assignment
7.0 References/Further Reading

1.0 INTRODUCTION

Widespread dissatisfaction with the performance of health systems in rich and poor countries alike have encouraged what has been described as worldwide movement of health sector reform. The term reform is used deliberately in the sense of a 'sustained process of fundamental change in policy and institutional arrangements, guided by government, designed to improve the functioning and performance of the health system, and ultimately, the health status of the population'. This unit will further look at key areas in health system reform, the role of the state in health care management as well as qualities of a good health care manager.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- describe the facets of health system reform
- state goals of health system reform
- explain the role of the state in health system reform
- illustrate the qualities of a good health care manager
- state the qualities of a good health care worker.

3.0 MAIN CONTENT

3.1 Health System Reform: Definition of Term

Health System Reform is a general rubric used for discussing major health policy creation or changes—for the most part, governmental policy that affects health care delivery in a given place. Health system reform typically attempts to:

- broaden the population that receives health care coverage through either public sector insurance programmes or private sector insurance companies
- expand the array of health care providers consumers may choose among
- improve the access to health care specialists
- improve the quality of health care
- decrease the cost of health care (wikipedia, 2009).

3.2 Health System Reform: Key Areas

The key problems that reforms are designed to address are as follows:

- inadequate resources and funds
- inadequate health facilities
- ineffective health services
- poor quality of services
- emergence of new diseases
- the problem of equity and access

3.3 Goals of Health System Reform

The goals of health system reform follow from the list of key problems. The goals are:

- increased efficiency
- increased equity and access
- consumer satisfaction

3.4 Role of the State in Health System Reform

Health care is a public right, and it is the responsibility of governments to provide this care to all people in equal measure. These principles have been recognised by nearly all governments of the world and enshrined in their respective constitutions.

The means of health system reform are being significantly influenced by shifts in belief about the appropriate role of the state in the delivery of public services. Current ideologies favour a slimmed down state, increased efficiency in the provision of public services through mechanisms such as contracting out and competition, and an extension in the role of the private sector. While these ideas are being applied to the government's role in general, they are influencing reforms in the health sector.

Health System Reform: Key Roles of the State

Current thinking emphasizes the following key roles of the state:

- setting and enforcing standards, including minimum quality standard
- monitoring the behaviour and performance of providers and insurance (where they exist), including ensuring information is available to do so
- defining an appropriate package of services and benefits
- regulating to encourage efficient and equitable financing and delivery of services and
- to contain cost inflation
- financing health services as a last resort for those unable to contribute to insurance arrangement (Mills *et al*, 2001).

SELF ASSESSMENT EXERCISE

The goals of health system reform are ………………………….

3.5 Qualities of a Good Health Care Manager

Beyond health system reform and the role of the state in health system reform, it is expected that effective ad reliable health institution should demand certain qualities from its managers and workers. Let us illustrate these qualities.

A good health manager should therefore possess the following qualities:

- effective communication skills
- ability to make effective decisions
- ability to communicate within and outside the organisation
- the ability to motivate and build good teamwork
- self motivated
- good leadership skills
- work well under stress or pressure

- implement, monitor and evaluate programmes and projects
- the ability to delegate
- ability to use analytical skills
- excellent organisational skills
- the ability to make use of control and measurements
- formulate effective plan with sound budgets
- the ability to train team members
- the ability to control budgets
- administration (paperwork) control and organisation

3.6 Qualities of a Good Health Care Worker

Careers in health care can be sources of great satisfaction. Health care workers perform services that make significant contributions to the community. Each day, their work makes a difference in the quality of life of those they serve.

As well as giving satisfaction, health care work makes demands on those who pursue it. The work must be taken seriously because it affects those who pursue it. All tasks must be performed thoughtfully and conscientiously. Nothing can be taken for granted. Health care workers must be willing to devote their full attention to everything they say and do. Below are essential qualities of a good health care worker.

- Care about others: Apply knowledge and skills to decrease the suffering and increase the well being of others.
- Have integrity: Be honest at all times
- Be dependable: Be at work on time and as scheduled.
- Work well with others: Strive to understand the need and feeling of others.
- Be flexible: Be willing to adapt to changing conditions and emergencies.
- Be willing to learn: Work hard to keep skills up to date.
- Strive to be cost conscious: look for ways to improve patients care while maintaining or lowering cost (Mitchell & Haroun, 2002).

4.0 CONCLUSION

In this unit, it was observed that health system reform is a general rubric used for discussing major health policy creation or changes. Health system reform typically attempts to increase efficiency, equity, access and consumer satisfaction. The role of the state in health system includes among many: setting and enforcing standards, including minimum quality standard and monitoring the behaviour and

performance of providers and insurance (where they exist), including ensuring information is available to do so. The unit also identified the qualities of a good health care manager and worker.

5.0 SUMMARY

This unit outlined the following:

- definition of health system reform
- goals of health system reform
- the role of the state in health system reform
- qualities of a good health care manager
- qualities of a good health care worker

6.0 TUTOR-MARKED ASSIGNMENT

What is the role of the state in health system reform?

7.0 REFERENCES/FURTHER READING

Abel-Smith, B. (1994). *An Introduction to Health: Policy, Planning and Financing*. London: Addison Wesley Longman Ltd.

Arvid, R. J. (1976). *Management, Systems, and Society: An Introduction*. Pacific Palisades, Calif.: Goodyear Pub. Co.

Campbell, C. (2007). *Essentials of Health Management Planning and Policy*. Lagos: University of Lagos press.

DeSweener, C.; Parker, R. L.; Taylor, C. E. & Reinke, W. A. (1979). Unresolved.

Encyclopedia of Public Health; Social Health. Answers.com Retrieved from ://www.answers.com/topic/social-health. Site Accessed on 20th July 2009.

Merson, M. H., Black, R. E and Mill, A. J. (2001). *International Public Health: Disease, Programmes, Systems and Policies.* Maryland: Aspen Publishers.

Mitchell, J. and Haroun, L. (2001). *Introduction to Health Care*. Canada: Delmar.

Newell, K. (1975). *Health by the People*. Geneva: WHO.

Reinke, W. A. (1995). Quality Management in Managed Care. *In*: H. Jolt (eds.). State *of the art Reviews* (Vol. 2, No. 1). Philadelphia: Hanley and Belfus.

Reinke, W. A. (2001). Health Systems Management. *In*: M. H. Merson, R. E. Black, and A. J. Mill, (eds.). International *Public Health: Disease, Programmes Systems and Policies. Maryland: Aspen Pub.*

Wikipedia, (2009). Health Care Reform. Retrieved from: http://en.wikipedia.org/wiki/Healthcare_reform. Site accessed on 27th July 2009.