HSR and national health system and policy development

From KT to Learning: The need for GKmP

Somsak Chunharas
Secretary general
National Health Foundation
Thailand

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Is there a place for HSR in national HSPD?

It depends........

What we mean by HSR?

What types of issues we are facing?

What knowledge is already there

What context we are in?
Habit 2: Begins with the end in mind
There is definitely a place for HSR in HSD.

The issue is how do we make it so

Need to look at HSR in the larger context of

Knowledge and knowledge management
(and KT as a subset of KM)
3 Major Policies

• Integrated health system
• PHC
• Universal coverage
• Sources of knowledge to guide policy decisions
  – International/external studies/experiences
  – WHO resolutions (with or without research backup)
  – Internal/domestic studies/experiences
Integrated health system

• Established in 1974 - significant organizational reform of MOPH
• Initiated by minister of health
• No prior research done nor reviewing experiences from other countries reviewed nor guided by WHO resolution
• Key source of “knowledge” = personal experiences leading to fear of curative bias + belief in theoretical knowledge about integrated and comprehensive health care system
• Debate at the international level still unsettled
• Modifying and adding new feature – Provincial health office (PHO), Community hospital and DHS, community participation
PHC

- Policy in 1978 after Ama Alta Declaration
- Preceeded by Lampang Project supported by USAID
  - focussed on “medical assistants” (not VHV)
- Championed by minister and subsequently PS of MOPH (who was one of the leading researchers in the team)
  - Could have been different
- Many innovations followed with action research
- Well received and supported by the communities and health workers in the rural areas
  - Continue despite change in top leadership in MOPH
- Evaluation research and many studies into the roles of VHV carried out
Universal Coverage

- Implemented in 2002 (capitation + DRG + high cost payment system)
  - NHSO established as “autonomous public organization” thru legislation
- Model adopted = combination of domestic HSR and learning from SSS + adapting from model used in other countries
  - no systematic review done
  - No clear-cut best model (from other countries) seen
- Many problems/issues emerged after starting the policy (should have been anticipated – how to deal with “salary” in the public sector?)
- On-going Active modification of purchasing system (rules and tools)
- Active HSR contribution (mostly closely linked with system manager)- not only financing aspect
PC system at a glance

NHSO

MOPH

Provincial Chief Medical Office

Regional Hospital (CUP)

Provincial Hospital (CUP)

Community Hospital (CUPC)

Private Hospital (CUP)

Medical Community Center

Health Center (PCU)

Health Center (PCU)

Private Clinic (CUP)

OP

PP area based

OP

PP Expressed

PPCom

PP Nat’l priority Program

Com. Health Fund

Counterpart from LA

Local Authority

IP, PP Area based

IP (DRG-Reimbursed)

Fix cost, Medicine

PPCom

PPCom
Lesson 1: Knowledge is more than (HSP)Research

• Knowledge = explicit + tacit

• (health system) Research is just one type of explicit knowledge (but the very important type of research)
  – Not only 1 study
  – Not even a research programme with close interaction with decision makers

• Other types of explicit knowledge is also useful
  – Any other types of “published documents” are welcome (sought after) – internet, reports, books, etc
SECI model

Source: Itami et al. (2000)
Lesson 2

Information from HIS is another important source of explicit knowledge (services utilization, service coverage, equity)

Lesson 3

Different types of knowledge played their roles in policy development cycle
4 Types of Knowledge in Policy Process

1. Policy Formulation
   - E. Knowledge from Information System
   - T. Knowledge from Individual

2. Policy Implementation
   - E. Knowledge from Research
   - E. Knowledge (non-research)

3. Policy Evaluation
   - Knowledge from Individual
   - Knowledge from Information System
   - E. Knowledge (non-research)

4. Knowledge from Research
   - Knowledge from Individual
   - Knowledge from Information System
   - E. Knowledge (non-research)
Lesson 4: different ways to learn from (translate) tacit knowledge

• Direct learning from those involved in the policy development and implementation – visits, discussion, lectures

• Opinions, ideas, critical reflections, tips, technics, insults, discouragement are all welcome

• Experiences and beliefs as well as non-technical aspects (political calculation) all played a great role in “absorbing knowledge” leading to final decisions

• Design and redesign are needed
Lesson 5: continuous learning is crucial

- Continuous evolution throughout policy cycle combining R&D&I with GKmP (Good Knowledge management Paradigm & Practice)
- Learning (lessons) thru action (not necessarily in the form of systematic research studies) contribute to the knowledge pool
- Continuous participatory learning of health workers and public at large are key to continuity and sustainability
Recommendation to global and regional partners (1)

• Databases of international experiences
  – Don’t limit to “research studies/papers”
  – Don’t advocate only systematic review
  – Include all types of “useful” documents
  – Include from both developed and developing world
  – Include also cases of failure
  – Web 2.0+
Recommendation to global and regional partners (2)

- Build national ownership in health system strengthening thru GKmP
  - Don’t push for scaling up of “intervention models” from a different context => modification + health system studies/analysis +/- testing in national context are crucial
  - Strengthening national units and teams that could do “good and effective” knowledge management (learning from both explicit and tacit knowledge + contextualizing + redesigning)
  - National HSR promoting unit with the right attitude and skills in knowledge management (beyond research granting)
Recommendation to global and regional partners (3)

• Define Capacity building more broadly
  – Not just knowledge translation skills among researchers
  – Equally important to build “research (translation/interpretation) literacy” among “users = policy makers, managers, civil societies/communities
  – Ability to learn/translate from “tacit knowledge” (SSS = success story sharing)
  – Not only skills to analyze but also synthesize and design
Design is at lest a risky process
But without design there is no progress

New Thinking for the New Millennium
Edward de Bono
New skills for the 21st century
A health system that can continuously learn thru actions
3 major paradigm shifts

1. Knowledge = explicit + tacit

1. Ability to synthesize and design is important (and not only analyse)

2. Learning of the demand side is key to continuous learning
Thank You