Quality Universal Health Coverage and Resilience

Technical Workshop

Convened by the WHO Service Delivery & Safety Department

at the

WHO Kobe Centre for Health Development

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Report

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Executive summary

This technical workshop was designed to develop consensus on the linkages between recovery, resilience and quality universal health coverage (UHC), based on the experiences of participants. The recent Ebola virus disease (EVD) outbreak has shone a spotlight on the links between resilience and UHC. As the affected countries negotiate the recovery phase, there is an opportunity to learn from that experience for countries across the world. The workshop took place at an important time in the light of the United Nations Sustainable Development Goals and Japan's Presidency of the G7 group of nations. The workshop background paper explores the relationship between recovery, resilience, and quality UHC. It discusses also a range of related areas, such as linkages with health emergency programming; quality improvement; policies for quality; water, sanitation and hygiene (WASH); community engagement; district health management; and essential public health functions.

Each of the 3 EVD-affected countries has developed a clear national plan for resilience that takes a long-term view, while recognizing the urgent and immediate needs for recovery. Of note, quality of care and UHC are considered integral to all of these plans. Challenges and lessons highlighted by these countries have common threads that were explored during the workshop.

Japanese UHC (achieved in 1961) covers all citizens by public medical insurance. It ensures freedom of choice of medical institution, provides high-quality medical services with low co-payment and is based on a social insurance system. Although it performs well in relation to health status and risk protection, this is less the case for public satisfaction. The systematic integration between curative service delivery, emergency preparedness and public health is notable. Practical lessons have been learned from both outbreaks and natural disasters that continue to shape the system. Japan is committed to delivering sustainable, equitable UHC, with quality as a foundation stone, and to support similar efforts around the world. The work of Japanese agencies (both domestic and international) provides a range of technical experiences that can be harvested for adaptation in other countries.

Through a series of workshop learning laboratories, a set of 7 recommendations were developed, each with a range of associated actions:

1. Develop clear and practical mechanisms for integration between health emergency preparedness and health service delivery that emphasizes UHC as a foundation of resilience.

2. Ensure that quality (including patient safety and infection prevention and control [IPC]) is integrated and applied to all aspects of health service delivery within a wider focus on health systems strengthening in support of UHC.

3. Update national public health acts, strategies, policies and plans, and support the development of implementation frameworks in line with the UHC and 2030 agenda for sustainable development;

4. Build /rehabilitate WASH infrastructure in health facilities and mainstream WASH in the IPC context of water safety and sanitation planning.

5. Develop a practical framework that mainstreams and embeds community engagement within health service planning and delivery that contributes to building trust.

6. Develop a practical framework to strengthen leadership and the management capacity of district health management teams with a focus on the quality improvement of health service delivery, emergency preparedness and community representation.

7. Establish strong health systems inclusive of all essential public health functions for quality UHC to achieve improved health outcomes and sustainable development.

The technical exchanges during the workshop provided a foundation for further technical collaboration for the benefit of all Member States.

Workshop objectives

1. Collate perspectives from experts with experience in EVD-affected West African countries on the linkages between early recovery, resilience and quality UHC.
2. Collate perspectives from Japanese experts on the linkages between early recovery, resilience and quality UHC, including lessons learned from Japanese experiences.
3. Develop consensus within the workshop on the linkages between early recovery, resilience and quality UHC.
4. Co-develop key suggested recommendations and actions informed by the collective wisdom of workshop participants.

Day 1: Proceedings summary

The formal welcome was provided by Alex Ross, Director of the World Health Organization (WHO) Kobe Centre, followed by representation from the Ministry of Health, Labour and Welfare and the Ministry of Foreign Affairs of Japan.

Day 1 of this workshop consisted of a number of short presentations from invited delegates that explored the relationship between resilience, recovery and quality UHC. The presentations included both reflections from countries recently affected by the EVD epidemic and on lessons learned from the Japanese experience of UHC. Key messages from each presentation are summarized below. **Full presentations available here.**

Recovery, resilience and quality UHC

Dr Shams Syed (Coordinator (a.i), UHC and Quality Unit, Service Delivery and Safety Department, WHO)

This technical workshop took place at an important time when there is a renewed global focus on UHC in the light of the United Nations global Sustainable Development Goals and Japan's Presidency of the G7 group of nations. Furthermore, the recent EVD outbreak has shone a spotlight on the links between resilience and UHC. As affected countries negotiate the recovery phase, there is an opportunity to build stronger health systems with stronger emergency risk management than existed pre-Ebola, and for countries across the world to learn from that experience. Health systems that are poorly resourced, fragmented, inequitable, without adequate emergency risk management capacities, and thus providing low quality services are understandably more prone to collapse in response to major shocks than those able to provide high quality, universal health coverage. Such shocks may then have a much greater effect and normal service delivery may be severely disrupted, as was seen during the Ebola outbreak. However, the recovery effort in such scenarios can begin to build the foundations of a better functioning, higher quality and more resilient health service. The focus of this workshop was to develop consensus on the linkages between recovery, resilience and quality UHC, based on the experiences and collective wisdom of participants (Annex 1: list of participants; Annex 2: agenda).

The background technical paper for the workshop provides definitions of key terms and explores in more detail the relationship between recovery, resilience, and quality UHC. It discusses also a range of related areas, such as linkages with health emergency programming, quality improvement, policies for quality, WASH, community engagement, district health management, and essential public health functions (EPHF). Key definitions and concepts outlined during this session were based on the background technical document (Appendix 3). The critical importance of examining the decades-long Japanese experience to harvest lessons for global application was emphasized.

Japan: an overview of the health system

Dr Satoshi Ezoe (Global Health Coordinator, Ministry of Health, Labour and Welfare, Japan)

The Japanese health system has a long history of providing UHC and performs well in relation to health status and risk protection, but less so in terms of public satisfaction.

In Japan, UHC has been achieved at a relatively low cost and low financial risk, with health spending accounting for 9.5% of the gross domestic product, representing US$ 3035 per capita, which is significantly less than many other high-income countries. However, an ageing population and the increasing burden of noncommunicable disease threatens the sustainability of the health service, with medical care and long-term care driving rising costs of social security.

Since 1961, the Japanese version of UHC covers all citizens by public medical insurance. It ensures freedom of choice of medical institution, provides high-quality medical services with low co-payment and is based on a social insurance system. The Japanese system is financed by compulsory insurance, state funding and small co-payments, with the costs of the insurance-based system controlled through a medical fee schedule. To ensure good value, the Japanese government leads negotiations with providers and agrees upon an appropriate and sustainable fee schedule.

Compared with other high-income countries, Japan has a relatively high number of hospital beds per capita, but lower ratios of physicians and nurses. Public health at the local level is based around comprehensive health centres. These provide not only clinical services, but also vaccination, control of infectious diseases, health promotion activities, disease surveillance and environmental health services, including technical support to local policy-makers. There is cooperation between municipalities, prefectural governments and national government on the control of infectious disease under applicable laws, with similar local and national cooperation on disease surveillance, for which information is collected and reported in a systematic fashion. Notably, the health centre is considered a hub in the public health system.

The basic concept of pandemic response in Japan focuses on: delay intrusion (waterfront measures); delay expansion (early containment); control expansion of infection (public health intervention); flattening epidemic trends; early development, production and use of vaccines; and lowering the epidemic peak to minimize the burden of health care delivery. The national pandemic plan promotes a “whole society” approach to maintain social and economic functions by strengthening public health measures involving families, communities and work places.

As a practical example, the 2009 pandemic influenza outbreak saw low mortality in Japan compared with many other affected countries. This has been attributed to the strong early response, which included the closure of schools, high quality treatment, early use of antivirals, and the promotion of personal voluntary measures (i.e. hand hygiene, cough etiquette).

Following the Great Hanshin-Awaji Earthquake in 1995, Japan revised its emergency response capabilities through the establishment of specific medical and psychiatric teams (disaster medical and psychiatric assistance teams), appropriate facilities (disaster base hospitals), and information systems to be used in disasters (emergency medical information system), as well as transfer and transportation systems for patients. This system was used to good effect in the Great East Japan Earthquake of 2011.

Japan is committed to delivering sustainable, equitable UHC, with quality at its foundation, and to support similar efforts around the world. This is a major focus during Japan’s Presidency of the G7.

Quality, universal health coverage & resilience

Ebola response and health systems recovery – lessons learned (Guinea)

Dr Karifa Mara (MPN/WHO), Dr Abdoulaye Kaba (DG/BSD), Mr Amadou Timby Bah (DIEM/MS)

The health system in Guinea has 3 levels of administration: central, regional and prefectural. Similarly, service delivery is through 3 central hospitals, 7 regional hospitals, and a much larger number of community facilities of various types. In 2015, there were 1.8 physicians per 10,000 population. Figures from 2012 show poverty levels of 55.2%; life expectancy of 59 years; prevalence of chronic malnutrition in children less than 5 years of 31%; and a maternal mortality ratio of 724 per 100,000 live births.

The outbreak of EVD in Guinea hit health professionals hard, with 211 cases and 115 deaths recorded among health workers. There were significant drops in health service usage due to the Ebola crisis, with an overall decrease in consultations from nearly 6 million to around 2.5 million. In addition, childhood vaccinations dropped from 224,022 to 157,432 and the number of hospitalizations decreased by over half between December 2013 and December 2014.

The outbreak was worsened by inadequate IPC capacity, with insufficient numbers of trained staff and a lack of required support and diagnostic services.

Ebola recovery plans are in place with a focus on getting to zero cases, improving district health services and strengthening the national health system. This focus is on immediate needs and is placed within the context of the national long-term health plan up to 2024. Specific priorities for building a resilient health system include disease prevention and control, governance and accountability, community engagement, and strengthening core public health capacities to support the International Health Regulations (IHR). However, significant financial challenges remain, with currently allocated donor and state funding for recovery and health systems strengthening falling short of the identified needs.

As part of recovery efforts within the wider UHC agenda, significant infrastructure projects are underway, including building 4 regional hospitals, renovating 3 national hospitals, and building facilities to treat illnesses of epidemic potential. There are also programmes for laboratory strengthening, training of a specialist epidemiological emergency workforce, provision of medicines and improvement of logistics.

Policies are also in place to improve quality of care through workforce development, improvement of facilities, the extended reach of facilities to a wider population, improved governance, and building of systems for diagnosis, monitoring, research and the handling/sharing of information.

In conclusion, the EVD epidemic took hold in a context of a low budget prioritization of health, the inequitable and inefficient distribution of resources and an inadequate health facility infrastructure. Capacity in epidemiological surveillance, health sector leadership and IPC was weak. Developing stronger mechanisms of stakeholder and partner coordination was also highlighted as a key lesson emerging from the EVD experience.

Ebola response and health systems recovery – lessons learned (Liberia)

Dr Catherine Cooper (Quality Lead, Ministry of Health), Dr Lawrence Sherman (Jackson F Doe Hospital), Dr April Baller (WHO Country Office)

The Liberian health system has a pluralistic model of service delivery (government, nongovernmental organizations, faith-based organizations and a private sector). It is coordinated by the Ministry of Health with decentralization of responsibility to county, district and facility level. The health system is currently allocated less than 11% of the national budget; 51% of costs are met out of pocket. The EVD outbreak in 2014 exposed significant health system weaknesses. Health system factors contributing to the outbreak included inadequate surveillance and laboratory capacity; poorly equipped health facilities lacking the required WASH infrastructure; underperforming emergency preparedness and response system; shortage of qualified and salaried staff; delayed decentralization; and inadequate government funding.

The EVD outbreak saw a decline in the use of health services in general, including outpatient attendance, maternal health services and immunization programmes. Reduced service use has been attributed to community distrust and health worker fear. During the epidemic, 184 health care workers died, supply chains for essential medicines collapsed, and the focus of resource use on EVD caused the neglect of other priority areas. A phased effort has been agreed (response - early recovery - recovery - functional health system). Resilience in the Liberian context means "building a health system that contributes to the achievement of the health outcomes described in the national health policy and plan 2011–2021 by restoring the gains lost due to the EVD crisis, optimizing the delivery of quality services towards UHC and reducing risks due to epidemics and other health threats".

Objectives in the investment plan for building a resilient health system in Liberia are 3-fold with assured UHC as the umbrella:
1. Universal access to safe quality services through an improved capacity of the health network to provide safe, quality essential packages of health services.
2. A robust, health emergency risk management system through building public health capacity for prevention, preparedness, surveillance, including alert and response for disease outbreaks and other health threats.
3. An enabling environment and restoring trust in the health authorities' ability to provide services, including community engagement, improving leadership & governance and accountable management systems.

Key areas identified for investment for resilience include: a fit-for-purpose workforce; a re-engineered health infrastructure; epidemic preparedness and response; medicine management; quality service delivery; information and research management; community engagement; leadership and governance capacity; and efficient health financing systems. However, significant funding gaps remain. Of note is the establishment of a quality management unit within the institutional care division.

There were many lessons learned in Liberia during the response to the outbreak, including the importance of information dissemination, intersectoral collaboration, community involvement, partnerships and cross-border collaboration. On reflection, the Liberian health system could have done a number of things differently before the crisis that would have limited its effect, including strengthening the workforce, embedding IPC within the system and improving preparedness, response and laboratory capacity.

Ebola response and health systems recovery – lessons learned (Sierra Leone)

Dr Samuel Kargbo (Ministry of Health and Sanitation), Dr Ronald Carshon-Marsh (Medical Superintendent, Kono District), Dr Adewale Oluwaseun Akinjeji (WHO Country Office)

Sierra Leone has made a commitment to delivering quality UHC, as outlined in the following statement: "The government of Sierra Leone is committed to building a functional and resilient national and sub-national health systems that deliver safe, efficient and high quality health care services that are accessible, equitable and affordable for all Sierra Leoneans". This is in the context of a challenging country health profile, with a maternal mortality ratio at 1100/100,000, huge health workforce deficits and US$ 107 total health spending per year per person on health.

Health system planning, coordination and quality assurance is done at national level by the Ministry of Health with district health management teams responsible for policy implementation and service delivery at subnational level. The 3 tiers of care involve peripheral health units, district hospitals and referral hospitals (total: 1264 health facilities; 40 of which are hospitals with 23 government-run). Most health care is provided in the community. Significant health gains were made between 2008 and 2013 across a number of domains, including childhood vaccinations, safe childbirth and the treatment of diarrhoeal disease. However, the EVD epidemic significantly set back this progress.

As of February 2015, there were a total of 296 Ebola infections among health workers, including 221 deaths, thus highlighting poor IPC capacity. Furthermore, a number of health professionals left the country as the outbreak spread and medical and nursing schools ceased to function. There was a markedly decreased use of health services due to reduced community confidence in the health sector, which was worsened by the closure of many facilities. Reassignment of staff from routine health programmes to the EVD control efforts led to the delayed implementation of key programmes. Children were greatly affected, with over 16,000 losing one or both parents and schools closing for around a year. The economy shrunk, poverty levels rose and teenage pregnancy rates increased.

Sierra Leone is in the early recovery phase, according to the "health sector recovery framework". The country aims to fully implement a basic package of essential health services by 2020 with the following key expected results: safe and healthy work settings; adequate human resources for health; essential (basic) health and sanitation services available; communities able to trust the health system and access essential health services; communities able to effectively communicate health alerts; improved health system governance processes and standard operating procedures; and full implementation of the IHR. A variety of reforms are set to drive these expected results.

Sierra Leone emphasises that health system strengthening is strongly interlinked with UHC and