HLSP Institute

Summary brief, June 2014

Achieving coverage with quality: a seminar on purchasing and quality in the context of UHC

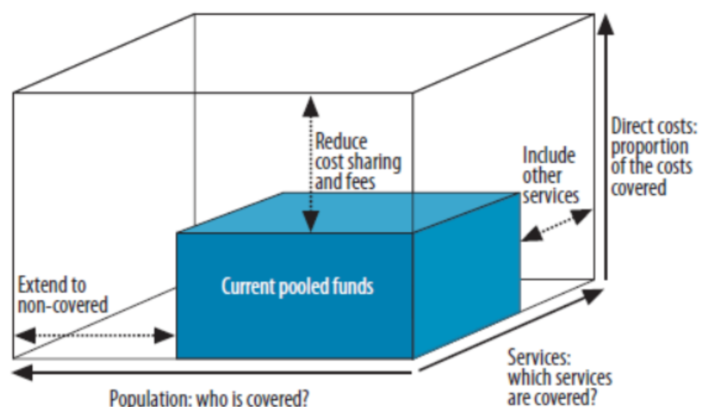
This brief summarises case studies and emerging lessons from a seminar hosted by HLSP in partnership with DFID and the London School of Hygiene and Tropical Medicine (London, 16 January 2014).

The seminar was sponsored by the Mott MacDonald-DFID Centre of Excellence.

Introduction

Universal health coverage (UHC) is a topical issue in global health. Yet in discussions about service expansion, quality is often neglected. For example quality is not explicitly captured in the widely used WHO health financing 'box'[1] which shows that moving towards UHC requires expansion along three dimensions: population coverage, services and the proportion of costs covered. In this figure, quality is in practice represented by 'what is inside the box'.

Three dimensions to consider when moving towards universal coverage
(WHO, 2010)



As countries strive to expand health service coverage, what can be done to ensure that a focus on quality is also maintained? The seminar attempted to answer this question by examining the cases of three countries at different stages of progression towards UHC:

- Ghana, which is ten years into implementation of the National Health Insurance Scheme (NHIS)
- South Africa, where preparations are under way for the introduction of national health insurance
- The UK, where universal health coverage is in place.

This brief summarises the three case studies and emerging lessons.

[1] World Health Report 2010. Health Systems Financing: the Path to Universal Coverage.

Ghana: purchasing as a key driver of quality[2]

Ten years on, proponents of UHC are citing Ghana as a model – but is it?

The Ghana NHIS was introduced in 2004. Ten years on, proponents of UHC are citing Ghana as a model – but is it? Global interest in UHC has been both a blessing and a challenge for the NHIS – it has helped by providing a 'global mandate' and a context conducive to the examination of the various aspect of universal coverage. However, it has also created expectations and put a strain on the system.

The NHIS is not perfect, but has significant potential. Key strengths include:

- Stability and consistency from inception, due to strong bipartisan political support (despite initial donor scepticism)
- Flexibility and responsiveness to changing circumstances (and to external criticism)
- Community schemes have been absorbed into a single pool
- Progressive revenue, 75% of which is from taxation.

However the NHIS still faces many challenges. One of these is adapting to a changing context: Ghana has graduated to Middle Income Country status and donors are reconsidering their support. For this reason, and changing demographics (dramatically increased life expectancy, combined with growing rates of non-communicable diseases) the government faces a bigger health expenditure burden. In 2013 for example, the health budget was entirely absorbed by staff salaries. After large initial increases, coverage is stagnating. In addition, inequities remain in the scheme, which is largely pro-urban and pro-rich (80% of wealthy people are enrolled, compared with 15% of the poor). But the biggest current challenges are cost-containment and sustainability, given that since 2010 expenses have started to outpace revenues. Key issues that now need to be addressed are:

- Whether to increase revenue
- The level of increases needed
- Where to increase revenue.

These questions show the different perspectives that have to be taken into account (e.g. political priorities vs economics vs efficiency).

The process of working towards UHC is a long one, consisting of a constant juggling act among equity of access, breadth of service provision, affordability and quality.

A similar range of perspectives, definitions and incentives is apparent when discussing quality. For the policy maker, it may be an issue related to financial sustainability and forecasting; for the provider, a matter of timely reimbursement; for the patient, whether the service is accessible, affordable and comprehensive. Decisions on purchasing – what services, who they are purchased from and how – have an impact on all these aspects of quality. The NHIS is still grappling with these.

Currently in Ghana there is a disconnect between what the NHIS says it provides, what the provider is actually able to provide and the 'quality service' that the patient expects. This can be illustrated through the example of a pregnant woman, from a rural Volta village, who decided not to renew her insurance card and not to use the services provided under the scheme (because the midwife was often away, drugs were lacking and costs unclear), but instead travelled a long distance, at significant cost, to deliver her baby at another facility which offered better quality. From the NHI provider's perspective, the clinic was accredited and functioning, but the reality was that resources were in short supply because demand outstripped supply. This situation was exacerbated by the fact that the Ministry of Health continues to provide some services separately and there is lack of clarity about who provides what, and to whom.

What role can development partners play? Within NHIS, development partners such as DFID have a particular interest in the purchasing methods used to drive quality

[2] Based on presentation by Susan Elden, DFID.

and improve health outcomes. However they also continue to have a key role in supporting the wider functions of health financing systems, mainly through funding, but also through influence and advocacy, making sure they contribute to the system in a way that will allow the NHIS to succeed.

The example of Ghana clearly illustrates that the process of working towards universal health coverage is a long one, consisting of a constant juggling act among equity of access, breadth of service provision, affordability and quality. At different times in the road to universality different aspects will be at the forefront of attention.

South Africa: the role of regulation in driving quality[3]

UHC focused solely on expanding access and not simultaneously addressing quality will have limited impact on population health.

South Africa is at a very early stage compared to Ghana in terms of National Health Insurance (NHI). The government has committed to introducing NHI to address the vast inequities of its health system. An essential step towards NHI will be improving the quality of public sector service delivery and management. The Office of Health Standards Compliance (OHSC) has been set up recently to help protect quality of services as the government moves toward NHI.

Modelled on the UK's Quality Care Commission, and lessons learned in the UK, the OHSC's remit is to:

- Monitor and enforce compliance with prescribed norms and standards. Basic quality care standards have been developed as a continuum of improvement: a) vital, b) essential and c) aspirational/desirable.
- Monitor indicators of risk (which are under development) to have an early warning system in place
- Consider, investigate and respond to complaints relating to breaches of norms & standards.

The OHSC is seen as a prerequisite for NHI. Public and private facilities providing health care under NHI will have to comply with standards, and will be accredited or licensed by OHSC. While in the past 'quality improvement' largely consisted of uncoordinated efforts (mainly by NGOs and at the district level), now the government is taking the lead in this area.

In the current, pre-NHI stage, the focus is on bringing all facilities to an acceptable level of care. Assessment tools for hospitals and PHC facilities, as well as user guides and training programmes to conduct self assessments have been developed. The DFID-funded SARRAH programme, managed by HLSP/Mott MacDonald, has supported these activities.

Initial inspections and audits were carried out in around 500 facilities. The intervention, which has given a broad picture of current quality levels, has also had some unintended positive outcomes. Care was taken to promote the OHSC as an enabling (rather than punitive) instrument, but some degree of resistance had been expected. Instead, facilities welcomed having standards to measure their performance, and the office was inundated with requests for self-assessment. A quality improvement culture seems to be in the making.

The South African experience has highlighted both the advantages and disadvantages of regulatory intervention.

Advantages:

- It has created, for the first time, a single regulatory regime
- It has ensured that minimum (i.e. life/death) standards are adhered to
- It has provided a legal basis for consequences/sanctions.

[3] Based on presentation by Myles Ritchie, HLSP (SARRAH Programme, South Africa: Strengthening South Africa's Response to HIV and Health).

Disadvantages:

- It is very resource intensive and costly (150 inspectors based in Pretoria are travelling most of the time).
- It may foster malicious and procedural compliance. This is addressed by using both announced and unannounced inspections, and through follow up to support facilities implement their quality improvement plan.
- Highly skilled health and other professionals are required, but the salary level has not managed to attract GPs, doctors, and specialists.
- It can be manipulated by politicians if not independent.

Regulation is only one part of the overall quality improvement space and by itself it will not raise standards significantly.

Broader lessons have also been learned from the intervention. First, that UHC focused solely on expanding access and not simultaneously addressing quality will have limited impact on population health. Second, that regulation is only one part of the overall quality improvement space and by itself it will not raise standards significantly. Importantly, experience to date has resulted in a greater coherence of quality improvement interventions, and has catalysed a culture of quality improvement – an unanticipated outcome.

Quality improvement in England[4]

In the UK, which has universal health coverage, the approach to quality is highly sophisticated. Yet quality remains an issue that requires constant attention and it is important to recognise that it has several dimensions. In an ideal world, high quality care should be: safe (does no harm); effective (does good); humane (treats people with respect and is timely); equitable; **and** is balanced by cost (i.e. it is efficient). Some uncomfortable decisions have to be made in the name of efficiency. One additional aspect of quality is sustainability: studies have shown the impact of health services on the carbon footprint (for example, in relation to the emissions produced by health care related journeys).

Different methods are used to assess quality in England, depending on the domain of quality (e.g. effectiveness can be assessed quantitatively through clinical audit data, but humanity can only be judged through qualitative methods). Similarly, there are several methods for improving quality, including (re-)education, incentives, regulation and legal action. Each has advantages and disadvantages.

Does quality improvement work? Evaluation is difficult, as generally it is not possible to experiment with interventions; attributing causality is difficult; and the cost-benefit of interventions remains uncertain given the assumptions that must be made (e.g. the length of any benefit). However some factors tend to be associated with success, such as:

- Recognition by participants of the need for change
- The problem is correctly diagnosed
- There is support and involvement of respected opinion leaders
- There is a sense of ownership by participants
- The focus is on improving quality rather than reducing costs
- Importantly, a combination of approaches is used and is changed regularly to ensure persistence of effect.

Both technical and relational interventions are needed.

A key lesson is that both *technical* and *relational* interventions are needed – but it is hard to find people that possess both sets of skills:

- Technical: scientific evidence/guidelines, quality assessment data. monitoring mechanisms
- Relational: organisational culture, leadership, clinician engagement, staff motivation, transparency, good communication, ward-to-board involvement, patient-centred approach.

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[4] Based on presentation by Professor Nick Black, LSHTM.

Quality is a dynamic concept.

Quality measures need to be developed and reworked continuously, with a constant trade-off between cost and equity.

Conclusions

There is no blueprint for achieving quality together with the three other essential dimensions of UHC (affordability, range of service provision and access). There is no fixed list of quality measures to be implemented in a specific order.

Quality has several dimensions and is a dynamic concept: it means different things in different contexts, at different stages of service expansion, over time. It requires constant attention, but the specific focus of this attention will depend on context and stage of UHC implementation. Perfection is not an option. Even in settings such as the UK, where universal coverage has been achieved, it is impossible to maximise *all* dimensions of quality. Quality measures continue to be developed and reworked, with a constant trade-off between cost and equity. It is up to each society to decide which trade-offs are acceptable.

The seminar was sponsored by the Mott MacDonald-DFID Centre of Excellence, set up in response to DFID's Key Supplier initiative which called for suppliers to better communicate the value of the services they deliver. The Centre of Excellence acts as a conduit for engagement between DFID and Mott MacDonald, facilitating information and expertise sharing.