Towards the Triple Aim of *Better Health*, *Better Care* and *Better Value* Community Health Workforce, a Health Systems Approach

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From Alma Ata to the SDGs …

The Approach

- Goals and results driven
- Based on Values and Principles
- Informed by the best evidence available

17 Sustainable Development Goals

*Acknowledging that the United Nations Framework Convention on Climate Change is the primary international, intergovernmental forum for negotiating the global response to climate change.

Better Health: Targets for Goal 3 Ensure healthy lives and promote well-being for all at all ages

1. By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
2. By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
3. By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
4. By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
5. Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

Targets for Goal 3 Ensure healthy lives and promote well-being for all at all ages …

6. By 2020, halve the number of global deaths and injuries from road traffic accidents
7. By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
8. ***Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all***
9. By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

Targets for Goal 3. Ensure healthy lives and promote well-being for all at all ages …

a) Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate

b) Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

c) Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

d) Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

The first 3 targets: profound health determinants

- 4.1 By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes
- 4.2 By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education
- 4.3 By 2030, ensure equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university

An Approach Based on Principle of ***Equity*** towards Universal Access and Coverage

- Address geographic access: effective measures exist and must be implemented for optimal geographic distribution of health workforce
- Financial access: ideally government as single payer
- Socio-cultural access: minorities and marginalized groups
- Gender equality


... SO, WHAT IS THE DIFFERENCE BETWEEN A GP AND AN NP?
... FOR ONE, LEGIBLE HANDWRITING
NURSE PRACTITIONER
℞

Myth: seeing a nurse practitioner instead of a doctor is second-class care

The need for solid evidence base!!

SPECIAL ARTICLE

THE BURLINGTON RANDOMIZED TRIAL OF THE NURSE PRACTITIONER

WALTER O. SPITZER, M.D., M.H.A., M.P.H., DAVID L. SACKETT, M.D., M.Sc. EPID., JOHN C. SIBLEY, M.D., F.R.C.P. (C), M.R.C.P., ROBIN S. ROBERTS, M. TECH., MICHAEL GENT, M.Sc., DOROTHY J. KERGIN, R.N., PH.D., BRENDA C. HACKETT, B.A., AND ANTHONY OLYNICH, C.A.

In Collaboration with W. I. Hay, M.B., B.S., G. Lefroy, R.N., G. Sweeny, M.D., C.M., I. Vandervlist, R.N., H.S. Nielsen, M.D., E. V. MacKrell, M.B., N. Prowse, R.N., A. Brame, R.N., E. Fedor, R.N., B.A., and K. Wright, B.N.

Abstract From July, 1971, to July, 1972, in a large suburban Ontario practice of two family physicians, a randomized controlled trial was conducted to assess the effects of substituting nurse practitioners for physicians in primary-care practice.

Before and after the trial, the health status of patients who received conventional care from family physicians was compared with the status of those who received care mainly from nurse practitioners. Both groups of patients had a similar mortality experience, and no differences were found in physical functional capacity, social function or emotional function. The quality of care rendered to the two groups seemed similar, as assessed by a quantitative "indicator-condition" approach. Satisfaction was high among both patients and professional personnel. Although cost effective from society's point of view, the new method of primary care was not financially profitable to doctors because of current restrictions on reimbursement for the nurse-practitioner services. (N Engl J Med 290:251-256, 1974)

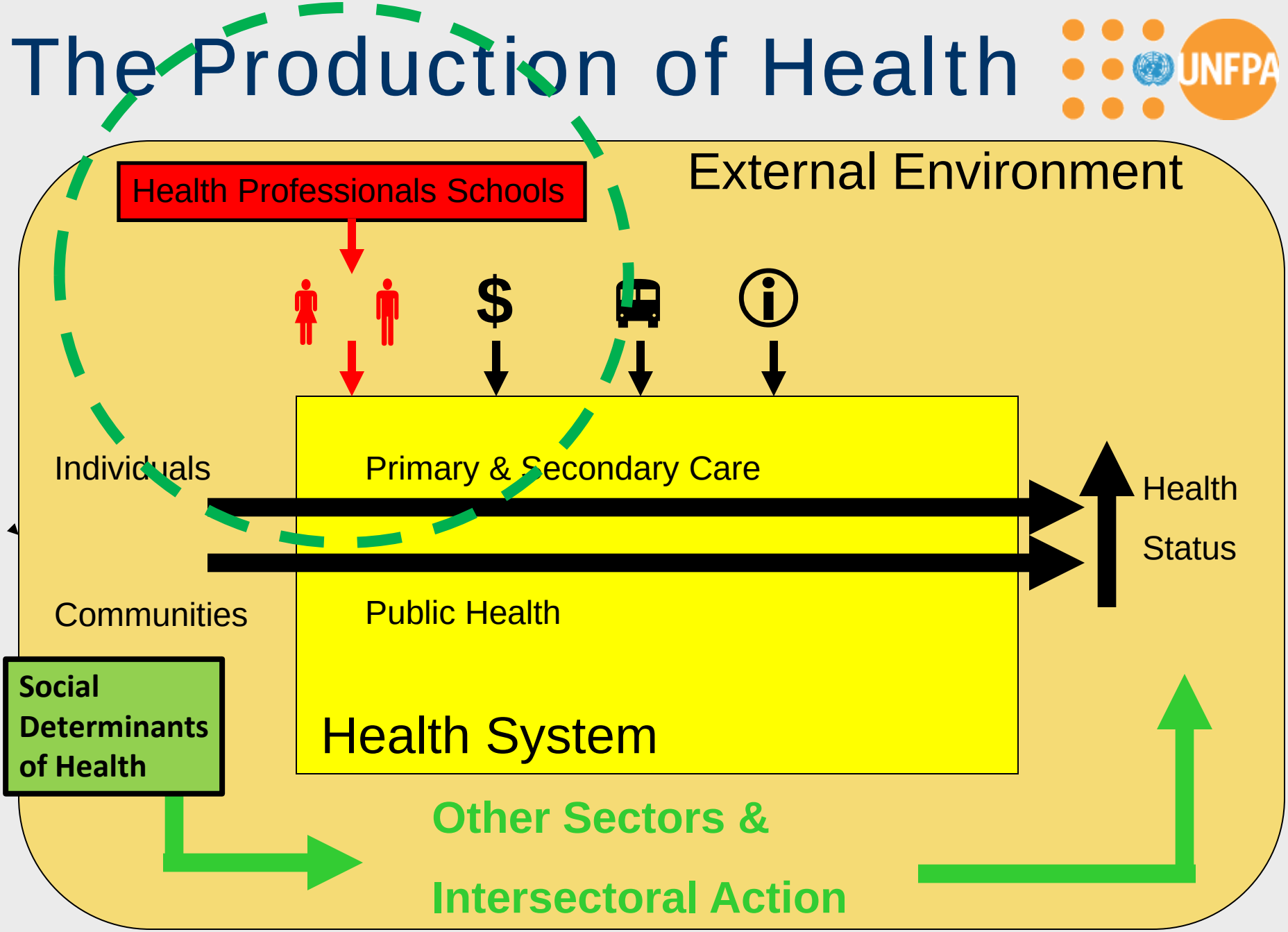
> 40 years!!

2017 … !!

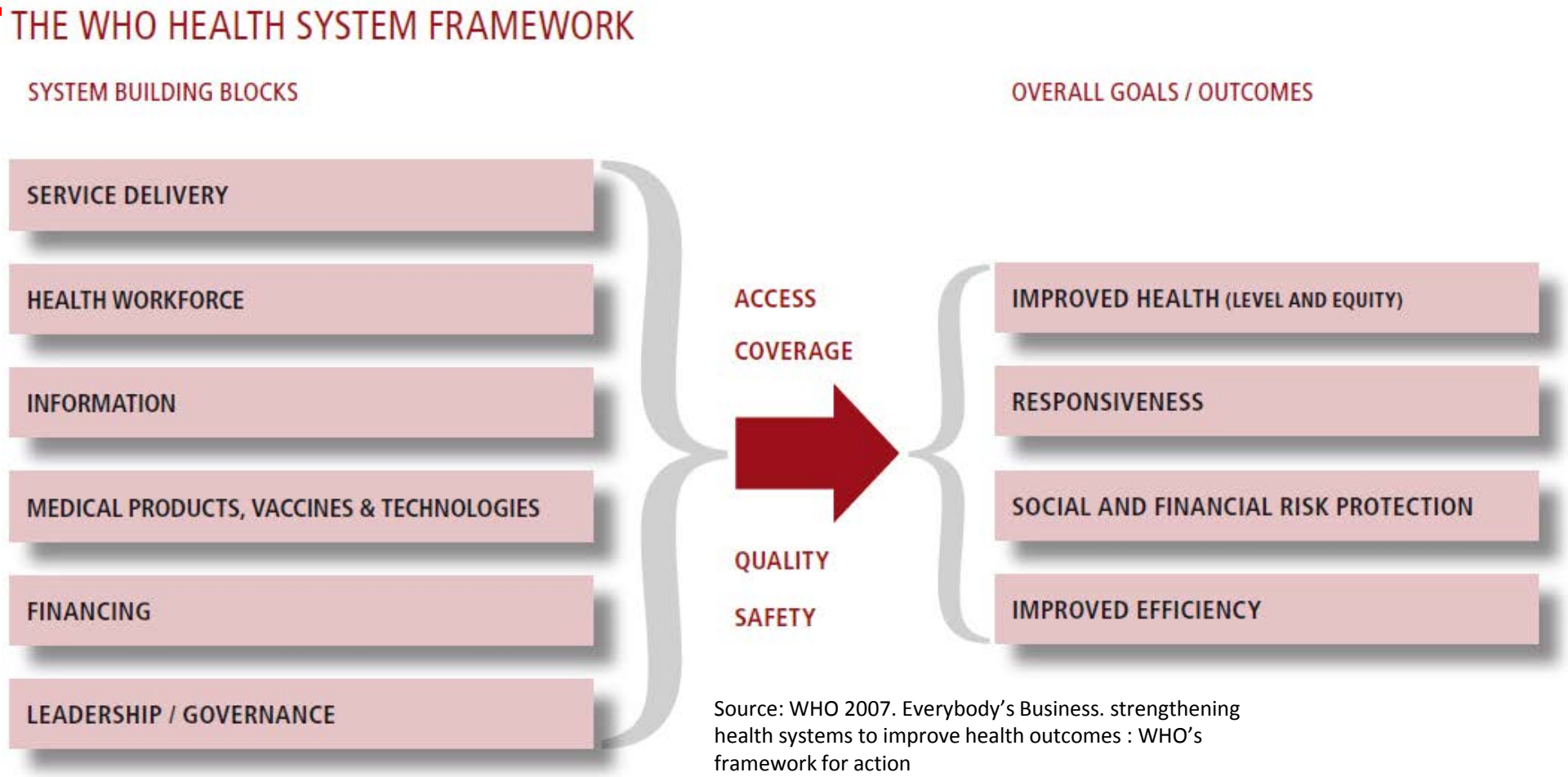
Achieving Health Impact through Four Complementary Approaches

- Empowered individuals and families leading their own health destiny (*Education Goal: SDG4*)
- Quality primary care (referral to secondary and tertiary care when needed)
- Public health
- Whole-of-government intersectoral action for health to address the social determinants of health

The Production of Health

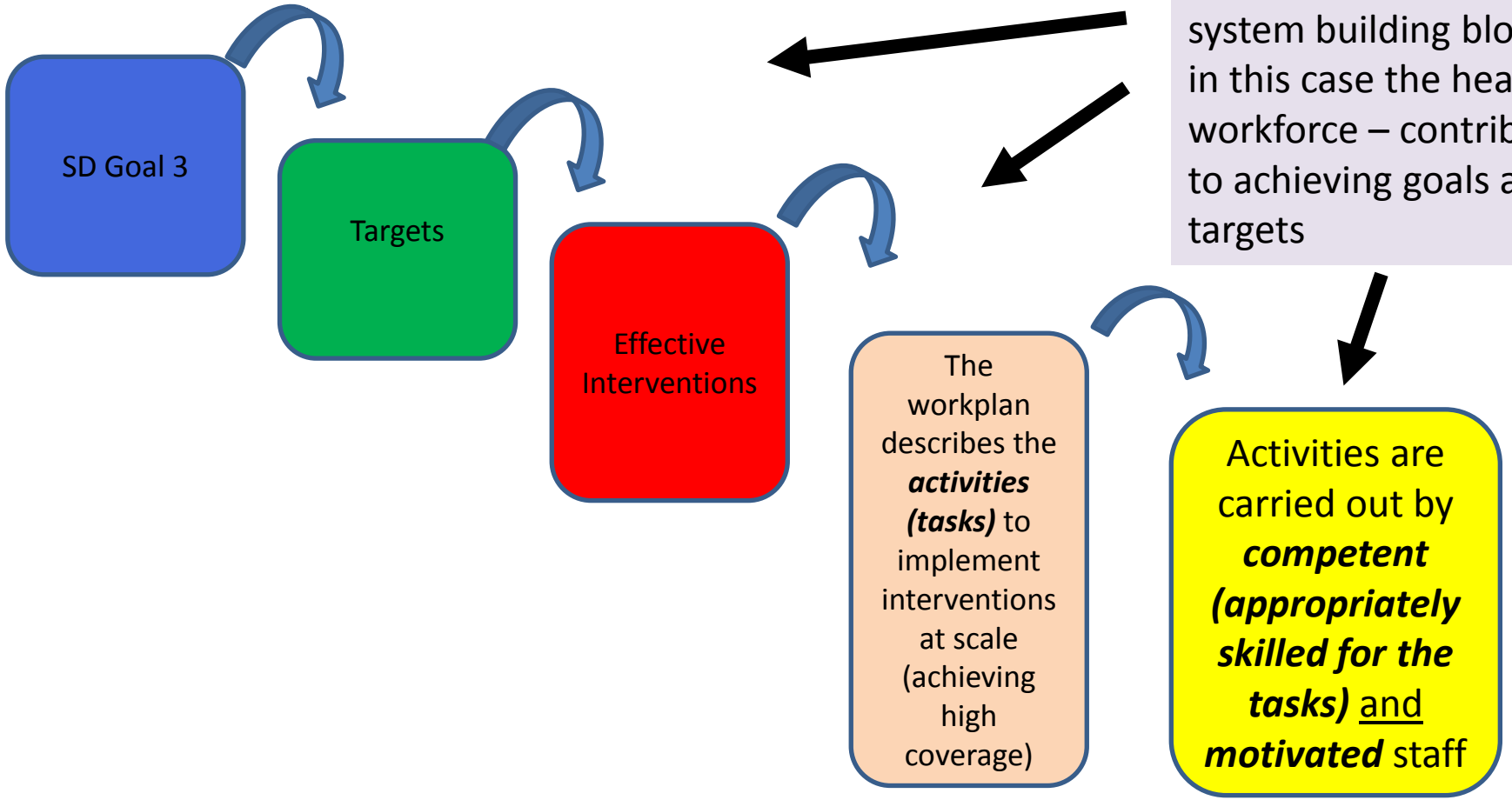


Scaling-up for sustained impact and resilient health systems



Source: WHO 2007. Everybody's Business. strengthening health systems to improve health outcomes : WHO's framework for action

Activities are carried out by *competent (skilled)* and *motivated* staff



Ensuring Emergency Obstetric and Newborn Care for all who need it: towards Quality Facility Deliveries, providing highly cost-effective life-saving interventions

PRIMARY HEALTH FACILITY

BASIC

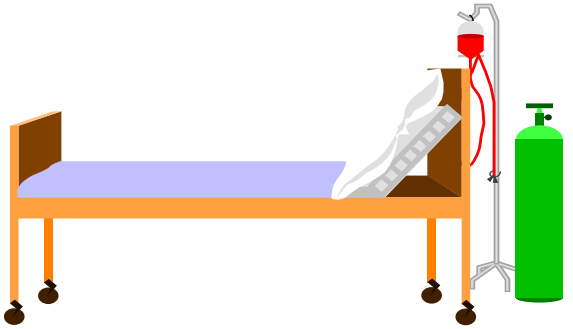
- Antibiotics IV
- Oxytocics IV
- Anticonvulsivant
- Manual removal of placenta
- Post abortion care (MVA)
- Assisted vaginal delivery (vacuum extraction)
- Newborn care

DISTRICT HOSPITAL

COMPREHENSIVE

all Basics plus:

- Surgery (caesarean -section)
- Blood transfusion
- Care to the sick and Low Birth Weight newborns



What are the skills required???

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Skills required to deliver Emergency Obstetric and Newborn Care for all who need it: providing highly cost-effective life-saving interventions through appropriately skilled health workers

PRIMARY HEALTH FACILITY

BASIC

*** • Antibiotics IV

*** • Oxytocics IV

*** • Anticonvulsivant

*** • Manual removal of placenta

*** • Post abortion care (MVA)

*** • Assisted vaginal delivery (vacuum extraction)

*** • Newborn care

DISTRICT HOSPITAL

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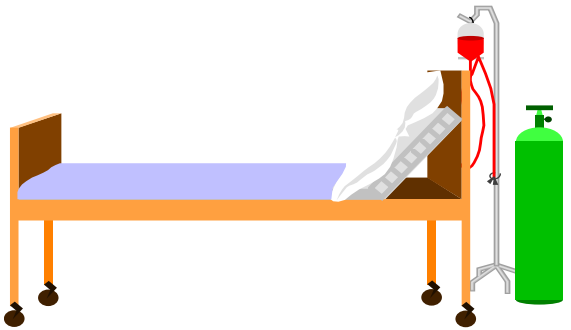


*** What *skills* are needed for each set of *tasks* (*functions*)???

McGill

Skills required to deliver Emergency Obstetric and Newborn Care for all who need it: providing highly cost-effective life-saving interventions through appropriately skilled health workers

PRIMARY HEALTH FACILITY

BASIC

- M, N • Antibiotics IV
- M, N • Oxytocics IV
- M, N • Anticonvulsivant
- M, M • Manual removal of placenta
- M, M • Post abortion care (MVA)
- M, M • Assisted vaginal delivery (vacuum extraction)
- M, M • Newborn care

DISTRICT HOSPITAL

COMPREHENSIVE

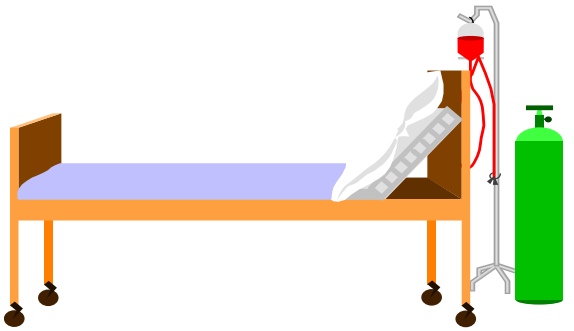
all Basics plus:

- M, S • Surgery (caesarean -section)
- M, M • Blood transfusion
- P, N+P • Care to the sick and Low Birth Weight newborns

*** What *skills* are needed for each set of *tasks* (*functions*)???

Skills for:
Decision, *Execution*

M = Midwifery skills
N = Nursing skills
S = Surgical skills
P = Physician skills



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Use the staff with the appropriate level of skills: *required skills for the tasks/functions*

High

Low

Skill level

Too skilled: boring, inefficient, expensive

Skilled just right (even for emergencies): job satisfaction, effective and efficient

Not skilled enough for the set of tasks/functions requested: danger! scary job, will lead to increased mortality and morbidity

Better Value.
Staff should work at the:

« top of licensure »

Human Resources for Quality PHC in Health Centres / Family Health Teams

Universal access and coverage – each citizen is *attached* to a competent and motivated member of a PHC team member:

- Community Health Workers
- Nursing Assistants
- Nurses, Nurse Practioners
- Family Phyisicians
- Social workers
- Receptionists and support staff
- … practising at « top of licensure »

Two Examples of Effective, Well Documented Community Health Worker Programmes

- Brazil's Family Health Strategy (see work of Group 4 led by Renato Tasca)
- Ethiopia's Health Extension Worker Program led by Tedros Adhanom Ghebreyesus

The five « S » of an Effective Community Health Worker Workforce

- **S**killed (Ethiopia: young women, 2 years of high school, 1 year skills- and module-based vocational training)
- **S**alaried
- **S**upervized
- **S**upplied
- **S**caled-up in numbers to cover the entire population (Ethiopia ~40,000 for 80 million people at the time)

Gross Underutilization of Nurses and Nurse Practitioners

- Medico-centric world with deep underappreciation of role of nurses and nurse practioners despite evidence
- Different skill set (including caring) and much better value when practising at « top of licensure »
- Critical importance for home care, decreasing recourse to hospital care

The Role of Family Medicine Training

- Learning in community settings
- Skilled for work with families, communities
- Better appreciation of clinical prevention / public health
- Learning of longitudinal care and integration / coordination of care with relevant specialists as needed (chronic care …)
- Appreciation of “Chronic Disease Self-Management”, web-based self-care resources, patient support groups, etc.
- Provinces in Canada are moving towards requirement for 2-year residency program and family medicine examination as requirement for primary care practice
- Gaining momentum in USA, Brazil, …

Engagement for Health at All Levels

- Individuals … leading their health destiny
- Household production of health: families, care-givers
- Municipalities
- Districts / Regions
- Provinces / States
- National Level

- Public Health Teams*
- Intersectoral Action through Whole of Government Approach

Skills of Public Health Teams in District / Regional health authorities

- Epidemiology
- Public health
- Program management
- Health promotion: behavior / social change communication; media and social media; work with civil society / virtual communities
- Work with municipalities for intersectoral action

Population size of districts / regions:
~ 100,000 – 1 million

Paradigm Shift: from hospital-centric episodic care towards evidence-informed population-based primary and community care with modern family health teams

- In order to effect this Paradigm Shift, all health resources should be under *one regional/district health authority*
- Key functions:
  - Populaton-based financing (PHC and hospitals)
  - Health situation analysis
  - Regional service delivery plans with focus on PHC through family health teams
  - Public health
  - Implementation of national electronic health records / HMIS
  - Engage with communities, municipalities and civil society for intersectoral action and work on social determinants

Source: Bergevin et al. Healthcare Papers 2016

National Human Resource Planning

- Decide which categories of health workers are needed / licensed in your country
- Have a clear service delivery plan for each district / region for the country/province
- Sum up these plans
- Assess current stock and desired stock
- Calculate current/realistic outflows and required inflows
- Assess impact on required outputs and changes to schools of health professionals
- Take production time / size of programs into account (CHW = 1y, nurse = 3y, FP =6y)
- Have a robust consultative process in place with districts/regions, training schools, professional associations, etc.
- Ensure appropriate incentives ("carrots" with as few "sticks" as possible/realistic) and performance drivers (session of 26 February on High Performing Health Systems)
- Implement, monitor and be prepared to problem-solve along the way

In most countries, Human Resources for Health represent > 50% of the health budget!

Can we contribute to a Paradigm Shift towards evidence-informed population-based primary and community care with modern family health teams?