MINISTRY OF HEALTH
REPUBLIC OF GHANA

NHIS
NATIONAL HEALTH INSURANCE SCHEME

Health Finance & Governance
Expanding Access. Improving Health.

USAID
FROM THE AMERICAN PEOPLE

World Health Organization

FINANCIAL PROTECTION AND IMPROVED ACCESS TO HEALTH CARE: PEER-TO-PEER LEARNING WORKSHOP FINDING SOLUTIONS TO COMMON CHALLENGES

FEBRUARY 15-19, 2016

ACCRA, GHANA

Day V, Session I.

HEALTH SYSTEMS GOVERNANCE & FINANCING

World Health Organization

HEALTH SYSTEMS GOVERNANCE & FINANCING

Monitoring and (especially) Evaluation for UHC

Joseph Kutzin, Coordinator
Health Financing Policy, WHO

Financial Protection and Improved Access to Health Care
Peer-to-peer learning workshop

15-19 February 2016, Accra, Ghana

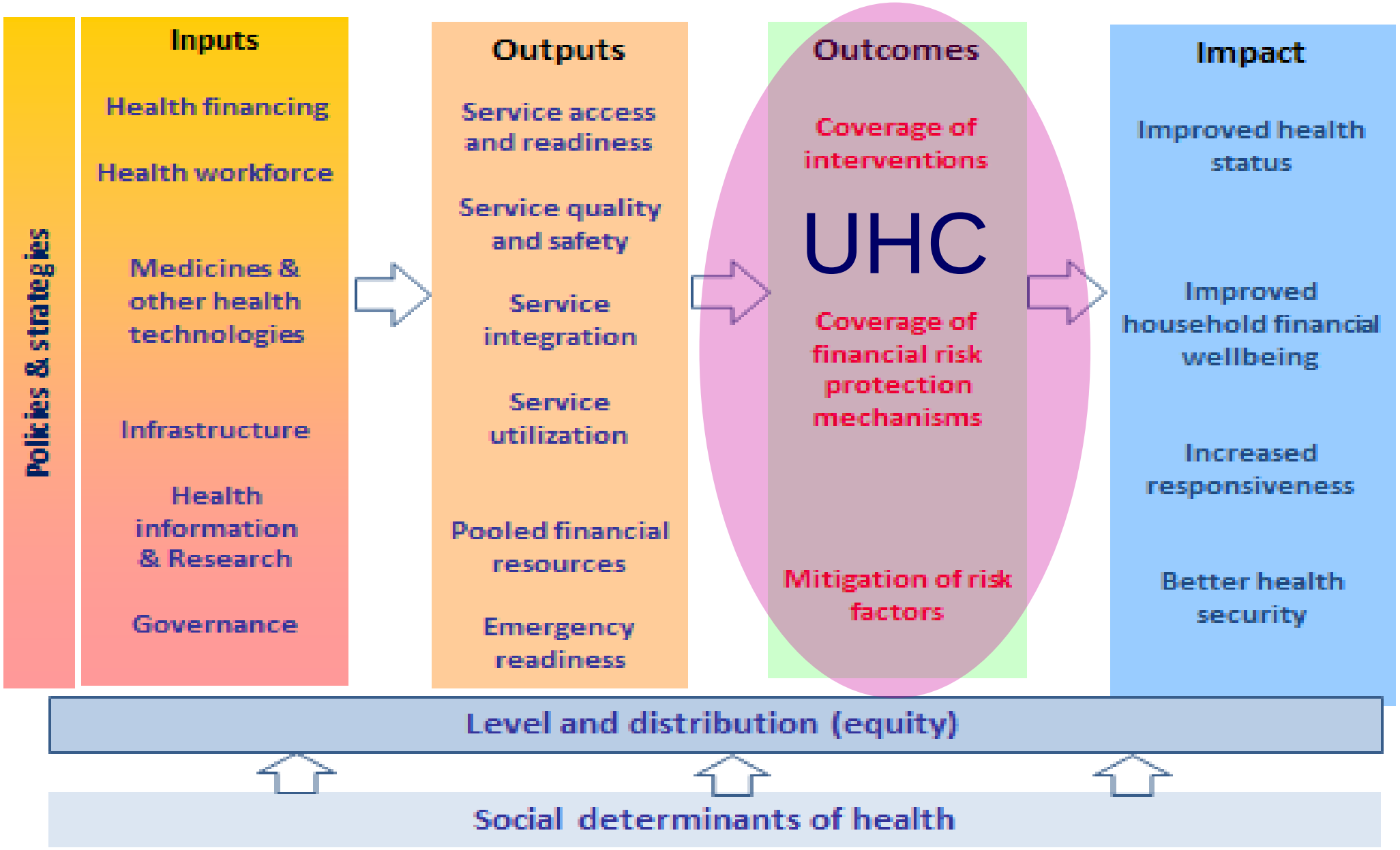
World Health Organization

M&E: CORE CONCEPTS AND FRAMEWORK FOR UHC

Definitions

- (Performance) Monitoring
  - Tracking routine data on indicators of performance
  - Answers “what?” (describing change)
  - “Early warning system”
  - Identify issues for more intensive investigation
- Evaluation
  - Involves research methodology oriented to specific issues of policy and implementation
  - Uses both routine and specially generated information, quantitative and qualitative
  - Answers “why?” and “how?” by analyzing process and outcomes (explaining change)

WHO-World Bank "causal chain" M&E framework for progress towards UHC



UHC MONITORING FRAMEWORK

Proposed WHO-World Bank SDG monitoring indicators for UHC (target 3.8)

Service Coverage

- RMNCH
  - FP, ANC, SBA, immunization
- Infectious diseases
  - TB, ARVs, ITNs, water
- NCDs
  - HTN, diabetes, cervical cancer screen, tobacco
- Service capacity & access
  - Service use, IHR, health worker density

Financial Protection

- Fraction of the population experiencing catastrophic out-of-pocket health expenditure
- Fraction of the population experiencing impoverishing out-of-pocket health expenditure
- Unfortunately, some countries pushing for "% of population covered by health insurance" (wrong!)

Don’t let the global framework get in the way of what you need

Global-level

- One monitoring framework, one common small set of targets and indicators
- Regular standardized reporting and review of progress using the common indicators

Country-level

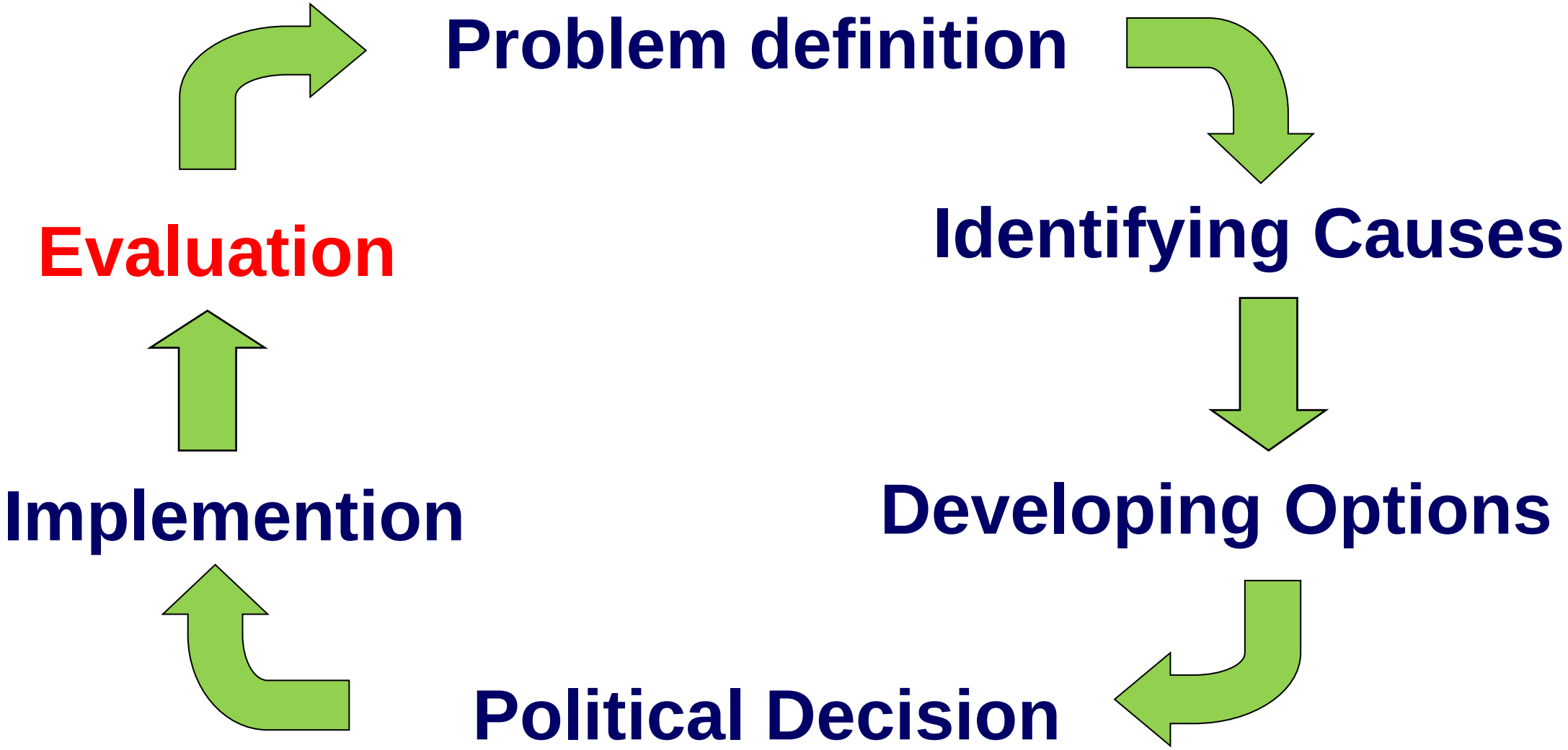
- No one-size-fits-all approach, but ideas from global framework
- Country monitoring based on your priority health issues (tailored tracers)
- Align monitoring of UHC with country mechanisms to review progress (e.g. JANS)

EVALUATION TO MOVE TOWARDS AN EVIDENCE-INFORMED POLICY PROCESSES

Putting the "E" in M&E (if you really want an intelligent, learning system)

- Reform strategies should address the likely causes of performance problems
- Monitoring can only describe change but can't get at causality. For this, need applied policy research (evaluation) to inform decision-makers
  - Try to answer "why?" and "how?"
- Evaluation involves analysis of implementation processes as well as effects
- Evaluation involves a research methodology and may use routine as well as specially generated information

The policy cycle in textbooks...

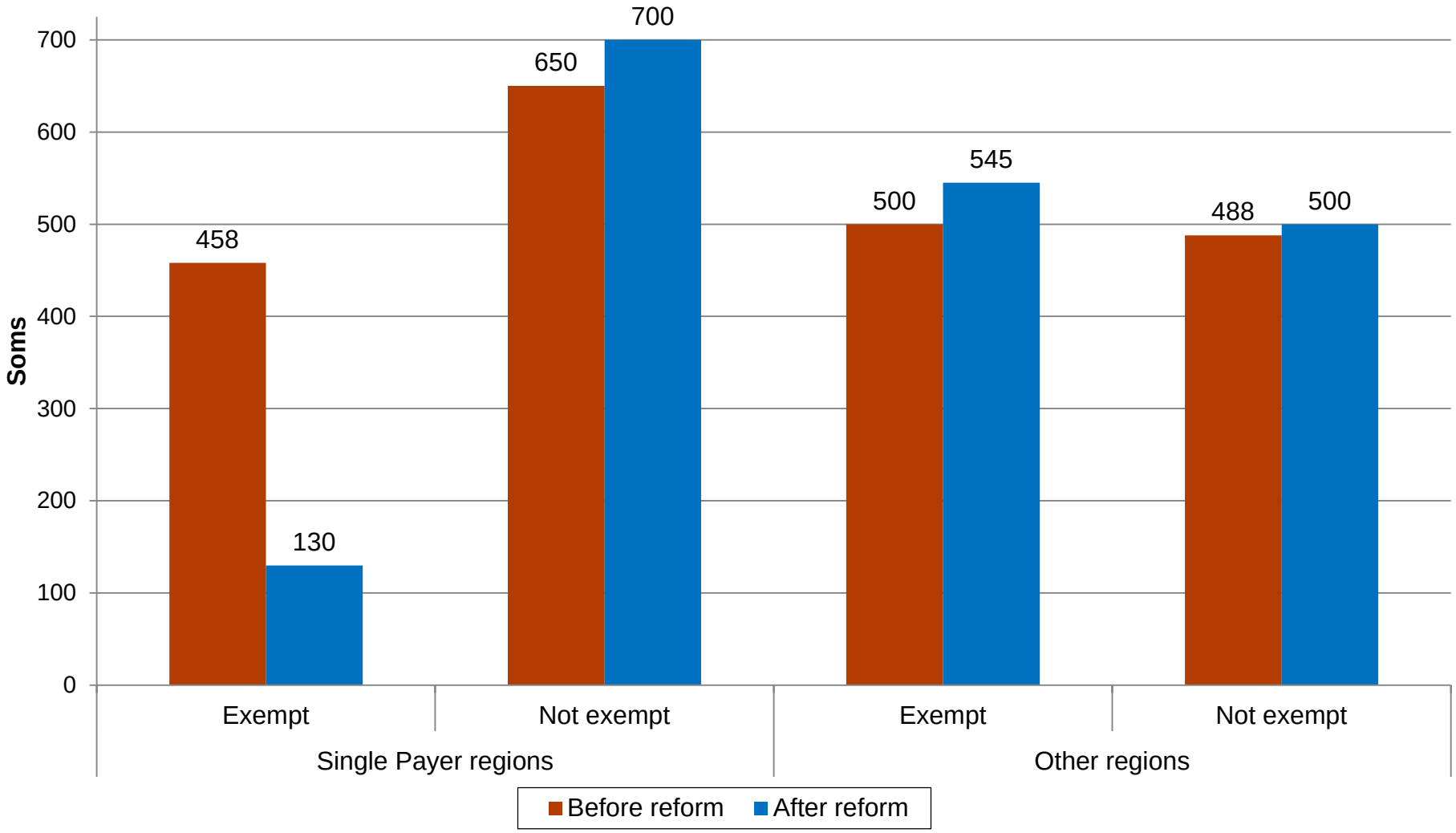


Source: Marc J. Roberts, Harvard School of Public Health

Health reform plans are hypotheses: should always include evaluations

- Reforms must be justified by a plausible hypothesized impact on the causes of performance shortcomings
  - If not, why are you doing them?
- Transform the hypothesis into indicators of performance
- Move from broad goals to increasingly specific and measurable objectives
- Define methodology based on issue to be analyzed and reform implementation process
- Example: provider payment and exemptions in Kyrgyzstan

Methodology tailored to implementation specifics (geographic phasing, in this case)



Source: WHO surveys of discharged hospital patients

What does it take to institutionalize this in the health system? Some ideas…

- Demand from the policy makers (they define priorities)
  - Technical value of evidence for policy adjustments
  - Political need for public accountability
  - Political value if there is a good story to tell !
- Supply – good researchers to do high-quality work
- Institutional platform (features, not a standard model)
  - Ability to attract and retain people with scarce skills (often difficult to do within core civil service)
  - Close enough to policy makers to be responsive, but far enough away to have independence to implement analysis

Timeliness essential for relevance – my embarrassing story

- Co-payment policy evaluation, Kyrgyzstan, March 2001
  - Phased approach and MHIF database allowed for powerful quantitative design, with baseline and follow-up surveys
  - Demand was there – Minister wanted the study
  - Baseline study in field in March. Updated Minister in early April
  - Baseline analysis ready end-May, follow-up survey November
  - "But I have to report to Parliament in May!!"
  - I got lucky – a Swiss project was using rapid appraisal analysis for other work, and I gave them $700 to do an excellent qualitative assessment of the policy in the two pilot regions.
- The "best" method may not be relevant if the results won't be available on time
  - And next year, our more rigorous analysis had a big impact

SOME LAST THOUGHTS

Don’t wait for us (the global health community)

- The global monitoring indicators are not sufficient to drive evidence-informed policy at country level
- Define evaluation study, methods, data sources and indicators at the same time as reform is being implemented
  - Avoid “last minute” efforts to “evaluate” the effects of policy reforms during a two-week World Bank mission or after an urgent request of the government
  - Process of defining the study at the same time as the reform can help focus the reformers on their objectives
- Don’t have donor-inspired pilots running in isolation – ensure you are learning from these, or don’t allow them

When you see a claims form…


NATIONAL HEALTH INSURANCE SCHEME
COMBONI HOSPITAL - SOGAKOFE

Claim Form
(Regulation 62)

Health Facility Code* 0 4 0 1 0 3 0 0 1

Important! The form should be completed IN CAPITAL LETTER using a BLACK or DARK BLUE ballpoint fountain pen. characters and marks used should be similar in the style to the following:

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 1 2 3 4 5 6 7 8 9 0

Scheme Code* S T G

Month of Claim (Batch)*

Client Information

Surname*

Other Names

Gender: Male / Female

Date of Birth

Age

Member Number*

Hospital Record No.

Card Serial Numbers*

Services Provided (to be filled all health care providers)

Type of Service* (a) select only one: Outpatients / Pharmacy / Diagnostic / In-patient; (b) All Inclusive / Unbundled

Date(s) of Service Provision*: 1st Visit/Admission / 2nd Visit/Discharge / 3rd Visit / 4th Visit / Length of Duration (days)

Outcome*: Discharged / Died / Transferred Out / Absconded / Discharged Against Medical Advice

Type of Attendance: Chronic Follow-up / Emergency / Acute Episode

Specialty Code:

Physician/Clinician Name*

Physician/clinician ID

Procedure(s) (to be filled by health care provider who have provided out or in-patient service)

	Description	Date	G-DRG
Procedure 1			
Procedure 2			
Procedure 3			

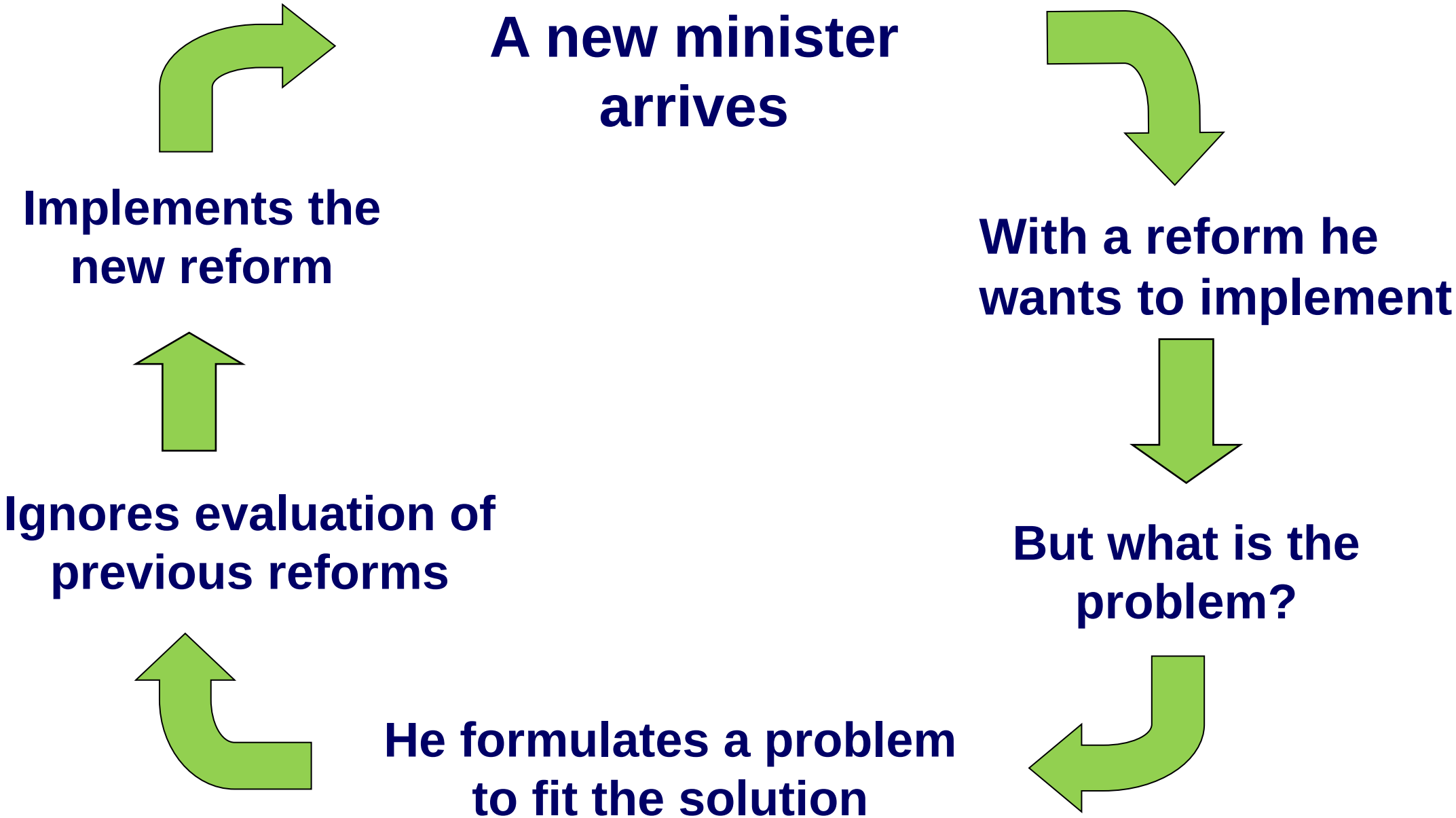
*Mandatory field

CF2009/V1

Page 1 of 2

- …imagine an (incredibly powerful) database
  - It's not just for payment; it's a key source for applied policy research
- And if you are interested in UHC, go beyond scheme
  - A key, practical step towards UHC is to unify the information system (even before everyone is part of scheme)
  - Unified national patient activity database provides technical foundation for a truly universal health system

And finally, an alternative policy cycle to avoid…



Adapted from Marc Roberts by Miklós Szócska