HEALTH SYSTEMS RESPOND TO NCDs – OPPORTUNITIES AND CHALLENGES FOR LEAPFROGGING

Voices from the WHO European Region

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As part of this special issue on the WHO Regional Office for Europe’s “Health systems respond to NCDs”, some prominent ‘voices’ from across the WHO European region were asked to reflect upon the opportunities and challenges for leapfrogging in this field. This select group represents a diverse range of stakeholders i.e. international and national policy makers, academic researchers, as well as representatives from regional networks, health insurance funds and civil society.

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Opportunities for leapfrogging

The growing burden of NCDs is one of the greatest challenges that health systems in the WHO European region are facing. As chronic conditions are intrinsically linked with a broad range of eco-political, social and individual determinants, leapfrogging could be possible in a wide range of health system areas to support fast adoption of innovation at scale. By leapfrogging we mean skipping inferior, less efficient, more expensive ways of delivering NCD-relevant core population interventions (i.e. tobacco, alcohol, nutrition and physical activity) and individual services (i.e. early detection and management of cardiovascular disease, diabetes, lung diseases, and cancer) and move directly to more advanced approaches representing today’s best practices within the health system. As such, our respondents were asked to reflect on important policies to strengthen the health system response to NCDs in their country or region, and identify opportunities and challenges of leapfrogging.

Zsuzsanna Jakab highlights that “we know what to do to address the burden of NCDs – we need to implement the core NCD population interventions and individual services, also referred to as the ‘NCD best buys’. Strong intersectoral governance embedded in the government structure is essential for implementing the best buys as well as strong public health agencies who can work closely with these intersectoral mechanisms. However, social determinants of health play an important role in how the best buys affect different population groups and how fast we achieve results. Therefore, an important area of leapfrogging is strengthening the equity orientation of health system policies to leave no one behind. This can be achieved through balancing the implementation of universal strategies with a scale and intensity proportionate to the level of disadvantage. For example, universal smoking bans in public places is a best buy, but an equity-oriented approach would also focus on prioritising smoking cessation workplace interventions in low-income and less-secure areas of employment with heavily subsidised or free nicotine replacement therapy and counselling. Designing equity into public health action is a critical area of leapfrogging in health systems, particularly for NCDs. More gender-sensitive health system policies are another area where greater results can be achieved. Many of the solutions are not short term. However, there are good practices, such as creating awareness on perception of risk of CVD among women, and building capacity of providers to detect depression in men”.

Recep Akdağ agrees about the critical role of intersectoral approaches and strong public health action and he highlights the importance of better priority setting. He uses the analogy of the ‘Angry Birds mobile game’ to explain the type of approach necessary to tackle the global burden of NCDs; “you need to hit the most vulnerable spots with your resources strategically and effectively”, and gives the example of the effectiveness of mass media campaigns to try to reach the entire population.

Francesca Colombo underscores the need for “policies cutting across different sectors. A variety of policy instruments such as regulation and fiscal policies are very cost-effective (often cost-saving). Prevention is a good investment, yet prevention budgets (only 3% of total health spending) are the first thing to be cut, and policies can be hard to push through”.

Elena Andradas Aragonés highlights that leapfrogging can come from better population health management linking morbidity patterns to priority setting at regional and community level. She explains that the “National Health Services Population Stratification Project in Spain, which forms part of the implementation plan for the National Chronic Diseases Strategy – provides a technological tool for stratification by Adjusted Morbidity Groups at different levels, to be used in different regions. This facilitates the identification of the needs of each patient and, therefore, the most appropriate and efficient care plan. According to a survey of the Autonomous Communities [Regions] that have implemented it, the strategy’s success lies in its adaptability and economic advantages”. Regarding delivery of individual services, Nigel Edwards sees an important opportunity to leapfrog in the “connection of NCD care to other service and resources in their community. These changes require larger units for delivering primary care. This in turn allows more standardisation of processes and also allows for new relationships between the hospital specialists and primary care”. Another significant leapfrogging opportunity will come from “the creation of larger scale multidisciplinary team based services with a different mix of professionals. This will support a much needed, significant change – a shift from responsive to proactive models of delivery, to allow more focus
on issues beyond the biomedical”. Enis Bariş agrees, and gives the example of primary care coordination for older people with multiple morbidities. “Take older people out of the hospital. They don’t enjoy the experience. They are over-medicalised, they are over-treated, and they are subjected to hospital-acquired infections which only add to their fragility. Far too often they are automatically picked up by ambulances and taken directly to the hospital. There is therefore a role for primary care to better coordinate this, to try to reduce as much as possible their hospitalisation”. These new relationships can facilitate the re-organisation of service delivery to overcome fragmented health care services and to be more people-centred and integrated, Zoltan Voko adds.

Yet, to enable primary care to work more effectively with both public health and hospital services, a number of things are required as Francesca Colombo mentions, such as “better information systems for primary care, designing smart payment systems and better equipping health professionals with the right skills in order to meet the needs of chronic patients”.

Tom Auwers illustrates many of these points through the example of Belgium. “One out of four of our inhabitants are confronted with a chronic disease. As a government, our ambition is to guarantee that these patients get good quality care that serves their needs and allows them to continue to live in their normal environment. The most important standard for us is quality of life – and not only the quality of care. Our strategy is to reverse the so-called ‘care pyramid’: empowerment of the patient, support for informal caregivers, integrated primary care, support by secondary to primary care, and integrated financing as key concepts. We also emphasise intersectoral action: seven ministers have competencies in the area of health. Through different intermediate steps they developed and adopted a shared vision and specific actions to realise integrated care in the field. They are being implemented and evaluated as we speak”.

The role of innovative financing mechanisms supported by appropriate information systems, is also seen as an important lever for leapfrogging. Brigitte van Der Zanden points out that “the financial systems in many countries are structured in a way that the focus is on curing, rather than on preventing diseases”; “it is common knowledge that prevention is important, but the many health systems are built in a way that it is ‘gaining’ from diseases. It is not only the system that needs to change but also the perspective of everybody”. To turn this around, Enis Bariş sees the development of new payment modalities, as a way to facilitate the provision and operationalisation of high quality, people-centred integrated health care. For Pavlo Kovtonyuk, “dealing with NCDs, long-term systematic information management is vital; information has to be gathered and systematised around individual patients, and it has to include unified health and financial data across all levels of care, and care providers. Moreover, the patient has to be empowered to work with this information and to take decisions accordingly”. Veronika Laušin agrees and adds that “payments in line with the achievements of efficiency and quality, will also be an opportunity to develop better management of NCDs as well as motivation for service providers to provide better quality and more active care”.

Several respondents see information system innovations as important levers for leapfrogging as they present opportunities to strengthen primary care services, to make health systems more people-centred, and to help people live independently in their homes, amongst other things. For Itamar Grotto “the use of advanced technologies, including Big Data, computerised applications and advanced medical devices and drugs offer many opportunities in the prevention and treatment of NCDs”. Maria Chiara Corti and Francesca Colombo agree, and note that information system innovations can also offer opportunities for clinical optimisation, personal health care records, and improved disease surveillance, as well as for advancing health research. Silviya Pavlova Nikolova explains that “technological leapfrogging has provided a window of opportunity in managing diseases and is a useful tool for data-sharing and monitoring. Currently, Bulgaria only maintains a the cancer registry and not data for any other NCDs. The use of adaptive learning and personalised health applications could strengthen our efforts in prevention, data gathering and timely detection of early disease symptoms”.

Main challenges in leapfrogging

Our respondents were also asked to reflect on what they consider to be the main challenges in leap-frogging and in using innovative methods to tackle NCD mortality and morbidity.

For Katie Dain a primary challenge is NCD governance; “for implementing effective policies in the region, especially those for NCD prevention, the issue is partnerships with certain industries, in particular those for tobacco, alcohol, food and beverages, and fossil fuels. The motives of such industries are directly opposed to the goals of NCD prevention, and governments must urgently review and adopt stringent regulatory mechanisms to prevent interference in policy making by these industries that could dilute or prevent adoption of health promoting policies. Far from accelerating the NCD response, such incompatible partnerships in fact drastically undermine efforts to improve health”. Recep Akdağ on the other hand, thinks that, in the presence of necessary regulations and precautions, a nuanced relationship between governments and the private sector – if appropriately managed – could assist in creating potential opportunities to support better governance of NCD outcomes. In his opinion involving private institutions in
the battle against NCDs could help to address the commercial determinants of health and inequitable NCD outcomes and reduce exposure to harmful risk factors.

Enis Barış sees “path dependencies as the main challenge blocking us from leapfrogging. Many countries have not yet reached the ‘tipping point’ where people say we can no longer be dependent on the path we set 100 years ago. So instead, they try to improve things at the margins”.

Itamar Grotto, Enis Barış, Pavlo Kovtoniuk, Veronika Laušin, Silviya Pavlova Nikolova and Zoltan Voko also see a major challenge in resistance to change – by people (professionals and the public) and by the system itself in terms of its organisation, structure and operations. They discuss how this is exacerbated by traditionalism, the bureaucratic mechanisms that aim to protect the organisations’ status quo, the lack of autonomy in purchasing of services, and the complex legal and regulatory frameworks, as well as the fear of higher expenses related to new processes and technologies.

Another source of resistance relates to concerns about data use, which hamper progress in making health system more knowledge-based to respond to NCDs and using health data to inform effective service delivery. Francesca Colombo is convinced that “it is possible to establish national health data governance frameworks that encourage availability and use of health data to advance public policy objectives while also promoting privacy protection and data security”. Maria Chiara Corti agrees, and adds that “legislation rarely offers solutions to overcome these struggles and to support efforts to integrate health and social personal information”.

Vasile Gustiuc sees a similar problem with current health workforce competencies. Francesca Colombo agrees: “health systems are too rigid. Take health labour markets. Entry into employment is restricted through controlled access to training. Tasks are restricted according to particular employment types. There is still ample self-regulation by professions. But despite these rules, skills mismatch is high, with nurses not using the skills they have to their full ability, and many physicians reporting that they do not have the training or transversal skills to perform the tasks they have been given”. Nigel Edwards also adds the issue of “professional silos that still exist”. Furthermore, Zsuzsanna Jakab sees the gender composition of the health workforce in particular as a challenge, as well as “the lack of the right skills and tools among health care providers to address gender bias in prevention, detection and management of diseases”.

Misaligned incentives are another concern, again linked to the health systems rigidity and resistance to change. Francesca Colombo adds that “wrong incentives mean that we encourage care that reflects what providers can do, and volumes of care, not what people need and outcomes of care”. Nigel Edwards gives the example of “activity-based payment for hospitals: it reduces their incentive to support new care models and the current payment and contracting models used. There is also a concern that policy makers believe that these approaches will produce cash savings – largely through reduced hospital activity. While outcomes and productivity should improve, savings may be hard to achieve”. Zoltan Voko agrees and mentions how “careful stakeholder analysis is required to explore their roles and interests in the current system and implement the changes in such a way that the incentives motivate the majority of the stakeholders to support the developments”.

Engines of transformation

Moving forward with some of these suggestions requires complex transformative processes at local, national and regional levels, where all stakeholders work together. As such, we asked our respondents where they see the engine of transformation in their country or region, and how could this engine be strengthened to go faster and further?

Next to the WHO Health 2020 European health policy framework, which aims to support action across government and society to improve population health and well-being, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality, Zsuzsanna JAKAB sees “initiatives such as the WHO Strategy for Women’s health and wellbeing and the Men’s health initiative [both of which] provide guidance on how to make health systems gender responsive”, as being aligned and complementary to this. She emphasises that “it is important to ensure that the gender and health equity agendas do not become parallel agendas but that they are fully integrated into national priorities to reduce the burden of NCDs”.

Similarly, Elena Andradas sees a powerful engine in “the refocusing of the Spanish health system towards health promotion and prevention. The Health Promotion and Prevention Strategy provides a framework to reach this goal through interventions targeted at health professionals such as guidelines and online training so that they become active stakeholders in this paradigm shift. Secondly, the local implementation plan of the Strategy enhances the inter-sectoral approach to NCDs, facilitating the transformation of local environments with structural changes that enables citizens to make healthier choices. Bringing together different sectors whose policies impact health is a powerful driver towards health in all policies. Health Equity is also, of course, a powerhouse of this transformation. Our unstoppable efforts to guarantee health equity include training on SDH,
equity, participation or intersectorality and tools such as national guidelines for integrating equity into health strategies, programmes and activities or WHO’s Innov8 for reviewing national health programmes to leave no one behind”.

Katie Dain adds that “while the impact of NCDs is observed in the health sector, these diseases have their roots across multiple sectors while solutions can be accelerated through partnership with the technology sector in particular. As such, governance structures are needed which enhance dialogue and allow collaborative exchange of expertise. Furthermore, actors outside government, including civil society, academia, and people living with NCDs, have unique and valuable competencies which can complement and strengthen government action on NCDs. A whole of government, whole of society approach can be facilitated through establishment of National NCD Commissions”. Furthermore, she adds that “change can often be effected much more rapidly at the municipal level. Urbanisation, while presenting a number of challenges, can also represent an opportunity for focused and dynamic change which can subsequently be scaled up across neighbouring cities”.

Several respondents also see patient involvement, citizen engagement and empowerment as important ways to support ‘whole of society’ approaches, and to deliver integrated people-centred care. For example for Silviya Pavlova Nikolova “the key word is engagement. Engaging patients in their own health prevention and treatment process”; Veronika Laušin also sees “knowledge and education for the whole population on the importance of prevention related to the empowerment of individuals”; and Tom Auwers mentions that these principles were a key part of the Belgium health care reform.

Moreover, cooperation agreements, governance reform and institutional alignments, as well as comprehensive change management strategies and appropriate leadership, are also all seen as strong engines of transformation by a number of respondents. For example, for Pavlo Kovtoniuk “expertise and financial support work best if they are concentrated around ‘agents of change’. Most transformations need strong political will and a powerful demand side”.

Zoltan Voko highlights that “the current small engines are local initiatives. Therefore, supporting them by increasing their visibility and technical support for example, could also help the transformation”. For Brigitte van Der Zanden “there is not only one engine for making change happen; it is a process that is maybe started by regional government but must be carried by four groups of stakeholders: citizens, government, health providers and knowledge institutes. Only when all these stakeholders are on board might there be a chance to be able to realise the complex transformation process, and the more everybody embraces this innovative way of thinking the faster it goes”.

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