No Universal Health Coverage without quality

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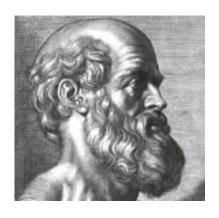
Goes back a long way...

- Hippocrates writes,
  "I will never do harm to anyone"

- Later translated (& changed)
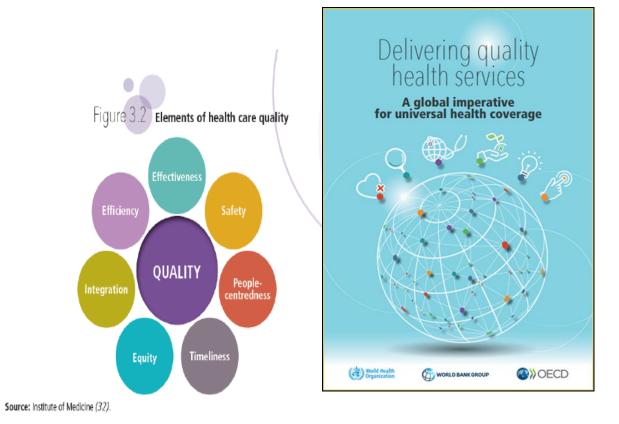 "Primum non nocere"

"First do no harm"

Fourth Century B.C

Source: Understanding patient safety by Robert Wachter. 2008

Quality health services? Health care that is...

- **Effective**
- **Safe**
- **People-centred**
- **Timely**
- **Equitable**
- **Integrated**
- **Efficient**

Figure 3.2 Elements of health care quality

QUALITY

Effectiveness
Safety
Efficiency
People-centredness
Integration
Equity
Timeliness

Source: Institute of Medicine (32).

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- Improving quality implies change.
- Quality is multi-dimensional.
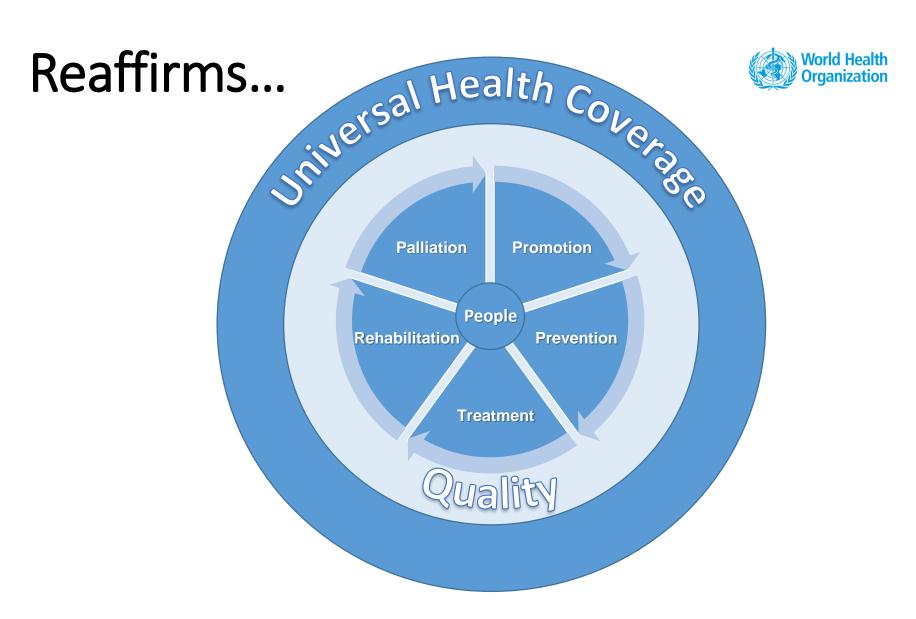- Quality is the product of individuals working with the right attitude in the right system.

3 GOOD HEALTH AND WELL-BEING

Ensure healthy lives and promote well-being for all at all ages

Target 3.8   Achieve **universal health coverage**, including financial risk protection, access to *quality* essential health-care services and access to safe, effective, *quality* and affordable essential medicines and vaccines for all.

Universal Health Coverage

Ensuring that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient **quality** to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

Reaffirms...

UHC – an empty promise without quality

- Access to care means little if services are not *effective*

- Substandard care wastes significant resources

- Poor quality often the result of health system failures, not the fault of individual providers

- Quality is not a luxury that only rich countries can afford--- arguably even more important where resources constrained

2018 - Affirming quality as central to UHC

Three Reports in 2018:
Building the evidence and responding to the call for a UHC with Quality

Strong & clear – united voice for quality!

A focus on people-centredness has to be the core of quality. People and communities must be engaged in the design, delivery, and ongoing assessment of health services to ensure they are built to meet local health needs – rather than those of donors, commercial or political interests, or because "it's always been done that way". Focusing on quality is critical, but leadership must also focus on celebrating excellence; communicating transparently; and fostering collaboration across clinical teams, as well as with patients, and civil society – including patient groups, nongovernmental organizations, and grassroots community groups.

Universal health coverage is not a dream for the future. It is already a reality in many countries; however, without quality health services, it can remain an empty promise. This foundational report builds a strong technical and political case for investing in quality health services. The collective prize is a healthier, safer and fairer world.
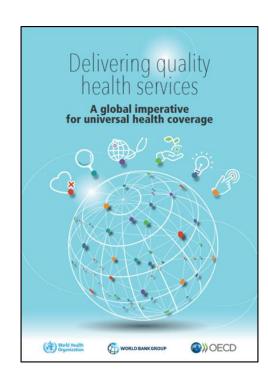
Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

Jim Yong Kim
President
The World Bank Group

Angel Gurría
Secretary-General
OECD

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A Call to Connect UHC to Quality

"Without a **deliberate and comprehensive effort** to improve the quality of health care services globally, UHC will too often prove to be **an empty vessel"** (NASEM)

"Universal health coverage ..... **without quality** health services, can remain **an empty promise**" (WHO/WB/OECD)

"The human right to health is **meaningless without good quality care** because health systems cannot improve health without it" (HQSS)

How could health care be anything other than high quality?

We now need to urgently support countries—together—to implement recommendations from these reports. One way we are doing that is through the WHO Initiative on National Quality Policy and Strategy.

https://www.thelancet.com/action/showPdf?pii=S2214-109X%2818%2930394-2
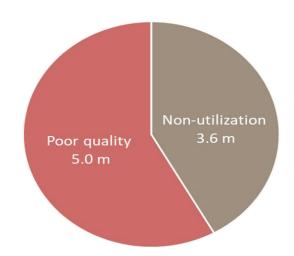
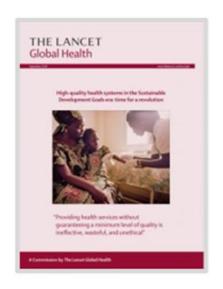Without quality, universal health coverage (UHC) remains an empty promise. Even with increased access to services, health improvements can remain elusive unless those services are of sufficient quality to be effective

Deaths due to poor quality

- **8.6 million** deaths per year (UI 8.5-8.8) in 137 LMICs are due to inadequate access to quality care.

- Of these, **3.6 million** (UI 3.5-3.7) are people who did not access the health system.

- Whereas, **5.0 million** (UI 4.9-5.2) are people who sought care but received poor quality care.

What do we know about the state of quality in low and middle income countries?

- Up to **15% of overall deaths** are attributed to poor-quality care each year in low- and middle-income countries. (NASEM)

- Nearly **134 million adverse events** are estimated to occur annually as a result of unsafe medical care, contributing to **2.6 million deaths** in low- and middle-income countries. (NASEM)

- **34% of people in LMICs reported poor user experience**, citing a lack of attention or respect from facility staff (41%), poor communication (21%), or short time spent with providers (37%). (HQSS)

- High-quality health systems could prevent **1 million newborn deaths and half of all maternal deaths** each year. (HQSS)

- One third of patients experience **disrespectful care, short consultations, poor communication or long wait times** (Lancet Commission for High-Quality Health Systems, 2018), and less than 25% of people in LMICs believe that their health system works well (HQSS)

- Costs of **lost productivity** from poor quality care amounts to between **$1.4 and $1.6 trillion each year** (NASEM), with **economic welfare losses of $6 trillion** (HQSS)

- Private vs Public Systems: **quality similarly lacking in both**

Beyond mortality: effects of poor quality

Morbidity, pain, loss of function, antimicrobial resistance

HUMAN SUFFERING

Loss of trust in health systems and government; Failure of Social Contract

Waste and economic losses

Health emergencies risk

Lancet Global Health Commission on High Quality Health Systems in the SDG era

- Poor-quality care is now a bigger barrier to reducing mortality than insufficient access.

- 60% of de
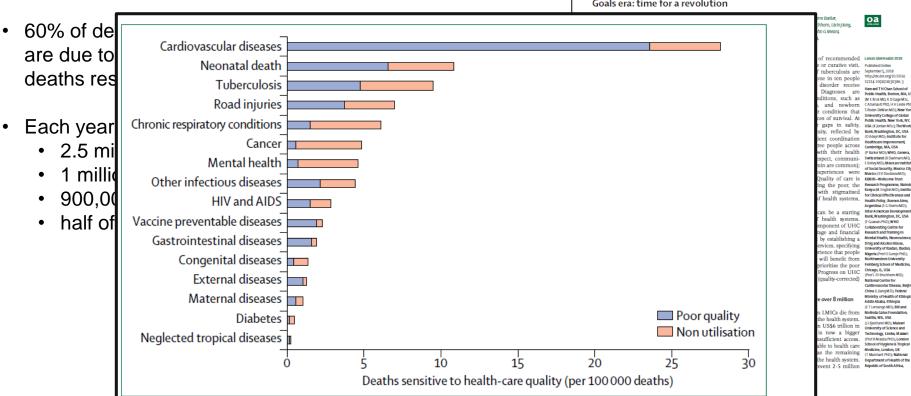 are due to
  deaths res

- Each year
  - 2.5 mi
  - 1 milli
  - 900,00
  - half of

Figure 5: Deaths from Sustainable Development Goal conditions due to poor-quality care and non-utilisation in 137 low-income and middle-income countries[94]

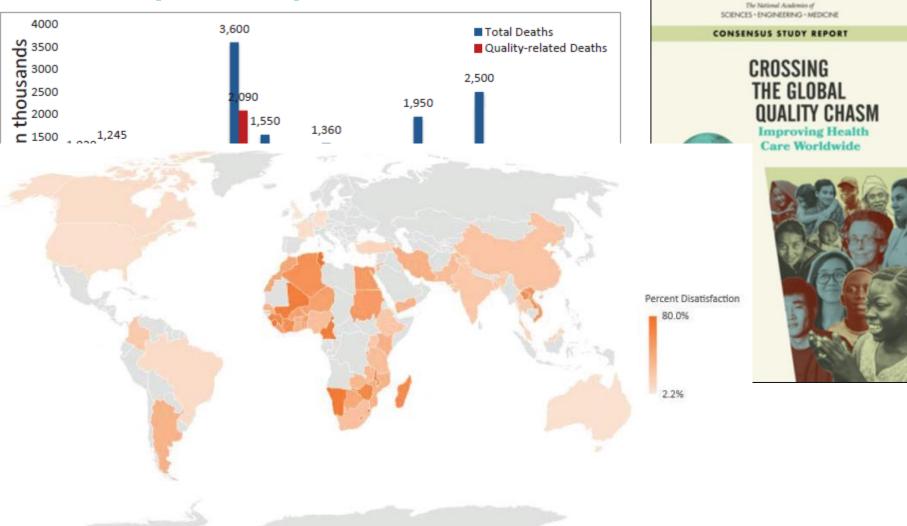# Crossing the Global Quality Chasm (NASEM)

FIGURE 4-2 National levels of dissatisfaction with care.

Delivering Quality Health Services (WHO-WB-OECD)

Box 6.1 **High-level actions by key constituencies for quality in health care**
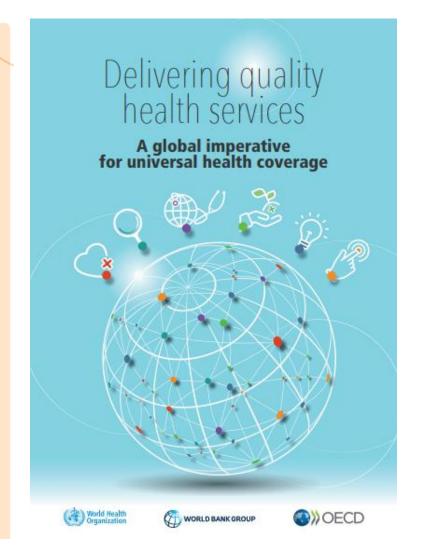
All governments should:

- have a national quality policy and strategy;
- demonstrate accountability for delivering a safe high-quality service;
- ensure that reforms driven by the goal of universal health coverage build quality into the foundation of their care systems;
- ensure that health systems have an infrastructure of information and information technology capable of measuring and reporting the quality of care;
- close the gap between actual and achievable performance in quality;
- strengthen the partnerships between health providers and health users that drive quality in care;
- establish and sustain a health professional workforce with the capacity and capability to meet the demands and needs of the population for high-quality care;
- purchase, fund and commission based on the principle of value;
- finance quality improvement research.

All health systems should:

- implement evidence-based interventions that demonstrate improvement;
- benchmark against similar systems that are delivering best performance;
- ensure that all people with chronic disease are enabled to minimize its impact on the quality of their lives;
- promote the culture systems and practices that will reduce harm to patients;
- build resilience to enable prevention, detection and response to health security threats through focused attention on quality;
- put in place the infrastructure for learning;
- provide technical assistance and knowledge management for improvement.

All citizens and patients should:

- be empowered to actively engage in care to optimize their health status;
- play a leading role in the design of new models of care to meet the needs of the local community;

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What can be done?

Do we know what works to improve quality?

Quality issues: common across world

World Health Organization

Human factors

- **Lack of knowledge—don't know right thing to do**

- **Know but don't do– lack of compliance to guidelines/standards**

- **Human Errors (ex . wrong diagnosis, medication errors)**

- **Failures in communication (between providers, with patients)**

- **Patients and families ; not understanding and non compliant**

System Issues
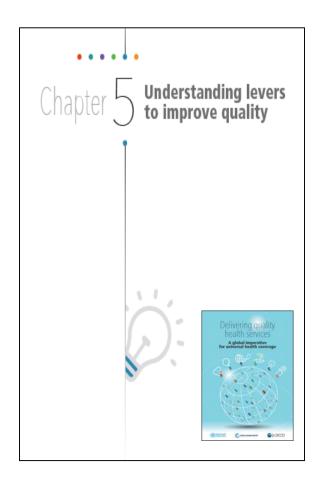
- **Lack of and/or unstable resourcing**

- **Unsafe environment (ex. hospital acquired infections)**

- **Information deficits (poor medical records; deficient HMIS)**

- **Lack of integrated care across levels – poor referrals and follow up care**

- **Lack of accountability for quality of care**

Quality Interventions

- **Interventions form the substance --the what and the how -- of the strategy. These are the change-oriented actions!**

- In each country, interventions should make up a coherent framework

  - Policies, processes, management actions etc.

  - Action required across all levels of health system (national, regional, facility, community, individual)

  - Engage all key actors-
    - policy makers, providers, facilities, patients, families, communities, regulators, payers, civil society

  - Address all domains of quality: safety, effectiveness, people centeredness equity, efficiency, timeliness, integration

Quality Interventions

Chapter 5 — Understanding levers to improve quality

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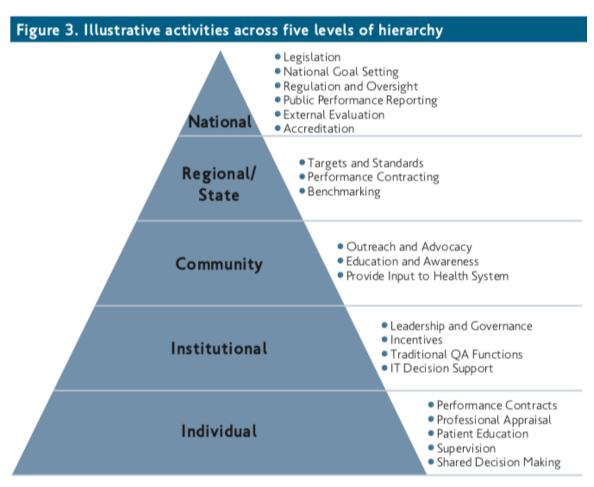| Category	Interventions
System environment	• **Registration and licensing** of doctors and other health professionals, as well as health organizations, is often considered a key determinant and foundation of a well performing health system.
Reducing harm	• **Inspection of institutions for minimum safety standards** can be used as a mechanism to ensure there is a baseline capacity and resources to maintain a safe clinical environment.
Improvement in clinical care	• **Clinical decision support tools** provide knowledge and patient-specific information (automated or paper based) at appropriate times to enhance front-line health care delivery.
Patient, family and community engagement and empowerment	• **Formalized community engagement and empowerment** refers to the active and intentional contribution of community members to the health of a community's population and the performance of the health delivery system, and can function as an additional accountability mechanism. • **Health literacy** is the capacity to obtain and understand basic health information required to make appropriate health decisions on the part of patients, families and wider communities consistently, and is intimately linked with quality of care. • **Shared decision-making** is often employed to more appropriately tailor care to patient needs and preferences, with the goal of improving patient adherence and minimizing unnecessary future care. • **Peer support and expert patient groups** link people living with similar clinical conditions in order to share knowledge and experiences. It creates the emotional, social and practical support for improving clinical care. • **Patient experience of care** has received significant attention as the basis of designing improvements in clinical care. Patient-reported measures are important unto themselves; patients who have better experience are more engaged with their care, which may contribute to better outcomes. • **Patient self-management tools** are technologies and techniques used by patients and families to manage health issues outside formal medical institutions and are increasingly viewed as a means to improve clinical care.

Quality Interventions

Figure 3. Illustrative activities across five levels of hierarchy

National
- Legislation
- National Goal Setting
- Regulation and Oversight
- Public Performance Reporting
- External Evaluation
- Accreditation

Regional/State
- Targets and Standards
- Performance Contracting
- Benchmarking

Community
- Outreach and Advocacy
- Education and Awareness
- Provide Input to Health System

Institutional
- Leadership and Governance
- Incentives
- Traditional QA Functions
- IT Decision Support

Individual
- Performance Contracts
- Professional Appraisal
- Patient Education
- Supervision
- Shared Decision Making

Source: Adapted from Leatherman and Sutherland.
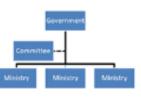
National Quality Policy & Strategy – Eight Elements

World Health Organization

The eight elements of NQPS

National health priorities

Local definition of quality

Safe?
Effective?
Integrated?
Efficient?
Accessible?
People-centered?
Equitable?

Stakeholder mapping & engagement

District Health Office
Civil Society
Health Provider

Situational analysis

Governance and organizational structure

Government
Committee
Ministry   Ministry   Ministry

Improvement methods & interventions

Standards ✓
Licensing ✓
Inspection ✓
Workforce ✓
Incentives ✓
Benchmarking ✓
Engagement ✓

Health management information systems & data systems

DHIS
—20%
—45%

Quality indicators & core measures

+

Operational planning

Integration of technical programmes

Tools & resources

HANDBOOK FOR NATIONAL QUALITY POLICY AND STRATEGY

A practical approach for developing policy and strategy to improve quality of care

World Health Organization

How health professionals in the UK address this agenda?

World Health Organization

Start locally…

- Quality improvement

- Innovation in clinical care

- Igniting demand

- Strengthen the quality movement

… and share globally

- Twinning partnerships for improvement, THET etc.

- Learning agenda: WHO Global Learning Laboratory

- International development

Build the evidence base

- What works where?

- What is the case for action?

- How can we build and sustain a culture of quality?

Global solidarity for quality

- The UK – and its health professionals and organisations – have a powerful voice

- We need passionate champions to sustain the quality UHC movement