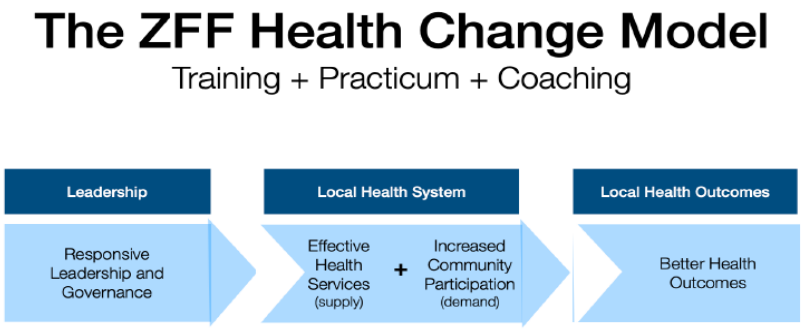
January 31, 2022

Improving the Health Change Model to Improve Local Health System and Health outcomes

Background

The ZFF Health Change Model (HCM) states that for the poor to have better health outcomes, they must be able to access quality health services brought about by a responsive health system which in turn was developed or strengthened by committed local leadership. The model was a product of consolidating various researches including case studies of the late Sonia Lorenzo of San Isidro, Nueva Ecija, who as mayor ensured access to good health facilities and services for her constituents and of a municipal health officer in Gattaran, Cagayan Province, who kept maternal deaths at zero for ten straight years, from 1998 to 2008. Given the vision of the Foundation to improve the health outcomes of the poor, the intervention focused on improving local health services since these are the services easily accessed by the poor. Moreover, it was strategic as well to work with mayors and municipal health officers responsible who have the mandate and resources to provide primary care (1).

Figure 1. The ZFF Health Change Model v. 1



Prototyping, scaling up, and results

From 2009-2013, the HCM was prototyped in 9 cohorts of health leaders in 72 municipalities. A health system roadmap consisting of the WHO 6 building blocks of the health system was used as a guide to fix the system with maternal and child health outcomes as the expected result of the intervention. To improve the health leadership, the mayors and their MHOs were trained and coached in BL. Application of BL was done in fixing the health system as the leaders mobilized stakeholders who can improve the

various building blocks of the health system. In general, it was observed that there were system improvements such as functional health boards, an increase in the health budget, and accreditation of facilities. There was also improvement in selected maternal health indicators (decreasing maternal deaths and increasing facility-based deliveries). The relative success of the intervention led to the scale-up of the HCM through a partnership with the Department of Health in 2013 and donor agencies such as UNFPA, UNICEF, and USAID as well as academic institutions. The area of intervention now also expanded to include not only municipalities but provinces and cities as well as DOH regional offices. The latter was accomplished through the Health Leadership and Governance Program. A formative evaluation of the HLGP showed there was an improvement in bridging leadership competencies among participants but there were no significant differences between the HLGP municipalities and the non-HLGP municipalities in terms of health output, health outcome, MMR, and IMR. This however may be attributed to the relatively early timing of the evaluation (2). There was no end of program evaluation conducted for the HLGP to offer new findings. An end of program evaluation, however, was conducted for IHLGP – a program with the USAID which aimed to institutionalize HLGP in the regions and provinces. It stated that IHLGP–supported provinces and cities generally improved their maternal health outcomes, wasting and stunting, and TB treatment success rate as shown in the proceeding pages. The study also showed improvement at the leadership and system-level which allowed various stakeholders to collaborate in addressing various health challenges and was deemed beneficial during the early days of the COVID 19 pandemic (3).

Limitations of the HCM

While there is general agreement among ZFF and stakeholders that the implementation of the HCM was able to contribute to the improvement of health outcomes, health system, and leadership competencies, the improvement of health outcomes was deemed slow and that gains made during the run of the ZFF programs may not be sustained. In the BOT meeting in May 2021, the BOT raised the concern that ZFF interventions are not achieving outcomes fast enough. The BOT suggested the provision of tangible inputs such as infrastructures and commodities to hasten the results. This insight is supported by the IHLGP end of program evaluation finding which showed for example that tuberculosis continued to be a public health concern in the IHLGP sites and attributed this to “low performance in case detection rate (CDR) to system problems such as 1) lack of medical technologists, 2) absence of or nonfunctioning remote smearing sites, 3) shortage of capable case finders, 4) non-accreditation of some health facilities due to their failure to comply with the requirements, and 5) challenges related to the availability of data.” The experience in PLGP Cycle 1 also showed that provinces would benefit from tangible inputs such as OB-Gyne specialists, maternal waiting homes, equipment, and facilities required for hospital accreditation. These may be outside of the planned LGU budget, the lack of which delay access to services and consequently health outcome improvement. The LGU may also have the budget for these but there may be few specialist applicants for example. A fast way of determining what tangible inputs are needed by partner LGUs is to look at the workshop outputs of their Local Investment Plans for Health planning and see which of the items have not been included in the final plan due to lack of budget, are to be funded by the LGU themselves but on a later year, or those items with the non-LGU funding source. These are the items that can benefit from resources from other partners.

Other limitations that may be worth looking into within the HCM but may be outside of tangible inputs are the leadership interventions provided to the participants (quality, mode of delivery) as well as policies that can constrain the health system. For example, in most hospitals in the PLGP, it was observed that shifting to the consignment of medicines addressed stock out since the hospitals were not encumbered by the delays of LGU procurement which was the normal course for getting medicines in the hospital.

Finally, an obvious limitation of the HCM in terms of achieving health outcomes faster is the lack of inclusion of the social determinants of health and community participation in the framework. In the HCM, the improved leadership only acts on the health system but not on the other determinants of health which may in the long run influence people's adoption of healthy behaviors (eg. high vaccination coverage among children of highly educated women vs. those with low education), and access to health care. The community as partners for health and households as centers of health and well-being have not been explored fully in the HCM. The COVID 19 experience shows that the community can be mobilized to support the health care delivery system (eg. BHERTs are being trained as contact tracers, community members organizing community pantries).

These and other limitations in the HCM prompted the review and revision of the model to improve the model so that its operationalization can lead to faster and better health outcomes.

Process for the review and revision of the HCM

The health change model was reviewed and revised through a series of consultations with ZFF management and staff including incorporation into the model various lessons learned from program implementation and review of relevant literature. The consultations include senior leadership meetings, learning management committee meetings, executive committee meetings, and partnerships meetings. A second version of the HCM was developed from the review of reports from selected concluded programs[1] and input from senior leadership meetings. This second version was then vetted in the learning management committee, executive committee, and partnerships meeting. The third revision of the HCM is the current final version of the model.

This third version is a combination of components that have been repeatedly observed to contribute to better health systems and better health outcomes such as the role of leadership as well as components from emerging lessons from the field and inputs from management such as strategic partnerships in health including inter-sectoral collaboration for social determinants of health and provision of tangible inputs. The discussion below aims to describe the revised HCM and illustrate how these revisions will contribute to better health outcomes.

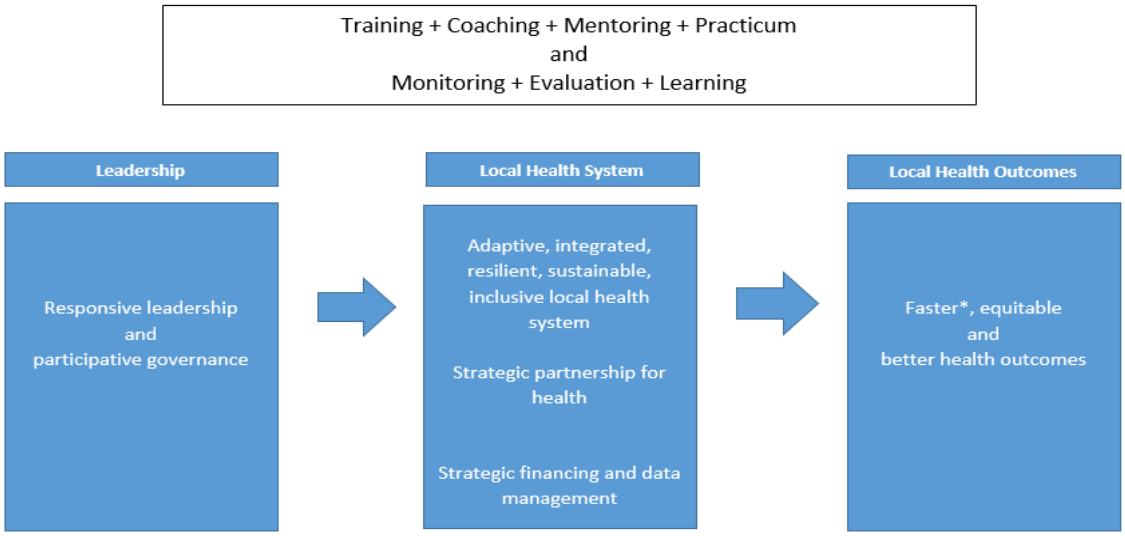
Operationalization of the HCM will be discussed in another document, Guide to Implementing the Revised HCM. This document draws its recommendations from the lessons learned from program implementation and other relevant literature.

[1] PLGP Cycle 1, PLGP Cycle 2, IHLGP, and CNGP

Describing the revised HCM and its contribution to improved health outcomes

The revised ZFF HCM is shown in Figure 2. The HCM is composed of four main components – the ZFF interventions, the desired state of leadership, the desired state of the local health system, and the desired state of local health outcomes.

Figure 2. The revised ZFF Health Change Model



The ZFF Health Change Model shows how faster, equitable, and better health outcomes can be achieved through an improved health system which is brought about by improved local leadership. Key changes from the first version of the model are: for ZFF interventions, the presence of mentoring and monitoring, evaluation, and learning; for leadership, the presence of participative governance; for the local health system, the emphasis on the characteristics of a desirable health system and emphasis on partnerships, financing and data management. These changes to the HCM are expected to contribute not only to better health outcomes (as shown in the first version of the model) but to better health outcomes that are attained faster and are more equitable.

ZFF interventions

In the new model, ZFF's interventions are composed of training, coaching, mentoring, and practicum and monitoring, evaluation, and learning. These interventions are directed at local leaders which may be composed of local chief executives, health officers, community leaders, among others. The leadership framework is Bridging Leadership (BL) with the development and effective use of BL competencies as

evidence of responsive leadership. Although BL is still the main leadership framework, not labeling the desired leadership as BL also allows ZFF room to explore in the future other frameworks outside of BL that may contribute to significant improvements in the health system. Mentoring was emphasized as a ZFF intervention to acknowledge the experience that leaders appreciate the presence of mentors who can directly share their knowledge rather than drawing the learning from the leaders. This is especially true in addressing technical issues such as COVID 19 response. Monitoring, evaluation, and learning before, during, and after program implementation are also emphasized. This highlights the need to measure the effects of ZFF interventions and make necessary adjustments that can further improve or hasten the leadership competencies of local leaders and their capacity to improve their health systems.

Leadership

Responsive leadership refers to the practice of bridging leadership wherein a leader such as the local chief executive, exercises ownership of the health challenge and response, co-owns these with relevant stakeholders, and co-creates institutional arrangements for a better health system that produces responsive programs and ultimately health equity. *Participative governance* acknowledges the essential role of people from all walks of life as collaborators together with leaders and expert in deliberation and decision making processes that can improve the health system and not as mere beneficiaries of the health system. Participatory spaces must be set up and maintained and there should be long term government support because skills for participation take time to build. Lastly, trust between leaders and the community should be established to encourage participation (4). Participatory governance is aligned to the primary health care approach of "empowering individuals, families, and communities to take charge of their health." The PHC has long been recognized by the WHO as one of the approaches to achieve UHC and community participation is one of the three inter-related components of PHC that can help achieve universal health coverage or UHC[2] (5) . This implies that ZFF programs should give significant emphasis on improving the capacity of communities or their leaders or representatives to effectively participate in local health governance and that the investment should be sustained because participatory skills especially of those with less power take time to develop.

Local health system

To improve local health outcomes, leaders who have undergone ZFF interventions need to develop the desired local health system. This local health system is integrated, resilient, inclusive, sustainable and adaptive. In this local health system, strategic partnerships for health and strategic financing and data management are effectively implemented. In contrast, the first version of the model only emphasized effective health services (supply) and community participation (demand). The description and importance of these additional components to the desired health outcomes are emphasized in the discussion below.

[2] "PHC entails three inter-related and synergistic components, including: comprehensive integrated health services that embrace primary care as well as public health goods and functions as central pieces; multi-sectoral policies and actions to address the upstream and wider determinants of health; and engaging and empowering individuals, families, and communities for increased social participation and enhanced self-care and self-reliance in health." (WHO, 2021). Primary care and multi-sectoral policies and actions are tackled in the local health system part of the model.

Fragmentation in governance, service delivery, and financing is recognized as one of the causes of health inequities, and a move towards integration of the system will address this (6). An *integrated health system* particularly in relation to the Universal Health Care law is at the minimum, characterized by managerial, technical, and financial integration. Managerial integration refers to the integration of the health system resources (eg. health human resources, health finances, health information) while technical integration refers to the integration of health services from primary care and to tertiary care services across different levels of facilities and care settings (7). This implies both vertical (from a lower level facility to a higher level facility) and horizontal integration (integrating complementary services in one facility or referral to the same level of a facility). For example, infant and child nutrition services may be integrated at the primary care level along with the program vaccination of infants and young children. Minimum characteristics of managerial and technical integration are local ordinances on integration, unified governance of the local health systems, integrated management system (eg. on health financing), functional referral system, functional disaster risk reduction, and management for health (DRRMH) system, functional epidemiologic surveillance system, and proactive health promotion program and campaigns. Financial integration is the "consolidation of financial resources exclusively for health services and health system development under a single planning and investment strategy by the P/CWHS, i.e. LIPH and AOP." Minimum characteristics of financial integration are the creation of a special health fund, health board resolution on SHF budget and allocation, and funds exclusively used for health services and health system development.

Health system resilience refers to the "ability of a system, community or society exposed to hazards to resist, absorb, accommodate, adapt to, transform and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions through risk management" (8). This also implies the capacity of the system to provide uninterrupted essential health services during a crisis (9). The lack of resilience of the health system can mean interrupted, delayed, or inequitable access to services as may be experienced during natural disasters and the COVID 19 pandemic.

To ensure health equity, the system also has to be inclusive. An *inclusive health system* does not discriminate in terms of access to services or participation to any population group regardless of gender, age, income class, among others. To do this, the system has to take a rights-based approach to health wherein policies and programs prioritize those that may have difficulty in accessing services or engaging in meaningful participation (ie. in all phases of programming: assessment, analysis, planning, implementation, monitoring, and evaluation) (10).

A sustainable health system refers to the ability of the system to continuously produce. better health outcomes even after ZFF interventions and even after the term of the. It is the "ongoing delivery of health programmes, which may be measured by the longevity of independent projects, or how well programmes become institutionalised in organisations or health and social systems." (11). However, there are limits to the concept of sustainability that can hinder leaders to seek alternative solutions and opt for the status quo even if these are no anymore relevant. It is suggested that sustainability be combined with other evaluative criteria such as effectiveness, equity, etc. to inform health care policy and planning.

Lastly, the health system has to be *adaptive* in which it is capable of gathering information or feedback from its internal components (eg. feedback from services) and external environment (eg. influence of political alliances in access of LGU to resources) and developing appropriate response to attain system objectives (12). The system should be able to seek alternate programs which require the system to continuously evaluate and evolve programs and interventions. (13). The need for the system to adapt given a dynamic environment has been made more apparent during this time of the pandemic.

Strategic partnerships for health refers to the purposive engagement of partners by local governments so that resources are mobilized for priority issues particularly those requiring resources outside the capacity of the LGU to provide. The LGU can use its limited resources as leverage for partnerships. It could also be that the LGU can finance the programs or projects but is constrained by current LGU policies and processes. Included in these resources are non-technical assistance types of resources such as grants for or actual facilities, commodities, equipment which are also referred to in ZFF discussions as tangible inputs. These tangible inputs are not explicitly mentioned in the previous HCM and are expected to hasten the delivery of services and therefore contribute to attaining better health outcomes faster. The partners may be other government agencies, private companies, NGOs, donor agencies, among others. These partnerships encompass inter-sectoral collaboration on specific issues to address social and other determinants of health (12). As discussed, addressing social determinants of health will in the long run contribute significantly to better health outcomes.

Strategic financing refers to the deliberate use of financial resources to bring about improvement in the health system to attain better health outcomes (12). This component still covers the core functions of health financing system block which are 1) revenue raising (sources of funds, including government budgets, compulsory or voluntary prepaid insurance schemes, direct out-of-pocket payments by users, and external aid) 2) pooling of funds (the accumulation of prepaid funds on behalf of some or all of the population), and 3) purchasing of services (the payment or allocation of resources to health service providers with strategic purchasing referring to purchasing decisions on information about provider behavior and population health needs to maximize health system goals) (14) (15). The term strategic financing is adopted to emphasize the need to ensure that the programs budgeted by the LGU are based on evidence and that the LGU is able to maximize available budget sources for these programs.

Data management refers to the system of gathering relevant information and using this information to make an informed decision about the health system. This is being emphasized in the HCM because quality information, upon which major decisions on strategies and financing are based, has been a common weakness among partner local government units (12).

Local health outcomes

With the implementation of the HCM, local health outcomes are expected to become better, be achieved faster, and be more equitable. Better health outcomes refer to the improvement of outcomes from baseline measurement. On the other hand, faster attainment of health outcomes may refer to any of the

following: that the local health outcomes are better than the national average; better than the outcomes of comparable LGUs; or better than the projected outcome. The finalization of the guideline on ZFF evaluation methodologies can help ZFF decide which definition/description to adopt. Lastly, health outcomes should also be equitable. Health inequities are differences in health status or the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work, and age (15). At present, the health outcomes identified by ZFF at the institutional level are a combination of the approved 2021 institutional indicators and additional indicators proposed during the workshop. These are maternal and child health (maternal mortality, infant mortality, facility-based delivery, skilled birth attendant, fully immunized child), nutrition (stunting prevalence, wasting prevalence), adolescent sexual and reproductive health (modern CPR and adolescent birth rate), infectious diseases (TB and HIV indicators), non-communicable diseases (hypertension and diabetes mellitus indicators), and LGU priority outcomes. These indicators may be finalized by ZFF in 2022.

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