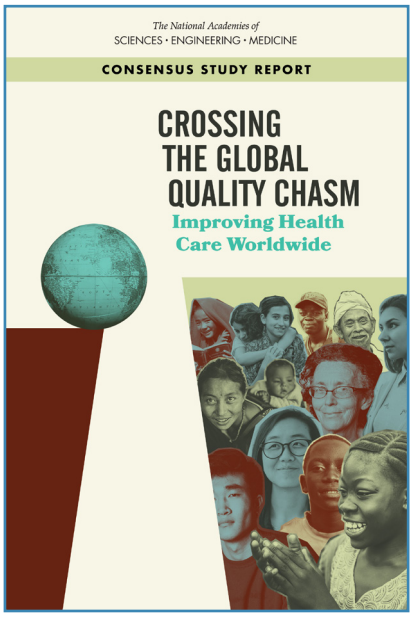
Consensus Study Report
HIGHLIGHTS
August 2018

Crossing the Global Quality Chasm

Improving Health Care Worldwide



Poor-quality health care around the globe causes ongoing damage to human health. In low- and middle-income countries (LMICs), between 5.7 and 8.4 million deaths occur each year from poor quality of care, which means that quality defects cause 10 to 15 percent of the total deaths in these countries. The resulting costs of lost productivity alone amount to between $1.4 and $1.6 trillion each year.

A move toward universal health coverage (UHC) is the central theme of global health policy today, but the evidence is clear: Even if such a movement succeeds, billions of people will have access to care of such low quality that it will not help them—and indeed often will harm them. Without deliberate, comprehensive efforts to improve the quality of health care globally, UHC will be largely an empty vessel.

With support from 7 sponsors, the National Academies of Sciences, Engineering, and Medicine undertook a study to examine the global impacts of poor-quality health care and to recommend ways to improve quality while expanding UHC, particularly in low-resource areas. The resulting report, *Crossing the Global Quality Chasm: Improving Health Care Worldwide,* builds on the work of the landmark 2001 Institute of Medicine (IOM) report *Crossing the Quality Chasm* by calling attention to the gaps in health care quality that still remain globally and suggesting approaches to bridge them.

THE SCOPE OF THE PROBLEM

Defects in health care quality deny many people and communities the benefits of effective care. In LMICs, 134 million adverse events (one form of poor-quality care) occur in hospitals each year, contributing to 2.5 million deaths annually. The problem is by no means limited to LMICs: Studies from the United States, the United Kingdom, and elsewhere reveal similar deficiencies.

Thus, even when people can receive care, quality problems are widespread. For instance, one study found that providers adhered to

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evidence-based treatment for such conditions as asthma, chest pain, diarrhea, and tuberculosis only 25 to 50 percent of the time. High levels of excessive and inappropriate care are also pervasive. In the United States, for example, 30 percent of estimated prescriptions for antibiotics are found to be unnecessary, posing risk to patients and contributing to the global problem of antimicrobial resistance.

DIMENSIONS OF QUALITY CARE

The six dimensions of quality health care put forth in the 2001 IOM report (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity) are still germane to the current global context. With a few modifications, this list of quality dimensions is thoroughly applicable to low-resource settings today. (The box below presents the definitions and the committee's modifications to the original dimensions.) In addition, the committee identified "integrity," the reduction and elimination of corruption and collusion, as a crucial overarching goal foundational to the pursuit of high-quality care.

THE COMMITTEE'S RECOMMENDATIONS

Improving the quality of health care will require investment, responsibility, and accountability on the part of health system leaders. This should be the daily work and constant responsibility of all health care leaders, including ministers of health. Embracing principles of transparency, accountability, continual learning, and health system–patient co-design, countries will need to work with patients to design health system strategies, policies, and clinical care delivery, as well as mechanisms for monitoring, evaluating, and reporting progress.

A systems thinking and person-centered approach should inform the redesign of health care systems, with a focus of the needs of the patient. It is crucial to examine each level of a health care system—

SIX DIMENSIONS OF QUALITY HEALTH CARE

- **Safety:** Avoiding harm to patients from the care that is intended to help them.
- **Effectiveness:** Providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit (that is, avoiding both overuse of inappropriate care and underuse of effective care).
- **Person-centeredness:*** Providing care that is respectful of and responsive to individual preferences, needs, and values and ensuring that these values guide all clinical decisions. Care transitions and coordination should not be centered on health care providers, but on recipients.
- **Accessibility, Timeliness, Affordability:** Reducing unwanted waits and harmful delays for both those who receive and those who give care; reducing access barriers and financial risk for patients, families, and communities; and promoting care that is affordable for the system.
- **Efficiency:** Avoiding waste, including waste of equipment, supplies, ideas, and energy, and including waste resulting from poor management, fraud, corruption, and abusive practices. Existing resources should be leveraged to the greatest degree possible to finance services.
- **Equity:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, race, geographic location, and socioeconomic status.

* Although the report uses the term *patient* when referring to the recipient of clinical medicine services, the committee's position remains that quality improvement requires emphasis on the *person,* to remind the reader that health is determined by circumstances far beyond the clinical setting.

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the environment, the organization, the front line care delivery, and the patient—and how they interact and either help or inhibit one another. Appropriate, meaningful metrics—including patient- and population-based outcome data—should be captured to understand quality of care and inform improvements.

Beyond commitment and strategy development, implementation is key. As countries move toward UHC, governments can use specific mechanisms, such as strategic purchasing or selective contracting, to only purchase services from health facilities that are providing high-quality health care.

Due to an explosion of digital health technologies, health care systems of the future will differ radically from those of the past. As such, health systems need to embrace emerging technologies, guided by a vision of patient care that is anticipatory rather than reactive; thoroughly integrated across time and space; and wholly centered on continually improving the experience of patients, families, and communities. A shift in care delivered directly to people wherever they are—in schools or in homes—will require new skills, attitudes, and culture among health care providers. It will also necessitate new, multisector governance mechanisms and regulatory oversight appropriate for these new technologies.

In many parts of the world, people seek care outside of the formal health system, from the so-called "informal sector," in which care may not be regulated, measured, or coordinated. All told, alternative care systems subject billions of people to care of largely unknown quality. Governments should assess and integrate informal providers into national health strategies in the pursuit of improved quality.

In addition, settings of extreme adversity, such as conflict zones, failed states, and refugee camps, pose severe quality challenges. Research on these settings should be a priority for governments, NGOs, and donors, to identify common quality problems, and to tailor and quickly implement improvement strategies to reduce both preventable deaths and the waste of scarce resources.

To achieve the needed improvements in health care quality in all settings, health care leaders should strive towards the vision and creation of a learning health care system: one that adopts bold aims for iterative improvement, is guided by systems thinking, and fosters a culture of continual learning and feedback. Unless nations and their leaders adopt a philosophy that improvement depends on learning, progress toward a future of high-quality health care will be slow.

To read all of the committee's recommendations, please visit nationalacademies.org/GlobalHealthQuality.

CONCLUSION

The changes recommended in this report could not be more urgent. The vast quality chasm that plagues health care around the world affects billions of people, and no nation is exempt. Yet it is possible to do better, even in low-resource settings. Improvement depends on investment and committed action on the part of leadership, and on thorough, scientifically grounded redesign of health care systems. As the momentum for UHC continues, so, too, is it time to seek high-quality care for all.

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