**Improving efficiency in health systems**

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It is a challenge to ensure adequate, equitable and sustainable funding and provide effective financial risk protection if health systems function inefficiently. Health system inefficiencies not only limit additional resources needed for health, but also limit the potential benefits from available resources, if they are wasted. The World Health Report 2010 highlighted ten leading sources of inefficiency which represents broad categories of problems. It suggested that countries need to address the specific manifestations of inefficiencies in their health systems to move towards universal health coverage. Currently, there is little documented experience and evidence with efficiency-oriented reforms especially in low and middle income countries although many health reforms aimed to address inefficiencies in their health systems.

Introduction by Prof Winnie Yip, Oxford University

China – successful expansion of insurance coverage last 8 years, but utilization rates of outpatient services flat; while hospital admissions rising especially tertiary hospitals with rising cost per patient. Good use of $?

India JSY – CCT successfully increases institutional deliveries, but MMR and IMR are flat. Good use of $?

Efficiency strategy of clinical protocols – not adapted without other interventions that address incentives

South Africa - Mrs Fatima Suleman, Associate Professor, Pharmaceutical Sciences, University of KwaZulu-Natal, South Africa

Updating of essential medicine list based on standard tx guidelines for PHC, pediatric, adult

Updated list is used to change procurement

Happening in the context of effort to strengthen PHC which faced resistance

Lessons: establish M&E from beginning; be transparent, allow peer review from many groups; require evidence to justify changes to essential medicine list; use evidence; align updating with procurement cycle

Dr Abebe Alebachew, Breakthrough International Consultancy, Ethiopia

Drivers: need to increase access and meet MDG goals because most of the supply was urban curative care; Ethiopia set ambitious goals for health post and clinics per population levels;

HR deficit so large that conventional training approaches would not work

Strategy: quick training; train mid-level to be GPs (task shifting), flood the market with nurses, midwives;

Results: universal coverage of all kebels 16k; HEPs, 3000 health centers; # of HCs; # of medical schools for GPs;

Lessons: 1. start bottom-up (PHC to curative); HR reforms must be sequenced and takes several years

2. To change outcomes, you need to know burden of disease – HEW package contextualized to 3 environments (agrarian, pastoral, urban) to be efficient and define training requirements

3. HEWs selected by the community, salaried civil servants (voluntary doesn’t work). He doesn’t think output-based payment would work.

4. Efficiency gains and improved outcomes due to shift to PHC and use of low cost HRH; shift estimated to save $20M per year in salary costs

5. Political commitment and multi-ministerial action critical.

Why 2 HEWs per post? 2 needed for intense training of each household in health promotion and prevention skills, very labor intensive.

Prof Soonman Kwon, Seoul National University, Korea

Merger of statutory funds into national HI agency in 2011

History of incremental but fragmented insurance schemes. 350 funds for 3 populations: formal sector workers, self-employed farmers and urban, public sector workers

Hospital sector is mostly private and still paid FFS so OOP expenses rising despite reforms due to provider-induced demand

Panel consensus that success in making PHC free (almost free) leads to consumers using the savings to spend more on hospital, tertiary services and brand name medicines due to misguided perceptions of quality and provider induced demand. This is why OOP may not decline. Solution is consumer education regarding quality and provider payment reforms.