The Lancet Global Health Commission on High Quality Health Systems—where's the complexity?

The Lancet Global Health Commission on High Quality Health Systems in the Sustainable Development Goals (SDG) Era (HQSS Commission).[1] The launch draws attention to the fact that high quality health care, rather than just access to health care, will be necessary to meet the health-related SDGs. The Commission aims to address the lack of an "agreed upon single definition" of high quality health systems and produce "science-led, multidisciplinary, actionable work with [...] measurable indicators". But phrases like single definition and measurable indicators in the context of an exercise seeking to strengthen quality in highly variable health systems in low-income and middle-income countries (LMICs) should raise red flags.

In 2012, WHO Task Force on Developing Health Systems Guidance proposed a series of processes and tools to support evidence-informed decisions about health system interventions.[2] Many of the processes were adapted from clinical evidence-based medicine and an insightful commentary by Peters and Bennet[3] noted that the focus on what works potentially overshadowed more pressing questions that country-level policy makers that needed answering, including: "what can work in our (non-research) environment?", "how can we make an intervention work well?", and "how can we overcome obstacles to implementation?".[3] To learn from this experience we need to ask how the HQSS Commission's aims will assist LMIC policymakers to answer questions they have about how to improve health system quality or overcome known implementation obstacles? Two specific issues come to mind: how (and by default what) we measure and how these measures are subsequently used.

First, regarding how (and what) we measure. Empirical research (not to mention expert opinion) increasingly draws attention to the contribution of relational components and social experiences, including accountability, trust, and perceptions of responsiveness and respect, to health system quality.[4,5] Capturing of these relational aspects is indispensable to the project of understanding health system quality sufficiently well as to improve it. But it remains unclear how such context-specific and less tangible components will be incorporated into the Commission's project of developing a universal definition and quantitative indicators, and how the latter will subsequently inform useful actions across highly variable settings.

Second, the highly visible (and probably highly respected) nature of any indicators the Commission produces means it has an ex ante obligation to consider the use to which these metrics might be put. Care should be taken, for instance, to avoid intentional or unintentional promotion of a solely indicator and target-dependent approach to quality improvement. Experience from management sciences shows how, when introduced into organisations with traditional bureaucratic cultures without addressing root causes of the prevailing work culture (eg, governance structures and power dynamics) such targets can become meaningless, or worse, perverse incentives to game the system.[6]

A focus on quality in health systems is obviously much needed. But the way in which the HQSS Commission defines measurement; how its efforts to produce quantifiable indicators take account of health system complexities; and to what use these indicators are subsequently put, should continue to be scrutinised. Without a broader effort to contextualise such measures, the current framing of the Commission's aims has distinct risks.

I declare no competing interests.

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