P14 / Public Policy and its Impact on the Health-related Sustainable Development Goals: Enactment, Enforcement, Effectiveness, and Equity

Topic : POLICY DESIGN, POLICY ANALYSIS, EXPERTISE AND EVALUATION

Chair : Arijit Nandi (McGill University)

GENERAL OBJECTIVES, RESEARCH QUESTIONS AND SCIENTIFIC RELEVANCE

Public policies feature prominently as potential solutions to and the “means of implementation” for achieving the health-related Sustainable Development Goals. As the former Secretary General Ban Ki-moon remarked, “With the right policies, adequate and fairly distributed funding, and a relentless resolve to deliver to those who need it most – we can and will make a life-changing difference for current and future generations.” But, which policies are the “right” policies?

Public policies are constantly evolving, both within and across countries, and the rigorous evaluation of policy reforms can generate causal evidence on the effect of a particular program or policy and can help assess if the intervention was effective (or not). As evidence builds incrementally, we can synthesize findings and generate timely and actionable evidence for improving population health and mitigating health inequalities.

Major gaps exist, however, in our understanding of how public policy impacts population health and health inequality. First, there are critical data gaps, in terms of the legislative reforms that have been recently enacted, the enforcement of these reforms, and the health outcomes plausibly affected. Second, we often lack information on the effectiveness of different policy interventions, or “natural experiments”, particularly those implemented at scale (e.g., nationally). Recent growth in the application of quasi-experimental methods for impact evaluation, coupled with qualitative methods for monitoring and evaluation, could enhance our understanding of the consequences of specific policy reforms in terms of their health effects, as well as their influence on gender and social inequalities in health. Third, impact evaluation of public policies remains a black box, and we frequently lack information on specific mechanisms of action. Fourth, the cost-effectiveness of distinct policy reforms is usually unknown, and this information could inform evidence-based policymaking. The objective of this panel is to identify solutions for addressing these gaps.

CALL FOR PAPERS

The 17 Sustainable Development Goals (SDGs) adopted in 2015 comprise a number of health-related targets, primarily under Goal 3: Good health and wellbeing. These health-related SDGs cannot be achieved without the design and implementation of effective national-level policies, including those targeting the social determinants of health By affecting the “circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness”, broadly defined as the social determinants of health, public policies have the potential to influence population health and health inequalities. However, our ability to use public policy as an instrument to improve population health and reduce health inequalities is limited: we do not yet understand well enough how public policies and programs can be used to influence social determinants of health. Rigorously assessing the impact of interventions, from national policies to smaller-scale programs, has become an active area of inquiry in social sciences such as economics, but less so in public health. Through impact evaluation, we can achieve a better understanding of which public policies and programs really make a difference to population health.

This panel is soliciting papers relevant to the study of national-level public policies and their impact on the health-related SDGs. Areas of interest include: comparative policy analysis and the identification of policy “experiments”, including those related to social, health, public health, and environmental health policy; enforcement and the assessment of policy enforcement; methods for impact evaluation, including quasi-experimental approaches, as well as how qualitative and mixed-methods approaches can be employed to complement quantitative tools for impact evaluation; cost-effectiveness and extended cost-effectiveness analyses for examining the effects of legislative reforms in relation to their costs. We welcome submissions from non-academics interested in the process of policy formation, as well as academics interested in policy evaluation.

Accordingly, some examples of interest include, but are not limited to:

(1) studies investigating the evaluation of public policy approaches and the factors influencing trends;

(2) research into the enforcement of different public policies approaches;

(3) studies assessing the impact of public policies on health-related SDGs, or inequalities in these outcomes;

(4) investigation of the mechanisms through which public policies might influence population health;

(5) accounting of the costs of alternative policy approaches, particularly when put in context with their effects.

The panel also welcomes discussion papers from knowledge users such as non-governmental organizations and government departments, on for example, their experiences with impact evaluation or what their organizations need from researchers.

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Session 1

Wednesday, June 26th 14:00 to 16:00 (MB 9 B)

Canadian Health Care Delivery: Federalism, Centralization, Decentralization and the Changing National Role

Howard Palley (Sch, of Social Wk, University of Maryland)

The political history of Canadian health care policy conveys a pattern of ebb and flow with regard to the exercise of centralized authority of national policy and periods of decentralization with greater involvement of provincial and territorial level. The implications of these trends will be addressed.
A level of national accountability for health and medical services was lost with the passage of the Established Programs Financing Act of 1977 which eliminated a matching grant arrangement, the Canada Health Act of 1984 (CHA) sought to restate and clarify the federal parameters governing federal funding of health care to the provinces and territories. While some oversight and review of provincial and territorial statutory requirements in return for federal funds for health care was reestablished with the CHA, the level of federal oversight of the actions of the provinces and territories was limited. Nevertheless, the CHA in 1984 reiterated the 5 obligated areas of Canadian national health care policy plus explicitly prohibiting user fees and “extra billing” (beyond agreed payment levels). However the increasing expenses of health care delivery led to protests by the premiers of the provinces and territories for increased federal funding. This led tp negotiations by the Liberal national government with the premiers of a 2004 National Accord with the provinces and territories with the assumption that this funding would lead to reforms regarding the efficiency and accountability of these units to the provision of less wasteful and better organized health care services regarding areas like wait times, uncoordinated levels of care, electronic record keeping and hospital utilization. Unfortunately this effort failed in the sense that Canadian performance in significant areas continued to poorly relative to other OECD nations.
With the ascendancy of a Conservative national government in February, 2006, the new government articulated a commitment to what it termed “open federalism.” Within the area of health care delivery that meant little willingness at the national level to determine whether the principles of the CHA were effectively implemented at the provincial and territorial levels. Furthermore towards the later period of Conservative rule, negotiations regarding federal funding of provincial and territorial health care budgets were not negotiated between levels of government meetings but rather solely through the action of Canada’s Finance Ministry. Upon assumption of national authority by the Liberal Party in November, 2015, the nature of federalism changed once more. Nevertheless, budget determination for health care delivery was still decided primarily at the national Finance Ministry level. What changed was a negotiation between the individual provinces and territories that in return for federal money, the various provinces and territories would make specific commitments to attend to specified improvements in health care delivery. Thus there was a return to a nationally directed fiscal federalism approach and a rejection of open (or laissez-faire) federalism.
This paper will examine the various political/historical shifts occurring in various political winds and examine whether and to what extent any of these political winds affected the local quality of and accessibility to more efficient health care delivery.

Understanding Public Policy Priorities for Childhood Disabilities in Canada Through Computational Text Mining of Public Consultation Data

Keiko Shikako (McGill University)

In 2017 the government of Canada conducted the largest stakeholder consultation of history, inquiring

Canadians to provide their input on what were the pressing issues related to making Canada "Accessible to all". This consultation aimed at informing the development of the "Accessibility Legislation" now in development as the Bill- 81 "The Accessible Canada Act". The stakeholder consultation followed an extensive and highly inclusive approach to consultations, including open public consultations across all major Canadian cities, youth forums, an online survey, in addition to opportunities for free submission by experts, advocacy groups, and persons with disabilities themselves. The consultation materials opened a historic opportunity to access the opinions of stakeholders across Canada about a diversity of factors related to disability in general, under the broad umbrella of Accessibility. While some of this material is being considered in the development and iterations of the Act, a wealth of additional information that may not apply to the federal legislation development may be revealed in the over 10,000 sources submitted during the consultation period. In an agreement with the Office for Disability Issues, we requested access to this information with a specific interest in identifying the priorities and aspects related to human rights for the population of children with disabilities in Canada. Over 500,000 Canadian children have some type of disability, and several health and education, civil society, and other organizations, as well as youth and families and experts in the field, may have contributed to raising important topics related to the needs of children with disabilities and their families in the context of creating a fully accessible country for all. In partnership with the Institute on Disability Policy based at American University, we are conducting computational text mining on these documents, to identify specifically child-related factors that can inform research, services, and policy for children with disabilities in Canada. Using the CRISP-DM (Cross-Industry Standard Process for Data Mining) approach to text mining, data from federal government public consultations are being analyzed inductively (Keyword frequency analysis, phrase frequency analysis, named entity extraction and topic modeling) and deductively (creation of key variables including: organization type, region, and language - to compare across each inductive items, and categorization model of key services aimed at children and youth - to assess absence or presence of these concepts in the dataset). Categorization models will capture articles in the UNCRPD and UNCRC to assess the relationship between Canadian public policy preferences and existing UN conventions, especially advancing the understanding of the SDGs related to reducing inequalities for the vulnerable population of children with disabilities. This study will also contribute to a longitudinal analysis of policy implementation as the Accessibility Legislation rolls out, and create a model to understand the use of stakeholders' priorities into public policy development, and the extent to which policies address inequities either by reducing or reinforcing them for groups of individuals who face multiple discrimination. Collaboration between research and government to access, analyze and use public consultation materials can be a source of information to guide research and policy towards the realization of SDGs.

Assessing the implementation of health promoting program: the case of the Health Academy in Brazil

Dalila Tusset (University of Brasilia)

Paulo Calmon (Universidade de Brasília)

The high prevalence of chronic noncommunicable diseases (NCD) is a global problem that demands specific interventions aimed to promote health and NCD prevention, especially in the most vulnerable regions and social contexts. In order to face this challenge, since 2011 the Brazilian Ministry of Health, through the Unified Health System (SUS), has been implementing a federal program called "Academia da Saude – Health Academy" (HAP), integrated to primary healthcare settings. The purpose of HAP is to make available in more than 3,000 Brazilian municipalities public spaces with suitable infrastructure for the practice of health promotion, health education, physical activities, complementary and integrative practices. Activities of HAP are supported by teams of certified health professionals that can offer health care activities, seminars and workshops aimed to engage the local community in a healthy and sustainable lifestyle. The construction of HAP's facilities followed two different paths. Part of the facilities was built according to a strategic plan developed by the Ministry of Health and was supported by funds provided by the Ministry´s budget. Other facilities were built only by request of congressmen and were financed with specific budget amendments proposed by these representatives. Therefore, HAP gives us a unique opportunity to evaluate the interaction between political, socio-economic and public health variables in the implementation of programs aimed to promote health and sustainable living. This study intends to examine the factors affecting the success in the implementation of HAP using a sample of Brazilian Municipalities. Our dependent variable is the implementation level of the HAP, classified in four different categories (withdrawn, low, regular and acceptable) according to a hierarchical cluster analysis technique and pseudo-T methodology. Independent variables at the municipal level are municipal Human Development Index; municipal coverage by other federal health programs; municipal Governance Index; political party convergences between politicians at the municipal, state and federal levels; municipal population size; macro-region; and municipal involvement on similar health/education programs. Nine regression models were tested. Stepwise regression method was used to automatically select the independent variables that should be included in each model. By comparing results from different modes of implementation, we are

able to show that institutional and political variables matters and the implementation level and effectiveness of the program is affected by political variables. We hope this study will contribute to the debate on improving strategies for the implementation of programs that aimed to promote health education and sustainable living.

Impact of Trauma Center Accreditation in Quebec

Brice Batomen (McGill University)
Arijit Nandi (McGill University)

Injuries are the leading cause of death under 40 years of age in North America. The introduction of trauma systems, defined as an organized and multidisciplinary response to injury from pre-hospital to rehabilitation and community integration, has led to important reductions in injury burdens in many high-income countries. Essential to the development of a trauma system is the designation of trauma centres, which is the role of the state or provinces. Trauma centres are medical centres where resources are prioritized to ensure that injured patients receive full and timely resuscitation and definitive care. Many North American trauma organizations have established trauma facility standard guidelines from which an accreditation process was developed to determine whether trauma centres fulfill the criteria for optimal care. Perceived advantages of accreditation include engagement and commitment, team work and the identification of improvement opportunities and priorities. Criticisms include the costs and mobilization of resources and the possibility that improvements in care are only transitory. Accreditation is, however, an expensive and resource-consuming process, which is generally accomplished by a center submitting a prereview questionnaire and completing an on-site review of the hospital by a peer review team experienced in trauma care. Accreditation of trauma centres is mandatory in Quebec, however, it impact remains unclear, due to several methodological shortcomings in the literature, such as the use of simple pre- and post-accreditation comparisons of outcomes. The Quebec trauma registry was queried, and we used a robust interrupted time-series analysis to assess if accreditation of trauma centres influences adherence to processes of care and patient outcomes between 2010-2017.

Can a new emergency response system reduce traffic fatalities? The case of Dominican Republic.

Jose Ignacio Nazif-Munoz (Université de Sherbrooke)
Arijit Nandi (McGill University)

Research question:

By 2015 the Dominican Republic had the highest traffic fatality rate of Latin America and the Caribbean with 34.6 fatalities per population. In May 2014, the Dominican Republic introduced the 911-emergency response system. Before that program more than 40 phone numbers were available to report emergencies. This lack of institutional coordination delayed the timely provision of emergency services to traffic accident victims. The Dominican government introduced this new program into Santo Domingo and planned its expansion throughout its territory for subsequent years. The objective of this work is to assess the extent under which this new emergency response system was effective in reducing traffic fatalities.
Methods:

Weekly number of traffic fatalities per population and per vehicle fleet from January 2013 to December 2016 were obtained from the Ministry of Health and the National Institute of Statistics. A difference-in-differences analysis using multivariate Poisson regressions, controlling for city characteristics, seasonality and time effects, was performed. The intervention group was the National District and the control group the city of San Cristóbal.
Results: Empirical estimates from the models suggest that the introduction of the 911-emergency response system was associated with a decrease of 0.52 (95% Confidence Interval [CI]: -1.06; 0.00) in the weekly number of traffic fatalities per capita, which is equivalent to a 4.2% reduction. No concomitant association between the control group and the exposure group was observed before the introduction of the 911-emergency response system. The impact of the intervention in the weekly number of traffic fatalities per vehicle fleet was associated with a decrease of 0.39 (95% CI: -0.64; -0.13), which is equivalent to a 3.6% reduction. Before the intervention the treated group had lower traffic fatalities per vehicle fleet relative to the control group.
Discussion:

Our findings suggest that coordinated emergencies systems should be considered more attentively as instruments to reduce traffic fatalities. However, the case of the Dominican Republic calls for more methodological research to understand how to assess road safety policies more accurately. While certain authors claim that vehicle fleet should be used instead of population rates when measures of kilometer driven are absent, in countries such as the Dominican Republic, in which motor vehicles sales have skyrocketed, this can be problematic

Can Conditional Cash Transfers Improve Maternal and Child Health? Evaluating India's Conditional Maternity Benefit Program

Raghav Puri (Maxwell School of Citizenship and Public Affairs, Syracuse University)

National-level public policies that aim to improve maternal and child health in low-income countries are pivotal for achieving the third Sustainable Development Goal (SDG) to "ensure healthy lives and promote well-being for all at all ages." This is particularly true for India which accounts for a significant share of maternal deaths across the globe. This paper will present the first estimates of the impact of conditional cash transfers on maternal and child health by evaluating India's conditional maternity benefit program – the Indira Gandhi Matritva Sahyog Yojana (IGMSY, or the Indira Gandhi Motherhood Support Program).

The IGMSY is a conditional maternity benefit program that provides a cash benefit to pregnant women for their first two live births. The cash benefit is provided in three installments conditional on meeting a set of criteria. The first payment is made at the end of the second trimester if the pregnant mother has registered the pregnancy, received at least one antenatal checkup and received at least one tetanus vaccination. The second payment is made after three months of delivery if the birth has been registered, the child has received the required vaccinations and has been weighed at least two times. The third payment is made once the infant completes six months, has been exclusively breastfed and has received the remaining vaccinations. By encouraging these positive behaviors, the conditional maternity benefit program aims to improve maternal and child health outcomes in India.

The program was implemented in 52 of India's 640 districts in 2011 and scaled up to all districts in 2017. The 52 districts for IGMSY implementation were selected using a composite score developed by the Government of India's Ministry of Women and Child Development (MoWCD). The composite score was created using six maternal and child health indicators from a national health survey conducted in 2007-08. The score was used to rank all 640 districts of India and a mix of high, medium and low scoring districts were selected.

The selection process of these districts along with recently released data from the National Health and Family Survey (NFHS) conducted in 2015-16 provide an ideal setting to use a quasi-experimental design to estimate the effect of conditional cash transfers on maternal and child health outcomes. This paper will use the composite score developed by the Government of India to select matching "control" districts for each IGMSY district. The impact of the conditional maternity benefit program on maternal and child health outcomes will be evaluated using a difference-in-differences identification strategy. The quantitative results will be supported by qualitative findings from in-depth interviews with program administrators and beneficiaries (conducted by the author in 16 villages across 4 IGMSY districts in the summer of 2018).

This paper fits well with the theme of the panel and makes an important contribution to research on national-level public policies on health related SDGs.