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 positive role** 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)

c. International organisations such as the United Nations and its specialised agencies (e.g. WHO)

d. 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 inputs – including producers, procurers and distributors of commodities (drugs/ supplies) & knowledge (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

Balabanova D, Oliveira-Cruz V, Hanson K (2008)
An analytical framework

- **Government**
  - Setting Policy Goals, Implementation: oversight, regulation, financing, inputs
  - Dialogue, financing, monitoring, accountability

- **Private Sector**
  - Information, skills, dialogue, inputs, accountability, influence

- **Donors**
  - Financing, monitoring, inputs, skills

- **Societal Values and Expectations**
  - Rules of Engagement / Rule of Law
An analytical framework
Forms of engagement between the public and the private sectors

Government interacts with the private sector at different levels:

- Protecting the public interest
- Working with the private sector
- Learning from each other

Minimum level of engagement

Higher degree of engagement
### Forms of public/private engagement

<table>
<thead>
<tr>
<th>Regulating</th>
<th>Financing</th>
<th>Stewardship</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Setting minimum standards</td>
<td>- Subsidies</td>
<td>- Formulating sectoral strategies and technical policies involving the private sector</td>
</tr>
<tr>
<td>- Strengthening public accountability</td>
<td>- Contracting out</td>
<td>- Provision of information</td>
</tr>
<tr>
<td></td>
<td>- Use of vouchers</td>
<td></td>
</tr>
</tbody>
</table>

### Indicators of progress

<table>
<thead>
<tr>
<th>Regulatory framework</th>
<th>Mechanisms for private sector finance</th>
<th>National strategic plans/technical policy documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated court system</td>
<td>Levels of financing</td>
<td>HMIS, NHA</td>
</tr>
</tbody>
</table>
Examples of how governments engage with the private sector

<table>
<thead>
<tr>
<th>Forms of engagement</th>
<th>India</th>
<th>Uganda</th>
<th>Afghanistan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation and development initiatives of a fast growing private insurance market</td>
<td>Public-private partnership with government providing subsidies for PNFP service providers</td>
<td>Contracting out of NGOs for the provision of health services</td>
<td></td>
</tr>
</tbody>
</table>

**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 **regulate** and **implement** flexible financing mechanisms
- Trained human resources that can **lead/management** collaborations
- Structure (institutional space) & processes to foster regular **communication** & coordination
- Willingness and ability to **incorporate innovative 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

Mills et al. 2001, and Hilderbrand and Grindle, 1997
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 organisational capacity and leadership, to establish coordinating bodies
- May need to acquire strategic capacities 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
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

Environment
- Political
- Economic
- Social/culture
- Geography

Living conditions → Disease → Health systems

Death → Disability → Recovery
Model of determinants of health

Environment
- Political
- Economic
- Social/culture
- Geography

Living conditions

Disease

Health systems

Death
Disability
Recovery

Lalonde Report, 1974
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

With permission from K. Kielmann
A health system?

‘Traditional’ drug sellers in Myanmar

Chemist shop in India stocking allopathic, homeopathic & ayurvedic drugs

Allopathic drug sellers in Peru

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)

**SYSTEM BUILDING BLOCKS**

- Service Delivery
- Health Workforce
- Information
- Medical Products, Vaccines & Technologies
- Financing
- Leadership / Governance

**OVERALL GOALS / OUTCOMES**

- Improved Health (Level and Equity)
- Responsiveness
- Social and Financial Risk Protection
- Improved Efficiency

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 complex adaptive social systems - 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
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
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

- **Capacity**: individuals and institutions
- **Continuity**: e.g. stable bureaucracies
- **Context**: e.g. income, beliefs, history
- **Catalysts, Windows of Opportunity**: e.g. social, political

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

- Vision and seizing windows of opportunity
- Ability to implement
- Accountability and transparency
- Responsiveness
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 **autonomy** and flexibility
- **Multi-sectororality**

- Ability to operate in pluralistic context: engagement 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
Third Global Symposium
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.

Male Life Expectancy
Westminster: 80.9 (CI 78.5 -83.4)
Waterloo: 80.9 (CI 78.5 -83.4)
Southwark: 80.9 (CI 78.5 -83.4)
London Bridge: 80.9 (CI 78.5 -83.4)
Bermondsey: 80.9 (CI 78.5 -83.4)
Canada Water: 80.9 (CI 78.5 -83.4)
Canary Wharf: 80.9 (CI 78.5 -83.4)
Canning Town: 80.9 (CI 78.5 -83.4)

Female Life Expectancy
Westminster: 86.8 (CI 84.1 -89.6)
Waterloo: 86.8 (CI 84.1 -89.6)
Southwark: 86.8 (CI 84.1 -89.6)
London Bridge: 86.8 (CI 84.1 -89.6)
Bermondsey: 86.8 (CI 84.1 -89.6)
Canada Water: 86.8 (CI 84.1 -89.6)
Canary Wharf: 86.8 (CI 84.1 -89.6)
Canning Town: 86.8 (CI 84.1 -89.6)

Source: London Health Observatory
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

<table>
<thead>
<tr>
<th>INPUTS</th>
<th>PROCESS</th>
<th>OUTPUTS</th>
<th>OUTCOMES</th>
<th>IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding Plan Harmonisation</td>
<td>National plan implementation</td>
<td>Improved services (access, quality, efficiency)</td>
<td>Increased service utilisation and coverage</td>
<td>IMPROVED SURVIVAL</td>
</tr>
<tr>
<td></td>
<td>Capacity building</td>
<td>Health systems strengthened (Governance, HR, etc.)</td>
<td>Reduced inequity</td>
<td>IMPROVED NUTRITION</td>
</tr>
<tr>
<td></td>
<td>Accountability</td>
<td></td>
<td>Responsiveness</td>
<td>REDUCED MORBIDITY</td>
</tr>
<tr>
<td></td>
<td>M&amp;E</td>
<td></td>
<td></td>
<td>IMPROVED EQUITY</td>
</tr>
</tbody>
</table>

**IHP+ Common assessment framework**
## Assessing HR retention in rural/remote areas

<table>
<thead>
<tr>
<th>INPUTS</th>
<th>PROCESS</th>
<th>OUTPUTS</th>
<th>OUTCOMES</th>
<th>IMPACT</th>
</tr>
</thead>
</table>
| Resources:  
- Newly graduated students  
- Health Workers  
- Budget for HRH  
- Health facilities Infrastructure | HRM interventions  
- Leadership (HRH Units)  
- National HRH Plan & Policy  
- Regulatory framework for recruitment and retention  
- System for performance evaluation  
- Career management | Attractivity  
Intentions to come, stay, leave | Productivity  
Service utilisation | IMPROVED PERFORMANCE & SERVICE DELIVERY |
| | | Availability  
Effective recruitment | Responsiveness  
Patient satisfaction | towards |
| | | Retention  
Duration in service  
Reduced absenteeism  
Job satisfaction | Accessibility | IMPROVED HEALTH STATUS |
| | | Workforce surveillance | | |

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

Huicho et al. 2010
‘Black Box’ models
‘Black Box’ models

Random disturbance variables

INPUT

Controlled variables

• OUTPUT
Approaches to addressing ’how’ and ‘why’: ‘Open Box’ models

Theory/framework based interpretation

INPUT • OUTPUT
An ‘open-box’ evaluation

Ssenyooba 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

- **Selection of targets**: hastily without sufficient communication about pilot, activities stalled for a year
- **Performance audit**: primary clinical registers used instead of monthly reports, auditors also evaluators
- **Performance feedback**: 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

SUPERVISOR

PROVIDERS

PATIENTS

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

De Silva, http://mhinnovation.net/resources/theory-change-toolkit#.VMIpThD9ah0
Introduction of P4P
Training of key stakeholders and provision of guidelines, opening bank accounts

Bonus payment to health workers

- Positive Effects
  - Increased motivation of health workers and managers
  - Re-allocate resources
  - Improve quality of care / increased patient satisfaction
  - Increased utilisation of targeted health services

Bonus payment to District and Regional managers

- Negative Effects
  - Damage intrinsic motivators
  - Coercive strategies to increase utilisation
  - Mis-reporting performance
  - Crowding out of non-targeted health services
  - Reduced quality of care

Borghi, 2014
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.

Multi-method [rapid] appraisals using ‘tracers’

Chronic disease as a marker for system performance

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

Effective care depends on:

- Rapid diagnostic
- Ensuring adherence to treatment
- Continuous care, follow-up
- Support for lifestyle changes
- Reliable drug supply
- Patient-focused approaches - multiple conditions & needs
  - E.g. in primary care settings
- Strong linkages between different episodes of care & services
  - E.g. referrals, exchange of information between providers
The role of theory (‘Realist evaluation’)

- INPUTS
  - Physical
  - Human
  - Intellectual
  - Social

- MECHANISMS & PROCESSES

- CONTEXT
- FUNDING
- MANAGEMENT

- The inputs need to be coordinated
- The inputs and the mechanisms have to be adapted to the context
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

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

**INTERPRETATION**
of findings within their political and socio-economic context

---

**UKRAINE**
access to insulin

brand instability, diverse market, >coma admissions

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)

<table>
<thead>
<tr>
<th>Knowledge Paradigm</th>
<th>Positivism (biomedical &amp; clinical research)</th>
<th>Critical Realism</th>
<th>Relativism (social sciences)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of questions</td>
<td>Is the policy or intervention (cost) effective?</td>
<td>What works from whom in which conditions?</td>
<td>How do different actors experience and understand the policy or intervention?</td>
</tr>
<tr>
<td>Key research approaches and methods</td>
<td>Deductive – hypothesis driven Methods: surveys, statistical analysis, semi-structured interviews, checklists</td>
<td>Deductive and inductive (theory testing &amp; building). Methods: documents, interviews, case studies</td>
<td>Inductive (theory building and/or testing) Methods: in depth interviews, FGDs, documents, observation, life histories</td>
</tr>
</tbody>
</table>
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 phenomena, combining different evidence and method?
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
Acknowledgements

With gratitude to:

Prof. Martin McKee


Dr Mary De Silva

Dr Josephine Borghi