Pluralistic health systems: the challenges

Dina Balabanova

Why the private/voluntary sector matters

- Private sector is increasingly important within LIC/MIC and at global level (globalisation, increasing aid & scaling up):
 - Unclear role of the government & private sector in pluralistic systems
 - Weak governance, lack of competencies and motivation in the public sector to engage with non-state actors
- A focus on market failures & the negative implications for:
 - households catastrophic expenditure. Poor outcomes (MDR TB)
 - health systems informal private practice, competition for resources
- But <u>positive role</u> of the private sector:
 - Complementary: fill gaps (geographically, stigmatised groups)
 - Parallel: the only available alternative (e.g. in fragile states, insurance for informally employed, in isolated areas)
 - Source of skills, ideas, capacities to improve outcomes

realising these benefits is dependent on governance – legislation, regulatory capacity, safeguards, oversight

The public sector: definitions

The public health sector comprises agencies that are:

- a. Government-owned and managed providers publicly financed to supply services
- b. Agencies safeguarding the public interest and improving system effectiveness (quasi-independent regulators, public payers, business regulators, Ministries of Labour, Commerce, the judiciary (e.g. licensing/ litigation)
- International organisations such as the United Nations and its specialised agencies (e.g. WHO)
- Institutions with intermediary position: consumer groups, civil society, professional organisations, media

Private sectors: definitions

Typologies according to:

- Status not-for-profit/ faith-based / for-profit
- Qualifications/ licensing
- Formal / informal status

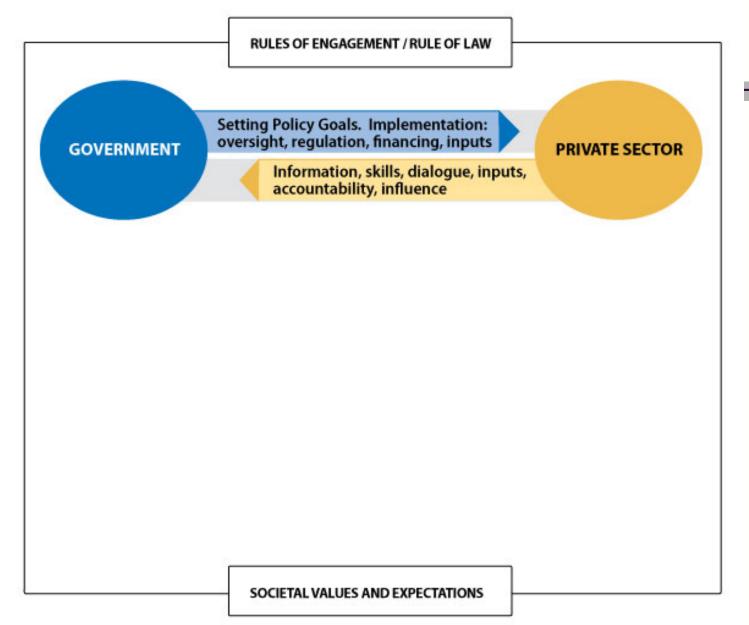
Type of product – no strict boundaries:

- Private care providers heterogeneity within each context (e.g. modern practitioners, certified health care professionals, traditional healers, lay persons). In or outside the health system
- Financers including private insurance, community-based insurance, employer-based insurance
- Private providers of <u>inputs</u> including producers, procurers and distributors of commodities (drugs/ supplies) & <u>knowledge</u> (e.g. medical training)

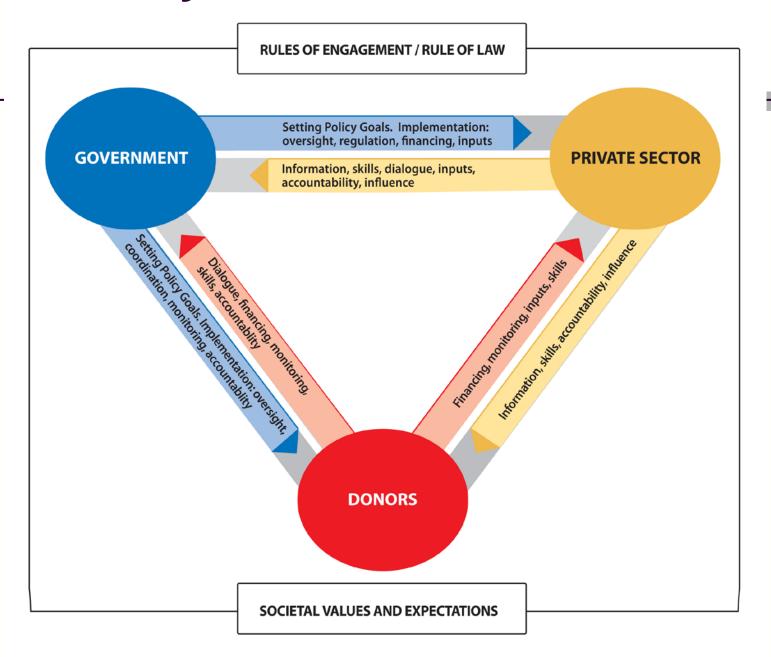
Barriers to public-private engagement

- Suspicion of the private sector & lack of information
- Lack of history of engagement
- Separate management procedures, patterns of care, and information systems hamper the effective collaboration
- Concerns about the opportunity cost of resources channelled through the private sector
- Incompatible ethos in the public and private sectors
- Complexity of the challenges (integrated and continuous care for chronic diseases)
- Evidence on the effectiveness of PPP is limited

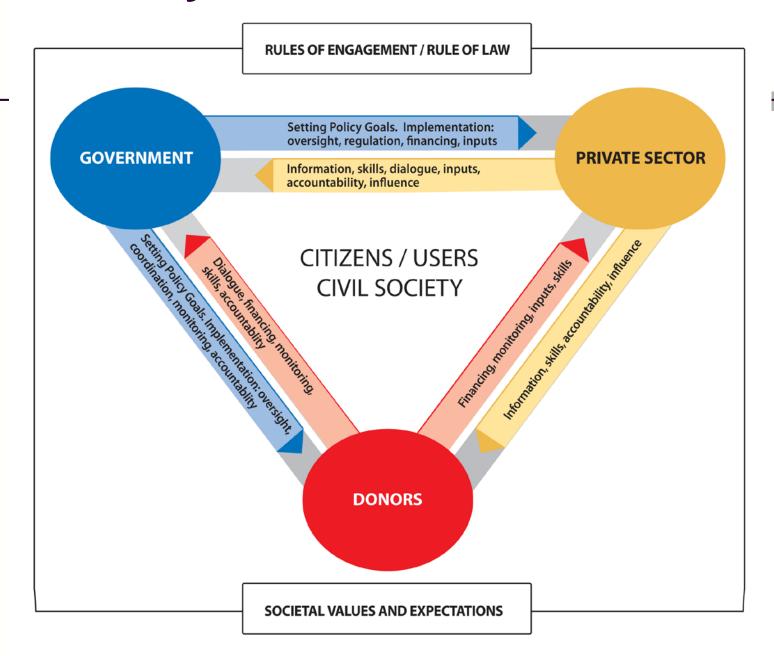
An analytical framework



An analytical framework



An analytical framework



Forms of engagement between the public and the private sectors

Government interacts with the private sector at different levels:

Learning from each other

Working with the private sector

Protecting the public interest

Minimum level of engagement

(Higher degree of engagement)

Forms of public/private engagement

Learning from each other

technical policy

documents

HMIS, NHA

Working with the private sector

Protecting the public interest

Dedicated court

system

Forms of public	public engagement with the private sector			
Regulating	Financing	Stewardship		
-Setting minimum	-Subsidies	-Formulating sectoral		
standards	-Contracting out	strategies and technical		
 Strengthening public accountability 	-Use of vouchers	policies involving the private sector		
		-Provision of information		
Indicators of progress				
Regulatory framework	Mechanisms for	National strategic plans/		

private sector

Levels of financing

finance

Examples of how governments engage with the private sector

	India	Uganda	Afghanistan
Forms of engagement	Regulation and development initiatives of a fast growing private insurance market	Public-private partnership with government providing subsidies for PNFP service providers	Contracting out of NGOs for the provision of health services

Common benefits

- Expansion of coverage
- Improved capacity
- Enhanced communication/dialogue

Common challenges

- Utilisation/ access
- Unpredictability of donor funding (Afghanistan/Uganda)
- Competition
- M&E

Source: country case studies

Strengthening public-private engagement: capacities needed in the public sector

Internal

- Skills to <u>regulate</u> and <u>implement</u> flexible financing mechanisms
- Trained human resources that can <u>lead/manage</u> collaborations
- Structure (institutional space) & processes to foster regular communication & coordination
- Willingness and ability to <u>incorporate innovative</u> private sector models
- Financial resources to regulate, finance and steward the health sector effectively. Alignment

External

- Existing institutions that can effectively regulate and enforce the rules in the public and private spheres
 - regulatory capacity at sub-national levels
- Functioning democratic institutions and processes – to allow a dialogue between different policy actors
- A stable political context

Strengthening public-private engagement: capacities needed in the private sector

Internal

- Managerial, professional, and technical capacities, to engage with the public health system
- If private sector is fragmented a need for <u>organisational</u> <u>capacity and leadership</u>, to establish coordinating bodies
- May need to acquire <u>strategic</u> <u>capacities</u> to engage in wider health system strengthening

External

- Influenced by a country's institutional and broader environment
 - rules of engagement/rule of law
 - societal values and expectations
- May be hampered by:
 - high entry costs,
 - bureaucratic hurdles,
 - insecure business environment
 - unpredictable changes in regulatory mechanisms

Concluding points...

Increasingly pluralistic health systems/ diverse relationships

- Given this, how to scale up, progress towards UHC?
- What type of governance is desirable and effective?
- Public/private engagement requires revisiting governance in the public sector and creating capacities
- Need to think about what role of the private sector in the long term

The task

Examine the role of the health system (building blocks) on a chronic condition (CVD, diabetes, hypertension).

Design an evaluation of a complex intervention to promote access to treatment and care for hypertension taking a health systems perspective

Take into account the *complexity*, e.g. interactions between blocks, and *feasibility*

Setting

- Lower-middle-income country (WB)
- Large inequalities (income/ethnic) + excluded groups
- Public sector provides extensive coverage (but quality vary)
- Pluralistic system: private and traditional providers operating in parallel to the health sector
- Low responsiveness
- Implicit rationing: waiting lists/ unclear patient pathways
- Limited civil society action

Health systems assessment

- Work across 'building blocks'
- Covering different levels of the health system
- Not 'what works' but 'what works under what circumstances'
- Multi-method
- Think about how you evaluate impact/ associations
- Systems thinking: unintended consequences and feedback loops (the systems adapt)
 - indicators that are measured often improve
 - Interplay of factors beyond the health system
- Plan synthesis and use of findings

Output

- Analysis: what are the major problems?
- What major 'building blocks' are involved?
- A focus of evaluation/ questions/methods
- Indicators (examples)
- Process (who and how will be doing this?),
- Anticipated challenges
- Plan for synthesis and promoting uptake of findings

Good health at low cost:

health systems contribution to "25 x 25"

Dina Balabanova Department of Global Health and Development

23 March 2014

World Heart Federation Emerging Leaders Think Tank
Seminar

Why health systems? The Treatment Gap

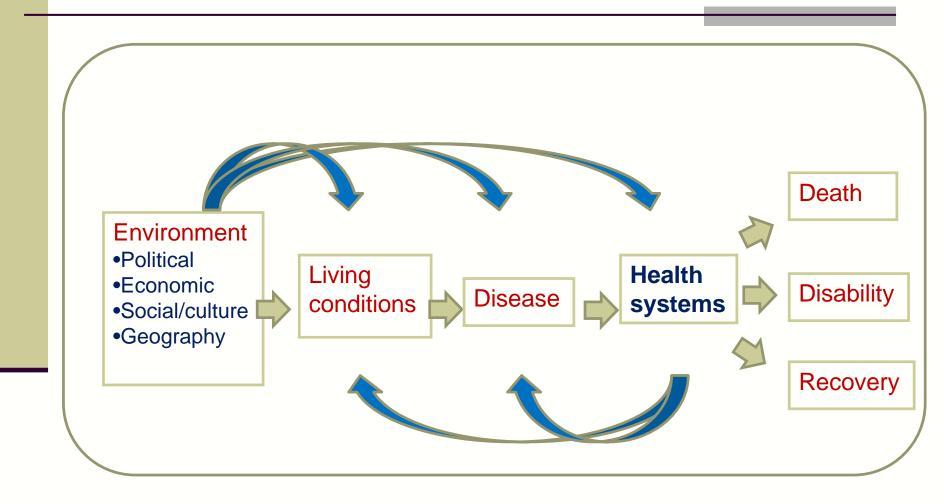
Why health systems? The Treatment Gap

- >80% of CVD deaths occur in low and middle income countries (LMIC).
- a paradox: risk factors for CVD (such as smoking and lipid levels) are highest in HIC and lowest in LIC yet major CVD are growing faster in LMICs (PURE).
- mortality from CVD is 4.3 times higher in MIC than in HIC and 7.5 times higher in LIC (PURE).
- HICs have achieved falls of >50% in CVD mortality, 40-60% due to improved access to effective care

Why health systems?

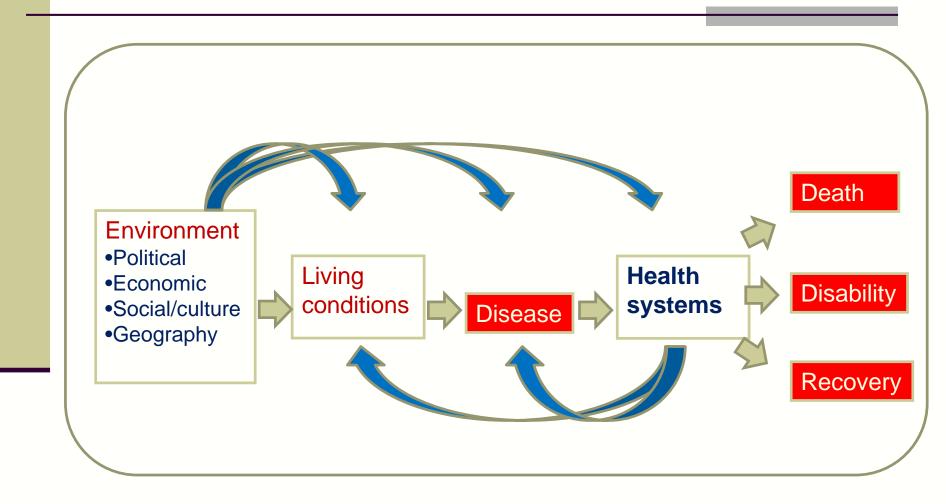
- Treatment gap can be addressed through effective (system) interventions
- Political momentum
 - on NCD
 - health systems for UHC
- Recognition of the burden of NCD: health / economic/ social

Model of determinants of health



Lalonde Report, 1974

Model of determinants of health



25 x 25: emerging focus on the contribution of the health systems

Goals

Improved blood pressure control

Enhanced treatment for those at risk from the major NCDs

What is a health system?

A health system?



Community mother-child clinic in Uganda



Patient consultation in India



Surgical team in UK operating theatre

A health system?



Allopathic drug sellers in Peru

'Traditional' drug sellers in Myanmar

Chemist shop in India stocking allopathic, homeopathic & ayurvedic drugs



With permission from K.Kielmann

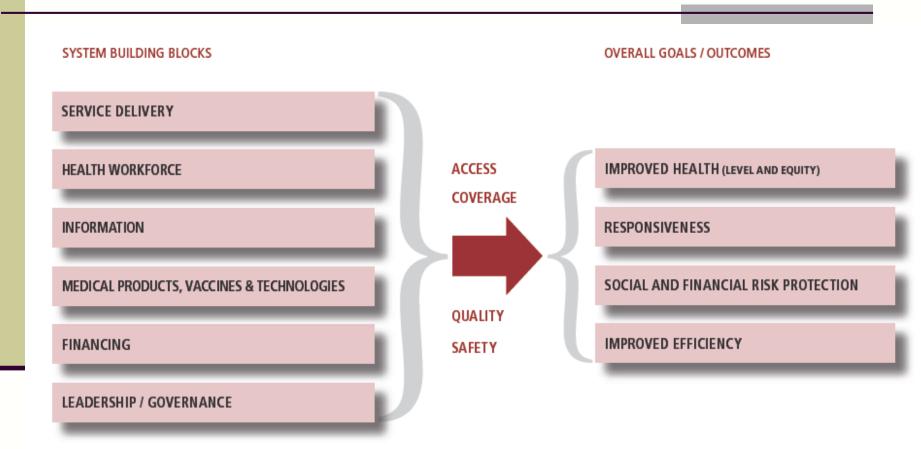
Definitions of a health system (WHO)

- A health system consists of all organizations, people and actions whose *primary intent* is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities.
- "... includes, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation, ... inter-sectoral activities, e.g. female education, a well known determinant of better health."

But boundary issues...

Selected analytical frameworks

The WHO health system framework (2007)



THE SIX BUILDING BLOCKS OF A HEALTH SYSTEM: AIMS AND DESIRABLE ATTRIBUTES

'Systems thinking' (de Savigny and Adam 2009 et al)



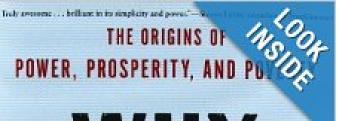
Why is it complex? 'Systems thinking' et al.

- Health systems are <u>complex adaptive social systems</u> a change in one area often has unpredictable and unintended consequences in another
- Complex interplay between determinants of health
- Time lag between implementing policies and impact
- Path dependency: institutional development over long period of time
- But also: windows of opportunities allowing change of direction (e.g. political events)

Responding to chronic disease: health system failures?

Treatments and models of care are often known and available, failures are often in broader health systems:

- Many health systems have been designed to respond to acute isolated episodes of illness or other one-off events.
- Specialists and hospitals have often had a lead role, with limited scope for patients to manage their condition.
- Complexity is a challenge:
 - E.g. difficulties in instituting integrated management and communication between providers and patients, and within teams, or providing care for co-morbidities
- Traditional disease-oriented treatment are still the norm
- Organisational and financial patterns failing to mitigate for individual circumstances of patients



WHY NATIONS

Success factors for reducing maternal and child mortality Shyama Kuruvilla, Julian Schweitzer, David Bishai, Sadia Chowdhury, Daniele Caramani, Laura Frost, Rafael Cortez y Romadette Daelmanch Andrec de Francisco y Tanhreed Adam; Rohert Cohens Rafael Cortez Bernadette Daelmans, Andres de Francisco, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, V Natalia Alfonso, Jennifer Franz-Vasdeki, Seemeen Saadat, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, Seemeen Saadat, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, Seemeen Saadat, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, Seemeen Saadat, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, Seemeen Saadat, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, Seemeen Saadat, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, Seemeen Saadat, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, Seemeen Saadat, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, Seemeen Saadat, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, Seemeen Saadat, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, Seemeen Saadat, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, Seemeen Saadat, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, Seemeen Saadat, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, Seemeen Saadat, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, Seemeen Saadat, Beth Anne Pratt, Beatrice Eugster, Sarah Bandali, Seemeen Saadat, Beatrice Eugster, Beatrice Snyama Kuruvilla," Julian Echweitzer," David Bishal, "Sadia Chowdnury," Daniele Caramani, Laul Robert Cohen, Andres de Francisco, "Taghreed Adam, Robert Cohen, "Taghreed Adam, "Robert Cohen, "Taghreed Adam, "Tag T NATAIIA MILOUSO, Jenniner Lique-Aaynevi, Jeanner

FAIL



Uncertain

INDIA AND ITS CONTRADICTIONS

JEAN DRÈZE & **AMARTYA SEN**



Progress

Dimension Paper



Pathways to progress: a multi-level approach to strengthening health systems

Findings on maternal and child health in Nepal, Mozambique and Rwanda, and neglected tropical diseases in Cambodia and Sierra Leone



Public health has known for at least two decades that good health can be achieved at low cost, if the right policies are in place.

We know this from comparative studies of countries at the same level of economic development that reveal striking differences in health outcomes.

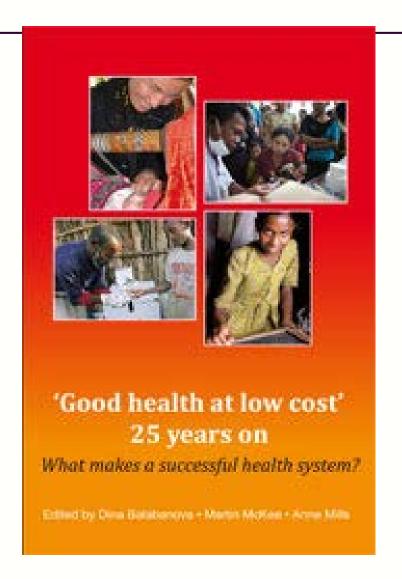
According to the study, factors that contribute to good health at low cost include a commitment to equity, effective governance systems, and context-specific programmes that address the wider social and environmental determinants of health. An ability to innovate is also important. ...

...Above all, governments need to be committed and they need to have a vision set out in a plan. This is also true for WHO.

Sixty-sixth World Health Assembly

Dr Margaret Chan, 2013
Director-General of the World Health Organization

'Good Health at Low Cost' 25 Years On. What makes a successful health system?



http://ghlc.lshtm.ac.uk/











Why some countries achieve health outcomes that are better than what could be expected at their income level?

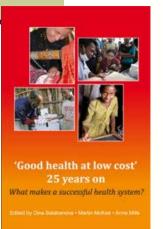
Bangladesh, Ethiopia, Kyrgyzstan, Tamil Nadu (India), Thailand

Factors related to:

- the health system
- broader determinants of health
- context: political, economic, social, geographical

Historical case studies

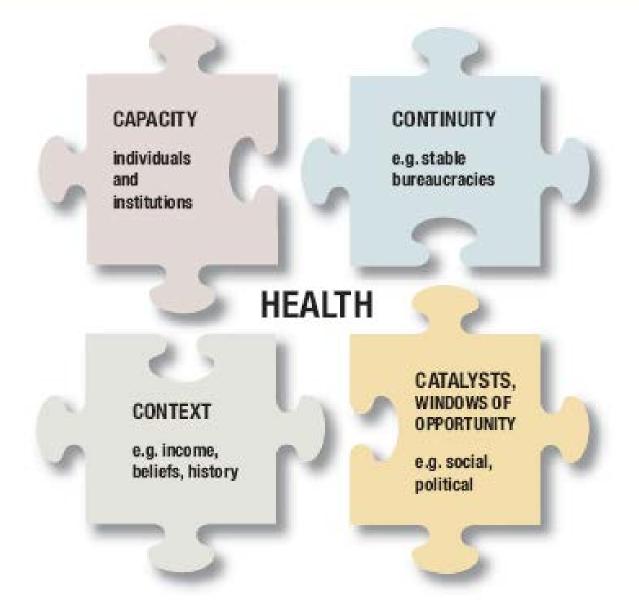
- Construct rich analytical case studies tracing pathways to good health over long periods of time (combine data sources)
- Analyse the interplay of multiple and interacting factors
- Recognise path dependency of health systems development. Unique experience



- ✓ Establish temporal and plausible relationships
- ✓ Recognise patterns within and between countries

Same approaches in different settings Different approaches in similar settings

Key cross cutting themes



Good governance: how does it help to achieve better health?



- Vision and seizing windows of opportunity
- Ability to implement
- Accountability and transparency







Capacity: individuals and governments

- Leaders with vision and influence
- Comprehensive programme that has been operationalised, goals and deliverables
 - e.g. National plan, strategy
- Political elites and lobbies for health
- Political commitment to prioritize health, embed reform in systems
- Commitment by governments to more equitable and pro-poor policies (e.g. education for women)
- Supportive politicians in other sectors

Capacity: bureaucracies and implementers

- Effective street-level bureaucrats
 - National
 - District level: managers / planners
- Stability of bureaucracies/ institutional memory
- Regulatory and managerial capacity. Clear rules.
- Institutional <u>autonomy</u> and flexibility
- Multi-sectorality
- Ability to operate in pluralistic context: <u>engagement</u> with the voluntary sector incl. community organisations, media, and coordination.

Human resource innovations

 Scaling up and deployment of health workers but taking a realistic approaches given the resource limitations



- Innovative use of health workers
- Supported by PHC infrastructure and low cost technologies

Continuity

- Within reform frameworks/ long term vision
- Within programme interventions
- Monitoring and evaluation informing policy cycles
- Coherence between elements of reform plans and strategies
- Careful sequencing of steps

Catalysts

- Political change
- Economic crises
- Natural disasters
- Geopolitical interests and aid flows
- Seizing 'windows of opportunity': situations that foster change

Context

- Evidence-based policies and interventions
- Locally adapted in managing, financing or delivery:
 - flexible use of health workers: health assistants/nurses in delivering home-based primary care (Bang/Eth/TN)
 - scale up of low-cost technologies (ORC/zinc/mats in Bangl)
 - system orientation towards essential care and prevention
- Economic factors, including strengthened infrastructure, increased external funding
- Communication technology and the ability to draw on resources beyond the public sector.

Health financing

- Advances are seen under very diverse models of financing; and cannot relate to increase in THE
- High out-of-pocket payments and use of the private sector in some of the study countries – a paradox?
- Move towards improved financial protection
- Efficiency improvements

Health system resilience

- Health systems being able to withstand shocks and emerging threats
- Innovative use of scarce resources
- The capacity to incorporate bottom-up innovation
- Lesson learning / feedback loops
- Preparedness ('addressing the low hanging fruit'?)
- System adaptability and internal impetus to change

A successful health system...

- has vision and long-term strategies;
- takes into account path dependency;
- builds consensus at societal level;
- allows flexibility and autonomy in decision-making;
- is resilient and learns from experiences;
- supported by the broader governance and socioeconomic context and population preferences;
- Enables dialogue & synergies across sectors and actors.

Group work

Making progress towards 25x25

- Strengthening systems beyond NCD
- Identify critical barriers to delivering effective care and contextually-appropriate solutions.
- Building momentum towards comprehensive approaches:
 - prevention and treatment;
 - across diseases
 - across sectors
- Address political issues (global and national level): advocate for integrated approaches

Key words, health systems

Complexity

Capacity



Catalysts

Context

Evaluating the effect of health systems on "25 x 25"

Understanding the 'How' and 'Why'

Dina Balabanova

Lima, 23-27 March 2015

Improving health worldwide

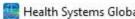


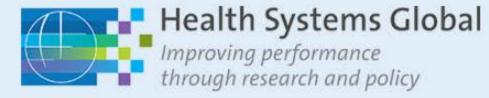
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Outline

- Evaluating health systems: rationale for the 'why' and 'how' questions
- Overview of approaches and examples
- Considerations when choosing approaches
- Conceptual and practical challenges
- Concluding points

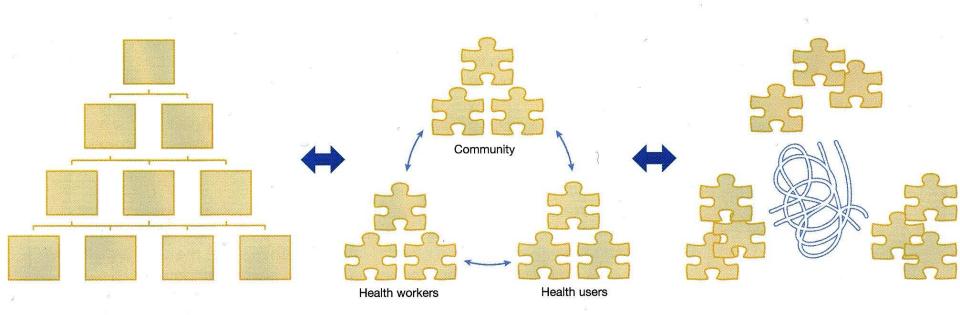


Moving from 'what' to 'how' and 'why' questions - 1

 Measuring inputs and outputs may not explain the mismatch between planned policies and reality



De jure versus de facto system



De jure system:

Organisational structures Intended incentives Management procedures Training courses

Dynamic system responses

De facto system:

Services as experienced by people access; quality; impact



Source: McPake et al, 2006

Moving from 'what' to 'how' and 'why' questions - 1

- Measuring inputs and outputs may not explain the mismatch between planned policies and reality
 - 'soft systems' approach: The health system is a complex 'whole' that is made up of a *hierarchy of levels* of organisation, or sub-systems. New properties emerging at each higher level.
 - Higher levels becoming progressively more complex.
 - New properties emerging at each higher level.

(Checkland 1981)

 A reductionist approach: combining components of a health system will produce a predictable result.



Emergent properties



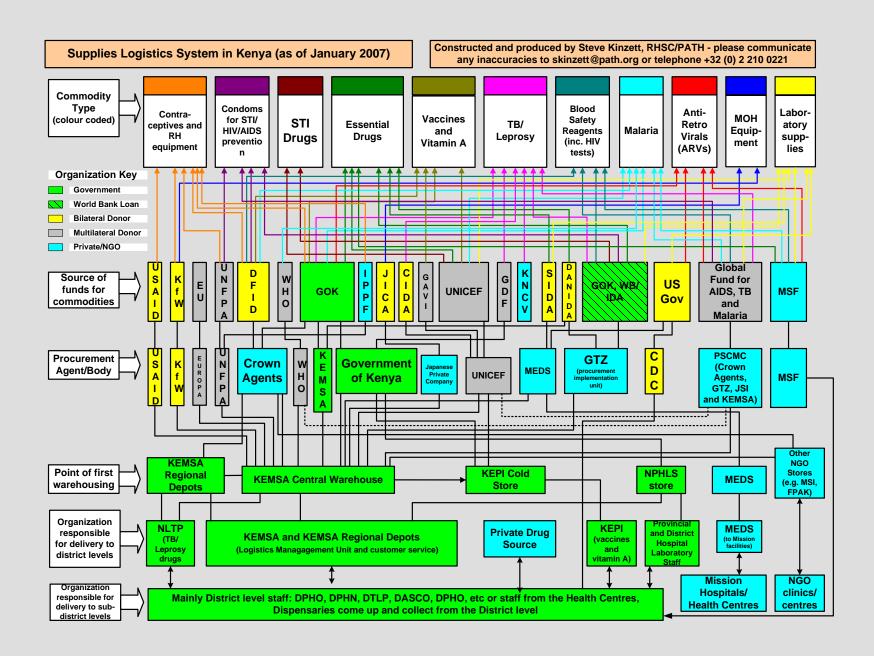




Moving from 'what' to 'how' and 'why' questions - 2

- Health system complexity
 - social systems: multiple decision-making subsystems
 & relationships
 - multiple actors: power, interests and behaviour
 - constantly changing
 - non-linear relationships between system elements unpredictable and unintended consequences





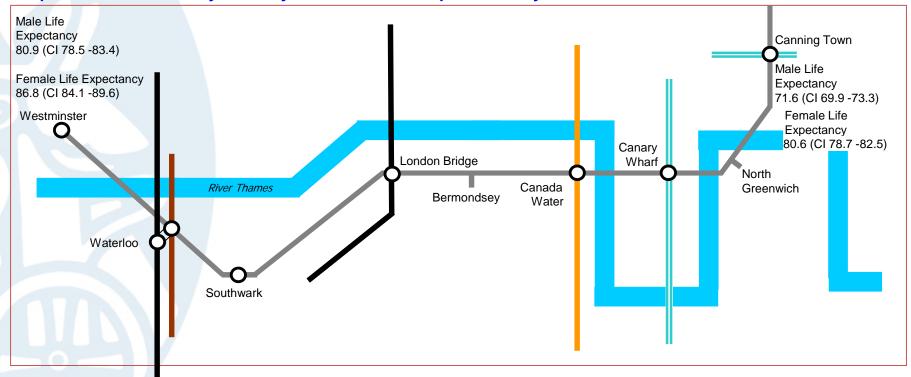
Moving from 'what' to 'how' and 'why' questions - 3

- Downstream / upstream factors
 - Multiple health system-related and non-health system related factors
 - Complex interactions between determinants of health
 - Time lag between implementing policies and impact



Inequalities in health outcomes – multiple causes

Travelling east from Westminster, each tube stop represents nearly one year of life expectancy lost



London Underground

Jubilee Line



Moving from 'what' to 'how' and 'why' questions - 4

- Path dependency
 - Initial conditions restrict the number of options available at a later point
- Appropriateness and significance for policy
 - Moving from what works to why does it work, for whom and under what circumstances



Approaches to addressing 'how' and 'why'



(Log) framework based assessments

INPUTS	PROCESS	OUTPUTS	OUTCOMES	IMPACT
Funding Plan Harmonisation	National plan implementation Capacity building Accountability M&E	Improved services (access, quality, efficiency) Health systems strengh- tened (Governance, HR, etc.)	Increased service utilisation and coverage Reduced inequity Responsiven ess	IMPROVED SURVIVAL IMPROVED NUTRITION REDUCED MORBIDITY IMPROVED EQUITY SOCIAL AND FINANCIAL RISK PROTECTION

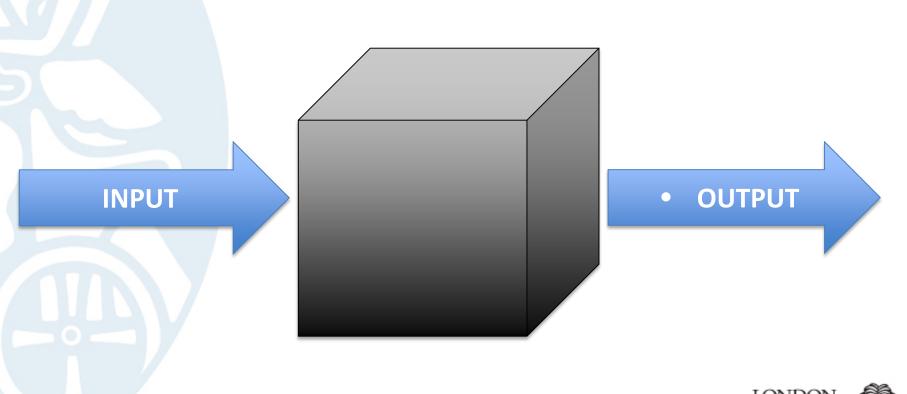
Assessing HR retention in rural/remote areas

INPUTS PROCESS OUTCOMES OUTPUTS IMPACT HRM Attractivity Producti-**IMPROVED** interventions Intentions to **PERFOR-Resources:** vity come, stay, leave **MANCE** -Leadership Service -Newly & SERVICE **Availability** (HRH Units) utilisation graduated **DELIVERY Effective** -National HRH students recruitment **Plan & Policy** -Health **Responsiv**towards -Regulatory Retention Workers eness framework for **Duration** in -Budget for **Patient IMPROVED** recruitment and service HRH **HEALTH STATUS** satisfaction retention Reduced - Health absenteeism -System for facilities Job satisfaction performance **Accessi-bility** Infrastructure evaluation Workforce -Career surveillance

CONTEXT: Social determinants, political situation, economic issues (fiscal space, fiscal decentralisation) individual level factors (marital status, gender)

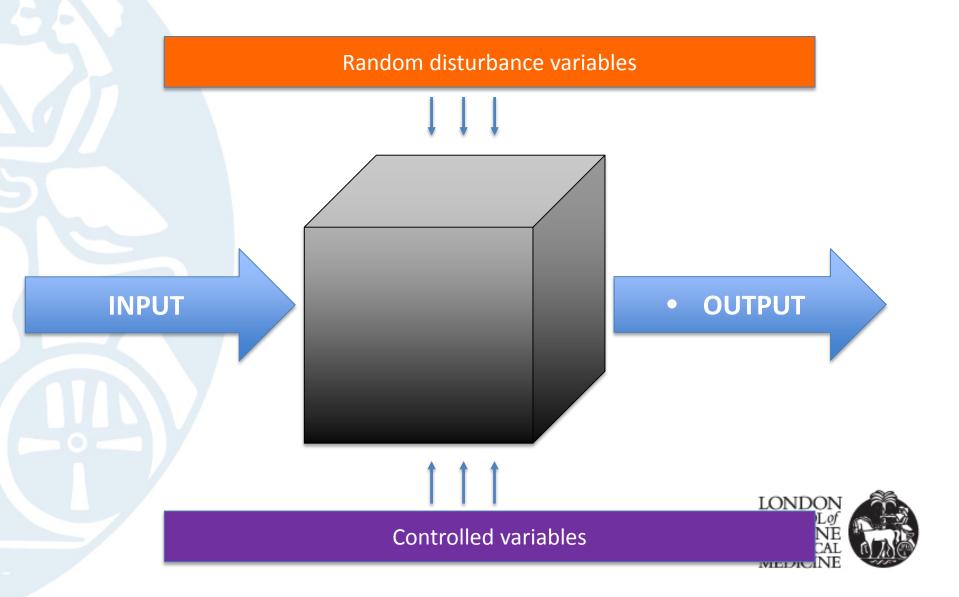
management

'Black Box' models

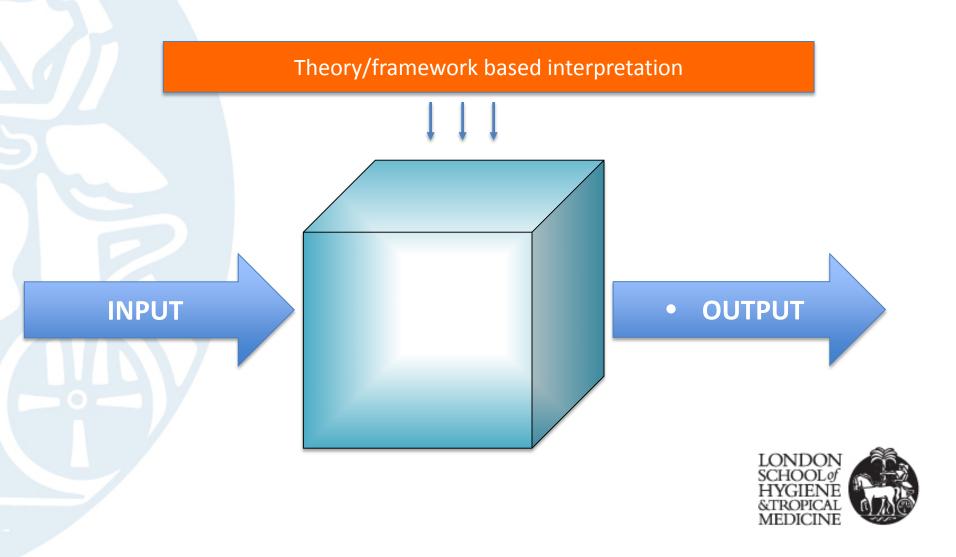




'Black Box' models



Approaches to addressing 'how' and 'why': 'Open Box' models



An 'open-box' evaluation

Ssengooba et al, 2012. Why performance-based contracting failed in Uganda--an "open-box" evaluation...

- Assessed performance based contracting (PBC), a 'complex health system intervention' in Uganda linking monetary or material rewards to achievement of targets (2003-2006)
- Drew on complex adaptive system theory
- Examined how it was implemented and why it failed in Uganda it failed to achieve its objectives.
- 'Black box' evaluation: effects of PBC
- 'Open box' evaluation: how these effects came about, embedded in implementation and processes

Evaluating PBC in Uganda: findings

- <u>Selection of targets</u>: hastily without sufficient communication about pilot, activities stalled for a year
- <u>Performance audit:</u> primary clinical registers used instead of monthly reports, auditors also evaluators
- <u>Performance feedback:</u> conducted at district level where all actors were invited
- Bonus payments: Payments uncertain and untimely, higher bonuses paid to re-kindle interest



Evaluating PBC in Uganda: conclusions

- Insufficient understanding of mechanisms; and learning from successes and failures
- Open-box approaches highlights new areas:
 - design problems, not well thought-out adaptations.
 - under-financing, underestimation of technical resources and capacity needed, no consideration of important actors and their workload
- "impacts of complex interventions are contingent on multiple micro-level implementation details"
- This pilot implementation can be called a 'failure' not
 PCB overall, context specific evaluation is required



Systems thinking

'It is the multiple relationships and interactions among the building blocks ... that convert these blocks into a system'



Source: de Savigny and Adam (2009)

Characteristics of all complex systems

Most systems, including health systems, are:

- Self-organizing
- Constantly changing
- Tightly linked
- Governed by feedback

- Non-linear
- History dependent
- Counter-intuitive
- Resistant to change



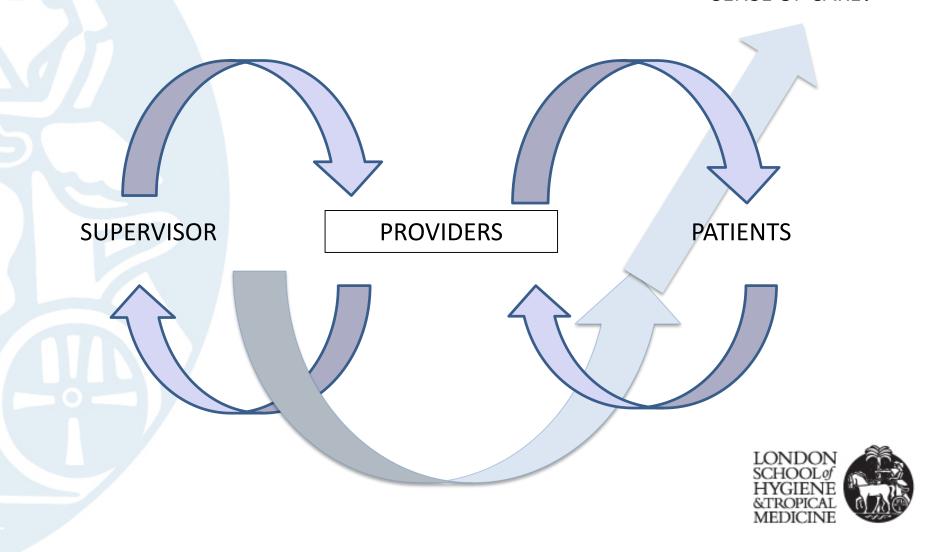
And

- nest sub-systems within them
- but are part of larger systems

Source: de Savigny and Adam (2009)

FEEDBACK LOOPS

SATISFACTION? ACCEPTABILITY? SENSE OF CARE?



Theory of Change

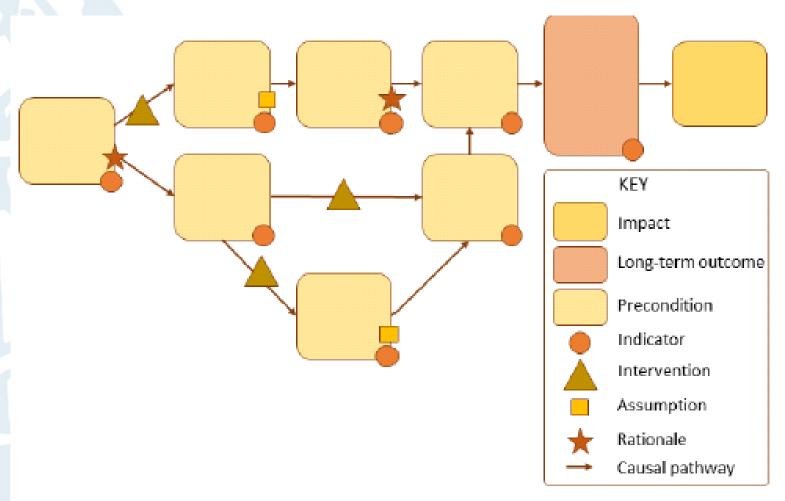


Figure 1: Example Theory of Change framework and key

From: De Silva (online resource)



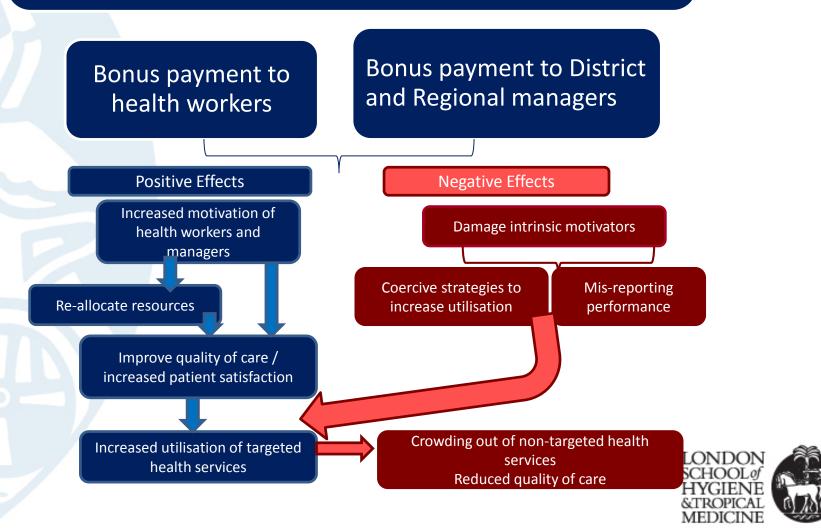
Theory of Change: key characteristics

- Theory of change: a theory about how and why an intervention works
- Plausible: where pathways to impact may be unclear
- Consensus-based
- Embedded in the real world
- Overarching framework & clear knowledge gaps
- Can be used to inform evaluation design and choice of indicators



Introduction of P4P

Training of key stakeholders and provision of guidelines, opening bank accounts



Realist Evaluation (Pawson and Tilley, 2007)

- Programs 'work' by enabling participants to make different choices (but choice is constrained by previous experience)
- Making and sustaining different choices requires a change in participant's reasoning and/or the resources
- ✓ Reasoning and/or the resources →a program 'mechanism'
- ✓ Programs 'work' in different ways for different people
- ✓ interaction between context and mechanism: Context + Mechanism = Outcome
- Programmes cannot be replicated with the same effect, but understanding of how mechanisms work is transferrable.

LONDON

Marchal et al, 2010. A realist evaluation of the management or regional hospital in Ghana.

Multi-method [rapid] appraisals using 'tracers'

Chronic disease as a marker for system performance

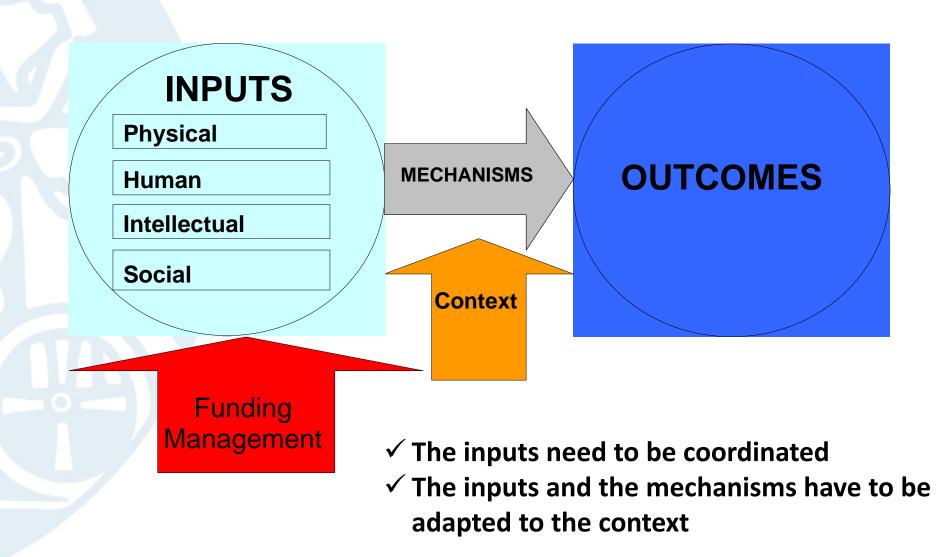
- ORapid diagnostic
- OEnsuring adherence to treatment

Effective care depends on:

- OContinuous care, follow-up
- OSupport for lifestyle changes
- Reliable drug supply
- OPatient-focused approaches multiple conditions & needs
 - E.g.in primary care settings
- OStrong linkages between different episodes of care & services
 - E.g. referrals, exchange of information between providers

- Often life-long or require a prolonged treatment.
- **O**Co-morbidities/ complications
- OInvolve a succession of contacts, access to variety of specialist skills at different levels.
- OPotentially fatal consequences if not successfully controlled

The role of theory ('Realist evaluation')



Multi-method systems appraisal using diabetes as a tracer (7+ countries, 2000-)

Physical resources

Insulin, drugs; diagnostic and monitoring equipment; appropriate facilities & diets

Human resources

Empowered patients; trained staff with resources; effective policy-makers

Knowledge resources

Capacity: patients (self care); staff (responsive and effective clinical care); policy-makers (implementation)

Social resources

Communication within the system; effective referrals; inter-sectoral policies to prevent social exclusion; ethos of empowerment of patients and staff



Multi-method appraisals using 'tracers'

RAPID SCANNING USING A TOOLKIT:

identifying major barriers and bottlenecks

IN-DEPTH EXPLORATION of key areas & identifying plausible pathways from health systems to outcomes

INTERPRETATION of findings within their political and socio-economic context

Multi-method appraisals using 'tracers'

RAPID SCANNING USING A TOOLKIT:

identifying major barriers and bottlenecks

UKRAINE access to insulin

IN-DEPTH EXPLORATION of key areas & identifying plausible pathways from health systems to outcomes

brand instability, diverse market, >coma admissions

INTERPRETATION of findings within their political and socio-economic context

deregulation of the pharmaceutical sector after transition/ procurement not supporting brand stability

Responding to chronic disease: health system failures?

Treatments and models of care are often known and available, failures are often in broader health systems:

- Many health systems have been designed to respond to acute isolated episodes of illness or other one-off events.
- Specialists and hospitals have often had a lead role, with limited scope for patients to manage their condition.
- Complexity is a challenge:
 - E.g. difficulties in instituting integrated management and communication between providers and patients, and within teams, or providing care for co-morbidities
- Traditional disease-oriented treatment are still the norm.
- Organisational and financial patterns failing to mitigate for individual circumstances of patients

Multi-method [rapid] appraisals using 'tracers'

+ pros

exploratory, rapid scan to identify key issues & focus, relatively quick, useful for policy;

Can be informed by theory and frameworks

- cons

dependent on researchers' skills, combining different types of analysis

can be superficial and descriptive, may produce poor quality data;





PRACTICAL



Choosing an approach for HS assessment: depends on the question (Gilson, 2012)

question (diison, 2012)			
Knowledge	Positivism	Critical Realism	Relativism
Paradigm	(biomedical &		(social sciences)
	clinical research)		
Type of questions	Is the policy or intervention (cost) effective?	What works from whom in which conditions?	How do different actors experience and understand the policy or
			intervention?
Key research	<u>Deductive</u> –	<u>Deductive and</u>	<u>Inductive</u>
approaches	hypothesis driven	<u>inductive</u>	(theory building and/or
and methods	Methods: surveys,	(theory testing &	testing)
	statistical analysis,	building).	Methods: in depth

Methods: documents,

Marchal, et al. (2010)

A realist evaluation, a

interviews, case

hospital. Ghana

studies

interviews, FGDs,

life histories

policy. India

Sheikh, (2010)

Discursive gaps, HIV

documents, observation,

Key researches approaches and method

semi-structured

interviews,

Bjorkman M,

(2009) RCT, Uganda

checklists

Conceptual difficulties

- What do we (need) to measure? Can we measure impact?
 - what is good quality evidence?
 - from attribution to 'contribution' and plausible linkages
 - indicators that are measured often improve
- How do we manage complexity & uncertainty?
 - definitions vary between countries (e.g. What is a nurse)
 - care requires often multiple contacts, complex pathways
 - outcomes determined by different care components
 - multiple factors at play including context
 - chance events, individuals?
- How to undertake evaluations of complex phenomeral combining different evidence and method?

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Concluding remarks on assessment

Instead of 'what works', 'what works, under what conditions, for whom'?

Study question should inform the approach but...consider appropriateness and feasibility: time, capacity and policy relevance.

Theories and framework development – a promising approach;

Multi-method evaluations are increasingly the norm for assessing health systems policies and interventions

'Impact' may be difficult to establish, consider plausible pathways

Employ strategies to address complexity

Reflect on value-based judgements in formulating the questions and conducting the research

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