HCAC 2019
5th QUALITY HEALTH CARE CONFERENCE & EXHIBITION
11 - 13 November 2019

Policy and Practice: A Partnership for Better Outcomes

"Accreditation and Patient Safety Right From the Beginning!"

Linking Quality of Care with Universal Health Coverage

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How does QoC relate to UHC?

"What good does it do to offer free maternal care and have a high proportion of babies delivered in health facilities if the quality of care is sub-standard or even dangerous?"

Margaret Chan, WHO Director-General, at the World Health Assembly, May 2012

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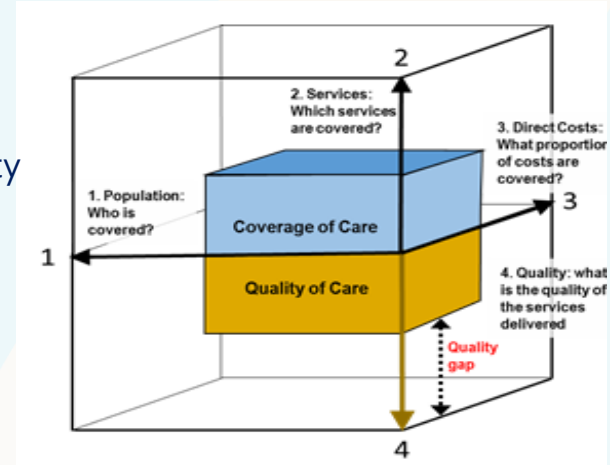
The 4th dimension of UHC: "Translating access into effectiveness"

QA/I processes:

- Regulatory
- Healthcare facility
- Health workers



Source: Barker, Pierre, "Making Universal Health Coverage Whole: Adding Quality as the Fourth Dimension." Institute for Healthcare Improvement, 2018.

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UHC drivers = QI drivers

Workers – doing the right things? Are there enough in right mix, right place?

Facilities – meet safety and operational standards?

Medicines – right quality & quantity? Used safely?

Devices & technologies – over or under used?

Information systems – capturing right data, right time, right accuracy? Used?

Financing – enough? allocated efficiently? Used appropriately?

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QoC gap: still large in most countries

22–44% - clinical practice guidelines adherence

7–10% - % of patients acquiring infection at facility

34–72% - diagnostic accuracy

5–17 patients - provider productivity

14–44% - provider absenteeism

40% - LMIC facilities without improved water

$42 billion - annual global cost of medication errors

Source: "Delivering quality health services: A global imperative for UHC. WHO, 2018

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Poor quality impedes UHC progress

Cost - efficiency

	Input quantities		
	Too little	Just right	Too much
Wrong inputs	Cost ✓ Outcome X	Cost ✓ Outcome X	Cost X Outcome X
Right inputs	Cost ✓ Outcome X	**Cost ✓ Outcome ✓**	Cost X Outcome ??

Low quality → poor efficiency → less $ for:

- Expanding population coverage
- Expanding benefits package

People recognize value for money

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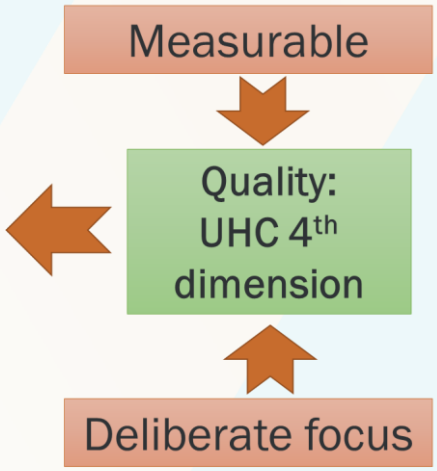
QoC elements – constant in any UHC approach

- Evidence-based
- Outcome-oriented
- Culture of quality
- National policy & strategy/roadmap
- Institutionalized
- Monitoring systems
  - Effective, safe
  - People-centered
  - Timely, efficient
  - Equitable
  - Integrated care



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How do UHC approaches "buy" it? (QA or QI?)

UHC Purchasing methods	Potential for impacting quality	
	Positive	**Negative**
Supply-side budgets	• Not left to "the market" (direct oversight of adherence to facility standards, worker certification, clinical standards & guidelines). • Can be augmented with outcome-based payments	• Resources for required supply-side monitoring are often limited. • Data capture for monitoring quality is weak.
Capitation	• Encourages cost consciousness with respect to inputs. • Promotes keeping people healthy. • Best if combined with outcome-based payments.	• Can encourage under provision of services. • Can promote adverse selection and over enrollment by providers. • Can promote early referral for issues that could be managed at the PHC level.

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UHC Purchasing methods	Potential for impacting quality	
	Positive	**Negative**
Fee for service	• Most direct means for knowing what a provider is doing. • Claims system can generate data for QA assessment.	• Can promote over provision of unnecessary services.
Case-based	• Encourages cost consciousness with respect to inputs. • Can ensure clients get all important care components. • Claims system can generate data for QA assessment.	• Reduce provision of services that may benefit quality. • Administratively difficult to know what services were provided. • Provider may "up-code" diagnosis and severity.
Outcome-based payment	• Encourages attention to good outcomes for patients.	• Can be administratively difficult to manage • May crowd out other services not tied to outcome-based payments.

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Thank you

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