How could health care be anything other than high quality?

The very fact that in 2018 *The Lancet Global Health* has commissioned a report on the state of quality care globally is an indictment on all of us for ever tolerating anything less than care that is effective, safe, and people-centred.

Poor care not only jeopardises the health of individuals; it erodes trust and puts entire health systems and populations at risk. By contrast, high-quality health systems earn the trust of the people they serve and deliver better results. In addition to the classic definition of quality care as being safe, effective, and people-centred, high-quality care is underpinned by four essential values: timeliness, equity, integration, and efficiency.

It is easier said than done, which is why the title of this Commission is so apt: ensuring high-quality care in every health system around the world requires nothing less than a revolution. An unrelenting focus on quality at the point of care, in the design of services, and in health system reform are fundamental to achieving both the Sustainable Development Goals and the “triple billion” targets of WHO’s General Programme of Work 2019–23.

Without quality, universal health coverage (UHC) remains an empty promise. Even with increased access to services, health improvements can remain elusive unless those services are of sufficient quality to be effective. For example, in some countries, increasing the proportion of births that happen in health facilities has not always translated into reductions in maternal mortality. Likewise, some populations experience inadequate control of hypertension despite increased access to treatment—an example of ineffective care. Health facilities without adequate water, sanitation, and hygiene can be a source of health-care-associated infections.

Designing benefit packages in the context of health system reforms is the perfect opportunity to embed quality into services, with a focus on primary health care. One of the biggest barriers to improved quality is the paucity of data on quality. Although it is relatively easy to count the number of antenatal care visits a pregnant woman receives, determining what happens during those visits is much more challenging. We must therefore go beyond counting simply what services are delivered to measuring how they are delivered, and to acting on what we find. Measurement is wasteful unless it results in improvement.

Quality health systems not only improve health outcomes in “peacetime”, they’re also a bulwark against outbreaks and other public health emergencies. UHC and health security are two sides of the same coin. This was painfully apparent during the west African Ebola outbreak of 2014–15, when the perceived lack of quality led to community distrust in the health system, decreased utilisation of services, and an increase in morbidity and mortality from non-Ebola conditions.

The strength of a country’s core capacities under the International Health Regulations depends on the quality of its health services. The same nurse who vaccinates children and cares for new mothers will also need to detect an unusual communicable disease. Similarly, people and communities are at the heart of quality health service delivery. We cannot talk about quality without placing them at the centre. When people are actively engaged in their own health and care, they suffer fewer complications and enjoy better health and wellbeing.

National action planning for health security must therefore pay careful attention to quality. The best-laid plans can be undone by poor infection control practices, a batch of expired medicines, or unmaintained vehicles. But quality improvement and emergency preparedness should not be discrete endeavours; Tanzania, for example, has taken steps to integrate the two, and is seeing promising results both in terms of improved health outcomes and enhanced preparedness. This is especially true in protracted emergencies and conflict-affected and fragile states, which require close attention to high-quality services, financing, human resources, information, and medical supplies to meet the needs of the most vulnerable.

All of this requires attention to developing active learning systems. But that does not just happen—it requires careful investment and design. We must go deep into the messy realities of health services to understand local problems, find innovative solutions, learn from mistakes, scale up what works, and share experiences. Local learning needs to be prioritised, but local lessons must also be shared nationally and with the world—we need a global learning laboratory for quality.
Just recently, WHO, the World Bank and the Organisation for Economic Co-operation and Development (OECD) released a report that outlines key actions all of us can take to enhance quality. The report offers specific recommendations to policy makers and practitioners on addressing the quality gap at global, national and local levels. The work of The Lancet Global Health Commission adds to this body of knowledge. We now need to urgently support countries—together—to implement recommendations from these reports. One way we are doing that is through the WHO Initiative on National Quality Policy and Strategy, for which we will look to work closely with colleagues from The Lancet Global Health Commission.

Quality is not a given. It takes vision, planning, investment, compassion, meticulous execution, and rigorous monitoring, from the national level to the smallest, remotest clinic.

I congratulate the members of the Commission for their hard work and insight. My hope is that the ultimate result of their labour will be that, in years to come, the term “quality care” will fall into disuse—because there is no other kind.

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I declare no competing interests.

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