

Universal Health Coverage and Patient Safety & Quality

Understanding the central role of PSQ in UHC
through practical experience in low- and middle-
income countries



WHO/HIS/SDS/2014.10

© World Health Organization 2014

All rights reserved. Publications of the World Health Organization are available on [the WHO website \(www.who.int\)](http://www.who.int) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int).

Requests for permission to reproduce or translate WHO publications –whether for sale or for non-commercial distribution– should be [addressed to WHO Press through the WHO website \(www.who.int/about/licensing/copyright_form/en/index.html\)](http://www.who.int/about/licensing/copyright_form/en/index.html).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Table of Contents

Executive Summary	3
Section 1. Background	4
Section 2. UHC-PSQ learning laboratory network	9
Section 3. UHC-PSQ convergence	10
Section 4. PSQ considerations for LMIC health service delivery as part of UHC	14
Section 5. PSQ as a means of driving UHC performance and accountability	18
Section 6. The barriers to integrating PSQ into UHC systems	22
Section 7. Potential implications for future efforts	25
Section 8. Acknowledgements	26
Appendix A: Learning laboratory partners	27
Appendix B: Semi-structured interview questionnaire	28

Executive Summary

Patient safety and quality (PSQ) is an integral aspect of a successful universal health coverage (UHC) system. However, there is a noticeable lack of information on the convergence of UHC-PSQ, especially in low- and middle-income countries. There have been efforts internally within the World Health Organization (WHO) to help bridge this gap, most recently with the establishment of the new Department of Service Delivery and Safety. In order for the work of the Department to be informed by frontline systems, a UHC-PSQ learning laboratory has been convened to capture tacit knowledge from five distinct and differing systems (community-based, small island states, public-private partnerships, national faith-based and national health insurance schemes).

Initial partner engagement focused on four questions. First, what are the key components of a UHC framework that requires PSQ consideration? Second, how should PSQ considerations be used to shape service delivery as part of UHC in low- and middle-income countries? Third, how can PSQ be utilized to measure UHC performance, ensure accountability and enhance efficiency? Finally, what are the barriers to integrating a PSQ approach into developing UHC in low- and middle-income countries? Each of these four questions were explored through the experiences of each participant interviewed, ranging from national to provider level personnel. Their responses are synthesized within this document.

Partners highlighted political will and moving from an "access" to a "safety & quality" mindset as critical. The need to develop/strengthen accreditation and regulation to enhance system performance was underscored. Specific action-focused tools for facility implementation of PSQ interventions was emphasized alongside integration with community-based efforts. Focused attention on three axes – credibility, accountability and efficiency – was stressed as vital for understanding UHC-PSQ convergence.

The importance of evidence-based PSQ tools, to aid in defining and refining health service packages, was highlighted. Learning lab suggestions were synthesized into fourteen PSQ action zones, spanning national, institutional and community levels. Ensuring that PSQ interventions are channelled through a motivated, dedicated workforce was seen as the engine for PSQ improvement.

Monitoring and evaluating the progress and application of these interventions has been a continuing challenge. Nonetheless, health information technologies are seen as a key tool to enhance health system performance, accountability and efficiency to people served by the UHC system. Standardized indicators – at the national, institutional and community levels – are considered an urgent need.

Progress in any of the above areas has not come easily for learning lab partners, with several common barriers emerging. These include a lack of clear understanding of how PSQ is related to UHC system design and implementation; structural challenges in health-care institutions; non-alignment of PSQ theory with practice; lack of standardized measurement; and a disconnect with wider social determinants key to receiving safe and high quality care.

Building on learning lab perspectives, ten potential implications are suggested for consideration. Learning lab partners are informing the global knowledge pool on how best to move forward in UHC-PSQ convergence. These perspectives have clear implications for WHO, as it moves forward in supporting country efforts in this area.

Section 1. Background

Universal Health Coverage, the origins and today

Universal health coverage (UHC) has its roots firmly planted within the evolving ethos of "health for all" that is echoed in the World Health Organization's Constitution, as well as international documents such as the Declaration of Alma Ata, the International Covenant on Economic, Social and Cultural Rights and the Universal Declaration of Human Rights^{1,2,3,4}. Since the early to mid-twentieth century, organizations and nations have joined together in moving forward on these promises, with no shortage of difficulties resonating to this day.

The relatively short history of universal health coverage started around 1948 with the development of the Declaration of Human Rights following World War II⁵. Along with the development of the Declaration, the formation and constitution of the World Health Organization came about in conformity with the United Nations to "promote and protect the health of all peoples"¹. Although the foundation was forming, it would be another twenty years before these principles would find their place in international law, as seen in the International Covenant on Economic, Social and Cultural Rights, articulated in article 12 that "recognize[s] the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".³ This foundation would lay the basis for further discussion in structuring how this care could then be delivered.

In 1978, the International Conference on Primary Health Care in Alma Ata yielded the Declaration of Alma Ata which placed primary health care at the centre of a call for universal access to effective health care for individuals and families.² The Declaration's emphasis on "health for all" came alongside a recognition of multiple factors that need an interdisciplinary and collaborative approach.

Since this time, various nations have moulded their health-care systems to reflect an evolution of thought. Universal health coverage has been implemented in differing fashions, with various ways of financing the respective systems.⁶ Particular challenges were faced in low- and middle-income countries.⁷ This clear and evident need to focus on UHC financing, especially in a recovering and fragile global economic state, yielded the World Health Report of 2010, which aimed to assist in guiding further understanding on how to build better sustainable forms of UHC financing.

Currently, the global emphasis on UHC is strong. Indeed, one of the latest UN resolutions has reaffirmed a commitment towards universal health coverage. Successive World Health Assemblies have reaffirmed

¹ WHO. Constitution of the World Health Organization. 22-Jul-46

² WHO. Declaration of Alma Ata. September 1978 (Accessed on 11/10/12)

³ UN General Assembly. International Covenant of Economic, Social and Cultural Rights. 16-Dec-66

⁴ UN. Universal Declaration on Human Rights. 1948 (Accessed on 1/3/13)

⁵ UN. The universal declaration of human rights: History of the document. Accessed on 2/9/13 from <http://www.un.org/en/documents/udhr/history.shtml>

⁶ WHO. The World Health Report - Health systems financing: the path to universal coverage. 2010

⁷ Stuckler, D., Feigl, A.B., Basu, S., Mckee, M. (2010). The Political Economy of Universal Health Coverage. First Global Symposium on Health Systems Research.

global commitment.⁸ Yet many barriers remain as countries move towards realizing a vision seen over 60 years ago when the groundwork for universal health coverage was laid.

Patient safety and quality: the origins and today

Patient safety can be traced back to the time of Hippocrates with his basic tenement of “First do no harm”⁹. Despite this principle, on which everyone agrees, there is still considerable harm being done – since as many as one in ten patients is harmed while receiving health care in hospitals.¹⁰ Similarly, quality has been a basic component of care as noted in the Alma Ata Declaration². Since then, science has evolved to improve the delivery of safe, quality care to patients – as seen in the recent series of World Health Reports¹¹. Much has been learned due to advances in multiple patient safety interventions, such as hand hygiene, sanitation and behavioural and structural changes to improve infection control. Yet the scale of the global problem remains significant with numerous unresolved issues for health systems.

Given the growing concern with both sub-optimal quality and safety, the World Health Assembly in 2002 composed a resolution to help address this need.¹² Following the Institute of Medicine's publication in 1999, *To Err is Human*, and subsequent studies emerging that contained very concerning data about the extent of adverse events, sub-optimal medical equipment and the effects of counterfeit medications, the 55th World Health Assembly in 2002 passed a resolution to highlight the need for providing safe, quality health care.¹²

This resolution highlighted areas requiring urgent attention including developing definitions for patient safety; emphasizing patient safety in health system performance and quality management; investigating the reporting and prevention of adverse events and establishing an evidence base on these practices; drawing up a framework to support countries in various safety capacity initiatives; establishing a network of centres of excellence to support research and implement findings; and, promoting public-private partnerships to respond appropriately to adverse events in health care.¹²

With the resulting resolution, the World Alliance for Patient Safety was created in 2004, renamed the Patient Safety Programme in 2009. This programme helped to build on and develop the issues ascribed to the resolution with promising success. Initiatives such as *Clean Care is Safer Care*, which focuses on hand hygiene, and *Safe Surgery Saves Lives* bringing about the use of the WHO Surgical Safety Checklist, have helped hundreds of institutions organize an international standard for safe, quality practices in patient care. Partnerships with patients, such as *Patients for Patient Safety*, have helped to ground and include all relevant stakeholders in finding collaborative solutions to health systems' needs. Partnerships among professionals have also been promoted through the *African Partnerships for Patient*

⁸ WHO. Universal health coverage. 66th World Health Assembly A66/24, Provisional agenda item 17.3

⁹ Translated by Michael North. Hippocratic Oath. US National Library of Medicine. Accessed on 2/11/13 from http://www.nlm.nih.gov/hmd/greek/greek_oath.html<http://www.pacifichealthsummit.org/downloads/UHC/the%20political%20economy%20of%20uhc.PDF>

¹⁰ WHO. 10 Facts on Patient Safety. Accessed on 6/8/14 from http://www.who.int/features/factfiles/patient_safety/patient_safety_facts/en/index1.html

¹¹ Noted World Health Reports 2008, 2010, 2013 citing the importance of health care quality as well as high quality research

¹² WHO. Quality of care: patient safety. 55th World Health Assembly A55/13, Provisional agenda item 13.9

Safety (APPS) initiative. Extending the culture of safety and quality into formal education has led to endorsements from over 300 universities. These initiatives have set the stage for a continued focus on patient safety and quality, as WHO continues to work towards systems improvements in the context of UHC.

This momentum surrounding patient safety has not gone unnoticed in recent global discussions. The report by the WHO Secretariat to the 132nd session of the Executive Board articulated three main future objectives: provide global leadership for patient safety; harness knowledge, expertise and innovation to improve patient safety; and, engage health-care systems, nongovernmental organizations, civil society and the expert community in the global endeavour of making health care safer. These objectives are seen as integral to the promotion of UHC systems.¹³

Service delivery and safety

In 2014, building on the momentum achieved through the Patient Safety Programme, WHO established its centre of excellence, launching a new department of Service Delivery and Safety (SDS) with a clear

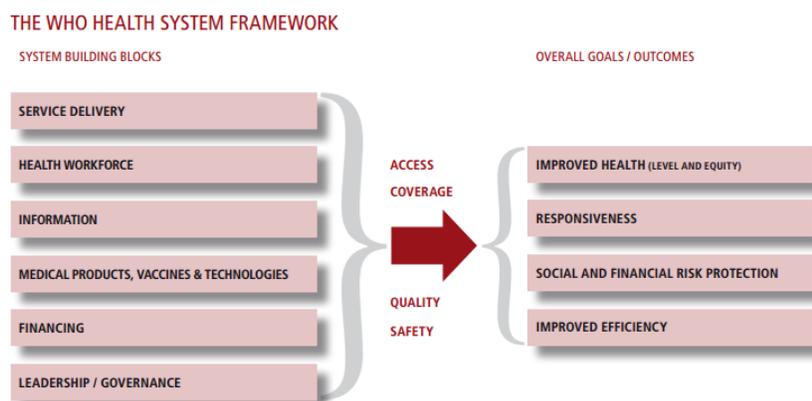


Figure 1. The WHO Health System Framework

vision: "all people receive safe, high quality, people-centred, integrated health services, at every interaction across the health services continuum."

One of the six system blocks within WHO's Health System Framework is service delivery. Each system building block must also consider safety and quality,

along with access and coverage.

According to the framework,

"good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources."¹⁴

The WHO SDS 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. The SDS mission is to identify, develop and disseminate knowledge models for effective interventions and innovative tools for countries to increase the quality and safety of their health service delivery.

¹³ WHO. (2012). Progress reports, Report by the Secretariat. Executive Board, 132nd session, Provisional agenda item 15.2. Geneva, Switzerland

¹⁴ WHO. (2007). Everybody's Business: Strengthening Health Systems to Improve Health Outcomes, WHO's Framework for Action. WHO Document Production Services. Geneva, Switzerland

Definitions

UNIVERSAL HEALTH COVERAGE^a

Ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

PATIENT SAFETY^b

The avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of health care.

QUALITY CARE^c

The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

UHC-PSQ WHEEL

Figure 2 represents the incorporation of PSQ in UHC, encompassing each component and representing the human life course as people transition and interface with various parts of the health-care system.

^aWHO. What is universal health coverage? Accessed from http://www.who.int/health_financing/universal_coverage_definition/en/

^bVincent, C. 2010. Patient Safety, 2nd edition. Oxford: Wiley Blackwell

^cIOM. Crossing the Quality Chasm: The IOM Health Care Quality Initiative. Accessed from <http://www.iom.edu/Global/News%20Announcements/Crossing-the-Quality-Chasm-The-IOM-Health-Care-Quality-Initiative.aspx>

SDS is currently driving the initiative for a WHO-wide effort aimed at formatting an interdisciplinary team to address service delivery and safety issues in major disease and population-centred programmes, within the context of UHC. The department's objective in strengthening UHC through best practices in safety and quality shows its clear commitment in this area.

UHC-PSQ are indivisible

Universal health coverage (UHC) and patient safety & quality (PSQ) have independent roots and origins. However, a UHC-PSQ integration is critical to achieving effective health-care service delivery in diverse health systems across the world. This report focuses on exploring UHC-PSQ convergence (Figure 2), with a particular focus on learning from a group of diverse systems already engaged with the question of how UHC and PSQ are inter-connected.

The Director-General of the World Health Organization, Dr Margaret Chan, stated during the World Health Assembly in May 2013 that “everyone, irrespective of their ability to pay, should have access to the quality health care they need, without risking financial ruin”.¹⁵ The 2010 World Health Report (WHR) gave particular emphasis to addressing financing mechanisms as an aid “to put more countries on the path to universal coverage and help others maintain their gains”¹⁶. The report focuses on financing systems for achieving UHC, but also highlights the importance of the safety and quality of health care. An important link between PSQ and achieving UHC is outlined in the chapter entitled “More health for the money” which focuses on inefficiencies in current health systems.¹⁷ The importance of “getting care right the first time” was highlighted, emphasizing that medical errors cost money. Building on the issues briefly discussed in chapter 4 of the 2010 WHR, patient safety and quality has a central contribution to achieving effective UHC systems in low- and

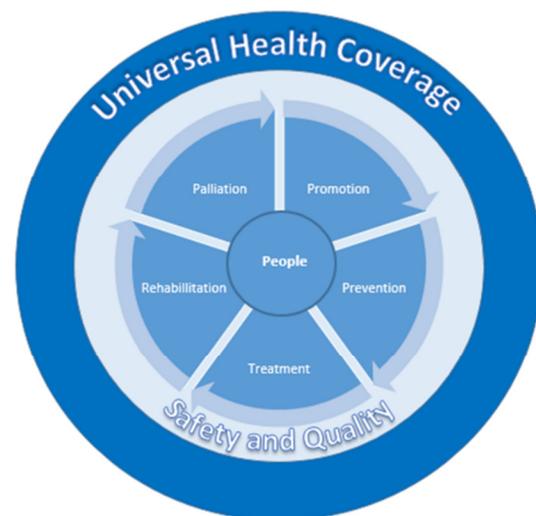


Figure 2. The UHC-PSQ wheel

¹⁵ Chan, Margaret. 20 May 2014 WHO Director-General addresses the Sixty-sixth World Health Assembly. Geneva, Switzerland

¹⁶ Chan, Margaret. World Health Report 2010: Keynote address 22 November 2010. International Ministerial Conference on Health Systems Financing. Berlin, Germany

¹⁷ WHO. (2010). The World Health Report – Health systems financing: the path to universal coverage. Accessed on 11/15/12 from <http://www.who.int/whr/2010/en/index.html>

middle-income countries. The unintended consequences of structures that are not vetted for safety and quality can potentially lead to system failure, substandard patient care, higher health-care costs and ultimately lost lives and preventable morbidity.

UHC is inclusive of service delivery in five areas: (1) Promotion; (2) Prevention; (3) Treatment; (4) Rehabilitation; and (5) Palliation. In each of these areas it is important to reflect on four specific “lenses” that are particularly relevant to patient safety and quality: equity, accountability, effectiveness and efficiency.

A focus on **equity** strives to ensure that safe, high quality health services are attainable regardless of racial, ethnic, cultural, economic or gender divides. The emphasis is on minimizing disparity within and across populations in terms of access to health-care services. This is a core principle of any UHC delivery system with PSQ at its core.

An emphasis on **accountability** focuses on ensuring systems are in place to achieve expected results. This is not limited to numbers of people covered, but considers PSQ issues such as iatrogenic infections, medical errors, medication stock-outs, etc. Indeed, a transparent and accountable system with clear standards can measure progress and continue to improve service delivery.

Effectiveness of service delivery systems are fundamental to building UHC in low- and middle-income countries, and a true challenge where good infrastructure is lacking. Service delivery systems can be further explored as facilities/supplies, human capital, financial capital and environmental contributors. Capacity-building in any of these areas can strengthen the effectiveness of service delivery systems; a balanced approach across all necessary areas is required to ensure a strong service delivery system.

Efficiency and **economic factors** are vital to system sustainability. If UHC is the engine, funding is the fuel. The 2010 WHR highlights this and emphasizes the need to improve current inefficiencies in health care delivery.¹⁸ Investing limited funds more wisely for health care, based on safety and quality measurement, can improve the use of best practice, thus enhancing the overall system.¹⁸

The above four “lenses” offer a foundation for reflection on the UHC-PSQ interface. But how can these perspectives advance UHC in low- and middle-income settings? Multiple questions remain unanswered. What are the key components of a UHC system that requires PSQ consideration? How should PSQ considerations be used to shape service delivery as part of UHC in low- and middle-income countries? How can PSQ be utilized to measure UHC performance, ensure accountability and enhance efficiency? What are the barriers to integrating a PSQ approach into UHC in low- and middle-income countries?

Each of these questions is complex and inter-related. Many systems are already attempting to tackle them, with a large body of tacit knowledge already in existence. This report attempts to highlight and centralize this knowledge to build a greater understanding of the UHC-PSQ interface.

In summary, the aim of this paper is to:

1. Capture the knowledge that exists in rapidly evolving UHC systems on the questions posed above.
2. Describe what is needed to strengthen UHC-PSQ convergence based on this experience.
3. Articulate potential implications of these findings for future efforts to strengthen the UHC-PSQ interface in low- and middle-income countries.

Section 2: UHC-PSQ Learning Laboratory Network

Why? A large body of knowledge exists in current UHC systems, dealing with PSQ issues in their day-to-day operations. However, there is limited global information currently available on the UHC-PSQ interface. A “learning laboratory” on integration of UHC-PSQ is helping this learning to be captured. The learning laboratory network also provides an opportunity for continued collaboration and knowledge sharing. These learning laboratories provide valuable sources of information and guidance on core questions, and has the potential to be a principal contributor to ongoing development in the scope of understanding on UHC-PSQ convergence.

What? The initial learning laboratory network represents differing UHC mechanisms, cultures and geographic challenges, which help collectively inform and analyse these questions. To gain a broad range of experiences, effort is put in to including a range of health system representatives. Having voices from the national level, to voices from workforce representatives – working in hospitals and communities – allows in-depth exploration of specific questions across multiple disciplines. Learning laboratories are active systems identified as partners in exploring the UHC-PSQ convergence in a bidirectional learning environment engaging in peer-to-peer communication.

How? For the purpose of identifying willing and engaged partners to contribute experiential information, the following criteria have been used:

1. Able to contribute experiential information on UHC-PSQ convergence;
2. Willing to engage in reviewing and discussing this initial scoping paper;
3. Able to communicate with WHO Service Delivery & Safety periodically.

The initial cluster of partners within the learning laboratory network represents a number of systems (see Table 1). Further detail on each system can be found in Appendix A.

System	Country
Community-based health insurance scheme	Uganda
Small island state system	The Commonwealth of Dominica
Public-private partnership	Bangladesh
National faith-based system	Uganda
National health insurance scheme	Ghana

Table 1. UHC-PSQ Learning Laboratory Network

Key participants contributed to a semi-structured interview with several questions pertinent to the scope of the paper. The questionnaire used can be found in Appendix B. Responses then underwent thematic analysis to feed into this report. All participants were aware that they were contributing to the scoping document and also welcomed bidirectional learning and communication. A learning lab partners meeting was held to consolidate feedback on an early draft of this document.

Section 3. UHC-PSQ convergence

Key learning laboratory perspectives:

- Convergence of UHC and PSQ work streams is vital.
- Political will and direction to strengthen “access” with safety & quality is critical.
- Need to develop/strengthen accreditation and regulation to enhance system performance.
- Specific actionable tools for facility implementation of safety & quality interventions are required to strengthen UHC systems.
- Patients/people are active participants in shaping UHC systems with PSQ at its heart.
- Focused attention on three axes – credibility, accountability and efficiency – form a key triad in UHC-PSQ convergence.

Universally, the learning laboratory agreed that patient safety and quality mechanisms were not just a component of UHC, but that their incorporation into the fabric was integral to UHC systems’ success. The convergence of UHC and PSQ was therefore considered critical.

Current experience and work has been developed in various areas among each of the respective learning laboratory partners, but the common theme of collaboration and coordinated efforts is paramount. Recognition is given to the importance of synchronizing political will from the top, at the national level, to the realities encountered at the ground level to minimize work flow disturbance and maximize safe, high quality health service delivery. Two principal mechanisms were highlighted for this purpose: promoting political will to move from merely “access” to access with safety & quality; and pushing political action in the form of national guidelines and a regulatory framework (including accreditation processes).

In addition to establishing guidelines and an accreditation process, partners agreed that monitoring and evaluation approaches are needed to gauge the progress of evolving systems. These systems must be publicly accessible and transparent and allow for input from people, as well as patients. It is recognized that these systems are dynamic and will be in constant need of improvement as health delivery continues to evolve. Systems should be in place to account for this gradual progression in safety and quality.

Hand Hygiene	Blood Safety
Medication Safety	Waste Management
Infection Prevention & Control	Triage
Surgical Safety	Transition of Care
Safe Practice Guidelines	Facilities Maintenance
Injection Safety	Safety & Quality Education

Figure 3. Key facility level PSQ interventions

The health-care facility was identified as fundamental to safety and quality in any health system. Specific PSQ interventions identified by partners are shown in Figure 3. Although not an exhaustive list, these areas were deemed particularly important.

Each of the learning lab partners mentioned encountering resistance to the introduction of safety and quality mechanisms at the facility level. Points of resistance revolved around clinical hierarchy and perceived workflow disruption. For this reason, buy-in is an important aspect for acceptance. Inclusion of not only employees working in the health system, but also of those engaging with the health system from the outside is imperative.

An equally important area mentioned by learning lab partners was patient and community engagement and respective attention being given to the social determinants of health. Natural extension into the community is advocated by improving mechanisms of connecting with outpatient services. Another important factor is collaboration with external partners working directly with the community. These engagements are deemed particularly important in improving preventive services, empowering people to demand higher quality care, and increasing health literacy. This requires all levels working cohesively to overcome challenges, improve inefficiencies and be accountable to people being served by evolving UHC systems.

The perspectives gathered from learning lab partners on the UHC components requiring PSQ consideration can be further clustered into three heavily inter-related axes: credibility, accountability and efficiency. Each of these three axes allows an exploration of ideas and lessons emerging from the systems-level experience and also mirror the UHC cube highlighted in the 2010 WHR.



“Patient Safety is an integral part of the health-care system, and at every level of the system, patient safety is a key component”

**– Chief Executive,
Ghana National
Health Insurance
Scheme**



Credibility

At the national level, the importance of a standardized accreditation process to ensure uniformity in health delivery quality is considered pivotal to system credibility. In addition, institutional attention to specific clinical domains – for example care of diabetic patients or care of the sick infant – was also highlighted as being critical to establishing system credibility. However, upper level factors that influence health policy require faithful engagement of the patient and community. In order for health facilities to build their trust and reputation with the community, a strong emphasis on safety and quality care was stressed as essential. One partner became reputable among its staff with a safety orientation prior to employment. Within the community, people come in to the health facility to see a ‘patient’s bill of rights’ allowing people to be aware and informed, active agents in their own health care. This reputation for safe and quality care is echoed through word of mouth. Accordingly, a positive reputation of safe, quality care directly influences service utilization and thus the success of a UHC scheme. People chose to bypass facilities offering comparable services closer to their homes for health facilities – which though further away – had a better reputation in terms of quality of care. Reputation is seen as very dependent on the culture of those working in the health delivery system. This shift in culture departs from the traditional hierarchy of medicine and instead engages people as partners in health care.

Accountability

All learning lab partners emphasized the importance of multiple stakeholders with a considerable interest in accountable UHC systems. Safety and quality affects all those who come into contact with the system and is thus considered a keystone of any UHC system that is held to account. Mechanisms for measuring its success are crucial to offering accountability, both nationally and locally. This means helping politicians to develop better policy, institutions to improve safe, integrated quality service practices, and communities to expect safe and high quality care. In the health facility, the role of safety and quality teams in conducting regular cycles of clinical audits on both structures and processes was highlighted as one method of accounting for safe, quality health delivery. But just as important, are monitoring and evaluation systems. These systems can efficiently use health information technologies as a versatile tool to collect, analyse and disseminate information in real time, to strengthen systems development. Integrating this evolving technology is challenging, with various noted barriers such as interoperability and maintenance. With effective use of data metrics and proper engagement of the community, a culture that expects accountable, safe, quality care can be established. This empowers people to be active participants in their care.

Efficiency

Modifying and supporting systems to achieve set efficiency standards is seen as important for the sustainability of safe, quality UHC systems. This means being responsive to the needs of facilities and the input from people receiving care. The focus here is to reduce redundancies, harmful practices and improve workflow in health-care delivery. While many learning lab partners recognized the inherent rationale of unsafe and low quality care leading to increased costs, they also emphasized that there was a lack of convincing data on the economic impact of unsafe care in their specific settings. While such data is urgently needed, efficiency considerations are being applied in each of these systems. At the institutional level, attention to efficiency means that facilities can optimize the investment in human capital by maximizing the skills of its workforce. Utilizing the full capacity of a well-trained workforce and integrating a safety agenda can prioritize improvements to workflow and care delivery. This means having multiple people empowered as a team to check and ensure the safe care of an individual, from admission to hospital, to transfer of care to the outpatient setting. In the community, efficiency gains can translate to reduced waiting times, improved communication between the patient and provider, improved satisfaction and better confidence in the health system by all those who are affected by it, whether health workers, staff, patients or their families.

Lessons in practice

Kisiizi Hospital, Uganda

Word-of-mouth has been the testimony for strides fostering a culture of safety and quality. People in this region of Uganda use services at Kisiizi versus other hospitals in the region in large part to this facet of care. This has also built a feeling of pride within the workforce, but this has been no simple feat. This culture now permeates with all employees of the hospital and has become an expectation to its care.

Triage as a tool for optimizing quality patient care and workflow

The medical superintendent of Kisiizi Hospital has strongly advocated for the importance of careful triage. Experience has shown that this diminishes the problem of delaying care for critically-ill patients, and ensures that services are rendered to reduce harm from delayed care, due to a lack of proper triaging. This translates into initiation of evaluation and treatment, with less disruption to patient care. Therefore, proper training as early in the patient encounter as the triage station seems to contribute to improved patient outcomes.

Section 4. PSQ considerations for LMIC health service delivery as part of UHC

Key learning laboratory perspectives:

- Specific evidence-based tools can help implement PSQ standards in health facilities as part of UHC service development.
- Motivation of a dedicated workforce and improvements in workflow are critical to PSQ development through the support of multidisciplinary teams.
- PSQ considerations in a number of "action zones" can contribute to defining and refining the scope of health service packages as part of a UHC system.

Partners readily identified either national or international guidelines as sources for informing safe, quality practices. However, a lack of clear context-specific guidance on its implementation, monitoring and evaluation were commented on as areas requiring concentrated global effort. Recognizing these limitations, all learning lab partners highlighted the important potential role in implanting PSQ considerations in the shaping of service delivery within UHC systems in low and middle income countries.

Lessons learned from partners regarding implementation quickly identified its largest resource as its most pivotal stakeholder – namely the health workforce. Although PSQ tools are available to assist in workflow, instilling new PSQ workflow practices are often faced with resistance. All partners agreed that stakeholders from national to community levels must be involved and integrated to embrace a culture of safe and quality care. PSQ interventions need to improve workflow and be seen as an overt benefit to service delivery. The importance of organic integration of PSQ into service delivery was stressed for two main reasons – allowing for individual circumstantial adaptation and also to promote ownership. This seems to add internal value to the initiatives, as people champion their efforts for safety and quality.

Once there is universal agreement to change, a plan for implementation and a means to monitor and evaluate workflow changes can occur. These mechanisms can then organically allow for continued innovation within the workforce. At the hospital level, mention was made of key practitioners – either physicians, nurses or pharmacists – who have engaged in innovative solutions to the challenge of improving facility safety and quality. Reward for these improvements was widely encouraged among partners in the form of formal awards or recognitions. These rewards help encourage and motivate positive change. There was also agreement that punitive measures should largely be discouraged to bolster honest feedback for system improvements. This will hopefully minimize fear among an overburdened workforce, and instead spark motivation.

Learning lab partners identified a number of key areas that they considered relevant to health service delivery design or refinement. Many of these core PSQ “action zones” for UHC systems have brought success to facilities able to carry them out, while other “action zones” are considered critical as systems further develop (Figure 4). The suggested “actions zones” are blocked into three groups – national, institutional and community. These fourteen action zones do not – of course – function in isolation, and

are deeply inter-connected and heavily influenced by the social determinants of health. A multidisciplinary approach in the application of these action zones was considered mandatory for the success of UHC systems that have service delivery with PSQ at their core. Further, within each action zone, the central frame of reference mentioned by learning lab partners was placing people at the centre of service delivery design.

National PSQ action zones

Policy refers to the relevant legislation that influences health, both directly and indirectly. Only the national government of a sovereign state can impose certain standards and expectations broadly, and more importantly ensure that these mechanisms are accounted for. This was highlighted as key.

Accreditation and licensing were cited as a common vehicle through which to uphold and regulate a set of PSQ standards. This is seen universally as an important tool for strengthening the safety and quality of service delivery, which in turn contributes to a robust UHC system.

Policy	Patient & Community Engagement	Health Promotion	Sensitization
Accreditation & Licensing			
Infection Prevention Control			
Safe Surgery			
Safe Birth			
Injection Safety			
Blood Safety			
Medication Safety			
Waste Management			
Health Worker Safety			
Safety and Quality Education			

Figure 4. PSQ action zones

Institutional PSQ action zones

Infection prevention & control (IPC) was mentioned by all learning lab partners as a central component of safe, high quality service delivery at the institutional level. At its most basic, it was described in terms of hand hygiene, maintaining clean bedding and preventing surgical site infections, but also extended to reducing added health-care costs from nosocomial infection.

Surgical procedures are among the most invasive interventions that leave patients particularly vulnerable. **Safe surgery** techniques and standards can help modify the patient’s recovery and prevent the need for aggressive post-surgical care as a result of complications that may occur due to deviations from standard safety practices and procedures. This can be factored into minimum standards within surgical service packages.

Childbirth is one of the most dangerous, yet common, events in health facilities around the world. For generations, suffering and death have occurred in the face of cost-effective, evidence-based and available interventions for both the mother and newborn child. Attention to PSQ **safe birth** practices was considered a priority for learning lab partners.

Immunization has been a true public health advancement helping reduce the prevalence of a number of infectious diseases. Therapeutic injections – although overused in many systems – are part and parcel of health service delivery. Compromising on **injection safety** can easily lead to patient and provider harm and was highlighted as a key area for attention when building service delivery.

All learning lab partners underlined the large contribution to patient harm when insufficient attention is given to **medication safety**. This includes not only safe prescribing mechanisms, but also safe medication stock, clear instruction on use and reduction of counterfeit and non-active medications. The quality of the medication has implications on safe treatment of the patient, as well as trust in health services, among the general population.

Medical waste, as a result of services rendered, should not contribute to harm, to either the patient or care-giver. In the handling and treatment of waste, exposure should be minimized and disposal conducted in a way that does not place others at risk or endanger the environment. As some partners pointed out, some facilities do not have the capacity to properly dispose of waste which may contribute to harm exposure. This was deemed particularly important for the communities that surround facilities.

Health worker safety is an investment that supports and gives value to the respective workforce, to enable them to provide care and conduct their duties safely. Health-care workers injured on the job not only pose a personal safety concern, but also place a strain on an already overburdened workforce. Limitations on patient care, as well as dependence on the income that the injured worker provides to support his or her family, can also be compromised.

The basis of **safety and quality education** should be instilled in every provider within their respective area of training as a basic principle of duty. Congruently, this same principle needs to be taught to the general public in a manner that sets expectations for PSQ and empowers people to ask for safe, quality treatment. PSQ education through context-specific curricula was thus highlighted as a critical to in-service training, one which focused on the realities of service delivery at the frontline as well as training in a formal education setting.

Community PSQ action zones

The following three PSQ action zones – particularly focused at the community level – are closely intertwined with all levels of the health-care system and each of the eleven other PSQ action zones.

Patient and community engagement was heavily emphasized by learning lab partners and has been used in various forms – simply through the inclusion of formal and informal feedback assessments to active advocacy groups that aim to improve facility and national policy. This contribution helps to address areas of improvement, even within action zones, to better address context specific challenges. Transparent communications and collaborations can enhance this interaction to develop organic solutions to transpiring difficulties in service delivery.

Active **health promotion** is not only a component of UHC, but its thoughtful application can help PSQ interventions move forward. A well-known example are the hand hygiene campaigns that empower



“We should take an evidence-based approach and begin with those risks that are the greatest ones in terms of patient safety”

– National
Epidemiologist for the
Commonwealth of
Dominica



patients to ask if their provider has washed their hands prior to examination. A wider and active development of health promotion techniques focused on PSQ issues was suggested. The role of this sort of health promotion was particularly highlighted in relation to safe, high quality care for non-communicable diseases e.g. hypertension and diabetic care. One of the best resources to help promotional campaigns and to champion safe and quality care are community health workers (CHWs) who are the interface between the community and the institution. CHWs have varying levels of knowledge and expertise, but are vital extensions of the formal health sector. The role of CHWs in developing robust PSQ systems was emphasized by all learning lab partners.

Sensitization to the culture of safety and quality must spread through the highest levels influencing service delivery right to those who are receiving the care being delivered. It is no small matter to change routine care practices as a result of adapting to resource constraints, but to expand access without changing potentially harmful practices would incur more problems in terms of service delivery and patient satisfaction. Simple measures may manage to modify behaviours that then improve the quality of health for all, but such changes require local champions to act as agents of change within their respective field.

Needless to say, but important to re-iterate, these action zones are not an exhaustive list of required actions. They are, however, considered to be core areas that contribute to specific aspects of the safety and quality of service delivery and patient care. These action zones are interdependent and require fluid contributions from multiple stakeholders in order to make meaningful progress in safe and high quality service delivery as part of UHC systems.

Lessons in practice

Health education, beyond the health professional – Building on the BRAC ethos

An important health promotion activity regards advocating for educating not only health professionals, but also the general public about safe, quality health care. In particular, what does this mean, how is it delivered, and how do we pursue improvements? How can we expect a culture of change if people don't know what safe, quality care is even supposed to be?

These concerns and issues need to be imparted on both providers and the public. Calling for legislative direction and professional education has been advocated. On the professional spectrum, including a standard applicable curriculum for doctors, nurses, pharmacists, medical assistants, etc., is important during their respective formal training and continued medical education.

To empower patients with the knowledge and confidence to act as active recipients of care and improve awareness of safety and quality practices could add a layer of protection in service delivery. An example of this in practice is a patient asking a provider if they have washed their hands prior to examination – understanding that this is a basic means of preventing disease transmission.

This proposal contributes to several of the action zones noted above – notably to the safety and quality education, but also builds on aspects of health promotion, patient & community engagement, sensitization and permeates into all other action zone items too. This example highlights the interconnectivity of the action zones in practice.

Section 5. PSQ as a means of driving UHC performance and accountability

Key Learning Laboratory Perspectives:

- A PSQ approach can drive UHC performance improvement through three streams: information technology, monitoring of key indicators, and transparent information sharing.
- Information technologies can support many aspects of PSQ, which may include creating actionable data and information that can be widely available to the general public.
- There is an urgent need for standardized indicators for all levels, including national, institutional and community levels.
- Patient-provider interactions focused on safety can enhance system accountability.
- Efficiency estimates need to be developed for multiple PSQ entry points to UHC systems.

Information Technology

A case study in Dominica

Although initial investment in IT is costly, the ability to track and monitor safety and quality indicators may itself be a cost-saving measure. The goal of better integrating outpatient clinics with the hospital aims to reduce redundant diagnostic testing and provide better care without delay. Being a small island state, they are using a partnership with a Chilean group for IT support.

A learning lab consensus

IT is an important tool for M&E, record keeping and patient care. Inter-communication between systems though is very important and ideally universal systems would help in patient transfer without losing vital information. This can also be a tool for health promotion, among other innovations.

Learning lab partners provided three main entry points through which PSQ can drive UHC performance, accountability and efficiency.

First, the use of information technology as a tool to assist in data collection, analysis and information sharing was highlighted by all. Such mechanisms have been used by some learning lab partners for tracking patient information flow from the outpatient to inpatient settings. This helps providers to keep information updated on patient encounters, minimizing exposure to repeated tests, giving providers prompt information to continue patient care after a transfer of care. In this case, information flow is important for improving service delivery efficiency and prompting more expedient care. However, difficulties associated with information technology – particularly in supplying and maintaining systems – were emphasized.

Second, the importance of standardized indicators for monitoring the system were highlighted as an urgent need. Indicators, such as those of the Millennium Development Goals, were seen as important to maintain objective measures of progress to hold systems accountable to services. Learning lab partners stressed the need for PSQ indicators to be concentrated on a few key areas, with the capacity for multiple branches of data to be collected as required. In this respect, having a few clear indicators could help keep focus and capture general trends, whereas having too many data points for a large system may distract from the work of the health system.

The final pressing point focused on how the PSQ information would be shared. The interface with the health management information systems was highlighted as key. All agreed that information must be available to the general public, as well as health workers, administrators and policy-makers. This level of transparency was recognized as a layer of

accountability for the investment of human capital and material resources. Sharing this information allows greater ownership by health-care workers, and spurs greater empowerment of patients and patient advocates. Greater involvement aims to improve overall health systems function.

With these general perspectives in mind, learning lab partners provided further insights regarding the influence of PSQ on performance, accountability, and efficiency.

Performance

All partners highlighted the need to optimize the performance of multiple components of the UHC system using a multi-tiered approach. An important point stressed is that performance indicators must be standardized and applicable between different settings, and offer a level of objectivity – such as that provided by the MDGs. This will allow for data to identify system strengths and deficiencies nationally and locally. Partners identified this as being a difficult endeavour to pursue, but ultimately needed to help monitor improvements in UHC systems.

Having a system in place at the institutional level to monitor personnel performance was deemed critical by partners. Optimizing workforce performance to achieve safe & quality care was considered a clear mechanism to ensure full function of its skill set. Qualitative measures, such as review committees to discuss performance, in addition to quantitative measures were mentioned as important sources of information.

Consensus was also clear around the requirement that PSQ data should not focus solely on mortality measures but also focus on morbidity. Indicators can monitor important facets of direct patient care to improve the safety and quality of service delivery. Global indicators may also monitor presence and activity of institution accreditation and policy to maintain accreditation of health institutions and personnel. Further, indicators at the institutional and community level also provide an in-depth review of the progress and reach of PSQ initiatives in UHC systems. These indicators should provide broad information to aid in further improvement efforts at a large scale. In addition, more detailed indicators are followed at the ground level, but need to be distinct from the global indicators that help inform broader policy implication. Indeed, all learning lab partners emphasized the need for a rapid development of such indicators.

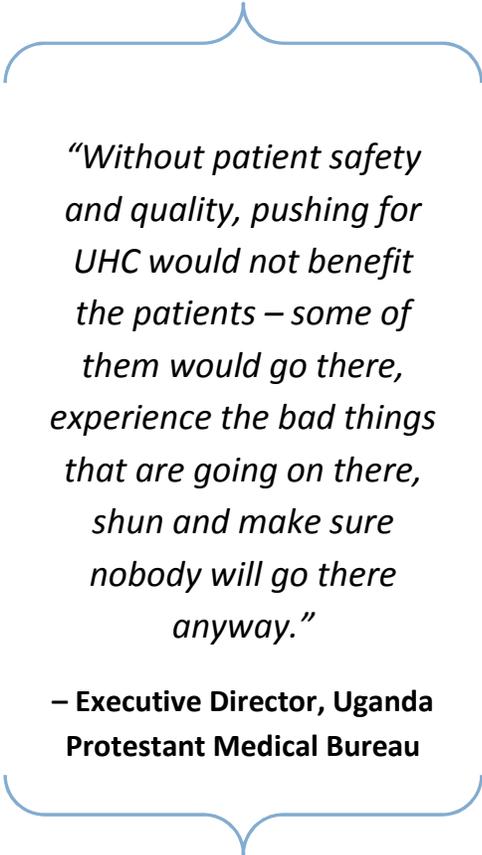
The national indicators suggested by partners focused on licensing and accreditation metrics. Institutional monitoring along with the noted action zones provides indicators to ascribe to key safety and quality programmes. This gauges a facility's commitment to these initiatives. Finally, the engagement of the community acts as a barometer of the greater culture of acceptance of safety and quality by looking at involvement of the community.

Accountability

UHC systems are meant to reach all people. Different levels of the system inevitably influences the health of the larger population. This includes national, institutional and community levels, and proper reporting mechanisms need to be in place to track how these various tiers interact. This aspect of safety and quality also requires multi-tier engagement among these stakeholders.

Open access to data and information for the public to monitor safety & quality of UHC systems was highlighted as important by all learning lab partners. At the national level, this allows for system-based improvements backed by public demand. Similar expectations at the institutional level can be monitored, which as one learning lab partner highlighted occurs in its own region with an appreciable elevation in patient reputation and service utilization. Objective measures offered to motivate quality improvements among facilities can be accessed through a ranking system that may be issued by an accreditation body, to help guide clear criteria for quality improvement. This could also aid the general public in becoming acquainted with standards of care.

A similar expectation of transparency can support local community engagement with the health system. In some cases, posted information such as nosocomial infection data, or hand hygiene compliance, allows not only patients, but also staff to gauge their own level of progress on safety and quality. This leads to an expectation and culture of safety and quality. Fostering this culture requires encouraging the reporting of adverse events to establish a “just culture”. Presenting adverse events as learning opportunities to change workflow processes can help better mediate patient experiences and offer a safe environment for staff to engage as active monitoring agents. Disclosing adverse events and being transparent is the ultimate measure of accountability at the ground level. This should be encouraged to strengthen trust within and among those interacting with the health-care system.



“Without patient safety and quality, pushing for UHC would not benefit the patients – some of them would go there, experience the bad things that are going on there, shun and make sure nobody will go there anyway.”

– Executive Director, Uganda Protestant Medical Bureau

Efficiency

Learning lab partners highlighted that parameters of efficiency are wider than focusing on financial criteria alone. Efficiency in communication, partnerships, enhanced service delivery flow, minimizing wastage as well as cost-control were all mentioned.

An important system vulnerability identified is communication and information sharing when patients require an escalated level of care. Lapses in transfer of care lead to repeated exams in some cases, as well as delays in care. Tighter communication streams within the health delivery system is important for maintaining safe and quality care. In the same respect, the various partner agencies that help provide screening and care in the community could be better engaged. Integrating independent partners to reduce redundancies could lead to better resource allocation and reduce waste from poorly allocated efforts.

Optimizing safety and quality of service delivery of health workers, through improvement in their workflow and standardized protocols should enhance the provider-patient relationship and not detract from it. Task shifting can ensure that staff are used to the highest level of their training – beginning with community health workers in the field, to providers in the clinics and hospitals that provide elevated

levels of care. Efficiency should not be confused with expedient care at the expense of the provider-patient relationship. Instead, the goal must be to improve overall workflow processes to best utilize the time available for each engagement.

PSQ interventions need to be implemented at an acceptable cost, which requires careful consideration of the financial structure of the UHC system. Indeed, making a clear case for cost-based efficiency savings through patient safety and quality interventions was highlighted as a ripe and important area for development by many learning lab partners.

Lessons in practice

Clinical audits in Dominica

Many facilities apply audit systems to track and trend care practices to ensure compliance with safety and quality standards. Dominica has a set of forms to assist in incident reporting, root cause analysis and case management. This system allows for a detailed and multisystem review of adverse events, or near misses. Although paper-based, moving towards interests in IT may allow even better workflow of reporting and action, as well as data on safety and quality parameters in the health-care system of the country.

Clinical audits had been identified as a useful tool. However, the most important aspect of a successful application of this tool is a culture of safety and quality that encourages reporting by diminishing the fear of punitive action. This may require additional training and changes in protocols or policy. Encouragement focusing on systems improvements instead of ascribing blame to people has been proposed as the way forward.

Decreasing redundancy and improving efficiency through coordination in Uganda

The Uganda Protestant Medical Bureau has coordinated to expand access to medications. A partnership has been able to manage and maintain an independent Joint Medical Store to supply quality medications to adjoining health facilities. These partnerships need not only operate in isolation, but also share a mutual connection with government to “optimize the use of resources; increase equitable access to health care; and improve service quality through quality assurance and integrated human resource development plans”. The importance here is aligning stakeholders as allies in a joint venture to optimize existing resources.

Tools used for establishing these partnerships are based on clear memorandums of understanding, legislation and contracts. These processes have allowed for a broader use of internal country resources to be organized and better utilized for service delivery.

Section 6. The barriers to integrating PSQ into UHC systems

Key learning laboratory perspectives:

- Lack of clear understanding of how PSQ relates to UHC system design and implementation.
- Lack of political will & motivation to consider the complexity of PSQ.
- Difficulty in financing PSQ interventions and structural challenges in health-care institutions.
- Lack of standardized measurement mechanisms and dissemination of information.
- The social determinants of health are identified as influential to quality care, but not well integrated.
- PSQ theory is not aligned with practice.

Several barriers emerged from learning laboratory partners through practical lessons learned from experience. In general, all partners highlighted the lack of a clear understanding of how PSQ is related to UHC system design and implementation. The relationship needs to be better understood by all stakeholders.

Nationally, the largest barrier highlighted is the lack of political will, not always aimed only at the Ministry of Health. Usually discussed as a “conceptual ideal”, political will to support and foster successful UHC systems usually displaces most of the burden to the facility level without necessary system level support. In some cases, this can lead to dependence on NGOs and aid agencies. Having strong political allies to prioritize internal, sustainable support for safe, quality health care is an important investment.

A notable limitation to achieving safe, quality UHC systems is funding. Although the learning laboratory partners represent differing systems, all face this barrier in different ways. Having the funding available to support health-care workers, supplies, facilities, and medications is essential but often overlooked; safety and quality considerations can seem hollow without consideration of structural elements of service delivery. With this in mind, several partners cited that many facilities have come up with creative solutions out of need, due to lack of resources. Many partners also cited that very basic safety and quality issues can be addressed with interventions that require little additional funding, using such mechanisms as in-service didactics and internal PSQ champions to change the culture of safe, quality care.

Another finance-focused barrier shared by partners as a strong point of concern is corruption. Corruption generally prevents or takes away funds and resources that should be prioritized to the general public, with the most poor being particularly vulnerable. Partners stated that greed is a

"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?"

Dr Margaret Chan,
World Health Assembly - May 2012

significant detractor of appropriating resources in a fair manner. Lack of transparent reporting and tracking mechanisms are also cited as contributors to masking this corruption that can have a direct influence on safety and quality of care. This leads to poor public perception and distrust. This in turn hurts the reputation of the health delivery system, losing the confidence and support of the general public. To earn their trust back, significant effort must be made to improve the level of transparency in funding, resources and action of the health system in striving to meet the needs of the people. How that information is relayed to both the workforce and the general public presents its own barriers.



“Change in attitude, when people are used to something for a long time, and you want to involve quality, there is a major check, and there would be some resistance.”

– Director General of Ghana Health Service



At the ground level, attitude and cultural shift towards a focus on safety and quality is also a significant barrier. Often the status quo competes with possible new changes, requiring at times a steep learning curve in alterations to current practices. Changing behaviour may be incredibly difficult to achieve, and does require local champions as agents of change in their respective institutions. One partner cited the case of a local champion changing the workflow for optimizing care to reduce neonatal infection treatment delay. This led to a complete departmental change and led to a new and improved workflow grown from within the care team. Another partner mentioned that to assist in engraining safety and quality in its culture, orientation is done to specifically incorporate this training for new employees prior to starting their respective duties. This training is given across all levels and disciplines – from the porters to the doctors – to underscore the importance of safety and quality care.

Learning lab partners also highlighted the barrier posed by the patriarchal hierarchy of medicine, which often leaves patients or patient advocates timid about challenging the safety and quality of care received. Indeed, there is dissatisfaction with areas such as medication stock-outs, lack of medical supplies and in rural areas lack of trained providers. System-level barriers exist in relaying this feedback to both national and institutional agents. Some learning lab partners reported meeting this barrier through formal feedback forms, interview sessions with people prior to leaving the hospital, comment boxes or informally by independently asking people about their care at the health-care facility.

Before people even interface with the health delivery system, they already have various factors that limit access to safe, quality health facilities. This is learned through the specific social determinants of health that affect access for a given population. Partners agreed that better engagement with agencies working in the community should be integrated to recognize and resolve individual barriers at the community level. Engaging people as a resource to help their own communities also imparts ownership, empowerment and pride to such communities.

All the learning lab partners highlighted the importance of keeping “grounded” in the real structural challenges at the facility level. Facilities burdened with large patient volumes creates long waiting times, delaying prompt care and lowers patient perception of the quality of care provided. This becomes extremely taxing on health workers. Without proper support, morale can wane and the quality of care begins to suffer. This perpetual cycle is a model that can be difficult to overcome, but is not impossible when a supported workforce is well oriented and trained to value safe, quality health delivery practices. This should not distract attention though to ensuring that health providers have the basic tools available to complete their jobs – functional diagnostic equipment, medical supplies, medication, clean water, electricity and appropriate waste management.

Lessons in practice

The medical hierarchy stunting patient safety

One of the learning lab partners shared a personal story of his daughter’s incident of a medical complication. He recalled the incident vividly because it occurred within days of his daughter’s birth. He mentioned that her belly had been warm and hard while at home. He brought his newborn daughter back to the hospital where she was delivered. He then came to discover that his daughter contracted an infection from the delivery. Further investigation discovered that the delivering provider used a blade that was likely not sterile. Despite the nurse advising the provider at the time, the physician proceeded to use the blade. When the culture works in a hierarchy in this regard, the staff is not empowered to work collaboratively with the physician which allows for errors to more openly occur.

Had the nurse felt more empowered, or a culture of teamwork in safety and quality been emphasized, such a complication may have been avoided. This would have prevented the three-day hospital stay and undue stress incurred by the parents in what should otherwise have been a joyful time.

The social determinants of health give insight to barriers of UHC outside the health-care facility

All learning lab partners shared a number of barriers, but specific examples were brought to light including a varied array of external variables. A few examples of some of the social determinants discussed include: transportation, water, culture, religion, poverty, education and gender – in which barriers exist to achieving safe, quality health care. These examples apply to a number of settings. Access to clean water in the community to reduce the occurrence of waterborne illness, or water in facilities to promote hand hygiene. Safe roads for transport to the health facility – citing that dangerous roads may actually result in further harm en route to the health facility. Poverty’s influence on hindering people’s ability to seek care due to inability to pay for medications or care, incurring most harm to the most vulnerable. Lower education, translating to lower health literacy acts as a barrier to proper compliance with medical treatment, and harmful medication usage. This results in marginalization of certain populations, usually the poor and those generally looked down upon by society.

The largest factor echoed by learning lab partners as noted was attitude and culture. This is often transmitted from one generation to the next. As noted by the BRAC partner, offering further education in this field may offer one way to help modify culture. Changes in culture though are recognized to occur slowly.

Section 7. Potential implications for future efforts

Each learning lab partner contributes their own experience towards UHC, given the differences in the building blocks of their respective systems. Learning lab partners have clearly stressed that there is a central place for safety and quality in UHC systems. Unanimously, there has been a call to ground the discussion on UHC-PSQ in real systems rather than theoretical constructs. Although each Member State and region will present their own unique challenges, common themes do arise. Given the perspectives synthesized in this document, ten key implications emerge for continued engagement.

1. All key stakeholders – ministries, health-care administrators, health-care workers, NGOs and the general public – need to clearly **communicate and engage** in the convergence between UHC and PSQ.
2. There is an urgent need to co-develop a set of standardized PSQ **indicators** that are universally applicable despite the divergent UHC systems.
3. Care **integration** is vital to PSQ, placing people at the centre of the UHC system and understanding multiple interfaces between the community and health facilities at all levels.
4. Effective and transparent mechanisms for **accreditation, licensing and regulation** need to be developed swiftly for application in emerging UHC systems across the world.
5. **PSQ interventions and teamwork** are required to enable its practice – use of the fourteen action zones identified by the learning lab partners’ offer a positive way forward.
6. A well trained and motivated **workforce team** operating in an integrated health system is the key to PSQ – capacity development is urgent.
7. **Health information systems** need to be designed or refined to facilitate PSQ and monitor and evaluate their performance within UHC systems.
8. **Structural challenges** (administrative, human resource, facility and social infrastructure, etc.) to PSQ need to be faced head-on within operational UHC systems.
9. The **economic case** for PSQ needs to be developed and highlighted within UHC systems.
10. Engaging with patients, families and communities in true **partnerships** is imperative to achieving safe, high quality UHC systems.

People should be empowered to engage as active participants, and should be at the core of any initiative that strives to deliver safe, high quality health services. Learning lab partners are informing the global knowledge pool on how best to move forward in strengthening UHC-PSQ convergence. These perspectives have clear implications for WHO as it moves forward in supporting country efforts in this vital area.

Indeed, there are three mechanisms in which WHO will be engaged in addressing these implications. A global working group is being established to build on the issues discussed in this document in order to refine thinking on UHC-PSQ convergence. Concurrently, an internal WHO taskforce is being asked to work across programmes and areas to strengthen UHC-PSQ convergence through actionable technical deliverables and information to guide UHC efforts internationally. Finally, implementation-based perspectives, such as those provided by the UHC-PSQ learning laboratory network, will remain a key component to grounding future work in real health systems.

Section 8. Acknowledgements

This manuscript could not have come together without the participation of our partners. Formal acknowledgements are given for the active contribution in both interviews and in-person meetings at the World Health Organization Headquarters in Geneva, Switzerland.

The following individuals are active participants in the learning laboratory network: Dr Ebenezer Appiah-Denkyira, Mr Clayton Bryan, Ms Alia Fry, Mr George Kumi Kyeremeh, Mr Sylvester Mensah, Mr Moses Mugume, Mr Nat Otoo, Dr Fatema Rasul, Dr Paul Ricketts, Dr Malabika Sarkar, Dr Ian Spillman and Dr Tonny Tumwesigye.

Special thanks for attending and participating in the group meeting held at WHO headquarters in Geneva, Switzerland go to Sir Liam Donaldson, Dr Bayarsaikhan Dorjsuren and Dr Hernan Montenegro.

Additional contributions were made by Dr Kedar Mate on behalf of the Institute for Healthcare Improvement, as part of contextual learning for the background of this paper.

Appendix A: Learning Laboratory Partners

Partner	Country	Financial system	Highlights
BRAC	Bangladesh	Public-private partnership	BRAC's mission statement is to "empower people and communities in situations of poverty, illiteracy, disease and social justice". This being one of the largest NGOs in the world with 100, 000 HCW providing maternal, neonatal and child health services covering 24.5 million people in Bangladesh alone. A programme to help insure people developed by BRAC is the bHIP (BRAC Healthcare Innovations Program). bHIP aims to provide equitable access to comprehensive, integrated, quality care that minimizes the risk of economic compromise – in line with the goal of UHC.
Commonwealth of Dominica	Commonwealth of Dominica	Small island state	This small Caribbean island nation has a population of 71, 000. There are seven health districts with 52 health centres/clinics that support two district hospitals and one main hospital. The country has established free primary health care. Secondary care is fee for service, while tertiary care is mostly provided overseas. Currently out-of-pocket (OOP) funds 34% of health costs, while government provides 62%. However, policy is being developed to reduce OOP costs.
Ghana National Health Insurance Scheme	Ghana	National health insurance scheme	A long history of reform exists in Ghana since 1957, when a free health care policy was implemented. The most recent reforms though have grown since National Health Insurance was introduced in 2003. Currently, capitation on primary care and G-DRG for secondary & tertiary care exist with fee for service charges for medicines. Active membership has risen since 2005 from 1.3mil to 8.9mil (35% pop) in 2012 with claim payments increasing from GH 7.6 million to GH 616 million. Most use is made in the outpatient setting, with the largest group being under-18 year olds (51.2%). The NHIS continues to move forward in expanding access.
Kisiizi Hospital	Uganda	Community-based health insurance scheme	This small rural hospital, operating since 1958, helps to cover 100% of the region – 34, 518 beneficiaries. To maintain such coverage a premium cost of \$4-6 for the year, covering acute and emergency care, helps to fund these services. This non-profit model has also developed a novel service, operating as an electricity provider in addition to offering health services. Further innovations continue to promote and expand service delivery.
Uganda Protestant Medical Bureau	Uganda	National faith-based system	This organization, founded in 1957, operates under the mission to “support members to witness for Christ through the provision of quality health care”. It is important to note though that services are not limited to Christians only, as other faiths are not discriminated against. The organization includes 19 hospitals, 259 health centres and 10 health training institutions, with 80% of member institutions in rural, poor or conflict-affected communities. UPMB continues to work with partners to provide quality care.

Appendix B: Semi-structured interview questionnaire

Universal Health Coverage – Learning Lab Interview

Country: _____

System details: _____

Interviewee Name and Role: _____

Questions

1. What does universal health coverage mean to you?
2. What does patient safety and quality (PSQ) mean to you?
3. How is PSQ currently integrated within your system (or how is it planned to be integrated)?
e.g. measurement, reporting, etc.
4. What are the key components of a UHC system that requires PSQ consideration? e.g.
reduced surgical errors, reduced nosocomial infection, etc.
5. How can PSQ be incorporated into the UHC system that you are involved with?
6. What would you like to see included in a “PSQ package” to support evolving UHC systems?
How can PSQ considerations be utilized to define or expand health service packages in your
system?
7. How can patient safety be utilized to measure UHC performance, ensure accountability and
enhance efficiency?
8. What are the barriers to integrating a PSQ approach into developing UHC in low income
countries?
9. In regards to PSQ, is there anything else you feel should be explored that was not already
discussed?

Revised 5.1.2013