



SITUATING HEALTH CARE QUALITY MEASUREMENT AND IMPROVEMENT WITHIN THE UHC AGENDA

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UHC has been defined as a situation where all people who need health services (prevention, promotion, treatment, rehabilitation, and palliative) receive them, without undue financial hardship. UHC consists of three inter-related components: 1) the full spectrum of quality health services according to need; 2) financial protection from direct payment for health services when consumed; and 3) coverage for the entire population. Indicators of access and coverage to health services comprise the MDG-related coverage indicators (such as skilled birth attendance and immunization), NCD risk factors (such as tobacco use) and treatment of chronic conditions (such as diabetes).

The World Bank and WHO have proposed a target for the poorest segments of populations: at least 80 per cent coverage of key interventions among the bottom 40 per cent (poorest two wealth quintiles) of the population in each country. The target for financial risk protection is zero impoverishment due to out-of-pocket health expenses.

Why attention to health care quality within the UHC agenda is important

Along with huge potential benefits, health care also carries significant risks. The most significant risk is that the quality of care provided is of poor quality, placing people's lives and their well-being at stake. Poor quality health care undermines every goal of modern health-care systems, resulting in patient dissatisfaction, premature mortality, waste, increased costs, and widening disparities in health outcomes (OECD, 2010).

The UHC agenda should include a clear focus on the quality of public services. It is not enough to assume that access to a health service equates with access to a service that is safe, or person-centred or effective in improving individual and population health. Instead, robust assessment of the quality of services in low- and middle-income settings must be in place. This is the case for several reasons. Foremost, the post-2015 development agenda should include a quality focus to reflect the increasing prominence of service quality measurement and improvement in high-income settings. Anything less would be inequitable. Second, high quality public services are essential in building civic society, trust and participation. Third, high quality brings value for money.

Despite the importance of capturing a quality dimension within the post-2015 indicators, thinking on how to do so remains preliminary. Terms such as "quality-adjusted coverage" or "effective coverage" are confusing and are hard to conceive of operationally. In practice, nesting quality measures inside coverage measures as adjusters, deflators or some other subsidiary instrument is unlikely to work. Instead, quality measures and coverage measures should be seen as complementary and parallel.

In short, measuring health care quality (or service performance) is an essential complement to measuring coverage and should have dedicated resources directed toward it.

Strategies to measure and improve health care quality thus far

Measurement of health care quality is well established amongst OECD countries. Emphasis has rightly been placed on choosing indicators of quality that are valid, feasible and actionable.

- "*valid*" means that sufficient evidence exists that the indicator measures an aspect of health care quality. Most indicators will at least have 'face' validity (i.e. initially appear plausible) and 'content' validity (i.e. be accompanied by real-world studies which support its plausibility). Other dimensions of validity, such as 'construct' (i.e. plausibly related indicator-

sets demonstrate expected covariance) or ‘criterion’ validity (i.e. expected covariance with ultimate outcomes such as health status), may also be evident or may emerge with time

- “*feasible*” means that mechanisms exist in the country of interest to collect and report data for a particular indicator as defined
- “*actionable*” means that knowing the extent of the prescribing pattern described in the country of interest could conceivably lead to policy change

The ability to compare and benchmark internationally is an additional bonus, but brings an additional set of challenges. These include deciding how many indicators are compared, at what level of granularity and how rigidly defined. In addition, international benchmarking efforts need a set of key relationships to work effectively: first, that between the coordinating centre and data correspondents, to offer continuous technical support and quality control; second, that between a technical secretariat and a body of experts, to advise on indicator validity, feasibility and on on-going trade-offs around breadth, detail and flexibility.

Strategies to improve health care quality are also well established amongst OECD countries. Broadly, they include attention to

- the quality of *system inputs*, through professional certification, continuing professional development, accreditation of health care services and authorisation of medical devices and pharmaceuticals etc.;
- the quality of *processes and pathways* in the system, through the development of clinical practice guidelines and auditing of adherence to them etc.;
- the *outcomes achieved*, through the development of indicators of the quality of care (including surveys of patient experience), and their collection, interpretation and dissemination etc.;
- “never events” and other *patient safety* concerns, through development and implementation of patient safety programmes, collection and analysis of adverse event reports and resolution of medical malpractice claims etc.

Quality measurement and improvement strategies in low- and middle-income settings

Self-evidently, the challenges of measuring, comparing and acting on quality indicators are different in low- and middle-income settings, compared to countries where health care quality measurement is well-established. First, the *epidemiology* of health care need is different. Low- and middle-income countries are often struggling with a “triple burden” of communicable disease, non-communicable disease and external causes of death (road traffic accidents and homicide, for example) that is unparalleled in high-income settings. Indicators of health care quality should reflect local health priorities.

Second, *data infrastructures* are different. Many low- and middle-income countries still do not have well-functioning civil registration and vital statistics systems. If countries are struggling to produce reliable mortality data, it is unlikely they will have extensive or reliable data on the performance of the health care services, given that high-quality regular health facility data will be needed to provide this. Indicators of health care quality should be feasible to collect in the countries concerned.

Finally, *institutional capacity* is different. Closely linked to the availability of data, the technical capacity of low- and middle-income countries to validate, analyse and interpret health service performance statistics may be limited. To some extent, these tasks could be supported by a technical secretariat working in conjunction with national data correspondents. Nevertheless, it is important that reported health care quality indicators are valid, particularly if used for international comparison.

Valid, feasible and actionable indicators of health care quality in low- and middle- income settings

Given these challenges, how should health care quality measurement be incorporated into the UHC agenda? A number of indicators meeting the criteria of validity, feasibility and actionability can be envisaged. These fall into two groups:

- *service-based indicators* such as survival estimates after a diagnosis of cancer, or adequate control of glycaemia during pregnancy.
- *population-based indicators* such as prevalence of hypertension or density of qualified nurses.

The first group of service-based indicators closely resemble, or may be identical to, the health care quality indicators by the OECD. Although valid service-based data may appear infeasible in low- and middle-income settings, an increasing number of sources are in fact available. The work of the CONCORD collaboration (global surveillance of cancer survival) or International Diabetes Federation, for example, would furnish data for the two indicators proposed above.

Population-based indicators are perhaps more feasible in more settings. Although they are not directly linked to a particular service, they nevertheless closely reflect the quality of health care services a population has access to. Low rates of hypertension suggest presence of a health care system capable of identifying and treating high blood pressure, for example. Likewise, density of qualified nurses may proxy for presence of a health care system capable of delivering a basket of basic health services. As for the service-based indicators, reliable population-based health data is increasingly available (typically derived from household surveys). The Demographic and Health Surveys programme, for example, has time series of population blood pressure and other measures of health status for over 90 countries.

Exactly which service- or population-based measures of health care quality are valid, feasible and actionable in each country is probably best decided by countries themselves, with support from an expert technical centre to maximise data quality and comparability. Given the OECD's experience in the measurement and comparison of health care quality, it would be well-suited to support this role.

Conclusion

Measuring health care quality is an essential complement to measuring coverage and should have dedicated resources directed toward it. Indicators related to health care quality should be prominent in the (sub)indicators accompanying the two headline indicators around UHC that have been proposed by the WB and WHO.

Individual countries are probably best placed wish to choose which quality indicators they wish to measure alongside coverage. A blend of population-based indicators and service-based indicators are likely to be both informative and feasible.

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