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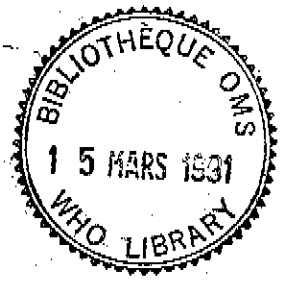
INTERREGIONAL MEETING ON ASSURANCE OF QUALITY IN PRIMARY HEALTH CARE

Shanghai, People's Republic of China
8-12 October 1990



DIVISION OF STRENGTHENING
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1. BACKGROUND

Primary Health Care (PHC) was born out by the noble ideal of the United Nations Charter which states in part that "health is a fundamental human right". It is a strategy which has the potential to bring health to all people at affordable cost and which gives people a chance to have a say in how this is achieved. The need for quality assurance is implicit in the definition of PHC which states in effect that health care will be provided using methods and technologies which are "scientifically sound and socially acceptable". The architects of the primary health care strategy and indeed many health experts have gone to great lengths to stress that it is not a second rate or inferior health care option. It is cost effective but it is not cheap.

Since the enunciation of the Alma-Ata Declaration of 1978, all countries have tried within the limits of their resources to implement primary health care using different approaches and combinations of its basic tenets. As might be expected, achievements have varied widely.

For most countries, the main thrust of this effort has been in the area of improving the coverage of health services. This, in itself, is commendable because it deals with the question of equity. However, the basic issue of quality assurance in its broad sense - including such elements as accessibility, acceptability and client satisfaction, efficiency in the use of resources and technical quality - this seems to have eluded most PHC programmes. This is evident from reports of progress in primary health care carried out by Member States in collaboration with WHO, in 1984 and again in 1988. In many instances no structures were in place for monitoring the quality of services on a continuing basis as an essential component of primary health care.

Admittedly several countries notably in Europe and America have made the effort to introduce quality into their health care services. However these efforts have almost always centered around clinical care - an area with which health services personnel are most familiar. To many health professionals, the concept of quality assurance in primary health care is nebulous and needs further clarification.

In recent times concern for the quality of health services has been growing. Increasingly, Governments and communities alike, are demanding good quality in the services they receive for the investments they make in health. This may be due partly to the extensive development of the concept of quality in industry and the contention that the medical world must be similarly transparent and open to audit. No doubt the difficult international economic order with its attendant steep rise in the cost of services, has also contributed to this.

One thing is certain. The need to build quality into the health services will assume greater importance in the years ahead. How can this objective best be achieved?

The World Health Organization has an important role to play both in advocacy and in providing support to enable countries to build quality assurance activities into their health care systems.

The essential first steps have already been taken by the Organization. It has produced publications which clarify the concept of quality assurance in PHC (Quality Assessment and Assurance in Primary Health Care, WHO offset publication No. 105, and the Programme Statement WHO/SHS/NHP/89.1). The interregional meeting on assurance of quality in PHC was another step in the same direction. It accorded participants the opportunity to get a clearer understanding of the concept of quality assurance and to exchange ideas on how quality assurance can best be promoted in Member States.

2. MEETING OBJECTIVES

1. To develop a better understanding of the concept and rationale of quality assurance in PHC.

2. To share information and lessons from current country initiatives.

3. To make recommendations to countries on strategies and activities for quality assurance.

4. To advise WHO and other Agencies on ways to intensify support to countries in the interest of quality assurance in PHC.

3. MEETING FORMAT

The meeting was formally opened by Dr. S.T. Han, Regional Director, World Health Organization, Regional Office for the Western Pacific. His opening statement which raises some quality assurance issues, is attached as Annex I. Annex II is a list of participants to the meeting.

To provide background information for the discussions, an issues paper covering "Improving the quality of PHC" and "PHC - Concepts and Issues" was presented and thoroughly discussed. This was followed by presentations on quality assurance programmes in a number of countries. Finally a field trip was made to Jiading Province to accord participants the opportunity to see some quality assurance activities on the ground.

The main issues discussed in the meeting from the opening speech, the background paper and the country presentations as well as lessons learnt from these and the field trip are presented in this report. The last part contains conclusions and recommendations

4. QUALITY ASSURANCE IN PHC - ISSUES AND LESSONS

Quality assurance in health has a long history which has developed almost entirely around patient care. Most countries have their own standards for assessing the quality of care provided for patients. For example, in Albania there is a programme for assuring good quality of care for diabetics irrespective of geographic location in the country. Malaysia on the other hand has established a mechanism for

monitoring the quality of various services provided in hospitals so as to detect shortfalls in quality and institute remedial measures in a timely manner. China too has standards for various aspects of hospital practice.

Concern for quality assurance in PHC, however, is relatively new. For many health professionals, the meaning of the concept and its implications for planning and implementing PHC activities are as yet unclear.

It is because of its wide perspective that many health services personnel have found the concept difficult to grasp. In spite of that difficulty, the meeting acknowledged the need for countries to come to grips with it and to introduce quality assurance activities into their PHC programmes. Each country may set its own standards or where feasible, adapt internationally accepted standards. Indicators for monitoring performance will also have to be selected.

4.1 Defining the Concept

While quality of care in clinical practice usually concerns individual patients, in PHC, quality of care concerns whole communities and population groups. For its implementation, it must have a structure which should be an integral part of the PHC management structure. Thus it has functions at the community level, the health centre, the district level, the regional or provincial and national levels.

Quality assurance in PHC is a dynamic process of continuous monitoring of standards. In scope, it covers all the programmes under PHC This means that standards of care might be set for maternal and child care, immunization, the control of communicable diseases, water supply, the supply of essential drugs the treatment of various ailments and so on.

In addition, it covers the various tenets of PHC including community participation, intersectoral collaboration, equity in coverage, ensuring accessibility and providing more services where more care is needed. It is also concerned with judicious use of human, financial and other material resources.

There are several country experiences to learn from. Indonesia for example has national standards for maternal and child health care. The standards relate to the number of visits to be made, the number and types of immunization to be given, as well as the specific examinations to be performed. Similarly China has standards and guidelines for a range of PHC activities to be carried out in the interest of quality assurance. Saudi Arabia too has standards for various PHC activities. These include protocols for conducting MCH clinics, standard management procedures for the control of diarrhoeal diseases and the management of acute respiratory diseases, the supply of essential drugs and so on.

With a little effort, every country could set up its own standards of care for these and other PHC programmes including the quality of water supply, housing and environmental sanitation in the interest of quality assurance in PHC.

4.2 Leadership

Quality assurance will not happen unless it is planned, initiated and its implementation actively pursued. An important first step is the creation of awareness, not only among health professionals but also among political decision-makers. Having opted for PHC as a national strategy for bringing health to their people, political leaders should feel the moral obligation to also ensure that the quality of services provided is the best resources will permit. They should support the programme of quality assurance in a concrete way by providing leadership as well as funding for its implementation. Unless this is done, the disparities which exist in many countries between hospital-based services provided for the urban minority and PHC services provided for the rural majority will not only persist but may widen.

Health professionals should also see the promotion of quality assurance as a legitimate responsibility. They have a social obligation to ensure the safety of the public and to protect it from services which are sub-standard or inappropriate.

Countries should organize appropriate training to enable health workers and other collaborators to understand the concept of quality assurance and how it can be introduced into the health care system.

4.3 Management

Quality assurance should be developed as an integral part of the PHC management structure. The system should be decentralized to regional and district levels and active community participation should be encouraged. This is one way to ensure the sustainability of quality assurance in PHC Community participation will also provide the opportunity to get a feedback from the community on such areas as accessibility, and client satisfaction with the services provided.

Several countries have used different management tools to promote the quality of their services. These include :

1. Decentralization of the management process. This improves management by removing administrative bottlenecks and promoting local initiative. In Saudi Arabia for example, central control is limited to policy formulation, providing technical support, monitoring and evaluation. Programme planning and implementation as well as financial and other resources management have been decentralized to regions and districts. Indonesia too has a similar system and is practicing area-specific planning.

2. The Use of Supervisory Check Lists. These make supervision more systematic and thorough. Service providers therefore benefit more from supervisory visits and tend to provide better quality services. Supervisory check lists also promote uniformity in task performance.

   Saudi Arabia, Indonesia and no doubt many other countries have developed supervisory check lists appropriate to their needs.

3. Providing incentives for good performance: award schemes encourage workers to give of their best. In Saudi Arabia for example, cash, better career prospects and opportunities for further training are used as incentives for good performance. China too provides incentives through public acknowledgement and the award of certificates of merit. Another form of incentive exists in Malaysia. A hospital's reward for good performance lies in not being included in the list of "outliers", a term used for hospitals whose performance is adjudged to be below standard.

4. Management Information System: A good management information system is an important requirement for quality assurance in PHC. In a decentralized management structure, the information needs of the different levels will differ and this should be taken into consideration in designing the system.

   Data collected should be based on need as determined by appropriate studies. Personnel at the different levels should be trained and given the requisite skills to enable them analyse data generated by them and use the information for planning and monitoring their own performance.

   Providing feedback is an important but often neglected aspect of data management. After data analysis at the national or regional level, it is important to provide a feedback to the different levels where the data was generated. This enables the personnel to view their performance against the performance of others. What is more, getting a feedback is an incentive for improving the collection of data.

   Some countries promote information sharing and provide feedback by publishing newsletters and bulletins.

5. Training: All aspects of PHC implementation including quality assurance, require skills for which training is essential. Unfortunately, many countries train their health professionals without including training in quality assurance activities. This is one reason the concept of quality assurance in PHC is proving so difficult for health personnel to grasp.

   Countries need to modify the curriculum for training health professionals at all levels to include quality assurance. In addition, training programmes in quality assurance should be organized for serving personnel.

   Training should not be restricted to health professionals alone. Other sector workers, including non-governmental organizations and community members, who have a stake in health, should also receive appropriate training.

4.4 Research

Quality assurance in PHC is a relatively new area of concern. Consequently, little experience exists in member countries regarding how best to assure quality in PHC programmes. Therefore, research has the potential to make useful contribution to the development of new mechanisms and approaches in support of quality assurance.

In Indonesia for example, research was carried out to determine what data was appropriate for use at different levels of the PHC management structure. In another research endeavour, 100 villages were used for trying out various options for providing sanitation. Countries could make significant contributions to knowledge and experience in quality assurance through research.

4.5 Financing

Most countries suffer from a shortage of funding for primary health care. This is usually due to a combination of factors. These include the age-old bias for hospital-based services, competition with other sectors of government, and the difficult international economic situation which makes resources generally short.

In many instances, government financial support for PHC is too small to make a significant impact on the quality of services provided. Yet because of the importance of health to socio-economic development, investing funds in quality assurance in PHC will be a good investment for the future well-being and development of the people.

5. CONCLUSIONS AND RECOMMENDATIONS

Quality assurance in PHC is a relatively new but important area of concern in health care development. It is concerned with the attainment of acceptable standards in the implementation of the different programmes under PHC. In view of the great potential that PHC has for bringing health to all peoples, countries should make the assurance of its quality one of the priorities in health care development during the rest of this decade.

Promotion of the concept presents challenges as well as excellent opportunities for international collaboration in health. The World Health Organization has an important catalytic role in the sharing of information and experiences in quality assurance programmes. Furthermore, the organization has a leadership role in encouraging countries to introduce quality assurance activities into their PHC programmes.

At the country level, health professionals, politicians and communities all have stakes in quality assurance in PHC. Health professionals have standards of professionalism to maintain. They also have the social obligation to ensure the safety of the public and to protect the public from substandard or inappropriate care. Politicians owe it as a duty to ensure that they get good returns for the investment they make in health care. Community members have a right to demand good quality care because it is they who generate the resources that go to support the health care services. What is more, it is they who bear the scars of poor quality care.

In support of the call for the promotion of quality assurance in PHC, the meeting made recommendations to countries and WHO in five main areas including management, training, research and development, financing and legislation.

5.1 Management

Many countries have not got in place, effective management structures which facilitate decentralized problem identification, priority setting and the planning and implementation of remedial action. Often, the data required for management decision making is also lacking. It was recommended, therefore, that :

- countries develop or strengthen their management systems for PHC by improving the managerial processes at the different levels and providing appropriate management tools for quality assurance in PHC;

- in recognition of the importance of community participation for the success of the quality assurance programme, community representatives should be involved in the development and implementation of action plans for quality assurance;

- at each level of the PHC management structure leaders should be identified or strengthened in their role of promoting the quality assurance effort. Persons in leadership roles should be selected from all governmental and non-governmental organizations which have a stake in health;

- at the central level, the leaders should be responsible for coordinating all quality assurance activities and should ensure the development of plans of action for quality assurance;

- WHO should strengthen its support to countries for the development of management capabilities for quality assurance in PHC. In addition, the organization should take up the challenge to urge governments to play a leading role in promoting quality assurance in PHC.

5.2 Training

Primary Health Care implementation including the assurance of its quality, requires skills for which training is necessary. Since quality assurance is a relatively new concept, much training will be needed not only for health professionals but also for all persons involved in P.H.C. implementation. It was recommended that:

- countries mobilize resources from all possible sources - government, non-governmental organizations, universities and the community, in support of the development of appropriate training programmes for quality assurance in PHC;

- countries provide appropriate motivation and training for personnel at all levels involved in PHC. implementation, irrespective of their sectors of origin;

- countries carry out appropriate modification of the training curricula for health professionals to include quality assurance in PHC;

- WHO support for training should give a high priority to training in quality assurance in PHC.

5.3 Research and Development

Experience in quality assurance is relatively limited. If new and more efficient ways of providing good quality care are to be found, then it is essential for countries to accord research some importance. It was, therefore, recommended that:

- countries should give research a high priority within their national plans and policies for health development in general and PHC in particular;

- research should be of a problem solving nature and should have a multi-disciplinary character, drawing resources and inputs from different sectors and institutions;

- Research should focus on:

  (a) issues of equity, community participation, accessibility, intersectoral collaboration and selection and application of appropriate technology;

  (b) the development of guidelines, standards and indicators for monitoring of quality in PHC.

- Research findings should :

  (a) be used for decision-making at policy and operational levels;

  (b) be built into the training and orientation programmes of all personnel in PHC.

  (c) should be integrated into the management information system.

- WHO should review critically the potential role which its collaborating centres could play in supporting national capacity building for this type of research and the development of guidelines, standards and indicators;

- WHO should strengthen its capabilities for supporting countries in their research efforts in the area of quality assurance in PHC and should set an example by making this type of research a component of its action programmes.

5.4 Financing

In view of the considerable contribution PHC could make, not only to health but also to socio-economic development in general, the programme deserves every support. Therefore, in spite of the world financial crisis affecting most countries, adequate funding should be provided for the different quality assurance activities under PHC including research and training. It is recommended that:

- countries should increase the proportion of the national budget allocated to PHC to a reasonable level;

- countries should seek additional funding for PHC from other sources;

- countries should utilize resources available for PHC more efficiently;

- countries should allocate funds specifically for quality assurance activities as an integral part of PHC;

- WHO should support country initiatives for the development of quality assurance programmes by allocating funds for interregional, regional and national training and research activities.

5.5 Legal Framework

The implementation of many aspects of PHC can be best assured if backed by appropriate legislation. The area of intersectoral collaboration for example, could benefit from legislation which in most countries does not exist. It was, therefore, recommended that:

- countries demonstrate their commitment to quality assurance as part of PHC;

- the managerial processes for the development of PHC, intersectoral collaboration, and the allocation of resources needed for PHC activities should be enforced at the national and other levels through legislation as necessary;

- countries should support quality assurance activities by providing legal backing for confidentiality of certain quality assurance activities such as a peer review;

- countries should enact appropriate legislation for enforcing standards of performance in PHC programmes;

- WHO should promote the implementation by countries, of the recommended activities.

ANNEX I

Opening Remarks by Dr S. T. Han, Regional Director,
World Health Organization, Regional Office for the Western Pacific

at the
Interregional Meeting on Assurance of Quality in Primary Health Care

Shanghai, People's Republic of China
8-12 October 1990

Honourable Chen Minzhang,
Minister of Public Health
Honourable Zhu Rongji,
Mayor of Shanghai,
Ladies and Gentlemen,

On behalf of the World Health Organization, I would like to welcome all of you to this Interregional Meeting on Assurance of Quality in Primary Health Care.

I thank the Ministry of Health, the Government of China and the Shanghai Municipality for agreeing to host this important meeting and for the excellent arrangements and facilities that have been put in place to ensure its success.

The problems of health services around the world were reviewed by the International Conference on Primary Health Care in Alma-Ata in 1978. there was great concern about the inequities in health and health care that afflicted every country in the world, developed and developing alike.

However, there were several examples of alternative approaches, including that of this country, China, where the concerted effort of the government and the people had resulted in substantial and widespread improvements in health. Encouraged by these, the Conference called for radical changes in both the content and the design of health systems, with the goal of achieving Health for All by the Year 2000. Primary health care, intersectoral action and community participation were set out as the approach to be used by countries and the global community in pursuing that goal. The Conference also stressed that to be effective these efforts should be based on "scientifically sound and socially acceptable methods and technology". Scientific soundness and social acceptability are, of course, major aspects of quality in health care. Thus this concern for quality is part of the definition of primary health care outlined by the Alma-Ata Conference. The practical details and the specific activities for achieving it were left for individual countries to determine.

Mid-term reviews of progress in primary health care recently carried out by countries in collaboration with WHO indicate that many countries are encountering enormous difficulties in the assurance of quality in primary health care. In some

reports the concept of quality is equated with sophistication, and thus it is seen as a threat to national efforts to extend health care to underserved populations. In such situations, primary health care is seen as second-rate care for countries or population groups that cannot afford good doctors and services. Quality assurance is an important means for health workers to identify their deficiencies and take corrective measures, but involves other issues as well. For instance, the need to involve the users of health care in quality assurance must be emphasized in all programmes. They are best judges of such factors as accessibility and effectiveness. Community participation is essential in planning, defining standards and managing quality. Quality must be emphasized at all stages of planning, organization and delivery of services, and in assessing their impact.

All countries are expressing increasing concern about value for money. Economic difficulties have resulted in severe budget cuts for health care in developing countries. But at the same time, the soaring costs of health care are putting heavy pressure on individuals and governments to increase their contributions for health services. This has resulted in more interest in financing arrangements and widespread calls for better accountability in the health services. Success in obtaining funds for health services will depend to a large extent on the ability to show that the available health resources are being used to deliver health care of the highest quality possible.

Discussions on assurance of quality in the past have centred on clinical medicine, but it is important to define quality assurance for primary health care as well. But this meeting is expected to go further than making definitions. Many questions are arising. For instance, how do we establish such a comprehensive concept of quality assurance? What are the ingredients? What is the role of the ministry of health? What are the implications at the national and local levels? What type of training programmes are needed? What examples are there for countries to draw on for inspiration, or for lessons in what to avoid?

That is what has brought us together for this meeting. Your objectives are:

1. to develop a better understanding of the concept and rationale of assurance of quality in primary health care;

2. to exchange information and lessons from current country initiatives to assure quality in primary health care;

3. to make recommendations to countries, particularly developing ones, on strategies and activities for assuring quality in their health systems;

4. to advise WHO and other agencies on ways of intensifying support to countries in this area.

Your findings and conclusions will directly affect the efforts of workers in primary health care in many countries. so I wish you a very fruitful week of hard work, as well as a pleasant stay in this fascinating city.

ANNEX II

INTERREGIONAL MEETING ON ASSURANCE OF QUALITY IN PRIMARY HEALTH CARE
Shanghai, People's Republic of China
8-12 October 1990

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