Editorial

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The Lancet Global Health Commission on High Quality Health Systems: countries are seizing the quality agenda

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Editor's note: Dr. Margaret E. Kruk is Associate Professor of Global Health at the Harvard T.H. Chan School of Public Health and Chair of the Lancet Global Health Commission on High Quality Health Systems in the SDG Era (HQSS Commission).

The health needs and expectations of populations around the world are changing, and health systems need to change with them. As disease burdens shift from infectious to noncommunicable diseases, as citizens grow to expect more from their health systems, and as leaders set ambitious global goals for health, health systems are struggling to keep pace.¹⁻³ While improving access to and utilization of care were important for reducing infectious diseases and improving maternal and child health, it is increasingly clear that skilled, integrated, and longitudinal health care is needed in addition to improved access and utilization to address emergent chronic and complex conditions.⁴⁻⁶ In others words, quality is more essential than ever.

The Lancet Global Health Commission on High Quality Health Systems in the Sustainable Development Goals Era (HQSS Commission), composed of 30 academics, policymakers, and health system experts from 18 countries, was assembled to generate a vision for high quality health systems and propose new approaches to defining, measuring, and improving health system performance.⁶ Its report, published one year ago, found that across low- and middle-income countries quality is poor. Poor quality does not discriminate by condition, but tends to be worst for the most marginalized populations.⁷ Many patients do not receive the full range of recommended clinical actions in visits, frequently receive incorrect diagnosis and poor management of illness, and face major gaps in other important elements of quality such as safety, continuity, and coordination of care.^{6,8,10} Commission research suggests that this poor quality results in more than 8 million deaths worldwide each year from conditions treatable by the health system; further, poor quality is now a greater contributor to mortality than poor access to care.⁶

One thing is clear: incremental fixes are inadequate to the task. Meaningful and lasting improvement in the performance of health systems requires reform in the foundations of health systems. The report proposes 4 such universal actions to improve health system quality. First, leaders of the health system must govern for quality, which includes adopting a shared vision for quality, developing a quality strategy, regulating the system, and creating

a system that learns and adapts. Second, countries should redesign service delivery so that conditions are treated in the right place by the right provider at the right level of care to maximize health outcomes. Third, a 21st century health workforce requires clinical education reforms, particularly a move toward competency-based education that hones teamwork and patient-centered care. Fourth, health system stakeholders should ignite demand for quality in the population to engage users in holding health systems accountable and in seeking high quality care. Importantly, the Commission noted that these actions are not primarily technical challenges but are rather political decisions.

Since publication of the Commission report, diverse groups of stakeholders have come together to begin to lay the groundwork for improving national health system quality through National Quality Consultations. Commissioners have engaged with politicians, policymakers, researchers, and civil society members in 5 countries across 3 continents: Argentina, Ethiopia, India, Kenya, and Nepal. While consultations were tailored to the needs and interests of each country context, several factors were consistent among these early champions: 1) a political or social opportunity for action was present; 2) multi-sectoral stakeholders were assembled under the banner of quality; 3) actors worked to articulate a shared vision for quality; 4) stakeholders emphasized that high quality health systems are systems that involve and work for people.

IDENTIFYING AN OPPORTUNITY FOR ACTION

For many of these countries, political, economic, or social change created an opportunity for action on quality. In India, the government recently unveiled a large-scale health policy change, the 'Ayushman Bharat,' that will expand health insurance for poor households and establish a large network of primary care facilities. This policy change opened a political window—an opportunity to incorporate quality into existing policy change.¹¹ The consultation aimed to build upon this working vision for improved health across India. In Kenya, universal health coverage is one of the President's Big Four policy priorities. Four counties in Kenya instituted universal health coverage programs in late 2018, aiming to meet the rising expectations of their populations. Such high-level agenda items presented an opportunity to incorporate and elevate health system quality into the existing health policy agenda, particularly the national drive to universal health coverage. Political support is critical for serious progress. In Kenya, this came from the First Lady Margaret Kenyatta, an HQSS Commissioner. Such support builds momentum for health system change and signals to policymakers in and outside of health care that the quality revolution is nigh.

UNITING STAKEHOLDERS FOR QUALITY

The National Quality Consultations in all 5 countries brought together a broad array of stakeholders, including ministries of health, academic institutions, non-governmental organizations (NGOs), development partners, and civil society. The Nepal Consultation, for example, included health activists, members of parliament, NGO leaders, researchers, clinicians, and the deputy prime minister. Involvement of diverse actors was considered essential in every setting in recognition of the need for intersectional expertise and widespread collaboration. For example, reform of clinical (medical, nursing) education cannot be achieved by the health ministry alone; rather, collaboration between ministries of health and education, universities, clinicians, and health professional associations is

essential for intelligently diagnosing current issues in preservice education and prescribing solutions for a high functioning health workforce. Similarly, governing for quality requires both high-level political commitment and buy-in from administrators and managers at all levels of the health system. It may also require alignment of international donors with new strategic priorities of the health system, and collaboration between the public and private health sectors. The meaningful inclusion of a wide array of stakeholders is paramount to laying the groundwork for health system improvement.

ARTICULATING A SHARED VISION

With a political opportunity identified and a multi-sectoral quorum present, stakeholders sought to create a shared vision for quality. While certain elements of a high quality health system are generalizable across borders, the path to quality and the approach to implementation will vary by context. Accordingly, consultation discussions focused on generating or updating a strategic plan for quality, or integrating quality as an important component of existing health system policies to customize the vision for quality. In Ethiopia, the Director of the Health System Quality Directorate discussed ways in which the national quality strategy could prioritize data collection, quality measurement, and the use of a quality dashboard to improve monitoring and accountability for multiple levels of the health system. During the Kenyan Consultation, the Ministry of Health indicated it intended to develop a National Quality Policy, composed of a common definition of quality across conditions, counties, and sectors. Such a policy can establish what a high quality health system means for Kenya, center quality as the defining function of the health system, and guide national policy. These discussions generate buy-in for progress on quality, building consensus around ultimate goals and helping place a tailored vision of quality on national agendas.

EMPHASIZING THAT HEALTH SYSTEMS ARE FOR PEOPLE

The Commission stated that health systems are for people and need be accountable first and foremost to their users. Users of health systems were at the center of discussions, which tackled changing population health needs, people's experiences of care, and how to generate sufficient public demand for quality. In Argentina, the government is developing indicators to measure progress towards universal health coverage that will include measures of patient experience and user satisfaction. A common theme across meetings and speakers in Argentina was the importance of the patient voice in ongoing health system measurement, including a mechanism to obtain redress when users are dissatisfied with their care. The Nepal Consultation included a day of meetings dedicated to building a social movement for health. The event, which included policymakers, health and human rights activists, and members of civil society, aimed to explore patient experience and people's expectations of care. In particular, participants called for a greater focus on health system inequities, especially between the various geographic regions of Nepal. As the First Lady of Kenya observed during the consultation in Kenya, "At the heart of quality is the simple idea that patients are people." This user focus motivated each consultation, bringing stakeholders to the table and helping generate innovative, people-first approaches to improving quality.

These initial forays into health system quality demonstrate the growing desire for and recognition of quality as the defining function of health systems. Their common features may

also serve as useful lessons for countries aiming to tackle health system quality in the future: countries that seek to improve health system quality should identify a window of opportunity to place quality on the national agenda. In many countries, universal health coverage presents such an opportunity. For universal health coverage to improve health and reduce financial burdens, high quality services need to be paired with insurance reform. Even when nominally free, poor quality services are easily overlooked; thus, successful reform requires a commensurate focus on quality. A diverse group of stakeholders should be assembled to develop a shared vision for quality, thus crafting a path towards a common goal. Finally, the power of the people's voice should not be underestimated. Health system quality is unlikely to be reached without careful consideration of the user and a groundswell of popular demand for better care.

Importantly, the road to high quality will vary by country and progress may not be linear; political intentions and quality interventions may not translate to improved quality on the ground. Countries will need to monitor the implementation agenda and adapt to the local context, relying on implementation science to identify the contextual factors that may inhibit or enhance reform. As more countries seek to transform their health systems to produce more health and gain the trust of their populations, sharing successes and failures and building an evidence base for what works will be paramount. It is only by uniting around the common goal of quality that we will be able to ensure high quality health systems for all.

REFERENCES

1. Lozano R, Naghavi M, Foreman K, Lim S, Shibuya K, Aboyans V, et al. Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet* 2012;380(9859):2095-128.
[PUBMED](#) | [CROSSREF](#)
2. World Health Organization. *Tracking Universal Health Coverage: First Global Monitoring Report*. Geneva: World Health Organization; 2015.
3. Roder-DeWan S, Gage AD, Hirschhorn LR, Twum-Danso NA, Liljestrand J, Asante-Shongwe K, et al. Expectations of healthcare quality: a cross-sectional study of internet users in 12 low- and middle-income countries. *PLoS Med* 2019;16(8):e1002879.
[PUBMED](#) | [CROSSREF](#)
4. Murray CJ, Ortblad KF, Guinovart C, Lim SS, Wolock TM, Roberts DA, et al. Global, regional, and national incidence and mortality for HIV, tuberculosis, and malaria during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet* 2014;384(9947):1005-70.
[PUBMED](#) | [CROSSREF](#)
5. Victora CG, Requejo JH, Barros AJ, Berman P, Bhutta Z, Boerma T, et al. Countdown to 2015: a decade of tracking progress for maternal, newborn, and child survival. *Lancet* 2016;387(10032):2049-59.
[PUBMED](#) | [CROSSREF](#)
6. Kruk ME, Gage AD, Arsénault C, Jordan K, Leslie HH, Roder-DeWan S, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. *Lancet Glob Health* 2018;6(11):e1196-252.
[PUBMED](#) | [CROSSREF](#)
7. Tessema GA, Laurence CO, Melaku YA, Misganaw A, Woldie SA, Hiruye A, et al. Trends and causes of maternal mortality in Ethiopia during 1990–2013: findings from the Global Burden of Diseases study 2013. *BMC Public Health* 2017;17(1):160.
[PUBMED](#) | [CROSSREF](#)
8. Carvajal-Vélez L, Amouzou A, Perin J, Maïga A, Tarekegn H, Akinyemi A, et al. Diarrhea management in children under five in sub-Saharan Africa: does the source of care matter? A Countdown analysis. *BMC Public Health* 2016;16(1):830.
[PUBMED](#) | [CROSSREF](#)
9. Semrau KE, Hirschhorn LR, Marx Delaney M, Singh VP, Saurastri R, Sharma N, et al. Outcomes of a coaching-based WHO safe childbirth checklist program in India. *N Engl J Med* 2017;377(24):2313-24.
[PUBMED](#) | [CROSSREF](#)

10. Lewis TP, Roder-DeWan S, Malata A, Ndiaye Y, Kruk ME. Clinical performance among recent graduates in nine low- and middle-income countries. *Trop Med Int Health* 2019;24(5):620-35.
[PUBMED](#) | [CROSSREF](#)
11. Kingdon JW, Thurber JA. *Agendas, Alternatives, and Public Policies*. Boston, MA: Little, Brown & Co.; 1984.