Health Sector Reform: Experiences Over Several Decades in Diverse Countries And Systems

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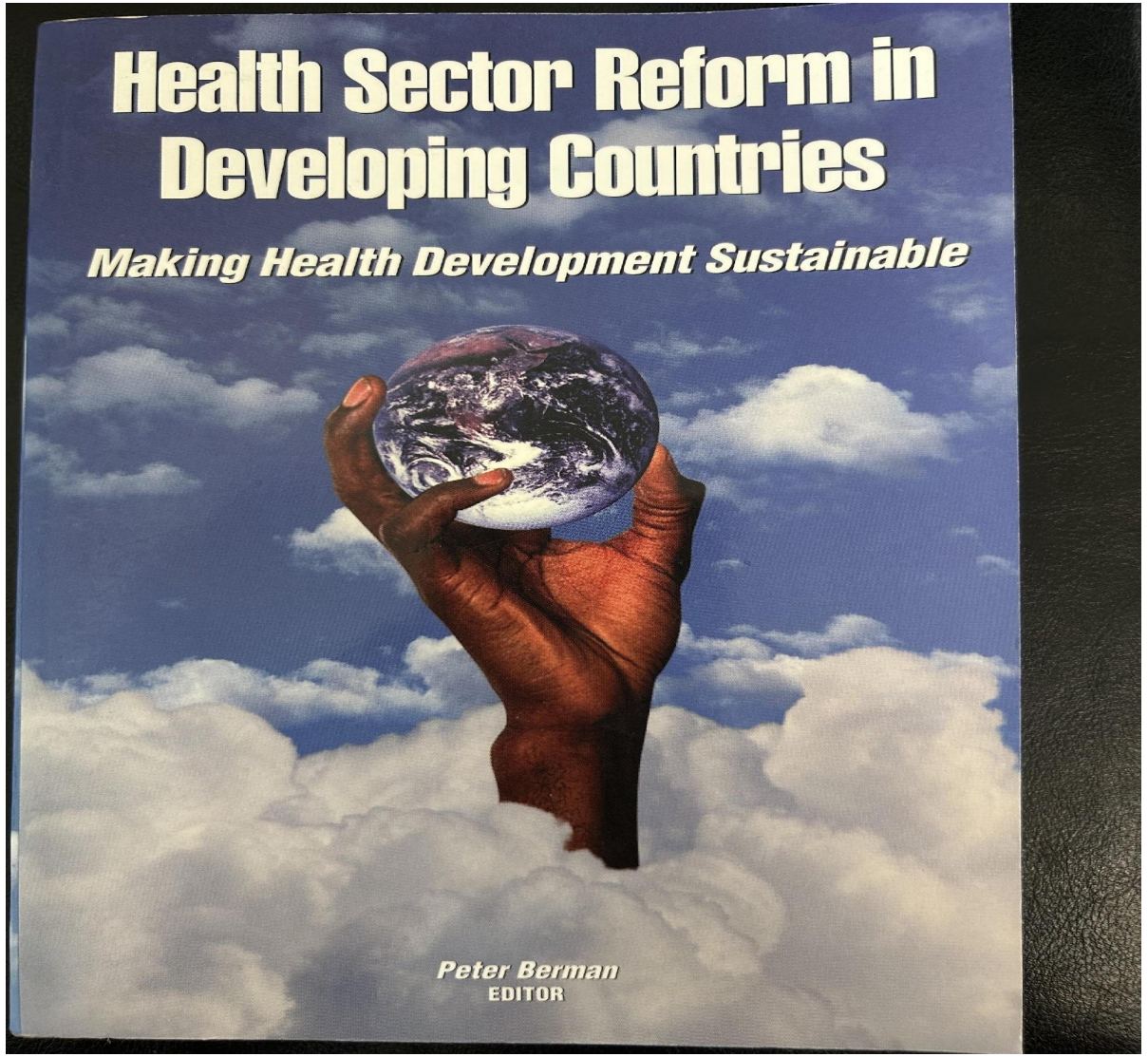
Early efforts: 1993 conference and 1995 publication – also as special issue of Health Policy 32:1-3, 1995



Four recommendations from the conference

- Development of an “international, horizontal, and independent consortium to foster exchange, learning, assistance, and institutional growth” on health sector reform
- Develop and expand tools for health system analysis and reform, e.g. BoD, CEA, NHA, political mapping, and organizational innovations
- Institutional strengthening, especially in national settings, to enable and sustain analysis, M&E, policy advice.
- Increase and assure adequate resources for health sector reform

Source: Berman and Bir “Introduction”

Defining "reform"

- "to convert to another or better form", "the amendment or altering for the better of some faulty state of things" (OED, 1971, p 2465)
- Generally, implies positive change
- More specifically defined as:

"sustained, purposeful, change to the improve the efficiency, equity, and effectiveness of the health sector"

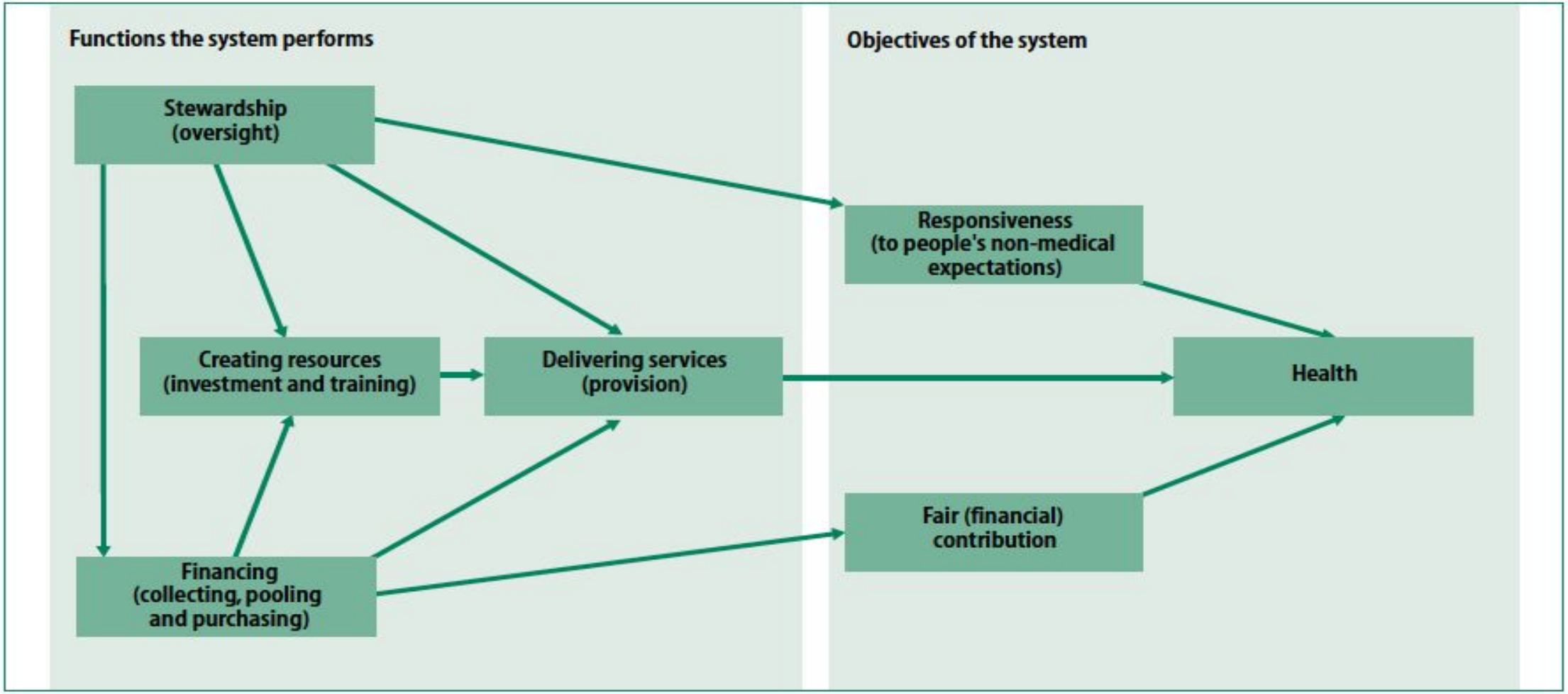
- Health sector defined as "totality of policies, programs, institutions, and actors that provide health care – organized efforts to treat and prevent disease" although acknowledged that other sectors e.g. related to food, housing, education also important for outcomes.

Source: Berman Chapter 1

Moving to the 2000's -- frameworks for analyzing health systems

- Health system: "…all actors, institutions, and resources that undertake health actions – where the primary intent of a health action is to improve health." (WHO 2000)
- A health system framework: a *heuristic* device to improve our understanding of the structure and function of a health system, to explain how it works. (Heuristic: "a process or method that enables a person to discover something for themselves.")
- Purpose?: to describe and compare; to analyze and predict
- There are many frameworks used for whole health systems and their parts
- And keep in mind "health system" and "health care system" ☺

“Functions”: the 2000 World Health Report Framework

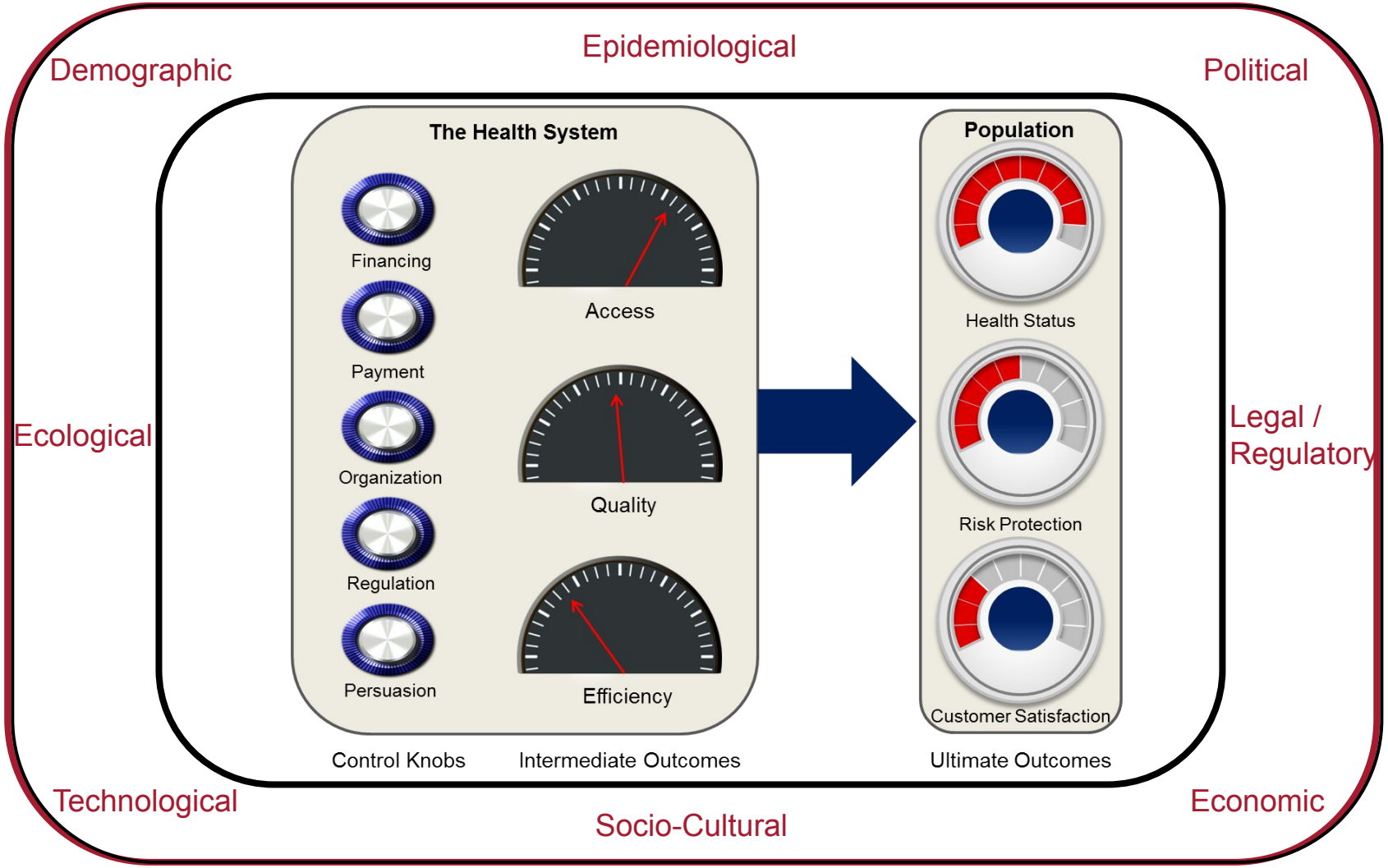


Source: WHO 2000 “World Health Report”

WHO's Revision in "Everybody's Business" (2006) – the "Building Blocks" framework

Source: WHO 2006 "Health Systems: Everybody's Business

Roberts et al Getting Health Reform Right – the "Control Knobs" framework (my favorite, as co-author ☺)



Source: Roberts et al "Getting Health Reform Right: A Guide to Improving Performance and Equity"
Oxford, 2008

GHRR's version of "Ultimate Outcomes": the purpose of health systems

	Level (Average)	Distribution
Health Status		
Financial Risk Protection		
Citizen Satisfaction		

Source: Roberts et al *Getting Health Reform Right: A Guide to Improving Performance and Equity, Oxford 2008*

The Complexity Critique

- A frequent critique of these frameworks is that they do not sufficiently recognize the health system as a **complex and adaptive system.**
- What does this mean?
- The thinking is too “linear” – complex systems are characterized by ”feedback loops” and “recursiveness” – actors “adapt” to change in novel ways that are hard to predict
- They portray action and effect in overly narrow categories – e.g. change provider payment mechanism (x) and (y) will happen – whereas there are multiple interactions between mechanisms and multiple mechanisms may be needed to effect change
- External factors act on the system in hard to predict ways – e.g. new technologies are invented (AI?), new mechanisms affect actors’ behavior (media?)

OK, valid – but too much focus on complexity can paralyze action

An important overview concept: the macro, meso, micro in health care systems

- The term "health system" is often used to refer to all of these. We should be clear in where our focus is...
- Micro – example – the interaction between patient and provider in a clinic, hospital ward, pharmacy
- Meso – example – the network of clinics under a district administration, a large hospital with multiple departments, a regional health care delivery systems –
- Macro - example – the collection of meso units influenced by system-wide factors such as the total level of health expenditure, the laws and regulations affecting licensure and quality, government and private sector roles, the ways prices or compensation are set by higher-level payer organizations

Back to “reform” – Why change, change what, how?

	Level (Average)	Distribution
Health Status		
Financial Risk Protection		
Citizen Satisfaction		

- Why change? – Health system “performance” – define the problems in terms of the outcomes
- Difficult ethical choices – whose needs of what should be given attention and priority?
- Change what? – Building blocks? Control knobs? Usually multiple elements
- How? Policy, intervention design, and implementation
- Politics throughout – the why, what, and how

Examples (1) – Financing

- Increase government funding for health? (increase “fiscal space”)
  - ✔ Allocate more to health
  - ✔ Increase existing taxes, improve collection?
  - ✔ New revenue sources, e.g. ”sin” taxes – tobacco?, alcohol?
- New funding channels
  - ✔ Government-linked health insurance
  - ✔ Private health insurance
- Reduce waste/increase efficiency?

Examples (2) -- Payment

- Government mostly relies on input-based financing – e.g. salaries for health workers plus other inputs like supplies, facilities, etc. Incentive for better performance is mainly service ethic
- Multiple other ways to pay for health care e.g. according to units of service like procedures, bed-days, diagnosis. These introduce stronger incentives for productivity. Can also be tied to quality and equity measures. “Purchasing” not just “payment”.
- More attention to “strategic purchasing” – targeted purchasing to increase specific actions or outcomes – “results-based” or “performance-based” financing (RBF/PBF).
- NB: New forms of payment are often linked to new structures of financing due to rigidities in traditional government funding – e.g. health insurance introduces purchasing mechanisms

Examples (3.1) Organization of service delivery

- Can intermediate outcomes like access, quality, efficiency be improved by changes in service delivery organization? And ultimate outcomes?
- Primary health care
  - ✔ Many LMICs developed a similar government model of multi-function health center, smaller satellite facilities – origins in Soviet Union, Yugoslavia, S. Africa
  - ✔ Significant addition of community health workers both paid and volunteer
  - ✔ Non-government providers with many varied organizations – individuals, group practice, multi-specialty practice.
  - ✔ Other providers – pharmacies, drug sellers, traditional, ”less than fully qualified”

Examples 3.2 (continued)

- Hospitals
  - ✔ Smaller general hospitals (district/municipal level) links to PHC?
  - ✔ Higher level referral hospitals – what structure?
  - ✔ Non-governmental hospitals – what relationship with government facilities?
- Other provider organizations
  - ✔ Free standing diagnostic facilities – X-ray, MRI, CT
  - ✔ Integrate with government facilities – in what ways?

Examples 4 -- Regulation

- Government role in licensing of health workers and facilities
- Government role in licensing of non-government financing
- Role of government-linked financing and non-government financing in purchasing from providers
- “Public-private partnerships” in facility development
- Regulation of inputs – drugs, medical equipment

Examples 5 – Persuasion/Behavior

- Health promotion for behavior change
  - ✔ Determinants of health – diet, exercise, screening
- Provider behavior change – e.g. proper use of antibiotics?
- Regulation of communications media?
  - ✔ Advertising
  - ✔ “Misinformation”

Stepping back view

- How do these domains of reform apply or differ according to macro, meso, and micro levels?
  - ✔ Decentralization of authorities to lower levels such as province/state or district/municipality?
  - ✔ Can government act to influence meso and micro levels without always having to intervene directly?
    - E.g. Change hospital accounting rules to modify provider incentives?
    - E.g. Legalize some services for paramedical workers directly to patients?

Some examples from Indonesia

- Development of Pos Yandu
- Granting of significant autonomy/authority to Kabupaten
- Purchasing incentives to health workers
- National health insurance (BPJSK/JKN)
- Government financing of JKN premia for lower income citizens
- Growth and regulation of private hospitals

Some concluding thoughts on health sector reform

- You can see – it is a complex area of analysis, policy, and action
- Clear thinking is important for sound design, but implementation really matters and sound design sometimes not enough
- Much to learn from one's own experience and others
- Different technical competencies are needed – clinical, public health, economics, behavioral sciences, public administration, business, etc.
- It is an ongoing and never-ending process – actions have consequences (remember complexity critique) and technology constantly changing – new inputs, AI, and other to be discovered things.
- But we can't do without it if we are going to achieve better health system performance

Terima kasih!
Diskusi!