Shift to digital during the pandemic could enable universal health coverage

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The coronavirus disease 2019 (COVID-19) pandemic, which started as an outbreak in one country and very quickly travelled around the world, makes a strong case for investment in global public health and has resurrected the debate on universal health coverage (UHC).¹

An estimated 400 million people around the world lack access to basic health services.² Each year, close to 100 million people are pushed into extreme poverty because they have to cover their own health costs. These numbers have increased with COVID-19 and will continue to increase as people lose jobs and health insurance and as health expenditures rise due to COVID-19-related spending on testing, treatment and vaccines.

The shift to value-based health care (VBHC) is fundamental to achieving the UHC objectives of quality health care, financial protection and equitable access to health care.³ Health systems are already stretched by dealing with chronic diseases and complex morbidities that have been further exacerbated by COVID-19.

It is crucial to optimize the efficiency of health systems and deliver patient-centric care where the focus is on health outcomes that truly matter to the patient and society. To achieve this, there are three ways in which VBHC can enable UHC in a world recovering from the pandemic.

1. Data-driven approaches optimize care delivery

Throughout the global effort to mitigate the spread of COVID-19, many traditional services have rapidly pivoted towards innovative remote-access care. The inherent inertia in legacy health care systems was swiftly overcome by an urgent need to facilitate remote health care delivery, which has created a digital health boom.

The value of digital health in advancing the UHC agenda has increasingly been validated by support from the World Health Organization (WHO), which agreed on a mandate for digital health as a tool for advancing UHC.⁴

In particular, telemedicine has allowed greater levels of doctor–patient engagement regardless of location, thereby significantly increasing the geographical reach of health care personnel. Other capabilities of digital health include e-learning and mobile-learning tools that can drive greater preventive and health-seeking behaviours, consistent with the goals of UHC.

Data captured through the shift to telemedicine during the pandemic illuminate the “digital divide”, highlighting that underserved populations lack the tools to engage in appropriate health-seeking behaviours. Recognizing this divide makes possible targeted approaches to care delivery for patients living in digital deserts, enabling them to access care through alternative models such as mobile clinics.

This data-driven approach to optimizing care delivery is consistent with VBHC, as it focuses on improving outcomes. WHO Director-General Dr Tedros Adhanom Ghebreyesus states that “harnessing the power of digital technologies is essential for achieving universal health coverage”.⁵

COVID-19 has accelerated this digital transition, and we must harness the power of data to identify key pain points and blind spots in our health care delivery models and to expand coverage to more of the world’s population.

2. Better health care access and outcomes improve population health

Despite many countries nominally providing UHC and improving access, there are still many problems related to quality of care and missed opportunities for improving outcomes. To maximize efforts to improve health coverage, we must move beyond access and benefits packages to an emphasis on quality of care and health outcomes – a defining pillar of VBHC.

Digital health and data-driven care are increasingly recognized as drivers of UHC, and we must ensure that digital health tools incorporate systematic collection and analysis of comprehensive health-outcome data. By meticulously tracking health outcomes for appropriately segmented groups, we can measure the impact of health interventions independent of access.

These models have been embraced by several countries, and it is expected that the seismic shift to digital health in the aftermath of COVID-19 will increase take-up of value-based decision-making. Rwanda is often touted as a developing country with a noteworthy health care system, which includes significant use of computerized medical records and comparatively good health care outcomes.

In India, Aravind Eye Care System (a network of ophthalmology hospitals) has been responsible for a substantial reduction in the incidence of blindness.⁶ This was achieved through innovative care delivery models, involving
value-based tracking of health outcomes following cataract surgery and providing high-quality, low-cost cataract surgery en masse. The high rates of good outcomes have increased consumption of the network’s services, which has allowed some cross-subsidized health care, enabling the network to spread costs and offer health care to a wider patient base.

3. New compensation models could reduce costs and improve care

Another defining pillar of UHC is ensuring that populations can receive the health services they need without suffering financial hardship. It is essential that new health care models seek to reduce the financial barriers faced by patients. Value-based models of care typically involve accurate measurement of costs across the entire cycle of care, with compensation dependent on the quality of care as measured by outcomes. This system differs from the traditional “fee for service” system, where medical providers use a “pay per use” type of compensation structure. Embracing alternative compensation models encourages health care providers to deliver more efficient care and also reduces the overall costs of health care for patients, thus reducing management inefficiency and broadening access for patients.

Increased commitment to health outcomes leads to long-term cost savings for patients, as they are incentivized to optimize their health. In a fragmented “fee for service” system, physicians often lack access to the information necessary to deliver care and can end up taking a piecemeal approach to patient management, treating the symptom instead of the patient.

In VBHC, providers are reimbursed based on the effectiveness of their care, encouraging greater coordination on patient care and producing cost savings for the patient. These models have been shown to yield between 8% and 3% increases in adherence to important care management factors such as medication adherence and blood pressure control management.7

Such interventions ultimately reduce avoidable health care spending and ensure that patients are able to utilize their saved resources in more prudent health-seeking behaviours.

The combination of superior health outcomes, lower costs and accessible care represents measurable clinical and social impacts that make VBHC a highly compelling model for moving the global health care needle towards UHC.

As we rethink our world post pandemic, we must harness the tools of VBHC to advance the welfare of collective humanity in line with Goal 3 of the United Nations Sustainable Development Goals: “Ensure healthy lives and promote well-being for all at all ages.”8 In so doing, we can reconcile the illusionary gap between VBHC and UHC and produce health systems that are defined by high value, low cost and extensive reach.

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References


