Implementing Strategies and Programs to Improve Healthcare Service Delivery in Emerging Countries, with Special Focus on Africa

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Addressing the Challenge of Patient-Centered Care and Safety

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HNP PRIORITY DIRECTIONS: Aligned with SDGs and Twin Goals of World Bank Group

1. End extreme poverty by 2030
2. Promote shared prosperity amongst the poorest 40%

1. Live healthy, prosperous, longer lives
2. Secure Productive and inclusive jobs
3. Create opportunities and be resilient in the face of economic, health, climate shocks and other risks

Assisting countries to accelerate progress towards UHC

- Establishing systems for fair, efficient and sustainable financing for HNP outcomes
- Ensuring equitable access to affordable, quality HNP services
- Harnessing the potential of other sectors to strengthen HNP results and generate global public goods
RATIONALE FOR A UHC FRAMEWORK IN AFRICA

Strong commitment to UHC in the region – SDGs and African declarations

UHC is political imperative
➢ Health is among top challenges in Afrobarometer

Opportunity to accelerate progress
➢ Despite diversity, many common health system challenges
➢ Many home-grown innovations and solutions to build on
➢ Framework to intensify country-led actions for UHC
KEY CHALLENGES

• High out-of-pocket expenditures at points of service delivery

• Weak public administration and financial management capacities

• Weak supply chains, especially in the public sector

• Sub-optimal use of the private sector

• Poor quality of clinical services

• Dysfunctions in architecture of Development Assistance for Health (DAH)
WHAT NEEDS TO CONVERGE?

- Patient- and community-centered accountability
- Fair and sustainable financing from domestic resources
- Purchasing services and managing service delivery contracts
- Effective planning, research and metrics functions in MOHs
- Public health functions and institutions
- Rational Development Assistance for Health (DAH)
ACCOUNTABILITY, CENTERED ON THE PATIENT AND COMMUNITY

• Voter-sensitive compacts
• Civil society engagement: activism with a positive purpose
• Quantitative scorecards at all levels of society, in the public domain
• League tables [yes, it is OK to “name and shame”]
TOTAL HEALTH FINANCING INCREASED MAINLY DUE TO HIGHER DEVELOPMENT ASSISTANCE -- BUT

- Government Financing for Health has been Stagnant
- Only 4 countries met Abuja target for government health spending in 2014
- 11 million people fall into poverty due to health payments yearly

Graph showing government budget allocated to health (2002) vs. Government budget allocated to health (2014) for various countries. The graph indicates a positive correlation between the two periods, with countries like AGO, BEN, BFA, BWA, and others falling above the poverty line of $1.90, suggesting a rise in health spending.
The incidence of catastrophic expenditures increased from 1.2% (1995) to 5% (2014).

One-third of Africans in need for care do not seek health care for financial reasons.

At 15% level of household consumption
Quality of Care in Contracted Out (PPA) Facilities compared to Government-run facilities (MOPH) in Afghanistan

22 percentage point improvement in quality of care in Contracted Facilities

No significant improvement in quality of care in Ministry-run clinics
Experience in Pakistan when Districts Contracted-In management and when Government took district wins

NGO takes over again

Government takes over again

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Greater global and regional collaboration of regulatory agencies will lead to

- Faster, more predictable and more competent regulatory processes for medicines and devices
- Easier market access for legitimate manufacturers and better functioning markets (more competition)
- Crowding out of grey market operators that trade in fake, sub-standard and diverted medicines and devices
- Higher attractiveness for investments into the pharmaceutical and medical devices sector
- Better financial basis for regulators (higher multiple for fee income and savings from giving up duplicative work), allowing them to invest in capacity building
More value for money through strategic purchasing and supply management

- Use trusted intermediaries to ensure quality (WHO Prequalification; global buying platforms; USAID prequalified wholesalers)
- Optimize for “landed costs”, not price for delivery to a central store
- Rational use is a challenge – limited resources are wasted if patients get the wrong medicines; additional risk of resistance development (malaria, TB, bacterial infections)
Broad consensus that public drug supply chains often perform poorly:

- Stock-outs, expired drugs on shelf, quality compromised due to storage condition (example oxytocin*)
- Underlying reasons – lack of funding? Bad logistics? Corruption and theft?
- “Free drug” programs seem most vulnerable to failure; large scale diversion feeding a grey market for donor funded drugs in Africa, within countries and across
- Training and investment into LMIS systems did not deliver as promised – incentives?

Future vision:

- Separation of prescribing and dispensing (good practice in all developed economies)
- Professional, well-run pharmacy chains under contract with public payers to implement pharmacy benefit programs; mobile technology solutions to e-prescription and e-payment, allowing for targeted subsidies to poor patients

INTEGRATION OF CARE

• For better management of individual case needs
• For more efficient use of resources
• In response to co-morbidities, the epidemiologic transition, and aging of populations
• Taking advantage of modern ICT
• Measurement is essential, but insufficient
• Need quantifiable improvements, on a large scale
• Perspectives and experiences of patients
• Knowledge, skills, & practices of service providers
• Whole-of-system enablers, inhibitors, and derailers of quality of care
Systemic Failures Behind Avoidable Deaths in Facilities

Reasons why mothers die: Modifiable Factors

- Healthcare Worker Issues
  - Substandard management
  - Problem with recognition / diagnosis
  - Delay in referring patient
  - Initial assessment
  - Managed at inappropriate level
  - Infrequently monitored
  - Incorrect management
  - Prolonged abnormal monitoring without action

- Administrative Issues
  - Lack of appropriately trained staff
  - Lack of specific health care facilities
  - Transport between institutions
  - Lack of blood for transfusion
  - Communication problems
  - Transport home to institution
  - Lack of accessibility
  - Barriers to entry

- Patient Issues
  - Delay in seeking medical help
  - Unsafe abortion
  - No antenatal care
  - Infrequent antenatal care

System-wide causes – not a ‘one problem issue’

Note: *Modifiable Factors contributing to Maternal death used as a barometer of state of healthcare system
Source: Saving Mothers, Medical Research Council
# Health System and Quality: Many Quality Improvement Strategies

<table>
<thead>
<tr>
<th>Generic topic</th>
<th>Categories</th>
<th>Examples</th>
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<tr>
<td>Patient-focused interventions</td>
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<td>Interventions to improve: Health literacy; Shared decision making; Self-care; Safety; Access; Patient experience</td>
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<td>Market</td>
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<td>Incentives</td>
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<td>Monetary rewards for Individual clinicians; Organizations; Patients</td>
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<td>Non-financial</td>
<td>Earned autonomy; Development opportunity</td>
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<td>Data-driven and IT-based institutions</td>
<td>Performance reporting and accountability</td>
<td>Public reporting; Performance monitoring and feedback</td>
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<td>Information and knowledge management</td>
<td>Electronic patient record; Decision support for clinicians and patients</td>
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<td>Organizational interventions</td>
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<td>Professional behaviour change</td>
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<td>Core processes</td>
<td>Quality Assurance; Safety and risk management</td>
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<td>Health-care delivery models</td>
<td>Disease or population groups</td>
<td>Prevention; Health promotion</td>
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Leatherman and Sutherland (2007)
Challenges to Measuring and Rewarding Quality Performance

• Ex-ante verification by district health team may be too gentle and not accurate: too close for comfort or still old fashioned ‘filling under the banana tree’?

• Regular counter-verification with credible sanctions are an important requirement

• Specifying incentives for district supervisors also seems a promising route (share of earnings; accreditation status; carrots and sticks)

• Introduction of modern ICT such as tablet based checklists, which embed meta data (location; time; interviewer passcode) seem a promising approach too
Technology Aids for Quality Measurements in PBF

- Tablets for quantified quality checklists (‘balanced score cards’) with automated uploads to a cloud based database and public dashboard. Offline data entry possible

- (as above) Tablet based solution for Vignettes (under development)

- Smart phone for community client interviews. Off-line data entry possible. Automated uploads to a cloud based database and public dashboard. Results impact on performance payments

- Web-based public dashboard for performance benchmarking
Using Dashboards for Benchmarking Performance

Benchmarking of Hospitals
Average score: Hospitals with payment 73% - Hospitals without payment 93%

Moscow Territorial Hospital: 94%
Balykchi City Territorial Hospital: 98%
Jumgal Territorial Hospital: 93%

Hospitals with payment: 73%
Hospitals without payment: 93%
IMPLICATIONS FOR
DEVELOPMENT ASSISTANCE FOR HEALTH

- Enabling, not driving, country strategies and programs
- Explicitly transitional financing
- Use external contractors only when there is credible evidence that local private sector entities cannot do the job
- Support institutional development, not through traditional “Technical Assistance,” but peer-to-peer learning among practitioners and institutions.
- Fitness for the recipient country’s combination of epidemiology, social narrative, and human resource capacity
Thank You