# Prince Mahidol Award Conference 2015: Side Meeting

# Universal Health Coverage: Ensuring quality care for all!

27 January, 2015

Bangkok, Thailand

This report provides an overview of the 2015 PMAC Side Meeting co-organized by the World Health Organization with USAID/URC and the Healthcare Accreditation Institute (HAI) Thailand

## Summary

Many governments and organizations have worked hard towards advancing health systems to reach the goal of Universal Health Coverage (UHC). However, a noticeable gap exits in the literature regarding best practices when it comes to quality improvement initiatives as it relates to UHC, especially in low- and middle-income countries. The knowledge base on quality improvement efforts – as well as a recognition of its value – have however grown in recent times. The new WHO Department of Service Delivery and Safety (SDS) has focused on harvesting this growing knowledge base for application in health systems across the world.

The Prince Mahidol Award Conference (PMAC) was an ideal venue to convene organizations involved with UHC & quality of care at the global level. Five partners – USAID, URC, Healthcare Accreditation Institute (HAI) Thailand, JICA and the Rockefeller Foundation – shared their organizational experience and perspective on UHC and quality. Patient perspectives were considered through input from the WHO Patients for Patient Safety alongside patient perspectives from Thailand. Further, the ingredients of a new WHO initiative on UHC and quality were shared with participants. Key components of a global consensus statement on UHC and quality were described.

The event allowed a rich discourse and an opportunity to harvest valuable perspectives from a range of technical experts from across the world. In fact, the second session of the half day event was a facilitated, interactive session that challenged everyone to consider key areas relevant to UHC and quality. The discourse yielded added insights to help propel further work for governments and agencies – including the WHO – on its efforts to enhance convergence between UHC and the efforts on quality of care.


### Meeting Objectives:

1. **Explore how national systems and global partners are contributing to quality care in UHC.**
2. **Share key messages from a global consensus statement on UHC & quality of care.**
3. **Define a major WHO Initiative on UHC and quality of care to be launched in 2015.**
4. **Synthesize inputs from PMAC participants to inform future global work on UHC & quality though a "learning laboratory".**

# Background

The Prince Mahidol Award Conference was selected as a key meeting to catalyze thinking on the importance of Universal Health Coverage (UHC) and quality. This comes at a particular time when the post-2015 MDG discourse concentrates on the anticipated social determinant goals marking the next era of global development and health. Many governments and organizations – including the WHO – have made commitments towards understanding and applying initiatives towards moving health systems towards UHC. There is anticipation and credence given towards the progress of health systems towards UHC from both countries as well as a range of global partners. Reports and focus has been given to financing these structures, but one of the main areas lacking clarity and guidance is how quality mechanisms are applied to health systems advancing towards UHC. The peer-reviewed literature has been lacking, but much work has been done along this front. In an effort to mobilize WHO initiatives and align them with the mandate of working towards UHC, the Department of Service Delivery and Safety (SDS) is working on bringing together efforts on UHC and quality of care. In its work with global partners, the department has been harnessing the growing practical lessons of both governments and NGOs to advance the knowledge base on quality improvement efforts within the context of UHC.

# Session Synthesis

## Session 1 – Setting the Landscape

**Overview:** The focus was on mutual learning and sharing of current work on quality of care in the context of UHC . Participants engaged in a panel format discussing their respective understanding, scope of work, challenges and future endeavours with the success of UHC being examined through a quality lens.

Opening remarks were provided by **Dr Anuwat**, CEO of HAI, Thailand, acknowledging the commitment that many countries have made towards advancing their respective health systems towards UHC. He noted that a specific focus and review of quality of care within UHC has been lacking and requires further detailed consideration. He highlighted that all countries across the world have made strong commitment to achieving UHC and the subject has been placed at the forefront of the global health agenda. He went on to emphasize that UHC is not just about financing, but about high quality and integrated services for people. Further, he mentioned that as countries now move into the post 2015 agenda, there is a clear need to systematically embed quality of care into evolving thinking on UHC.

Dr Anuwat then went on to explain that the event has brought together a wide body of knowledge & expertize from across the world on the panel from WHO, USAID, URC, JICA and the Rockefeller Foundation. He expressed his delight to see Thai experiences on patient and people centeredness being presented. He highlighted that the event has been designed to be participatory to ensure that the collective wisdom of the room is captured through a "learning laboratory" on UHC & quality. He recognized that the room is full of people with deep experience in this subject.

**Dr Shams Syed**, Strategic Advisor and a.i. for UHC & Q, Department of Service Delivery and Safety (SDS) at WHO Headquarters, then provided an introduction and overview of UHC & quality. A brief review of foundational definitions of UHC and quality were provided. The evolution of the global health landscape on UHC was described and the increasing prominence of quality within UHC discourse was highlighted. In addition, the introduction of the Global Working Group Consensus Statement on UHC and quality was presented. The 12 key areas covered in the consensus statement were introduced, namely the UHC cube; integrated people-centred care; efficiency & effectiveness; patient safety; leadership & governance; measurement; workforce; primary health care; hospitals; non-state providers; knowledge base; and equitable care. A particular focus was placed on the classic three dimensions of UHC and the need to carefully consider quality of care as a starting point in each of the three dimensions of UHC. Dr Syed highlighted UHC thinking needs to move – as is already evident in some countries – beyond the 3-dimensions of the "UHC cube." He emphasized that without quality of care, UHC is an empty promise.

Panel Participants were briefly introduced and then each participant discussed key insights of work relating to UHC and quality.

**Rhea Bright**, Quality Improvement and Human Resources for Health Technical Advisor, Office of Health Systems, Bureau for Global Health, USAID, discussed initiatives by USAID to support quality initiatives that advance the health system towards UHC across the world over the last 25 years. Five areas were highlighted: working with countries to develop cost-effective national essential benefits packages; partnering with countries to identify populations in need of government health subsidies; facilitating public-private collaborations to harness private sector capacity; promoting application of national health accounting methodologies to track health spending; and partnering with countries to advance efficient, effective systems for managing commodities, information, human resources, and service quality. A range of focus areas include: maternal and child health, HIV/AIDS, family planning, tuberculosis, and health workforce and community health.

The main lesson stressed regarding improving quality of care in its application towards UHC was the failure of traditional approaches to address processes of care. A case study in Niger was discussed to highlight a finding that birth attendants were not following the national guideline for the active management of the third stage of labour (AMTSL) resulting in serious post-partum haemorrhage. Through collaborative means with midwives and assistants from 33 maternities, problems were identified and addressed using a quality improvement approach. Using this as an example reflections were made on what needs to be considered when improving quality of care for UHC. First, frontline providers can analyse and use data to make decisions. Second, leadership needs to be involved from the beginning. Third, scaling up appears to be cost effective and needs to be considered as part of UHC efforts. Fourth, the role of external assistance needs to be clear and transfer of quality improvement expertize to the host country needs to be prioritized as part of UHC efforts. Finally, sustainability depends on making improvements a permanent, integral part of the system. Four considerations were put forward for establishing a sustainable culture of improvement under UHC: capacity building; ownership/sustainability; transparency/accountability; and institutionalization. The challenge lies in how these areas are dealt with in practical terms.

**Dr M. Rashad Massoud**, Director, USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project and Senior Vice President of the Quality Performance Institute at University Research Co., LLC, discussed the current scope of work in regards to the ASSIST project. Current work is ongoing in 28 countries around the world. A quote from David Nicholas, defining quality of care as "what happens at all the points of service along the continuum of care" was used as a starting point and then proceeded to "high quality care is a function of the system's ability to produce care that will address the client's needs in an effective, responsive and respectful manner".

To emphasize this point, a story of a woman's delivery in Nicaragua was described. The case was a woman with uncontrolled bleeding due to a retained placenta during delivery while being cared for by a traditional birth attendant in her village. The birth attendant was trained to identify the complication and alerted her to send her brother to the health centre to inform the team of the current situation. An ambulance was dispatched to the birth attendant and upon arrival to the health centre, a team was already awaiting her arrival and began life-saving measures and manual extraction of the placenta with a few minutes. The woman survived and was resting comfortably two hours after arrival nursing her baby. The use of this case example highlights quality efforts that allowed this woman to have a positive outcome with the appropriate system in place to meet the specific challenges of the population. The challenge is in the detail of how these systems get implemented. To meet this challenge, importance is given to the perspective of clients, not just as a right of the patient, but because efficacy of medical interventions depends on people seeking care, feeling reassured by providers and adhering to treatment recommendations. That in mind though, having the interventions is not sufficient, but focusing on how those interventions can be applied is how quality improvement can best be utilized.

A case study of south-south partnership with Niger and Mali was used to highlight how lessons in Niger could be reciprocated and scaled in Mali to help increase use of AMTSL to reduce post-partum haemorrhage. The importance of practicing evidence-based medicine with every patient at every time was stressed – its failure of consistent application leads to weaknesses in delivering safe and effective healthcare. For this reason, quality must be an integral part of the Sustainable Development Goals, especially in reference to the UHC cube. Quality is seen as a key aspect to strengthen the three dimensions of the UHC cube – population coverage, health services covered, and proportion of cost covered.

**Dr Piyawan Limpanyalert,** Deputy CEO, The Healthcare Accreditation Institute (HAI), Thailand, and **Nittita Prasopa-Plaizer,** Lead, Global Patient and Family Engagement and Patients for Patient Safety Programme at WHO discussed the current patient focused efforts at improving quality of care in the context of UHC in Thailand and the linkages with wider global efforts. **Nittita Prasopa-Plaizier** began by providing an overview of the Patients for Patient Safety Programme which empowers and builds the capacity of patients and families as informed and knowledgeable healthcare partners. The programme acts as a platform to bring the patient voice into health care discussions and facilitate and foster collaborations among patients, families, communities, healthcare providers and policy-makers. The WHO has been committed to this area and collaborates with multiple partners to foster this relationship. The WHO Framework on Patient and Family Engagement is being developed to guide and facilitate meaningful engagement and respond to WHO Global Policy on UHC. The programme has a global

network of over 400 advocates among 54 countries, of which, Thailand has an avid representation. With that, **Dr Piyawan Limpanyalert** continued the discussion highlighting the Thai experience with patient and people at the centre of UHC. A brief review of the Thai health system history was introduced the focus on UHC being started since the early 2000s. To meet accountability and policy-makers emphasis on quality, The Healthcare Accreditation Institute was established as an independent government agency to promote quality improvement through self-assessment and self-improvement along with external evaluation and recognition. This led to development of a 3 step accreditation process – risk prevention, quality assurance and improvement, and quality culture. To date, 40% of hospitals have achieved accreditation; 60% are at the second step. Accredited hospitals have received higher marks from both patients and providers. Looking closely at the HIV/AIDS control initiative, the ambition of increased screening would lead to increased caseloads, which will be a challenge for the system to absorb and maintain quality care, while also ensuring affordable financing to maintain the initiative. In a patient survey, the leading quality dimension expressed was safety. This led to the establishment of the Engagement for Patient Safety programme whose main vision is to engage public participation in the healthcare system's development for safety and equity with evidence-based and common understanding of all partners. The four point strategy for the programme involves sharing, chain, shape, and change. The group has four aims: create public awareness, educate the public on health and safety, promote safe healthcare, and encourage collaborative movement among all stakeholders for safer healthcare. All these efforts are within the context of an evolving system based on UHC principles.

**Maki Ozawa**, Deputy Director of Health Group 1, Human Development Department, Japan International Cooperation Agency (JICA), stated that UHC is the overarching theme for Japan's strategy on global health diplomacy, and three barriers (financial, physical and social) along with quality of health care, are the cornerstones to achieve UHC. A simple, yet effective, quality improvement intervention has been 5S-KAIZEN-TQM, focusing on bottom-up quality improvement and establishing organizational structure to promote quality improvement activities. An overview of the 5S-KAIZEN-TQM involves initial engagement with work environment involvement and engaging a highly motivated team, then problem solving leading to resource optimization, ultimately leading to top management decisions based on evidence produced from the frontline. This evidence would yield improved service, employee satisfaction and patient satisfaction to better the overall health system. This model has been able to reach 20 countries at over 300 health facilities since it was first applied in 2000 in Sri Lanka. Examples of implementation of this model shows improved organization of health facilities and improved care practices. Application of this model in Tanzania showed improvement in service and administrative outcomes. The 5S-KAIZEN-TQM model has helped to bring efficiency and improve quality through a simple, low cost quality improvement intervention. There are also two courses offered for 5S-KAIZEN-TQM training hosted in Sri Lanka as well as Japan that has serviced countries implementing 5S-KAIZEN-TQM activities. These quality improvement mechanisms are seen as integral and at the centre of achieving meaningful UHC for countries across the world.

**Stefan Nachuk**, Associate Director, Rockefeller Foundation, focused on conceptual issues and practical challenges affecting UHC and quality. To start the discussion, a definition for quality using the Institute of Medicine's six dimensions of high quality care – safe, effective, efficient, timely, patient-centred, and

equitable – was emphasized. Through three domains – optimal health for all, responsiveness of the system and fair financing – a number of goals and outcome measures can help gauge and guide ambitions towards UHC that is responsive and dynamic. To ground this work, examples of Thailand, Malaysia and Singapore were used to describe their "long march" to improved system quality through CQI, development of organizational culture, data and experimentation. He went on to highlight that quality remains a problem in many countries and that the desire to move towards UHC may exacerbate challenges in the short run. Four "pressures" were highlighted: pressure to enrol large numbers of people into schemes quickly; pressure to ensure that basic service provision (facilities, staff) is available; pressure to reduce out of pocket payments; pressure to demonstrate efficient purchasing of services (by Ministries, Insurers). A number of different studies focusing on primary care quality being sub-optimal in Ghana, India, China and Indonesia were described, showing similar conclusions that quality and service readiness is problematic.

A possible way forward to integrate quality into the UHC agenda was described. First, gather better, ongoing evidence regarding current status of patient experience, clinical quality and outcomes. Second, use this evidence to re-frame discussions with ministries, payers, and regulators regarding what a system is providing, not what it should provide. Third, use this evidence to integrate quality concerns with those of provider payment modalities, regulation, data gathering, organizational culture, and stewardship of private sector providers. Finally, focus on the political economy of quality, aiming to expand the quality reach outside of the QI community to other vested entities that stand to benefit from QI initiatives. The example of the ministry of finance asking "what are we getting for our money in a UHC scheme?" was used and the fact that quality is central to this question was emphasized. Conversely, citizens and civil society, through taxation and social health insurance premium finance, would allow people more onus on their care by asking "what am I getting for my taxes?" These issues help integrate a wider vested audience in the QI realm towards UHC to continue to make progress.

**Dr Shams Syed**, summarized key points mentioned by each of the panellists and then provided closing remarks. Participants were invited to stay for the second session which would be an interactive Learning Laboratory session to capture audience insights and thoughts on UHC and quality.

# Session Synthesis

## Session 2 – Co-developing future action

**Overview:** The focus of the session was to engage and capture critical thoughts and considerations on UHC & quality from the session audience. The discussion yielded further consensus and understanding on key issues that affect UHC & quality. Closing remarks were given by Dr. Anuwat Supachutikul with thanks to the audience and the panel for their contributions.

**Dr Shams Syed** opened the session with an introduction to the new WHO initiative for UHC and quality that is to be taken forward by the WHO Service Delivery and Safety (SDS) Department. The WHO Department supports countries in moving their health systems towards universal health coverage through increased access to safe, high quality, effective, people-centred and integrated services. A schematic showing the convergence of safety and quality within UHC throughout the continuum of care with people at the centre was utilized to describe the conceptual basis of the major initiative. The scope of the project was then discussed along three arms – catalysing global change, WHO UHC-quality taskforce, and implementation to transform health systems These arms are deeply grounded in front line realities of health systems in an attempt to help foster quality UHC. Further detail was discussed regarding the nine areas of focus within the three arms of this initiative.

The presentation was then transitioned to welcome the audience to participate in an interactive Learning Laboratory session to harness discussion on thoughts in regards to UHC & quality. A rich contribution from representatives from governments and wider organizations is summarized below.

A representative from the **Maldives** asked very practical questions from the perspective of a nation of dispersed islands that necessitates different thinking on health systems. What does UHC mean? What is quality? Who defines quality? What are the actual needs of the people? The difficult position was also posed about asking patients what they want from health care services that are universally accessible. Patients often express they want all the high tech equipment; fiscal realities make this impossible. How would this issue be addressed when quality meets UHC? The representative expressed that the tension between what is doable and possible often conflict. In a system where they try to cover 100% of the population, they encounter difficulty maintaining it. Being hard pressed by the financial reality of making difficult choices in prioritizing certain services knowing that *everything* is not able to be provided has stressed work on achieving UHC. The role of non-state actors and the private sector, and how they can be integrated into the larger mission of UHC to ensure high quality service delivery was highlighted. Further, the importance of examining motivation and incentives for health workers to start process improvement such as 5S-KAIZEN-TQM was underscored.

A representative from **IntraHealth** stressed the importance of focusing on the role of leadership and governance, stating that in order to build resilience, you have to engage leaders at multiple levels. He agreed with previous points made by the panel on needing to critically think about the 'function' of

health systems working towards UHC. A strong statement was made to feed into planning global initiatives on UHC and quality: “When you are sitting in a country office, and look at the global initiatives, you think ‘really, how do we do this?’”

A representative from **Bangladesh** discussed the importance of generating a knowledge base for UHC and quality – among professionals and the general public. The expectations of people need to be taken into consideration to maintain quality of care. A proposed method for building the knowledge base is through utilizing operations research, which requires government support. The critical importance of a culturally sensitive health service delivery model was highlighted as key when moving towards UHC. A way forward would be to empower communities with information to allow more influence in the direction of services delivered. Again, the question was raised about the inclusion of the private sector in the development of UHC and quality. The final reflection focused on the need to have conceptual clarity on people centred integrated care with a clear meaning that all could understand.

A patient from **Thailand** highlighted the importance of co-development and partnership between patients and providers to redesign systems. “Health care providers, you are not sick, you don’t know what the patient needs.”

A **UNICEF** representative reaffirmed the need for inclusion of non-state providers (traditional healers, faith-based organizations and private providers). The point was made that in many locations, these are usually the first access point for patients seeking care before going to the public system. The expectation was recommended that it is important to monitor the actions of non-state provider institutions to also influence quality of care within the context of UHC.

A **Kenyan** representative discussed the importance of the health workforce – with special consideration for its evolution, recruitment, selection, retention and motivation. The importance of motivation among physicians was highlighted, emphasizing high rate of absenteeism in the workforce. Efficiency and effectiveness were also discussed in reference to trying to bridge ties between private-public partnerships. The example in Kenya was described that there has been tension between health workers and the government, leading to discontent. The lesson here is to place workforce-government relations at the centre of efforts at achieving high quality UHC. The other significant point made questioned affordability and cost containment.

A representative from **South Africa** reaffirmed that quality of care is highly affected by the quality of the health workforce (in reference to training) and the volume of the health workforce. A solution discussed for addressing rural versus urban distribution has been mediated primarily through allowances and incentives. A major problem was the loss of providers to Western countries. The point was made that the country makes an investment in training a workforce, and would prefer to see the benefits of that investment returned to serve in the public sector. The inter-connectedness of different national health systems as they move towards UHC was thus highlighted. What happens in high-income countries effects UHC in low and middle income countries.

A **Nepalese** representative expressed concern about how quality could be measured, especially when looking at scale-up of services. The issue of provider payment based on quality is a difficult one for low

income countries with weak systems. Further, important to have simple means of tracking progress on quality as part of a move towards UHC. Both outcome or output quality measure would present challenging to define and collect, necessitating new ways of thinking. The other concern discussed was how to ensure provider payment with expansion in coverage.

A representative from **Indonesia** shared concerns about the ability for busy frontline providers to self-assess and analyse their own data. Concern was expressed that time is already stretched among providers engaged with clinical care. Expecting additional work of them would prove to be burdensome. Citing the case of Brazil, the key point made advocated for a ground-up motivator between the community and health providers. This requires a close connection with the community and trust but helps foster positive motivation among providers to maintain a culture of quality improvement. This helps providers to strive for further improvement. Keen interest was discussed about transfer of ideas from USAID and JICA experiences back to Indonesia to help frontline providers contribute to problem solving on quality issues as Indonesia moves forward with UHC. The challenge mentioned with capturing these ideas is how to incentivise providers to take on this work, and how quality "thinking" can be embedded within a wide range of stakeholders, particularly decision makers.

**Dr Shams Syed** discussed summary points from the audience for further consideration in the discussion of UHC and quality. He emphasized five key points. First, he highlighted the need to continue to harvest the collective wisdom from the frontline to ensure quality of care is embedded within evolving systems. Second, he highlighted the clear need demonstrated within the event of having a robust mechanism to share problems, issues and solutions across the world and that learning can flow in all directions. Third, he highlighted that there is a clear resonance between the perspectives shared today and the consensus statement on UHC quality. Fourth, there is clear need to institutionalize quality improvement mechanisms within everyday business of health systems. Finally, there is a clear and urgent need to bring together the parallel universes of "quality improvement " and "everyone else." He stressed that the new UHC Quality initiative would take careful stock of all the discussions that have taken place today to inform its development.

**Dr Anuwat Supachutikul** thanked the panel and the audience. He ended with three key points. First , quality care is an integral component of UHC. It warrants consideration of service delivery along a continuum – promotion, prevention, treatment, rehabilitation and palliation. Quality of care is relevant to each of these areas along the continuum – not just treatment. Second, enhanced understanding of UHC-quality convergence – from policy makers to the frontline – is urgently required in order for UHC focused efforts to be successful in improving population health. Third, we need close linkages between the global and local levels to achieve real results in this subject area. The WHO initiative in this subject areas is thus particularly welcome and I hope we can all support this critical work.

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## *Panellists*

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**Stefan Nachuk**
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