January 2015

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Howard L. Sobel
World Health Organization

Dale Huntington
World Health Organization

Marleen Temmerman
Aga Khan University, marleen.temmerman@aku.edu

Health Policy and Planning, 31, 2016, 547–549
doi: 10.1093/heapol/czv095
Advance Access Publication Date: 29 September 2015
Commentary

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Quality at the centre of universal health coverage

Howard L Sobel[1,*], Dale Huntington[2] and Marleen Temmerman[3]

[1]Reproductive, Maternal, Newborn, Child and Adolescent Health, Division of NCD and Health through Life-Course, World Health Organization, Regional Office for the Western Pacific, Manila, Philippines, [2]Asia Pacific Observatory on Health Systems and Policies, World Health Organization, Western Pacific Regional Office, Manila, Philippines and [3]Department of Reproductive Health and Research, World Health Organization, Regional Office for the Western Pacific, Manila, Philippines

*Corresponding author. Reproductive, Maternal, Newborn, Child and Adolescent Health, Division of NCD and Health through Life-Course, World Health Organization, Regional Office for the Western Pacific, Manila, Philippines. E-mail: sobelh@wpro.who.int

Accepted on 6 September 2015

ABSTRACT

Abstract: The last decade of the MDG era witnessed substantial focus on reaching the bottom economic quintiles in low and middle income countries. However, the inordinate focus on reducing financial risk burden and increasing coverage without sufficient focus on expanding quality of services may account for slow progress of the MDGs in many countries. Human Resources for Health underlie quality and service delivery improvements, yet remains under-addressed in many national strategies to achieve Universal Health Coverage. Without adequate investments in improving and expanding health professional education, making and sustaining gains will be unlikely. The transition from the Millennium Development Goals (MDG) to the Sustainable Development Goals (SDG), with exciting new financing initiatives such as the Global Financing Facility brings the potential to enact substantial gains in the quality of services delivered and upgrading human health resources. This focus should ensure effective methodologies to improve health worker competencies and change practice are employed and ineffective and harmful ones eliminated (including undue influence of commercial interests).

Key words: Health systems, maternal and child health, Millennium Development Goals, policy, priority setting, quality of care, Sustainable Development Goals

Key Messages

- The last decade of the MDG era witnessed substantial focus on reaching the bottom economic quintiles in low and middle income countries (LMIC).
- There is a compelling need to shift what has been an inordinate emphasis on reducing financial risk burden towards policy and increased coverage to expand quality of services.
- As the SDG era emerges onto the global scene, countries will be increasingly called upon to address long-standing challenges.

The transition from the Millennium Development Goals (MDG) to the Sustainable Development Goals (SDG) brings new opportunities to continue progress towards achieving universal health coverage (UHC) in low- and middle-income countries. The Global Financing Facility in support of the renewed Global Strategy 'Every Woman, Every Child, Every Adolescent' will be one of the first new financing initiatives in the post-MDG world (GFF Working Group 2014). We support the bold vision of the Global Financing Facility and hope its financing roadmaps will support expanding coverage of better quality services for women, adolescents and children health.

The last decade of the MDG era witnessed substantial focus on reaching the bottom economic quintiles in low- and middle-income countries. UHC is an expression of inclusive development, and ensuring social solidarity is a critically important attribute of progressive health policy. WHO, World Bank and others acknowledge quality as an integral part of universal health care (WHO, The World Bank 2015). However, in our opinion, reducing financial risk burden and increasing coverage has been inordinately emphasized without sufficient focus on expanding quality of services.

In contrast to common perceptions, quality usually means basic services and interventions, not high tech/high cost care. Poor hand hygiene is rampant among health workers in lower- and middle-income countries and is a grossly underestimated cause of deaths of babies and mothers alike. For simplicity, quality means providing an appropriate health-care service in the right quantity and at the right time.

Improving quality is not limited to low-income countries. In middle-income countries, economic development has fuelled growth in the middle class who have heightened aspirations for health care and low tolerance for poor quality. Witness the violence against doctors in China and Vietnam as consumers react to malpractice and misdiagnoses (Jiang et al. 2014; Tuoitrenews.vn. 2014). In other countries, civil and criminal suits and sanctions on malpractice soar.

Slow progress of the MDGs in many countries reflects neglect of quality during expansion of coverage. For example, in the quest for universal coverage, India invested heavily in skilled birthing attendants but saw only minimal reductions in maternal mortality (Montgomery et al. 2014). In addition, the availability of primary care services in rural areas of many countries remains underdeveloped. However, studies looking at health services utilization found similar utilization rates in India, Burkino Faso and Thailand across wealth quintiles (Das and Hammer 2014). As the SDG era emerges onto the global scene, countries will be increasingly called upon to address longstanding challenges—just as they confront new issues such as non-communicable diseases, ageing societies and a proliferation of costly, high-tech medical devices and drugs. The issue of wide coverage with quality services remains paramount in our opinion.

The Know-Do gap, i.e. what health workers know vs what they do, is large. Clinicians in Delhi, India were found in public clinics to practice just over one-tenth what they described as their standard practice. The same clinicians practiced one-third what they described in private clinics (Das and Hammer 2014). Basic hand hygiene is something most health providers were taught as children. Poor infection control including hand hygiene leads to newborns having 20 times the risk of acquiring a health care-associated infection in lower and middle income vs high-income countries. In many countries, health care-acquired infections account for more than half of neonatal deaths (WHO Global Alert and Response 2015). That half of health facilities do not have running water further exacerbates the problem. Meanwhile, overuse of technology often increases the risk of death. For example, keeping a stable pre-term baby in an incubator doubles the risk of death compared with in direct skin contact with the mother ('Kangaroo Mother Care') (Das and Hammer 2014). Harmful and non-urgent practices often interfere with lifesaving ones. Sustained skin-to-skin contact between newborn and mother at birth keeps babies warm, calm and breathing well and makes that lifesaving early first breastfeed almost universal. Yet this does not happen or is interrupted by routine care in most lower- and middle-income countries (Lawn et al. 2010; Sobel et al. 2011a; WHO 2013; Khan et al. 2015). The first breastfeed is too often held hostage to health workers promoting infant formula (Sobel et al. 2011b). Even high coverage of essential interventions is not sufficient to lower maternal mortality if quality is not addressed such as timeliness and back up with comprehensive emergency obstetric services (Souza et al. 2013). However, overuse of such services such as caesarean sections also increases adverse outcomes (Lumbiganon et al. 2010). Quality means performing the right evidence-based action at the right time and eliminating interventions and products that comes at increased risk of death and illness.

With the Global Alliance on Vaccines and Immunizations supporting broad scale delivery of new vaccines in lower- and middle-income countries, children are protected against more diseases than ever before (GAVI, The Vaccine Alliance). The increased protection comes at a cost that has risen 40–50 times per fully immunized child compared with earlier set of vaccines provided by many countries. Meanwhile, 21.8 million children remain unprotected against diphtheria, tetanus or pertussis, as well as other vaccine preventable diseases (WHO 2014). Ensuring national immunization programmes reach underserved populations needs to remain a priority for the GFF, just as it will be addressing difficult issues in the transition from Global Alliance Vaccine Initiative to domestic funding sources for the fully immunized child in MICs. Persistent issues that have to date been largely unaddressed, such as reaching the urban poor and remote, sparsely populated settings will require innovative delivery strategies. The WHO Commission on the Social Determinants of Health report (2008) provides good insights into the multi-sectoral responses that are required to overcome normative barriers and cultural-bound constraints on achieving equity in access (CSDH 2008).

Improving health care services requires among other things, increasing capacity of human resources for health and accountability of health providers. The growth of the private sector needs to be specifically looked at.

Human Resources for Health underlie quality and service delivery improvements, yet remains under-addressed in many national strategies to achieve UHC. Without adequate investments in improving and expanding health professional education, making and sustaining gains will be unlikely. Rural retention strategies are ubiquitously challenging, requiring locally adaptive responses to ensure high quality health providers are available.

Financing is needed to upgrade and expand health professional education, particularly pre-service educational systems to increase the use of competency-based and client-centred pedagogies curricula on methods to improve quality in ambulatory and tertiary care settings. Governments need to eliminate investments in ineffective lecture-based pedagogies which abound and are often weighted by Power Point Presentations *in lieu* of interactive, competency-based training (Rowe et al. 2005). Updating medical and nursing school curricula and professional recertification processes are important priorities that are overlooked in many countries. However, better training does not address the Know-Do gap. Addressing this gap requires focus on improving health worker effort (e.g. increasing

time spent with patients and following protocols to make correct diagnoses, improved hand hygiene). Provider payment methods that aim to influence clinical practice are required and feature in the Global Financing Facility development. Cambodia provided incentives to health providers for every birth resulting in a live mother and a live baby. This approach led to skilled attendance at birth rising from below 20 to nearly 80% in a decade while incentivising improved attention to care for patients (National Institute of Statistics, Directorate General for Health, and ICF Macro 2011). Other trends in purchasing mechanisms such as the use of case-based payment systems can also be vehicles to improve quality of care. In all cases we hope that future directions of global financing will make investments in developing national capacities for monitoring performance and quality of care.

The expansion of the private sector during the past two decades has challenged governments to develop effective and appropriate regulatory mechanisms to ensure quality, control costs and manage the labour market dynamics of the health professional workforce. In most countries in the Asia Pacific region, the health sector has become pluralistic with multiple service delivery systems operating simultaneously. Some studies suggest care provided by the same doctors in the private sector exceeds that of the public sector largely due to different incentives in each setting. In general both sectors provide good and poor quality services. This again points to the need to increase accountability (Tuoitrenews.vn). Furthermore, unregulated private clinics, especially by lay health workers, have led to visible health disasters. One is reminded of the HIV outbreak in Henan, China, more than a decade ago (Yan et al. 2013) and most recently in Cambodia (Ng 2014).

The Global Financing Facility and other financing initiatives in the post-MDG era have the potential to enact substantial gains in the quality of services delivered and upgrading human health resources through country-level strategies and operational plans. This focus should ensure effective methodologies to improve health worker competencies and change practice are employed and ineffective and harmful ones eliminated (including undue influence of commercial interests).

Conflict of interest statement. None declared.

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