Chapter 1

Background: striving for quality in health care services
Universal health coverage is an important and noble objective. Enshrined in the Sustainable Development Goals (SDGs), universal health coverage aims to provide health security and universal access to essential care services without financial hardship to individuals, families and communities, thus enabling a transition to more productive and equitable societies and economies.

But universal health coverage should not be discussed and planned, let alone implemented, without a focus on quality. It is essential to ensure that care is effective, safe, and in keeping with the preference and needs of the people and communities being served. Further, provision of care should be timely and equitable across populations, coordinated across the continuum of care and throughout the life course, while minimizing resource waste.

Quality of care therefore underpins and is fundamental to universal health coverage. For if quality of care is not ensured, what is the point of expanding access to care? Access without quality can be considered an empty universal health coverage promise.

Quality is not a prerogative of high-income countries. If countries can afford to provide any health care – and even the poorest can and should do so – they must provide care of good quality. The alternative – poor-quality care – is not only harmful but also wastes precious resources that can be invested in other important drivers of social and economic development to improve the lives of citizens. Billions of dollars are spent on the consequences of poor-quality care – money that can fund schools, social services and infrastructure. And poor quality can also undermine the trust of the population in the benefits of modern medicine. Seen this way, universal health coverage without quality of care is a job half done.

1.1 WIDESPREAD EVIDENCE OF POOR QUALITY IN ALL COUNTRIES

Much progress has been made in improving some aspects of quality of health care across the world, for example with regard to cancer survival rates and mortality from cardiovascular diseases (1, 2). But in other areas, progress has been slow and uneven. The numbers speak for themselves.

- In high-income countries, one in 10 patients is adversely affected during treatment (3).
- In high-income countries, seven in 100 hospitalized patients can expect to acquire a health care-associated infection (in developing countries this figure is one in 10), infections that can be easily avoided through better hygiene and intelligent use of antimicrobials (4).
- Unwarranted variations in health care provision and delivery persist, and a considerable proportion of patients do not receive appropriate, evidence-based care (5, 6).
- Influenza vaccination rates vary across high-income countries from 1% to over 78%, despite a goal of 75% by 2010 set by the World Health Assembly in 2003 (7).
- Antimicrobial resistance has become a major global public health issue, partly due to the misuse and overuse of antimicrobials in health care (8).
- Globally, the cost associated with medication errors has been estimated at US$ 42 billion annually, not counting lost wages, foregone productivity or health care costs (9).
While the rate of skilled birth attendance increased from 58% in 1990 to 73% in 2013, mainly due to increases in facility-based births, there are still many women and babies who, even after reaching a health facility, die or develop lifelong disabilities due to poor quality of care. The World Health Organization (WHO) estimates that 303,000 mothers and 2.7 million newborn infants die annually around the time of childbirth, and that many more are affected by preventable illness. Further, some 2.6 million babies are stillborn each year (10, 11).

Nearly 40% of health care facilities in low- and middle-income countries lack improved water and nearly 20% lack sanitation – the implications for quality of care are clearly evident (12).

Cross-country estimates of the distribution of diagnosis and control of raised blood pressure in selected countries outside the OECD highlights the importance of quality preventive services. In most, at least half of the adults with raised blood pressure have not been diagnosed with hypertension. Hypertension treatment coverage is therefore low, ranging from 7% to 61% among people who have presented with raised blood pressure in the household surveys. However, effective coverage is considerably lower than coverage, ranging from 1% to 31%, indicating a quality issue (13).

1.2 THE ECONOMIC ARGUMENT FOR GOOD QUALITY

Beyond the effects on people’s lives, poor-quality care wastes time and money. Making quality an integral part of universal health coverage is both a matter of striving for longer and better lives and an economic necessity. Building quality in health systems is affordable for countries at all levels of economic development. In fact, the lack of quality is an unaffordable cost, especially for the poorest countries.

Substandard quality of care not only contributes to the global disease burden and unmet health needs, it also exerts a substantial economic impact, with considerable cost implications for health systems and communities across the world. Approximately 15% of hospital expenditure in high-income countries is used to correct preventable complications of care and patient harm. Poor-quality care disproportionately affects the more vulnerable groups in society, and the broader economic and social costs of patient harm caused by long-term disability, impairment and lost productivity amount to trillions of dollars each year (14).

In addition, duplicate services, ineffective care and avoidable hospital admissions – features of many health systems – generate considerable waste. Up to a fifth of health resources are deployed in ways that generate very few health improvements. These scarce resources could be deployed much more effectively (3).

1.3 QUALITY AS A FUNDAMENTAL FEATURE OF UNIVERSAL HEALTH COVERAGE

Quality does not come automatically; it requires planning, and should be a clearly identified priority of universal health coverage, along with access, coverage and financial protection. This document shows that building quality into health systems is possible if a number of steps are followed and principles applied, namely transparency, people-centredness, measurement and generation of information, and investing in the workforce, all underpinned by leadership and a supportive culture. With these fundamentals in place, proven interventions and practices to ensure quality – such as hand hygiene, treatment protocols, checklists, education, and reporting and feedback – can be implemented and sustained.
Transparency is paramount. It is the bedrock of continuous learning and improvement. The overarching conclusion from 15 reviews of quality in national health systems conducted by OECD between 2012 and 2016 was the need for greater transparency about performance in terms of quality and outcomes of care (15). A key component of transparency is being open and honest about results, including lapses and mistakes. In such an environment these become opportunities to learn, as is the case in other sectors, including air transport. Successful outcomes should be celebrated and shared for the same reasons. This culture of transparency can take time to build, but it can and must be instilled in all health systems, regardless of resources available.

Involving people and communities in their own care and in the design of their health services is now recognized as a key determinant of better outcomes. People and the communities in which they are born, raised, live, work and play are at the heart of delivering quality health services. People who are actively engaged in their own health and care suffer fewer complications and enjoy better health and well-being. At the clinical level, this means enabling patients to partner in their care and in clinical decisions, and to actively manage their health. People-centredness is the “doorway to all qualities” (16). Indeed, the common thread of success stories detailed later in this document is putting the patient’s needs and values front and centre. This means caring with compassion and respect.

But people-centredness goes beyond individual care. People and patients should be involved in priority setting and in policy development. Nowhere is this more important than in primary and community care. These services need to be designed with input from the communities that they serve, based on their unique needs and preferences, as discussed in Chapter 4 of this document.

Quality requires measurement and generation of information. Health care is changing all the time, so quality needs to be continually monitored and assessed to drive improvement. This relies on accurate and timely information. The banking industry devotes 13% of its income for an information-intense sector. And when they exist, the data generated by health systems are too often concentrated on inputs and volume of activities. This needs to change if quality is to become a routine part of health care. Reliable quality metrics must be embedded in local and national health information infrastructures – this is even more important than measuring inputs. In the spirit of transparency, information must be available to all relevant actors, including patients, providers, regulators, purchasers and policy-makers.

All dimensions of quality should be measured. It is important to know about adherence to essential protocols and the quality of processes and pathways, for example hand hygiene; surgical safety checklists; adherence to clinical practice guidelines; and clinical outcomes, for example readmissions, mortality rates, adverse drug reactions, survival after a diagnosis of cancer and adequate control of glycaemia during pregnancy. But knowledge must also be generated on the outcomes and experiences of care that are valued by patients through the measurement of patient- and community-reported quality indicators (17). All this needs to be done with a clear eye on strong linkages between measurement and improvement – measuring alone will not improve quality.

A skilled, motivated and adequately supported health workforce is critical. Health care providers want to deliver the best possible care to their patients. Often, however, the systems and environments they work in make this task difficult. Many countries face significant deficiencies in both the quantity and quality of their health
workforce. Of course, not all care should be delivered by doctors. Nurses, allied and community health workers, care coordinators and managers all play important roles in delivering high-quality care in the 21st century. It is possible to achieve high quality by leveraging their skills throughout the chain of health production (18).

In providing high-quality care, technical knowledge needs to be augmented by the ability to communicate and work as a team with other professionals, and to partner with patients and their carers. It also requires a workforce trained in the principles and practice of continuous quality improvement, as well as recognition of the “hidden curriculum” that arises from the fallibility of human-designed systems. Quality is also a function of how well efforts are organized and integrated with other sectors, taking account of patterns of behaviour, human interaction and relationships. This in turn depends on the incentives that are in place, including funding and remuneration, regulation, reporting and feedback, which need to be carefully built into all processes and institutions. In the end, systems provide the fertile soil in which high-quality practice and improvement can bloom.

None of the above is possible without leadership and an enabling culture. A buoyant culture in which all actors are motivated to collaborate, communicate and work with their communities to deliver high-quality people-centred care, without fear or intimidation, has been shown to deliver better outcomes (19). Many factors influence such a culture of continuous quality improvement. First and foremost, a transparent environment should be cultivated, as described above. Also important are training and socialization of workers, improvement measures, feedback on performance, and shared learning, as well as upstream factors such as financial incentives. But the key ingredient is consistency of leadership from governments, policy-makers, clinical leaders, health system managers and civil society. This does not require a high level of resources – it rather requires investment in a culture shift towards transparency for continuing improvement.

These fundamentals provide the backbone for policies and practices to continually improve health care quality. But quality must be the responsibility of all stakeholders and institutions. It must be supported by a crystal-clear national strategic direction, with well defined objectives and goals, and strong stakeholder engagement across the entire health system, as well as with other sectors.

1.4 AFFORDABILITY OF QUALITY FOR ALL COUNTRIES

While high-quality health care for all may seem ambitious, it can be achieved in all settings with good leadership, robust planning and intelligent investment. For example, in Uganda a model involving citizens and communities in the design of health care services has improved a range of indicators, including a 33% reduction in child mortality (20). Costa Rica has achieved remarkable improvements in primary care quality through a carefully planned, implemented and resourced improvement strategy (21). These and other examples are provided later in this document.

For low- and middle-income countries, addressing quality while building universal health coverage is a huge opportunity. A health system that is maturing and becoming established can be influenced, steered and nurtured in the desired way. Quality can be embedded into policies, processes and institutions as the system grows and develops.
The challenge is how to learn from the experiences – both the successes but also (and especially) the mistakes – of health systems in high-income countries. A key lesson is that retrofitting quality into established health systems is certainly possible but can be arduous; rather, quality must be built in from the start, along with access, coverage and financial protection.

Of course, quality care cannot be conjured up entirely for free – it requires some investment of capital and other resources. This investment is not beyond reach, even for the poorest countries. The costs of poor quality to people's lives, to health systems and to societies are massive. If applied intelligently, investment in quality will deliver better individual and population health, and value for money; the return on investment in ensuring high-quality care is likely to far outweigh the costs. Better outcomes also further economic and social development; for example, healthier people are more productive at work, and healthier children perform better at school. So striving for universal quality health coverage is not just an investment in better health – it is a commitment to building a healthier society and a healthier world.