# Implementation in Health Systems Transformations

## FUNDAMENTALS OF IMPLEMENTATION SCIENCES IN GLOBAL HEALTH

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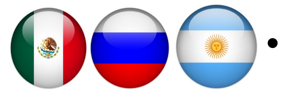
# Today

- Key questions we face when called by MoH, MoF and PMs about Health Systems
- A Health Systems approach
- Two Country Examples
  - AUGE in Chile (Universal Explicit Guaranteed Access)
  - Provider payment reform in one GCC country
- Some Health Systems Research priority topics
- A few key lessons in engaging with policy makers on technical evidence and research

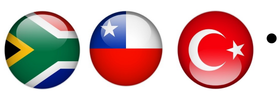
# Some of the Key questions we face when called about Health Systems

- We want to provide more instruments for the population, specially the poor, to be able to demand compliance with their entitlements in health. Should we design the **health service benefit package**? Should we make it explicit?



- We want to improve incentives for quality, efficiency, and responsiveness for our public providers. Should we introduce **results based funding** for public providers? How?

- We seem to have a huge variance in **efficiency among our PHC facilities**, how do we bring them all to the level of the best performers?



- We have a fragmented mixed (public and private) health insurance system, should we improve it as **multiple payors or transition it towards single public payor**?

- Global Burden of Disease analysis shows a **huge shift from MNCH to NCDs** for our country. What are the implications for MoH organization, CAPEX planning, and HR planning? How do we implement them?

- A large proportion of our population is covered by competing private health insurance and/or service providers? How do we ensure **patient and user protection**? What kind of **regulations and regulation governance** should we introduce?

- How do we ensure **long term financial sustainability** of the system?

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# A Health Systems Approach

- Frame the problem
  - What is the problem (s) you need to solve?
  - Distinguishing between instruments and objectives
  - Systems v/s operations optimization, or both
  - Shifting from a solution in search of a problem to solution alternatives and solution space
- We often need to Focus on Overall country system architecture (all parts of the system and their interaction) and country level effects not only on the specific change we are called to discuss
- A health systems practitioner policy and performance focus (beyond diagnostics: solutions)
- Baseline, monitoring and evaluation
- A systemic review of options and consequences: Health Systems Framework (s)

# There are multiple ways to analyze a health system: a large number of health system frameworks exist

**5 control Knob**
William Hsiao- Harvard School of Public Health

**"Integration of health Interventions "**
Atun

**Building blocks**
WHO (2007)

**Performance framework**
WHO (2000) → WB 2007

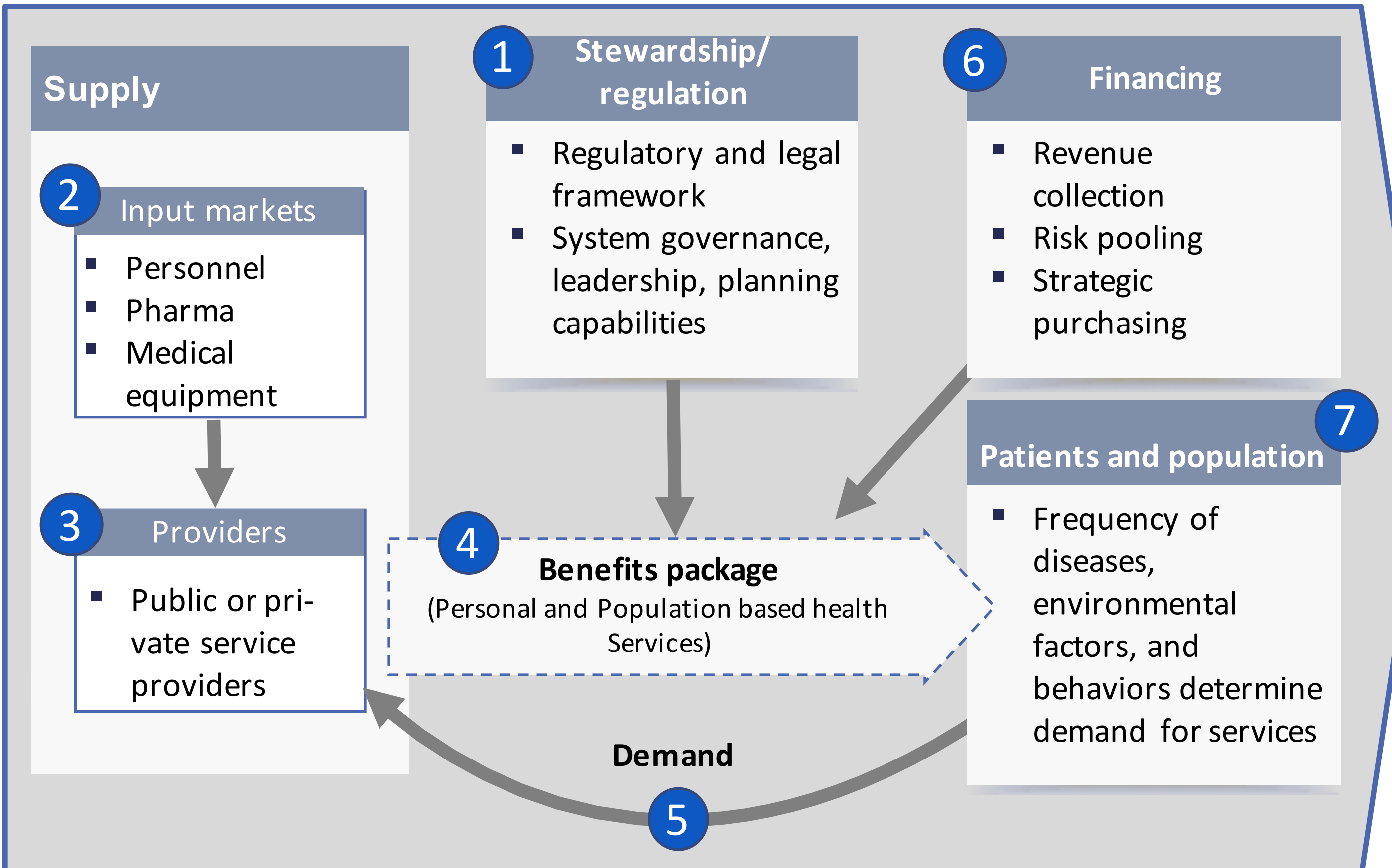
- **4 functions:**
  - Stewardship (oversight)
  - Creating resources
  - Financing
  - Provision
- **3 objectives:**
  - Fair (financial) contribution
  - Responsiveness (to expectations)
  - Health

# Health Systems aim at optimizing at least 3 objectives, not only Health Status

| | |
|---|---|
| **Population Health** | **Best Population Health Status possible.** Increase life expectancy, reduce maternal and child mortality, reduce Burden of Disease. |
| **Financial Protection** | **Provide good Financial Protection**. Protect households from the empoverishing effects oof health shocks, including out-of-pocket expenditures, lost income and high costs of insurance. |
| **Patient and Population Satisfaction** | **Satisfy the legitimate expectations of patients and users as well as ensuring dignified access to health care.** |
| **In a long-term sustainable way** | All in the context of **system sustainability**, and contributing to the **long term socioeconomic development and competitiveness** of the country. |

CHD, Based on WHO 2000, ILO 2003, World Bank 2007

# To achieve these objectives, all system functions and components need to work in synergy. Reforming one will always require adjustments to the others




## Health system objectives

- Good health outcomes
- Financial protection
- Responsiveness (patient satisfaction)
- Country competitiveness

SOURCE: Based on WHO 2000, World Bank 2007 and ILO 2003

CHD
Center for Healthy Development
www.centerforhealthydevelopment.org

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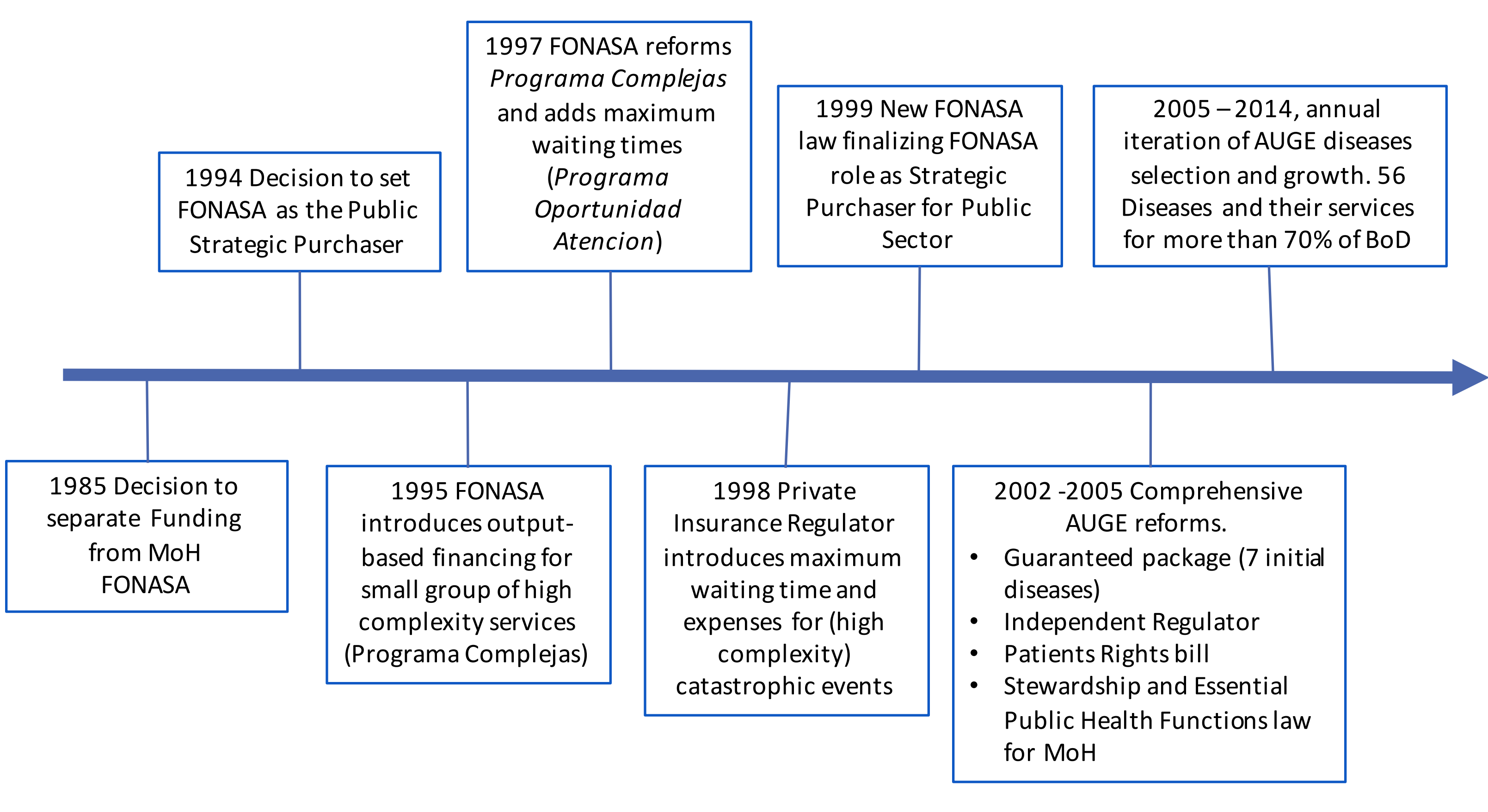
# AUGE in Chile (Universal Explicit Guaranteed Access)

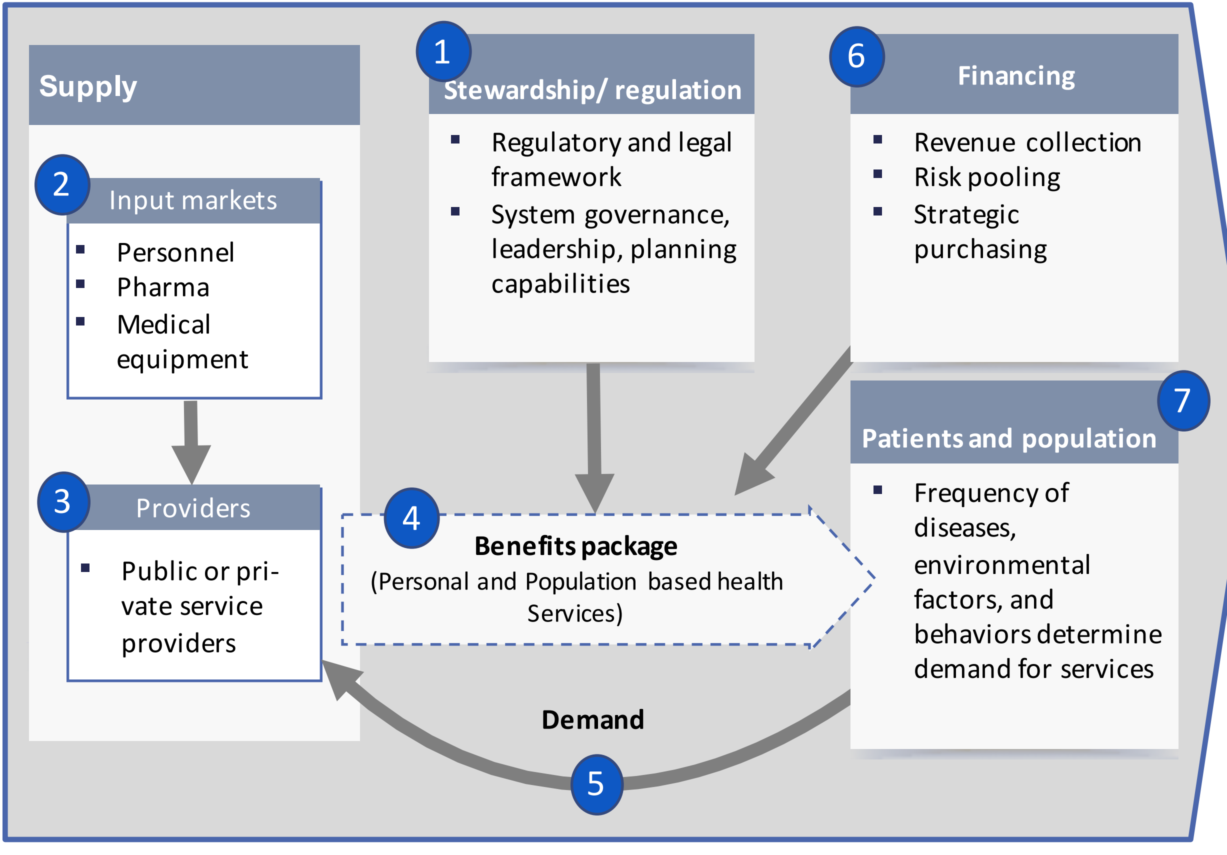
- In 2005 Chile implemented a state Guaranteed Benefit Package for the entire population irrespective of their type of health insurance coverage.
- It guarantees a (maximum) waiting times, quality (explicit protocols), and a (maximum) household expenditure.
- Although initially it included only 7 diseases account for less than 10% of BoD for Chile, the country designed a governance system and a transition to grow the guarantee in time.
- Today **it has been scaled up to include 56 Diseases** that account for more than 70% of Chile's BoD
- Its implementation was **the continuation of 7-10 years of incremental benefit package and patient protection measures** implemented voluntarily and mandatorily by the national health insurance (FONASA) and private insurers (ISAPRES).
- Chilean policy makers engaged with systems experts, sociologists, and BoD researchers to decide **how to move forward**

# AUGE in 2016 is the result of a 20 years successful scaling strategy



# AUGE required revising, strengthening, and modifying all systems functions to be successful

## Health Systems Functions and components




- **4** Explicit Benefit Package with guarantees, mandatory for public and private insurers
- **1**
  - Enacting independent regulator, with guarantees monitoring and enforcement capacity
  - Reforming and strengthening stewardship capabilities of MoH
  - Patient Rights laws
  - Creating AUGE Governance
- **7** Mayor update of Chilean BoD demand estimates
- **2** Short, medium, and long term planning and intersectoral coordination for INPUTS (HR, CAPEX, Pharma)
- **6**
  - Additional Fiscal Space
  - Linking guarantees to provider payment mechanisms (output-based financing)
- **3** Mayor provider adaptation including capacity to respond to output-based payments, CAPEX, HR, and management framework
- **5** Communications and demand orientation

SOURCE: Based on WHO 2000, World Bank 2007 and ILO 2003

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# Introducing output-based financing in one GCC country

- In 2009 a country in GCC decided it needed to change the incentive framework for public providers to increase efficiency and responsiveness
- Accordingly, it decided to transition its public service providers from historical line-item budgets to output-based financing.
- The country chose to introduce DRGs (Diagnostic Related Groups) as its output -based payment of choice.
- It requested advice on how to do so.
- The process is still in implementation

# Introducing output-based funding required revising, strengthening, and modifying most systems functions to be successful

## Health Systems Functions and components

**Supply**

2 Input markets
- Personnel
- Pharma
- Medical equipment

3 Providers
- Public or private service providers

1 **Stewardship/ regulation**
- Regulatory and legal framework
- System governance, leadership, planning capabilities

6 **Financing**
- Revenue collection
- Risk pooling
- Strategic purchasing

4 **Benefits package**
(Personal and Population based health Services)

7 **Patients and population**
- Frequency of diseases, environmental factors, and behaviors determine demand for services

5 **Demand**

1. Independent regulator capable of standardizing new payment mechanism across providers and payors, with guarantees monitoring and enforcement capacity
2. Short, medium, and long term planning and intersectoral coordination for INPUTS (HR, CAPEX, Pharma)
6. Linking guarantees to provider payment mechanisms (output-based financing)
3. Mayor provider adaptation including capacity to respond to output-based payments, CAPEX, HR, and management framework

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# Some health systems research priority topics emerging from the two cases

- What are the key determinants of successful scale-up?
- Importance of leadership in system transformations: clinical, managerial, political, policy. How to model and predict successful leadership?
- Do explicit packages improve access to services, financial protection, and/or satisfaction level and distribution?
- What is the role of BoD in country priority setting? What are next steps in research to enhance its role?
- What are the short and long term effects of transitioning to output / results-based financing on quality, efficiency, satisfaction, and fiscal/financial performance of the system?
- Are there any differences of those consequences between high, middle and low-income countries? What explains it and how to mitigate undesirable effects?

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# Some personal lessons from 25 years of experience as expert, policy maker and former polititian

- **Complexity is the enemy of persuation** in policy translation: clarity and simplicity in comunicating the (3) key messages is critical ... there will be time for complexity when the immagination of the policy maker has been captured...
- **Critical to communicate succinctly**. Most experts will have 5-10 minutes to make the case for research implications in their first encounter with senior policy makers and polititians. You need a clear "elevator speech" and to frame the results and impact up-front (counterintuitive to researchers) ... sucess in the first engagement will bring many hours of atention and methods and complexity discussions ...
- There is a **huge difference between disecting a problem (deep diagnosis and understanding) and solving it** ... Policy makers and polititians want to solve it, not to publish in a journal...
- **What is in it for me ?** is a crucial implicit or explicit question from policy makers and polititians. In addition to saving the world, why should him/her embrace your recomendation?
- The large mayority of **polititians and policy makers are not stupid or corrupt** and should not be treated as such. They have to optimize for a much more complex utility function, where science is only one dimension...
- **A picture is worth more than a thousand words** ... persuasive visualizations ...

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