# The Task Force on Global Advantage Report

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*Arnhold Institute for Global Health*

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# The Task Force on Global Advantage




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# Executive Summary

The Task Force on Global Advantage asks, *how can the United States improve community health by applying global lessons?*

## Who is the audience for this report?

There are two main audiences for this report: 1) United States-based global health organizations that have solutions and strategies that can be applied to domestic health challenges and 2) a small (but growing) contingent of United States health care leaders who are seeking global community solutions. Individuals working in United States-based global health organizations have tremendous knowledge about best practices and are eager to translate it into impact in the United States. In most cases, the United States health care leaders have less familiarity with global approaches, but are keen to apply promising strategies. This report can form the basis for collaborations between these groups.

## How did the Task Force reach its findings?

The Chair and Secretariat identified leading global and United States health care leaders to participate in the Task Force. The initial framework was developed using an environmental scan, data analysis, and interviews. Task Force members have provided strategic guidance and feedback.

## What is the Global Advantage?

Global Advantage refers to the benefit that the United States would gain from applying global lessons to improve community health. It focuses on improving health outcomes by locally adapting a suite of breakthrough components, processes, and mindsets from global settings that can form the basis for a new national approach to health care.

## Why now?

The moment is now. Health in the United States has fallen behind global peers. Millions have the same life expectancy as the American national average in the 1970s. In more than 2,000 United States counties, mortality has increased by more than 200 percent related to substance abuse and mental disorders since 1980. Health outcomes in these counties are similar to those of low- and middle-income countries. **Instead of waiting for national legislative change, bottom-up, locally-driven strategies pioneered across the world can form the basis for a national path forward.** The United States can learn from the journey of dramatic bottom-up improvements in low- and middle-income countries with far less resources.



Low- and middle-income countries have experienced dramatic improvements in health, primarily from investments in community health. There is much to be gained by applying their lessons to communities in the United States. Furthermore, global challenges—chronic disease, pollution, and the threat of pandemics—are converging, creating greater incentives to look globally for solutions.

## The Origins of the Global Advantage

In 1978, the Alma-Ata Declaration was crafted at an international conference on primary health care organized by the World Health Organization and the United Nations Children's Fund in Alma-Ata, Kazakhstan. Expressing the importance of primary health care and "health for all," the declaration provided governments with a mandate to pursue universal health coverage.

Rwanda, Ethiopia, and Brazil all significantly improved health outcomes by making primary care accessible in communities. Countries that have made the greatest improvements in health outcomes have:

- A national emphasis on equitable community health,
- A participatory process and adaptive design to advance a shared vision,
- Sustained political will and local leadership.

## Translating the Global Advantage for Breakthroughs in American Health Care

The critical differences between low- and middle-income countries' health systems and the United States health system create learning opportunities for the United States, including:

- Strengthening the relationship between primary health and community development,
- Improved utilization of frontline workers,
- Defining health packages,
- Increased use of mobile tools,
- Integrating community health goals into national strategies.

Based on an analysis of core themes of successful health initiatives in low- and middle-income countries—with particular emphasis on Ethiopia, Rwanda, and Brazil—the Task Force identified five breakthrough components:

- **Cover & Define**—Coverage and access gaps should be mapped at the community level. Additionally, gaps in access and affordability of primary health services should be well defined.
- **Anchor & Embed**—Primary care health practices should be anchor institutions in their neighborhoods. Practices should know where patients live, and proactively link them to a community-based team and local services.
- **Shared & Actionable Goals**—Communities and health systems should be able to track progress toward common goals.
- **Simple Protocols & Accountable Care**—In order to develop an integrated community-based health workforce, a local integrator organization should foster ownership for health management in community settings.
- **Train & Organize**—A network of community-based workers should be developed to organize community members, with the goal of identifying the most pressing health needs.

The Task Force determined that components will have to be adapted in United States communities through a participatory process, similar to the approach employed by the Seattle-based non-profit *Global to Local.* This transformation work should be championed by local change agents, who would benefit from the peer support of a national learning network.

## Accelerating the Global Advantage

The Task Force has the following recommendations:

**Accelerate Global Exchange with Domestic Communities through Learning and Testing.**

**Develop Processes and Tools to Proactively Link Global and United States Health Initiatives.**

**Advocate for Investment and Implementation of Task Force Recommendations.**

A guiding coalition has paved the way in applying global health lessons to the United States. They must continue to collaborate to advance this emerging field and improve American community health.

# Words of Encouragement from Agnes Binagwaho, MD, PhD, Task Force Commissioner

In Rwanda, we achieved extraordinary gains in health—doubling life expectancy and vaccinating more than 90 percent of children for 11 illnesses. This was not the work of one person or one ministry—with leadership from the top, we worked closely with villages, their community leaders, and community health workers. Together, we broke down barriers—and improved access to care across gender, age, geography and socioeconomic status.

We are eager to share our experience in the hopes of improving health care for Americans with the greatest need. The secret to success is designing a system that is appropriate to your environment, and developed with community members. We built trust, and a health care system that delivers care to people where they work and live—with community health workers as the foundation. If we in Rwanda can do it, given all of our constraints—then I know you in the United States can. We are your partners on this journey.

—Agnes Binagwaho, MD, PhD



# Letter from Chair

Photo credit: Patrick Schnell

The residents of Oglala Lakota County, South Dakota have a lower life expectancy, on average, than people living in India, Sudan, and Iraq. In more than 2,000 counties across the United States, mortality related to substance abuse and mental health disorders has increased by more than 200 percent since 1980. While American politicians struggle with their obligations to ensuring health for all, communities across the country do not have this luxury. The virtuous relationship between healthier lives and community development is clear, and when it falters, we all suffer.

Meanwhile, some low- and middle-income countries have doubled their life expectancy over a twenty year period. What can we learn from them? Global Advantage refers to the benefit that the United States gains from applying global lessons to improve domestic health. This Task Force on Global Advantage focused on improving population health outcomes by locally adapting a suite of breakthrough components, processes, and mindsets sourced from global settings that can form the basis for a new national approach to health care.

Global experience, particularly in low-resource settings, proves that another path is possible. Instead of waiting for national legislative change, bottom-up, locally-driven strategies can form the basis for a national path forward in the United States.

The work of the Task Force has been challenging. The availability of global case studies, data below the national level, and rigorous impact studies—particularly in low-resource settings where community-based approaches are emphasized—is limited. As the former World Bank Chief Economist Lant Pritchett recently wrote in his essay, “The Perils of Partial Attribution,” it is possible to understand and convey “optimal actions,” without overstating the rigor involved. This is what the Task Force endeavored to do.

In broad strokes, the “optimal action” in global low-resource settings is to iteratively develop proactive population health systems that harness the energy of activated communities and primary health systems.The Task Force translated common themes across countries into five components, which we humbly offer as starting points for adaptation.

The Task Force acknowledges that there are many initiatives underway across America to insource global learnings and adapt them locally. Some are focused in one place, while others are part of national initiatives. Fortunately, many of their leaders are part of this Task Force, and have helped frame the Global Advantage to be useful in settings that may find global solutions jarring.

The Task Force is committed to putting these insights into practice, and incorporating the Global Advantage into a strategy to dramatically improve health in the United States. On behalf of the Task Force on Global Advantage, I hope you will join us on this journey.

Prabhjot Singh MD, PhD
Chair of the Task Force on Global Advantage

# 1

# What is the Global Advantage? Why now?

**KEY POINTS**

- Global Advantage is learning from abroad with the goal of improving community health in the places that need it most. It combines global mindsets, processes and a solution set.
- A set of low- and middle-income countries that have had dramatic breakthroughs offer lessons the United States can learn from.
- Applying global best practices to improve community health in America has historical precedence, and needs to be dramatically expanded.



Global Advantage refers to the benefit that the United States gains from applying global lessons to improve community health. It focuses is on improving health outcomes by locally adapting a suite of *breakthrough components, processes, and mindsets* that can form the basis for a new national approach to health care.

In 1978, the world came together in Almaty (formerly Alma-Ata), Kazakhstan, to set a goal for basic health care for all by 2000. The Alma-Ata Declaration, the world's first underlining the importance of primary health care, re-defined health as a responsibility that governments must ensure is available for their citizens, and empha-sized the foundational role of primary care and community-guided design. The United States has lagged in answering this call. Instead, it has chosen a path that has prioritized large hospital systems and specialty services. Nearly forty years later, American health care costs continue to skyrocket while delivering uneven results that leave vulnerable communities behind.

Life expectancy in the United States varies dramatically by region. Alarmingly, the bottom ten percent of United States counties, which we refer to as the bottom decile, have the same average life expectancy of America in 1978. We are unlikely to see national reforms that adequately address inequities in life expectancy in the near term. In a land of infinite resources, health outcomes should not be profoundly influenced by wealth, race and location. Instead, motivated communities and regional health care systems across the country must lead the way in defining a breakthrough approach to better health. To do this, initiatives like the *100 Million Healthier Lives* movement are already building a national network of community leaders and identifying adaptable solutions, from within the country and abroad. Many of the superior health gains achieved in wealthy countries can be attributed to their national health care choices. We must learn from their systems while also examining countries that have overcome great odds to achieve significant gains. Our Task Force focused on countries that have achieved locally-led breakthroughs in health despite significant contextual challenges and limited resources. Places like Rwanda and Ethiopia—where life expectancy dramatically improved over a short period—are examples of countries the United States can learn from, distilling their achievements into practical lessons. To do so, we must identify the mindsets, processes, and solutions used to advance breakthroughs. This report identifies common features that exemplify the Global Advantage and principles that enabled these features to emerge across several countries.

Ultimately, the success of the Task Force will live in the practical adaptation of these ideas in domestic settings where communities and health systems are ready for breakthroughs. Fortunately, that time is now.

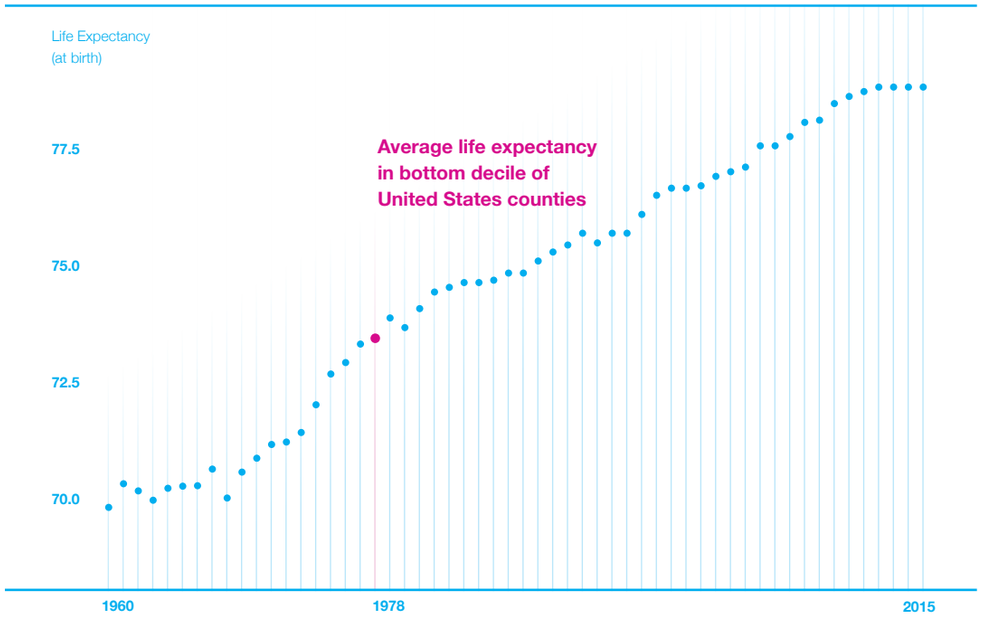
This report aims to make relevant global mindsets, adaptive processes, and breakthrough features. Its findings will be accessible to a diverse group of American leaders working to elevate health care in their communities. While agnostic about where the ideas originate, it is essential that our audience understands why they were successful in order to adapt within their communities. We have no doubt that Americans will make the Global Advantage their own, sparking further innovation to share with the world.

We hope to catalyze a different type of global health engagement—one where networks of peer communities across the world are learning from each other in a systematic and mutually beneficial way.

## Health in America has fallen behind, and in some areas it has gotten far worse.

In 2015, 30 countries achieved higher life expectancy than the United States. Most of those countries spent two to four times less on health care. Only five countries (out of 55) in the 2016 Bloomberg Healthcare Efficiency index were less efficient in delivering health care than the United States. Poor performance and outcomes have not been equally distributed across the United States. There is a two decade gap in life expectancy between Summit County, Colorado and Oglala Lakota County in South Dakota. Since 1980, more than 2,000 United States counties had increases in mortality of more than 200 percent, largely attributed to substance abuse and mental health disorders. During this period, a cluster of counties in Kentucky, West Virginia, and Ohio had mortality increases of 1,000 percent.

### Average Life Expectancy in Bottom Decile of United States Counties




### Who are the United States' Peers in Health?


| Index | United States County | Life Expectancy | Comparison Area | Life Expectancy |
|---|---|---|---|---|
| 1 | Oglala Lakota County, South Dakota | 66.8 | Western Cape, South Africa | 65.9 |
| 2 | Union County, Florida | 67.6 | Rajasthan, India | 67.7 |
| 3 | Sioux County, North Dakota | 68.6 | Talas, Kyrgystan | 68.9 |
| 4 | Owsley County, Kentucky | 70.2 | Yunnan Province, China | 69.5 |
| 5 | McDowell County, West Virginia | 70.3 | Maranhao, Brazil | 70.3 |
| 6 | Kusilvak Census Area, Alaska | 70.8 | Arusha, Tanzania | 70.5 |
| 7 | Tunica County, Mississippi | 70.9 | Moscow, Russia | 70.9 |
| 8 | Phillips County, Arkansas | 71.3 | Sucre, Venezuela | 71.3 |
| 9 | Madison Parish, Louisiana | 71.6 | Chihuahua, Mexico | 71.5 |
| 10 | Walker County, Alabama | 71.6 | San Martin, Peru | 71.6 |

The bottom decile of United States counties is disproportionately poor and rural. Without dramatic change, circumstances are likely to get far worse. These areas have a difficult time recruiting and retaining health care providers, and the shortage gap is predicted to grow. Twenty-one percent of the United States population lives in rural areas, but only 10 percent of physicians practice in those areas. Similar disparities exist for economically disadvantaged urban areas. Seventy percent of these counties' state leaders declined to expand their Medicaid programs.

Researchers at the Harvard Global Health Institute have emphasized that international comparisons should focus on relevant comparisons, rather than the pageantry of a high-level contest. For the Task Force on Global Advantage, we focused our efforts on American places with poor life expectancies and relevant global comparisons that give us insight into ways forward. The poorest Americans have life expectancies on par with low- and low-middle income countries. In 2014, the life expectancy in Oglala Lakota County, South Dakota was 66.8 years, which was less than that of India (66.9), Sudan (67.2), and Iraq (67.7). However, a lack of sub-national and sub-county data makes rigorous comparisons imprecise, or impossible. What we do know is that these outcomes are a function of more than health care, and that any global search would focus on the interactions between health systems and the communities they serve.

The Institute for Health Metrics and Evaluation released a landmark study in 2017. Its findings attributed 74 perent of the twenty year difference in life expectancy across United States counties to socioeconomic, race/ethnicity, behavioral, and metabolic risk factors in addition to health care factors. Social isolation, the opiate crisis, and workforce limitations extend beyond the scope of the health care system. These challenges

necessitate community solutions. Even though the challenges may look significantly different in low- and middle-income global settings, such as responding to the Ebola pandemic or addressing child mortality, strengthening community cohesion is a foundational step.

## Global challenges are converging, and there are major initiatives underway in search of solutions.

More than ever, problems facing the world are similar and require urgent, meaningful collaboration. Pandemics, pollution, antimicrobial resistance, and chronic disease are rising, global problems. These challenges are borderless and demonstrate a need for global cooperation to implement solutions. These problems challenge traditional views of health care that solely focus on hospitals and clinics, or methods that see community-based strategies as unique in each local setting rather than as part of networks within, and across, nations.

We used to think of chronic conditions as occurring primarily in high-income settings. Over the past decade, low- and middle-income countries have seen rates of chronic conditions surge, rivaling levels seen in the United States. The United States invested in specialty care and hospital infrastructure, while lower-resource settings abroad leveraged communities to deliver proactive health services. As the United States aims to tackle health care challenges, there is much that can be learned from the global approach.

Many low- and middle-income countries used the principles outlined in the Declaration of Alma-Ata as the model for building their health systems. Not all succeeded. However, a subset of low- and middle-income countries established systems to support the principles and achieved exemplary gains in life expectancy (and a variety

**Breakthrough Countries' Life Expectancy**

Gains made from 1990 to 2015

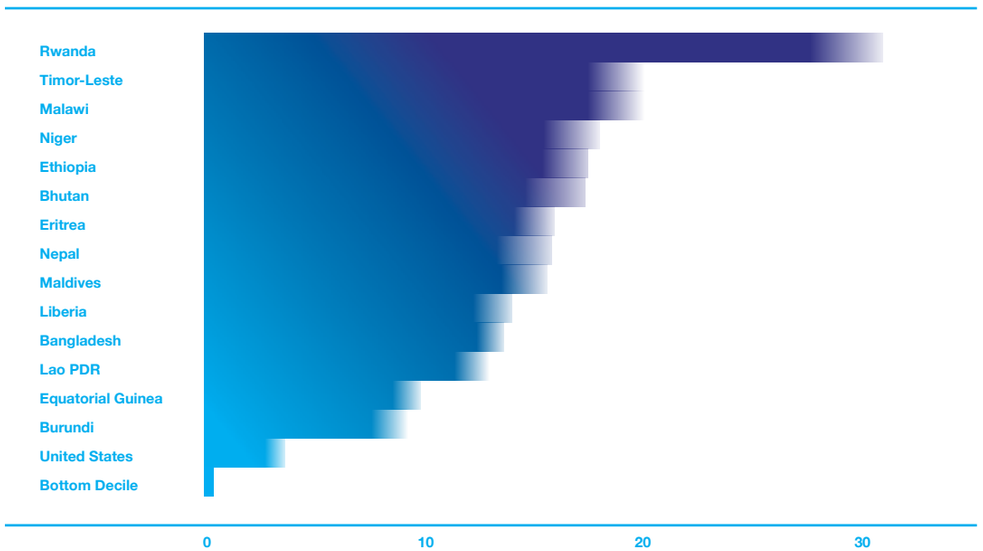





Photo credit: Patrick Schnell

of other metrics) over the past 25 years. Their experience provides us with a potential roadmap for improving national health from the bottom up, with support from the top.

We believe that Americans are looking for a different approach, and that they will consider practical approaches so long as they work. In 2017, over half of Americans felt that income-based health care inequalities were unfair. Disparities in health at zipcode and regional levels in America have fueled national interest in a fresh approach to health care that is more linked to place-based and socioeconomic challenges. Many initiatives seek to strengthen health in communities across the United States.

These organizations and initiatives include, but are not limited to:

- The Way to Wellville, a five community, ten-year challenge to produce visible improvements in health and economic vitality.
- *100 Million Healthier Lives,* led by the Institute for Healthcare Improvement, aims to achieve the goal of 100 million people living healthier lives by 2020.
- Healthy Communities, the Robert Wood Johnson Foundation initiative, focuses on improving local environments and food access, disease awareness and prevention, health disparities, and social determinants of health.

Local efforts across the nation vary in scope and quality, and are not yet seen as a national strategy. There has been work on alternative payments, but the progress is uncertain. This is the time to look globally for well-defined, community-based solutions that have the potential to form the foundations of a national strategy.

## What is the focus of the Task Force on Global Advantage?

This Task Force report focuses on the intersection between primary health systems and engaged communities, which is a limited and modest view of what it takes to create a healthy society. As people and places begin to meet their basic health care needs, they will have to confront a more complex set of questions about why they were neglected in the first place. Community leaders will have to develop a culture of health, which includes a broader scope of activities, ranging from creating walkable public spaces to addressing food deserts.

We have focused on an important, however, narrower, opportunity: applying global mindsets, processes, and solutions in an effort to improve national health at the community level.

There is a dearth of sub-county or census tract level data, both in the United States and abroad. This makes rigorous quantitative comparisons and attribution assessments imprecise, or in many cases impossible. As a result, we have employed a set of hybrid approaches to identify the design of appropriate interventions that could gain greater traction and adoption in America. Federal health care reforms in America are likely to be stymied for the foreseeable future. **The utility of this report will increase with the United States' ability to shift its lens of health improvement to the community level. In all cases, breakthroughs will require significant political will, enabling regulatory environments and the ability to experiment locally in innovative ways. This is the most viable path forward to dramatically improve health across the United States.**

Dr. H. Jack Geiger and Dr. John W. Hatch during construction on the Delta Health Center, 1968. Courtesy Jack Geiger

## This strategy has historic precedent, with nationally transformational results.

IIn the 1960's, Jack Geiger, MD, M.Sc., ScD, along with Count Gibson, MD, applied what he had learned as a medical student in rural Natal, South Africa by developing the nation's first community health centers in urban Dorchester, Massachusetts and in rural Mound Bayou, Bolivar County, Mississippi. The community health center focused on integrated community-based care and featured significant community representation in its governance. Since their introduction, there has been widespread bipartisan support for the health centers. In 2017, these community health centers served nearly 26 million people, or one out of every twelve United States residents. They are projected to reach 40 million Americans in the next decade. Nearly three quarters of community health center patients live below the poverty line.

Their impact has been transformational. The community health center system helped to reduce black infant mortality by 12 percent between 1970 and 1978. Within 10 years, the system resulted in reduced mortality for adults over 50 and significantly impacted the narrowing of the wealth-health disparity. In 2009, health centers generated approximately $20 billion dollars of economic activity in the areas they operated. Centers are primarily concentrated in areas with high rates of uninsurance and unemployment.

However, Dr. Geiger's vision was more than a clinic. He focused on building a layer of services that extended into community life in targeted ways. In some ways, this report builds upon his vision, updates it with what we have learned from our peers abroad, and points to a revitalized effort in places that need it most. ■


Kigali, Rwanda: Professor Binagwaho leads a group discussion during the University of Global Health Equity's first Executive Education course, the Global Health Delivery Leadership Program, in December 2016.

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# 2
# The Origins of the Global Advantage

**KEY POINTS**

- The principles of Alma-Ata laid the foundation for the goals of Universal Health Coverage 2030.
- Rwanda, Ethiopia, and Brazil significantly improved access and health outcomes by expanding access to primary health care in communities.
- Countries that have made the greatest progress have a national emphasis on equitable community health, sustained political will and local leadership, and a participatory process and adaptive design to advance a shared vision.



"Primary health care is the best system for reaching households with essential and affordable care, and the best route towards universal coverage."

—Margaret Chan, MD, MPH
Former Director-General of the World Health Organization, 2007

Fortunately, the essential interventions highlighted here are generally not technically exacting. Few require hospitals. Most can be delivered at health centers, at smaller facilities that we refer to as health posts, or through outreach services from these facilities.

—WHO Commission on Macroeconomics and Health 2001

## From Alma-Ata to Universal Health Coverage 2030

In 1978, officials from 134 countries came together in Almaty, Kazakhstan to develop an ambitious vision of health for all, which was codified in the historic Alma-Ata Declaration. It provided many governmental leaders with the confidence to pursue a universal health agenda, emphasized the accessibility of primary care, and encouraged countries to assist each other in this mission. The declaration's focus on primary health care at the local levels continues to be reaffirmed by the World Health Organization (WHO):

> "Primary health care is the best system for reaching households with essential and affordable care, and the best route towards universal coverage. It is also the best gatekeeper for ensuring that simple conditions receive appropriate and affordable care, at an appropriate and cost-effective level of the health system (…) A community's mutual concern for the welfare of others is a vital form of social capital, and primary health care is well placed to tap this resource. As abundant evidence shows, communities have great ingenuity and managerial capacity, especially when health literacy is improved."
>
> —Margaret Chan, MD, MPH
> Former Director-General of the
> World Health Organization, 2007

Although the Alma-Ata Declaration created a mission statement of "health for all," national governments faced considerable economic and political challenges in making this vision a reality. The global consensus may have faltered in the 1980's, however, the HIV/AIDS epidemic changed the terms of global debate and put civil society and community-based action at the forefront of driving political commitment. As political commitment for health was growing from the bottom-up, the World Bank released the historic "Investing In Health" World Development Report in 1993, followed by the WHO's landmark Commission on Macroeconomics and Health in 2000. Instead of a high-level vision, the Commission on Macroeconomics and Health provided a clear roadmap for accelerating the virtuous cycle between health and economic development:

> "The Commission examined the evidence relating to organizational requirements for scaling up and some of the key constraints that will have to be overcome. Fortunately, the essential interventions highlighted here are generally not technically exacting. Few require hospitals. Most can be delivered at health centers, at smaller facilities that we refer to as health posts, or through outreach services from these facilities. We call these collectively the close-to-client (CTC) system, and this system should be given priority to make these interventions widely accessible. These, in turn, must be built on a foundation of strong community-level oversight and action, in order to be responsive to the poor, in order to build accountability of local services, and in order to help ensure that families take full advantage of the services provided."

Perhaps more importantly, many low- and middle-income countries across the world made these principles the centerpiece of their national strategy and have achieved extraordinary gains (see "Breakthrough Countries' Life Expectancy"). In a 2015 World Bank publication entitled, "Going Universal: How 24 Countries are implementing Universal Health Coverage from the Bottom-up," it is clear that there is no one pathway to achieving "health for all," as each country grapples with its own political and economic constraints. However, in nearly every case, the countries that have made the greatest progress have a national emphasis on equitable community health, sustained political will and local leadership, and a participatory process and adaptive design to advance a shared vision. Of note, low- and middle-income countries have also emphasized cross-country learning and incorporation of successful approaches.

In the subsequent section, The Task Force shares three mini-case studies of countries that have been on the journey from Alma Ata to Universal Health Coverage. The Task Force on Global Advantage reviewed programmatic case studies, data-driven or strategic analyses of regional or national efforts, as well as global policy documents. In choosing information to present, the Task Force prioritized mini-cases and key global programs that reflect the Task Forces focus on primary health care-centric strategies that build upon, and strengthen, community health and social capital. In the final section, we hone in on common components that could be relevant in the United States context.

## Paths to Progress: Rwanda, Ethiopia, and Brazil

Rwanda, Ethiopia, and Brazil achieved extraordinary health gains during a relatively short period. It was not a foregone conclusion that this would happen—they outperformed many of their neighbors in the same period. Rwanda is a country of about 11 million people living in an area twice the size of Connecticut. After sustained periods of war, genocide, and political instability, Rwanda has emerged as a regional success story in sub-Saharan Africa. Ethiopia is a country of about 100 million people, in an area twice the size of Texas, which has focused on reaching its most rural people through an extension system that closely mirrors the close-to-client system described above. Brazil has about 200 million people in an area the size of the United States. It has the added complexity of 150 languages and dialects spoken across its varied cultural and geographic landscape. Each country features varied sociopolitical environments, economic constraints, and health system trajectories. However, the proceeding mini-case studies allow us to see core themes that emerge in settings where the public sector guided the development of health systems in collaboration with communities, emphasizing local accountability, autonomy, and action, while providing support from the top.

# Rwanda

"My target is not my grandchild, my target is the child of the poorest woman in Rwanda, because when she is served, that means everyone else will be as well."

—Agnes Binagwaho, MD, PhD, former Minister of Health, Rwanda

### Breakthroughs

**From 1994 to 2012, life expectancy in Rwanda doubled**

**Fertility decreased from 6.1 in 2005 to 4.2 in 2014–2015**

**The mortality rate of children under 5 fell from 196 out of 1,000 in 2000 to 50 out of 1,000 in 2014–2015**

### How did they achieve breakthroughs?

After the genocide in Rwanda in 1994, Rwandan leaders embraced a new phase of rebuilding in the resource-poor and devastated country. Leaders like Agnes Binagwago, MD, PhD, who had risen from being a clinician in a public hospital to a political leader, believed that investing in the health of Rwandans was crucial to the nation's success. Rwanda is a small, densely populated and mountainous country, with more than 11 million people. Dr. Binagwaho played a critical role in redesigning the health system. She focused on bringing health care to all, working closely with communities to accomplish this feat. Confronting a severe shortage of health professionals, she knew the foundation of the system had to be community health workers from the villages they served. They would have a deep understanding of the community and their trust.

Dr. Binagwaho and others from the Ministry of Health spent a tremendous amount of time in the field, working closely with communities to understand their needs and adjust their approach accordingly. Roles and protocols for health professionals were clearly defined and standardized. Through this process, they determined that each village should have three community health workers with specific roles. One male and one female community health worker were responsible for community health including basic diagnosis and treatment of conditions like malaria. A female maternal health worker focused on infant, pre- and post-natal care. The community health workers were a bridge between the clinic and the community—knowing when to refer people to the clinic, and playing an active role in their care after they had visited the clinic. However, their main priority was to prevent illnesses by educating community members about healthy foods, handwashing, and other basic health information.

The government did not want to increase salaries, and preferred to use funds to improve the quality of care delivered. In response, they developed a pay-for-performance approach, whereby community collectives played a significant role in distributing funds based on quality of care.

As part of the government's goal of universal coverage, the cost of care and the unequal distribution of clinicians was an obstacle. As a result, in 2008, the government made health insurance enrollment mandatory. Most people have *Mutuelles de Santé,* which is a mutual health insurance scheme. For those who cannot afford it, payments are subsidized by the government. This helped to decrease out-of-pocket costs. Many clinicians moved out of the capital city of Kigali because they felt confident that they could count on an income in rural areas.

The government decentralized much of Rwanda's health resources, placing much decision-making and management power in the hands of districts and communities. By collecting data at the local level and sharing it with the Ministry of Health for regular analysis, communities and districts made more informed decisions about resource allocation.

### What challenges remain?

The Rwandan system faces significant challenges, including improving the performance-based financing system, the quality of the community-based health workforce, and the growing demand for non-communicable disease services and specialty care.



# Ethiopia

"By linking the grassroots communities of our country to the top leadership of our national government, I have been able to strengthen our ability to address the needs of our health system through improved priority setting and more collaborative implementation of health systems strengthening efforts."

—Kesetebirhan Admasu, MD, MPH, former Minister of Health, Ethiopia

### Breakthroughs

**From 1990 to 2015, life expectancy improved by more than 17 years**

**Child deaths decreased by 26 percent**

**Maternal deaths decreased by 50 percent from 2000–2010**

### How did they do it?

In 2003, the Ethiopian government committed to provide all of its citizens with basic health care coverage. A local community health officer, Kesetebirhan Admasu, MD, MPH, was elevated to lead this transformation as Minister of Health. Ethiopia is a country of more than 100 million people, with more than 80 percent of its population living in rural areas. Without enough clinicians to reach everyone, especially people in remote areas, the Ministry of Health developed a lean system to bring primary care to the community. Primary Health Care Units include a health center, five health posts, health extension workers, and Health Development Army volunteers.

Health Extension Workers are women who live in the community, providing a standardized package of 16 services focused on health education and prevention. In order to understand the specific needs of the community and customize their approach, health extension workers conduct a baseline survey, prioritize problems, set targets, and develop an action plan. The health extension workers' goal is to encourage households to adopt positive behaviors like sleeping under treated mosquito nets and vaccinating their children. After they demonstrate adopting a specific set of health behaviors, they have "graduated." To date, more than three million households have graduated. In 2011, 68 percent of the population was covered by the Health Extension Program.

In 2012, the Ministry of Health realized that the health extension workers could not reach every household in the country. They developed a plan to engage women from graduated households as volunteers, calling this the Health Development Army. Volunteers customize their support depending on the needs of different community groups. After realizing that informal workers had special health care needs, the Ministry of Health developed a community health insurance plan for them. The Health Development Army works closely with community members to encourage them, incorporating political and social messages into their work. They help to build community capacity around shared goals. Many members of the Health Development Army have helped establish solidarity funds, which finance community-identified priorities. In 2015, more than 200 ambulances were purchased using these funds.

In 2015, in an attempt to further expand access, the Ministry of Health adapted their approach to focus at the community or *kebele* level, rather than household level. 80 percent of the households must practice model behaviors in order for the community to graduate.

Ethiopia's aspiration for universal coverage is dependent upon community ownership, through achieving model household and village goals. Action plans are submitted to village councils for approval and then disseminated to district, regional council and health offices. Every primary health care unit has a performance contract. Citizen scorecards were used to ensure community accountability.

Ethiopia has become a global role model in delivering comprehensive primary care. In an effort to help other countries replicate their model, Dr. Admasu envisioned an International Institute for Primary Health Care in Ethiopia's capital, Addis Ababa. In collaboration with Johns Hopkins University, the Institute officially opened in 2016, training policymakers and implementers from Ethiopia and around the world.

Community health workers collect data that drives decision making, and provide community members with a cohesive experience of care. One of their goals is to create demand for better information from the people they serve.

### What challenges remain?

Although Ethiopia has made great strides in improving health, challenges remain, including the community's trust of health extension workers, breakdowns in the referral system, and drug and medical supply shortages. In some areas it is difficult to build the capacity of the Health Development Army.

# Brazil

"We have learned that it is possible to build a new model for primary health with the principles of fairness and solidarity as long as there is the political will."

—Maria Fatima de Sousa, MD, PhD, MPH,
Director of Non-communicable Diseases and Health Promotion, Ministry of Health Brazil

## Breakthroughs

**Life expectancy improved by eight years from 1990 to 2014**

**Infant mortality rate more than halved from 2000-2014**

**Maternal mortality halved since 1990**

## How did they achieve breakthroughs?

In the early 1990's, there were limited public health services in Brazil. Approximately 60 percent of the population had access to private health services. After many decades of military rule, civil society began to demand that equitable access to health be recognized as a universal right, ensured by the government. In 1988, equitable access to health care was incorporated into Brazil's new constitution.

In 1994, the *Programa Saude de Familia*, or Family Health Program, was developed as a pilot in the northeastern state of Ceara in response to a cholera outbreak. The foundation of the program was primary care teams comprised of a doctor, nurse, nurse assistant, dentist, social worker, and four to six community health workers. They had clearly defined catchment areas, roles, and protocols with regards to which team members performed which tasks. Community health workers focused on health promotion and education. They also delivered basic care, which included supporting chronic disease management. Community health workers forged critical connections and trust, regularly visiting homes, schools, and other community-based organizations. They identified people who needed extra support, and linked them with appropriate resources, such as water and sanitation services, law enforcement, schools, and enrollment in the conditional cash transfer program, *Bolsa Familia.* The program transfers money to households if they meet specific health and education milestones, such as vaccinating children and sending them to school. A decrease in post-neonatal mortality has been partially attributed to the combination of increased coverage under the Family Health Program and the conditional cash transfer program.

Community health workers have provided critical support with infectious disease outbreaks including Zika virus, dengue fever and chikungunya. They report on incidents and share disease prevention advice with community members. With a rapidly growing chronic disease burden, community health workers are increasingly focusing their efforts on prevention and management.

Given Brazil's size, the government decided to decentralize the delivery of the Family Health Program. Residents are involved in local health councils, with influence over budget and management decisions. In 2014, the public health program provided comprehensive services in 95 percent of municipalities, covering around 60 percent of the population. The program has been estimated to have saved nearly 450,000 lives between 1996 and 2012.

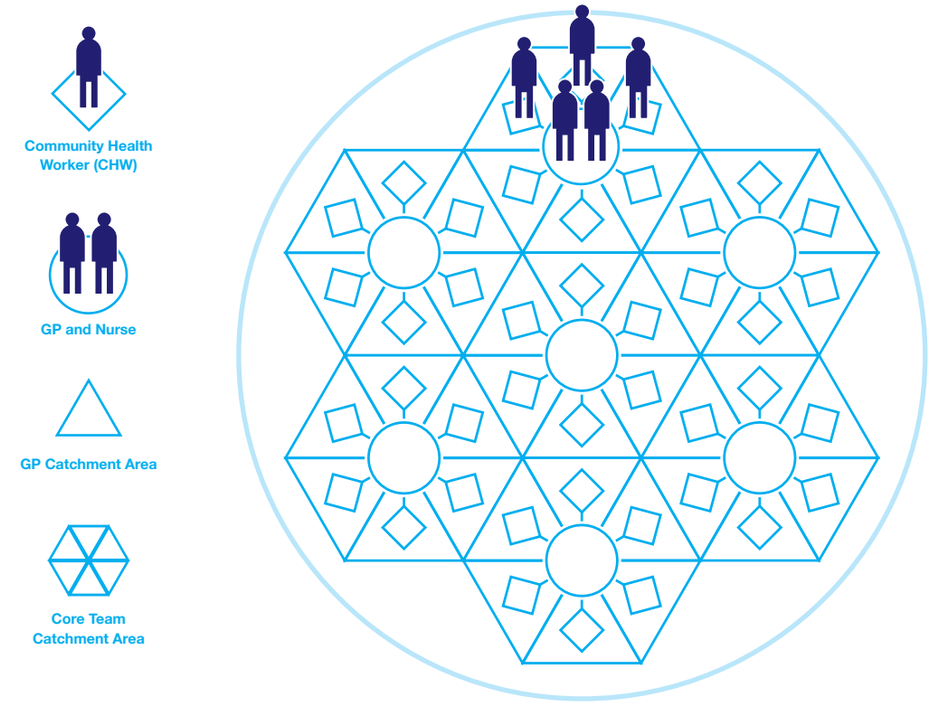
## What challenges remain?

Financing the program continues to be a challenge, with much of the cost burden falling upon local communities. Health care quality varies across the country, with a lack of skilled professionals and equipment in some areas. Technology has not been widely incorporated into the program, but there are plans to introduce mobile phones and tablets to assist with providing quality care in remote areas. Despite the government mandate and provision for universal coverage, many middle and upper class Brazilians continue to seek care in the private sector.



## Family Health Strategy Team Structure

Universal service provision
No gap between teams or CHW catchment areas




Source: Wadge et al. "Brazil's Family Health Strategy: Using Community Health Care Workers to Provide Primary Care." The Commonwealth Fund. December 2016. (www.commonwealthfund.org/publications/case-studies/2016/dec/brazil-family-health-strategy).

## Similarities Between National Approaches and The Hazards of Generalization

Both Rwanda and Ethiopia's leaders embraced the principles of the Alma-Ata Declaration, and invested heavily in making primary health care accessible to everyone, particularly the vulnerable. In Brazil, the principles were embraced, but after civil society pressed for changes. Rwanda and Ethiopia are predominantly rural, while Brazil is mostly urban. However, all three countries invested in building community workforces because they had a limited number of clinicians. They relied on them to provide basic health education and treatment, and to act as connectors between the community and the clinic. The national government enabled local autonomy, while providing strong financial and strategic support. The Rwandan and Ethiopian programs relied on strong data and information systems which helped to inform local and national decision-making.

In Rwanda and Ethiopia, the governments' knowledge of challenges at the village level helped identify areas where innovation was needed. This clarity regarding challenges and goals made it easier to develop solutions. Realizing the obstacles that traveling hours to get critical care presented, the Rwandan government changed regulations and devel-

oped a partnership with Zipline, a drone company which now delivers lab tests, drugs, and blood transfusions to areas throughout the country in fifteen minutes. This access to blood transfusions prevents deaths from postpartum hemorrhaging, which is the leading cause of maternal mortality. In Ethiopia, the Silicon Valley based non-profit Watsi is helping to build a new generation of insurance management systems. In recent years, there has been far more privately-driven innovation in Brazil's health care sector at a time when confidence in the public sector is low.

Generalizing across countries is a hazardous exercise, particularly in the context of poor data availability and comparability, significantly different political and economic histories, and health challenges. Furthermore, any expert group brings its bias to an already complex challenge. At the same time, any consensus themes that emerge from the perspective of a diverse Task Force body (academics, policy experts, and practitioners from global and United States settings) are all the more notable. Given the persistent global narrative around primary and community-based care, a shifting focus towards non-communicable diseases across all regions, and the emerging role of technologies in addressing challenges of scale, equity, and efficiency, the Task Force focused its efforts at the interface of primary health systems and their communities.

## What are the components?

Through the process of multiple low- and middle-income country reviews and in-depth case studies, five key components emerged, which will be elaborated upon in the next section.

### Global Advantage Framework

| Component | Brief Description | Examples | Authoritative Global Reviews |
|---|---|---|---|
| **Anchor & Embed** | Health systems are anchor institutions in their neighborhoods, with primary care forming the foundation for linkages with community-based workforce and local partnerships. | Ethiopia's Health Transformation Plan (2015-2020) | Health in the Framework of Sustainable Development |
| **Train & Organize** | Develop a network of community-based workers to organize community members. Workers jointly identify the most pressing health needs in the community. | BRAC in Bangladesh harnessed its population to address the cholera epidemic | One Million Community Health Worker Task Force Technical Report & The Global Health Workforce Alliance Annual Report 2014 |
| **Shared & Actionable Goals** | Communities and health systems should be able to track progress towards common goals and act to achieve them. | Mexico's Casalud's program for improving chronic conditions and population health | Global Diffusion of eHealth |
| **Simple Protocols & Accountable Care** | In order to develop an integrated community-based health workforce, change agents must be able to simplify and create ownership for health management in home and community settings. | India's Healthy Activity Program for severe depression and Mexico's Casalud | Task Shifting for Non-Communicable Disease Management in Low and Middle Income Countries: A Systematic Review |
| **Cover & Define** | People who are uninsured, underinsured, or without sufficient support should be identified, and decisions made at the community level about whether and how needs will be addressed. | Thailand's 30 Baht Health System | Going Universal: How 24 Countries Are Implementing Universal Health Coverage from the Bottom Up |



## Looking to UHC 2030

Globally, community-based health and the goal of universal coverage are at an inflection point. The 2017 election of Ethiopia's Tedros Adhanom Ghebreyesus, PhD, MSc, to be the Director General of the World Health Organization has heralded a recommitment to achieving universal coverage across all countries, not just low-resource settings. Dr. Tedros has emphasized that achieving universal health coverage is technically and economically feasible, but that it requires political commitment.

The International Partnership for Universal Health Coverage 2030 (UHC 2030), an initiative co-led by the World Bank and the World Health Organization, focuses on building stronger health systems for universal health coverage. The movement focuses on five dimensions of health system performance: equity, quality, responsiveness, efficiency, and resilience. Efficiency and equity necessitate an increase of frontline care, with primary health care integrated into the national system. The demand for innovation in how primary health systems are designed, financed, and focused on the health needs of the most vulnerable continues to grow.

UHC 2030 rests on the half-century old foundation of the Alma-Ata declaration. Alma-Ata played a critical role in inspiring a principled focus on primary health across countries, enabling government and civil society to make the case for the government's role in health care for all. These examples illuminate the high-level principles and specific areas of focus that the United States—at the local, regional or the national level—could build upon to improve health for all. While the United States lacks a clear political mandate to provide health for all, perhaps these examples can inspire community leaders to implement key components, later influencing national legislation to support autonomy at the community level. ■

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# 3 Translating the Global Advantage for Breakthroughs in American Health Care

"It is easy to forget how dramatically United States politics changes from era to era. New issues rise onto the agenda, different national values grow more (or less) important, underlying political assumptions evolve, and an entirely new coalition grows influential. What seems impossible in one generation is taken for granted in another. The kind of turbulence we are experiencing in contemporary party politics often signals precisely this sort of sea change. One necessary condition for a breakthrough change is already in place: a righteous band of reformers, deeply committed to a cause, pushing against all odds."

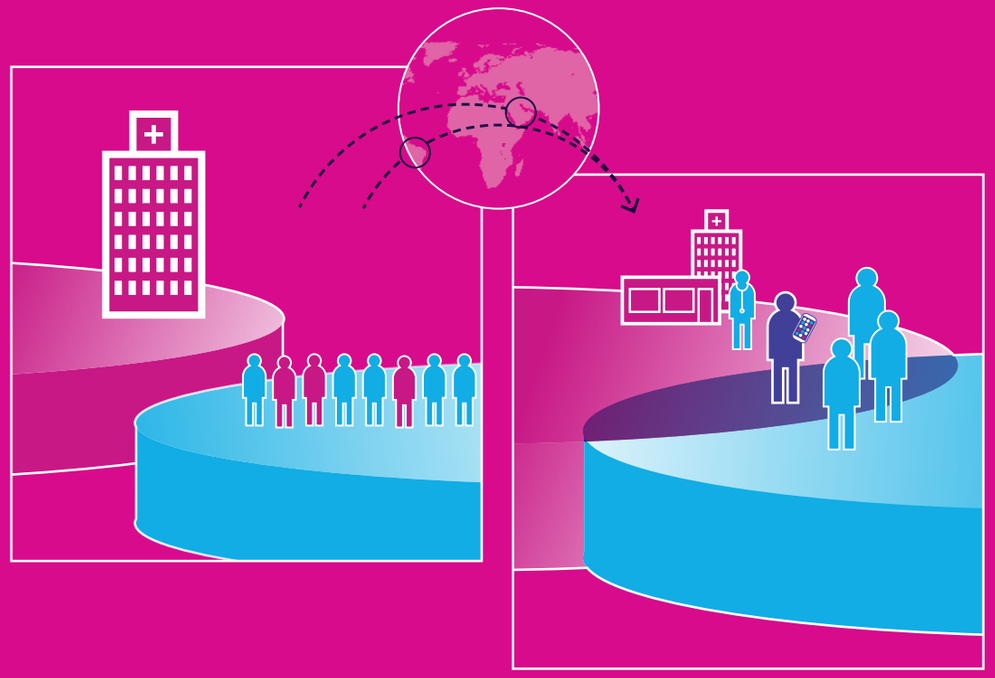
—James A. Morone, PhD

The work of translating the Global Advantage into adaptable components that are practical and relevant for domestic implementers is a challenging exercise. On one hand, if they are too familiar, it may not be clear how they lead to breakthroughs. If they are too foreign, they may feel impractical in a challenging domestic setting (see table on page 26). The key insight from the Task Force is that the five identified components should be integrated through an adaptive process. A new generation of network infrastructure that can enable learning within and across American communities will be needed to make this a reality.

Underlying all of these components are important assumptions about local governance and integration of services. In global low-resource settings, there is a higher level of integration between local governance (e.g. district, municipal area, county unit), clinical, and public health services. By design or as the result of budget constraints that limit specialization, integrated and sustained development is possible to a degree that is unusual in the United States. As a result, it is increasingly common to see a community organization designated to be a "local integrator" to catalyze collective impact. On a national scale, efforts like the Accountable Health Communities model that the United States Department of Health and Human Services launched in 2017 respond to a growing awareness of what is required to achieve collective impact.

# What are key differences in health care between global settings and United States communities?

| Health care components | Low and middle income-countries | United States | Global Advantage Opportunity |
|---|---|---|---|
| **Workforce** | Insufficient number of physicians and nurses | Oversaturation of specialists in cities, shortages of clinicians in rural areas | Improve utilization of frontline non-clinical workers |
| **Primary care** | Community-based, foundation of the system | Often bypassed for specialty care | Strengthen investment in primary care and reinforce linkages with community development |
| **Specialty and inpatient care** | Secondary and inpatient care often limited | Very developed, major driver of increases in price of services | Define core health services in insurance coverage |
| **Insurance market** | Universal health coverage goals guide development of national insurance systems. Diversity of alternative insurance products for private markets | No national consensus on coverage goals; private markets are dominated by a few large players | Devise universal health care strategy to guide public and private insurance design |
| **Information systems** | Human-centered design principles guide technology development | Heavy emphasis on traditional electronic clinical records; minimal use of contextual and mobile information | Incorporate human-centered design principles across all technology platforms |
| **Role of government** | Universal coverage is explicit long-term strategic goal; strong support for community-level change | Inconsistent goals and aims; lack of strategic interplay between top-down and bottom-up aims | Integrate community-level health goals into national strategies |





# Global to Local's model for community-led health

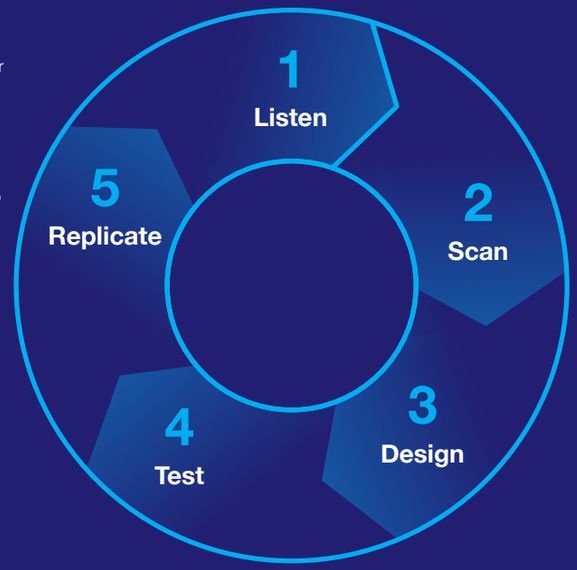
Over the last six years working in Washington communities, *Global to Local* has developed their concept into a model for replication. It can be adapted to any community and is summarized below in five essential elements.

**REPLICATE**

Global to Local shares their knowledge and provides expertise to institutions, community-based organizations, government agencies and community groups. Starting from deep listening, their model and programs can adapt to all communities.

**TEST**

Impact is tested through evaluation metrics and community feedback. Adjustments and modifications are made during implementation. Programs are tested to ensure solutions are effective.




**LISTEN**

Global to Local values communities as experts on their local environment. Engaging communities as well as local organizations and institutions ensures true community ownership. Through relationships, successful pilots are transferred to local organizations, generating community power and resilience. Listening is a crucial first step and continues through the entire process.

**SCAN**

Global to Local gathers best practices and research from around the world to be assessed as potential program material in addressing community needs. There is no need to re-invent the wheel.

**DESIGN**

Strategies are adapted through a co-design process involving community feedback and buy-in from local institutions. Designing in partnership is essential to a successful strategy.

Source: "Global to Local: a new model to improve community health." Global to Local Resources. (https://www.globaltolocal.org/resources/).

# Global Advantage Framework

## Cover & Define

**Coverage and access gaps should be mapped at the community level, and gaps in the ability of individuals and families to access and afford primary health services should be well-defined.**

In order to act strategically and efficiently within a defined community at existing resourcing levels, a backbone or a local integrator organization could be designated and developed to:

1. Define the geographic boundaries, demographics, and payer coverage and gaps including the uninsured.
2. Determine the primary health practices or clinics that serve them, as well as gaps in care or structural barriers to living a healthy life.
3. Utilize data analysis tools to determine who lacks access to health services or faces challenges in meeting their basic needs, including the need for social support.
4. Achieve community agreement on the role and the limits of the health system in meeting basic needs, and where coordinated community development activities should begin.
5. Continuously educate community members and frontline workers about policy changes that could impact their health and lead to more effective advocacy goals.

## Anchor & Embed

**Primary care health practices are anchor institutions in their neighborhoods. Practices should know where their patients live, and they should proactively link them to a community-based team and local services.**

In order to make primary care and community-based partnerships the foundation for breakthroughs in community health, a local integrator organization should be enabled to:

1. Identify all traditional primary care and population health-related assets, and map how they interact with community development activities.
2. Assign patients to health teams based on neighborhood, forming the basis for long-term relationships with health systems.
3. Engage the community in mapping community assets, rating the quality of existing services and identifying important cultural partnerships (e.g. congregations, advocacy groups for vulnerable populations).
4. Define and plan the ideal size and scope of activity for a community health team that includes health coaches, community health workers, community-based social workers and health care coordinators.
5. Develop a coordinated action plan that involves local social service agencies and relevant businesses to ensure that patients are able to meet their basic needs beyond clinical care.

## Shared & Actionable Goals

**Integrate mobile technologies that follow journeys of community members' care and track collaborations between the health system and community.**

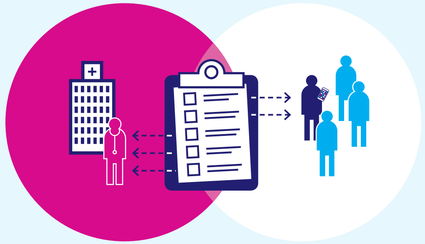
Progress should be displayed in a way that motivates communities and health systems to action.

In order to ensure a common set of goals that are shared between health systems and communities, and to build a shared and participatory implementation strategy, a local integrator organization should:

1. Design a participatory strategic planning and goal prioritization process.
2. Develop performance management systems that value improved health outcomes (vs. outputs).
3. Create compelling public-facing dashboards in community spaces to amplify progress and challenges to better health.
4. Integrate mobile technologies that follow journeys of community members' care and track collaborations between the health system and community.
5. Incorporate local knowledge and context to improve the design and effectiveness of health system workflows and follow-up.

## Simple Protocols & Accountable Care

**In order to develop an integrated community-based health workforce, a local integrator or backbone organization should foster ownership for health management in community settings.**

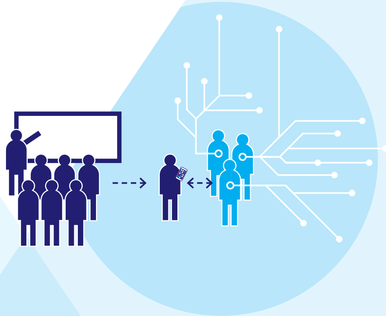


Accountable care has transitioned from a United States concept to one that is increasingly being adapted globally. Simplicity and community participation are increasingly emphasized abroad.

1. Help to define the complementary roles and responsibilities of different actors across community organizations that participate in the clinical or social care of a geographically-defined population.
2. Simplify care for people with chronic conditions by defining opportunities within care protocols where non-clinical providers can advance clinical goals.
3. Clarify and improve hand-offs with community-based clinical workers, social service workflows, and caregivers.
4. Ensure that the community is incentivized to support the health system in assembling the right care in the right place at the right time, particularly if it relates to their basic needs.
5. Incorporate community-generated protocols and workflows into clinical systems with appropriate confidentiality and permissions in place.

## Train & Organize

**Develop a network of community-based workers to organize community members, with the goal of identifying the most pressing health needs.**



In order to build an effective community health team that enables everyone to sees themselves as change agents, a local backbone organization should equip people to:

1. Train facility and community-based workers in joint teams to build situational awareness of roles and responsibilities required to accomplish shared goals.
2. Organize community members and caregivers to raise concerns and goals in dialogue with local health systems, which can act as partners in health.
3. Define one to three shared, high-priority goals that leverage health system investments as well as community-based assets and social capital.
4. Ensure clinical or public health communications are available to community stakeholders in clear, compelling language.
5. Co-design processes to include the voices of the community's most vulnerable people.

Icahn School of Medicine at Mount Sinai
*Arnhold Institute for Global Health*

## What tools can be used to implement breakthrough components?

A number of tools have been used in the United States and globally that can facilitate the implementation of components. Below is a brief description.

| Component | Tool(s) |
|---|---|
| **Anchor & Embed** | Collective impact business models and multi-sector partnerships |
| **Train & Organize** | Open-source curricula, peer learning networks |
| **Shared & Actionable Goals** | Community balanced score card, technology platforms |
| **Simple Protocols & Accountable Care** | Checklist protocols, comprehensive shared care plan supported by technology platforms |
| **Cover & Define** | Real-time health data at individual and community level, pathways for transforming regional health |

### The Accountable Care Framework Helps to Organize Breakthrough Components

| | Population | Performance measures (outcomes and resource use) | Continuous improvement | Payment and non-financial incentives | Care coordination and transformation |
|---|---|---|---|---|---|
| **Component definition** | Identify a defined population for which providers are responsible | Define a set of targeted performance measures that ensure patient-centered outcomes are met | Develop key data and evaluate performance through ongoing feedback loops to permit continuous improvement and adaptation | Establish aligned payments, non-financial incentives, and rewards for outcomes that matter to patients | Support the implementation of specific health care organizational and delivery steps to improve coordination and transform care |
| **Support areas for improvement** | Engage individuals and institutions in value-based care | Develop quality metrics that capture value | Develop and enhance capacity to assess performance and provide timely feedback on opportunities to improve performance | Identify financing and regulatory reforms to support care improvement | Support specific areas for improvement: workforce, data, team-based care, better decision support systems, better IT and analytics |
| **Key accountable care innovations** | • Identify priority needs to address a particular population (such as geographic area, low-income, or other subgroups)<br>• Primary care/care coordination for chronic diseases (initial step)<br>• Comprehensive health care (more advanced) | • Cost measures<br>• Measures based on individualized care plans<br>• Outcome measures<br>• Patient experience | • Timely and frequent feedback to providers<br>• National standardized set of measures<br>• Patient access to health record | • Transparent quality and utilization reporting<br>• Simple budget across services<br>• Bundled episode payments<br>• Aligned patient financial incentive<br>• Rewards for better performance<br>• Risk sharing<br>• Capitation with accountability | • Team-based care with non-clinicians<br>• Electronic health record that spans care continuum<br>• Pre-defined clinical care pathways<br>• Talent development<br>• Other needed organizational capabilities |
| Alignment of policy goals and sustainable financial support for health care reforms, to improve care and ensure the long-term viability of an innovative health system. | | | | | |

Source: McClellan, Mark et al. "Implementing Accountable Care to Achieve Better Health at a Lower Cost: Report of the WISH Accountable Care Forum 2016." Qatar Foundation and World Innovation Summit for Health. 2016. (www.wish-qatar.org/wish-2016/forum-reports).



## What does it take to implement components?

The Task Force identified three principles that have enabled low- and middle-income countries to make breakthroughs:

1) participatory process and adaptive design to advance a shared vision;

2) national emphasis on equitable community health;

3) sustained political will and local leadership.

There are initiatives underway across the country pursuing each of these approaches.

## Translating through an adaptive process and local champions

To improve American health outcomes, significant investments in knowledge production are needed. One critical area of investment is operational research on the design of breakthrough health systems that serve low-income communities. Much remains to be learned about what works, and why or why not, especially where existing approaches have not been used or documented to date. Even when the basic principles of community health are clear and universally applicable, each local setting poses special logistics, engagement, and delivery challenges that must be uncovered through operational research at the local level.

# Global to Local

*Global to Local* is a non-profit that began working to improve health outcomes in King County, (Seattle), Washington, by translating successful global health approaches to the region. They engaged local groups through interviews, online surveys and community focus groups. People mentioned financial instability, difficulty navigating health care and social services, language and cultural barriers, and feeling voiceless in how the community was run.

As a result, they developed community health worker programs to help residents. They also worked to identify and train "connectors" who could bridge city government staff and under-represented communities. Attuned to cultural differences, they have partnered strategically with groups like HealthPoint to refer community residents for women's only fitness programs.

*Global to Local* continues to evolve in response to community needs, and they have recently developed plans to expand to rural communities in Washington.

Other groups, such as ReThink Health, are developing adaptive pathways for transforming regional health that build from these local initiatives.

***100 Million Healthier Lives*** **has three core aims**

1) **Unprecedented collaboration of change agents**
2) **Innovative improvement approaches**
3) **System transformation**

The Task Force findings are only valuable if they solve problems in American communities. While many local leaders may not be interested in the global aspect of solutions, there is an appetite for a new approach, regardless of origin. For frontline implementers, the challenge is adapting solutions to their context.

Based on community needs, an implementation guide and roadmap for systemic change will need to be developed. Over time, implementers will likely find that certain components or sub-components provide more value or are more feasible in specific settings. One group that has led the way is the Seattle-based group *Global to Local.* They use a participatory design process to build community consensus, adapting global best practices.

In 2010, they collaborated with the University of Washington's Institute for Health Metrics and Evaluation and analyzed census tract level data for King County, Washington, to illustrate how different parts of the county compared across health outcomes. They spent seven months leading a participatory, adaptive process. They asked people, "What makes it hard for people in this community to be healthy?"

Other groups, such as ReThink Health, have developed adaptive pathways for transforming regional health that build from these local initiatives.

The Task Force's global scan and mini case studies illustrate that communities need strong leadership and political will to transform health. In the United States, nationwide political support for local solutions is growing and efforts to support dedicated local leaders are underway across the country.

The Last Mile health initiative, led by the *100 Million Healthier Lives* initiative and the Georgia Health Policy Center, borrows from the global "last mile" paradigm and aims to identify and support the five percent of American counties that face the greatest obstacles to achieving breakthroughs. Although it is in the early stages of development, it aims to co-design solutions with engaged American communities and their leaders through a participatory, adaptive process. Much of the emphasis will be on identifying and supporting local champions. The participation of groups like the National Association of County and City Officials is more likely to make this initiative a success.



## Changing the national conversation about community health

While a strong participatory process and engaged community leadership is essential, it is not enough to improve the health of people with the most complex conditions. Innovations usually start modestly, in one location. Brazil's Family Health Program began in the state of Ceara, and oral rehydration salts were first used to treat cholera in a refugee camp in West Bengal. After demonstrating impact, they *might* get adopted nationally. There are many examples of proven solutions that were slow to be adopted. Atul Gawande has said that problems which are visible and immediate are easier to respond to than invisible ones, the effects of which take a long time to become apparent. Formal evaluations can take upwards of ten years and may still not reach change makers. Even if they do, change makers may be hesitant to introduce them or community members may not be receptive. National learning networks facilitate the rapid dissemination of bright spots across the country, increasing the likelihood of adoption.

Task Force member Kedar Mate said, "We have learned at IHI when making any change, it helps to have colleagues, and friends, to help you in your darkest hour—because almost certainly you will have a dark hour when leading a change process." Peer support, and the process of individual and collective self-reflection improves implementation.

People are emboldened by being part of a movement. The knowledge that others are facing similar challenges—and surmounting them—is powerful. *100 Million Healthier Lives* is a global movement with the audacious goal of 100 million people living healthier lives by 2020. It has helped to cultivate a national focus on health equity in communities across America. As the global focus on Universal Health Coverage grows, a new generation of domestic change agents and place-based networks is getting ready to join the movement. ■

"People talking to people is still how the world's standards change."

–Atul Gawande, MD, MPH

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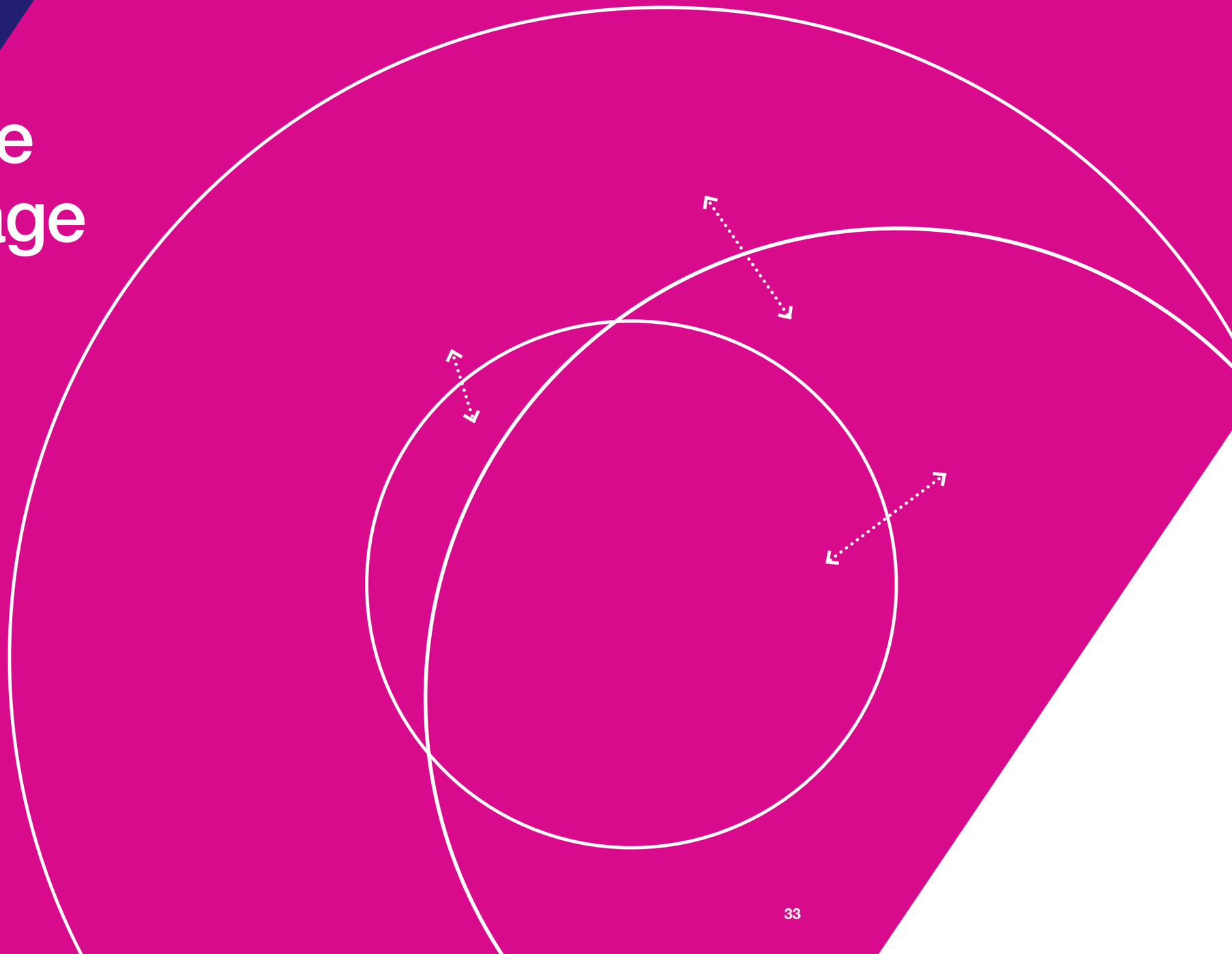
# 4
# Accelerating the Global Advantage

Growing interest in the United States in moving health care out of facilities may point providers toward global models.

—Task Force member Krishna Udayakumar, MD, MBA and co-authors in Health Affairs



# Key Recommendations

When America realizes the Global Advantage, it will be expected to look for solutions to health care challenges from abroad. Currently, this is the exception rather than the norm. To move forward, the Task Force has identified key recommendations, the initial members of guiding coalition, and the profile of change agents who can increase the impact and influence of this coalition as it grows.

### Accelerate Global Exchange with Domestic Communities through Learning and Testing.

1) Translate Global Advantage Task Force findings into next steps for adaptation and implementation, including a timeline.

2) Select an organization to develop a national learning network of health systems and communities to collaboratively test, adapt, and implement ideas sourced from global settings.

### Develop Processes and Protocols to Proactively Link Global and United States Health Initiatives.

1) Conduct in-depth case studies of break-through strategies and solutions in low- and middle-income countries to build upon Task Force findings.

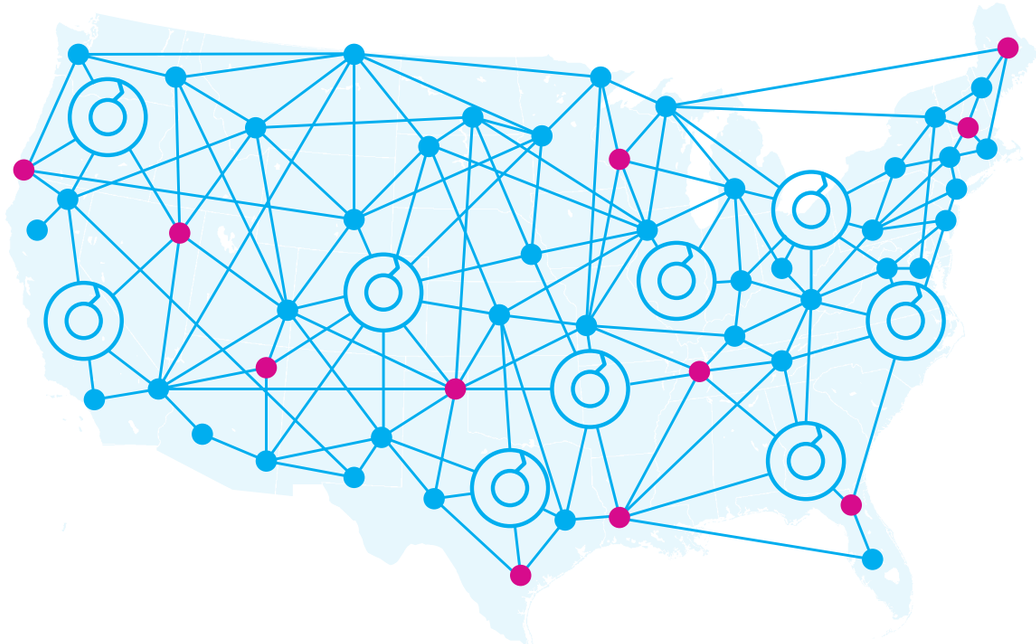
2) Develop a common framework to collect sub-district data in the United States and in low- and middle-income countries. This will help to identify promising strategies beyond those in the Task Force findings.

### Advocate for Investment and Implementation of Task Force Recommendations.

1) Develop a business case for the guiding coalition to package and spread high performing solutions from a national learning network.

2) Advocate for local and state policy to test Global Advantage-related findings.





# A Guiding Coalition

Over the past few years, there has been an upsurge in networks and coalitions that are working to insource global best practices to accelerate the transformation of American health and health care. Many more are in early stages of development or on the horizon. The Task Force on Global Advantage is working with many of them and sharing lessons learned.

| Initiative name | Host Organization(s) | Brief description | Status |
|---|---|---|---|
| **The Task Force on Global Advantage** | The Arnhold Institute for Global Health | The Task Force is comprised of leading global and United States health care leaders, focused on distilling global best practices and mindsets which are relevant for introduction in the United States. | Ongoing |
| **Global to Local Coalition** | Global to Local | Focus is testing global approaches in diverse United States geographies. | Early stages |
| **International Program for United States Health Care Delivery System Innovation** | Institute for Healthcare Improvement, Commonwealth Fund | Identifies frontline delivery system innovations from abroad that can be transferred to the United States health care system to improve quality, control costs, and increase value. | Third phase |
| **Transfer of Payment and Delivery System Innovations from Abroad to the United States** | Duke Global Health Innovation Center, Duke Margolis Center for Health Policy | Working with an advisory board and implementation partners to identify a set of care innovations for high-need, high-cost patients that were implemented outside the United States and appear promising to implementation partners. | Ongoing |
| **Last Mile Communities** | 100 Million Healthier Lives, Georgia Health Policy Center | Co-design one or more support system approaches that would be effective in Last Mile communities, test them, and develop a plan for scale. | Early stages |

### Key Reference

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# Appendix

# Appendix: Methods, Limitations and Strengths


## Methods

- Identified leading global and United States health care leaders.
- Invited leading experts to participate in the Task Force and recommend experts.
- Led subject domain calls with Task Force members to identify focus areas.
- Conducted an environmental scan of literature, reports, and informant discussions to inform framing and thematic conclusions. Analyzed similar initiatives for key findings and next steps.
- Analyzed available data to inform core concept development; shifted data-driven strategy to include mini case studies due to lack of relevant data availability.
- Solicited Task Force feedback on report.
- Convened Task Force members twice to address framing, review findings and provide feedback on analysis and messaging.

## Limitations

- Lack of global sub-national data, model case studies and performance evaluations.
- Lack of standardized global metrics to facilitate cross-country comparisons on service models.
- Limited descriptions of components of national health systems in low- and middle-income countries.

## Strengths

- Composition of Task Force members and commissioners reflect a wide range of domestic and global (high- middle-, and low-income country) experience.
- Report transitions discussions from lists and individual solutions to core themes, mindsets, and implementation processes.
- Applying approaches of high-performing low- and middle-income countries to lowest-performing United States communities forms the basis for future work.



# Appendix: Key Points from the First Meeting of the Task Force on Global Advantage

## Framing questions

- There is no norm for health care leaders in the United States to look abroad for solutions to complex health problems.
  - How do we make it easy to look globally for solutions to United States health care problems?
- How do we catalyze a mindset shift among health care leaders who do not think to look globally for solutions to their problems?
  - Does anyone care to have this mindset shift?
  - Catalytic events lead to mindset change.
- Ebola is an example of a catalytic event which prompted African governments to accelerate investments in commmunity health. Could the opioid epidemic do the same?
- What is the incentive for global practitioners to produce knowledge for United States' health care leaders?

## User and design questions

- Who are the actors and adopters that we aim to serve with global models?
- The user-driven nature of problem identification and solution-finding is important.
- How can users be engaged in the design process in the United States?
- User-centered design is time intensive; how can it be scaled?

## Translation questions

- Why are some effective global initiatives difficult to translate into the United States context?
- How can we measure impact and efficiency in faster cycles?

## Final thoughts

- The United States needs to improve coordination across sectors and create more space for experimentation.
- Alternative payments have created a space for innovation.
- There is demand for solutions wherever they exist.
- The role of the Task Force is to focus on synthesizing solutions holistically, which will support rural, low-income settings.
- Now is the time to argue for enabling environments where there is a critical need for a new solution.

# Appendix: Key Points from the Second Meeting of the Task Force on Global Advantage

## Framing Global Advantage

- A stronger case for seeking global solutions to domestic health problems is needed.
- The hypothesis of global advantage is complex.

  Greater clarity is needed around the following areas:

  - Where are the parameters—what is and isn't global advantage?
  - Distinguishing between similarities and differences (e.g. culture, disease burden) between global and domestic areas in focus.
  - There could be value in analyzing health outcomes across a range of measures in the Global South and the United States to identify peers.
    - Global Advantage is an experimental theory—framing does not have to be perfect yet.
    - Being granular is more important than being splashy.

## Report feedback

- Acknowledge the political elements of the report.
  - Need for political will should be mentioned.
- What was the process of distilling down to the components?
  - Recommendation to add a section to the report that includes mini case studies to illustrate the origin of the components
- The final section should include a series of action plans.
  - Intermediaries will be necessary to translate an action plan into implementation.
- The report should consider in depth the challenges of global to local translation; otherwise it risks sounding like platitudes.

## Messaging

- Who are the decision-makers for whom this is relevant?
- Health executive and county leaders are likely to be skeptical about global comparisons when implementing.

  A frame for audience type was proposed:

  - Doers—People who implement initiatives.
    - This is the most important audience.
    - They need clear, practical and specific guidance on solutions.
  - Makers—Service designers to apply human-centered design to understand community needs and build solutions to address them.
  - Shapers—People who influence the environment.
- Greater depth around a few cases would be beneficial.
- The examples should either be more general, or much more detailed. Preference for greater depth.
- People invest in people's stories.
- Simplicity matters.
  - Be specific and clear about the change(s) being proposed, their features, and the design process that contributed to it.



Design: Stislow Design, Brooklyn, NY