LACHSR LATIN AMERICA AND CARIBBEAN REGIONAL HEALTH SECTOR REFORM INITIATIVE

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QUALITY-ORIENTED HEALTH SECTOR REFORM TRAINING MODULE: PARTICIPANT MANUAL

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MSH Rational Pharmaceutical Management Plus Management & Leadership Program

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This half-day training course was developed to orient senior policy-makers and program leaders about how to integrate health sector reform (HSR) and quality assurance (QA) strategies in quality-oriented health sector reform. The framework was developed as a collaborative effort of the Quality Assurance Project (QAP) and the Pan American Health Organization (PAHO). The framework document, *Maximizing Quality of Care in Health Sector Reform: The Role of Quality Assurance Strategies*, was published for the United States Agency for International Development by the Quality Assurance Project and is available at www.lachsr.org as LACHSR Report No. 64. The companion document to this Participant Manual—*Quality-Oriented Health Sector Reform Training Module: Instructor Notes*—is also available at www.lachsr.org as LACHSR Report No. 66.

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ACRONYMS

HSR	Health Sector Reform
LAC	Latin America and the Caribbean
MOH	Ministry of Health
PAHO	Pan American Health Organization
QA	Quality Assurance
QAP	Quality Assurance Project
QI	Quality Improvement
WHO	World Health Organization
USAID	United States Agency for International Development

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SESSION 1: OVERVIEW OF HEALTH SECTOR REFORM

OBJECTIVES

At the end of this session, you will be able to:

- Define health sector reform as used in this course
- Identify four components of healthcare within which health sector reforms are commonly grouped
- Describe at least two health sector reform strategies in each component

DEFINING HEALTH SECTOR REFORM

Health sector reform (HSR) can be defined as efforts or activities that seek to improve health sector performance by making fundamental changes in the way healthcare is organized and financed and in the way legal mechanisms regulate care. It can also include attempts to change or develop health sector leadership and culture (Brenzel 2002).

The HSR rubric presented in this course is based on the Pan American Health Organization framework for reform (PAHO 1997) and draws insights from a model that describes five "control knobs" that can be manipulated to affect the performance of the complex machinery of the health system. (Roberts et al. 2001, pp. 37-40).

COMPONENTS OF A HEALTHCARE SYSTEM

For the purpose of this course, health reforms can be said to focus on four components of the health system:

Steering:

- Regulatory actions (rules, law and decrees provided by an authority to standardize, change or channel provider behavior and to protect patients' rights)
- Stewardship efforts that define the roles of actors within the system and
- Leadership efforts that shape the culture of the healthcare system itself.

Financial Mechanisms

- Income-generating mechanisms that provide resources for healthcare, preventive services, early detection, and health promotion.
- Payment mechanisms that provide money to individual and institutional providers of healthcare, preventive services, and health promotion.

COMPONENTS OF A HEALTHCARE SYSTEM, CONTINUED

Healthcare Guarantees

- Specification of a package of health benefits to be provided to all citizens or specified sub-populations.

Delivery

- Determination of how and by whom services are to be provided, both sector wide and within specific service delivery settings.

STRATEGIES FOR HSR

Small Group Exercise

Form groups of 6 - 10 participants. Use 30 minutes to have a discussion about HSR strategies used in your country, or strategies you have heard about.

Use the following page to group the strategies you discuss under the four components of healthcare described above.

The organizers may ask you to post these lists on flip chart paper.

After your discussion, the organizers will lead a debriefing session in which you will list and describe the strategies your group(s) identified.

REFERENCES

Brenzel, L. 2002. USAID background paper: LACHSR Initiative. Washington, DC: U. S. Agency for International Development.

PAHO. 1997. Cooperation of the Pan American Health Organization in the Health Sector Reform Processes. Washington, DC: Pan American Health Organization.

Roberts M, Hsaio W, Berman P, and Reich M. 2001. *Getting Health Reform Right.* Draft. Boston, MA: Harvard University School of Public Health.

Steering	***Financial Mechanisms***
Healthcare Guarantees	***Delivery***

SESSION 2: OVERVIEW OF QUALITY ASSURANCE

OBJECTIVES

At the end of this session you will be able to:

- Define quality in health care as a multi-dimensional concept incorporating the views of providers, health care managers, clients and the community
- Define Quality Assurance
- Identify the three main strategies of Quality Assurance as defining quality, measuring quality and improving quality.
- Give at least two examples of activities for each Quality Assurance strategy.

DEFINITION OF QUALITY

Dimensions of Quality

Quality in health care can be defined in a number of ways. When quality is considered in the context of HSR, it is often associated solely with technical performance - compliance with standards. In fact, quality is a multi-dimensional concept. While various experts in QA may define quality differently, most describe some common dimensions of quality. The Quality Assurance Project has identified these nine dimensions that comprise quality care.

Technical Performance

Compliance with regulations, adherence to standards

Access to Services

Removal of geographic, economic, social, organizational, linguistic, gender, or other barriers to care

Effectiveness of Care

Degree to which desired health results are achieved

Efficiency of Care

Extent to which minimal resources are used to achieve desired results

Interpersonal Relations

Effective listening, establishing trust, respect, responsiveness and confidentiality

DEFINITION OF QUALITY, CONTINUED

Safety

Degree to which risk of injury, infection, or side effects is minimized

Physical Infrastructure / Comfort

Amenities of care such as physical appearance, cleanliness, comfort and privacy

Choice

Choice of provider, treatment or insurance plan as appropriate and feasible, implying informed choice; access to information that allows a client to exercise autonomy

Perspectives of Quality

Quality is defined differently depending on who is defining it. Although the descriptions below give some common views of quality, the only way to know how someone personally identifies quality is to ask.

Client

Clients are people who receive care, whether promotive, preventive, curative, or rehabilitative. Some common “quality” definitions by clients include: available drugs and supplies, access, information about diagnosis and treatment, relief of pain, return of function, comfort, and reasonable cost of services.

Community

The community may define quality as being free of communicable disease, having appropriate treatment easily available, attention to clinical needs that affect the most people, or state of the art care.

Provider

People who deliver care or services are providers. Often, providers define quality as compliance with standards, appropriate resources to provide effective care, timely diagnosis and treatment, safety for staff and clients, and so on.

Healthcare managers

Healthcare managers may focus on the effectiveness and efficiency of care, while also defining quality according to access to care or technical performance.

SMALL GROUP EXERCISE Read the following scenario and answer the questions.

A Nicaraguan woman who was about to give birth called on a traditional birth attendant in her village for assistance. The traditional birth attendant had been trained to recognize that if the placenta was not delivered 30 minutes after the baby was born, there was the danger of hemorrhage. In fact, hemorrhage due to retained placenta is the leading cause of maternal mortality in Nicaragua. When the placenta was not delivered in that time, she sent the brother of the woman to the road to flag down a vehicle to take him to the health center in Bocay. He reported the problem and an ambulance was sent to fetch the woman. When the woman arrived at the health center she was bleeding due to her retained placenta. The health center team admitted her quickly, inserted an IV, and began an Oxytocin drip. Her placenta was removed manually just a few minutes after her arrival at the health center. One half hour later, and only two hours after the baby's birth, the mother was resting comfortably in bed nursing her infant.

In the table below, imagine you are the various people listed. From your point of view, list some examples of good quality from the story. Which dimension(s) of quality are associated with each? Try to find at least one example for each dimension.

Perspective	***Example of Good Quality***	***Dimension(s)***
Client		
Community		
Providers		
Healthcare Managers		

DEFINITION OF QUALITY ASSURANCE

Quality Assurance (QA) can be defined as all actions that may be taken to make health care better at the service delivery entry point a across the continuum of care.

Principles of Quality Assurance

Experiences with QA across the work, developed and developing countries, has led to the identification of four principles which guide QA activities: These principles are consistent with quality management literature, and modern management approaches (Berwick et al. 1992, Langley et al. 1996).

Focusing on clients and communities

Understanding and meeting needs of clients, to the extent possible and practicable, within available resources

Thinking of healthcare services in terms of systems and processes

Looking for solutions to problems and areas for improvement with an assumption that poor systems and processes, not poor people, are the basis for most poor quality. In order to improve health outcomes, health systems and processes must improve.

Using data to measure the effect of changes and to monitor performance

Understanding what current systems and processes are capable of delivering, knowing when to act based on changes in performance, and routine use of data for decision-making.

Using team-oriented participatory approaches to improvement

Getting input from everyone involved in a process or system, in order to understand and improve it. Using teamwork to foster better planning, decision making, and commitment to action.

Quality Assurance Strategies

There are three basic strategies in QA - defining, measuring and improving quality.

Defining Quality

Developing expectations or standards of quality as well as designing systems capable of producing quality care

DEFINITION OF QUALITY ASSURANCE, CONTINUED

Measuring Quality

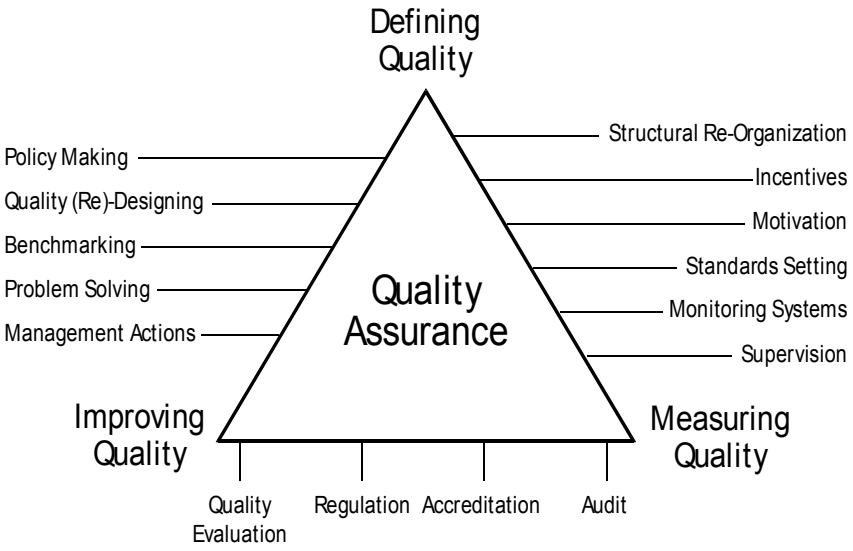
Documenting performance of health workers and health systems too determine if defined quality is being delivered

Improving Quality

Use quality improvement methods and tools to make changes to health care systems and processes to enable workers to improve and sustain quality care

The Quality Assurance Triangle

The three QA strategies can be represented by a triangle, showing that there is a range of possible activities which relate to one or more of the strategies. Central to the QA strategies is the focus on improving quality of care.



QA Project 2000

Institutionalized Quality Assurance

QA institutionalization is an ongoing process in which activities related to defining, measuring and improving quality become formally and philosophically integrated into the structure and functioning of a health care organization or system. QA institutionalization means that people know what needs to happen to provide quality care, they have the skills to make it happen, and they are committed to making it happen over time within the available resources (Franco 2002).

SESSION 3: RELATIONSHIPS BETWEEN HEALTH SECTOR REFORM AND QUALITY ASSURANCE

OBJECTIVES

At the end of this session you will be able to:

- Describe the difference in how traditional HSR and QA address quality
- Describe the difference in the level and scope of interventions between traditional HSR and QA
- Recall from Sessions 1 and 2 at least 4 strategies unique to each of HSR and QA
- Identify at least four strategies which are common between HSR and QA

QUALITY IN HSR AND QA

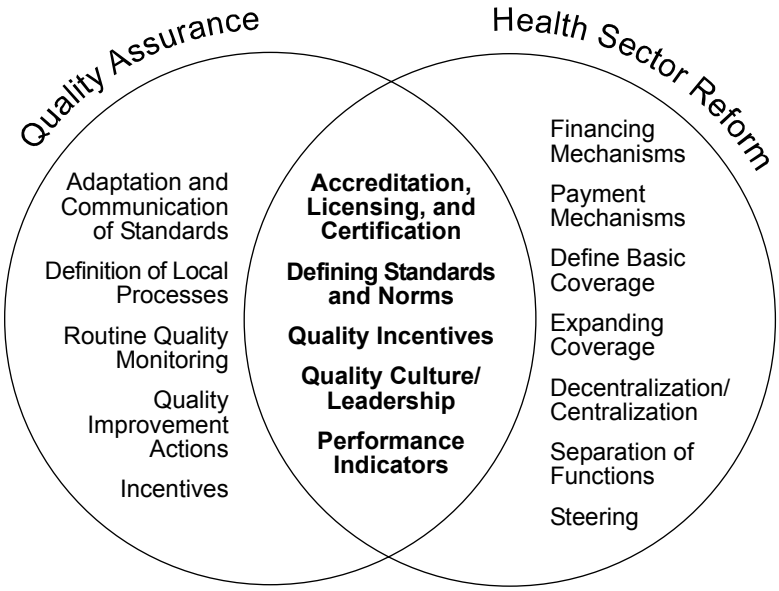
An important difference between HSR and QA is that HSR focuses broadly on a number of important goals including health status, efficiency, equity and access, while QA focuses primarily on quality of care.

While a concern for quality is implicit in HSR, in QA it is explicit and is expressed in terms of measurable indicators. If quality of care is not a focus of health reform, efforts to increase efficiency, sustainability and equity will be for naught.

It is important to measure quality of care while undertaking reforms to demonstrate the causal link between HSR and improvements. When other influences impact on health status, it is important to know whether reforms have reached their goals related to improved quality - if health status declines, yet HSR goals for quality are met, it is possible that the reforms actually kept things from being worse.

SCOPE / LEVEL OF HSR AND QA INTERVENTIONS

- Health Sector Reforms are usually policy level changes that occur at the national level. These policy shifts are intended to impact care by changing the environment in which care is delivered.
- While QA includes some policy level actions, its main interventions occur at the service delivery level. QA promotes operational changes carried out locally, or throughout the system.



AREAS OF OVERLAP BETWEEN HSR AND QA

This diagram illustrates that in spite of differences noted earlier, HSR and QA do have some strategies in common, though the differences in scope and level noted earlier usually exist.

Regulatory Strategies

Accreditation, certification, licensing and development of national norms and standards are carried out under both HSR and QA. Their approaches, however, vary, with HSR focused at the policy level and QA focused at the organizational, health-care process level. HSR regulations tend to be developed at the top levels of government, and implemented “by order” throughout the health system. The QA approach to regulation uses participatory, implementation-oriented methods of development, and depends on buy-in from the health system for implementation.

Efficiency

While both QA and HSR strategies seek efficiency, QA works toward *technical* efficiency at the operational level, that is, the extent to which services are delivered at minimal cost. HSR strategies see *allocative* efficiency at the macro level, determining what constellation of health services maximizes health outcomes and satisfaction to a given population.

AREAS OF OVERLAP BETWEEN HSR AND QA, CONTINUED

Performance Indicators

QA promotes monitoring clinical performance indicators at the level of individual providers or patients, groups of providers or patients, or organizational levels. These indicators are usually a mix of input, process and outcomes measures. HSR performance monitoring tends to focus on system performance. When clinical performance is measured, it is usually in terms of effects and impacts on the health of the population at large.

REFERENCES

Roberts M, Hsaio W, Berman P, and Reich M. 2001. *Getting Health Reform Right.* Draft. Boston, MA: Harvard University School of Public Health.

SESSION 4: CASE STUDY

OBJECTIVES

In this case study, you will:

- Identify the HSR strategies in use.
- Identify QA strategies appropriate to add to promote quality-oriented health sector reform.

***Background**: La Paloma* is a country in South America. It has a population of 5 million and the climate and topography of the country vary, with tropical, cold, and semi-arid regions. Thirty percent of the population identify themselves as belonging to an indigenous group, of these, half speak Spanish as well as their own language. Life expectancy in La Paloma is 65 and the literacy rate is 70%. The county has a primarily agrarian base, but 50% of the population live in urban areas. In spite of economic reform efforts in recent years, seventy percent of the Paloman population have incomes below the poverty line.

Health status summary: Just under 40% of the population of La Paloma is under the age of 14. The infant mortality rate is 56/1000, with a large disparity between the general population and the indigenous minority, who suffer an IMR of 97/1000. Vaccination coverage rates have risen in recent years, but are still well below country targets of 80%. La Paloma has the highest rate of death due to cervical cancer in the region and has suffered rising rates of tuberculosis in the south. The government does not collect data on people living with aids but there were 300 deaths due to aids over the past several years. For the purposes of health service delivery Paloma is divided into 8 districts, each with a small general hospital and associated health centers. Four districts are rural, and 4 are in urban areas. Overall area hospitals are highly utilized, with long waiting lines at the emergency rooms at all hours of the day. While there are true emergencies cases presenting in the ERs, the majority of people who seek care in the hospital ER could be better served in the health centers if those centers were equipped to provide basic care. Another problem that health centers face is the difficulty of serving a large transient population (many are seasonal agricultural workers) in the urban areas.

Healthcare reform: The MOH has traditionally been a highly centralized organization with a mandate to provide promotive, preventive, and curative care for the entire population. Although some physicians see private patients, this is a very small proportion of overall healthcare. There are no fees for service.

Efforts to develop a national health services reform policy have been underway for the past five years. A comprehensive plan was developed by a consortium of local leaders and international experts and awaits final approval by the Minister of Health. The plan would have been adopted as national policy by now, except that a new president was recently elected and the entire top levels of government have changed hands. The international donors and healthcare experts who worked so hard to craft the reform are disappointed and frustrated. The following reforms were among those suggested in their proposal:

1. Given that the 8 regions face different challenges, the reform package proposed decentralizing the system so that regional leaders can customize the organization, delivery, and financing of care within their regions. Some changes are under the direct authority of district leaders, others require approval from the Minister of Health.

2. The reform package proposes a healthy mother and child initiative, where all women are guaranteed prenatal care, support during childbirth, and care in the peri-natal period. Infants are guaranteed well-child care, to include vaccination, growth monitoring, and other basic services prescribed for infants by WHO.
3. In an effort to address barriers to service utilization, a system has been proposed where patients who seek non-emergency care at hospital centers must first be seen at health centers and can only seek further care at hospital centers with a referral from the health centers.
4. Health centers, which have traditionally been financed with a global budget, will now be financed based on the number of patient visits that occur on a quarterly basis. A per capita financing option is also outlined, with the idea that regional leaders can choose this mechanism if they feel it best serves their population.

The new Minister of Health is an obstetrician with a degree in Public Health from a prestigious American University. He wants to make visible improvements in healthcare as quickly as possible and has decided to use the existing health sector reform proposal as a starting point. After reviewing it he feels the proposal has merit, but he is concerned about some of the unintended consequences that it may have on quality. He has called your team in to evaluate the proposal and make recommendations to make the policy more quality-oriented.

INSTRUCTIONS FOR THE CASE STUDY ANALYSIS

Please analyze the case and fill out the matrix below. Discussion should focus on the following questions:

1. Column 1: What health reform strategies were used or could be used?
2. Column 2: How would you classify each strategy (i.e., steering, financial mechanism, healthcare guarantees, or delivery)?
3. Column 3: How does each strategy impact quality of care? List both the ways that the strategy might enhance quality (mark with +) and the ways that the strategy might inhibit quality (mark with -).
4. Column 4: For each HSR strategy in column 1, what QA activities might help to maximize its impact on quality of care? Consider strategies that you learned about today. Use Tables 3.1 through 3.6 in the conceptual framework document, *Maximizing Quality of Care in Health Sector Reform: The Role of Quality Assurance Strategies*, as a resource.

CASE STUDY ANALYSIS

Health Sector Reform Strategy	*Type*	*Opportunities / Threats to Quality of Care*	*Quality Assurance Strategies*

Please be prepared to present your matrix and a brief summary of your discussion in a plenary session.

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