INSTITUTIONAL ROLES AND RELATIONSHIPS GOVERNING THE QUALITY OF HEALTH CARE

Country Experiences, Challenges, and Lessons Learned

AUGUST 2016

This publication was produced for review by the United States Agency for International Development (USAID) and authored by Lisa Tarantino, Kelley Laird, Amanda Ottosson, Ruben Frescas, Kedar Mate, Vivian Addo-Cobbiah, Cynthia Bannerman, Paulina Pacheco, Daniel Burssa, Andrew Likaka, Mirwais Rahimzai, M. Rashad Massoud, and Shams Syed. The work described was carried out by the USAID Health Finance and Governance and USAID Applying Science to Strengthen and Improve Systems projects and made possible by the generous support of the American people through USAID.

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HFG Cooperative Agreement No: AID-OAA-A-12-00080

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USAID ASSIST Cooperative Agreement No: AID-OAA-A-12-00101

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Recommended Citation

Tarantino L, Laird K, Ottosson A, Frescas R, Mate K, Addo-Cobbiah V, Bannerman C, Pacheco P, Burssa D, Likaka A, Rahimzai M, Massoud MR, Syed S. 2016. Institutional Roles and Relationships Governing the Quality of Health Care: Country Experiences, Challenges, and Lessons Learned. Bethesda, MD: Health Finance & Governance Project, Abt Associates and USAID Applying Science to Strengthen and Improve Systems Project, URC.

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ACRONYMS

APC	Annual practicing certification
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
BPJS	Badan Penyelenggara Jaminan Sosial (Indonesia)
CHRE	Council for Healthcare Regulatory Excellence
DHMT	District Health Management Team
DOH	Department of Health
EPCMD	Ending Preventable Child and Maternal Deaths
FBO	Faith-based organization
FMOH	Federal Ministry of Health of Ethiopia
HFG	USAID Health Finance and Governance Project
HSSF	Health Sector Services Fund
IHI	Institute for Healthcare Improvement
IMR	Infant mortality rate
IPCHS	Integrated People-Centered Health Services
JLN	Joint Learning Network
LMIC	Low- and middle-income countries
MMR	Maternal mortality rates
MOH	Ministry of Health
NGO	Non-governmental organization
PBF	Performance-based financing
PhilHealth	Philippine Health Insurance Corporation
OECD	Organization for Economic Co-operation and Development
UHC	Universal health coverage
URC	University Research Co., LLC
USAID	United States Agency for International Development
WHO	World Health Organization

ACKNOWLEDGEMENTS

The United States Agency for International Development (USAID) Applying Science to Strengthen and Improve Systems (ASSIST) and Health Finance and Governance (HFG) projects are grateful to Dr. Jim Heiby and Ms. Jodi Charles for their active participation, advice, and analytical reviews throughout this exploration. Kelley Laird, Amanda Ottosson, Sinit Metsun, Surabhi Batt, and Amanda Folsom organized country representative engagement and the meeting itself. The authors thank all those who participated in the Product Development Roundtable Meeting in Tanzania in March 2016 for their active participation, frank and thoughtful contributions, and continuing engagement in this work.

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EXECUTIVE SUMMARY

Improving the quality of patient-centered health services is paramount to delivering on the promise of universal health coverage (UHC). Many countries seek to expand access to affordable care; but ensuring quality of care during and after significant UHC reforms is recognized as a key challenge (JLN 2013). In a survey of over 100 government officials from nine Joint Learning Network (JLN) member countries, the need to improve the quality of health care emerged as a priority—in particular, creating the institutional architecture (roles, responsibilities, and relationships) needed for the governance of quality.[1]

This report documents recent efforts by the United States Agency for International Development (USAID) and the JLN, with the active participation from the World Health Organization (WHO) and a dozen countries from Asia, Africa, Europe, and Latin America, to tally key challenges and successes. USAID's Health Finance and Governance (HFG) and Applying Science to Strengthen and Improve Systems (ASSIST) projects have worked closely with JLN member countries to explore this inquiry into the challenges and successful experiences of governing quality at the national and subnational levels. HFG and ASSIST conducted a literature review of 25 country experiences and qualitative interviews with stakeholders from 18 countries, then worked with the JLN to offer countries with a high interest in improving governance to ensure quality care the opportunity to meet and share learnings in Dar es Salaam, Tanzania, in March 2016. This report is the result of that meeting between representatives of 12 countries and development partners (see **Annexes A** and **B** for the meeting agenda and list of participants).

What is quality care and how can we define it in the context of UHC? The WHO includes the following six dimensions when defining quality health care: effective; efficient; accessible; acceptable/patient- or person-centered; equitable; and safe (WHO 2006). At the March 2016 Tanzania meeting, country participants expanded on these concepts and articulated their vision of quality to be timely, centered on patient needs and expectations, and an integral part of the UHC agenda.

> "If quality is not considered during implementation of UHC, what is the point of the service being provided?"
>
> – Cynthia Bannerman, Deputy Director, Quality Assurance, Ghana Health Service

Leadership and governance in the health system "involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design, and accountability" (WHO 2007). Good governance has been found to be linked to positive health outcomes (Hatt et al. 2015a).

At the Tanzania meeting, participants identified eight themes, or "stones," connoting a foundational structure on which to build strong governance and that must be addressed when considering strengthening governance to ensure quality of care:

1. **Governing quality with strategies, policies, and other mechanisms:** Some countries have stand-alone strategies for quality, while others embed quality in a broader health-sector strategy; some ministries of health have established quality improvement units. Policies are common tools used by governments in the quest to better govern for improved quality.

1 The Joint Learning Network, an innovative country-driven network of practitioners and policy makers around the globe, is committed to expanding UHC to progressively improve health outcomes in low and middle income countries. For more information, see: www.jointlearningnetwork.org

2. Data for quality improvement: Most governments are challenged to measure quality, determine which data to use, get the data that is needed to the appropriate users; and integrate the use of data into decision making, accountability mechanisms, and policy decisions. In the context of UHC, insurance institutions often have some data, while ministries of health have other. The collection and use of data to improve quality continues to be a challenge complicated by multiple data streams.
3. Developing a quality improvement culture: Ensuring mechanisms for quality is not enough. In order to continuously improve care, an improvement mentality needs to extend throughout all levels of the system, ideally led from the national level.
4. Using regulatory techniques to improve quality of care: The evidence base is mixed on regulation's ability to improve quality of care over time. And yet, most governments view regulation as one of their most accessible and direct levers to influence quality of health service delivery.
5. Linking finance to quality: Health financing, budgeting, purchasing arrangements, cost of care, and linking care to incentives were cited in the interviews with country stakeholders as significant challenges facing countries in pursuing the governance of quality.
6. Addressing the knowledge gap of quality care at various levels: It is important to standardize understanding of quality concepts, both within the country and internationally. Technical leadership should be effectively deployed to ensure this understanding exists at all levels.
7. Institutionalizing non-state involvement in pursuit of person-centered quality care: Effective non-state engagement has the potential to strengthen every aspect of governing quality, including technical inputs on policy, monitoring, and accountability of health service delivery.
8. Garnering political will to pursue quality: Without political will to improve the quality of health care, prioritizing quality improvement to deliver on the promises of UHC will be challenging.

This report documents experiences, challenges, tested solutions, and practical ideas for countries as they strengthen governance, improve quality health services, and pursue UHC. While there is no one 'roadmap for success' in national quality management to fit all countries, ASSIST, HFG, country stakeholders, and partner organizations attempt in this report to identify key experiences, challenges, and lessons learned in establishing an institutional architecture for governing for quality service delivery.

INTRODUCTION

As countries work to achieve universal health coverage (UHC), there is a renewed focus on ensuring services are not only accessible, but also of adequate quality, and delivered consistently and with equity. In a 2013 survey of over 100 government officials from nine Joint Learning Network (JLN) member countries, the need to improve the quality of health care emerged as a priority (JLN 2013). JLN countries identified the challenge of establishing efficient and effective institutional roles and responsibilities to govern national health care quality delivery as a key challenge to quality improvement.

USAID's Health Finance and Governance (HFG) and Applying Science to Strengthen and Improve Systems (ASSIST) projects have worked closely with the JLN and the World Health Organization (WHO) to understand the institutional architecture (roles, responsibilities, and relationships) needed for the governance of quality, including potential levers for leaders to improve quality in the context of UHC. This report, the product of literature review, interviews, and peer consultation held in Dar es Salaam, Tanzania, offers practical, action-oriented ideas for countries as they strengthen quality health services while pursuing UHC. It represents a first step in this important inquiry around the institutions, roles, and responsibilities that will foster good governance of quality and enable quality health services.

WHAT ARE THE PRINCIPLES OF GOOD HEALTH SYSTEM GOVERNANCE?

Governance features prominently in health systems frameworks and is described as leadership, stewardship, regulation, or oversight (Health Systems 20/20 2012). Good governance has been highlighted as a core component of resilient health systems (Kruk et al. 2016). USAID defines health system governance as the process of "competently directing health system resources, performance, and stakeholder participation toward the goal of saving lives and doing so in ways that are open, transparent, accountable, equitable, and responsive to the needs of the people" (USAID 2006). According to WHO, leadership and governance in the health system "involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design, and accountability" (WHO 2007).

The framework in **Figure 1** showcases interactions between the three main sets of health system actors (Brinkerhoff and Bossert 2008):

- **Clients/citizens,** including clients, civil society groups, advocacy, and professional organizations
- **Providers,** including public, private, and voluntary health service providers and also educational institutions, insurance agencies, health maintenance organizations, the pharmaceutical industry, etc.
- **State,** including politicians, policymakers, administrators, and technocrats, but also members of parliamentary committees, regulatory bodies, etc.

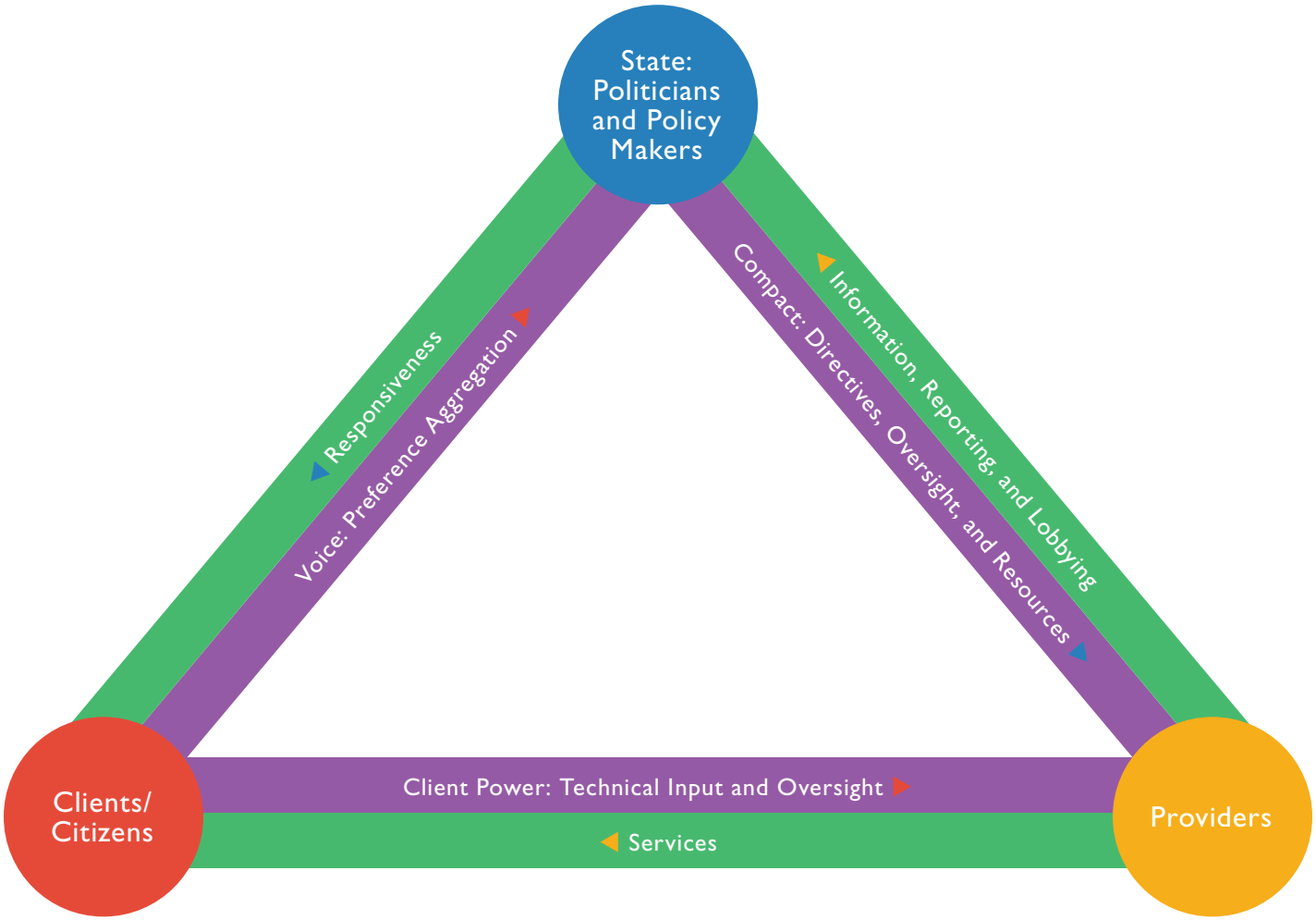
Figure 1 illustrates that while the primary governance responsibility for achieving health systems goals lies with the state, non-state engagement is critical to achieving:

- The health system goals of improved health status,
- Improved health system responsiveness to patient and public expectations, and
- Reduced financial risk for those in need of services.

This framework has been used in over 25 countries to assess health systems and is the conceptual framework underlying the concept of "good governance" in this report (Health Systems 20/20 2012).

Country representatives engaged in this effort through individual interviews and the March 2016 Tanzania meeting recognized that national-level health governance is not solely defined by the actions of the government, yet acknowledge that the Ministry of Health (MOH) plays a key role as steward of

FIGURE 1.
A health governance framework



Source: Brinkerhoff and Bossert 2008

their health system. Participants agreed that other institutional actors, including the private sector and civil society, must be engaged for effective governance of quality—such as the Ministry of Education, national insurance institutions (where they exist), and subnational governments in the case of devolution or de-concentration.

Governance should be light-handed: rules, regulations, and enforcement should not be overly burdensome and punitive, to the point of interfering with the delivery of quality care. Leadership—a related concept—is essential to direct the health system and expand governance beyond accreditation standards, policies, and other requirements, to impact the behavior of health workers to provide quality care. Clinicians have some control over how resources are allocated and need to be effectively engaged, through governing mechanisms and norms, to provide responsive, cost-effective care.

Some of the overarching challenges to good governance of quality cited by the meeting participants include weak information systems; corruption; inadequate resources for rolling out quality improvement initiatives and assurance mechanisms; failure to consider providers' perspectives; inadequate adherence to policies and guidelines; and health

services not offered with compassion and care.

According to meeting participants, good governance to ensure quality requires:

- Better communication across the health sector and vertically, among local, regional and national levels;
- Strong health information systems and monitoring and evaluation systems;
- Adequate resources assigned to achieve the objective;
- Accountability;
- Enforced policies (beyond simply writing and announcing them);
- Leadership;
- A facilitative role that does not get in the way of good care; and
- Transparency.

The Tanzania meeting participants also considered the role and impact of global health governance on quality health services. There is an acknowledged role for global governance and a demand for guidance, sharing of experiences, and communication. The important interface between national-level governance of quality and global governance requires that information flow both from and to countries. For example, the recent WHO global framework on integrated, people-centered health services has recently been endorsed by all WHO-member countries. The framework emphasizes the importance of strengthening governance and accountability as one of the five strategic directions for integrated, people-centered health services, as well as the critical importance of striving for quality improvement and safety. This global framework must now be translated to national and local action, and local and national action must inform the further development of global endeavors. Indeed, participants recognized the challenge inherent in translating internationally recommended norms and initiatives into national-level policies and regulations that impact health care delivery.

WHY IS GOVERNANCE IMPORTANT TO QUALITY HEALTH SERVICES?

WHO's Global Working Group on UHC and Quality of Care highlighted leadership and governance as central to embedding quality of care into the development of the overall health care system. Recent evidence supports this position. In a recent study of 43 Sub-Saharan African countries, "the same amount of resources was twice as effective in improving health outcomes in countries with higher quality of governance as in those countries with lower quality of governance" (Makuta and O'Hare 2015). Evidence suggests that interventions to promote providers' accountability to communities can have significant positive effects on health outcomes (Hatt et al. 2015a). Björkman and Svensson showed impact on health outcomes, including a 35% reduction in child mortality, when community-based monitoring of public health care providers increased (Björkman and Svensson 2009).

HOW DO WE DEFINE QUALITY HEALTH SERVICE?

WHO defines quality of health care as having the following dimensions:

- Effective: delivering evidence-based care that results in improved outcomes and is based on need;
- Efficient: delivering care that maximizes resource use and avoids waste;
- Accessible: delivering care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;
- Acceptable/Patient or person centered: delivering care that takes into account the preferences and aspirations of patients and the cultures of their communities;
- Equitable: delivering care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;
- Safe: delivering care that minimizes risks and harm to patients.

At the March 2016 Tanzania meeting, country participants agreed to this definition and articulated that their vision of quality care is integral to the UHC agenda and entails providing care to all of the populations served.

HOW DO WE IMPROVE QUALITY IN A HEALTH SYSTEM?

Quality improvement is defined "as systematic, data-guided activities designed to bring about immediate improvement in health care delivery in particular settings" (Lynn et al. 2007). Key principles for improvement include:

- Understanding work in terms of processes and systems;
- Teams of health care providers and patients developing solutions;
- Focusing on patient needs;
- Testing and measuring effects of changes in service delivery structures and processes; and
- Shared learning.

While quality improvement is fundamental to achieving better health outcomes, it can be challenging to emphasize in the context of UHC. Many governments associate quality improvement or assurance with high costs. There is often a lack of clarity on roles and responsibilities for managing and implementing quality improvement activities.

METHODOLOGY

The HFG and ASSIST projects designed this inquiry into the governance architecture needed to provide quality health services, taking into account the principles of governance for health systems and interrelationships between health care structures, processes, and outcomes. We explored governance architecture, including the structures and processes, roles and relationships, for ensuring quality health services through literature review, semi-structural interviews, and an in-person peer consultation in Dar es Salaam, Tanzania. See **Figure 2** for a quick snapshot of the methods used in this activity. Our research leading up to the meeting, documented in this report, focused on national and subnational governance structures. We did not delve into facility-level governance, i.e., clinical governance or community governance structures.

LITERATURE REVIEW

As a first step to understanding the issue, the team conducted a rigorous literature review of 25 countries' experiences implementing the functions of governing quality. These research questions guided the literature review:

- What are the essential roles and capacities for governing quality?
- What institutions/organizations are best positioned to govern?
- What institutions have roles related to the functions of governing quality?
- What relationships are essential to consider?
- What is the path to improving quality through effectively functioning institutions and relationships governing quality (i.e., policy, capacity development, etc.)

The team used an inductive decision tree to narrow the analysis to 25 countries in order to capture a broad range of country experiences (Cico et al. 2016). See **Annex C** for a description of the country selection method and **Annex D** for a list of the 25 countries researched in this review. The information found in the literature was reviewed and verified, to the extent possible, by HFG and ASSIST country staff and by country government officials.

FIGURE 2.
Methods used to explore the governance of quality

"I have learned something today from my colleague from Ghana, and I will surely follow up to share mutual lessons."

– Dr. Daniel Burssa, Medical Service General Directorate, Federal Ministry of Health, Ethiopia

ASSIST and HFG, in consultation with WHO, developed a framework to map out the functions of governing quality and the attributes that make those functions most effective. This helped guide the research and analysis of the structures and processes, institutions, and roles and responsibilities established in countries to govern the quality of health care services. The overarching functions of governing quality care at the national and subnational levels were defined as: leadership and management, laws and policies (development and existence); regulation; monitoring and evaluation; planning; and financing (allocation decisions and mechanisms). This framework was used to identify the levers that were in place for governing quality, which institutions housed the functions for governing quality, and how the various institutions related to each other in the process of governing quality.

SEMI-STRUCTURED INTERVIEWS

Semi-structured key informant interviews were conducted to augment the information found in the literature. The ASSIST and HFG teams collaborated closely with WHO for these interviews, which aimed to ground the literature review findings with frontline experiences, from the Ministry of Health to local perspectives at the district and facility levels. Nine countries of the initial 25 included in the literature review were chosen from among countries that were not part of the JLN, since similar interviews within the JLN captured this information through a parallel process. Interviews with 18 individuals were conducted anonymously. The results of some of these interviews have been documented in a series of two-page country case studies.

PEER CONSULTATION

In March 2016, HFG and ASSIST technical specialists joined governance and quality experts from USAID, WHO, the Institute for Healthcare Improvement (IHI), and 12 countries engaged in governing for improved quality of health services in Dar es Salaam, Tanzania, to conduct a Product Development Roundtable meeting. The objectives of the meeting were to validate research findings, discuss the most pressing challenges to date, document examples of solutions that have worked, and identify key unanswered questions. The three-day roundtable brought together senior government quality stakeholders from Ending Preventable Child and Maternal Deaths (EPCMD) priority countries and JLN member countries studied in the literature review. Participants hailed from Ethiopia, Ghana, India, Indonesia, Kenya, Malaysia, Malawi, Mexico, the Philippines, Scotland, Tanzania, Uganda, and the United States.

The three-day roundtable meeting was highly participatory and succeeded in validating the functions for governing quality, identifying common difficulties when governing for quality, and sharing tacit country experience in developing institutional roles and responsibilities for governing quality. On Day 1, participants defined the challenges and unanswered questions and set a strong foundation of common concepts and terms. The team presented key findings from the research for discussion. On Day 2, participants worked together on the priority pain points/issue areas identified on Day 1. On Day 3, participants agreed to a shared vision and to designing a responsive, practical, and useful product to carry forward. Detailed notes were taken of the proceedings. The meeting agenda and participant list can be found in **Annexes A** and **B,** respectively.

INSIGHTS FROM THE RESEARCH

LITERATURE REVIEW FINDINGS[2]

Whereas the evidence provides some indication of how countries manage each function, there exists little and uneven documentation of roles, relationships, and, importantly, the effectiveness and functionality of these institutional architectures and their impact on quality of care. However, a review of our findings against quality and governance indicators did yield early insights into associations between institutional architecture to support quality in health care and improved health outcomes. These findings should serve to inform a global research agenda on the governance of quality at the national and sub-national levels.

In four of the countries studied with the highest blended aggregate percent change in maternal mortality ratio (MMR) and infant mortality rate (IMR) between 2000 and 2013, dedicated quality units have been created within ministries of health. In two of those countries, quality initiatives rely on donor support, indicating the potential importance of dedicated resources for quality improvement.

Countries increasingly are linking quality to financing, and our analysis suggests a plausible association with positive health outcomes, using MMR as a proxy indicator. In the three countries with the lowest MMR in 2015, health insurance agencies assess quality, grant accreditation, and/or set quality standards. Among the 12 countries with lowest MMR (with a ratio of 190 per 100,000 live births or less), six of these countries also have explicit patient rights or safety laws and policies in place, pointing to the importance of defining a legal basis for quality and patient safety.

Finally, the effectiveness of governance can be impacted by the levels and effectiveness of stakeholder engagement, data use for decisions, transparency, accountability mechanisms, capacity, stability, and corruption and rule of law.

A review of findings against countries' corruption perceptions scores revealed that in five of the 12 most perceived-corrupt countries, quality monitoring is conducted by the MOH; in four of the six least perceived-corrupt countries, it is conducted by dedicated quality assurance units or programs.

Despite these encouraging findings, evidence for the most sustainable impacts of governance tools or approaches on the quality of health care is limited.

QUALITATIVE INTERVIEW FINDINGS

The interviews provided diverse perspectives. A number of points were made that illustrate each country's unique experiences. At the same time, similarities across countries were captured to inform a deeper understanding of governance of quality. The following seven points provide a synthesis of the perspectives:

1. Respect for country autonomy and priorities and coordination with the MOH, as the responsible entity entrusted to oversee health sector policy in the interest of its population, are considered foundational to all endeavors to govern health care quality.
2. Decentralization and health sector-supporting structures must be well integrated with national priorities, informed by the best evidence available, and grounded in the real challenges faced in organizing and implementing quality strategies, plans, and initiatives.
3. Partnership between public and private sectors, including active community participation, can help reinforce quality initiatives and structures and is required for change in "quality culture" to occur as part of wider governance efforts.
4. Institutionalization and development of a national quality policy and strategy can help consolidate and clarify understanding, and action towards improving quality.

2 For a complete documentation of the findings discussed in this section, see Cico et al. 2016. Governing quality in health care on the path to UHC: a review of 25 country experiences. Bethesda, MD: USAID Health Finance and Governance Project, Abt Associates.

5. MOH engagement with other ministries, areas of government, and development partners is critical in supporting governance of quality in the best interest of the population.
6. There is an urgent need for the global health community to engage, coordinate, and share cross-country lessons to reinforce quality processes at all levels of the national health system.
7. In order for countries to achieve UHC, it is not enough to achieve access and financial risk protection alone; the quality of the care provided must simultaneously be addressed through effective governance of quality.

The interviews informed the tables of positive country experiences found in Annex E. The interviews also contributed to stimulating discussions at the Product Development Roundtable.

THE EIGHT STONES FOR GOVERNING QUALITY

At the Product Development Roundtable meeting, government stakeholders identified their key challenges in governing quality, as well as goals for the meeting. They agreed on the following eight key themes—"stones," as referred to by participants—for improving the governance of quality health services:

- Governing quality with strategies, policies, and other mechanisms
- Using regulatory techniques to improve quality of care
- Institutionalizing non-state involvement in pursuit of person-centered quality care
- Garnering political will to pursue quality
- Measuring and using data for quality improvement
- Developing a quality improvement culture
- Addressing the knowledge gap of quality of care at various levels
- Linking finance to quality

We organize the eight stones according to Donabedian's quality framework, i.e., process, structure, and outcome (Donabedian 1988). First, we look at the structural stones that affect the institutional architecture for governing quality, including policies, regulation, non-state actors, and politicians. Then, we review the process stones that focus on the processes surrounding health care delivery, including using data, linking financing to quality, developing a culture for quality improvement, and improving the knowledge gap. The desired outcome, of course, is the delivery of quality health care.

The next section reviews country challenges for each stone, providing concrete examples and potential creative solutions from countries to ensure, foster, and enable quality health services in the age of UHC.

STRUCTURAL STONES FOR GOVERNING QUALITY

Governing quality with strategies, policies, and other mechanisms

Governing quality must first begin with a vision. In setting a national vision for quality, it is important to think big, but start small (Ottosson 2016). The vision will act as a road map to achieving success within the health care system. However, vision is only one of many components to enabling, ensuring, and fostering quality care.

A clearly defined vision that all can understand is essential to governing quality: this may be accomplished through a national quality policy, strategy, and/or other mechanism, such as a framework. These can be extremely useful tools, if developed in line with the country's overall health priorities and kept within the realities of the local context. The relative neglect of including quality of care as a policy priority, or within policy development, stems in part from the lack of government priority, failure to define or understand what quality is, difficulty in measuring quality, and an unmet need to measure the impact of policies on quality of care (Dayal and Hort 2015).

Challenges in implementing strategies, policies, or other mechanisms

Establishing policy, strategy or other quality mechanisms at the national level does not necessarily translate to implementation on the ground. Countries discussed the challenges of developing strong policy and translating those documents into action and shared some of their successes.

Aligning policy and competing policy priorities (for funding)

Different sectors or institutions may have policies which impact quality and yet are not aligned, resulting in gaps, overlaps, or even contradictions. In Malaysia, parallel multi-sectoral national policy development among multiple government sectors challenges efforts

to align the national health plan with health quality policy. Kenya and India representatives contend that insufficient linkages between policies governing health service quality and human resources are a challenge. In the face of competing policy priorities, the Philippines struggles to secure a budget adequate for governing quality. This is a challenge in Kenya, as well.

Grounding policy in data and facility-based evidence

Several country representatives referenced challenges related to policy that is not grounded in data or the realities of facility-level service delivery. One contributing factor is the difficulty of gathering and using facility-level realities and data in policy development. These latter challenges are captured in more detail below in the discussion of using data for quality improvement.

Stakeholder engagement

Meeting participants recognized the importance of stakeholder engagement. Stakeholder engagement supports policy development by fostering dialogue and discussion, and this creates a more conducive environment for legitimizing and implementing policy. In Ghana, the Ministry of Health is at times challenged in its quest to secure the involvement of various stakeholders at all levels, without slowing down the process.

Private sector policy

Mexico and India are challenged to develop and implement policy that recognizes the needs of the private sector as well as national health priorities.

Lack of understanding of key concepts

Participants agreed that what the representative from Uganda described as a lack of common understanding of "quality policy and strategy" and "governance of quality" posed a barrier to stakeholder engagement in policy formulation and implementation. This topic is explored more deeply in the section on addressing the knowledge gap of quality care.

Political will and champions

This is a topic addressed below, as it has earned its own "stone" given its particular importance as voiced by country participants: Garnering political will. The challenge to using strategies and policy for quality improvement is clear: without clear and consistent commitment at all levels, policy development and implementation can suffer.

Previously in Ethiopia, different non-governmental organizations (NGOs) implemented their own quality improvement initiatives but now the MOH prepared a clear quality strategy, and the quality improvement initiative is owned by the government. Uganda could use more champions for quality at all levels—at the national policy, subnational, and facility levels.

National and subnational dynamics

Challenges in implementing policies or strategies related to quality improvement are often linked to competing national and subnational priorities and poorly functioning decentralized systems. This challenge was cited by Indonesia, Mexico, and Kenya.

Successes, best practices, and creative solutions

Successful practices in using policies, strategies and other mechanisms to govern quality of care

Below are some common themes and select country examples of successful experiences using policy, strategy and other mechanisms to govern quality of care (see Annex E Table 1 for a list of country examples). A number of countries participating in the roundtable meeting are undertaking the development of quality policies, strategies, and mechanisms to guide and ensure quality health service delivery. Participants agreed that policies and strategies must be informed by data and local context. They also highlighted the impact of dissemination and communication—the ability to disseminate success and the relative lack of evidence to establish the overall impact of national quality policy and strategy on health system performance and outcomes.

In group discussions, the Mexico representative described using the concept illustrated in Figure 3 for

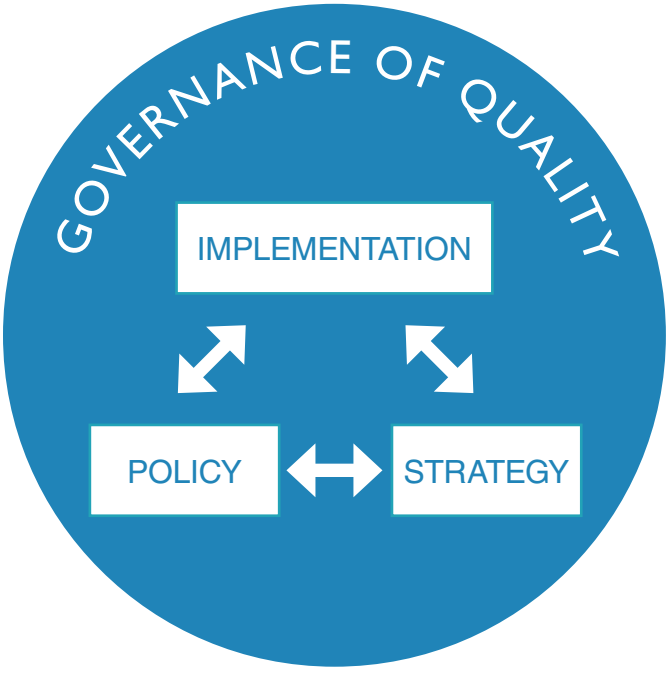
monitoring to inform implementation, policy, and strategy. It was also cited as an important methodology when undertaking a situational analysis. In Mexico, the voice of patients and communities is taken into consideration through a citizen participation mechanism, the "citizen eval." Conducted every four months, surveys assess patient satisfaction and waiting times. Survey results are fed back to the federal government for any additional support that may be needed.

Other ideas and potential best practices shared at the meeting included answers to the following questions:

How do we ensure quality policies and strategies are informed by the reality of service delivery?

- Understand the difference between the available mechanisms (i.e., policy versus strategy) to ensure that they are used effectively.
- Involve representation from all levels of the system in the development process, including practitioners, civil society, private sector, managers from various levels of health care, etc.
- Use evidence to inform the policy, strategy, or other mechanism.

FIGURE 3.
Mexico's approach to governing quality



How do we foster ownership of quality initiatives?

- Shared ownership must be not just among physicians, but should include other staff, partners, patients, and communities.
- The opportunity for career progression and dedicated quality managers responsible for this aspect was noted as important. The mindset, "do your work and improve your work" illustrates the responsibility everyone should take to ensure that quality improvement is instilled as a core value.
- A central information repository on policy and strategies facilitates governance.
- Including recognition and awards as part of policy and strategy may prove to be a mechanism to motivate the workforce.
- Engage civil society through community awareness and empowerment.
- There should be a culture that fosters reporting on the care being provided, neither punitive nor "no blame," but rather, a "just" culture.

How do we ensure that there are strong linkages throughout the system?

- National, regional, and district level steering groups should be coordinated to help operationalize quality policies within a decentralized system in countries where steering committees already exist. Steering committees, if not properly coordinated, may actually present a further challenge or barrier.
- A quality policy, strategy, and/or mechanism must have strong links to the national health vision, plan, and policy.
- Report on patient-reported outcomes to show the impact of quality interventions.
- Set up strong leadership/management structures throughout the government structures to support the work.

How do we balance federal, state, private, and civil society mechanisms?

- When developing a quality mechanism, consider all active elements of the system (public, private, federal, state) and how they interconnect.

How do we ensure a unified vision and priority for quality, especially when there are changes in political leadership?

- Creating demand from the bottom up, so that communities demand high-quality care as their right and facilities demand the support and resources to provide that care.

Using regulatory techniques to improve quality of care

Countries all over the world have imperfectly used regulation as a mechanism for monitoring, measuring, and mandating quality in health services for many years, yet regulation remains an important tool when governing for quality health care and improved outcomes (van Stolk 2015).

The most widely used tools for regulation of quality health services are establishing guidelines, protocols, and standards for service delivery, requiring certification and licensing of health professionals using standards and guidelines, and applying accreditation to assure that facilities and providers are performing at a certain level. In most of the countries studied in the literature review, guidelines and protocols are established by the MOH or equivalent. While guidelines and protocols exist for inputs (facilities, equipment, drugs, and provider competencies), more attention is needed to develop standards for process and outcomes related to ensuring quality of care (Dayal and Hort 2015).

Challenges of applying regulatory approaches

There are many complex layers and challenges to effective regulation to ensure a quality service is delivered, i.e., developing evidence-based standards and enforcement for physical, clinical services, human resources, drugs, and technologies. Countries at the Product Development Roundtable discussed many challenges to developing and enforcing regulation of health care.

Enforcement

"Regulation is only as effective as the power and mechanisms that governments and other regulatory bodies have to enforce it" (Zeribi and Marquez 2005).

Lack of enforcement of regulations contributes to a general disregard of the government's regulatory authority, Zeribi and Marquez also found. One potential root cause is insufficient resources to monitor adherence to standards (especially in rural areas) and to provide remediation and sanctions for non-performance when necessary. Citizen engagement in regulation is a related challenge, both in providing citizens with information on standards and engaging them in enforcement of regulations.

Regulation of private sector facilities and individuals

Difficulty engaging with and a lack of resources to robustly regulate the private sector are among the reasons it often is less regulated than the public sector. Similarly, community health and outreach workers are frequently unregulated, and yet their work impacts health outcomes.

Corruption

Whenever an organization or individual has the power to determine whether a person or business can earn an income, there is a risk of corruption. Thus, regulation can be used to solicit bribes and kick-backs.

Lack of coordination among regulators

This can result in conflicting regulations, overlap, or gaps in regulation.

Regulating for continuous quality improvement

Often, certification is not tied to continuous quality improvement, nor is recertification or relicensing a requirement for continuing to practice.

Successes, best practices, and creative solutions

Countries discussed a number of strategies to improve the effectiveness of regulation to ensure and improve quality of care (see Annex E Table 2 for detailed country experience).

Horizontal collaboration for regulation development and enforcement

Purposefully engaging other health sector institutions and non-government stakeholders (such as health professional associations) can help achieve buy-in and leverage additional resources to develop and implement regulation.

Decentralization and strong communication and systems between the national and subnational levels

In Tanzania, devolution has contributed to better monitoring by providing resources at the regional and local levels to ensure compliance with inspection, supervision, and mentoring. Indonesia, an increasingly decentralized system, places enforcement responsibilities at the district level, and communications are being strengthened between the national, provincial, and district levels in order to improve support to those districts.

Dedicating adequate personnel

Malaysia has dedicated personnel at the national and regional levels to monitor compliance with standards.

Establishing autonomous or semi-autonomous regulatory institutions

Ethiopia has established an autonomous regulatory body, funded by the Federal Ministry of Health (FMOH), to license and monitor facilities and professionals in both the public and private sectors. Scotland's National Health Services has recently established the Council for Healthcare Regulatory Excellence (CHRE). The CHRE will set and review standards across the regulatory bodies for nurses, doctors, pharmacists, dentists, etc.

Linking quality improvement activities with regulation

The MOH in Kenya intends to embed the quality improvement methodology and processes within regulation. Facilities must demonstrate that quality improvement processes are happening (i.e., improvement teams established, clinical audits occurring, regular feedback loops, etc.) in order to receive licenses and renewals.

Institutionalizing non-state involvement in pursuit of person-centered quality care

Effective non-state engagement has the potential to strengthen every aspect of governing quality, including technical inputs on policy, monitoring, and accountability of health service delivery. At the Tanzania meeting, a common theme among successful policy implementation experiences was the early involvement of non-state actors in policy development and implementation. There is evidence that non-state involvement—specifically, community engagement—in health service delivery is linked to improved reduction in neonatal mortality rates, greater utilization of services, lower child deaths, and better quality of care (Hatt et al. 2015b).

In January 2016, the WHO Executive Board approved an agenda item to be discussed at the World Health Assembly in May 2016, a Framework on Integrated People-Centered Health Services (IPCHS), which is guided by five strategic directions for which citizen engagement and non-state involvement is vital (**Figure 4**) (WHO 2015).

While each strategic direction is important, the following are particularly relevant points for how non-state actors can contribute to the governing of quality utilizing the IPCHS framework:

- Empower and engage people to become co-producers of health services
- Strengthen governance and accountability by bolstering participatory governance as well as enhancing mutual accountability

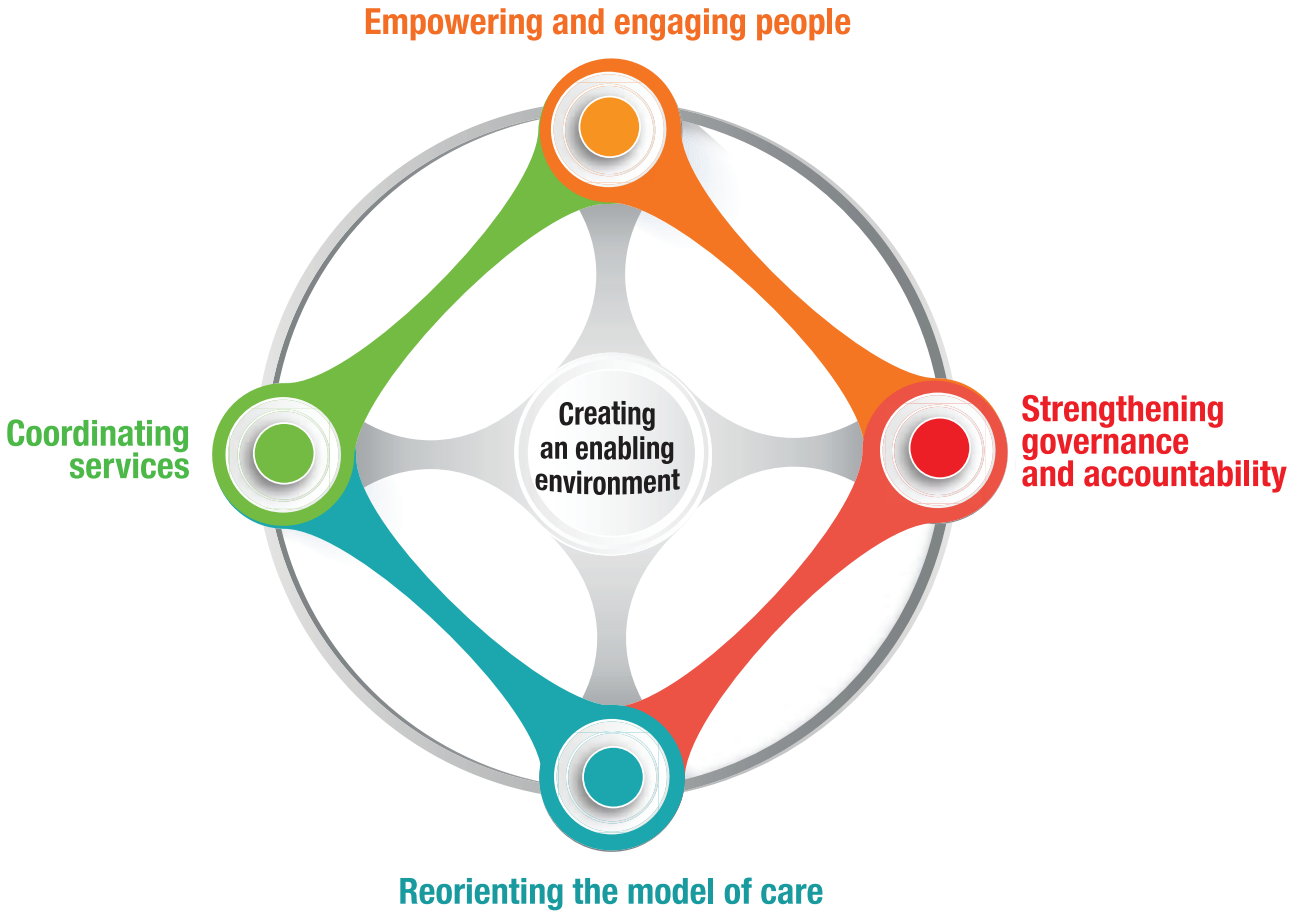
When discussing and dissecting non-state actor involvement, country stakeholders at the roundtable discussed three sets of non-state actors, including:

- Private sector providers, including commercial providers, NGOs, and faith-based organizations (FBOs),
- Broader society, including citizens and/or beneficiaries of health services, and
- The role of provider unions.

Challenges of involving non-state actors in governing for quality

The challenges of involving non-state actors in long-term quality improvement strategies for health at the country level are myriad. One cross-cutting challenge that emerged was how time-consuming engagement can be—and how best to use inputs from engagement.

FIGURE 4.
WHO strategy for providing integrated people-centered health services



Engaging private health care providers in regulatory and quality improvement processes

Whereas protocols and guidelines from the MOH apply to both public and private facilities, the ability to monitor and provide surveillance or auditing of private facilities is lacking. Also, private sector facilities may not value ongoing quality improvement as a viable investment, once minimum facility certification standards are met.

Patient and community awareness of quality and standards of care

For example, multiple countries cited that in rural areas where services are poorer, many citizens will rate those services of higher quality than in peri-urban or urban areas, where service quality is distinctly better but receives lower quality marks from patients. The impression was that those in peri-urban areas are better educated and informed, and therefore demand better services. Also, while many countries have village health committees or equivalents to engage citizens in subnational analysis of health service quality, feedback and improvements at subnational levels do not feed up to national levels, or horizontally to other regions to inform other community health efforts.

Engaging provider associations and unions

Country representatives discussed these stakeholders' tendency to advocate that the bare minimum of provider standards be followed. This presents a barrier to quality improvement processes when stakeholder groups see quality initiatives as additional work for no additional compensation.

"Failure to integrate community perspectives in providing quality services was cited as a major weakness when drawing lessons learned from the Ebola crisis in West Africa."

– Dr. Shams Syed, Coordinator, a.i., UHC & Quality Unit, Department of Service Delivery and Safety, WHO

Successes, best practices, and creative solutions

The following are some potential best practices from country stakeholders in establishing institutional arrangements, roles, and responsibilities for addressing the challenges of involving non-state actors in governance for quality of health care (see Annex E Table 3 for specific country examples).

Institutionalize private sector participation at national and subnational levels

When the private sector can benefit and have a voice, it is more likely to be positively engaged with the government to meet the health needs of the population. In Malaysia, the private sector is represented on the national patient safety council. In Tanzania, private sector (including commercial sector, NGOs, and FBOs) entities are eligible for government support for quality improvement.

The most common mechanisms facilitated community and facility level engagement

In Malaysia, community advisory boards engage in improving health services in communities. Several countries include community representation on hospital boards or committees, including India, Tanzania, the Philippines, and Ghana. Ethiopia has a community governing board for health facilities elected from the local communities.

A number of governments established mechanisms to engage individual consumers

In Mexico, the MOH engages citizens directly, through a survey. Scotland's web-based tool, administered by an independent organization, provides consumers the opportunity to report their experiences when accessing care. The stories are tagged to facilities, but not to individual consumers to maintain client confidentiality. In Ethiopia, each public hospital holds a community forum every three months with the community they are serving.

Provider unions and associations are engaged in a number of ways, at different levels

In Scotland, the government provides funding to support the lobbying efforts of 96 voluntary non-profit societies that focus on health and social care. In Indonesia, provider councils are actively engaged in distributing norms, regulations, and protocols from the national to the district level, provide some training to the members, and are engaged on a regular basis at the national level in policy debate (Hatt et al. 2015b).

Garnering political will to pursue quality

Political will is defined as "society's desire and commitment to support or modify old programs or to develop new programs. It may be viewed as the process of generating resources to carry out policies and programs" (Kotelchuck 1993). Founded on public support, which includes both government leadership and greater societal support, political will is the natural bridge between public health evidence and action (Lezine and Reed 2007). Without political will to improve the quality of health care, prioritizing quality improvement to deliver on the promises of UHC will be challenging. Moving towards UHC is difficult and often requires sustained political commitment from national leaders (Nicholson 2015). Retrospective analyses of successful UHC reforms frequently identify 'political will' as a key ingredient for success (Hussein 2015).

Challenges to garnering political will for quality

Many challenges were discussed in great detail during the roundtable. Stakeholders highlighted a few of particular importance, summarized below.

Lack of understanding of (and appreciation for) quality care

Politicians often fundamentally do not understand what quality health care looks like, nor do they have an appreciation for the value of quality of care in rural areas and at the primary care levels. Government leadership, which include politicians, technocrats, and administrators, have internal competing power dynamics, hierarchies, and priorities. Politicians also have constituent priorities and vested interests. In many countries, health expenditure as a percent of total government spending is low, and politicians are often dividing government spending among multiple competing priorities. According to a recent study, investments in preventative health care is the least politically salient of public service investments, from the viewpoint of government officials (Batley and Harris 2014). Politicians often do not prioritize quality issues in rural areas. There is a lack of awareness and communication on rural issues, and priority goes to urban areas. Higher-level facilities and consumers therein are often more knowledgeable and informed and know how to garner political attention. Thus, politicians tend to view quality of health care as a priority only at the hospital level.

Inadequate advocacy

Technocrats, administrators, government stakeholders, journalists, and civil society need to improve their ability to communicate with politicians and advocate for quality services. By using information to make the case more effectively, these groups can increase political will among policy makers to improve the quality of health care, which may lead to greater resource mobilization and attention to quality.

Insufficient data

Often, politicians lack the data to strategically prioritize decisions to improve service quality. More and better data is needed to show politicians what quality of health care looks like, especially in rural areas, and to show the burden of disease without good quality health care. Data is also needed to prioritize quality improvement, identify where the biggest changes might be seen in health outcomes, and inform leaders of the costs and benefits of investing in quality care.

> "Part of community participation includes building demand in communities for quality. Many communities are afraid of speaking negatively about facilities, because they don't want to lose people or offend political parties. Citizens in rural areas often don't appreciate their rights, and they are less informed on what quality services mean."
>
> – Dr. Andrew Likaka, Head, Quality Control Dept., MOH, Malawi

High turnover of politicians

Frequent changes among political leadership make ongoing support difficult to maintain, particularly at subnational levels.

Corruption

Corruption was also cited as an important challenge to garnering political will for quality, given the global history of corruption in politics—and in some countries, in the government health sector, in particular. However, stakeholders agreed on a separate discussion to analyze corruption as a cross-cutting challenge that hampers the governance of quality across the eight stones.

Successes, best practices, and creative solutions

The following are some potential best practices from country stakeholders in establishing institutional arrangements and roles and responsibilities for addressing the challenges of garnering political will. See **Annex E Table 4** for highlights of specific country experiences.

Effectively using data for lobbying

- Multiple countries mentioned that lobbying with data is important, including creating the right narrative or story: package the data in an easy-to-consume format, using a story or infographic as much as possible. Scotland and Tanzania use dashboards so that politicians can see the change and have evidence of the difference their investments in quality are making.
- The representative from Scotland learned that politicians need care and handling and also attention from senior delegates. It is important that technocrats and administrators manage up and provide positive optics for politicians, including giving credit and attributing success.
- Field trips can be used effectively, if well planned, to emphasize the human face behind the data.

Ensure quality is articulated in a national-level strategy

National health strategies should prioritize quality. By featuring quality prominently in the strategy and integrating it within service delivery strategies, quality will have the political support needed to advance.

Leverage global agreements, resolutions, and advice

It is important to use global statements, resolutions, commitments, and alliances to garner regional, national, and subnational political will by sharing the global and regional agreements and commitments made between countries regarding quality of health services, including, among others:

- Global Resolution on Quality of Care and Patient Safety made in 2002 at the Fifty-fifth World Health Assembly
- World Alliance for Patient Safety's Research for Patient Safety and Better Knowledge for Safer Care, published in 2008 by WHO

Peer-to-peer accountability and benchmarking

Peer-to-peer accountability for politicians in the region (national, regional, district) can be powerful. East Africa representatives highlighted that regional benchmarking against harmonized indicators can facilitate competition to improve health outcomes.

PROCESS STONES FOR GOVERNING QUALITY

Measuring and using data for quality improvement

As discussed in the previous section, governance mechanisms and leaders should be informed by facility-level data. Quality is assessed by analyzing service delivery data and population outcomes data, such as maternal and infant mortality. However, ensuring that accurate and reliable data on service delivery and population outcomes is collected and used can be very difficult. Countries increasingly are attempting to establish systems or indicators for monitoring performance or measuring quality; our literature review found evidence of such systems or indicators in ten of the 25 countries studied. In the majority of the countries, monitoring and evaluation of quality is conducted by ministries of health or by quality assurance units or programs. However, quality monitoring data are rarely published or made widely available. In the literature review, we found evidence of data being used to inform quality improvement in only five countries.

Challenges and failures in using data for quality improvement

Challenges in collecting and using data for quality improvement are related to infrastructure, capacity, and the incentive structures around collecting, reporting, analyzing, and using data. Participants discussed how the use of data can be hindered by unreliability—including data accuracy, level of completeness, and timeliness, which are symptoms of the above factors.

Infrastructure of the health information system

Many low- and middle-income countries do not have the required resources needed for robust data collection, reporting, and analysis. Also, LMICs often have subpar information technology systems for data collection and management, making it very difficult to ensure that data is collected in a timely, efficient, and reliable manner. In addition to physical infrastructure (connectivity, computers, software, networks), the systems of collection and reporting can be poorly defined, redundant, and/

or inefficient. Different institutions or programs could have different reporting requirements, even systems, in which to report data (for example, data related to patient safety monitoring versus accreditation). The more burdensome the data collection process, the more likely it is to experience human error and incomplete or late reporting. Institutions sometimes do not share relevant information at the national and subnational level. Many countries are faced with the burden of collecting data for too many indicators across disparate systems. Indicators to measure quality also pose challenges, including how to minimize the number of indicators so they are not excessive, which indicators to use, etc.

Capacity

At different levels of the system, low capacity—to collect, report, analyze, and use data—can pose a challenge to using data for quality improvement. If these duties are not part of a health worker or manager's job description, or sufficient capacity building has not been provided, and/or adequate time is not allocated for these tasks, then data collection processes can be neglected or overlooked.

Successes, best practices, and creative solutions

The following are some potential best practices from country stakeholders in establishing institutional arrangements and roles and responsibilities for addressing these challenges. More details are found in Annex E Table 5.

Data training should be provided for everyone, including roles for checks and balances

Create roles for data checks throughout the system. Creating checks and balances for data collection and usage throughout the system is a good intermediary measure until a data management system can be integrated. Data management tools should show reports, maps, graphs, etc., in formats that are easy to understand and use.

Foster community-level and facility-level data collection and use through collaboratives

Collaboratives can serve to improve data collection and usage. Supervisors at the facility level should use data to make decisions and supervise. Once data is utilized at all levels, the importance of data collection and validity is better appreciated. Data should be validated by quality improvement and data validation teams to improve quality of data. In Ghana, Uganda, and Ethiopia, there are specialized teams focused on validating data, rather than working to improve clinical processes. Ethiopia launched an information revolution strategy to improve data usage at all levels of the health care system.

Simplify the data that is required to be collected

As programs are often siloed, with each requiring different data be collected, health care workers are already overburdened with existing data collection requirements. Quality data indicators should be simplified to include only the necessary indicators to inform the facility staff, managers (facility level and beyond), and decision makers. All of these key stakeholders should therefore be included in the process to determine what indicators should be used. When data requirements and inputs are simplified, they are more likely to be accurate.

Promote data to be collected and tracked in real time

Falling behind in data collection at the facility level will create a huge backlog and only increases the risk of inaccuracy.

Developing a quality improvement culture

Ensuring mechanisms for quality is not enough. Continuous quality improvement is needed to ensure the quality of care provided by individual health workers within facilities always doing the right thing at the right time. Quality is affected by many different aspects of the system, which provides multiple opportunities for improvement. To continuously improve care, there needs to be an improvement mentality throughout all levels of the system, ideally led from the national level. Continuous improvement is an important consideration for governing quality: assurance mechanisms alone are not enough and should be coupled with improvement efforts. Furthermore, leaders must ensure that quality is not a stand-alone activity or program, but is integrated throughout all health care programs, including feedback mechanisms that allow data and improvement needs to flow bi-directionally and be acted upon. A culture

"Developing a culture of quality must be a collaboration among different stakeholders, different government agencies, the private sector, provider groups, NGOs, etc. Quality is not and cannot only be the responsibility of the Ministry of Health."

– Marc Anthony Cepeda, Division of Policy Research and Standards Development Division, PhilHealth, Philippines

of quality improvement should be mainstreamed across technical areas and operations; regardless of someone's role within the health care system (administrator, provider, or district-level manager), they should understand the definition of quality and how to pursue improvement. Institutionalizing a culture for quality improvement requires thoughtful planning around the enabling environment (leadership, policy, core values, and resources), organizing for quality (including the structures for implementing quality assurance and improvement), and support functions (including capacity building, communication and information, and rewarding quality) (Silimperi et al. 2002).

Challenges and failures

Challenges overwhelmed the discussion that took place on how to develop a quality improvement culture, and yet participating countries had very similar experiences and challenges to report. Many of the challenges have been cited above in the context of other stones, as they also work against developing a culture of quality improvement. Some of the conditions that are necessary to create a culture for quality improvement, but are challenging to engender, are:

- A supportive environment to make changes;
- Leadership that supports and drives quality improvement;
- Data that is reliably and accurately collected by frontline workers;
- Evidence-based decision making;
- Teamwork; and
- Shared learning.

One approach that was specifically cited as ineffectual is erring towards a punitive approach to enforcing a quality culture. Challenges are myriad when engendering a culture of quality improvement throughout a health system, regardless of the level (local, national, or global).

Successes and creative solutions

The following are some potential best practices from country stakeholders in establishing institutional arrangements and roles and responsibilities for addressing these challenges. See **Annex E Table 6** for more details.

Sharing successes

Tanzania, Uganda, Malawi, and Kenya described the good results that have been achieved by implementing quality improvement methodologies in public facilities within their health systems. They discussed some of the changes that were made in facilities when they implemented the quality improvement process. By showing how positive changes were made in facilities and sharing these results and changes across facilities, motivation increased within other facilities to start testing their own changes and improving the quality of care.

Working across sectors and with a variety of actors

Country representatives discussed the value of integrating quality improvement into the pre-service education curricula to get people on board from the beginning. This would involve coordination between the Ministries of Education and Health and creating a culture of quality improvement outside of the health care system to show that quality of health care is everyone's responsibility, not just that of facilities and the MOH.

Governments should promote transparency and accountability, including providing forums to give and receive feedback on care delivered.

Engaging health workers in multiple ways

Active engagement of front line health workers and supervisors is important in a decentralized

environment. Health workers can prioritize and own the issues that they work on; mentor-mentee programs can also have value. Creating collaboratives across different sectors could be useful to facilitate shared learning and a culture to improve.

Using data effectively

Use existing facility-level data to inform changes that should be made. Use data at the national level to motivate and show results. When and where possible, make data available electronically.

Strong leadership

Leaders need to provide incentives that are contextually and culturally appropriate and create a just environment, as opposed to a punitive or "blame-free" one. They should set realistic priorities for what to improve so facility workers do not feel overwhelmed when attempting to improve care. Leaders must actively communicate priorities, successes, and challenges with various levels. Leaders must promote sharing of best practices and facilitate collaboration.

Addressing the knowledge gap of quality care at various levels (global, national, subnational, local)

Quality is a complex term. With UHC and quality at the forefront of the global health agenda, many stakeholders are interested in improving quality of care. With changing institutional roles and responsibilities in the wake of UHC and new institutions, it can be challenging for countries to coordinate, ensure adequate capacity, and prioritize where to start on the journey to improving quality. An important step in governing quality is to standardize understanding of the concept, both within countries and internationally, and for technical leadership to be effectively deployed to ensure this understanding exists at all levels.

Challenges and failures in closing the knowledge gap

Addressing the knowledge gap across all levels—globally, nationally, and locally—is a huge challenge for countries around the world. Some of the most widespread obstacles are listed below.

Non-standard terminology

Different terms for improvement approaches, caused by different development partners and implementers using their own terms for methods, can cause confusion on the ground, even though the underlying principles are the same.

Different quality definitions and standards

Country representatives relayed that in those countries where donor or government funding for vertical programs (such as HIV or TB) creates resource inequalities among programs, some services may be of higher quality than those that don't benefit from high levels of donor or government funding. Levels of training and quality expectations can vary among health workers, all the way up to national-level program managers and international development partners.

Knowledge sharing within and among countries is highly delimited. Most countries struggle with horizontal knowledge sharing. If a district or region has developed a successful quality improvement technique, rarely are there ready mechanisms in place for sharing these lessons or knowledge with other subnational managers or facilities. Within countries, announcing standards and protocols is not enough; in particular, top-down communications are not enough to improve knowledge of quality practices and improvement. Even training, particularly one-off trainings, can be insufficient without ongoing support and mentoring. At the national level, the MOH and Ministry of Education are often not aligned on pre-service education requirements and standards.

International knowledge sharing is a particular challenge. Often, countries are reluctant to discuss and share their failures openly, but these can be the most instructive experiences for others.

Reaching the private sector

While the public health sector generally has access to technical updates and continuing professional development opportunities, the private sector in some of the countries represented at the roundtable are excluded from information sharing and do not have the same opportunities for continuing professional development.

Insufficient resources and techniques for capacity building

Participants cited reliance on training as the sole means of increasing capacity as a further limitation to increasing knowledge, in addition to resource constraints.

Successes, best practices, and creative solutions

Country stakeholders reported the following successful experiences when establishing institutional arrangements and roles and responsibilities for addressing these challenges.

In addition to the solutions listed below, other potential solutions were discussed and a few examples from Kenya and Afghanistan were offered on what approaches are being tested (see Annex E Table 7 for details).

The MOH should lead by developing common definitions and a vision for quality care

Quality must be understood at all levels of the health care system. Public and private facilities should have the same standards for quality care and also should learn from one another. Country representatives acknowledged that the MOH should take the lead in clarifying the common language used; provide a vision of quality care; and coordinate partner efforts to improve quality. It should set the national definition and understanding of quality and the approaches to be used, and implementing partners should follow these. MOH leadership should decide on a quality definition for their context and integrate it into existing programs. The MOH, as a steering mechanism, should guide the process and ensure that the right messages are communicated to the various levels.

Promote knowledge sharing between different technical areas

Training and education materials should be standardized, and incentives for knowledge sharing should be culturally and contextually appropriate. Knowledge sharing on quality can be achieved through collaborative learning sessions and facility exchange visits.

Collaborative learning sessions have been used successfully to share learning from quality improvement activities. They can and should be inexpensive and held in a hospital or a facility, with location rotated among participating sites. Existing resources should be utilized to ensure collaborative learning sessions are conducted with the resources available, to build ownership.

Increase international learning

All meeting participants agreed that the sharing of knowledge across countries should be increased and brainstormed various solutions on how to do this in an efficient and cost-effective manner. Leaders can strive to understand international priorities and utilize these as catalysts for change within the country.

It is helpful to identify best practices and document them to share with other countries. As quality improvement is context-specific, it is important to document clearly how quality was improved. Sharing the realities of local context, including aspects like community priorities and the socioeconomic situation, is helpful to countries that are learning from the case studies provided.

The country representatives expressed a strong interest in breaking down barriers to knowledge sharing through one-on-one communications and visits, virtual fora for access to resources and expertise, and the establishment of a community of practice.

Engage health workers of all cadres

Participants considered having quality improvement responsibilities be explicitly stated as a component of every job description within the health care system. Nurses, doctors, administrators, etc. all need to work together to achieve quality care within the facility. When staff are not united in their understanding of each other's roles and responsibilities in achieving quality care, health care workers begin blaming each other for deficits in quality of care, instead of working together to solve the service quality challenges.

Promote ongoing knowledge building for quality improvement

Governments should establish mechanisms to evaluate knowledge of quality. In that context, a safe space is necessary to facilitate learning from failures. Forums for patients to provide feedback on the care they receive and for that feedback to be heard can contribute

to ongoing learning and improvement. Mentorship programs were mentioned again as a good approach to assist in quality promotion and understanding. Lastly, quality improvement education should be integrated into continuous professional development.

Linking finance to quality

Health care purchasing can be either passive or strategic. Passive purchasing simply follows predetermined budgets or paying bills when they are presented; strategic purchasing uses a deliberate approach to seeking better quality services and low prices (Health Systems 20/20 2012). UHC requires strategic purchasing.

Health financing, budgeting, purchasing arrangements, cost of care, and linking care to incentives were cited in interviews with country stakeholders as among the most significant challenges countries face in pursuing the governance of quality.

Some of the early challenges to country progress towards UHC involve expanding access to care at costs that are affordable to users and providers.

Many countries are also attempting to link payment to quality, with varying degrees of success. Financing links to quality of care can be in the form of performance-based financing; insurance payments linked to facility standards (accreditation), licensing requirements, and/or adherence to service protocols, among other factors; and/or other purchasing arrangements involving the public and private sectors. For example, in the Philippines, only accredited facilities may be eligible to receive Philippine Health Insurance Corporation (PhilHealth) payments, and this accreditation has quality indicators such as facility, equipment, and health worker standards.

The challenges associated with linking finance to quality

Meeting participants identified the following challenges in linking finance to quality, some of which are related to institutional roles, while others are more general challenges.

> "A strategic approach to purchase health care services based on quality, or to encourage participating systems to engage in quality improvement activities, can improve patient outcomes and systems efficiency. Linkages between reimbursement (institutions and workers) and quality of care can be harnessed for effective UHC."
>
> – Position Statement, Global Working Group on UHC and Quality of Care, November 2014

Conflict of Interest

There is perceived institutional conflict of interest and risk of corruption when a government insurance entity also plays a role in governing quality (assurance or improvement or both). For example, in the Philippines, the PhilHealth is often accused of having a conflict of interest with the Department of Health (DOH), which is nominally the steward of the health system, including quality of care. PhilHealth has an objective to implement quality improvement policies. However, they have been accused of solely trying to cut costs when providing quality advice. There are challenges to emerging institutional relationships in Indonesia among Badan Penyelenggara Jaminan Sosial (BPJS), MOH, and other national institutions regarding policy setting and quality oversight roles. Without clear roles and responsibilities, including leadership from the most qualified institution on issues related to policy, there is a risk of BPJS setting policy that could, inadvertently, adversely impact quality of care. For example, BPJS has established waiting periods for coverage for the newly insured which can detrimentally affect individuals seeking time-sensitive medical care (Hatt et al. 2015b).

In Kenya, the insurer is also the accrediting body. This is perceived as a conflict of interest for many in Kenya as it provides opportunities for corruption and misuse of authority. When the insurer also performs accreditation, some private facilities are not accredited because they do not meet the required standards. This has a financial impact on the facility, as it precludes it from inclusion in the Kenyan national insurance scheme, thus limiting its customer base. Some inspecting officers have asked for a job in the facility that does not meet accreditation standards, so as to help the facility to meet accreditation requirements. This results in an unintended financial benefit to the inspectors, and cost to the facilities, related to the accreditation. In Ghana, the insurance authority carried out facility accreditation, client insurance, and claims resolution, which created an appearance of a conflict of interest and created opportunities for corruption or collusion. The accreditation function has now been removed from the Ghanaian insurance authority.

Coordination

Coordination among government entities is challenging. For example, in the Philippines, the DOH provides funding for facilities by paying salaries and providing medicines and supplies, and PhilHealth pays for services delivered and cases managed. The DOH only provides drugs which that institution includes in its established formulary. PhilHealth has its own list of recommended drugs for conditions. This lack of coordination extends to protocols for payment for quality services. This creates a friction between the two organizations that could result in confusion at the facility level and substandard quality of care. DOH licensing of facilities has different standards than PhilHealth accreditation requirements. In this case, PhilHealth standards are higher, with a focus on quality of services.

Getting incentives right

Getting the incentives right in context of strategic purchasing is challenging. Performance-based financing (PBF) has had mixed results to date in achieving quality outcomes. One challenge lies in selecting the right indicators to measure for quality improvement. Incentive payments for services can have unintended consequences: for example, if a health care clinic receives bonus payments for the number of vaccinations and pre-natal visits delivered—but receives lower, or no, incentives for other services—then other essential services may be deemphasized as providers focus on maximizing the profit benefit of prenatal visits. In some participants' opinion, donor-funded PBF is not sustainable once the donor pulls out, as providers who no longer receive reimbursement for those services may stop providing them.

Accreditation, as an incentive method, is input-based, thus insurance providers can choose to pay for services by facilities or providers who are accredited. Yet this is a quality assurance mechanism, but may not actually yield ongoing improvement of service quality.

Private sector linkages

The private sector faces unique challenges related to meeting standards to be eligible for payment of services and be included in a UHC program. Sometimes private health care providers cannot afford to meet facility standards, or they cannot hire professional staff to provide care according to accreditation requirements. If they are not accredited by the insurance company, they cannot get paid. In Uganda, a barrier is the government's capacity to accredit private providers and monitor their quality.

Budget constraints

The amount of financing available and ability of the government (MOH or insurance) to make timely payments can be barriers to quality care. In Ghana, the health insurance scheme's insolvency has been a challenge. When reimbursement of claims is delayed for long periods, some providers do not accept health insurance patients and occasionally revert to cash and carry. In Ethiopia, high out-of-pocket expenditure is still a challenge and impacts quality of care.

Sustainability and scaling up

Currently, links between accreditation and funding in Mexico is only done through a special program for people who don't have social security, called Seguro Popular. Many in Mexico would like to extend the program to the wider health system, including private facilities and social security employees.

In Malawi, sustaining and scaling up PBF is a challenge because it is costly, and donors will only pilot PBF for a short period of time.

Successful practices linking finance to quality

Annex E Table 8 lists some practices that were identified as successful by country stakeholders in institutional arrangements and roles and responsibilities for addressing these challenges. Other ideas and potential best practices shared at the meeting included answers to the following questions:

How to get incentive payments for quality care right?

- Outcome indicators are the most essential measurement for assessing safe care. Move to case-based payments or diagnostic-related groups.
- Add quality indicators to the PBF schemes.
- Currently, many countries use line-item budgeting. Try performance-based budgeting.
- Non-financial incentives should be explored to a greater extent. People can be motivated by non-financial or even smaller financial rewards if the involve real recognition. However, "people don't want certificates anymore," so seek an alternative non-financial reward.
- Quality standards and protocols should be purposively linked with PBF and capitation models, and provider-payment mechanisms should include measurable indicators for quality.

What to do about perceived conflict of interest with one institution paying and overseeing quality?

The Philippines are exploring creating an organization that would operate semi-autonomously and outsourcing the survey/audit function to that organization.

In Ghana, when the health insurance scheme was initiated, the National Insurance Authority was the purchaser as well as the agency responsible for facility accreditation. In 2012, the accreditation function was ceded to the Health Institutions and Facility Regulatory Agency.

How to mitigate the risks of leakage or inadequate funding?

Countries might consider using mechanisms like the Health Sector Services Fund (HSSF) in Kenya, which credits central funds directly into facility bank accounts quarterly. The funds are managed by health facility management committees with community representation. An HSSF-type financing mechanism has the potential to reduce leakage, support reductions in out-of-pocket spending, and improve access to services in hard-to-reach locations. However, if linked to outcomes and performance, the mechanism could be structured in such a way as to increase quality outcomes in peripheral locations.

CONCLUSION

Without quality, UHC is an empty promise. Commitment and political will currently exist, supported by rapid global consensus around providing quality people-centered health care. To that end, the Organization for Economic Cooperation and Development, WHO, and the World Bank are assessing global health quality; the WHO currently is designing an initiative to support countries in the development of national quality policies and strategies. Many countries are developing national quality strategies, including eight in sub-Saharan Africa in the last three years.

However, the evidence base is thin regarding inquiry into the institutional architecture needed to institutionalize and govern for quality within country contexts. Countries are looking for direction. Common challenges identified include defining and appropriately structuring roles, capacity, and responsibilities; communication and well-designed mechanisms for quality assurance and improvement within the context of decentralization; and the often shifting roles among institutions. While some progress has been made in capturing successful experiences, there are still many unsolved questions, which are likely to have no right answer. Given the different country contexts, important questions emerge:

- Should quality assurance and quality improvement be housed in the same institution?
- Should quality assurance be managed separately from the payment mechanism and institution?
- How does a country foster a culture of quality when several institutions (with differing core capacities) manage and impact quality of care?
- How can the front-line-implementation realities of health service delivery drive the development of effective quality governance structures?

Many of the successes documented had common themes. One was multi-stakeholder engagement from the very outset of the process, informing policy, implementation plans, etc. If multi-stakeholder engagement was employed, then when it came to implement reform or quality improvement initiatives, government stakeholders (especially at the subnational level), health care workers, and community groups were already positively engaged to make it work. Another common theme was the importance of transparency. Country representatives cited that transparency helped to ensure support for quality assurance and improvement, mitigate corruption, and increase effectiveness, particularly when third-party payers have a role in quality supervision and improvement.

Through this process of country engagement and shared learning in Dar es Salaam, Tanzania, we have developed ideas for how donors and governments can support quality improvement at the national level as part of UHC:

1. Start a journey towards UHC with quality explicitly in mind, not as an afterthought. Structured institutional roles and relationships at the outset should be established, with sustained and improved quality of care as an objective.
2. Invest in a health information system and the use of data for decision-making. This is essential for UHC regardless and should include quality of care metrics, for all of the reasons cited above.
3. Clarify the roles of quality assurance, improvement, and monitoring and work to prevent overlap and overburdening, or gaps in oversight. Strengthen the technical role of the MOH vis-a-vis the payer.
4. Invest in research—specifically, implementation research on the topic of institutional roles, relationships, and capacities for quality care in the context of UHC. Further research in understanding the institutional architecture for governing quality will add to this evidence base and provide useful guidance to country stakeholders in their search for the right governance architecture to ensure and support quality health services and UHC.

5. Promote ongoing shared learning among countries at the national and global levels. Country representatives expressed a strong interest in establishing a community of practice, including an online platform that offers opportunities to communicate one on one or as a group (with virtual meetings or webinars), share publications, and access other resources.

The time is right to move this agenda forward. There is still a long road ahead, but with continued international and intra-country sharing of best practices and lessons learned, successes can continue to be tracked and used to inform the global community and solutions to challenges can be identified.

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ANNEX A. PRODUCT DEVELOPMENT ROUNDTABLE MEETING AGENDA

Governance and Quality
Product Development Roundtable Meeting
February 29th-March 2nd, 2016
Hotel White Sands

Objectives

1. Compile best practices and lessons learned about institutional roles and responsibilities to govern health care quality efforts in various countries
2. Define priority unanswered questions about the governance of quality at national and sub-national levels
3. Co-develop a practical and useful resource that addresses priority areas identified by country participants
4. Identify concrete actions countries can take to improve the governance of quality that enables, fosters and ensures quality health services

Monday, February 29th - Setting a Strong Foundation

8:30 – 9:00	**Registration**
9:00 – 10:00	**Welcome** *led by Dr. Mpoki Ulisubisya, Permanent Secretary of Tanzania's Ministry of Health, Community Development, Gender, the Elderly and Children, USAID, WHO, HFG, JLN and ASSIST*
10:00 – 10:30	**Coffee Break**
10:30 – 12:00	**Understanding the Context: What do we mean by Quality? – Moderated Discussion** **Lead Facilitator** – *Rashad Massoud, Director of Applying Science to Strengthen and Improve Systems (ASSIST) project* *Discussants: Jason Leitch, National Clinical Director of Scottish Government and Senior Fellow at the Institute for Healthcare Improvement; Shams Syed, Strategic Advisor of Universal Healthcare Unit with WHO; and Jim Heiby, Medical Officer, USAID Office of Health Systems* **Objective:** To achieve common understanding of the definition of quality of care and the goal(s) or vision of quality that the meeting participants are aiming to achieve.
12:00 – 1:00	**Governance of Quality: Themes and Perspectives – Moderated Discussion** **Lead Facilitator –** *Jodi Charles, Senior Health Systems Advisor, USAID Office of Health Systems and Shams Syed, WHO* **Objective**: Validation of the definition and themes of good governance for quality health services, review and discuss the findings of recent research on this topic.
1:00 – 2:00	**Lunch + Group Photo**

2:00 – 3:30	**Scan of County Experience and Synthesis of Key Priority Areas – Small Group Discussion** **Lead Facilitator –** *Kedar Mate, Senior Vice President, Institute for Healthcare Improvement (IHI)* **Objective:** Identify priority unanswered questions, current country challenges in governing quality, what the knowledge gaps are, and brainstorm on how to address knowledge gaps to meet the challenges
3:30 – 4:00	**Coffee Break**
4:00 – 5:00	**Interactive Discussion on Strengthening the Governance of Quality Improvement** **Lead Facilitator –** *Jim Heiby, USAID* *Discussants: Paulina Pacheco, Director of Interinstitutional Entailment and Follow-Up to the International Agenda of Quality in Healthcare, Ministry of Health Mexico and Francisco Soria, Vice President, Philippine Health Insurance Corporation* **Objective:** Share experiences of strengthening existing governance structures in a country through various mechanisms.
5:00 – 5:10	**Day 1 Insights –** *Shams Syed, WHO* **Wrap up, housekeeping –** *Amanda Ottosson, Healthcare Improvement Fellow, ASSIST*

Tuesday, March 1st - Co-Development

9:00-9:30	**Recap of Day 1 and Plan for Day 2** **Lead Facilitator -** *Lisa Tarantino, Senior Associate and Governance Specialist, Health Finance Governance (HFG) project*
9:30-10:30	**Co-Development of Creative Solutions, Successful Lessons, Useful Resources for Governing Quality- Small Group Discussion** **Lead Facilitator –** *Ruben Frescas, Consultant, Department of Service Delivery & Safety with WHO, Lisa Tarantino, HFG, and Kelley Laird, Technical Project Officer, HFG* **Objective:** To further identify common challenges, and share creative solutions, useful resources, and successful lessons related to governing quality services within key thematic areas.
10:30 –11:00	**Coffee Break**
11:00-1:00	**Co-Development of Creative Solutions, Successful Lessons, Useful Resources for Governing Quality– Report Out of Small Group Discussion** **Lead Facilitator –** *Kelley Laird, HFG*
1:00- 2:00	**Lunch**
2:00 – 3:00	**Principles of Governing Quality – Roundtable** **Lead Facilitator –** *Rashad Massoud, ASSIST, Jason Leitch, Government of Scotland* **Objective:** Further establish principles or key processes to align institutional roles and relationships for effective governance that enables, fosters and ensures quality health services
3:00-3:30	**Coffee break**
3:30 – 4:30	**Principles of Governing Quality** – Roundtable Continued Continued Round Table
4:30 – 5:00	**Day 2 Insights** - *Kedar Mate, IHI* **Wrap up, housekeeping –** *Amanda Ottosson, ASSIST*

Wednesday, March 2nd- Way Forward

9:00 – 10:30	**Wrap Up Session – Synthesis** **Lead Facilitator** - *Shams Syed, WHO* **Objective:** Wrap-up session focused on 1) solidifying models and promising practices around institutional arrangements governing quality and tools or principles for governing quality health services, 2) capturing and gaining knowledge on how to structure roles and relationships governing quality, 3) solidifying unanswered questions, 4) determining what tools and practical information countries will find most useful
10:30 - 11:00	**Coffee Break**
11:00 – 12:50	**Moving Forward to Strengthen the Governance of Quality Health Services** **Lead Facilitator-** *Lisa Tarantino, HFG* *Discussants: Rashad Massoud, ASSIST Project & Cynthia Bannerman, Ghana JLN* **Objective:** To develop consensus on next steps when developing a practical resource for countries, including how to disseminate the resource; identifying key actions/next steps for co-developers of the resource
12:50 – 1:00	**Closing Remarks** **Lead Facilitator -** *Jim Heiby, USAID and Dr. Mohammed Ally Mohammed, Director of Quality Assurance, Tanzania Ministry of Health, Community Development, Gender, the Elderly and Children*
1:00 – 2:00	Lunch

ANNEX B. LIST OF PARTICIPANTS

Governance and Quality Product Development Roundtable Meeting

February 29–March 2, 2016

Dar es Salaam, Tanzania

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ANNEX C. TECHNICAL NOTE ON LITERATURE REVIEW METHODOLOGY AND COUNTRY STUDY SELECTION

Excerpted from Cico et al. 2016:

"Country Selection

To facilitate robust findings and country experiences governing successful quality improvement programs, the team used an inductive decision tree to narrow the Governing Quality analysis to 25 countries.

In Phase I and II, we calculated the percent rate of change in infant mortality and maternal mortality between 2000 and 2013 for the 216 countries and territories included in the World Bank World Development Indicators (WDI) database.[5] We selected the year 2000 as the start date due to the completeness of the data for the maximum number of countries, while the end date of 2013 offered the most recent data for the greatest number of countries. We excluded 57 countries with a population of less than one million people as we determined that their findings might be less representative for the target audiences of our review, including JLN and EPCMD countries, leaving 154 countries in the matrix for consideration. We calculated a composite score based on the percent rate of change in infant mortality and maternal mortality for each remaining country; a low score signified a greater percent rate of change in the two indicators.

In Phase III, we highlighted other inclusion and exclusion factors, compiled the relevant country data, and analyzed countries for these factors. Potential exclusion factors included: lack of percent change in infant mortality and maternal mortality, high levels of corruption, as indicated by countries' Transparency International corruption perceptions rank and score, and recent conflict (within the time period of the data), potentially contributing to rapid quality improvements. Potential inclusion factors included: geographic mix (including countries from Africa, Asia, LAC, and Europe), health performance status (including a mix of high, medium, low, and very low health performers, based on composite IMR/MMR score), known policies or strategies in place for governing quality (including a mix of those countries with strategies in place and those without), human development attained (including a mix of high, medium, low human development achieved based on Human Development Index (HDI 2014), current or planned health benefit plan (i.e., health insurance or financial mechanisms for funding health), and finally active JLN engagement.

Next, the panel of experts reviewed the list of countries, including those with the 50 lowest scores, analyzing based on the data presented and their own knowledge of governance of quality in countries to make recommendations for a final list of 25 countries to be included in our review. From this analysis, for example, Kenya, originally suggested for exclusion because of its score on the corruption index, was included in the 25 countries for review after this expert panel review."

Countries studied in the literature review included:
Bangladesh
Cambodia
Chile
Colombia
Estonia
Ethiopia
Ghana
India
Indonesia
Kenya
Liberia
Malawi
Malaysia
Mexico
Moldova
Mongolia
Mozambique
Namibia
Philippines
Rwanda
Senegal
South Africa
Tanzania
Uganda
Zambia

5 Infant mortality and maternal mortality rates are considered particularly strong indicators of quality improvement (Source: World Bank, Health Nutrition and Population Statistics; Last Updated: 04/15/2015).

ANNEX D. SAMPLE OF LITERATURE REVIEW DATA

Where certification, licensing and registration responsibilities are located[6]

COUNTRY	PROFESSIONAL GROUPS RESPONSIBLE	GOVERNMENT RESPONSIBLE	MMR (MODELED ESTIMATE, PER 100,000 LIVE BIRTHS) IN 2015	CORRUPTION PERCEPTIONS SCORE (OUT OF 100)
Bangladesh	√		176	25 (Corrupt-C)
Cambodia	√		161	21
Chile		√	22	73 (Clean- Cl)
Colombia		√	64	37 (C)
Estonia		√	9	69- CL
Ethiopia		√	353	33 (C)
Ghana			319	48 (Medium -M)
India	√	√	174	38 (C)
Indonesia	√		126	34 (C)
Kenya	√		510	25 (C)
Liberia	√	√	725	37 (C)
Malawi			634	33 (C)
Malaysia	√	√	40	52 (M)
Mexico			38	35 (C)
Moldova			23	35 (C)
Mongolia	√	√	44	39 (C)
Mozambique	√		489	31 (C)
Namibia	√		265	49 (M)
Philippines	√		114	38 (C)
Rwanda			290	49 (M)
Senegal			315	43 (M)
South Africa	√		138	44 (M)
Tanzania	√	√	398	31 (C)
Uganda	√		343	26 (C)
Zambia	√	√	224	38 (C)

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ANNEX E. SUCCESSFUL COUNTRY EXPERIENCES REPORTED

TABLE 1.

Governing quality with strategies, policies. and institutional mechanisms

POSITIVE COUNTRY EXPERIENCES REPORTED	
Tanzania	Successfully used facility assessments to inform policy making.
Malawi	Tested quality guidelines on a small scale, which allowed quality guidelines to be updated based on lessons learned in the pilot communities. MOH then scaled up implementation of the guidelines once quality guidelines were finalized.
Malaysia	Quality has been an integral agenda in the Malaysia's five-year health plan. In 1998, a document known as the Strategic Plan for Quality in Health defined the broad agenda in institutionalizing quality in health. In June 2013, Malaysian Patient Safety goals were implemented in all health care facilities in Malaysia to address the key areas of patient safety. Other important policies are National Policy on Blood Transfusion from 2008 and National Medicine Policy. Within MOH facilities at the federal and state level, quality improvement activities are shared through a platform known as Quality Conventions, scheduled annually and biennially at regional (zones) and national level. Sharing of quality improvement projects results in uptake for others to adapt and adopt the best practices. Between the public and private sectors, the Patient Safety Council is the platform for discussions related to patient safety and quality improvement.
Mexico	In Mexico, policies and strategies in place are intended to achieve the expected goals and outcomes underpinned by strong governance. There must also be alignment between national priorities on health and the national health policy, with strong state-federal connections. A priority exists to support and ensure systematic analysis of health care data to identify areas requiring attention. Information from implementation is intended to provide feedback and inform policymakers, technocrats, and administrators to improve strategies.
The Philippines	The content of health service quality policy is in alignment with the national goals. To do this, the government defines the stakeholders involved for accountability, plans for their engagement, strategizes how to implement those policies and concurrently finds the funding support needed.
Ghana	The MOH's medium-term strategy includes strategies for UHC. Health sector stakeholders, including regulators (medical and dental, nursing and midwifery, etc.), are involved in strategy development as well.
Ethiopia	The MOH launched a five-year quality strategy as well as established a quality steering committee, which includes representatives of different stakeholders.

TABLE 2.
Using regulation to improve quality of care

POSITIVE COUNTRY EXPERIENCES REPORTED	
Ethiopia	Ethiopia has one autonomous regulatory body, the Food, Medicine and Health Care Administration and Control Authority, which receives operational funding from the FMOH. This regulatory body licenses and monitors all professionals and facilities in the public and private sector. Fees for licenses are collected from doctors, nurses, midwives, other professionals, and facilities. Health Extension Workers (HEWs) get certification after completing their year-long training. They are paid by the regional governments. Supportive supervision for these workers comes from health centers, where they receive further training from doctors and nurses. HEWs are able to provide integrated community case management (iCCM). The HEWs are formally registered. The health development army (women community health volunteers who are largely from rural areas and mainly provide health information and referrals) is not regulated, and currently there is an informal registration process. The FMOH's 5-year plan is to certify at least 3 million volunteers, and provide supportive supervision through the HEWs. Maternal mortality rates are higher in rural areas. The FMOH has a system for Maternal Death Surveillance and Response (MDSR), which includes mandating that facilities perform internal reviews when a maternal death occurs and make service delivery corrections or improvements. Health development army members give a red or yellow card when referring a woman to a health facility; the red card mandates providers' rapid response.
Ghana	Some of the regulatory agencies generate funds internally, which are used for monitoring, instead of relying on central funds, which are not reliably disbursed. The agencies' zonal offices perform the monitoring activities. In 2009, National Health Insurance Agency representatives began traveling to health care facilities in the districts to conduct clinical and compliance audits. In 2015, representatives from professional regulatory bodies, such as the Medical and Dental Council, Nurses and Midwives Council and Pharmacy Council, were co-opted to join in these visits as another way to enable supervision. The Health Institutions and Facilities Regulatory Agency (HIFRA) currently regulates both private and public health facilities and the National Health Insurance Authority (NHIA) credentials both public and private facilities, using the same standards. For facilities to renew their credentials with NHIA, an average fee of $100 is paid every 2 years for the lowest level of care. In addition, they must submit each provider's facility certification from the Health Facility Regulatory Authority. Doctors are required to meet a set number of credit points for CPD annually. Nurses are also required to obtain three CPD credits a year to renew their licenses.
India	In India, the MOH is expanding the IT infrastructure to develop an eHealth platform. Around 40% of frontline health workers currently have tablets (goal: 100%) and are responsible for uploading real-time client data. In this way, India is increasingly targeting human resource deployment and monitoring/ continuous improvement of facilities that have higher morbidity or disease burdens than other facilities.

POSITIVE COUNTRY EXPERIENCES REPORTED	
Indonesia	While enforcing standards in underdeveloped regions is challenging, the Indonesian MOH, which sets all standards and policies, divides all regions of Indonesia among officials at national level, so one senior MOH official manages and monitors one region. The local health office in the district is responsible for implementing the regulations from the central level. MOH central level oversees the districts, though it's periodic. The central MOH responsible official examines data and will follow up if there are problems.
Kenya	Kenya is testing a franchising model that connects public and private services in a network that works together to improve the quality of health services and improve health outcomes for people served in the network. There are currently three franchise programs being tested in Kenya to improve the quality of private and public services. Kenya's policy requires training curriculums for medical educational institutions to be approved by the respective health professional boards before curriculum is implemented, thus regulating the content and quality of training materials in medical professional schools. The MOH in Kenya wants to embed quality improvement activities within regulation. Thus for facilities to receive licenses and renewals, they must now demonstrate that quality improvement processes are happening, i.e., improvement teams are established, clinical audits occurring, etc. Also, in the near future, ongoing CPD for provider licensing will become part of the law, and will be linked to facilities or providers reimbursement rates.
Malaysia	The MOH of Malaysia sets the guidelines and protocols for providers, pharmacists, and dentists, but standards for meeting these guidelines and protocols are developed and enforced by the Malaysia Medical Council, Dental Council and Pharmacy Board. The norms are communicated in the form of monthly updates and progress reports at the State level and twice a year updates at the national level through meetings. Each provider must apply for annual practicing certification (APC). They obtain CPD points linked to ensuring their competencies each year, and every year each must take compulsory minimum CPDs as mandated by the councils. For doctors CPD points are being used as evidence but for APC renewal purposes, this will commence in 2017. Dental practitioners need to give evidence of their CPD to Council with their APC application form. Malaysia has many Acts that regulate the quality of care, among others Private Hospital Act, 1971, Medical Act,1971, Nurses Act Revised 1969 and Private Health Care Facilities and Services Act has been implemented in 1998 and the requirement is all facilities need to provide incident reporting, reporting of assessable deaths that occurred in the private health care facilities and a board of visitors are being established in the private hospitals to monitor quality aspects of the health care facilities. The MOH has dedicated personnel at national and regional level to monitor whether standards are being met by providers, facilities, supplies and drugs—though there is a shortage of dedicated personnel. Malaysian Society for Quality in Health (MSQH) is an independent non-profit NGO. It is formed through partnership between MOH Malaysia, Association of Private Hospitals (APHM) and Malaysia Medical Association (MMA). The MSQH plays a major role in the accreditation of both public and private hospitals.

POSITIVE COUNTRY EXPERIENCES REPORTED	
Malawi	The MOH, in collaboration with the local government and Rural Development authorities in Malawi have built in feedback mechanisms at the local level. Village Health Committees are involved in and child health audits, including causes of maternal and child deaths. Communities in some areas are involved in establishing punitive or corrective measures when there are problems. For example, by-laws are set in communities to promote facility deliveries for maternal and child health initiatives: any birth at home is punishable by a locally agreed-upon fine, such as a goat or money paid to a village chief. The regulatory bodies, such as the Medical Council of Malawi, Nurses and Midwives Council and the Pharmacy and Poisons Board, are parastatal institutions that make decisions independent of government, though they each implement the policies, protocols, and guidelines of the MOH. All facilities and providers in the private sector must be licensed and certified by the regulatory bodies. The regulatory bodies provide checklists for facilities to monitor the infrastructure and quality of service provision based on standards.
Mexico	The Federal Commission for the Protection against Sanitary Risk (COFEPRIS) issues the initial operating license to all public health facilities (a one-time issuance). However, each facility that provides services to the "Seguro Popular" (a program for people who do not have social security) must be accredited by the MOH (General Direction of Quality and Health Education –DGCES) to ensure they meet minimum standards to operate. Accreditation validity period is currently being modified, and will last five years.
Philippines	Accreditation standards for facilities are in place, with mandatory indicators to be assessed every two years. PhilHealth has streamlined the licensing process for facilities, and has combined accreditation and licensing. Hospitals licensed by the MOH are now qualified for accreditation with PhilHealth. If a hospital desires a higher level of accreditation, they have to apply. Since 2012, accreditation criteria include quality improvement standards as part of the requirements. For example, facilities must show improvements in outcomes over time. The accreditation system is not static; it evolves constantly. Regulation must be flexible when disaster strikes; regulators should relax policies in these situations. In 2013, after the typhoon, the MOH had to relax the accreditation rules, allowing facilities to keep accreditation and health workers to continue working, despite minimal regulation, to ensure responsive distribution systems.
Scotland	Scotland's National Health Services has recently established the CHRE. The CHRE will set and review standards across the regulatory bodies for nurses, doctors, pharmacists, dentists, etc. Facilities do not pay to be licensed, but professionals do pay. However, to receive their licensure they must collect CPD credits, and they must revalidate their licenses every year.
Tanzania	Devolution is a positive change. District Health Management Teams (DHMTs) under the Prime Minister's Office of Regional Administration and Local Government are responsible for inspecting, supervising, and mentoring the over 8000 public health facilities, using standards set by the Ministry of Health, Community Development, Gender, the Elderly and Children. DHMTs enforce and report.
Uganda	In Uganda, professional bodies are coming together to combine regulation processes and functions (included allied professionals and midwives associations). This allows DHMTs, who are responsible for monitoring, supervising and regulating facilities, to review compliance and regulation standards across professions.

TABLE 3.

Involving non-state actors in governing health care quality

POSITIVE COUNTRY EXPERIENCES REPORTED	
Ghana	Some hospital quality improvement teams involve community representatives (e.g., improving referral system) in order to include community perspectives when addressing problems. Some of the hospital boards have a community representative who brings community concerns and perspectives to discussions and relays information to the community. Professional Associations organize continuous professional education for their members.
India	Empowering local government and supporting local bodies (hospital development committees) can help delegate tasks and create ownership at subnational levels. The quality improvement initiatives in hospitals are overseen by local communities (for training, improvement, etc.), with funding support from the government and instituted monetary awards for quality improvement.
Malaysia	The regulation structure which regulates both the private and public sector bears the responsibility in showing a proven level of progress or health improvements for private and public facilities—in place since 1998. An enforcement team comprised of both public and private sector representation has been developed to help monitor this licensing. If facilities fail to show progress, they may have their license to practice revoked or suspended until the facilities comply with the rules and regulations. The private sector is also represented in the patient safety council, which is committed to establishing a safe Malaysian health care system. The council developed the Malaysian Patient Safety Goals to improve patient safety issues in Malaysia. These goals are applicable to both public and private health care facilities in Malaysia. As of June 2013, every health care facility must monitor key performance indicators related to patient safety and submit to the patient safety council. The council will analyze performance and take action to improve patient safety. There are 36 members in the council, comprised of MOH, Malaysia top-level managers, representatives from other ministries, the universities, medical associations and academies as well as patient representatives. At the community level, an advisory board exists for health services provided in that community, and any death that occurs in a local facility must be reported There are many disease-specific NGOs in the country (e.g., Malaysian Diabetes Association, National Stroke Association, Mental Health Association) that provide services, public education and advocacy for their members and the public in general. These NGOS are funded mostly from public donations and a few receive small annual grants from the government. Within the hospital, patient involvement is in the form of Hospital Visitors Boards, where prominent members are appointed. They act as a liaison between the community and the local hospital and safeguard the interest of the patients. In the government primary care clinics, the Health Clinic Advisory Panel serves as a voluntary body and the majority of the members are from the community. The objective is to support two-way communication between health clinics and the community. Among the specific objectives are to speed up delivery of accurate information relating to local health issues in the community and to provide opinions and views from the community in planning and implementation of health activities relevant to local conditions and culture.

POSITIVE COUNTRY EXPERIENCES REPORTED	
Mexico	The citizen participation mechanism used to improve quality of health services in Mexico is called "citizen aval." This mechanism supports quality improvement by sharing the client's perceptions of quality of services provided by health facilities. By December 2015, the MOH DGCES had recorded 14,556 "citizens aval" in the 32 states of the country, integrated by NGOs, universities, private companies and citizens. Continuously, the "citizen aval" develops commitment letters to restore public confidence in health facilities by providing suggestions for improvement. The letters allow the MOH to drive improvement in the quality of health services, by analyzing recommendations and suggestions therein and determining those that can be implemented. The "citizen aval" follows up on the commitment letters by documenting evidence of compliance to making the agreed upon changes based on the recommendations. Every four months, surveys on satisfaction and waiting times are conducted, which are sent to the DGCES for analysis and comparison with the results auto reported by health care facilities in the National System of Health Quality Indicators (INDICAS).
Philippines	Accreditation and contracting for specialized services (i.e., cancer) with private and government hospitals are important mechanisms for securing service quality in the private sector. Private facilities find their own funds to support infrastructure development, but the Philippines prioritized one contract mechanism between the public and private health sectors for improving infrastructure and referral system for cataract diagnosis, treatment and recovery, as it was identified as a priority health issue. Community representation in hospital level committees is important. The local government in the health sector should also hold one seat for a community representative
Scotland	ALISS, a web-based tool for counseling or addiction services, is continuously updated to better orient people and providers to services available. Patient opinion is captured through a web-based "trip advisor" mechanism, listing raw stories to hear the voice of the consumer. These stories and reviews are tagged to facilities/organizations, but not the individuals, and the mechanism is operated by an independent organization. There are 96 organizations ("third organizations"—i.e. voluntary non-profit societies) with some focus on health and social care that receive funding support from the government to fund lobbying events for these health and social care organizations.
Tanzania	The public-private partnership model, including FBOs, is eligible for some governmental support to improve facilities to operate with improved quality. A hospital governing board monitors facility operations and works with the district authorities. The board must have community representation.

TABLE 4.
Garnering political will to pursue quality

POSITIVE COUNTRY EXPERIENCES REPORTED	
Kenya	In Kenya, the MOH uses County Assembly breakfast meetings from 7–9 AM to advocate with local and county politicians on the challenges and priorities for quality health services.
Malawi	In Malawi, Village Health Committees are modeled after the Nepali experience, bringing together technical working groups for improving maternal health, including community leaders, and involving communities in the health improvement process. The committees are located at the community level and involve a wide range of leaders, including village heads, women, youths, representatives from local NGOs, and community health workers. They are involved in setting up priorities for health care delivery in their areas, as well as community mobilization for health care interventions, such as net distribution and immunization campaigns. Some of the committee members are appointed to Health Center Advisory Committees, where they act as a bridge between the community and the health facility workers. They can act as a mouthpiece for the communities.
Malaysia	At the national level, key indicators are developed to monitor the performance of the top level managers in the MOH, including the Minister of Health. Quality is institutionalized in the health system as all staff are geared to ensure that a certain standard is achieved. Trends and patterns of indicator performance, based on specific diseases and procedures, act as a flag to policy makers. This information is reported back to the local managers for immediate action.
Mexico	Enlist support with non-state actors, including interest groups, opinion leaders and the consumers who can be allies voicing the same story with the same data. Can be very powerful. Collect economic data as well to show cost savings and efficiencies as much as possible in improving health quality. Quality of health is currently high on the agenda for the president and he knows the costs of not having quality care (monetary and political). An example where health has been positioned as a national priority is the president's 2013 launch of the National Strategy for the Prevention and Control of the Overweight, Obesity and Diabetes. One of the axes of this strategy is the Quality of Health Services, through the implementation of specific health care models. The strategy was founded on the analysis of the costs of those diseases, and its complications: *"Due to their magnitude, frequency, rate of growth and the pressures on the National Health System, overweight, obesity and non-communicable diseases (NCDs), particularly diabetes mellitus type 2 (DM2), represent a health emergency. In addition, they significantly affect the productivity of businesses, school performance and economic development as a country."* *"According to the National Survey of Health and Nutrition (ENSANUT 2012), the levels of overweight and obesity in the Mexican population pose a threat to the sustainability of the health care system, because of its association with non-communicable diseases, the use of specialized resources and greater technology services, which impose high costs for health care."* *"The relationship between economics and health shows that an increase of 20 years in life expectancy of the population translates into 1.4% additional increase in gross domestic product, so it should be considered that the increase in the prevalence and burden of disease caused by obesity or diabetes may limit such growth."*

POSITIVE COUNTRY EXPERIENCES REPORTED	
Mexico (cont.)	*"According to the Organization for Economic Co-operation and Development (OECD) an overweight person spends 25% more on health services, earn 18% less than the rest of the healthy population and presents laboral absenteeism."* *"The annual direct cost on health care for the public health system of 14 complications from four groups of diseases associated with obesity was estimated at 42 billion Mexican pesos for 2008, under a baseline scenario equivalent to 13 percent of total expenditure on health in that year. The indirect cost of lost productivity was estimated for that year in 25 billion Mexican pesos."* A citizen participation mechanism, called "citizen aval," supports the actions of perceived quality and dignified treatment made by institutions providing health services, in order to assist in improving them. By December 2015, the MOH DGCES had recorded 14,556 "citizens aval" in the 32 states of the country, integrated by NGOs, universities, private companies and citizens. Continuously, the "citizen aval" develops commitment letters to restore public confidence in health facilities by providing suggestions for improvement. The letters allow the MOH to drive improvement in the quality of health services, by analyzing recommendations and suggestions therein and determining those that can be implemented. The "citizen aval" follows up on the commitment letters by documenting evidence of compliance to making the agreed upon changes based on the recommendations. Every four months, they conduct surveys on satisfaction and waiting times, which are sent to the DGCES for analysis and comparison with the results auto reported by health care facilities in the National System of Health Quality Indicators (INDICAS).
Philippines	In the Philippines, PhilHealth works with and sensitizes regional politicians to health priorities. Regional PhilHealth offices are responsible for reaching out and advising and advocating with regional politicians on priorities. We liaise with those who report directly to the politicians and who have a voice with them. Use the PhilHealth accreditation process to collect and present data to local governments in an ongoing and systematic way to show local government politicians the rates of impact from ongoing health investment.
Scotland	Emphasized the need to have a voice at the table. • The Director for Quality and other key stakeholders for governing quality must be in the room to advocate among government leadership. • Important to have a quality voice at the Steering Committee level and able to influence the Chief Medical Officer. • Important to get to know the Special Advisors of important politicians and create allies.
Tanzania,	In Tanzania, reducing maternal mortality became a cross-cutting national issue beyond health service delivery. The MOH, along with other ministries, developed score cards (with the indicators) that pushed accountability of each region to the President on a monthly basis. It became a permanent agenda point for the President, thereby garnering substantial political will and/or priority throughout the system. The scorecards were also monitored and intermittently independently verified by internal and external auditors.
Uganda	Created a Quality Assurance Department, assigning high ranking staff to the department and enabling them to oversee improvement work at the country level to promote political will for quality improvement.

TABLE 5.

Measuring and using data for quality improvement

POSITIVE COUNTRY EXPERIENCES REPORTED	
Ethiopia	The Ethiopian Health Management Information System (HMIS) has been implemented since 2008 to capture and provide core indicators used to improve the provision of health services, and ultimately to improve the health status of the population. The health sector has since showed significant achievements in planning, budgeting, decentralization, review of plans and progress, involvement of partners and utilizing information in decision making. HMIS is a major source of information for monitoring and adjusting policy implementation and resource use. Ethiopia has a scorecard that illustrates current status in relation to what is trying to be achieved. The scorecard communicates to the regional government where facilities lie within the target outcome that was set.
Ghana	Implementation of District Health Information Management System DHIMS II (web-based) has led to significant improvement in data management and access to data by managers and QI teams. Data is validated by quality improvement/data validation teams to improve quality of data. These specific teams are not working on improving clinical processes.
Indonesia	Indonesia has a deliberate process to minimize numbers of indicators. Currently, multiple agencies are coming together to determine the minimum hospital indicators that are necessary. The ultimate objective of this process is to lessen the burden of collecting data, however to fully implement this plan will take time.
Malawi	Malawi is training journalists to represent the information that is given out to the public.
Malaysia	Malaysia is in the process of creating a data warehouse to be utilized throughout the system.
Mexico	The MOH DGCES has developed INDICAS, a tool for recording and monitoring quality indicators in the units of health services that allows comparisons between health care units in the country. Information is self-reported, and so is not completely reliable. DGCES is developing a project with NICE International to strengthen the existing monitoring system, taking into account international experience in the design and implementation of quality indicators. Mexico has an admission identifier that facilitates differentiating patients within the same hospital. Additionally, we are verifying the consistency of a unique patient identifier, which follows patients throughout their care path, from hospital to hospital. Mexico publishes hospital evaluations every year. Results for 2015 may be accessed in the following link: http://www.dged.salud.gob.mx/contenidos/dess/descargas/mh/MH_2015_F.pdf
Tanzania	Tanzania has a health facility scorecard, as well as a district-level council scorecard. These are linked to quality improvement plans. They use the STAR rating system. In Tanzania, a facility's license renewal will be delayed until data is completed.

TABLE 6.

Developing a quality improvement culture

POSITIVE COUNTRY EXPERIENCES REPORTED	
Ethiopia	The Ethiopian Hospitals Alliance for Quality (EHAQ) has been established in 2012, with the aim of sharing experiences among lead and general member hospitals for quality improvement. Best performing public institutions are awarded on regular basis, after being evaluated through a transparent data driven approach.
Malaysia	Best practices from quality assurance projects are presented at Quality Assurance Conventions and then are adopted and adapted into guidelines. The other health facilities are encouraged to uptake the quality projects where applicable.
Tanzania	Set up mentorship programs. Tanzania has found that mentoring works better than training of trainer programs.
Uganda	Uganda engages the community to hold facilities accountable.

TABLE 7.

Addressing the knowledge gap of quality care at various levels

POSITIVE COUNTRY EXPERIENCES REPORTED	
Afghanistan	In Afghanistan, medical schools are governed by MOE and hospitals, by the MOH. After a lot of work, the MOE and MOH agreed that there would be a two-month orientation on priorities, demography, diseases, and environmental challenges. One week of the two-month orientation was specifically dedicated to quality improvement training.
Kenya	Universities and mid-level colleges are embedding quality improvement in their education systems. Kenya has begun to build this into their curricula.
India	Conducts exposure visits to realities within a community. Beyond the health issues but understanding the realities of the rich and poor.
Ghana	In addition to learning sessions, Ghana selected some best practices from other facilities and facilitated visits between facilities to share their experiences.
Malaysia	Quality assurance and patient safety trainings are being conducted in all MOH facilities. Quality assurance modules and a workbook has been developed to ensure standardized understanding of the concept. Surgical safety checklist and incident reporting manuals have also been developed to address patient safety.
Philippines	Conducts exposure visits to realities within a community. Beyond the health issues but understanding the realities of the rich and poor.

TABLE 8.
Linking finance to quality

POSITIVE COUNTRY EXPERIENCES REPORTED	
Ethiopia	Creation of community-based health insurance (CBHI) and other health insurance mechanisms to ensure quality care is adequately financed and thus reduce the risk of poor quality/improper care that can result from heavy reliance on OOP expenditures.
India	Instituted electronic transfers to make payments quicker, which has resulted in better quality. They did not change what they paid for, or the amount, just started paying more reliably. This has resulted in better-run facilities and less corruption.
Malawi	Supporting quality improvement with policy and a budget to come with it. IFMIS the PFM system with auditors help protect strengthen PFM and help ensure that the health budget is not spent on other sectors.
Philippines	Accreditation requirements provide incentives to private and public facility managers to upgrade facilities including equipment, infection control requirements, properly trained health care workers, and increased access to emergency care if needed. It is also an incentive to provide care for the poor (because by meeting the requirements, they can be paid by PhilHealth, the national health insurance agency of the Philippines, for providing services to all those covered, including the poor). Hospitals had improper incentives for offering services under a pay-for-service scheme. Thus, PhilHealth changed the payments to hospitals from service-based to a mix of service and case-based The result so far is that costs of care have increased significantly, but it is expected that quality of care has improved. One of the original motivations to shift to case based was to streamline the claims process and thus reduce administrative costs to PhilHealth. PhilHealth adopted a strategy of very transparent processes to counter the accusation that they have a conflict of interest in governing quality as the payer in the system. PhilHealth and the DOH are working together on another hospital payment reform with the dual objective of increasing quality of care and controlling costs. The DOH has developed performance-based financing for hospital budgets. The system takes into consideration utilization of PhilHealth, (what proportion of clients are PhilHealth), and structure, process and outcome indicators are incorporated. The new payment program reviews length of stay, and if hospitals are being efficient, if patients stay less days, then they have a financial reward. Local government unit hospitals are also in this program. PhilHealth has contributed to the DOH fund. This is the first year of nationwide implementing and thus impact on quality remains to be seen.

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