Why care about quality of care?

The case of Lao PDR

Azusa Sato, Health Specialist, ADB
Kirthi Ramesh, Social Development Specialist, ADB

ADB

HEALTH SECTOR GROUP

Follow the Health Sector Group:
https://twitter.com/ADBHealth

Outline

1

Why care about quality?

2

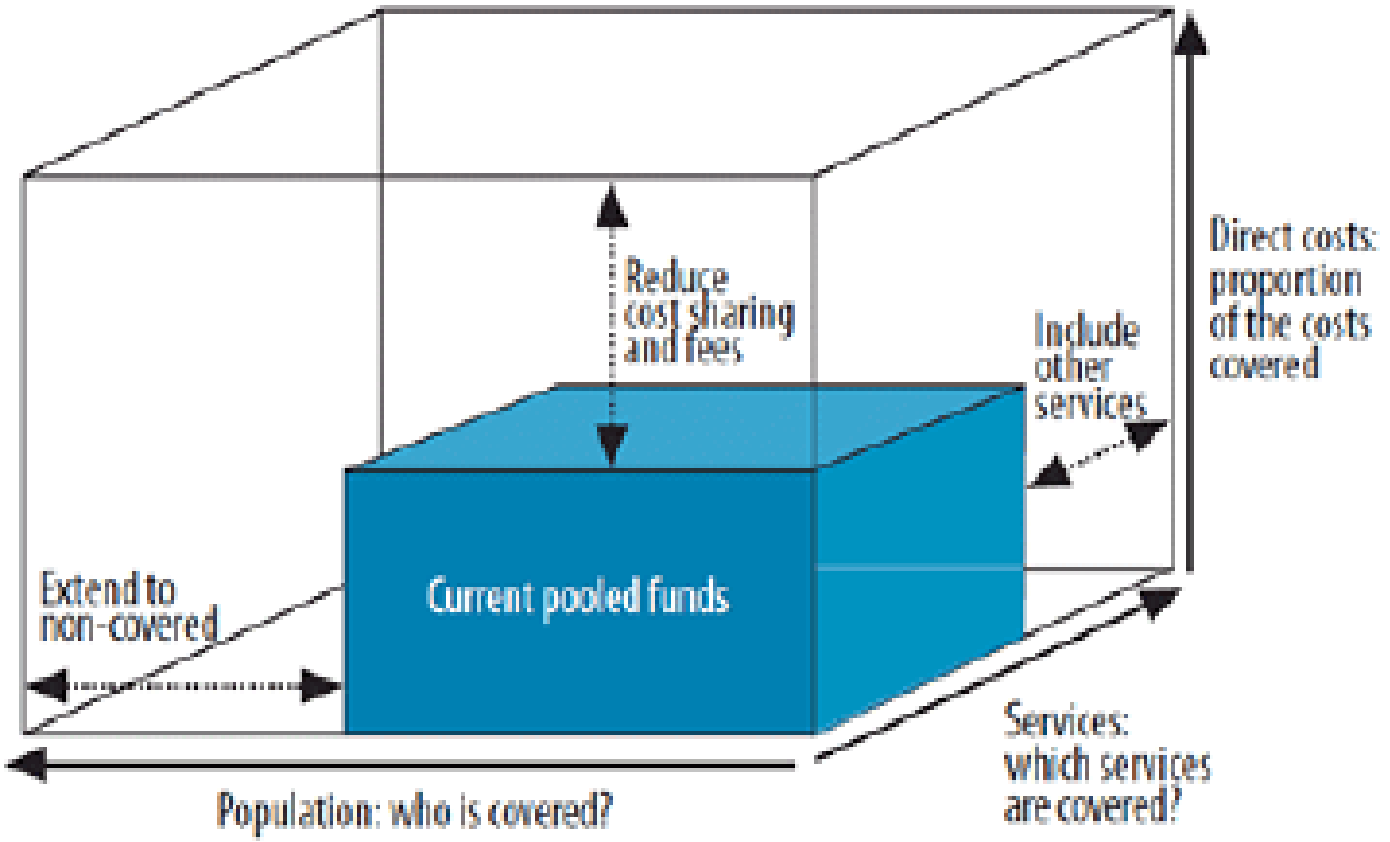
Concept and tools

3

Case of Lao PDR

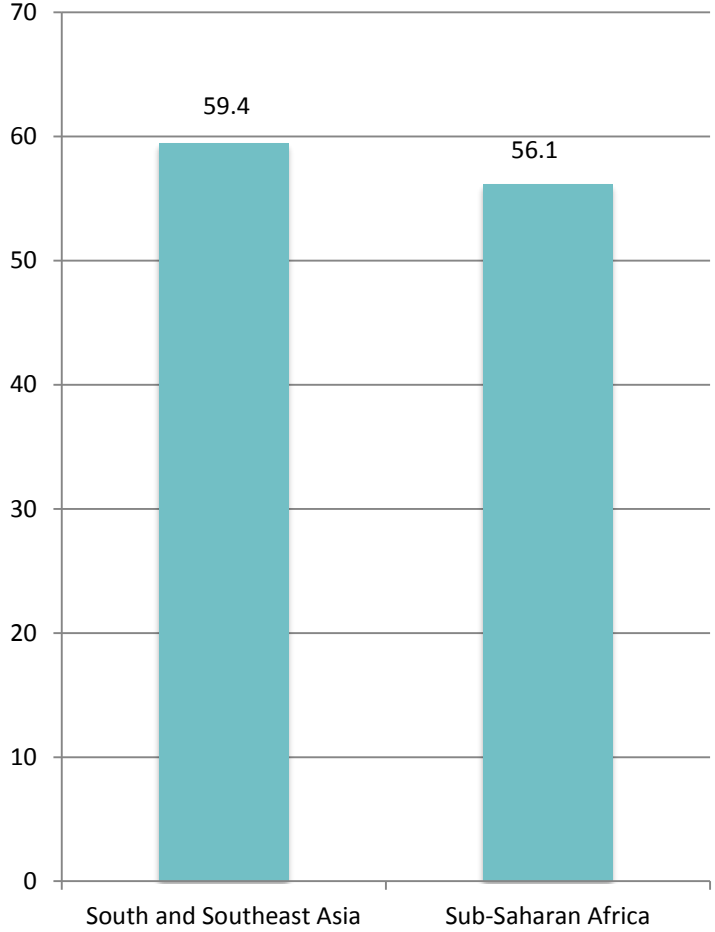
ADB

Moving towards UHC

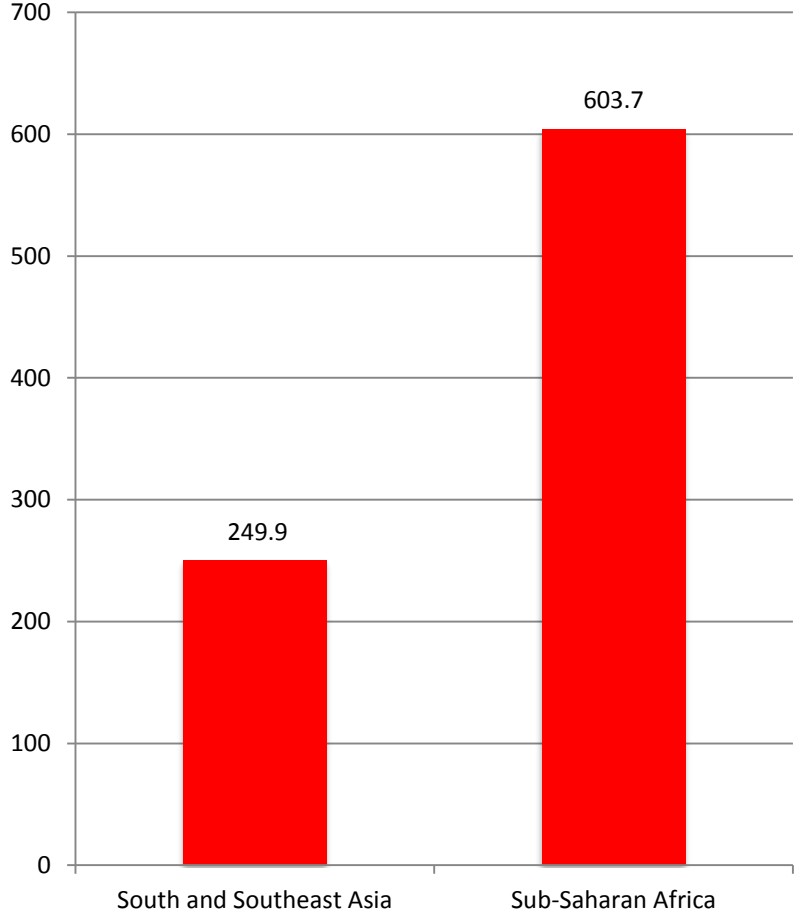


Coverage is not enough

% with skilled attendant at birth

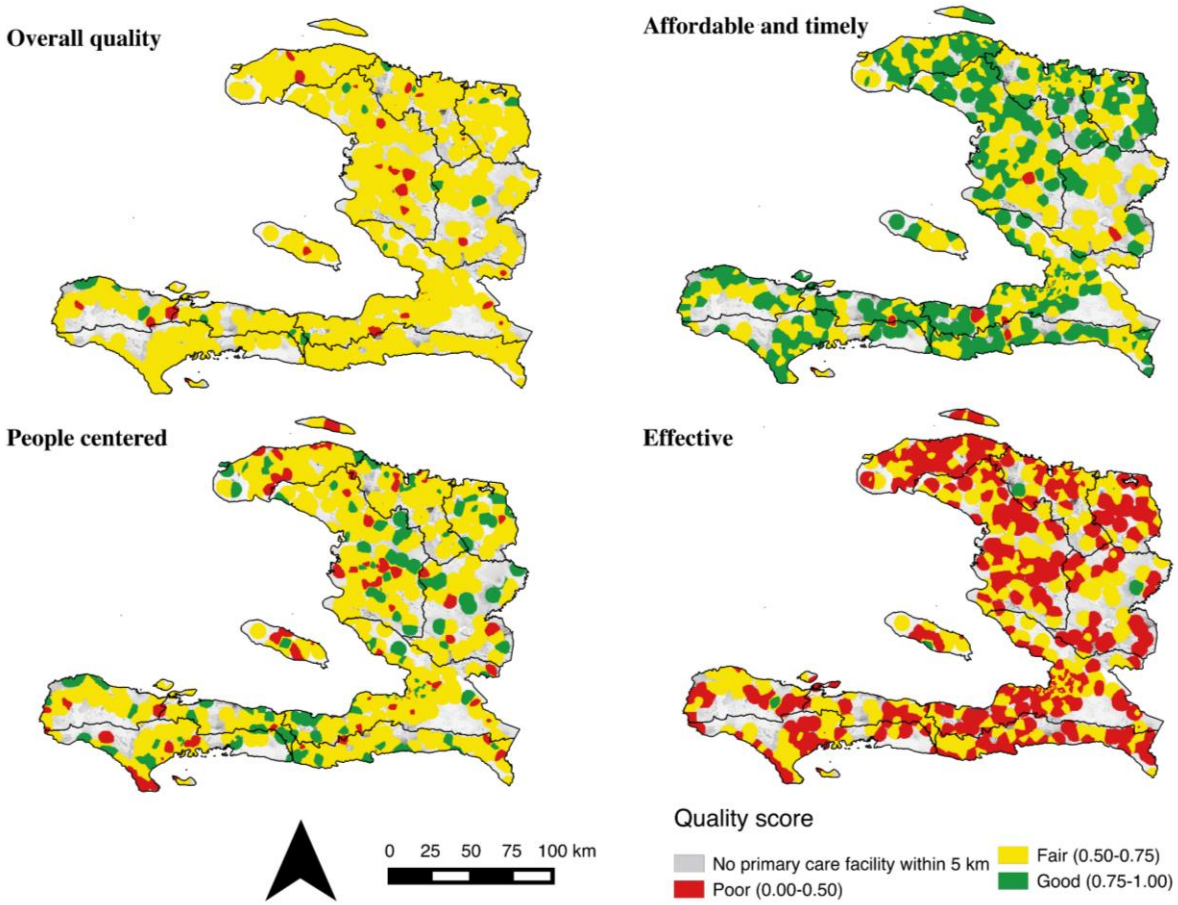


maternal mortality ratio



Note: data from 12 countries in Asia; 34 in Africa

Access to care ≠ access to good care in Haiti



?

Utilization x Quality = Health

Proportion of births with skilled attendant
Coverage of treatment interventions for substance use
Coverage of UHC tracer interventions
Access to vaccines
Health worker density/distribution

Maternal mortality
Mortality of CVD, cancer, lung
Under-5 mortality
Neonatal mortality
Malaria cases
Hepatitis infections
TB incidence
Mortality from pollution
Mortality hazardous chemicals

Good services are essential for building trust and accountability in the health system

- What do people want?
  - People are not beneficiaries; they are active agents
  - Services have to meet expectations to be used

- What do people do?
  - Use/non-use/bypassing are signals of primary care performance
  - Health worker productivity

- How do people experience care?
  - Patient-reported outcomes and processes are core measures of performance
  - Provision of good quality of care is the basic obligation of health systems to users
  - Interpersonal quality is a crisis
  - Quality deficits undermine trust in PHC and UHC

Outline

1

Why care about quality

2

Concept and tools

3

Case of Lao PDR

ADB

THE SIX KEY DIMENSIONS OF QUALITY
(IOM 2001, WHO 2006)

EFFECTIVENESS	Evidence-based health care that results in improved health outcomes for individuals and communities
EFFICIENCY	Health care that maximizes resource use and avoids waste
SAFETY	Health care that minimizes risks and harm to service users
ACCEPTABLE/ PATIENT-CENTERED	Health care that takes into account the preferences and aspirations of individual service users and the cultures of their communities
EQUITY	Health care that does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status
ACCESSIBILITY	Health care that is timely, geographically reasonable and provided in a setting where skills and resources are appropriate to medical need

QUALITY MANAGEMENT THROUGHOUT THE HEALTH SYSTEM

SYSTEM LEVELS FOR QUALITY

Medicines

HEALTH SYSTEM QUALITY

INFORMATION

SUPERVISION/INFORMATION

QUALITY OF A HEALTH CARE INSTITUTION/CENTRE

INFORMATION

SUPERVISION/INFORMATION

QUALITY OF INDIVIDUAL HEALTH CARE

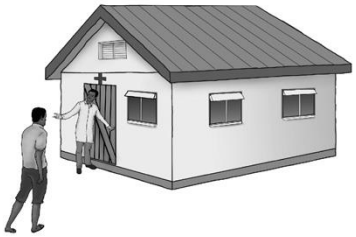
CHARACTERISTICS AND RESPONSIBILITIES

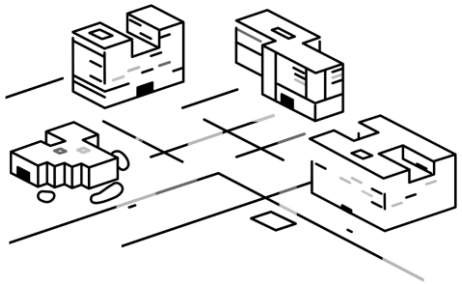
- **Population-based indicators**, including all dimensions of quality and all institutions.
- Focus on **overall system strategies**, setting standards through accreditation and certification.
- Responsibility of **high level managers and political authorities**.

- Indicators on the quali**ty of the specific services for the specific population served by the institution**.
- Focus on **optimizing resources** and regulating processes.
- Indicators on the **quality of the organization**.
- Responsibility of the **managers of the institution**

- Indicators on **satisfaction, technical quality and effectiveness for specific conditions and type of patients**.
- Focus on **clinical quality** on a broad sense.
- Responsibility mostly of **clinical personnel.**

Need to expand solution space for quality improvement interventions





Local (micro)

Facility-level
Behavior change
Local scale

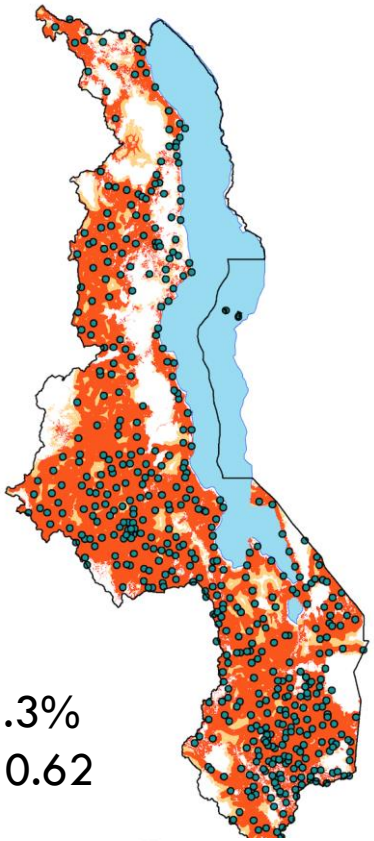
Structural (macro)

System-level
Slower to implement
Large scale

Service delivery network

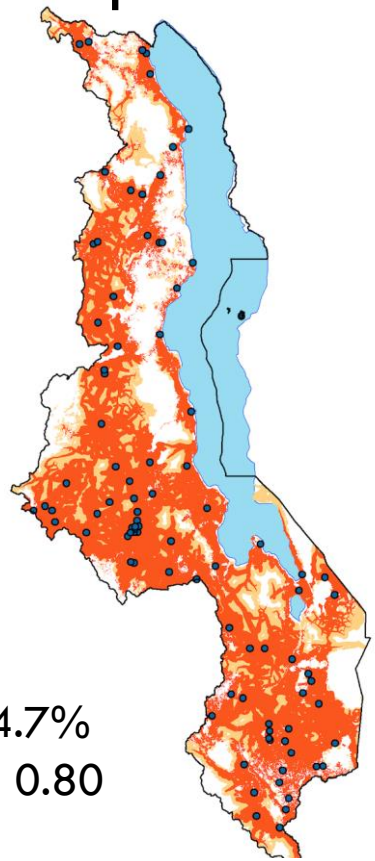
Is regionalization feasible in LICs? The case of Malawi

Delivery facilities



2 hour access = 95.3%
Average quality = 0.62

Hospitals

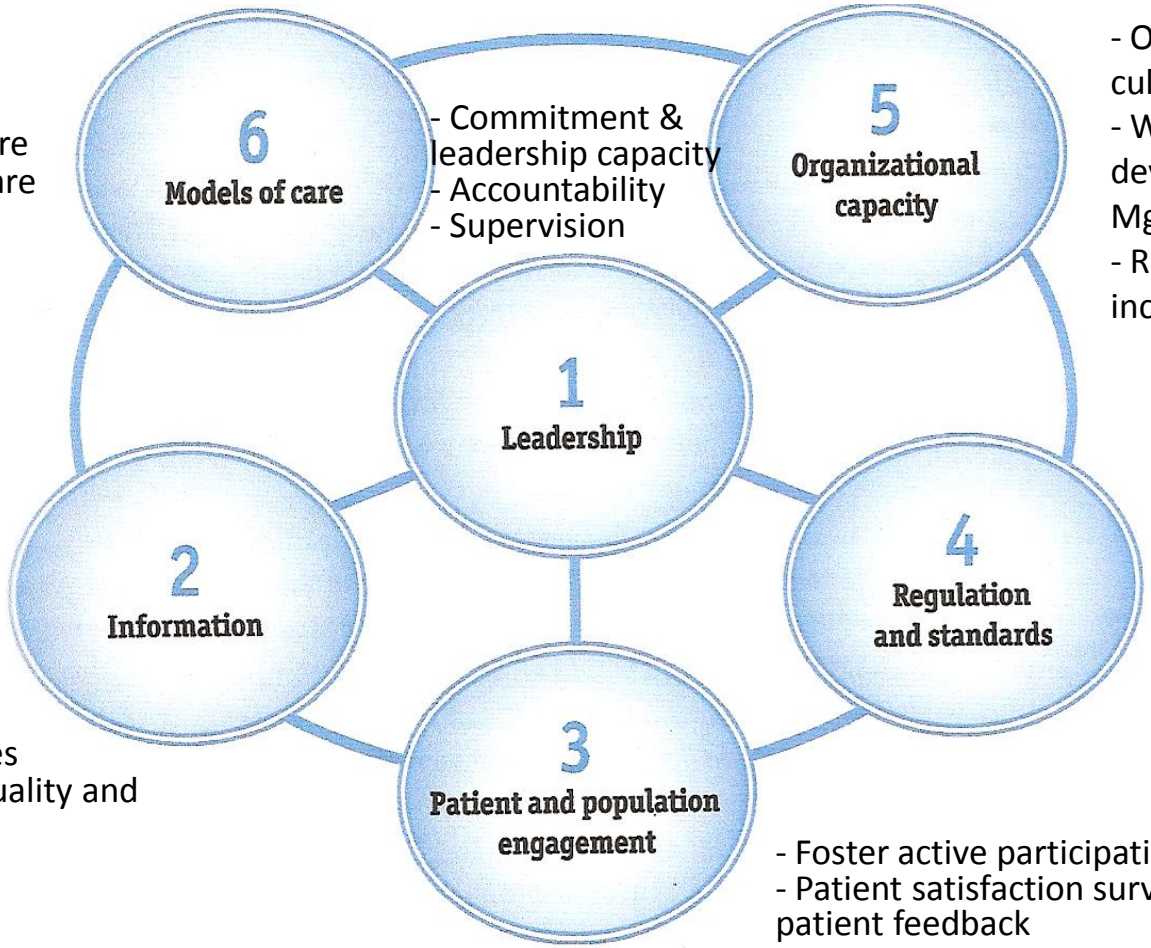


2 hour access = 94.7%
Average quality = 0.80

BUILDING A STRATEGY FOR QUALITY

CHOOSING INTERVENTIONS FOR QUALITY (6 QUALITY DOMAINS)

- Integrated care (e.g. chronic care model)



- Organizational culture
- Workforce and skills development/ HR Mgmt.
- Rewards and incentives

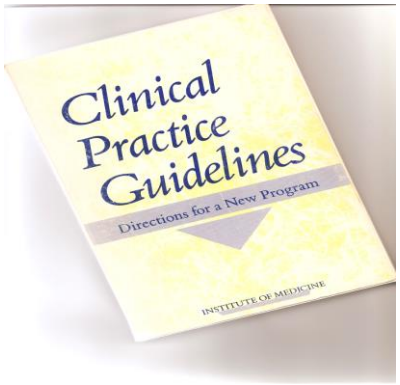
- Measures to comply with
- Inspection, accreditation
- Min. service standards

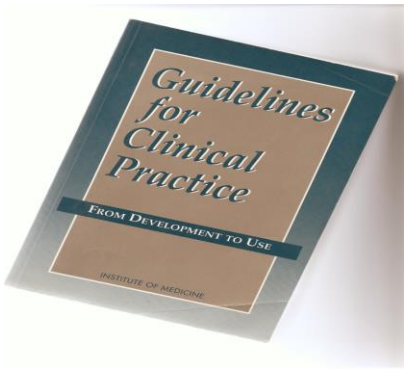
- Monitor changes
- Improve data quality and accessibility
- ICT solutions

- Foster active participation
- Patient satisfaction surveys, patient feedback

TOOLS: Clinical Practice Guidelines

*"Systematically developed statements to **assist practitioner and patient decisions** about appropriate health care for specific clinical circumstances"*





*'Clinical guidelines are **statements that include recommendations intended to optimize patient care** that are informed by a systematic **review of evidence** and an assessment of the benefits and harms of alternative care options' (IOM 2011)*

→ intended to improve quality of care, decrease variations in clinical practice and decrease costly and preventable mistakes and adverse events.

→ provide standards and indicators against which individuals can audit; compare and potentially improve their practices

→ Translates research/evidence into practice.

Institute of Medicine, Clinical Practice Guidelines: Directions for a New Program. Eds. Field M and Lohr K. Washington, DC: National Academy Press, 1990, p. 38

TOOLS: Patient Satisfaction Surveys

- HCAHPS Measures -

Summary Ratings

- Overall rating from 0 to 10
- Likelihood to recommend the hospital

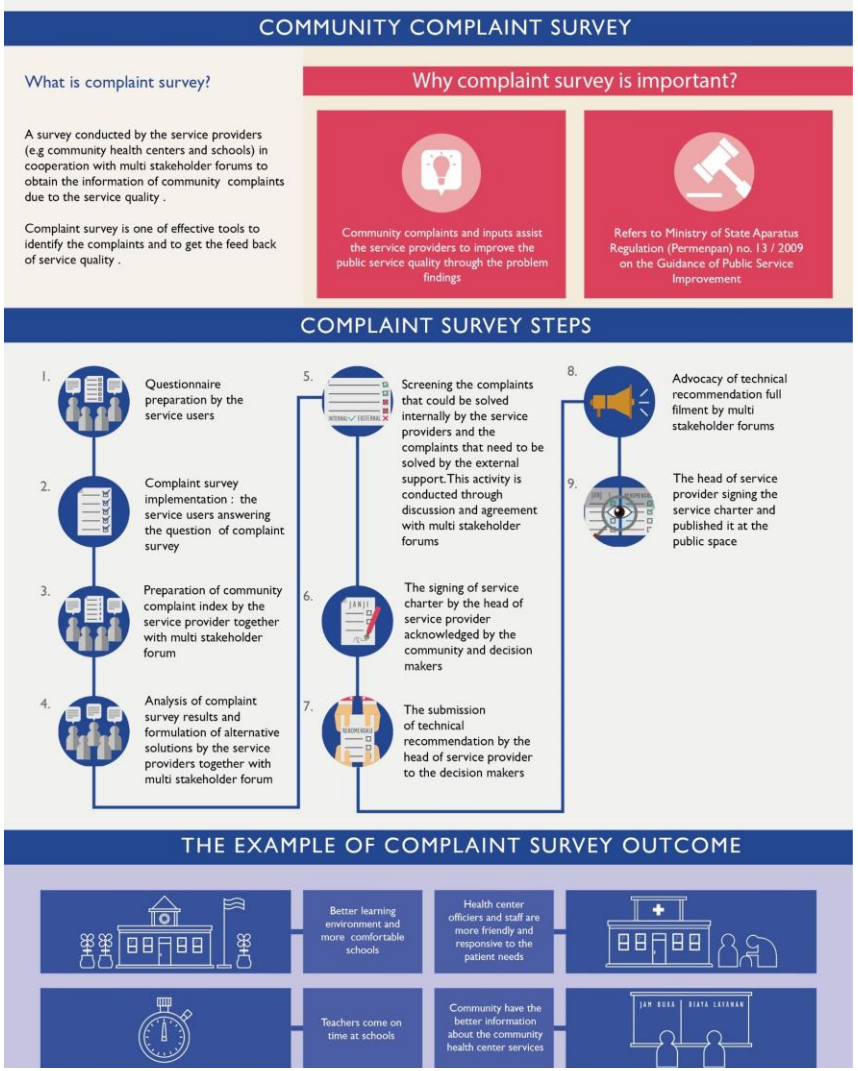
Topic Specific Ratings

- Communication with doctors
- Communication with nurses
- Responsiveness of hospital staff
- Cleanliness of hospital environment
- Quietness of hospital environment
- Pain management
- Communication about medicines
- Discharge information

Quality improvement through governance reforms

Improvements in
- Waiting time
- Facility cleanliness
- Staff attitudes

- Health outcomes?
  Clinical practices?



TOOLS: Performance incentives

Balanced Scorecards

Results-based Financing

Conditional Cash Transfers

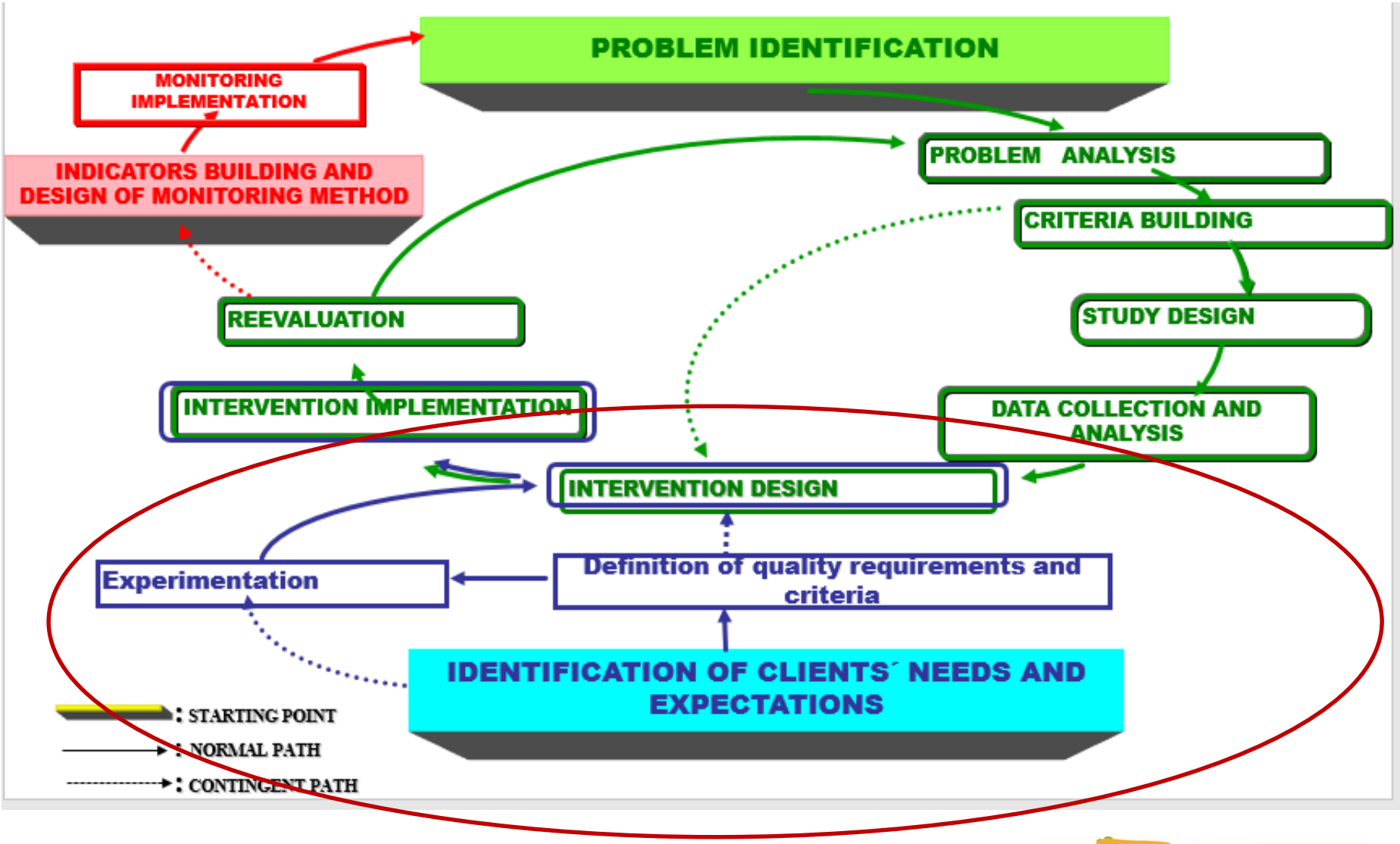
Performance-based Financing

Vouchers

Pay for Performance (P4P)

Value-based Purchasing

QUALITY MONITORING, IMPROVEMENT AND DESIGN



Outline

1

Why care about quality?

2

Concept and tools

3

Case of Lao PDR

ADB

Lao PDR macroeconomic context

- 8th National Socio Economic Development Plan (NSEDP) (2016–2020): graduation from LDC status
- Equitable and inclusive growth requires targeted policy interventions for vulnerable groups
  - Investment to improve access to, and quality of, basic social services such as health care, to improve health outcomes especially for the poor, women and children

2017 indicators	
GDP growth (%)	6.8
GDP per capita ($)	2,579
Poverty rate (%)	20
Fiscal deficit (% of GDP)	6.2
Public debt (% of GDP)	68

Health outcomes

- Good progress on many health targets
- But compared to neighbors, fares poorly and MNCH indicators remain challenging
  - U5 mortality remains the highest in SEA
  - infant mortality rate 48.9/1,000 (target 37)
  - child malnutrition (underweight below 5 years) 27% (target 20%)
- Equity gap
  - Children in the poorest quintile are 3.6 times more likely to die before reaching 5 compared to those in the wealthiest quintile
  - Children born in Phongsaly province are five times more likely to die before reaching 5 than those born in Vientiane City
- Utilization: 0.6 visits per person per year

Indicator	1995	2015/6	SDG target
Life expectancy (yrs)	56	68	-
Maternal mortality (per 100,000)	905	206	226
U5 mortality (per 1000 live births)	162	63.9	70

Could limited utilization be due to poor quality?

Low satisfaction remains unaddressed?

INTERVENTIONS FOR QUALITY

Quality Hospital model (5G-1S etc)

HR
Organizational capacity
Rewards and incentives/NHI as a tool

Minister of Health vs MOF

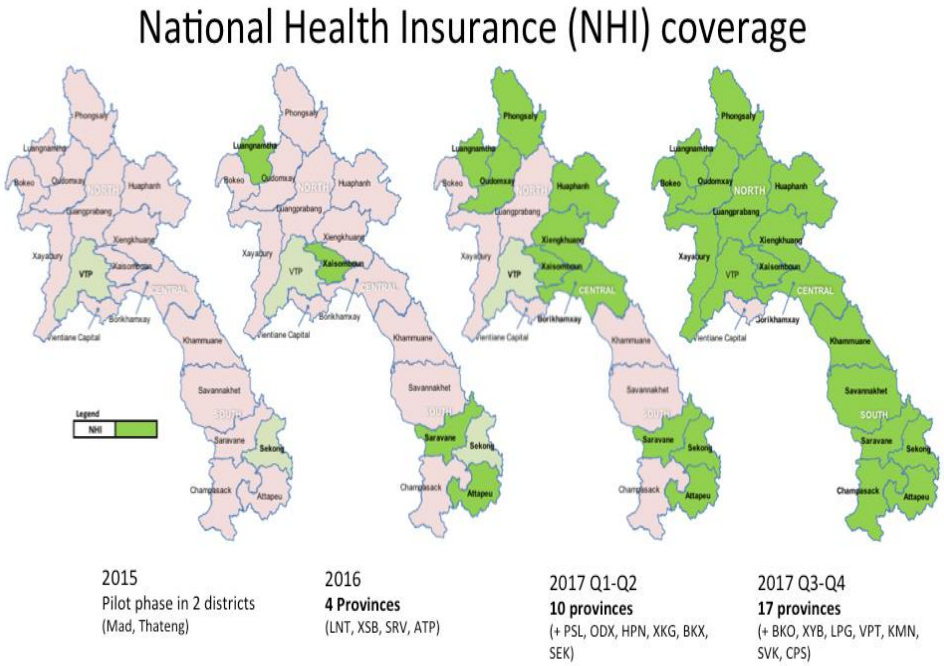
Service standards and guidelines

M&E and data on quality Information systems

Satisfaction surveys

National Health Insurance

- Spending on health
  - Government low, reliance on out of pocket (OOP) expenditure (45.1% of total health expenditure; target 30% by 2025)
  - Health Equity Funds (HEFs) and Free Maternal, Newborn and Child Healthcare (FMNCH) schemes
- Shift towards NHI (2016)
  - Drastically increased population coverage
  - Enlarged risk pool
  - Reduced fragmentation between different schemes
  - HIF and NHIB
  - NHI has empowered people with simplified rules on accessing health benefits and increased predictability of health care financing
  - By June 2019, NHI will cover 80% of the population (5.65 m)



HEALTH SECTOR GROUP

ADB

Human Resources

- 3.09 health workers/1,000 population (WHO recommends 4.5)
- Worse in rural and remote areas
- Skills mix
- Many health workers have < 3 years' professional training and do not benefit from regular in-service training
- Difficulties hiring and retaining good quality staff (34% of health workers moved post within 2 years)
- Inadequate regulations for accreditation, licensing and registration

Quality assessments and policies

- **SARA 2014**
  - *40 district hospitals, 80 HCs*
  - *Geographic disparity (central region does better)*
  - *60% ready to provide basic health services*
  - *Lack of basic amenities, limited diagnostic capacity, absence of essential medicines*
  - *Basic services problematic (water, sanitation, power)*
  - *Connectivity not bad – emergency transport and phone*
- **Private sector regulation**
  - *2014 Regulation of Private Hospitals*
  - *2008 Regulation of Private clinics*
- **Model Healthy Villages**
  - *basic services, esp. CDC and MNCH*
- **10 min requirements**
  - *24/7 service provision, gd communication skills etc, linked with 5G1S*
- **Standard treatment guidelines, essential drugs lists**
  - *need revising (since 2010)*
- **5 goods, 1 satisfaction (5G-1S)…**

5 Goods - 1 Satisfaction (5G-1S)

- **Warm welcome** (acceptability/patient centeredness), **cleanliness** (acceptability and safety), **convenience** (accessibility), **accurate diagnosis** (effectiveness), **quick treatment** (accessibility) and **satisfaction** (patient-centeredness)

Policy at each facility:

1. Make teams – leadership, technical management and implementation to determine procedures, targets
2. Set plan for all 3 teams to work together, job roles
3. Submit proposal to DHC for approval
4. Set date and ceremony for implementing plan
5. Monitor and supervise
6. Evaluation
7. Meeting to endorse quality health facility
8. Certification of Dok Champa hospital

Date	Target central	Target provincial	Target district	Target community /village
2020	80	50	30	20
2025	90	70	50	30
2030	100	90	70	50

- Department of Health Care (DHC) approves plans and certifies as 'service quality hospital'– copper (90%+ performance for first time), silver (90% twice continuously), gold (three times continuous)
- Assessment carried out every two years (facility can be recommended before then too)

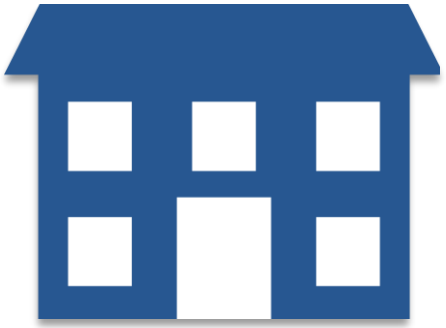
Implementation of 5G-1S

- 5G-1S launched mid-2016 to all hospitals and PHO, but implementation guidelines are still being developed
- Indicators are yet to be set (DHC responsibility)
- Similar project (service quality improvement project) in 4 southern provinces with JICA before 5G1S; some work on first 3Gs have already been done
- Need support on management, training and cap building
- Focus is now on MNCH but need support beyond this
- Satisfaction of providers is also important, not just patients

Model quality facility

Evidence-based clinical guidelines

Patient satisfaction surveys/ complaint mechanisms

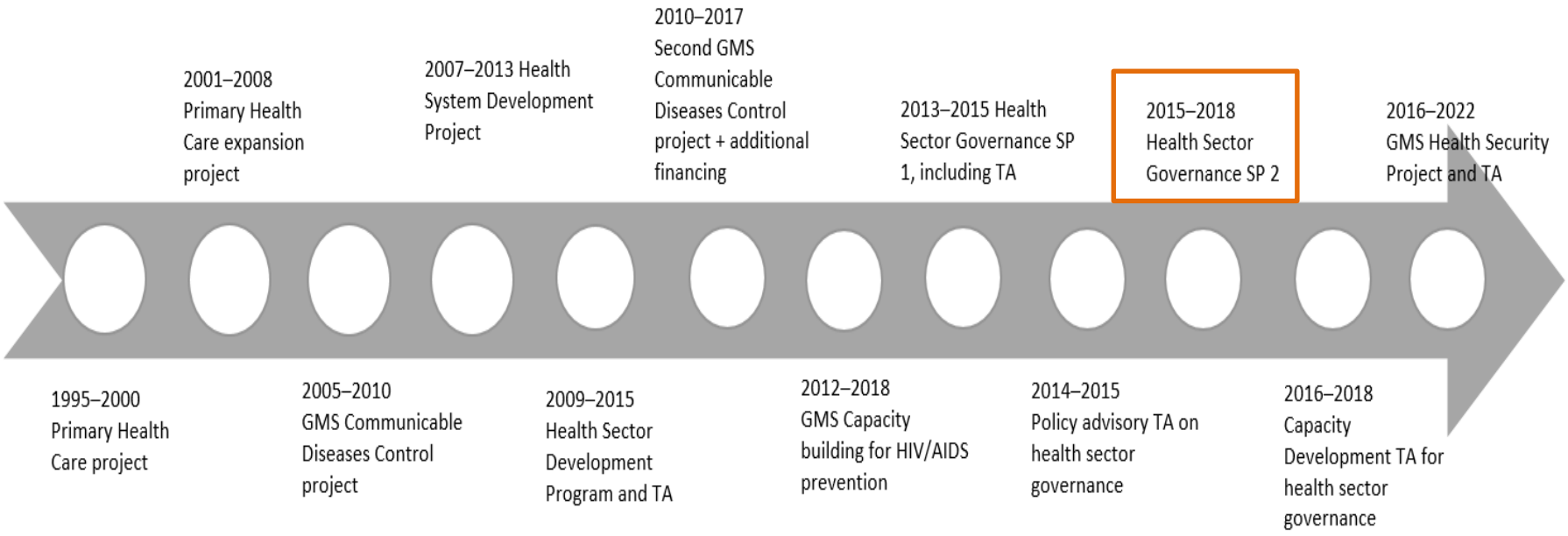


Performance based incentives

Supervision

Accreditation

ADB interventions



Source: Asian Development Bank

After the current subprogram (phase 3 HSRS)

- Sustain free service delivery for the poor, mothers, and children under 5 under NHI and reduce OOP expenditures
- Expand NHI benefits to include more health promotion, prevention and rehabilitative interventions
- Focus on quality
- Performance-based incentives? (P4P/RBL)
- Appropriate number and level of skilled health workers who are motivated, trained and appropriately incentivized
- Increase domestic health expenditures to 13% of general government expenditure by 2025

DP coordination

- JICA – licensing nurses, service quality improvement initiative
- WB – nutrition, health service delivery, M&E
- WHO – health service delivery
- Lux Dev + SRC – HEF/NHI

As a cross-cutting theme, there is space for ADB intervention

Potential project

- Outcome: Quality of health care improved
- Outputs:

1. Health human resource enhanced (organizational capacity)
   I. Continuing medical education
   II. Accreditation, examination, licensing
   III. Mix of staff and skills/rural areas
2. Health financing tools leveraged for quality improvement
   I. Performance or results based payments
   II. Public financial management
3. Health service delivery network improved
   I. Model quality facility expanded (inc. referrals and HI)
   II. Facility distribution and identifying strategic investments for better access (eg district levels strengthened)
   III. Guidelines and policies on quality properly implemented

Going forward

- CPM – March 2018
- COBP – 2 pipelined projects
- Existing TA loan (to March 2019) and CDTA (August 2018)
- NHI evaluation (this year)
- Project concept

Discussion Questions

1. How does quality of care look like in the countries you work in?
2. Any suggestions for project ideas?
3. How can ADB strengthen work on quality of care? What technical expertise will be required?