UHC Charter Expert Papers

TOPIC OF FOCUS

Delivery Systems. UHC requires a people-centered, integrated health service delivery system that can deliver high-quality services and meet the evolving health needs of the entire population. Service delivery systems with both public and private providers should allow them to cooperate and/or compete fairly, fostering quality, innovation and efficiency.

Nigel Edwards and Jonty Roland

Delivery Systems
UHC requires a people-centered, integrated health service delivery system that can deliver high-quality services and meet the evolving health needs of the entire population. Service delivery systems with both public and private providers should allow them to cooperate and/ or compete fairly, fostering quality, innovation and efficiency.

Nigel Edwards and Jonty Roland

Introduction

An effective healthcare delivery system frequently makes the difference between improved coverage in theory and the reality in practice. While Precepts 1 - 4 describe the essential components of universal, progressively realized, comprehensively pooled and publicly-mandated UHC financing, without a 'UHC-ready' provider system these will have little impact. As Kutzin observes, "Countries cannot simply spend their way to universal health coverage".[1]

Fortunately, many of the reforms described in earlier Precepts provide the mechanisms and incentives for transformation of the healthcare delivery system towards providing the quantity and quality of care required by UHC. For example:

- Compulsory participation creates the possibility of risk equalization, which can correct misaligned incentives for providers to give preferential treatment to richer patients.
- Comprehensive pooling enables the consolidation of fragmented and inefficient provider systems defined by employment and/or socioeconomic status.
- A dominant payer has the critical mass to develop an effective strategic purchasing function, capable of driving through long-term transformations in the supply of care, as well as leveraging competition and redesigning the flow of funds to prioritize those services that will generate the maximum health gain.

The challenge of building up provider systems to deliver UHC is a long-term one, and many countries face daunting gaps in supply, with half of the world's population currently lacking access to essential health services.[2] The challenge is not just one of quantity but also of quality, with poor quality care now estimated to be responsible for more deaths in low and middle income countries than lack of access.[3]

There is an urgent need to address these gaps, and move beyond fragmented and inefficient delivery models often serving single diseases or specific segments of the population, and resulting in 'poor services for the poor'. The goal is to build systems that can remove this fragmentation and create coherent, universally-accessible, people-centred services, access to appropriate medicines and health technologies, and with targeted interventions and

---

[1] Kutzin J. "Anything goes on the path to universal health coverage? No." Bulletin of the World Health Organization. 90:867–868. 2012.

[2] World Health Organization. "Reforming Health Service Delivery for UHC." 2017.

[3] Kruk ME et al. "Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries." The Lancet. 392:10160. 2018.

innovations for vulnerable and marginalized groups.[4] Whether delivered through public, non-profit, for-profit or a mix of providers, it is first and foremost the role of governments to steward the health system towards this goal.

Even among high income countries with mature delivery systems, there is a pressing need to change how care is provided in response to epidemiological trends, increased complexity and rising costs of care. Many OECD countries are undergoing reforms to shift their delivery systems away from cure-centred care models towards prevention and integrated care. This includes redesigning care pathways, introducing new cadres of health workers, new incentives and organizational forms.[5]

Countries at all stages along the journey to UHC therefore face fundamental challenges to (re)develop the systems through which care is delivered, and to do so in the face of expectations from the public and patients that are increasing at a faster rate than change can be made. Countries that fail to effectively steward their provider systems risk this consumer demand leading to uncontrolled and uncoordinated growth – especially among private providers targeting groups and locations that stand to benefit least: a missed opportunity to direct this investment where it could make far greater impact.[6] And provider infrastructure, once built, can take generations to shift again.

This paper covers three key areas of guidance for policy makers and health system leaders on the journey to UHC:
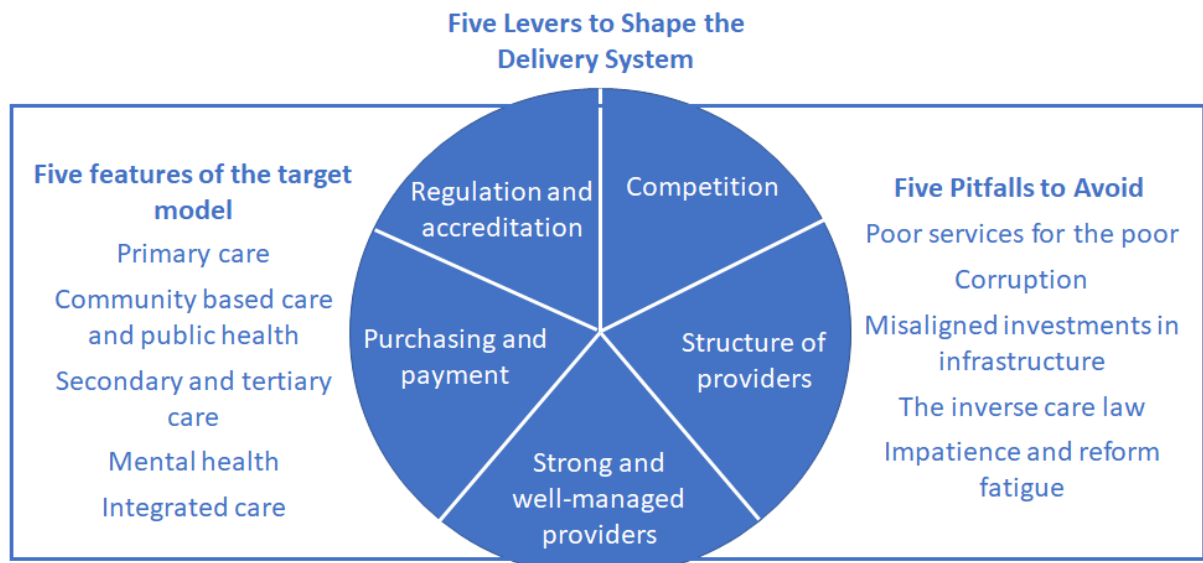
1. Five features of the target model for a 'UHC-ready' service delivery system
2. Five levers to shape the delivery system towards this ideal, plus three long-term enablers of change
3. Five common pitfalls to avoid

5 x 5 x 5 Framework for a 'UHC-ready' service delivery system

---

[4] World Health Organization and The World Bank. "Healthy systems for universal health coverage: A joint vision for healthy lives." 2017.

[5] I'd like to reference the forthcoming OECD report "The Future of Primary Health Care" but if it isn't out by the time we publish we can reference this instead: https://www.oecd.org/els/health-systems/Universal-Health-Coverage-and-Health-Outcomes-OECD-G7-Health-Ministerial-2016.pdf

[6] Roland J et al. "Healthy returns: The role of private providers in delivering universal health coverage." Doha, Qatar: World Innovation Summit for Health. 2018.

Five Levers to Shape the Delivery System

Five features of the target model
Primary care
Community based care and public health
Secondary and tertiary care
Mental health
Integrated care

Regulation and accreditation
Competition
Purchasing and payment
Structure of providers
Strong and well-managed providers

Five Pitfalls to Avoid
Poor services for the poor
Corruption
Misaligned investments in infrastructure
The inverse care law
Impatience and reform fatigue

These are interrelated reforms that need to be designed and implemented alongside the development of UHC. They are likely to be much less effective if not addressed simultaneously. For example, competition is not likely to be successful without strong independent providers, appropriate regulation or capable purchasers.

The target model

While no country has a perfect model of healthcare delivery, there is an emerging consensus about the principles that underpin a system that can meet the challenges set out above and support UHC. The specifics of this system will differ between settings as a result of history and the resources available, but they will share many of the same characteristics and underlying principles. The five main features of this target model, outlined below, are:

- Primary care
- Community-based care and public health
- Secondary and tertiary care
- Mental health care
- Integrated care

Across all of these five features run a number of critical principles, most importantly that of 'people-centered care': that is, services designed around the needs of individuals and populations rather than organised on the basis of diseases, institutions or professional silos. The is defined by WHO as shown below.

People-centred care: an approach to care that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects social preferences. People-centred care also requires that patients have the education and support they need to make decisions and participate in their own care and that carers are able to attain maximal function within a supportive working

environment. People-centred care is broader than patient and person-centred care, not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services.[7]

1. Primary care

A strong UHC system requires a primary care system capable of meeting a wide range of the population's needs and managing their health in a holistic and proactive way. The 2018 Declaration of Astana sets out an ambitious concept which goes well beyond a traditional view of primary care (PHC):

"PHC will be accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable, and will deliver continuous, integrated services that are people-centred and gender-sensitive. [It] will strive to avoid fragmentation and ensure a functional referral system between primary and other levels of care."[8]

Having a UHC system provides the basis for a model in which individuals can be registered with a primary care provider responsible for the care of patients over time, and the provision of proactive and preventative approaches. This is an essential component of sustainable UHC, as it ensures that resources are directed to helping people stay healthy or to manage their condition, reducing their risks and supporting those most likely to deteriorate or need hospital treatment. To be most effective, the providers need to be able to connect to the population they serve either directly, digitally, using outreach workers (such as those in Brazil), or through other social institutions such as schools, community groups, etc.

To enable this approach to work most effectively, the primary care team will need to have access to a range of multidisciplinary skills. The core components are medical, nursing and administrative staff. In some countries, paediatricians are part of the team and take responsibility for children– in others they are cared for by generalists. In addition a range of other services can greatly increase the capacity and effectiveness of primary care. The following is a long-term aspiration and will have to be built up over time. These additional components ideally include:

Mental health. Many conditions treated in primary care either produce depression and anxiety or are caused by it. With psychological trauma, these conditions create a lot of demand in primary care which means that professionals will need mental health expertise. Easy access to dedicated mental health professionals as members of a wider primary health team can greatly increase the effectiveness of primary care.

Pharmacists. With the growth of NCDs and multimorbidity, medicines management is a growing and increasingly complex problem. Cost control through effective use of medicines as well as antibiotic stewardship will be important to sustainable UHC. Many systems are also endeavouring to better leverage community and retail pharmacies to provide advice on healthy living, minor ailments and a range of other issues.

---

[7] http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf?ua=1
[8] https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf

Social services support. Patients often need help with social problems such as housing, employment, abuse at home and problems at school. Social isolation can also be a serious problem, with implications for long-term health. Primary care cannot solve these problems alone, so being able to direct patients to appropriate support services and having a strong relationship with non-health providers and NGOs is helpful particularly where resources are constrained.

Other professionals. A range of other clinical staff can add value to the primary care team. For example, physiotherapists can provide diagnosis and treatment for patients with musculoskeletal problems, midwives can provide antenatal care, and nutritionists can give healthy lifestyle advice and support for complex conditions. These staff are also helpful when doctors and nurses are in short supply, but this is not the main reason for widening the team. Dentistry and other oral health services may also be a valuable addition depending on the availability of these services elsewhere.

Specialist input. Giving primary care providers registered populations and restricting open, direct access to specialists are important components of strong primary care systems. Most systems do this through mandatory gatekeeping and GP registration, although some – like France – use higher co-payments for patients who ignore these rules as a way of incentivising the right behaviours without restricting freedoms. For some common conditions, a relationship between primary care and hospital specialists that is not just based on gate-keeping or referral is needed. This will include ensuring that primary care staff have easy access to diagnostic tests and that specialists are available to provide advice and guidance, teaching clinics in primary care as well as visiting outpatient consultation. This will be particularly relevant for chronic disease, gynaecology, developmental problems in children and other common issues in primary care that can be complex and would benefit from specialist advice.

This multi-professional, integrated approach to primary care requires a major shift away from the 'cottage industry' model still typical in most countries, towards planning, organization and delivery on a much larger scale. In achieving this scale up, health systems can also create an infrastructure that can offer common diagnostic tests, imaging and minor procedures within primary care settings, reducing the need for patients to travel to hospital. This can also support more rapid response to infectious diseases.

These solutions will need to be adapted for rural areas. In many countries primary care services find it hard to recruit and retain doctors, and first line services are instead provided by nurses who may have relatively basic levels of training. Providing these staff with digital technology for decision support and telemedicine links to medical staff and other advice can greatly add to their capability. This, combined with point of care tests, can also reduce the need for patients to travel, which is important as this imposes costs on the population not covered by insurance and is a major disincentive to seek treatment.

As the burden of disease shifts to long-term conditions, several features of the traditional model of care that has been based on episodic treatment will need to change. Firstly, as mentioned above rather than simply responding to patient demand, services need to become proactive. Secondly, the use of narrow clinical outcome and process measures will

need to be broadened to ensure that patients' broader goals about health and wellbeing inform the approach to how care is managed. Single disease guidelines do not provide a good guide to managing complex multimorbidity and a more holistic approach needs to be taken.[9] Many systems are looking to patient outcome and experience measures (PROMs and PREMs) as key indicators of provider quality, performance and even payment. Thirdly, continuity of care will become increasingly important, as an understanding of the patient's context and history is a key part of providing effective care.[10] [11] At the same time continuity is more challenging to provide because as expectations about health services rise, rapid access to health services will also be seen as increasingly important. Balancing the demands for access with the need for continuity is a difficult challenge. One solution is using dedicated case managers to those patients whose need for continuity is greatest.[12] Providing continuity through electronic records can also help where the patient's usual clinician is not available.[13] [14]

In some systems, being able to offer primary care via the phone or digital applications is being adopted. In high income countries this offers rapid access and convenience, but this is also potentially attractive in low and middle income countries, especially where there are large rural areas, long distances, poor transport and a chronic shortage of clinicians. The development of triage based on algorithms and artificial intelligence could significantly enhance these services, and rapid progress with this is being made in China and may come to provide an important front-end to primary care in these settings.

In designing these models, particular attention will need to be given to ensuring that services are tailored to ensure that they respond to different patterns of service use by socio-economic group and gender.[15]

2. Community-based care and public health

Home and community-based care provides an important adjunct to primary care, and can also assist hospitals by providing ambulatory treatment to prevent admission as ease discharge. There are benefits to linking these services to prevention and health promotion activities for work with the wider public health system and primary care, to ensure full coverage for immunization, vaccination, screening and other population health services.

For example, Health Promotion Centres in Slovenia provide:

● Workshops, lectures and presentations related to health promotion

---

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3381278/

[10] http://www.annfammed.org/content/15/6/515#aff-1

[11] https://bmjopen.bmj.com/content/bmjopen/8/6/e021161.full.pdf

[12] https://www.ijic.org/articles/10.5334/ijic.2477/

[13] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2576310/

[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC274066/

[15] https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf?ua=1

- Presentations to encourage target populations to participate in preventive care programmes and national cancer screening programmes
- "Open doors for health" at the locations of various partners in the local community
- Motivational workshops for vulnerable individuals or groups

They work closely with local governments, social services, education institutions and NGOs such as the Local Health Promotion Groups.[16]

One effective model is found in Brazil, which uses community health agents organised in teams. While their work varies with geographic location, most teams provide comprehensive care through promotive, preventive, recuperative, and rehabilitative services. The agents (lay workers with special training) register the households in the areas where they work and are also expected to empower their communities and link them to the formal health system. The agents are supervised by nurses and physicians from the local clinics.[17]

Another example of community mobilisation is the Village Health Committees in Kyrgyzstan, which are made up of volunteers who work with primary healthcare services to identify health-related priorities and implement actions to improve the health of local people. One of the most ambitious areas of work has focused on hypertension.[18]

In high income countries, community providers have developed an even wider range of services that have enabled reductions in hospital stays, and meant that growing demand can be met without the need for a large hospital building programme. These include:

- Nursing care for end of life care, post hospital care and specialist support for problems such as incontinence, leg ulcers, etc.
- Rehabilitation
- Specialist support and care for long-term conditions
- Care for addictions, TB, Hepatitis and HIV (the transfer of this to the community in former Soviet health systems has improved care and reduced costs).

3. Secondary and tertiary care

The hospital sector presents major challenges to policy makers in many countries: either because it is too large (as is the case in many post-Soviet systems), is highly fragmented (for example, serving only sub-groups such as civil servants or the military), or it needs to change, modernise and grow (as in most low/middle income countries). This is complicated by the political power and visibility of hospitals as institutions which can obstruct the reform process and out-compete other parts of the system for resources.

---

[16] http://www.euro.who.int/en/countries/slovenia/publications/health-promotion-centres-in-slovenia-integrating-population-and-individual-services-to-reduce-health-inequalities-at-community-level-2018
[17] https://www.chwcentral.org/blog/community-health-agent-program-brazil
[18] http://www.euro.who.int/en/countries/kyrgyzstan/publications/community-action-for-health-in-kyrgyzstan-hypertension-detection-2016

Traditionally, hospitals have been designed around specialties and departments rather than around the needs of patients. As a result, patients often spend much of their time in hospitals waiting for something to happen, with large areas provided for this inactivity. People's needs are often complex, and hospital services need to be organized to respond to all aspects of physical health including multiple acute and chronic conditions, mental health and wellbeing, and social and support needs.

As UHC develops people will expect improved access to hospital care and more responsive, higher quality services. There is often a trade-off between quality and access, as there are a number of services where limiting procedures to a smaller number of centres of excellence will produce better outcomes (through higher volumes and specialization) but will increase travel times for patients.[19] This affects services such as cancer and vascular surgery, neonatal intensive care and the initial treatment of stroke – the important factor is to ensure that changes are clinically led with visible clinical support, so as not to be misconstrued as cost-cutting.

At the same time changes in technology and standardization have allowed many hospital services to be decentralized away from specialist centres and into the types of multidisciplinary primary care services described above. This has great advantages for patients – particularly those with chronic conditions that require regular check-ups. Examples include: routine monitoring (such as management of diabetes and high blood pressure); procedures for investigation and treatment (including endoscopy, hysteroscopy, bladder cystoscopy, removal of skin lesions, other minor surgical operations); routine treatment (such as home renal dialysis and chemotherapy); post-procedure follow-up; ultrasound and x-ray; and other outpatient and office-based consultations that do not require specialist equipment.

Clinical networks can be used to provide expertise to areas that are distant from specialist centres, and technology is an important part of this.[20] Networks also allow standardised approaches to the provision of care between centres of specialised expertise and local providers, for example allowing chemotherapy and routine care to take place in smaller hospitals linked to tertiary centres for major surgery, immunotherapy, advanced diagnostics and care planning. Digital technology also offers the opportunity to replace traditional outpatient appointments with remote consultations over voice or video, to support primary care providers, or follow up of cases using data collected from patients digitally (e.g photographs of skin lesions, or pain and mobility data).[21] .

One solution to this access-quality conundrum has been the development of hospital groups or chains – either voluntarily or as part of formal mergers. This can provide a governance framework to ensure that there is cooperation between different locations, as well as offering some economies in areas such as procurement.

---

[19] Halm EA, Lee C, Chassin MR (2002). Is volume related to outcome in health care? systematic review and methodologic critique of the literature. Ann Intern Med. Sep 17;137(6):511 (http://annals.org/article. aspx?doi=10.7326/0003-4819-137-6-200209170-00012) .

[20] http://www.euro.who.int/en/publications/abstracts/health-systems-respond-to-noncommunicable-diseases-time-for-ambition-2018 Chapter 9

[21] https://www.rcplondon.ac.uk/projects/outputs/outpatients-future-adding-value-through-sustainability

As UHC and the hospital sector develops, there are two particular risks that need to be managed. Firstly, there are risks over hospitals focusing on activity that has a high profit margin or is attractive to affluent individuals. This will distort the labour market for skilled medical staff and can lead to over-supply in these areas, which in turn can produce over-treatment and over-investigation. Secondly, hospitals may try to expand the scope of their services into areas that should be performed in centres of excellence. Some of the approaches to dealing with this are discussed in the next section.

4. Mental health

The burden of disease from mental health problems is high, and a significant proportion of people using primary and secondary care will have a mental health comorbidity or have this as their primary diagnosis. It is therefore very important that UHC covers mental health treatment in these settings as well as in specialist mental health providers.

The power of other parts of the health system, stigma, workforce shortages and artificial divisions between physical and mental health often mean that these services are underdeveloped. Policy makers also need to take care to ensure that the criminal justice system is not used inappropriately to deal with people who primarily have mental health needs.

High income countries have been moving away from inpatient and custodial models for treating serious mental disorders and instead have emphasised care in community settings. Low and middle income countries have likewise been experimenting with the large-scale use of trained community mental health workers or even peer-support networks. The fast evolving applications of digital technology to support lay and non-specialist mental health workers holds particular promise for accelerating progress towards UHC for psychological disorders.[22]

5. Integrated care

As the comprehensive providers and pathways described above each become more sophisticated and specialist, there is increasing awareness of the additional harms that can be caused by the fragmentation and inefficiencies of modern healthcare systems. As trends in epidemiology (towards increased complexity and multimorbidity) and medicine (towards increased specialization) seem unlikely to slow, there is a growing consensus of the need to provide integrated care. By this, it is generally meant getting providers of all the above services to appropriately collaborate to offer safer and more seamless flow of patients, resources and information between them. The concept also often involves coordination with other public services such as social care, schools and the welfare system.

Established health systems are finding it difficult to make this transition and it is particularly challenging for those with powerful hospital systems, a history of fee for service payment or where primary care is fragmented. WHO Regional Office for Europe suggests that some

---

[22] Empowering 8 Billion Minds: Enabling Better Mental Health for All via the Ethical Adoption of Technologies, WEF White paper by Future Council on Technology and Mental Health (2019)

countries might be able to leapfrog some stages of health systems development to put aspects of integrated care models in place more rapidly.[23] The model of primary care described above would create a strong platform that could facilitate this, but the task in terms of developing a different culture of medicine, supporting information systems and other aspects of these models should not be underestimated.

Five levers to shape the delivery system

Moving towards the target model for a 'UHC-ready' provider sector is an immense challenge – especially in countries with significant legacy infrastructure, entrenched political divides or powerful lobby groups. Policy makers have a number of levers that they can use to drive change, however. These include:

1. The careful use of provider competition
2. Influencing the shape of the provider system
3. Developing strong and well managed providers
4. Creating a purchasing function that is capable of acting strategically
5. Operating a robust system of independent regulation to ensure quality

Experience suggests that successful reforms require a combination of all of these levers to be used in a coordinated manner. Policy makers should avoid the – very common – temptation to over-emphasise the importance of any one of these mechanisms (for example, payment reform or changes to provider ownership) as these rarely succeed in isolation. The following section summarizes some global lessons on how best to operate these levers, but all health systems will need to adapt them to their own unique context and history – and may require additional capability and capacity to be developed before they can be deployed.

1. Competition

Weak -- Where there is sufficient capacity, price regulation and information available to inform patient choice, some element of competition between hospitals can be beneficial and is associated with higher levels of quality.[24] However, this relationship is not always found and it is not necessarily the case that increases in competition automatically increase quality.[25] There is some evidence that with regulated prices, competition on quality may improve services in primary care as well.[26]

Competition seems to be more effective in the area of routine planned care, diagnostics and outpatient care where there is patient choice and competition for referrals. Patients are

---

[23] http://www.euro.who.int/en/publications/abstracts/health-systems-respond-to-noncommunicable-diseases-time-for-ambition-2018

[24] https://oxfordre.com/economics/view/10.1093/acrefore/9780190625979.001.0001/acrefore-9780190625979-e-60

[25] Scanlon DP, Swaminathan S, Lee W, Chernew M. Does competition improve health care quality? Health Serv Res 2008; 43(6):1931-51.

[26] https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP151_spatial_competition_quality_family_doctor_market.pdf

usually less able to exercise informed choice for emergency care and so competition is as effective.[27] Competition on price and quality has a rather more mixed record, and without strong competition on quality as well can lead to reductions in quality[28] particularly if there is a 'race to the bottom' for the lowest possible price.[29] Likewise, higher hospital market share and market concentration both tend to be associated with lower quality of care and so hospital mergers can have undesirable quality consequences.[30] [31] [32]

So while competition has significant benefits, making the most of it requires the right incentives, regulatory structure and deterring inefficient duplication of highly specialist services and expensive equipment. The context in which competition will operate and the goals of policy makers will determine its success or otherwise.[33] [34] To do this, policy makers will want to distinguish between three very different forms of competition that they can deploy for different types of services and to varying degrees and combinations depending on their circumstances:

- Areas where there is free competition – here the policy emphasis is on ensuring minimum quality standards, ensuring transparent and comparable information about quality and preventing the emergence of monopolies. The main mechanisms here are choice by patients or their referring clinicians.

- Services where there is competition to be the main provider of a service that has a natural monopoly – e.g. because the service needs to be provided in only a few specialist centres or because the population size, geographical isolation or other factors have insufficient space to allow for multiple providers. The main mechanism is competitive bidding to meet a specification.

- Services where competition is not desirable – because provider collaboration across a network is required, or because of clinical interdependencies there can only be one provider. The mechanism in this case is based on planning.

The structure of providers

Ownership

Some countries and health systems can become fixated on the issue of who owns their providers, and specifically whether they should be public, for profit or non-profit. There is, however, very little evidence to make a definitive judgement on which of these are superior for delivering UHC, or indeed if it makes much difference at all. There is some suggestion that not for-profit providers achieve better patient outcomes than private for profit[35], but this

---

[27] https://onlinelibrary.wiley.com/doi/full/10.1111/j.1468-0297.2011.02449.x
[28] https://core.ac.uk/download/pdf/84338586.pdf
[29] https://www.oecd.org/daf/competition/50527122.pdf
[30] https://www.nejm.org/doi/10.1056/NEJMsa1901383
[31] https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html
[32] https://link.springer.com/article/10.1007/s10198-016-0862-6
[33] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4556571/
[34] https://www.oecd.org/daf/competition/50527122.pdf
[35] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4249790/

is not a universal finding. The evidence on differences in efficiency is equivocal, although for profit providers may be quicker to respond to incentives and market signals.[36] In practice, almost all countries use a mix. There is no reason why private hospitals should form an important part of any delivery system for UHC.

Much more important than ownership are questions about the capability of the management, their accountability and authority to enact change. For this reason, many countries have recently sought to change the management and ownership of public healthcare providers into autonomous non-profit institutions free of Ministry of Health control, often as part of the implementation of national health insurance reforms. Often a natural consequence of creating a purchaser-provider split, many governments over-optimistically anticipate dramatic improvements as a result of devolving decisions down to individual hospitals or primary care groups. While this may well be the right approach, shifting ownership on paper may not do much to shift decades-old ways of working and professional cultures. It is equally important, therefore, to focus on directly developing management capabilities as described below.

Provider consolidation and collaboration

Fragmentation of the provider landscape is a common barrier to aligning healthcare supply and demand. It impedes the adoption of common standards, makes it harder to design more coherent and efficient care pathways, and leads to duplication of capacity in sub-optimal locations and disease areas. This means that an important change that will need to accompany the development of UHC will be the consolidation of the provider sector, and in particular the removal of the fragmentation that typifies some systems – for example separate hospitals for some parts of the population such as civil servants, the military, mining employees, etc. and for single diseases such as HIV or TB. There may also be many small hospitals with different types of ownership that will need to be rationalised. It is also common for there to be some maldistribution of services, typically with high levels of provision in major cities, especially the capital, but with poor access in rural or remote areas.

Mechanisms to allow providers to collaborate – even in markets that rely on competition – are an important foundation for developing integrated care and spreading best practice. Referral systems and networks of individual specialists are among the most basic levels of provider coordination, with more mature forms including care clusters and hub-and-spoke models. Many low and middle income countries have experimented with social franchising – a powerful means of grouping highly fragmented markets of small, independent primary care providers or drug shops into networks with a common brand, training, quality standards, and contracting.

Strong and well managed providers

Management capability

Healthcare providers are complex organisations that need professional management and well designed internal systems and processes. These are weak or absent in many countries.

---

[36] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6033142/

As a consequence there are very large opportunities for improvements in safety and efficiency in most providers.

As a minimum, providers must have the ability to manage staff effectively to get the best from them and to ensure they are effectively supervised and supported. The selection, pay and reward, discipline and dismissal of staff and decisions on the mix or type of staff to be deployed have often been carried out by ministries or bodies that are distant from the organisation providing care. This is not compatible with the provision of efficient services adapted to meet local needs, although in some cases there are reasons for retaining a few of these functions (such as overall human resource policy, pay scales, etc.) at higher administrative levels due to consistency or economies of scale. However, providers need to have control over their operational budgets and have the ability to move money between budget lines, change the mix of staffing and make other financial decisions. The allocation of fixed line item budgets (often also specifying staffing numbers and grades) to hospitals has been an obstacle to the development of effective provider management in many countries.

The ability to manage staff and money needs to be underpinned with systems for costing, budgeting and financial control and internal performance management so that the managers of the organisation can set objectives for departments and monitor their achievement of these, their productivity, quality and other important aspects of performance. These are a minimum requirement for providers to be able to operate autonomously or to work in an environment where payment is related to case mix and volumes (e.g. DRG payment mechanisms).

The ability to monitor and continuously improve the quality and safety of the care provided is a key capability that providers need to develop, and requires that attention be given to the standardisation of work processes, equipment and care pathways. As with the other areas, the development of information systems and the ability to analyse the results are essential.

Management and leadership represent a set of skills and competences that need investment and are developed over time. Health systems have deployed a wide variety of policies to directly develop better management capabilities, from bespoke training schemes, to secondments outside of the health sector, to improvements in job quality, pay and career progression of managers.[37] Continuity of professional leadership is an important factor in the successful management of providers. The practice in some countries of the political appointment of hospital directors can be a serious obstacle to effective management and long-term decision making.

Governance

As well as having well functioning internal management systems there is also a need for effective governance to oversee providers. There is no one best way to structure the governance of providers, but there are a number of principles that form the basis for an

---

[37] https://assets.kpmg/content/dam/kpmg/xx/pdf/2016/09/what-works-the-trillion-dollar-question.pdf

effective system. The following recommendations[38] are made for the health system but apply to providers as well. The authors suggest that there should be:

- Transparency – in terms of making clear decisions, the basis on which decisions are made and who are the decision makers.
- Accountability – ensuring that anybody who acts must account for their actions to appropriate other actors who can reward or sanction them.
- Participation – ensuring that people who are affected by a decision can express their views about it in a way that ensures they are at least heard. This requires mechanisms for ensuring a strong voice for patients and the public in the decision making process.
- Integrity – a system in which organizations and jobs have clear definitions, and procedures such as hiring and contracting are regularized and clear.
- Capacity – employing the necessary expertise.

### Holding providers to account

An issue in many systems is the poor capacity and capability of the institutions acting as the 'owners' of the hospitals to hold them to account effectively. The creation of autonomous hospitals does not necessarily solve this problem and requires an even greater investment in the development of governance processes, and in the capability of the bodies acting as owners.

Whether they are publicly or privately owned, there will need to be mechanisms to hold hospital management to account for performance. These also need to be mirrored by strong performance management systems inside the providers to support their own governance. Payers will have systems to ensure they are receiving high quality services, but this is not a substitute for oversight by owners who will need a method for overseeing their providers. One example of a performance framework is the PATH model which is based on six performance domains, with cross-cutting dimensions that shows the relationship of safety and patient centeredness to the other areas.[39] This is illustrated below.

---

[38] http://www.euro.who.int/__data/assets/pdf_file/0012/416100/PolicyBrief_PB33_TAPIC.pdf?ua=1

[39] http://pathqualityproject.eu/upLoad/file/a_performance_assessment_framework_for_hospitals:_the_who_europe_path_project_int._j._for_quality_in_health_care_2005.pdf
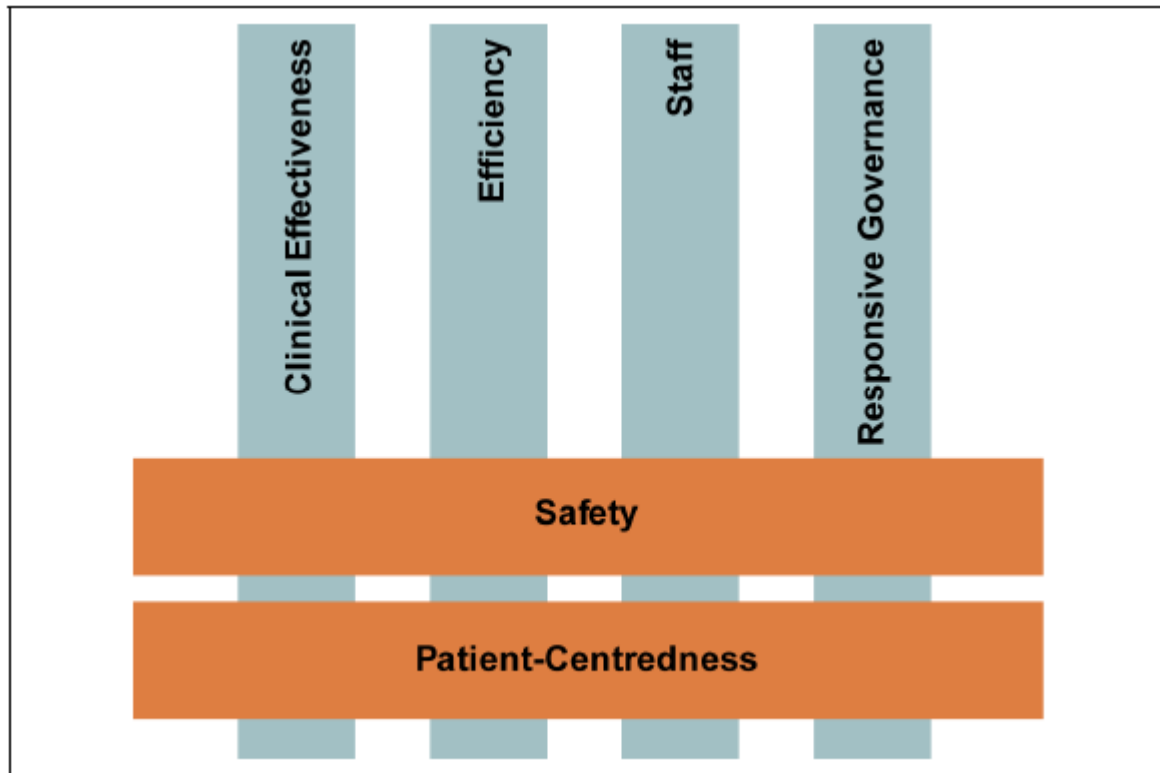
Clinical effectiveness refers to outcomes and appropriate treatment as well as conformance with guidelines and accepted best practices. Efficiency looks at the optimal use of resources to achieve maximum output and includes productivity, the use of health technologies to achieve best possible care, and the appropriateness of interventions. The safety domain reports on the application and promotion of structures and processes for which evidence demonstrates prevention or risk reduction. Safety is not restricted to patient safety, but also relates to staff and environmental safety.

The staff domain is designed to capture the degree to which hospital staff are appropriately qualified to deliver required patient care, have the opportunity for continued learning and training, work in positively enabling conditions, and are satisfied with their work.

Responsive governance covers the extent to which a hospital is responsive to community needs, ensures continuity and coordination, promotes health, is innovative and provides care to all citizens irrespective of racial, physical cultural, social, demographic or economic characteristics. This covers a broad range of issues, covering equity of access, population health and the role of hospitals within the overall healthcare delivery system.

One omission from this framework is a domain explicitly related to access times – however, these can be included in patient centeredness, efficiency or responsive governance. Given their importance in many health systems, they are generally collected and reported. Similarly there will be a parallel mechanism for ensuring that providers meet their financial targets for performance against budgets, cash flow and other indicators of financial health.

Purchasing and Payment

Active purchasing

A key role in most UHC systems is the development of a dominant strategic purchaser that has six key responsibilities:

1. Identifying which services need to be purchased to meet the needs of the population and national priorities
2. Selectively contracting with service providers on the basis of quality and the optimal configuration of services
3. Developing appropriate payment and contractual mechanisms with supporting transactional and audit systems
4. Maintaining oversight of the quality of services, access, equity and other important goals for the delivery system
5. Providing information on provider performance to the public
6. Working with policy makers to define the scope of services that are covered

In many countries this purchasing function has historically been passive, making only marginal changes through the above mechanisms and often being little more than a 'clearing house' for payments. Single (or dominant) payers have the advantage that they can be proactive and work to improve and shape the system through their design of incentives, the specification of standards, the oversight of clinical pathways, and in some cases taking an active role in the strategic planning of aspects of the system. They should also ensure that they have a good understanding of needs at a local level and an assessment of any gaps in the services required to meet these.

The use of market mechanisms such as purchasing and selective contracting can be effective at improving the efficiency and effectiveness of provider systems, but only if two foundational assumptions are true:

- That providers have the capability to identify and respond to market signals. This may be an issue for a number of reasons, for example, if hospitals have limited freedom to change the number of staff they employ, or do not have access to capital to acquire equipment or to build they may be unable to respond.

- Payers have the capability and willingness to use selective contracting to stop services at particular providers, for example because of poor quality or failure to comply with standards such as minimum numbers of procedures or the availability of equipment.

Decisions about how to deploy strategic purchasing are complex and involve difficult trade-offs between quality, access and cost. For these reasons some countries (e.g. Estonia, Denmark) have opted to develop plans for the shape of the hospital system and the designation of hospitals for services such as neurosurgery, trauma, hyperacute stroke and other more specialised services. These processes used evidence about travel times for patients, forecasts of expected volumes and expert and stakeholder viewpoints to reach their conclusions. Since plans often involve a major relocation or closure of services political

legitimacy for the actions of the purchaser will be important. This may require government giving a clear mandate and the purchaser having governance and consultative arrangements to support this.

Payment mechanisms

A strategic or activist purchaser will need to develop payment systems that will allow them to achieve their strategic goals. The OECD summarise the strengths and weaknesses of some of the main categories of payment models as:[40]

- Fee for service payments typically incentivise providers to increase their clinical activity and as a result the associated costs.
- Capitation payments control costs better but can encourage providers to deliver less healthcare than is optimal for patients.
- Global budgets, too, control total costs, but may lead to access problems and waiting times.
- DRG payments focus on technical efficiency to make better use of available resources and reduce average length of stay, but they also encourage hospitals to increase the number of patients.

This means that a mix of different methods of payment will be required depending on the policy goals and the ability of different parts of the system to manage risk. These can be combined with a variety of pay for performance incentives linked to process or outcome measures. The principles that should inform the design of payment models are:

- Avoid mechanisms that incentivise the volume of services unless increasing volumes is a key policy goal – this means that fee for service, per diem or case payment should be used with care or at least accompanied with measures to reduce the risk of over-production such as caps on volumes or global budget constraints.
- Case payment methods should try and reflect the entire episode of care rather than individual components, to reduce fragmentation and to focus the payment on value and outcomes rather than just inputs or outputs. For example, a bundled payment for hip replacement would include preoperative mobilisation, diagnostics, the operation and post operative care and rehabilitation. The payment might also be linked to the outcomes reported by the patient rather than just the performance of the procedure.
- Try to ensure that performance bonuses and other incentives are high powered enough to change behaviour but not so much that they unhelpfully distort provider behaviour, undermine professionalism[41] or encourage gaming.

For primary care and other services where longitudinal care of a defined population is required, blending capitation with judicially selected pay for performance and fee for service payments will be necessary. As more integrated care models develop, payment for the management of the population can be developed. These allow integrated providers more autonomy to develop their own approach to effective population health goals. This changes the role of the purchaser to being more about exercising oversight on outcome measures than managing detailed transactions.

---

[40] https://www.oecd.org/els/health-systems/Better-ways-to-pay-for-health-care-FOCUS.pdf
[41] https://qualitysafety.bmj.com/content/28/6/511

Payment systems will need to be constructed in a way that accurately reflects the cost of different types of care. This requires providers (or at least a sample of them) to have costing systems capable of providing information to calibrate the payment model. The use of cost weights from other countries as a substitute for this can cause some difficulties.

Mechanisms to audit coding and guard against fraud are often needed and can consume significant resources. The more complex the payment model, the higher the costs of these mechanisms.

Not a very thorough section on payments

Regulation and accreditation

The development of regulation and/or accreditation has been seen by policy makers as an important mechanism for improving services, and in some cases for preventing providers from continuing to offer services that are unsafe or that have very low volumes.

The deployment of independent indicators of quality to appraise providers on is highly desirable both for trust and transparency. However, pass/fail standards which are often set based on international gold standard practice can create a situation in lower income countries where most providers are a long way from being able to comply. This renders the regulator somewhat powerless and fails to create a dynamic for improvement. Regulators may have the theoretical power to order improvement or close services but in practice, where there are very low levels of compliance and there is no alternative provider, they cannot.

Accreditation is an alternative approach to external validation of quality in providers, and there have been moves to develop specific, tiered models that are appropriate for low and middle income countries, such as SafeCare.[42] Accreditation standards tend to measure process and structure and other proxies for quality, and meeting these is not an absolute guarantee of long-term performance. However, studies do suggest that it can help poor quality hospitals improve more quickly, and there are useful approaches linking accreditation to quality improvement and standards that can be adapted to local circumstances without undue compromise.[43]

The separation of regulation from purchasing is generally desirable as it removes a potential conflict of interest in which purchasers that are dependent on a particular provider are prepared to overlook its regulatory failings. It also means that the regulator can inform other purchasers and individuals about the quality of the providers without creating duplicative systems.

---

[42] https://www.safe-care.org/who-we-are/safecare-standards/
[43] https://www.sciencedirect.com/science/article/abs/pii/S0168851019301071

Three long-term enablers of change

For many countries it will be a long journey to achieving a fully 'UHC-ready' service delivery system with all of the capabilities and levers outlined above. Where to begin depends heavily on context and the particular strengths and weaknesses of each health system, as it is often not possible to improve one element of delivery model in isolation. For example, introducing multidisciplinary primary care clinics without the necessary changes to referral mechanisms, management capabilities, payment models and patient demand.

Nevertheless, there are several cross-cutting priorities for decision makers looking to reform their delivery systems that will help to enable sustained improvement over the long term.

1. Workforce Capabilities

Developing the right mix, distribution, quality and quantity of skills within the healthcare workforce is one of the slowest elements of any system to reform, but also one of the most impactful. While investments in new cadres of health worker can take a decade or more to pay off, the work of adapting clinical curricula, reforming educational institutions and changing task profiles is essential to developing models of care that fit the needs of the population in the future. Extending the scope of practice for non-physicians has been one of the key success stories from countries that have made the most rapid progress towards UHC, such as the more than 30,000 Health Extension Workers deployed in rural Ethiopia to deliver essential primary care and public health.[44] OECD countries too have undergone equivalent reforms, such as the introduction of Nurse Practitioners and Physician Assistants/Associates in the USA, UK, Canada and the Netherlands.[45]

2. Culture

Developing a culture of innovation and continuous improvement around quality and efficiency can pay long-term dividends to health systems in low, middle and high income countries. There is a rich literature on interventions that have demonstrated impact in improving the quality of care at scale, including clinical decision support, clinical audits, patient reviews, professional education, safety protocols and checklists.[46] Less well documented but equally important are the mechanisms for spreading a wider culture of innovation across the healthcare system, including process redesign to improve cost efficiency.[47] The use of continuous improvement methodologies at scale has shown some success, particularly when supported by dedicated institutions or programmes charged with seeding, supporting and spreading innovation across the health system.[48]

---

[44] WHO & Global Health Workforce Alliance, Ethiopia's human resources for health programme, GHWA Task Force on Scaling Up Education and Training for Health Workers (2008) *Will try and find more up to date ref.*

[45] OECD, Universal health coverage and health outcomes, OECD (2016)

[46] WHO, World Bank & OECD, Delivering quality health services: An imperative for UHC (2018)

[47] Nolte E, How do we ensure that innovation in health service delivery and organization is implemented, sustained and spread? WHO Policy Brief (2018)

[48] Darzi et al, Global diffusion of healthcare innovation: Accelerating the journey, World Innovation Summit for Health (2015)

3. Communities

'Provider-centric' delivery models can be a major barrier to reform, as the interests of existing institutions or vertical programs take precedence over the most efficient path to UHC.[49] Empowering and engaging communities themselves is an effective long-term step to planning and providing health services that people trust, protect and which are aligned to their needs.[50] Further benefits include the ability to harness community assets such as social networks, peer support workers, and other social programs. Forms of community engagement are many and varied, but include actively seeking input from community members on priority setting, citizen representatives on provider boards and transparency around provider performance. In Mali, community-owned and operated primary care centres were an effective vehicle for doubling effective service coverage over a 10-year period, as well as proving more effective at changing patterns of patient demand compared to top-down primary care reforms pursued elsewhere.[51]

Five common pitfalls to avoid

While there is no one right path towards a UHC-ready service delivery system, the experience of countries that have struggled most to sustain improvements in care shows there are a number of pitfalls to avoid – primarily because once made they can be very difficult to reverse.

1. Creating 'poor services for the poor': While it is important to prioritize new investments around the needs of the most vulnerable and under-served, trust in healthcare services by the whole population is essential to ensure they are utilized and drive down out-of-pocket spending. Where services are stigmatized or perceived as low quality they are often rejected by the majority, leading to fragmentation and lower social solidarity. Wherever possible, policy makers should seek to progress towards universal provider systems that are open, accessible and acceptable to all.

2. Corruption: When allowed to take root, corruption is one of the most damaging and dangerous forces in undermining a country's progress towards UHC. Informal payments by patients to obtain care, by clinicians to obtain qualifications, or by organizations to obtain favourable contracts have all been implicated in the failure of service delivery reforms worldwide. This is one area where increasing financing is not the answer, but rather a mix of measures to strengthen top-down control and bottom-up accountability.[52]

3. Misaligned investments in healthcare infrastructure: Most countries pursuing UHC have a pressing need to expand and improve their healthcare infrastructure, both hard and soft. However, the decisions over what to invest in and where can often be driven by overly narrow considerations around bed numbers, bottlenecks or generating short-term political capital. Health system leaders should instead look to align new capacity to long-term health system plans and the development of a strong provider ecosystem.

---

[49] WHO Europe, Health systems respond to non-communicable diseases: Time for ambition, WHO (2018)
[50] WHO, Framework on integrated people-centred health services, WHO (2016)
[51] World Health Report, 2008 – *I'll try to find a more up to date reference*
[52] Transparency International, The Ignored Pandemic: How corruption in healthcare service delivery threatens universal health coverage, Transparency International (2019)

4. The inverse care law: Health system leaders often underestimate how difficult it can be to reach the most marginalized and vulnerable populations, and over-estimate the flexibility of demand to new services. Tackling both of these problems requires in-depth involvement of target groups in service design and delivery, as well as being realistic about the pace of change that is possible.

5. Impatience and reform fatigue: While there is much encouraging evidence of health systems that have significantly improved their delivery systems, there is no avoiding that this is one of the elements of UHC reform that takes the most time to bear fruit. Reform fatigue – whereby countries shift strategies every 5–10 years or abandon them altogether – is an ever-present danger, and so patience and a consistency of purpose are perhaps the most important ingredients of all.