Governing for Better Quality Health Care in Low and Middle Income Countries: Promising Practices

A Technical Brief

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ABSTRACT

This technical brief provides policy makers in low and middle income countries (LMIC) with an innovative way to view and exercise their governance role in the health system to improve the quality of health services. It is a departure from traditional approaches such as command-control and provider training. It recognizes that no external regulatory enforcement system, no matter how well-funded, can ever ensure consistent health service quality for all patients. Good governance can harness the reality that most health professionals want to deliver quality care and are ultimately the only ones who can ensure consistent health service quality for all patients. Health policy leaders in partnership with providers, purchasers, consumers, and communities should build a system that motivates and enables health providers and support staff to deliver quality services and continuously seek quality improvement.

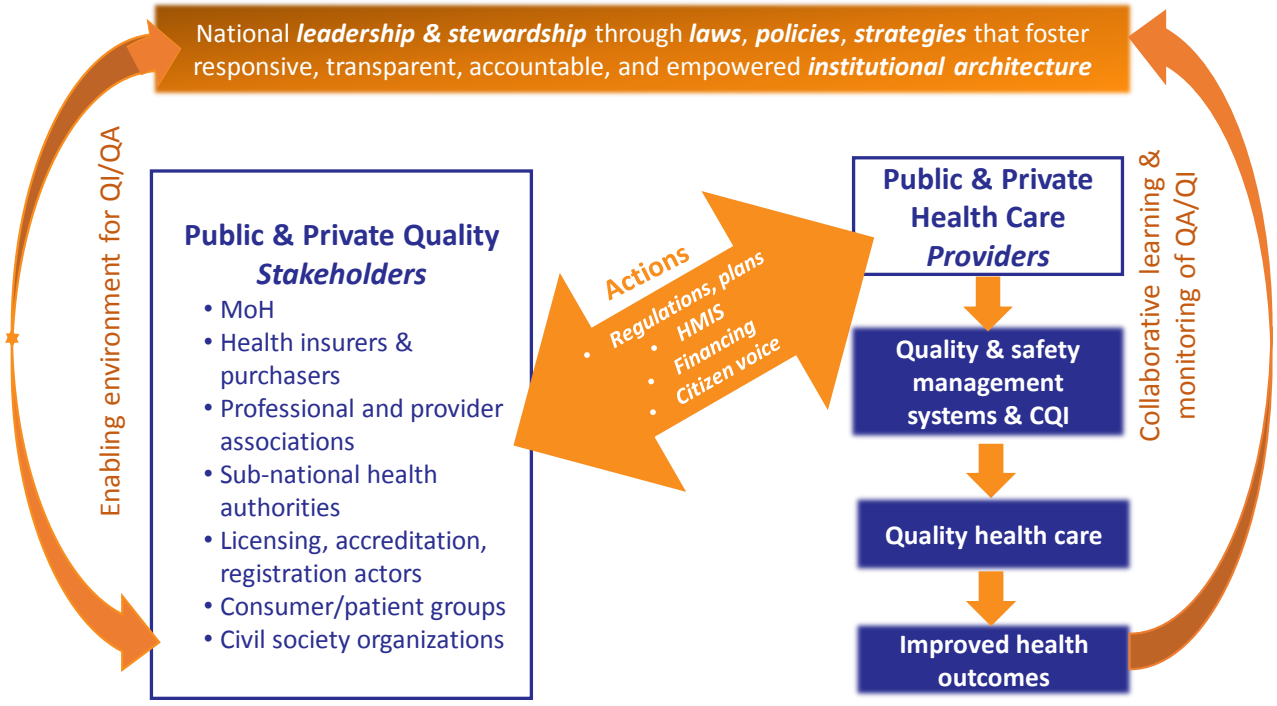
INTRODUCTION

Without quality, patient-centered service delivery, the promise of Universal Health Coverage (UHC) is an empty one. In this brief, the ***governance of quality in health care*** refers to the process of competently directing health system resources, performance, and stakeholder participation toward the goal of delivering health care that is effective, efficient, people-centered, equitable, integrated, and safe (Cico et al., 2018a). Through good governance, health government leaders must harness the commitment of health care professionals to deliver quality care and the opportunity these professionals alone have to ensure consistent health service quality for all patients. To achieve good governance, health policymakers and practitioners need to work collaboratively to build a system that motivates and enables health care professionals to deliver quality services and continuously seek quality improvement (CQI). Governing quality involves more than just nationally led command and control regulation (e.g., inspections, penalties), one-off trainings, annual auditing, and certification. Government actors must use a complex range of professional, market, and political levers dynamically to enhance quality (Leatherman and Sutherland, 2007). The World Health Organization (WHO) and the Health Systems Governance Collaborative's recent efforts to develop a framework for actionable health system governance highlights this by emphasizing the importance of multiple actions by stakeholders working together including developing the appropriate architecture and organization, supportive laws and regulations, information and intelligence processes and use, and strengthening participation and voice across all stakeholders to ultimately improve the health systems performance, including quality and safety (WHO HS Governance Collaborative 2018). Government stakeholders must take time to structure and monitor institutional roles and relationships such that, together, the institutions in the health system have the capacity and enabling environment to support quality health service delivery (Tarantino et. al., 2016).

DEVELOPING THE INSTITUTIONAL ARCHITECTURE FOR GOVERNING QUALITY

With the right governance architecture in place, officials can define priority quality objectives, design incentives for healthcare providers strategically, and motivate providers to pursue QI and report on quality metrics. Building the architecture should involve multiple stakeholders in public and private sectors (e.g. ministries of health and other government actors, accrediting bodies, purchasers of health services, civil society organizations, communities, and provider associations), and should support the development of meta-regulation (i.e. legal frameworks, regulatory bodies, CQI processes, major regulations defining quality assurance and improvement) and appropriately devolve autonomy across actors involved in ensuring quality health care. Stewardship by national government actors should enable collaboration and learning across actors influencing CQI and quality assurance, which should help align objectives and eliminate waste and redundancies. Government actors must instill accountability, and use multiple quality enhancing strategies to encourage pursuit of quality by health providers and demand of quality by civil society and consumers (Cico, et. al., 2018a).

Figure 1. Good governance of quality



Our proposed framework for governing quality is intended to serve as a helpful visual and build from the WHO's actionable framework for health system governance (see above) to support policymakers and practitioners to think through the institutional architecture needed to govern

quality effectively (Figure 1). The framework shows the inherent interrelationships within the institutional architecture and the importance of the cyclical flow of support and information among all actors to ultimately improve health care quality. The framework highlights the importance of responsive regulations, an HMIS system, financing, and citizen voice and participation to allow actors in providing quality health care to adapt to changes in patient needs, available resources, and service delivery requirements.

Researchers of regulatory systems in LMICs are emphasizing the important role that various actors play as stakeholders in establishing laws, policies, plans, and strategies (WHO, 2006), and as cooperating implementers of those national-level initiatives to improve quality (Bloom et al., 2014). Promising country level innovations including closer collaboration with civil society and government and more transparent information systems are demonstrating how cooperation and collaboration are improving health care outcomes (Fryatt et. al. 2017). Thus, a responsive, multi-actor/multi-faceted system for governing quality is more likely to produce the desired outcome of safe, high-quality health care delivered consistently, compared to one that avoids consultative processes and relies on fewer actors to make decisions.

The MOH should develop guideline documents, such as clinical guidelines and checklists, to help providers improve quality of care. Guidelines and other facilitators of voluntary provider behavior should be supplemented by oversight: government or non-governmental monitoring of the process through which providers implement CQI, rather than direct monitoring of specific quality-related indicators. Regulatory agencies can still employ "command-and-control" interventions when needed to provide rewards (e.g., accreditation) and punishments (e.g., fines or suspended contracts) (Braithwaite et al., 2005). Purchasers also have various mechanisms at their disposal to improve quality and strengthen quality assurance, including selective contracting, provider payment mechanisms, public disclosure of information related to provider quality, incentives for consumers to seek care from higher-quality providers. (Cico et al., 2018a). Finally, consumers, communities and civil society organizations can play an important role in holding providers accountable to improve and ensure quality, and governments should create the legal frameworks to uphold patient safety and rights. Evidence also suggests that interventions to promote providers' accountability to communities can have significant effects on health outcomes (Bjorkman and Svensson, 2009, Hatt et al., 2015).

WHAT ARE THE FUNCTIONS OF GOVERNANCE FOR QUALITY HEALTH CARE?

The table below summarizes the primary control knobs or functions of governing quality that actors in the institutional architecture will employ, using a variety of actions and levers to ensure and improve quality services. These are also highlighted in the framework above.

Table 1. Critical functions of governing quality health care

Health governance functions	Definitions and relationship to quality
Leadership and stewardship	Refers to the existence of an enabling environment and commitment at different levels of the government to improve quality and safety and work with all actors to ensure collaboration, efficiency and cooperation. National, health system-level laws and policies governing health care quality. Ideally, a package of complementary regulatory measures is defined that maximizes self-regulation (e.g., standards and rules set by professional associations), meta-regulation and fosters a culture of continuous improvement and accountability.
Laws and policies	Public sector instruments to direct and codify how quality will be governed, including establishing the regulatory bodies and/or authorities, and legal frameworks that guide development of meta regulatory environment and regulations.
Plans and strategies	They may take the form of governmental plans or strategies that include quality in health care as a specific goal or objective, and encourage citizen awareness of what quality health services look like. At the health facility level, plans and strategies may focus on improving quality of specific service packages, and on establishing processes and systems for CQI.
Regulation	Refers to a wide variety of levers/methods/tools to affect providers and health markets to improve safety and quality, such as standards, guidelines, protocols, licensing, accreditation, adverse event registers. Often involves non-state actors as key partners in ensuring effective regulation, encouraging CQI.
Financing	Refers to the existence of a variety of market-orientated approaches that purchasers can use to incentivize and affect the provision of quality health care. These may include selective contracting, provider payments based on quality, the inclusion of quality considerations in benefit package design, public disclosure (e.g., Nursing Home Compare website), and consumer and provider education.
Monitoring	Almost all regulations and CQI processes call for some form of monitoring of provider performance, and therefore data capture and use, to regulate and improve quality. Electronic claims processing and/or electronic medical records are necessary for some regulatory strategies. One form of monitoring is by benchmarking, which is a standard of reference for measuring quality or performance. There is a trend for more open-data in recognition that data on medical errors, clinical guideline compliance, and other quality metrics are a public good that helps all providers to continuously learn and change behaviors. Consumer groups, communities and civil society organizations play an important role in monitoring health service quality.

Adapted from Cico et. al., 2016

PROMISING PRACTICES FOR GOVERNING QUALITY HEALTH CARE IN LMICS

We have distilled numerous promising practices country actors are employing using the functions described above. These practices come from an in-depth literature review across 25 countries (Cico et al., 2016) on institutional roles and relationships for quality; a qualitative research study on

exploring the institutional arrangements for linking health financing to the quality of care in Indonesia, the Philippines and Thailand (Cico et al., 2018b); and in-person engagement with officials from over 13 countries, the Joint Learning Network for Universal Health Coverage (JLN), the World Health Organization (WHO), and the USAID ASSIST project conducted 2016-2018. We present a synopsis of these findings below to support country policymakers in LMICs in identifying the appropriate mix of interventions or institutional arrangements to try as they strengthen governance of quality health care.

Leadership and stewardship

The existence of dedicated institutional structures and financial and human resources to support quality initiatives could improve health outcomes. According to Governing Quality in Health Care on the Path to Universal Health Coverage: A Review of the Literature and 25 Country Experiences (Cico et. al., 2016) four of the five countries that had the highest percent change in Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) between 2000 and 2013, had dedicated quality units created within ministries of health (Cambodia, Zambia Moldova, and Tanzania). Furthermore, in Cambodia and Zambia (the two countries with the highest percent change in MMR and IMR between 2000 and 2013) quality initiatives relied on donor support, indicating the potential importance of dedicated resources for quality. In the Philippines, HFG found that the lack of a coherent strategy for quality, exemplified by the absence of an office or bureau responsible for the quality of care, has in fact hindered the ability of the Department of Health to drive the quality agenda in the country (Cico et al., 2018b).

Country voices: Leadership & stewardship

At a 2016 workshop, JLN member country policymakers from Ghana, the Philippines, and Ethiopia attested to the effectiveness of *involving multiple stakeholders* to implement policies for assuring and improving health service quality. Policymakers in both Mexico and Tanzania cited the importance of *presidential leadership* in improving the quality of health services in both countries. Due largely to strong leadership, the President of Tanzania was able to include maternal mortality as a permanent agenda point in Cabinet meetings, expecting ministries (including the MOH) to report on indicators and targets. These formal processes have contributed to decreases in maternal mortality. (Tarantino et. al., 2016)

Laws and policies

Quality initiatives seem to be more effective when supported by laws and policies. We did not find evidence of laws incorporating specific aspects of quality (facility regulation, explicit patient rights or safety laws, or mandates around CQI and quality measurement) in any of the five countries with the highest MMR in 2015 in absolute terms (Kenya, Liberia, Malawi, Mozambique, and Tanzania). This

Country voices: Laws & policies

In Mexico, national health quality priorities align with the national health policy. Government actors use systematic analysis of health care data to inform policymakers and technocrats in further refinement of policies, strategies, and plans (Tarantino et. al., 2016).

correlation may be indicative of the importance in defining a legal basis for quality and patient safety. (Cico, et. al., 2016)

During our engagement with country health quality policymakers, we identified several promising practices through which laws and policies are being used to improve quality.

Malaysia has many Acts that regulate the quality of care, e.g. Private Hospital Act, 1971, Medical Act of1971, Nurses Act Revised in 1969 and Private Health Care Facilities and Services Act of 1998. The last act mentioned requires all facilities to provide incident reporting, including deaths that occur in the private health care facilities, and establish a patient board in the private hospitals to monitor service quality at health care facilities. In Malaysia, quality has also been an important feature underpinning health policies, with multiple health policies in place with explicit quality provisions, e.g. National Policy of Blood Transfusion 2008, National Medicine Policy 2008, and Malaysian Patient Safety Goals 2013.

Plans and strategies

Our in-depth literature review found that in the five countries that had the highest percent change in MMR and IMR between 2000 and 2013 (Cambodia, Zambia, Moldova, Tanzania, and Mozambique), quality is incorporated in health sector plans or strategies. This indicates the potential significance of explicitly making quality a priority in health planning. WHO has recently emphasized the need to align the development of national quality policies and strategies with broader health sector planning and health reform (WHO, 2018).

Country voices: Plans & strategies

In 2016, the Government of Ghana developed the *National Healthcare Quality Strategy, 2017-2021,* and established the National Quality Technical Committee as responsible for implementation, monitoring and oversight of the strategy. The strategy has likely resulted in strengthening institutional capacities for quality improvement and assurance, and institutionalized multi-stakeholder engagement. (Cico et. al., 2018a)

Regulation

In our literature review, we found most countries have registration, licensing, or certification systems for individual providers. In 10 of the 25 countries, these systems are mandatory for at least some categories of providers. Variation exists among countries in terms of renewals, periods of validity, and the categories of health providers regulated through these mechanisms. In most countries, professional councils, boards, or associations are primarily responsible for the regulation of individual providers. We found no

Country voices: Regulation

In Thailand, the Healthcare Accreditation Institute (HAI), an independent organization, is seen as the champion for quality health care in the country. A key feature of its success is the emphasis on continuous learning and improvement, rather than auditing. (Cico et al, 2018b)

evidence of renewal of registration, licensing, or certification of individual providers in all 10 countries that had the lowest percent change in MMR and IMR between 2000 and 2013, indicating the potential importance of periodic renewals and continuing professional development (CPD).

We found that accreditation is the most common form of health facility regulation and a key driver of quality health care; it was documented in 19 countries. As with individual providers, variation exists in whether accreditation is mandatory or voluntary, as well as in the institution responsible for the accreditation process (Cico et. al., 2016). Our research demonstrated that establishing an independent accreditation body, free of potential conflicts of interest, is perceived as the gold standard (Cico et al, 2018b).

During our engagement with country quality actors, we identified promising practices through which regulatory approaches are being used to improve quality. In Malaysia and Ghana, country policymakers cited improvement in certifying health workers, including CPD mechanisms to encourage health service quality. In Malaysia, each provider must apply for annual practicing certification. They obtain CPD points linked to ensuring their competencies each year. Facilities in both the private and public sector are required to show that they are making improvements over time. If facilities fail to show progress, they may have their license to practice revoked or suspended until they comply with the rules and regulations. An enforcement team with representation from both public and private sector helps monitor the licensing process.

Financing

When making decisions about the institutional architecture for quality, it is important to clarify the role of the purchaser. A purchaser can have a significant role in driving quality by actively using health financing levers. (Cico et al., 2018a) In order to successfully engage purchasers in quality, tensions that may arise between purchasers and institutions (e.g., ministries of health) need to be addressed by strategically communicating and educating stakeholders on the benefits of linking health financing to quality (Cico et al., 2018b).

Country voices: Financing

In Indonesia, the purchaser requires accreditation as part of its credentialing process for hospitals to join the National Health Insurance Scheme (Jaminan Kesehatan Nasional). As a result, the Indonesia Hospital Accreditation Body (KARS) now receives a sustainable revenue stream from hospitals to continue to support them to reach higher levels of accreditation and provision of good quality health care. (Cico et al., 2018a)

Linking provider payments to quality by granting health insurance agencies a regulatory role seems to be a promising approach. Particularly as country governments pursue UHC, they are increasingly linking quality to provider payments. Our analysis suggests a plausible association between linking financing with quality on the one hand and positive health outcomes on the other. In the three countries that had the lowest MMR in 2015, health insurance agencies assess quality, grant accreditation, or set quality standards. This contrasts with the five countries that had the highest MMR in 2015, where we did not find any evidence of such a role for health insurance agencies or

purchasers. We also did not find evidence of a role for health insurance agencies in health care quality in the 10 countries that performed most poorly on governance indicators including corruption perceptions, government effectiveness, and regulatory quality (Cico et. al, 2016).

Other global literature also explores the mechanisms that are available to insurers or purchasers of health services to control or improve quality of care. Mate et al. (2013) present the following examples through which insurers or purchasers can directly control quality: selective contracting; linking provider payment mechanisms to quality; benefits package design; and investments in infrastructure, patients, and providers. Zeng et al. (2016) argue that pay-for-performance, alternatively referred to as performance-based financing (PBF) or results-based financing, can be a powerful tool to address quality improvement; however, such programs require the development of robust quality indicators. In LMICs, these indicators are most often found in the form of structural or output indicators (for example, number of health workers to patient ratios or percent of people receiving preventative care), while indicators related to the outcomes of care (e.g. percent of people with diabetes who have blood sugar levels under control) are seldom used. Efforts to compile quality indicators used in pay-for-performance programs across countries have been made recently (see below). A 2018 guide provides a compendium of lessons and a framework for structuring institutional roles and relationships to link health financing to the quality of care (Cico et. al., 2018).

Monitoring

Other key predictors of success appear to be having monitoring systems or indicators for quality, as well as specific quality monitoring mechanisms, including monitoring by independent parties. Our literature review found that quality indicators or monitoring systems have been established in four of the five countries that had the highest percent change in MMR and IMR between 2000 and 2013 (Zambia, Moldova, Tanzania, and Mozambique). Our analysis also suggests the importance of mechanisms for monitoring regulatory compliance and quality, specifically mechanisms that enforce accountability for quality of care. In the five countries with the highest MMR in 2015, in absolute terms, we found no evidence of patient complaint mechanisms, community feedback mechanisms, or systems for reporting and investigating malpractice and/or adverse events. Finally, data indicate the potential importance of giving external or independent parties a role in quality monitoring. In the 10 countries with the

Country voices: Monitoring

In Mexico, the MOH created "citizen aval" to foster citizen participation, engagement and voice in ensuring quality health service delivery. Clients share their perceptions of services provided by health facilities. Based on feedback from *citizen aval*, facilities develop commitment letters to restore public confidence by providing suggestions for improving services. The letters allow the MOH to drive quality improvement, by analyzing and selecting which recommendations to adopt. The MOH documents whether health facilities make the agreed upon changes. Every four months, surveys on satisfaction and waiting times are conducted. The MOH also developed INDICAS, a tool for recording and monitoring quality indicators. INDICAS allows comparison across health care units nationally (Tarantino et. al., 2016).

highest maternal mortality, quality monitoring does not seem to be conducted by institutions other than the MOH, government QA units or programs, or health care providers (Cico et. al, 2016).

During our engagement with country quality actors, we identified several promising practices through which monitoring strategies are being used to improve quality. In India, the MOH is expanding the IT infrastructure to develop an eHealth platform. Around 40 percent of frontline health workers currently have tablets (with the goal for 100 percent). They are responsible for uploading real-time client data. In this way, India is increasingly targeting human resource deployment and monitoring for CQI in facilities that have higher morbidity or disease burdens than other facilities (Tarantino et. al., 2016).

Previous studies suggest that communities can play an important role in monitoring quality, and patient feedback can be an important driver of quality improvement in facilities. A randomized field experiment of community-based monitoring of primary health care providers conducted in Uganda found that the approach "increased the quality and quantity of primary health care provision." Quality indicators, such as waiting times, improved significantly in the sites where the community-based monitoring was being conducted, relative to control sites. (Bjorkman and Svensson, 2009).

Measuring quality remains a complex challenge to tackle and robust data on quality of health care in LMICs are scarce (the HFG and ASSIST projects, 2018). Kruk et al. (2016) attempted to compile existing data on quality by developing indicators that address each of the six dimensions of quality mentioned in our definition: effective, efficient, accessible or timely, acceptable/patient-centered, equitable, and safe. They conclude that to effectively measure quality, countries and global partners should develop quality "tools and metrics that are robust, comparable, and financially efficient." They point to the World Bank's Service Delivery Indicator Surveys as a promising effort. (Service Delivery Indicators, the World Bank, 2013). The Quality Checklist Database, a multi-country list of quality indicators used in performance-based financing programs, has also been recently compiled by the USAID Translating Research into Action (TRAction) Project (TRAction, 2016).

LMIC GOVERNMENTS CALL FOR PRIORITY INVESTMENTS IN GOVERNING QUALITY CARE

In a 2018 Consensus Statement "Strengthening Governance to Improve the Quality of Health Service," governments from an international community of practice (COP) in governance of quality care called on governments, the private sector, global organizations, and development partners to invest in strengthening the transparency, accountability, and responsiveness of health care delivery to assure and improve quality. Figure 2 below is a high-level summary of the COP's areas for increased and sustained investment to impact governance of quality care.

Figure 2. A call to action: priority areas for investment

KEY CONSIDERATIONS FOR POLICY MAKERS AND PRACTIONERS

In addition to traditional human resource and community focused inputs for CQI, governance at all levels can impact quality of health service delivery. Governance of quality requires a meta-regulatory structure, building a collaborative and coordinated institutional architecture that uses multiple functions to enable all actors to be responsive, transparent, accountable, and empowered to assure and improve the quality of health care. Based on the research and evidence presented in this paper, we conclude with the following key considerations for policymakers and practitioners to effectively govern health service quality:

1. Leadership and stewardship can pave the way to improving quality of health care by: garnering political will to pursue quality, establishing the institutional architecture including laws, actors, and structures, ensuring dedicated resources are available, and promoting a culture of quality in all levels of the health system.

2. Defining a legal basis for quality and patient safety can lead to a more effective implementation of quality initiatives.

3. It is important make quality an explicit priority in health planning, whether through a stand-alone plan or as part of a broader health sector development plan. Quality plans must be intimately connected and linked to existing health sector development plans and strategies and aligned with national policies.

4. Ministries of Health and government actors alone cannot achieve improved quality of health care. It is important to develop mechanisms that foster multi-stakeholder involvement in governing and pursuing CQI in health care. Purchasers, professional associations, independent accreditation bodies, patients, and other stakeholders can and should contribute to establishing the institutional architecture for quality health care. Communities and consumer groups can play important and effective roles in helping to define quality priorities and monitoring and holding providers accountable for the delivery of quality services.

5. Command and control mechanisms and self-regulation encompass only a few of the tools available in the governing quality health care tool box. Governments can more effectively use regulatory mechanisms by adapting a responsive regulatory approach, successively moving from soft to hard mechanisms (i.e. facility CQI planning and implementation, warnings, performance improvement plans, fines and suspension).

6. Creating financial incentives for the delivery of quality health care has the potential to contribute to an environment of quality improvement, and certainly supports quality assurance. Purchasers can influence quality service delivery not only through the design of payment mechanisms linked to quality, but also by accounting for quality in the design of benefit packages and in the selection of participating providers (i.e. contracting and empanelment).

7. The ability to monitor and measure quality lies at the heart of the success of any regulatory mechanism. Robust quality monitoring systems should include structural, process, and outcome indicators. The involvement of multiple stakeholders in quality monitoring is critical to ensuring quality health care is delivered.

8. The governance of quality is complex and context-specific and no one-size-fits-all approach exists. Policymakers should consider using implementation research to test the various promising governance practices presented in this paper and in other literature in order to determine their ultimate effectiveness in improving quality of health services in specific countries

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