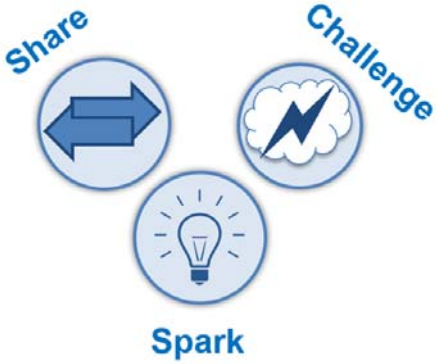
World Health Organization

Global Learning Laboratory for Quality Universal Health Coverage

Fourth Global Symposium on Health Systems Research

14 November 2016

Vancouver, Canada



WHO/HIS/SDS/2017.4

Suggested citation. Global Learning Laboratory for Quality Universal Health Coverage - Fourth Global Symposium on Health Systems Research. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Printed by the WHO Document Production Services, Geneva, Switzerland

Summary

The Global Learning Laboratory (GLL) for Quality Universal Health Coverage (UHC) was announced at the Fourth Global Symposium on Health Systems Research, held on 14 November 2016, with an interactive world café format session which engaged the audience in a learning laboratory activity. The session was opened by Dr Ed Kelley with remarks on the importance of a learning agenda and the potential influence of a learning laboratory model. Dr Shams Syed discussed further detail regarding the importance of a shared learning agenda, stressing the importance of local lessons driving global learning. Ms Lani Marquez provided an overview of the activities of the session and its interactive nature. Dr Nancy Dixon then facilitated the world café activity, allowing for two rounds of discussion focusing on four key themes: policy & strategy; quality interventions for quality UHC; monitoring & research; and health resiliency and security. Leading questions engaged the groups in discussions, which were collected and reviewed at the end of the two rounds. This allowed all participants to receive a briefing and discussion on key ideas shared and to converge on key themes within each discussion topic. Participants were also asked for their thoughts on additional areas that the GLL should consider in the future.

Dr Ruben Frescas gave a presentation on the WHO GLL, where he demonstrated how to access the site, highlighted key features available on the site and discussed how participants could become members of the GLL, along with the benefits of membership. Dr Shams Syed then lead a round of reflections and opened the floor to the audience. Dr Ed Kelley closed the session with final remarks.

The session yielded some valuable information along the four themes discussed. Similar questions will be introduced periodically on the GLL site for virtual members to participate. These findings will also inform the quarterly report of the GLL. Active outreach will aim to recruit attendees of the event to the GLL, and these findings will inform the content of a 'welcome' webinar to be hosted in January 2017.

This report provides an overview of the side session organized by WHO and USAID ASSIST on the Global Learning Laboratory for Quality Universal Health Coverage.

Meeting objectives:

1. **Give an overview of the importance of shared learning globally.**
2. **Introduce the world café session discussing four topic areas and capturing ideas, questions and shared experiences.**
3. **Provide overview of the Global Learning Laboratory for Quality UHC, and announce the launch of the website.**
4. **Collect contacts to enrol interested participants to the GLL.**

Background

The World Health Organization (WHO) Department of Service Delivery & Safety (SDS) launched a unit on Universal Health Coverage (UHC) & Quality in October 2015. This unit has a broad global knowledge management agenda to catalyse change in and across countries, to harvest, synthesize and disseminate lessons on quality health services in the context of UHC. Central to this agenda is the development of a WHO Global Learning Laboratory (GLL) for Quality Universal Health Coverage.

The GLL will be created as a central and safe space for sharing lessons, resources, and tools related to reinforcing the role of quality in UHC. Members of the GLL will include frontline providers, administrators, policy-makers, advocates, civil society, experts and academics, as well as all levels of WHO. The virtual platform is hosted under the Integrated Care for People website to align the contributions of the GLL with the mission of supporting integrated, people-centred approaches in moving towards achieving quality UHC.

The new WHO GLL will build on prior experience from a learning lab convened in 2013 on UHC and Patient Safety & Quality that involved five distinct systems. Participants convened to share experiences and recommendations, after earlier virtual and personal meetings, then co-developed a knowledge report that helped shape the new WHO unit on UHC & quality.

With development of the GLL, WHO seeks to engage more countries in an ongoing learning community related to UHC and quality. The USAID Office of Health Systems is assisting WHO in development of the GLL, given USAID's interest in improving the knowledge base to strengthen health systems and create a supportive environment for sustainable UHC. The USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project collaborated with WHO's UHC & Quality Unit to carry out a landscape analysis to inform the design of the GLL.

This session at the HSR Global Symposium sought to familiarize health systems colleagues from across the world with the objectives and components of the GLL and engage them in discussing critical topics to be further explored within the GLL. The session was an opportunity to identify promising strategies, research and implementation experiences that could inform others, suggest resources and tools that would help implementers address quality in their UHC strategies, and identify potential interest to participate in the GLL. The topics chosen and discussed during the symposium were selected due to the particular relevance of the conference, which focused on research and resiliency as a running theme. Each of the four topics chosen for discussion were related to the themes of the conference.

Purpose

The session aimed to immerse participants in a shared learning activity, across four themes, to discuss personal ideas, experiences and thoughts on how these themes influence UHC through a quality lens. The format sought to maximize participation through a world café format. Key thoughts and lessons were summarized for audience review and reflections at the end. This was also an opportunity to advertise the GLL hosted on the Integrated Care for People website and to promote recruitment of participants to the GLL.

Session overview

Overview: The session provided an introduction to the importance of shared learning as a global mechanism to build on the learning agenda. The session continued with two rounds of discussion covering four topics. Each theme presented a summary of the discussion, highlighting common themes. A brief presentation introduced the audience to the GLL and to the site which hosts the virtual platform. Finally, reflections and thoughts were shared on the exercise and ways the GLL can continue to grow.

The meeting was introduced by Dr Ed Kelley, Director, SDS, who welcomed participants and highlighted the significance of shared learning and the learning lab model. Dr Shams Syed, Coordinator, UHC & Quality (QHC), proceeded to discuss in greater detail the context of shared learning and its implication on the global learning agenda, highlighting the importance of local lessons informing global audiences. Ms Lani Marquez, Knowledge Management Director, USAID ASSIST, then discussed the overview of the session, introducing Dr Nancy Dixon, Principal, Common Knowledge Associates, who facilitated the world café activity.

Over 30 participants were present for the event. The world café had up to 8 tables available, covering four different themes: Policy and strategy; Quality interventions for UHC; Monitoring and research; and System resilience and security. Two tables covered each topic area, with up to eight individuals at each table (including table hosts). Table hosts helped to facilitate introductions and the topic. Each table host was guided by an outline and key questions to help nurture the discussion. Below is a list of the principle questions by theme.

1) **Policy and strategy**: How can quality be integrated or included into national health policies and strategies within the context of UHC? How can we build in other aspects of quality like compassion, equity, integration and people-centredness?
2) **Quality interventions for UHC**: What quality improvement practices and interventions are we seeing that contribute to UHC? How do they advance the success of country efforts to move towards effective coverage?
3) **Monitoring and research**: What measures will help us to monitor progress in expanding access to quality health services? What research and evaluation designs are needed to provide evidence for policymakers and donors to invest in quality improvement interventions within the context of UHC?
4) **System resilience and security**: How can a focus on quality within the context of UHC improve national and global health security? How can quality improvement interventions make health systems more resilient?

In addition, each host was provided with additional probing questions to be used as needed. The table hosts primarily took notes and ensured that the discussion moved at a steady momentum. The first round of discussions lasted about 28 minutes. Participants were also encouraged to write important points or highlights on sticky notes that would be posted on the wall for later reflection. Participants were then able to change tables and choose another theme of their choice to discuss. This next round lasted about 25 minutes, following the same format as previously, with a quick summary of the discussion from the previous round. Participants were highly engaged in their discussions, which presented a slight challenge to the moderator to maintain the time scheduled for each activity during the session.

Table hosts and participants were then involved in reviewing the comments written on the sticky notes and organizing them into themes or topics to be reported back to small groups. Small groups were encouraged to feed back on the collective input from the participants who had shared, challenging some ideas while coming to consensus on others. This process was repeated three more times, affording the opportunity to all participants to listen and share thoughts on each of the four topics.

Dr Ruben Frescas, Consultant, QHC, then provided a brief overview of the GLL and where it can be found on-line at integratedcare4people.org, as well as discussing its features and the benefits of joining the GLL. Dr Shams Syed shared reflections on the sessions activities. He also opened the floor to general reflections from the participants. Dr Ed Kelley then provided closing remarks, thanking the audience for its participation.

Discussion synthesis

These notes are summarized from the four topic areas discussed during the session. A conclusion at the end will summarize the main themes and recommendations for next steps moving forward.

(1) Policy and strategy

Three common threads were defined within this topic area: people-centred perspectives, defining quality and policy in action.

People-centred perspectives

This section grouped comments that reflected on the importance of having an approach to policy that addresses the direct needs of people, making a clear link between national and community levels. As one participant commented, "having a people-centred approach is key to quality". This was discussed and all agreed that it would require committed financial resources. This process would also require greater patient involvement (through patient commissions, hospital boards, etc.). Both the perspective of patients, as well as their actual experience, are seen as valuable information in the development or reform of policy. This is a facet that has often been a missed opportunity among countries pushing a top-to-bottom approach to policy development. Recognition of an integrated strategy to policy development was identified as important in making a clear linkage to UHC.

Defining "quality"

There was an expressed concern that there should be a shared and agreed understanding on 'quality', citing several definitions, but stating that there needed to be a common definition locally to build on. Again, this approach should engage people as active partners, as well as build partnerships and meaningful engagement with other relevant stakeholders. This will require assisting national policy-makers with developing skills to engage and respond to people-centred care, and learning how to manage demands and needs from both the poor and wealthy in a population. This will require an analysis or review to identify the gaps in the quality definition regarding the specific needs of the local context. One interesting point mentioned was to question whether patients are the "right people to define quality health care". This debate highlighted the difference between the patient's expectations and perspective of quality (a qualitative perspective), versus that of the professional public health sector expectations and perspective (often focusing on quantitative measures such as morbidity and mortality).

Policy in action

Much discussion took place not just on the theory and concept of policy development, but also on its application and implementation. Discussion points focused on mechanisms to ensure that quality policy and strategy receive traction by anchoring it to national policy and finance schemes. Also, engaging donors and stakeholders, as well as developing and aligning public-private partnerships, were also identified as important allies. Much of this would have to be presented in a business case model to explore the cost versus value-added of investing in quality policy and strategy. This will largely depend on the elements of a UHC approach being emphasized by each respective country, but that within these policies and strategies, inclusion of both private and public facilities must be achieved. Some common barriers discussed included the complexity and difficulty for systems to adapt to change; the narrow understanding of quality limiting broader systems change; the lack of clarity between policy and frontline change; how to address human resource needs; medication safety/procurement/logistics, incentives and payment mechanisms, etc. It was also agreed that quality cannot be isolated, but that it is a cross-cutting theme that touches every aspect of the health system. How each level of

the health care system reacts and addresses these needs is important, particularly at the ground level where it may start from something as simple as strong mentorship and having a team-based focus.

(2) Quality interventions for UHC

Three primary categories for quality interventions were identified: community and civil society, health worker level quality improvement interventions, and structural (from physical structure to systems structure).

Community and civil society

The importance of supply and demand-side quality interventions was discussed, emphasizing the importance of mobilizing citizen groups, civil society, etc. A personal example of the Uganda Consumer Union was used to illustrate this point in discussion. This approach requires engaging communities with the health system, making patients partners in improving health, through engagement and active participation. An example of this engagement may be to gain the perspective of quality with respect to the client/patient. Another example illustrated a performance-based finance model in Burkina Faso which used community satisfaction survey data (such as waiting time and drug availability) which counts for 50% of the performance-based finance payment. Another suggestion to empower and inform patients was in relation to innovations in eHealth which provide patients with access to medical records and results to allow greater control of their health information. Although an even more basic approach is the “mum-test”, where quality interventions are vetted by being able to get to the most essential elements that make tangible sense to the general public.

Quality improvement interventions at the health worker level

Emphasis on the important role of the health worker focused on their salary support/ incentives as well as technical skill and knowledge in quality improvement. The issue of concern is that a poorly compensated workforce leads to worsening morale and migration of workforce to better paid jobs. This has led to a void in the public sector, affecting the quality of care. Additionally, the training of health workers in quality, whether in curriculum during pre-service education, or in-service training, needs to be considered. This includes the areas of people-centred care, ethics, problem-solving, team-building, implementation science and learning and supply and demand-side interventions. This underscores the importance of addressing quality early in one’s career, and to also carry it forward in one’s practice. Having diverse and strong teams inputting in quality interventions can help support implementation of quality interventions and identifying everyone’s role in quality improvement. One mechanism to help foster this in the workforce, specifically mentioned, was mentorship. Identifying that supervision may not be sufficient, but that mentorship can actually foster and promote the actions required to lead to change and quality improvement.