Introduction

This book looks at health systems from a new perspective. It argues that they are not, as is often believed, simply a drag on resources but rather are part and parcel of improving health and achieving better economic growth. The relationship between health systems, health and wealth is complex, but the three are inextricably linked so that investing cost-effectively in health systems can contribute to the ultimate goal of societal well-being (Figueras et al. 2009; McKee et al. 2009).

The policy debate on health systems has been dominated in recent decades by concerns about sustainability and the system’s ability to fund itself in the face of growing cost pressures. More recently, the economic crises that have afflicted some countries have added to these concerns. Health expenditure in many European countries has been growing at a faster rate than the economy, accounting for an increasing percentage of gross domestic product (GDP) and creating unease about the costs falling upon industry and thus its competitiveness in an increasingly globalized economy. Containing costs has, consequently, become a major priority for most health systems in the World Health Organization (WHO) European Region and beyond. Typically, policy-makers have sought to find a balanced combination of different strategies acting on both the supply and demand sides of health services (Box 1.1).

There is, however, a new wave of thinking that seeks to re-examine the long-standing focus on cost-containment. It draws on new understandings of the interdependency between health and wealth, of the value attached to
Health systems, health, wealth and societal well-being

Box 1.1  Cost-containment strategies

Policy-makers have, for years, sought to contain costs rather than invest in health systems. They have used a combination of strategies that act on the demand and the supply sides of health systems.

**Demand-side strategies**

Demand-side strategies have focused largely on shifting the cost of health care from statutory sources to health service users by increasing cost-sharing and/or by rationing access to publicly funded services. Consequently, in some countries, services (e.g. dentistry) have been taken out of the statutory benefits package or, more often, new, expensive types of care (e.g. anti-cancer drugs) have not been included but are payable ‘out of pocket’ or through voluntary health insurance. These measures are often highly regressive and tend to undermine social solidarity by decreasing access for those with the highest needs. However, policy-makers have often seen such measures as the only viable option in the face of ever-increasing upward pressure on public expenditure.

**Supply-side strategies**

Strategies acting on the supply side have tried to secure more or better value for money. They include the introduction of strategic purchasing, market mechanisms introducing competition between providers to improve efficiency, performance-related payments, health technology assessment, better integration between levels of care, and strengthening the role of primary care. These have commanded broad support among policy-makers and some have resulted in efficiency increases. However, they have not succeeded in containing overall costs.

This re-examination of the contribution health makes and the value attached to it has been termed the ‘health and wealth’ debate (European Health Forum Gastein 2003; Council of Europe 2007; European Commission 2007). It has brought to the fore the interrelationships between health status, health systems and economic growth. Increasingly, better health is now hailed as a driver of economic growth. This is in no small part due to the seminal work of the Commission on Macroeconomics and Health (2001), which, while focusing on developing countries, did much to bring evidence of the impact of health on economic development to a global policy audience. Three more recent studies have further developed this approach, looking at the European Union (EU) Member States before May 2004 (EU15) (Suhrcke et al. 2005, the countries of central and eastern Europe and the former Soviet Union (Suhrcke et al. 2007), and the Russian Federation (Suhrcke, Rocco and McKee 2007). They have demonstrated its relevance to high- and middle-income countries, explored
the pathways by which improved health leads to economic productivity in the European Region and illustrated the magnitude of its impact.

At the same time as the utilitarian ‘case for health’ has been strengthened, WHO Member States of the European Region have restated the fundamental value of health as a human right, most recently at a major ministerial conference held in Tallinn in 2008 (WHO Regional Office for Europe 2008). They have committed to the principles of universal access, equity and solidarity as core values of European societies in a number of pan-European policy initiatives (Council of Europe 1996; WHO Regional Office for Europe 2005; Council of the European Union 2006; European Commission 2007). Even in the midst of austerity programmes, most governments have sought to safeguard health spending as far as possible. Health is seen as a key indicator of social development and well-being, as well as a means to increasing social cohesion.

This shift in the debate, and with it our views on the value of health in our societies, has shed new light on the role of health systems and the challenges they give rise to. From this new perspective, health systems, to the extent that they produce health, can be seen to be a productive sector rather than a drain on our economies, which, in turn, forces a re-examination of concerns about financial sustainability (Thomson et al. 2009). Increased spending on effective health systems can be recast as a contribution to a bigger (and more productive) economy, as well as a way of achieving health improvement and higher levels of well-being, which themselves are desirable societal objectives. In the EU context, this has placed health systems firmly at the centre of measures to further the Lisbon Agenda and the subsequent EU 2020 Agenda, pursuing the twin goals of economic competitiveness and social cohesion (Council of the European Union 2000), and challenges the simplistic view that health expenditure is a threat to financial viability.

Some analysts have gone further in arguing that investing in appropriate health system interventions may result in reduced growth of health care expenditure in the future. The two Wanless Reports commissioned by the United Kingdom Treasury are a case in point. They examined the financial sustainability of health services in the United Kingdom and recommended further investment to strengthen the National Health Service (NHS) (Wanless 2002) and, in particular, its contribution to public health (Wanless 2004) as a means of achieving long-term sustainability. There is also considerable interest in ways that appropriately targeted interventions by health systems might mitigate the health (and expenditure) consequences of population ageing, when coupled with coordinated action on retirement age and pension policies. Effective investment can be instrumental in securing longer life expectancy and, crucially, longer lives in good health, by preventing and/or treating premature or avoidable morbidity. This has been termed ‘compression of morbidity’ (Fries 1980, 2003) and can already be observed in some European countries with well-developed health systems. This could create a virtuous health systems cycle by which healthier older people use fewer services, retire later and contribute to the economy for longer, drawing less from pension funds and generally reducing the potential challenge to sustainability (Rechel et al. 2009).

However, while these arguments create a strong case for maintaining investment in health systems, they are far from justifying additional funds. Especially
at a time of economic recession, there are inevitable concerns about value for money and competing calls to use available funds to safeguard investment in other sectors, some of which may themselves contribute to health. Claims for health spending need to be seen in the context of substantial, and in many cases justified, concerns about the appropriateness of current health interventions and technical inefficiencies in many parts of Europe’s health systems. In some countries, many treatments provided are not supported by evidence. At best they provide no benefit for the patient and at worst may do actual harm. Whichever is the case, such treatments waste scarce resources and have a substantial opportunity cost. There also needs to be consideration of the way in which priorities are set and resources allocated between alternative or competing interventions and programmes, so that the choice between expenditure on areas such as mental health, primary care, prevention, secondary care and so on is made on the basis of outcomes, with the goal of maximizing health gains. However, it is just as important to take into consideration the opportunity costs of investing in health services rather than acting on determinants of health through action in other sectors.

It is also important to recognize the growth in attention to the social determinants of health (Commission on Social Determinants of Health 2008) and the renewed emphasis on Health in All Policies (Ståhl et al. 2006; Health Ministerial Delegation of EU Member States 2007), which demonstrates that investment in the physical environment, education or transport systems may yield higher health returns than investment in health systems. By the same token, health policy-making must acknowledge that additional expenditure in other areas of government activity may result in higher societal well-being, which is, after all, the ultimate societal objective in most, if not all, countries of the European Region. Indeed, a recent analysis in European countries found that reductions in spending on social welfare had even greater effects, at least in the short term, than reductions in health care expenditure (Stuckler, Basu and McKee 2010). The case for health systems investment, therefore, needs to be supported by strong and transparent performance assessment, demonstrating cost-effectiveness as well as its strengths over other competing expenditure areas.

This book synthesizes the evidence linking health systems, health and wealth, undertaking a systematic exploration of the various issues involved and the interaction between them. Its main aim is to assist policy-makers as they assess the case for investing in health systems. An earlier version of this volume was prepared to support the proceedings of the WHO Conference on Health Systems, Health and Wealth (Tallinn, June 2008) which gave rise to the Tallinn Charter on ‘Health Systems for Health and Wealth’ (WHO 2009).

**What is a health system?**

Policy-makers who seek to lever investment for health or to assess the impact of investment in health systems over investment in other areas must be able to define and delineate what they mean by ‘health system’. So, what is a health system? This question seems straightforward, yet there does not seem to be a simple answer. The definitions of health systems put forward by analysts and
organizations vary enormously, especially in the way that health system boundaries are determined. At one end of the spectrum are narrow definitions that focus on medical care, with ‘patients, clear exit and entry points and services regarding disease, disability and death’. At the other end are broad approaches that encompass all those determinants that contribute directly or indirectly to health. We need to find a balance between the narrowest definitions that cover curative services only and the all-embracing notion of a health system that includes everything which might improve well-being (not least housing, education and environment). This process of establishing a balance or ‘manageable boundaries’ is particularly important when it comes to making definitions operational, as well as for managing and overseeing health systems and their performance in practice.

**Definitions and functions**

The health system definition put forward by *The World Health Report 2000* (WHR2000) (World Health Organization 2000) forms (along with later work) the basis for our approach here. The WHR2000 defines a health system as ‘all the activities whose primary purpose is to promote, restore or maintain health’ (p. 5). This definition incorporates ‘selected intersectoral actions in which the stewards of the health system take responsibility to advocate for improvements in areas outside their direct control, such as legislation to reduce fatalities from traffic accidents’ (Murray and Evans 2003: 7).

This definition underpinned the Health Systems Assessment Framework (HSAF) (see Chapter 2), designed to enable review of the performance of health systems against three major societal goals (Box 1.2). Performance is then understood as the attainment of these goals relative to the resources invested in them, which, in turn, implies a fourth goal, namely efficiency or productivity. In order to achieve these goals, all health systems have to carry out four core functions, regardless of how they are organized or of the terminology they use (Box 1.2).

The HSAF, with its goals and functions, is presented in more detail in Chapter 2 and is used later in this book as the basis of discussion on health systems reforms and strategies (Chapter 9), and on measures to improve performance (Chapter 10).

This approach is taken further here. A health system includes, in practical terms, the following three items:

1. The delivery of (personal and population-based) health services, including primary and secondary prevention, treatment, care and rehabilitation
2. The activities to enable the delivery of health services, specifically the functions of finance, resource generation and stewardship
3. Stewardship activities aimed at influencing the health impact of ‘relevant’ interventions in other sectors, regardless of whether or not the primary purpose of those interventions is to improve health.

This approach relies on the understanding that the health system functions of financing, resource allocation and delivery relate directly to health services,
while the stewardship function (above all others) has an additional role in other sectors beyond health services, influencing the determinants of health.

**Steering health systems: the role of government**

The definition above asserts that the responsibility of those charged with oversight of health systems, typically ministries of health, extends beyond health care. It emphasizes the crucial message that they are accountable for exercising stewardship in other sectors to ensure that health objectives are considered in their policies – what has been termed Health in All Policies. The corollary is that it also acknowledges that the funding, provision and management of many health-relevant interventions are the responsibility of other sectors. The ministry of health, or equivalent has a stewardship function assessing performance across sectors and influencing the allocation of resources to maximize health gains and allocative efficiency. This means that ministries of health should be held accountable not only for health services but also for the stewardship they exercise over other sectors.

This approach, however, is more normative than descriptive. While it might be desirable that ministries exercise stewardship across sectors, in practice many share responsibility even for the formal health sector and have only limited authority beyond it. Furthermore, health ministries are often relatively weak, both technically and politically. Context is all important and the level of decentralization, models of finance or delivery, and the role of other actors, among

---

**Box 1.2 Health system goals and functions**

<table>
<thead>
<tr>
<th>Goals</th>
<th>Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve:</td>
<td>To achieve:</td>
</tr>
<tr>
<td>• the health status of the population (both the average level of health and the distribution of health);</td>
<td>• financing (revenue collection, fund pooling and purchasing)</td>
</tr>
<tr>
<td>• the responsiveness to the nonmedical expectations of the population, including two sets of dimensions: respect for persons (patient dignity, confidentiality, autonomy and communication) and client orientation (prompt attention, basic amenities, social support and choice);</td>
<td>• resource generation (human resources, technologies and facilities)</td>
</tr>
<tr>
<td>• fairness of financing (financial protection; i.e. avoidance of impoverishment as a consequence of health payments, along with equitable distribution of the burden of funding the system).</td>
<td>• delivery of personal and population-based health services</td>
</tr>
<tr>
<td></td>
<td>• stewardship (health policy formulation, regulation and intelligence).</td>
</tr>
</tbody>
</table>
other factors, all complicate the ministry’s own role. Moreover, exercising influence across sectors is far from easy. It requires the ability to exert leverage, and there are not always the appropriate intersectoral tools, mechanisms or implementation capacity available. Nor is it easy to hold other ministries accountable for the health impact of their policies.

Nonetheless, despite the complexities of implementation and the normative nature of the assertion, a ministry of health must seek, in whatever way is appropriate in the context, to develop a central role in the governance of the health system and to influence health determinants in other sectors. This is not to say that accountability for a population’s health should fall solely on the ministry of health, rather, as noted, health governance is a whole government affair involving other ministries including the office of the prime minister who should ultimately be held accountable for the health of the population.

**A conceptual framework**

The case for health systems investment rests on the understanding that health systems are intricately linked to health and wealth. The relationships between them are complex and dynamic. This book, therefore, employs a conceptual framework that can guide policy-makers in articulating the links between issues, providing the backbone of this analysis (Figueras et al. 2009). The framework links health systems (as defined above) to health, wealth and societal well-being, with the causal, direct and indirect relationships between the key elements captured (at least in part) by the ‘conceptual triangle’ shown in Fig. 1.1. It supports a systematic review of the issues and also, crucially, positions health system investment in a direct relationship with the ultimate goal of all social systems: societal well-being.

The notion of societal well-being requires some explanation. It is generally accepted that health, despite its importance to the public, is not viewed explicitly as the ultimate goal of organized societies. Rather, societies strive towards a

---

**Figure 1.1** Health systems, health, wealth and societal well-being: a triangular relationship
positive and sustainable state of well-being. This is a multidimensional concept and a very difficult one to pin down, not least because so many disciplines and experts have used overlapping but slightly different language to explore it. For the present purposes, societal well-being stands for the total well-being of the entire society and touches on notions of happiness and quality of life. It can also be taken to reflect many other elements, such as quality of the environment, levels of crime, access to essential social services as well as the more religious or spiritual aspects of life. ‘Societal well-being’ has been chosen in preference to ‘social welfare’ to avoid any potential misunderstanding, as social welfare is also understood to be primarily about welfare services.

The understanding captured by the framework in Fig. 1.1 is that health systems contribute to societal well-being in three main ways. The relationships between health systems, health, wealth and societal well-being are indicated by 1–3 and A–C. First, and above all, health systems produce health (1), which is both a major and inherent component of well-being (A) and through its impact on wealth creation (2), an indirect (yet key) contributor to well-being (B). Second, although to a much lesser extent, health systems have a direct impact on wealth as a significant component of the economy (3), which again impacts on societal well-being (B). Third, health systems contribute directly to societal well-being because societies draw satisfaction from the existence of health services and the ability of people to access them, regardless of whether or not services are effective or indeed whether or not they are used (C). One final point must be raised here – that of context. Context refers to the country-specific social, economic, cultural and political environment in which the triangular relationship between health systems, health, wealth and societal well-being is embedded. Figure 1.1 seeks to reflect the importance of different contexts in determining the nature and the extent of the individual causal relationships shown.

There is a subset of relationships or ‘lesser triangles’ nested within the main triangle. These are not all of equal importance and not all are covered in equal detail here. Nonetheless, the most important are addressed in the subsections that follow, including health systems and their contribution to health and societal well-being; health’s contribution to wealth and societal well-being; and health systems’ impact on wealth.

**Health systems: their contribution to health and societal well-being**

In reality, this is the subset of relationships that is uppermost in the thinking of most health policy-makers. Most important of all is the impact that health systems have on health improvement (1 in Fig. 1.1). The impact of health systems on health includes all the goals and functions of the HSAF, outlined in Fig. 2.1 (p. 28), namely health (levels and equity), responsiveness and fairness of financing (financial protection and equity in the distribution of funding) that are not explicitly captured by the triangle. Later chapters look at the impact of health systems on some of these goals including health (Chapters 5 and 6), health inequalities (Chapter 7) and responsiveness (Chapter 8).
Others look at how health systems can be improved and efficiency maximized through strategies for reform (Chapter 9) and performance assessment (Chapter 10), recognizing not only that value for money is absolutely indispensable for sustained investment but also that there is a significant potential gap between the ‘what health systems can do’ of theoretical debate and the ‘what they achieve’, which policy-makers have to address when competing for resources.

It should also be noted that the relationship between health systems and health is bidirectional and that levels and patterns of ill health will feed back into the health system, shaping its priorities and the allocation of resources between interventions.

In addition to their impact on health, health systems make a direct contribution to societal well-being (C in Fig. 1.1) by virtue of the value that citizens attach to them as guarantors of health protection. The right to health protection is not to be understood as the right to be healthy. Most societies attach a distinct value simply to the fact that an organized health system exists and can be accessed – these are held to be truly important and are de facto a fundamental component of social cohesion and societal well-being (Council of Europe 1997; Council of the European Union 2006).

**Health: its contribution to wealth and societal well-being**

A second set of key relationships links health, wealth and well-being. These form the ‘inner triangle’ at the base of the main triangle in Fig. 1.1. They also encapsulate the argument at the heart of this book (see Chapter 4). The contribution of health to societal well-being can be characterized as taking two main forms. Health constitutes a major component of well-being in its own right (A in Fig. 1.1). Citizens draw satisfaction from living longer and healthier lives and value health regardless of whether or not they are economically productive. As already noted, health also plays an important role in increasing economic productivity and thus national income (2 in Fig. 1.1), which, in turn, makes a key contribution to the dimension of societal well-being (B). In addition, health has an impact on wealth (2 in Fig. 1.1) and may contribute to budgetary gains from savings on health expenditure. Any discussion that touches on wealth demands figures to be produced as evidence. Quantifying wealth and the value of health in economic terms is of course complex, not least because health is not a normal traded commodity. Some of the concerns surrounding the use of gross domestic product as a measure of wealth and societal well-being are outlined in Box 1.3. In that regard the 2009 report by ‘The Commission on the Measurement of Economic Performance and Social Progress’ (CMEPSP) established by Nicholas Sarkozy and chaired by Joseph Stiglitz shows the limits of GDP as an indicator of economic performance and social progress and suggests alternative and more relevant indicators and tools to measure social progress (Stiglitz et al. 2009).

While the focus of this analysis is on the impact of health on wealth, it should be noted that this relationship is also bidirectional. Wealth has a major effect on health in its own right, both collectively and individually. Its impacts are direct through the material conditions that improve biological survival and health, as well as indirect, through its effects on social participation and people’s control
Health systems, health, wealth and societal well-being

**Box 1.3** Some concerns surrounding the use of gross domestic product per capita as a measure of wealth and well-being

There are at least three major sets of caveats relating to the use of GDP per capita both as a measure for wealth and as a proxy for societal well-being.

1. First, GDP per capita is no more than the sum of monetary transactions in the economy. It pays no attention to the use of resources and does not differentiate between expenditure that increases well-being, such as on many consumption goods, and that which diminishes it, such as the cost of clearing up pollution or responding to fear of crime. Yet the true purpose of economic activity is to maximize social welfare or societal well-being, not solely to produce goods.

2. It does not capture the important economic benefits from people who are not formally employed or paid but who provide significant support, for instance in terms of caring for older and younger people.

3. Finally, it pays no attention to those elements of the economy that are not linked to money, whether negative, such as pollution or fear of crime, or positive, such as happiness or, indeed, health itself. There are concerns about capturing the contribution of health to wealth too narrowly through foregone GDP income, which tends to privilege those in employment over the rest of the population. This can be partially addressed by translating the contribution of health to social welfare or societal well-being into economic terms and thus attributing a monetary value to health – and indeed, this is done routinely when individuals demand income premiums to undertake jobs associated with a risk of death. Following this approach, and in spite of the methodological challenges involved, a number of studies have calculated what is termed the value of statistical life through ‘willingness to pay’ (WTP) methodologies and developed ‘full income’ measures (Chapter 4).

over their life circumstances. It should be possible, then, to establish a virtuous cycle whereby better health improves economic performance and better economic performance improves health. This makes it all the more important that health systems exercise stewardship of relevant public health interventions and interventions in other sectors, as well as taking responsibility for seeking to address the socioeconomic determinants of health (Chapter 6).

**Health systems: their contribution to wealth**

The third relationship explored here, albeit far less significant, refers to the direct contribution of health systems to the economy (3 in Fig. 1.1), irrespective of their impact on health improvement. Health services are an important economic sector in many countries, often being the largest employer and playing a significant role as a driver of and consumer of technological innovation and research and development (R&D). A note of caution is needed at this point, as
the sizeable impact of health systems on the economy does not alone create an automatic justification for investing in health systems, since investments in other sectors may yield better returns. Finally, as with the other relationships discussed, this ‘third side of the triangle’, linking health systems and wealth, is also bidirectional. There is a widely held view that health care spending increases inexorably with growth in national income but this is not supported by the available evidence (Parkin, McGuire and Yule 1987). The impact of economic growth on health care expenditure is, therefore, addressed in more detail in Chapter 3.

Finally, although we believe that it has valuable explanatory power, this conceptual framework must be treated with a degree of caution. There are certain issues to be considered that relate to its deceptively normative outlook, the strength of causality of its various relationships, the bidirectional nature of some of those relationships, the variation in meaning and terminology, the role of context and the values associated with societal well-being. These are outlined in Box 1.4.

This section has explored the complex interactions between the four components of a dynamic model (health systems, health, wealth and societal well-being). Clearly, this model cannot establish a set of quantitative functions or tools that will lead policy-makers automatically to the optimal investment decisions. Nor does it argue that increasing investment in health systems is automatically ‘the right choice’. Rather, it constitutes a framework for policy-makers that will help them to balance the key elements in decision-making. While it acknowledges, on the one hand, the inexact nature and limitations of measurement, it also emphasizes, on the other hand, the need to measure, evaluate and assess performance in order to improve decision-making.

**Objectives and structure**

This book presents an analysis of the existing evidence on the impact of health systems on health, wealth and, ultimately, on societal well-being, with the overall aim of exploring the case for investing in health systems. This is developed by means of the following eight objectives.

1. To propose a conceptual framework to assess the relationship between health systems, health, wealth and well-being.
2. To propose a definition for health systems and a framework building on, and further developing, the WHO HSAF approach (Chapter 2).
3. To re-examine the impact of major cost pressures (Chapter 3).
4. To assess the contribution of health (level and distribution) on economic growth, health expenditure and societal well-being (Chapter 4).
5. To evaluate the impact of health systems on the goals of health, equity and responsiveness (Chapters 5–8).
6. To review the main health system reform strategies to improve performance (Chapter 9).
7. To outline the main approaches to measure performance (Chapter 10).
8. To draw policy lessons on making a case for investing in health systems (Chapter 11).
The first of these objectives is the conceptual framework that constitutes the backbone of this book and which has already been explained. The remaining seven objectives are outlined in more detail in the following paragraphs.

**Health systems framework**

The second objective is to propose a health systems framework that builds on the WHO HSAF. This was introduced briefly above and is addressed in more detail in Chapter 2. An overview of the main health system definitions and
Health systems, health, wealth and societal well-being: an introduction

13
typologies is followed by a detailed review of the definition, boundaries, functions and goals set out in WHR2000 on health systems performance (World Health Organization 2000). The chapter focuses particularly on the role of health systems in public health and intersectoral work and on the practical uses of the framework to facilitate improved performance. Chapter 2 concludes with a discussion of the implications of the framework for management, governance and accountability – for health ministries in particular.

Cost pressures

The third objective is to re-examine the actual impact of major external challenges on health systems, including the ageing of the population (the demographic transition), medical progress through new technologies, higher expectations, economic growth and higher relative prices for health care inputs. These are considered to push costs upwards and thus threaten financial sustainability. However, the effect of these challenges has not been well quantified nor have we fully understood the dynamics and the interplay between them. Chapter 3, therefore, re-examines and clarifies the role and impact of these drivers of health expenditure. Reviews of the role of each factor (ageing, new technologies, expectations, economic growth, price of inputs) are followed by the latest evidence on their combined impact on current and future (projected) health care expenditure. The chapter concludes with some policy lessons about how best to address those cost pressures.

Economic consequences of ill health

The book’s fourth objective is to summarize the evidence on health’s contribution to economic growth and thus societal well-being, which forms the basic tenet in the case for investing in health systems. Chapter 4 explores the evidence on the impact of health on wealth along three strands. The first examines health as a ‘consumption good’ – exploring (and quantifying in economic terms) the value that individuals and societies attribute to better health as a major component of societal well-being. The second takes a human capital approach – reviewing the impact of ill health on economic productivity and the economy as a whole. The third provides an examination of the economic consequences in terms of health care expenditure and social security benefits that stem from reduced morbidity and mortality.

Health systems impact

Fifth, and perhaps most significantly, Chapters 5–8 seek to reassess the evidence on the contributions of health systems to health improvement, population health, equity and responsiveness. Chapter 5 provides an overall assessment of the role of health services in population health, first reviewing the current state of the art in methodologies
for measuring their impact. These include the use of the inventory approach, amenable mortality and tracer condition indicators. The authors use some of these measures to quantify approximately the impact of health services in improving health status. In particular, they look at the contribution of amenable mortality to changing life expectancy and assess recent trends in a selection of European countries for which data exist. The authors also discuss how to identify the best buys (i.e. the most effective health service interventions available) bearing in mind the burden of disease in different parts of the European region, cost-effectiveness considerations and contextual differences in values and priorities.

Chapter 6 is a review of the evidence on the costs and effectiveness of a range of public health interventions within health and in other sectors – particularly as they act on the determinants of health. An overview of the economic argument for investment in public health and health-promoting interventions begins by briefly highlighting the nature of health problems in Europe. This illustrates that, at least in principle, a large share of the existing disease burden is preventable through early intervention. The authors highlight the case for the use of economic evaluation as a tool in the policy-making process. They also discuss the state of the cost-effectiveness evidence base, providing examples from different areas of public health and health promotion and focusing particularly on interventions delivered outside the health system.

This analysis supports the view that health systems impact on societal well-being by improving health and increasing equity and responsiveness. Chapter 7 assesses the extent to which health system interventions can address inequalities in health and thus promote equity. The authors aim to bring together the policy implications of the results of recent studies on health inequalities in European countries as well as those on the effectiveness of specific interventions and policies to tackle health inequalities. In particular, they look at interventions in three fields: (i) labour market and welfare policies, (ii) interventions and policies to improve health-related behaviours, and (iii) health service interventions and policies in both finance and delivery. This chapter also presents estimates of the economic implications of health inequalities in terms of overall economic performance, health care and social security expenditure and societal well-being. The impact on societal well-being includes direct damage to overall health as well as the value that societies attach to equity itself. This clearly highlights the dual roles of the health system as both a deliverer and a steward of health services and as a steward of health and equity in other relevant sectors.

Chapter 8 addresses the relationship between health services and responsiveness. The authors explore the basic concepts behind responsiveness and satisfaction and consider major methodological approaches and actors to measure them. They outline the results of various studies to compare the levels of satisfaction and responsiveness between different health systems and highlight the complexities when attempting to interpret them. This chapter concludes with a review of the impact of a range of health service strategies (such as increasing choice of provider or addressing waiting lists) aimed at improving responsiveness and a consideration of any trade-offs with efficiency and equity.
**Health system reforms**

Chapter 9 addresses the sixth objective in a review of the main reform strategies that have been adopted to improve health systems performance in countries of the European Region. This examination is grouped according to the four main functions of the health systems framework introduced previously: (i) delivery of health services (i.e. reforms that tackle appropriate and cost-effective delivery), (ii) resource generation (i.e. reforms that seek to ensure the right level and mix of inputs, particularly human resources, technology and capital), (iii) financing (i.e. reforms that focus on revenue collection and pooling, to improve sustainability and solidarity, and purchasing, with an emphasis on effective purchasing to improve allocative and technical efficiency), and (iv) stewardship and initiatives to strengthen governance, accountability and responsiveness.

**Performance measurement**

If reforms are to succeed and contribute to societal objectives, then policymakers must be informed about their progress and effects. Performance measurement is central to the design, stewardship and implementation of reform strategies; therefore, the seventh objective is to outline the main approaches to measure health systems performance and link them with governance. Chapter 10 provides a synthesis of the main methodologies for assessing performance; it draws lessons for the implementation of performance measurement systems and puts forward policy recommendations to link measurement with governance mechanisms and the improvement of health systems.

**Drawing the lessons**

Chapter 11 provides some reflections on the implications of this study for policy-makers and for the case for investment in health systems. It draws a series of policy-relevant lessons from each one of the chapters of the study concluding that societies should invest in health systems as part of societal efforts to enhance health and wealth and achieve societal well-being, provided that they have the performance assessment systems in place to demonstrate the investments are cost effective.

**Endnote**

1 The conceptual triangle was developed in a seminar at the WHO Regional Office for Europe in Copenhagen in 2007, with the participation (in alphabetical order) of Rifat Atun, Antonio Durán, Josep Figueras, Joseph Kutzin, Nata Menabde and Elias Mossialos.
References


