

Cleaner, safer health facilities: what else should SEARO be doing on the quality and safety agenda?

Informal experts' consultation, 27–28 March 2019

Why this expert consultation—and why now?

Poor quality care remains common, especially in developing countries. Disadvantaged groups are particularly affected. A recent report has called it “the global quality chasm”¹. A range of statistics reinforce this message. Incorrect diagnoses and treatment are frequent: in low and middle-income countries mothers and children get less than half of recommended clinical actions in a typical visit; less than half of suspected cases of TB are correctly managed.² Millions of cases of diarrhoea are unnecessarily treated with antibiotics, increasing the risk of antimicrobial resistance. Health care itself has unnecessary risks to health. One in ten hospital patients in developing countries gets a health-care associated infection, of which many are preventable.³ Unsafe injections were responsible for as many as 33,800 new HIV infections and 1.7 million hepatitis B infections in 2010.⁴ Even more concerning, some real basics are missing: nearly 40% of health care facilities in low- and middle-income countries lack improved water and nearly 20% lack sanitation.⁵ Even in facilities where supplies are available, low adherence to hand hygiene and other safe care practices has been found. One-third of patients experience disrespectful care, short consultations or long wait times. Emerging evidence on the “know-do” gap shows that short consultation times are more prevalent in low-income countries, even where providers have fewer patients.⁶ Poor quality, unsafe care is not just a hospital problem. A significant share of adverse events occurs in out-patient settings. Inadequate integration across levels of care and weak referral systems undermine care for complex conditions.

Poor quality and unsafe care extracts a heavy toll. The Lancet Global Health Commission on High-Quality Health Systems estimates that more than 8 million people a year die from conditions that should be treatable by the health system. “Poor-quality care is now a bigger barrier to reducing mortality than insufficient access. 60% of deaths from conditions amenable to health care are due to poor-quality care, whereas the remaining deaths result from non-utilization of the health system”.⁷ Perceived poor quality can also deter timely care-seeking or promote bypassing of facilities. The Lancet Commission found that wealthier households fare better than poorer ones in receiving care of adequate quality, with inequities being the widest in low-income countries compared to middle-income countries.

The associated costs are also high. For example, medication errors are estimated to cost US\$42 billion each year.⁸ Poor quality care wastes scarce resources.⁹ Harm to patients results in broader economic and social costs, including from higher health costs, disability, lower productivity and earnings.

Progress towards universal health coverage (UHC) will be seriously constrained without improvement in the quality of both frontline services and inpatient care. Adequate quality and

safety, especially in frontline services, can improve the public's trust in health services and lead to increased use by those in need, reducing the pressure on secondary and tertiary care.

Political commitment to improving quality and safety as part of UHC is increasing. The Sustainable Development Goals have a UHC target (3.8), which recognizes this: "Achieve universal health coverage, including financial risk protection, access to **quality** essential health-care services and access to **safe**, effective, quality and affordable essential medicines and vaccines for all". WHO's 13th General Programme of Work includes the "UHC billion". A high-level meeting of the United Nations General Assembly will discuss UHC in September 2019

There is fresh attention to positioning primary health care (PHC) as the cornerstone for accelerating progress on UHC, for example in the recent Astana Declaration on Primary Health Care in October 2018.¹⁰ In the South-East Asia Region, the reality is that despite long political commitment to PHC, frontline public health services are often underutilized, in part because of perceptions about poor quality care. If PHC is indeed going to be 'the cornerstone' for advancing UHC, then some transitions are needed including a re-examination of ways to improve the quality and safety of frontline services, and links to secondary care (see Box 1).¹¹ Managing change in countries is both a technical and political challenge.

Box 1 Moving the PHC and public health agenda forward as part of UHC: transitions needed

- From institutional prescriptions, to a focus on health system outcomes: universal access to needed care without financial hardship.
- From primary level care in isolation, to addressing frontline and hospital services together, and harnessing new technologies.
- From episodic, low quality frontline services, to continuity of high-quality care.
- From familiar to fresh approaches to community engagement, given more informed populations.
- From partial and ambivalent to more systematic and managed engagement of private providers.
- From routine primary care, to primary care also capable of outbreak surveillance and response.
- From political commitment to equity, to practical implementation of effective solutions for all.

Three key reports in 2018 have provided new global momentum on quality:^a

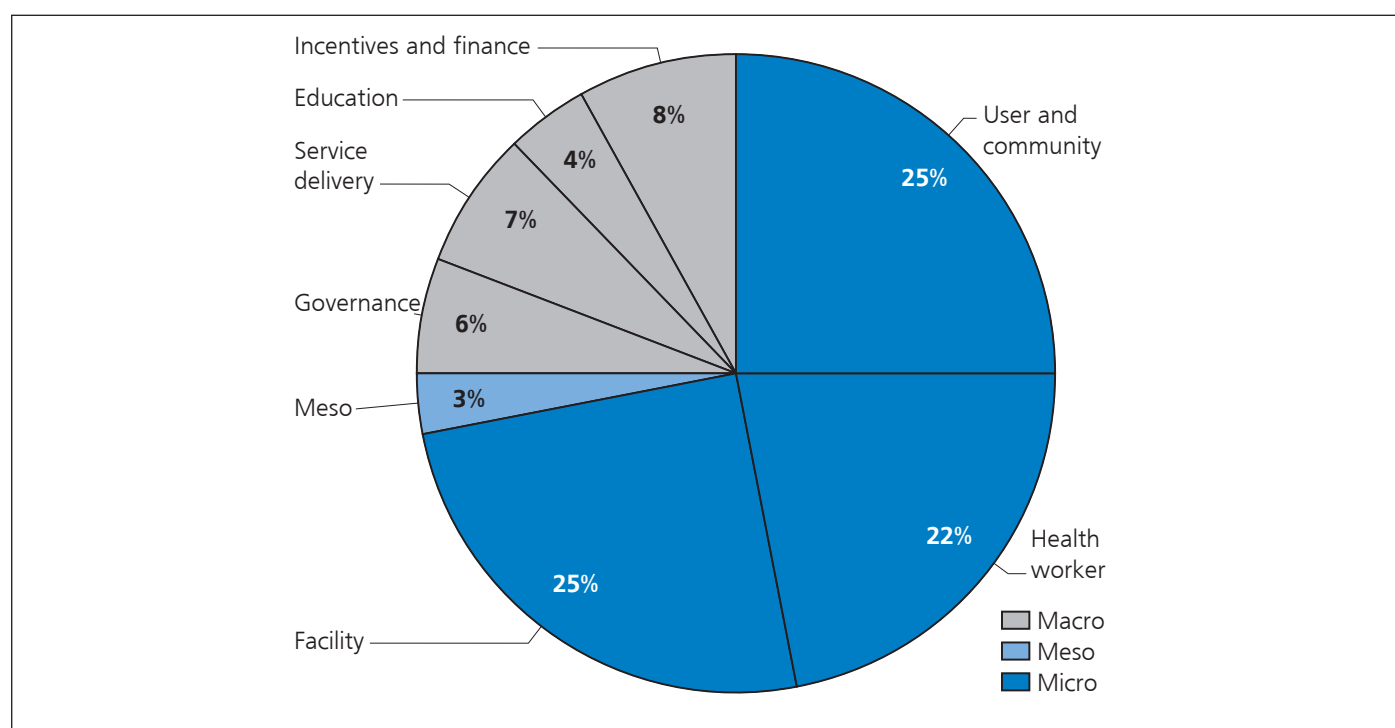
- Crossing the global quality chasm: improving health care worldwide, by the Committee on Improving the Quality of Health Care Globally, of the National Academies of Sciences, Engineering, Medicine.
- Delivering quality health services: A global imperative for universal health coverage, from WHO, OECD and the World Bank
- High-quality health systems in the Sustainable Development Goals era: time for a revolution, from The Lancet Global Health Commission on High Quality Health Systems in the SDG Era.

Each confirms the magnitude and costs of the problem and suggests concrete ways forward. All argue that improving quality of care requires action at multiple levels of the health system. The Lancet Commission in particular makes a clear case that point of care or 'micro-level' interventions alone have modest effects on provider performance if the surrounding system does not change, and that they are difficult to scale and sustain over time. It also notes that multiple microlevel

^a Annex 1 provides a brief overview and summary of each report.

interventions can lead to dilution or duplication of effort, and even the distraction of managers from other health priorities. However, the evidence shows that almost three quarters of the strategies for quality improvement have focused on point of care interventions (Figure 1).

Figure 1: Types of interventions and levels targeted to improve PHC quality according to published literature from 2008-17



Source: Lancet Global Health Commission on High-Quality Health Systems in the SDG Era: Time for a revolution, 2018

How can this informal experts' consultation help?

This informal experts' consultation will discuss how to 'expand the solution space', as the Lancet Commission calls it, to accelerate progress on health care quality and safety in SEAR, while keeping a strong focus on ensuring that WHO actions collectively contribute to many more 'cleaner, safer health facilities'.

This consultation's unit of focus is health facilities, including frontline health facilities. It is designed to build on what is already being done by Member States, WHO and others to improve health care quality and safety in the South-East Asia Region. Its underlying premise is that some real basics still need more attention, and on the reality that after many years there is still a major problem with access to adequate quality care. The consultation will help to identify gaps and consider what could and should be done in addition, or differently, to accelerate progress.

What do we know about the scale of the problem in SEAR countries?

A. Data on quality and safety in SEAR are scarce; trend data even more so.

This section provides a short summary of published multi-country information on health care quality in this Region. It is organized around three commonly accepted dimensions of quality: basic amenities or 'inputs'; service coverage of essential interventions, and service quality i.e. processes of care. Given the many apparent information gaps as well as data quality challenges, one session of this consultation will consider how to better monitor progress on improving quality and safety in SEAR.

(1) Service inputs: basic amenities, equipment

Information on essential service inputs is available from surveys such as WHO's Service Availability and Readiness Assessments or equivalent in a few SEAR countries. Figures 2 and 3 show significant variations and gaps in the availability of basic amenities and equipment in frontline facilities in five SEAR countries.

Figure 2: Basic amenities in frontline facilities

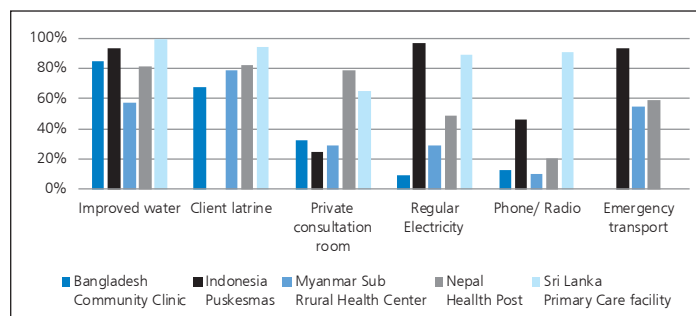
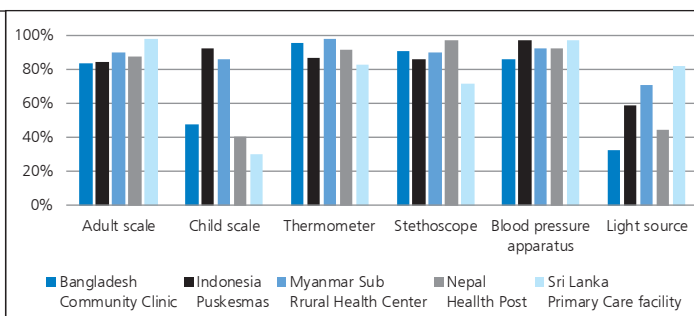


Figure 3: Basic equipment in frontline facilities



Sources: 1. Bangladesh Health Facility Survey 2014 Final Report; 2. *Is Indonesia Ready to Serve?: An analysis of Indonesia's primary health care supply-side readiness*, World Bank 2018; 3. *Nation-wide service availability and readiness assessment (SARA) Myanmar 2015*; 4. *Nepal Health Facility Survey 2015 Final Report*; 5. *Service availability and readiness assessment, Sri Lanka, 2017*, Ministry of Health and Department of Statistics, WHO, the Global Fund.

(2) Service outputs: coverage and continuity of care

A second dimension of quality is % population coverage of effective interventions. Vaccination rates – for example, for DPT3 and measles – are universally available and quite commonly used as a (very) crude proxy for system quality in data-limited situations. Coverage data for antenatal care and hypertension detection and control are increasingly available and can be considered proxies for continuity of care. Figures 4 and 5 show that these rates vary widely across countries. Hypertension detection and control show the largest gaps.

Figure 4: Antenatal care coverage (4visits)

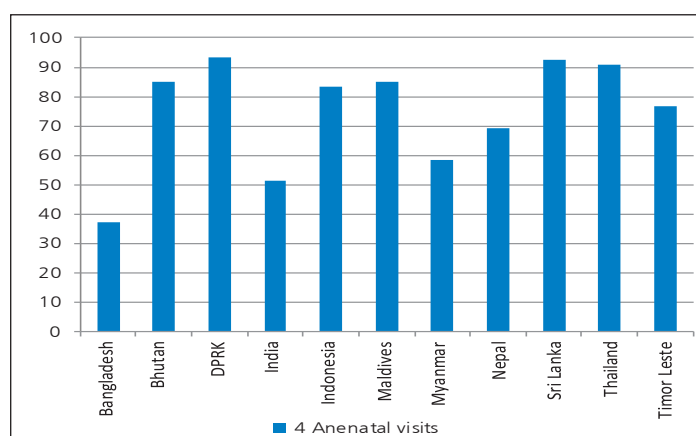
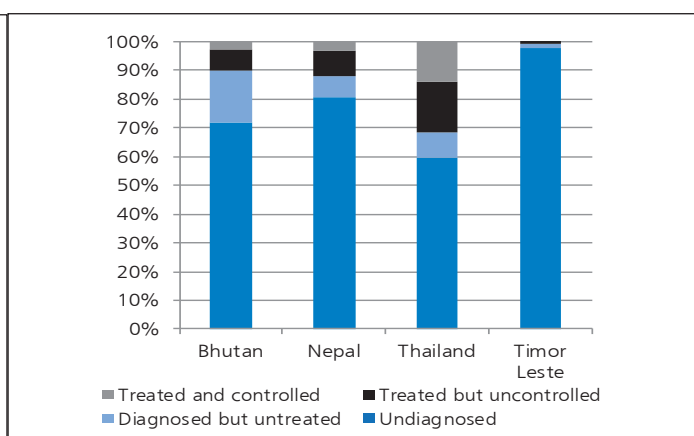


Figure 5: Hypertension detection and control, selected countries



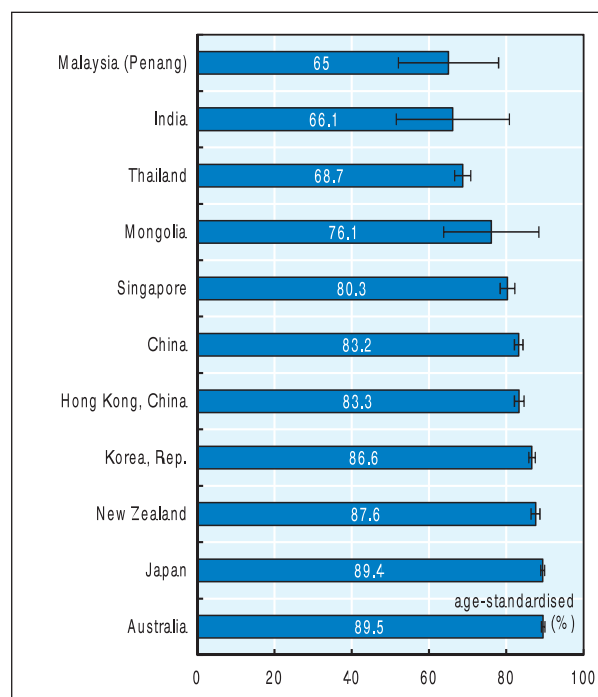
Sources: National DHS, MICS and STEPS surveys.

(3) Health service quality: survival rates; antibiotic use

A third dimension of quality is the quality of clinical care provided. The OECD-WHO publication *Health at a Glance in the Asia-Pacific*¹² reported using two types of indicator: in-hospital mortality following acute myocardial infarction and stroke, and five-year net survival rates for breast, cervical and colorectal cancer. SEAR country data were scarce: of the 11 Asia-Pacific countries reporting

on 5-year survival for breast cancer, only 2 were from SEAR. Survival rates ranged from 65 to 89.5 percent (Figure 6). Some limited data on case management exist from case studies in 10 SEAR Member States and two provinces in India. These show an inappropriately high percentage of upper respiratory tract infections being treated with an antibiotic (Table 1).

Figure 6: Breast cancer 5-year net survival (%), adults (15-99 years), 2010-14



Source: Global surveillance of trends in cancer survival 200-14 (CONCORD-3).

Table 1: % Upper respiratory tract infections treated with an antibiotic

Country	% upper respiratory tract infection cases treated with an antibiotic
Bangladesh, 2014	59-60%
Bhutan, 2015	26-42%
DPR Korea, 2012	58-81%
Rajasthan, India, 2013	81-100%
Karnataka, India, 2013	64-78%
Indonesia, 2011	72%
Maldives, 2014	34-48%
Myanmar, 2014	73-96%
Nepal, 2014	63-71%
Sri Lanka, 2015	47-85%
Thailand, 2012	54-62%
Timor Leste, 2012	69-88%

Source: WHO country situational analyses 2011-15

B. What actions are being taken in SEAR to improve service quality and safety?

SEAR Member States are not starting from scratch.

Most have long had a range of policies and strategies to improve quality and safety. Many interventions are implemented by programmes such as maternal and child health; WASH; AMR; infection prevention and control (IPC) or health emergencies' programmes. Many countries also have national quality and/or patient safety strategies, with interventions targeted at different types and levels of health facility. Box 2 offers a snapshot of selected policies and strategies being used by SEAR countries. It is illustrative, not complete, but can be used to stimulate discussion in the meeting.

Box 2 Selected policies and actions by Member States

- **Bangladesh** has introduced quality improvement committees at all levels of care in the public health sector, with a facility performance scoring system that is publicly accessible online in real-time.¹³
- **India** has developed a national patient safety implementation framework (2018-2025) and introduced Health and Wellness Centre reforms to ensure better quality and more integrated care.^{14,15}
- **Indonesia** has used accreditation of hospitals as a key policy instrument to improve quality for over two decades. In 2015 it established an Accreditation Commission for Primary Health Care Facilities. By 2018 over 53% of hospitals and about 3,500 primary health care facilities had been accredited.¹⁶
- **Sri Lanka's** National Policy on Healthcare Quality and Safety, 2015 sets 7 key result areas spanning clients, managerial and process systems, clinical effectiveness and staff development. A set of national quality guidelines and frameworks of standards are guiding progress.
- **Thailand** has developed outcome-based primary care quality monitoring indicators that capture progress on outcomes for high-burden conditions from existing data and are scored for use in pay-for-performance.¹⁷
- **Timor-Leste** has entered into a Twinning Partnership for Improvement with Macau (SAR)China to obtain focused support on specific aspects of quality improvement in selected health facilities.

C. What is WHO doing to improve health care quality and safety in SEAR?

Different SEARO programmes are already pursuing a wide range of activities (see Table 2 for an overview). The meeting will discuss how to build on these activities; it will identify where opportunities may exist for further synergies or simply greater coordination between them; and it will identify gaps that exist in the current response repertoire, which – if not addressed – will hinder efforts to accelerate progress towards cleaner, safer health facilities.

Table 2: Snapshot of WHO-supported activities in SEAR countries

WHO program activities in SEAR	BAN	BHU	KRD	IND	INO	MAV	MYA	NPL	SRL	THA	TLS
POCQI (# of hospitals)	55	4		>100	6	4	5	6	16		1
WASHFIT assessments											
JEE of IHR core capacities											
AMR NAP situation analysis*: WASH	4	5	5	3	4	4	2	4	4	4	3
AMR NAP situation analysis*: IPC	2	2	3	3	3	2	2	1	4	3	1
Patient safety assessments											

*AMR NAP situation analysis phases: 1: exploration and adoption; 2: programme installation; 3: initial implementation; 4: full operation; 5: sustainable operation

- **Point of Care Continuous Quality Improvement (POCQI)**: Within the regional framework for improving quality of care for RMNCAH, the POCQI approach supports actions by teams of obstetricians, pediatricians, nurses and midwives to improve the quality of care in labour rooms or wards and newborn care units in health facilities. Several hospitals across 9 Member States in the Region^b have begun implementing these practices, ranging from 1 in Timor-Leste and 4 each in Bhutan and the Maldives to 55 in Bangladesh and over 100 in India.

^b These are: Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Timor-Leste.

- **WASH:** WHO supports reporting on and implementation of WASH standards and the IPC core components guidelines in health facilities. At least three SEAR Member States are implementing the WHO/UNICEF Water and Sanitation for Health Facility Improvement Tool (WASH FIT), covering water, sanitation, health care waste and general management.¹⁸ The WHO-led UN-Water Global Analysis and Assessment of Sanitation and Water (GLAAS)^c helps track progress on WASH in health care facilities. In the 2017-18 situation analysis of AMR national action plan implementation, Myanmar reported being at the installation phase, India and Timor-Leste at the initial implementation phase, Bangladesh, Indonesia, Maldives, Nepal, Sri Lanka and Thailand at the full operation phase, and Bhutan and Democratic People's Republic of Korea at the sustainable operations phase, with regard to sanitation and hygiene in the AMR context.¹⁹ WHO supports vulnerability assessments and implementation of actions to strengthen **climate resilience** and the adoption of green technologies, including at the health care facility level.
- **IPC:** Infection prevention and control is an essential element of good quality care. It features in many regional and global strategies and action plans, as well as clinical guidelines. For example, IPC is included under Focus Area 5 (Prevention through health care) of the Asia-Pacific Strategy for Emerging Diseases and Public Health Emergencies; improving IPC and WASH is one of the 5 objectives in WHO's AMR Global Action Plan.

Box 3 IPC: summary of progress from AMR national action plan situation analysis

In the 2017-18 situation analysis of AMR national action plan implementation, countries reported on their IPC related activities. Nepal and Timor-Leste reported being at the exploration phase, Bangladesh, Bhutan, Maldives and Myanmar at the programme installation phase, Democratic Peoples' Republic of Korea, India, Indonesia and Thailand at the initial implementation phase, and Sri Lanka in full operation phase with regard to IPC in health care settings.²⁰

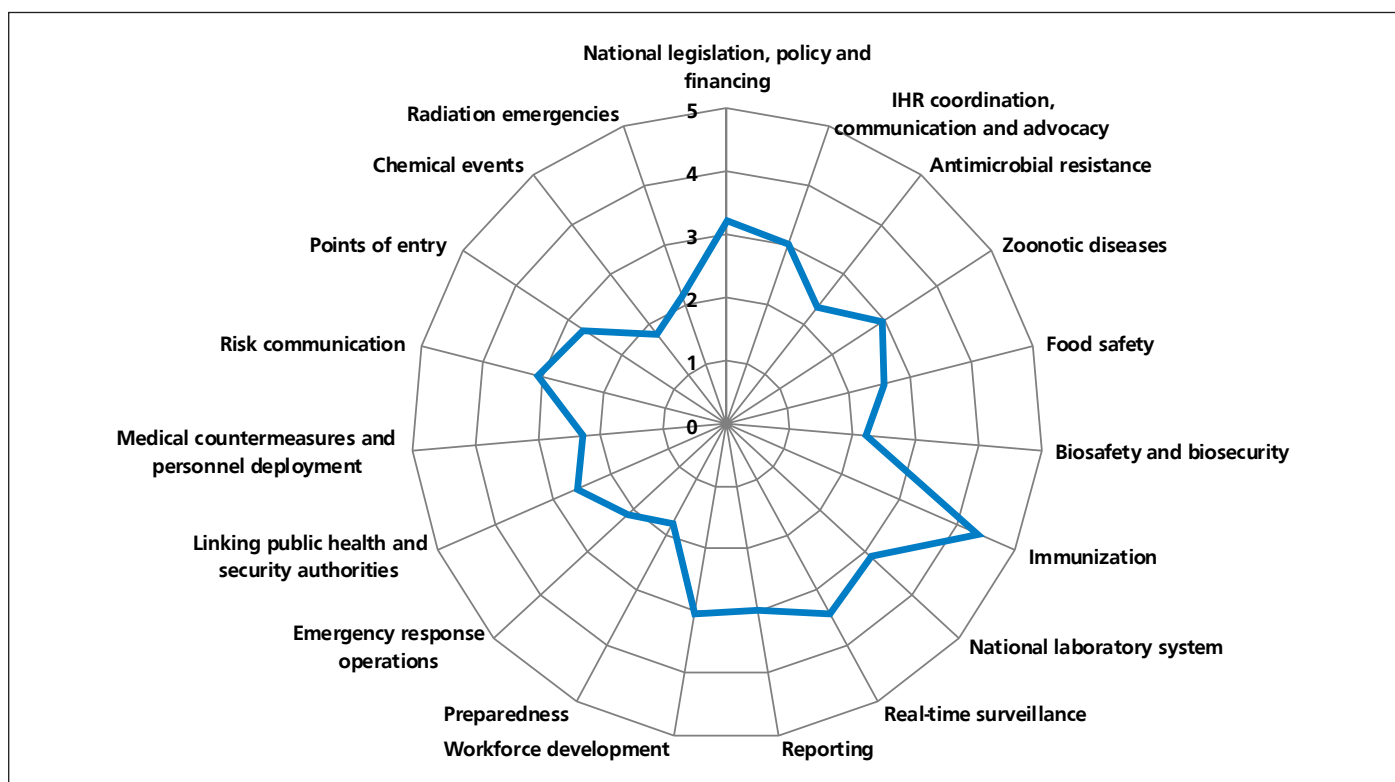
SEARO itself needs to develop a more systematic, substantial and sustained approach to supporting improved IPC in frontline and secondary level health facilities. A range of global IPC tools and guidelines exist. WHO has identified 8 core components of IPC programmes, namely, IPC programmes at health care facility and national level; national and facility level IPC guidelines; IPC education and training; health-care associated infection surveillance; multimodal strategies for implementing IPC activities; monitoring and evaluation and feedback; workload, staffing and bed occupancy at the facility level; and built environment, materials and equipment for IPC at the facility level. WHO is currently conducting a global survey on the current level of progress of IPC programmes and hand hygiene activities in health care facilities, based on two WHO facility-level tools, namely, the IPC assessment framework and the hand hygiene self-assessment framework. The meeting will discuss how WHO can best support existing national interventions.

- **Health security and emergencies:** WHO also supports improved quality and safety in health facilities as part of strengthening preparedness and response to health emergencies. The Asia-Pacific Strategy for Emerging Diseases and Public Health Emergencies, which guides support to Member states in this area, has "prevention through health care" as a focus area, which includes recommendations on IPC, clinical management, AMR and health facility preparedness. WHO tracks progress in and supports national efforts across 19 International

^c GLAAS is different from GLASS, or the Global Antimicrobial Resistance Surveillance System.

Health Regulation core capacities through annual IHR self-assessments by Member States and periodic Joint External Evaluations (JEEs). JEEs in 7 SEAR Member States have found weak country capacity in areas such as AMR detection, the surveillance of infections caused by antimicrobial resistant pathogens, HCAI prevention and control and antimicrobial stewardship programmes. As Figure 8 shows, Member States' capacities are relatively weaker in several areas that are closely related to health care quality and safety.

Figure 8: Average JEE scores, selected SEAR Member States²¹



- ⦿ **AMR:** WHO has supported all SEAR Member States to develop national AMR action plans (including IPC and WASH activities and rational use of antibiotics) and conduct annual AMR self-assessments. Nine SEAR Member States have enrolled in the Global AMR Surveillance System. In 2018, 10 Member States had active advocacy campaigns during the annual World Antibiotic Awareness Week. WHO also promotes national strategies to optimize the use of antibiotics by implementing interventions such as evidence-based selection (using the AWARE categorization of antibiotics) and improving adherence to clinical guidelines/standard treatment guidelines.
- ⦿ **Other SEARO support to improve quality and safety** Programme-specific strategies generally include national level interventions to improve quality of care within the mandate of that programme. There are also some more 'system-wide' quality-related activities by SEARO. Almost all of this work focuses on quality and safety in public sector facilities. We know that several SEAR countries have large private sectors, where much—if not most—health care is sought. Much of what SEARO recommends to Member States can apply to the private sector, too. Successful implementation of these actions by the private sector needs governments in the Region to play a strong stewardship role.

To date, WHO SEARO has mostly used patient safety as its entry point to work on health system aspects of quality. There is a regional strategy for patient safety and it has supported patient safety assessments in 9 SEAR Member States (see Box 4).

Box 4 Patient safety: key findings from national assessments

Scope of assessments: aligned to Regional Strategy's 6 strategic objectives, namely,

- (1) To improve the structural systems to support quality and efficiency of health care and place patient safety at the core at national, subnational and health-care facility levels
- (2) To assess the nature and scale of adverse events in health care and establish a system of reporting and learning
- (3) To ensure a competent and capable workforce that is aware and sensitive to patient safety
- (4) To prevent and control health-care associated infections
- (5) To improve implementation of global patient safety campaigns and strengthen patient safety in all health programmes – safe surgery, safe childbirth, safe injections, medication safety, blood safety, medical device safety, and safe (organ, tissue and cell) transplantation
- (6) To strengthen capacity for and promote patient safety research

Findings: The most common areas for improvement across Member States include:

- ⦿ Adverse event monitoring
- ⦿ Workforce competence
- ⦿ Patient safety risk management
- ⦿ Infection prevention and control

Subsequent actions

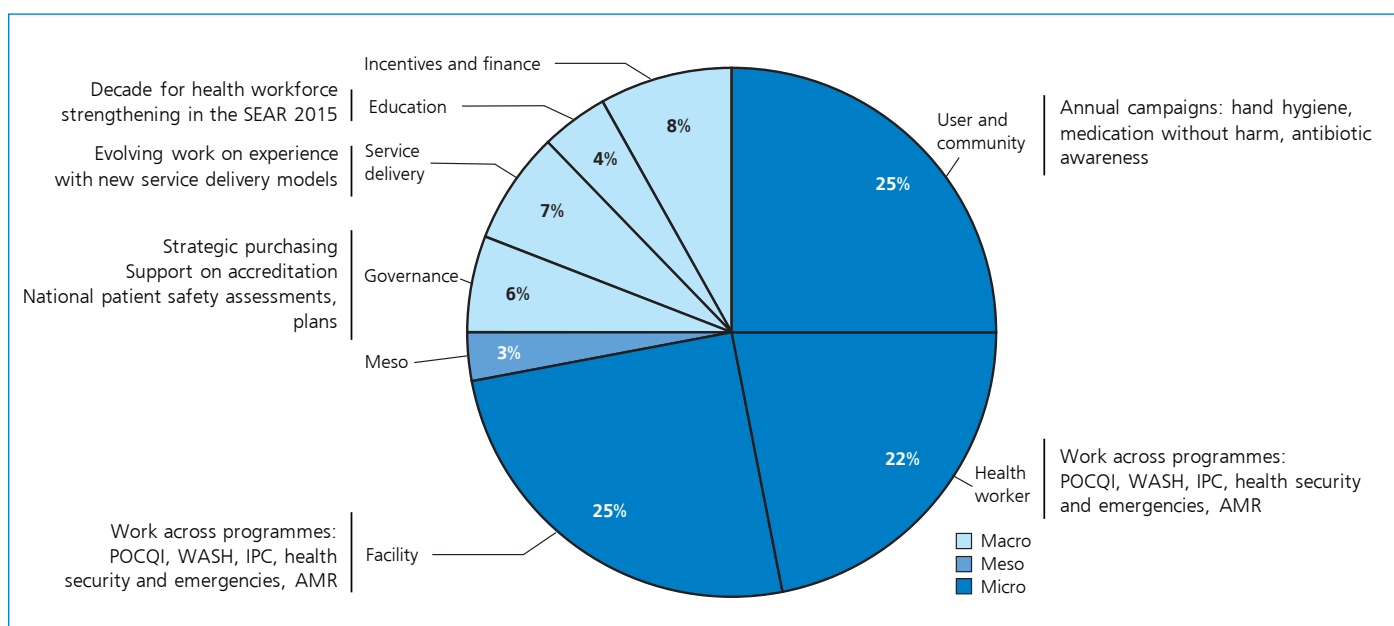
- ⦿ Most SEAR Member States have set up high level mechanisms and focal points for patient safety and quality
- ⦿ All have developed national action plans for anti-microbial resistance and blood, laboratory and medication safety

SEARO runs advocacy campaigns for the different themes launched under the Global Patient Safety Initiative – hand hygiene, medication safety, antibiotic awareness, etc.

In addition, the WHO Regional Offices for South-East Asia and the Western Pacific have held joint annual meetings of the 'Asia Pacific Healthcare Quality Improvement Network' with OECD, since 2011. These have helped raise awareness, collect data, share experiences and gather a nascent network of potential quality champions in countries. An OECD-WHO survey in 2013 yielded information on the availability of quality of care policies, legal frameworks, indicators, error reporting systems, accreditation systems, infection prevention and control, and public reporting of quality of care in 34 Asia-Pacific countries.²² The information received from SEAR Member States was patchy, with 10 responding to the general questions on quality of care policies, 9 to those on information infrastructure for measuring quality of care; and only 5 to those on quality improvement initiatives and activities.

Figure 9 maps WHO's various action areas to the Lancet Commission's typology for types and levels of interventions.

Figure 9: WHO's action areas mapped to the Lancet Commission's typology



What next in SEARO: proposed approach to discussion in the consultation

The recent global reports stimulate thinking about ways to accelerate quality and safety improvement. Their recommended interventions have many common elements (Annex 2). We find the Lancet Commission's way of analyzing the issues particularly compelling and useful for this meeting. It keeps health system outcomes clearly in mind and addresses some fundamental areas that are not addressed by 'traditional' quality improvement programmes. These are organized in a way that is coherent and easy to remember – even if not easy to implement. It recommends four 'universal actions', or macro-reforms, to improve quality:

- (1) govern for quality
- (2) redesign service delivery to optimize quality
- (3) transform the health workforce
- (4) ignite population demand for high-quality care

In conjunction with these four basic reform areas, it notes some additional interventions at different levels of the health system that may be needed, depending on country circumstances:

- ⦿ In health financing policy development, introducing more strategic purchasing, which can have quality benefits;
- ⦿ Promoting learning across networks of facilities, which can encourage more rapid learning and adaptation;
- ⦿ Actions to directly improve provider and facility performance, which are necessary but should not be introduced in isolation.

In the meeting, we will use this framework as a rough guide to identify actions that will achieve a substantial expansion of clean, safe health facilities over the next 4-5 years. We focus less explicitly on the fourth universal action, selecting instead the narrower issue of monitoring for increased accountability, including to foster demand-side approaches to quality improvement. We think these can be used to develop some more unified, mutually reinforcing activities to improving quality.

Questions for discussion at the consultation

In this meeting, we will discuss what we should be doing differently across existing activities, and in addition, to generate a sense of urgency for, and support, improvements in health care quality and safety under the rubric of 'clean, safe health facilities', organized into the following four dimensions:

- (1) Facility essentials
- (2) Health worker essentials
- (3) Policy and management essentials
- (4) Essentials to track progress and stimulate demand for cleaner, safer care
- (5) Taking the facility as the unit of interest also enables looking across and building on the various programmatic approaches, as well as identifying opportunities for coordination/mutual reinforcement.

Facility essentials

This is the first dimension of cleaner, safer health facilities. It includes basic inputs such as water and sanitation, waste management, medicines, equipment etc. In the meeting, this session is where we will also discuss what to do in relation to IPC.

- (1) How big a contribution do improved facility essentials make to better health care quality and safety?
- (2) What do we know about the effectiveness of approaches to improve facility essentials at scale in low- and middle-income settings?
- (3) Infection prevention and control is central to health care quality and safety, and health security. What are the priority actions for improving IPC, especially in frontline facilities, in SEAR?
- (4) Given what governments, WHO and other partners are already doing, what else could SEARO do to accelerate progress? What about agreeing a simple time-bound target, such as % of health facilities in SEAR with adequate water and sanitation by 2024? Could a regional campaign on clean, safe health facilities with such a target help 'ignite action' and 'ignite demand'?

Health worker essentials

This is the second dimension of cleaner, safer health facilities. Studies show low health worker adherence to clinical guidelines, diagnostic errors and underuse, misuse or overuse of care. Well-performing health workers can ensure evidence-based, competent care and a positive user experience, build trust in frontline services and increase their use. Simply providing access to trained medical staff does not guarantee universal access to quality care. There is a weak link between what health workers know and what they do (the "know-do" gap). In-service training is widely used but well-recognized to be only part of the solution to achieving better quality care. The wide prevalence of poor quality and disrespectful care points to the need for additional solutions. Today's health care challenges require additional competencies, including a greater emphasis more respectful, person-centred care. Changes are needed in how students are taught as well as what they are taught, to meet today's health needs. Supportive work environments are needed. The Decade of Health Workforce Strengthening in SEAR was launched in 2015, and within it there is a focus on transforming health professional education. WHO guidelines emphasize the need to adapt curricula to the changing health needs of communities and recommend introducing inter-professional education to facilitate team-based care and to create a culture of life-long learning through continuing professional development (CPD). While changes

to both pre-service and in-service education are needed for long-term benefits, arguably a focus on CPD programmes is likely to give earlier gains in terms of quality and safety.

- (1) How big a contribution do current approaches to quality improvement focused on health workers' knowledge, skills and practice make to large scale improvements in health care quality and safety?
- (2) What do we know about approaches that do and don't work to strengthen the capacity and actual practice of health workers to improve quality and safety, in low and middle-income countries?
- (3) Given what governments, WHO and other partners are already doing, what else could SEARO do to accelerate progress? Could a focus on ensuring that emerging national CPD programmes contain a strong emphasis on health care quality and safety be the most practical first step?

Policy and management essentials

This is the third dimension of cleaner, safer health facilities. It corresponds to the Lancet Commission's call to 'govern for quality' at different levels of the health system and also to 'service delivery redesign'. The right policies and management practices can improve efficiency and responsiveness and build learning systems, bringing quality and safety to the centre of efforts to strengthen performance. They can address the equity concern mentioned at the start of this document. An increasing number of countries in SEAR are identifying a need to support basic health district and facility management capacity strengthening, within existing service delivery arrangements.

There is also a larger question about whether there is an urgent need for service delivery 'redesign', given changes in health care needs from ageing populations and the rise in NCDs. Many countries in the Region are already introducing changes in their frontline service delivery models to address these trends. Much attention is focused on service 'upgrading'. Redesign involves larger questions such as which services should be delivered in primary versus secondary care. Should the ways providers are paid change? How to secure greater accountability for results? To what extent is quality being considered? It would seem sensible to see reforms to the organization and management of services as part of, rather than separate from, work to improve quality.

- (1) How big a difference does improved local health facility management make to service quality and safety? What approaches work best?
- (2) To what extent are changes in frontline service delivery models explicitly keeping quality in mind?
- (3) At national level, to what extent do national quality policies help improve quality, and in what circumstances? Do they give special consideration to vulnerable groups, who experience the worst quality care?
- (4) Can greater use be made of financing policies, especially more strategic purchasing, to improve quality of care?
- (5) What already is, or could be, a greater role for communities, parliamentarians, to generate more demand for quality care?
- (6) Given what governments, WHO and other partners are already doing, what else could SEARO do to accelerate progress? Given SEARO's existing commitment to improve documentation of changes in frontline service delivery models and their results, one obvious dimension to be evaluated is of course changes in quality of care. What about a more systematic approach to creating more synergies/coordination across existing programme-specific interventions?

Essentials to track progress and stimulate demand for cleaner, safer care

Quality indicators and measurement methods can become detailed and complicated, as well as expensive, fragmented, and burdensome. Fewer and better metrics are needed that can capture effective coverage, competent care processes, confidence in health systems and quality impacts. The private sector, where many seek care, needs to be included – a challenge for all monitoring exercises. While this meeting will not discuss measurement in detail, it is an opportunity to consider which types of information are essential and available. An earlier section of this paper noted some of the data sources that currently exist in LMICs and have quality relevant information: patient records, population surveys, facility surveys, etc. (see Annex 2 for the Lancet Commission’s summary of existing sources of data on quality subdomains). A multitude of tools exist. The Lancet Commission has designed a high-quality health system dashboard which goes beyond the traditional quality of care indicators and presents these in an accessible way. Others are doing similar exercises, for example the Primary Health Care Performance Initiative (PHCPI). Annex 3 summarizes some of these efforts.

- (1) What do we know about existing national or global measurement frameworks for monitoring or evaluating quality, and their utility and relevance to SEAR countries?
- (2) Dashboards are a popular and effective way to summarize information and capture the attention of policy makers and managers. SEARO could develop a regional frontline health services performance dashboard that includes a few recognized quality and safety metrics. This could be adapted by countries.




In conclusion: pulling together ideas on possible near- versus longer-term priorities for SEARO

By the end of the meeting we would like to have some practical ideas that can be discussed with colleagues and in the upcoming regional consultation on strengthening frontline services in July 2019. The following have been mentioned as possibilities in previous sections of this paper.

- (1) Launch a regional campaign on clean, safe health facilities by end 2019, with simple clear, time-bound targets for 2024 and 2030, that targets parliamentarians and the general public.
- (2) Define priority SEARO actions to reinforce existing national strategies improve IPC and reduce hospital acquired infections by mid-2019, possibly focused on nurses.
- (3) Ensure emerging national CPD programmes in the Region have a strong focus on health care quality and safety. *Medium- to longer-term.*
- (4) Ensure any SEARO-supported evaluations of service delivery reforms and their results examine their effects on both access to care and quality and safety of care. *Near- to longer-term.*
- (5) Within SEARO, develop a more systematic approach to creating more synergies/coordination across existing programme-specific interventions by mid-2019.
- (6) Develop a regional frontline services performance dashboard that includes a few recognized metrics on quality and safety; present to the Regional Consultation on Strengthening Frontline Services in July 2019; use this to report biennially to the Regional Committee. *Near- and longer-term.*
- (7) Support facility management capacity-building courses and networks within SEAR countries. *Longer-term.*

Criteria to guide the discussion are: potentially large impact/influence; straightforward versus complex; can be started with existing resources; near-term versus longer-term benefits. There may be others.

Annex 1: Summary of global reports on health system quality and safety published in 2018

	High-quality health systems in the Sustainable Development Goals era: time for a revolution	Delivering quality health services: a global imperative for universal health coverage	Crossing the global quality chasm: improving health care worldwide
Published by	Lancet Global Health Commission on High Quality Health Systems in the SDG Era	WHO, World Bank, Organization for Economic Cooperation and Development	The National Academies of Science, Engineering, Medicine
			
Objective, scope	To describe quality across health system platforms, its variation, and the impact of poor quality on health outcomes	To build a strong technical and political case for investing in quality health services	To review the available evidence on the quality of care and the gaps and to suggest how to bridge that chasm
What's new and unique	Adds user experience, paradigm shift of quality measurement from inputs to impacts	Abundant case studies	Emphasis on the organization and delivery of safe and effective care at the patient/provider interface
Key actions and recommendations	Four universal actions to improve health system quality (Figure 16 p.e1232) <ol style="list-style-type: none"> 1. Govern for quality 2. Redesign service delivery to optimize quality 3. Transfer the workforce 4. Ignite population demand for high-quality care 	Key actions to improve quality (Box 5.5 p.69) <ol style="list-style-type: none"> 1. Develop, refine, and execute a national quality policy and strategy 2. Adopt and promote universal quality goals 3. Design a quality strategy that includes a set of quality interventions 4. Monitor and report quality of care results for continuous improvement efforts 	2-1 Fundamentally redesign health care using systems thinking 3-1 Build a global community for digital advances in health and health care deliver 3-2 Adopt and adapt the new technological realities of the present and future 4-1 Embed and refine quality measurement in health care 5-1 Incorporate the informal care sector in the pursuit of improved care delivery 5-2 Make settings of extreme adversity a high priority 6-1 Address corruption and collusion 7-1 Make accountability for quality a top priority 8-1 Encourage a culture of learning to fundamentally redesign health care 8-2 Define and mobilize a research and development agenda

Annex 2: Representation of quality subdomains in global, cross-national and national measurement sets

	Indicators	Quality-relevant indicators	Foundations	Processes of care		Quality impacts			Patient-reported
			All*	Competent care	User experience	Health outcomes	Confidence	Economic benefit	
Global measurement sets									
Countdown 2030 indicators	137	91	41	26	1	23	0	2	0
EURO health for all database	603	130	68	16	0	45	0	1	3
OECD health care indicators	183	160	87	11	9	42	0	6	13
SDG health indicators	89	28	11	7	1	8	0	1	1
WHO core 100 (2015)	100	49	15	14	0	18	0	2	0
WHO IPCHS global indicators	14	11	6	4	1	1	0	0	1
Cross-national measurement sets									
DHS	NA	72	4	51	2	14	0	1	63
SARA	NA	268	268	0	0	0	0	0	0
SDI	761	726	723	2	0	1	0	0	0
SPA	1413	1269	784	349	108	22	6	0	156
Example of national measurement sets for routine health system measurement									
Ethiopia HMIS	121	30	8	11	0	11	0	0	0
Kenya HIS	198	135	60	53	3	17	0	0	3
Mexico IMSS, ISSSTE, MOH	1055	471	205	97	36	103	17	13	21
Nepal HMIS	305	183	89	39	0	32	0	0	0
Senegal DHIS2	398	168	51	35	3	29	5	0	0

Source: High-quality health systems in the Sustainable Development Goals era: time for a revolution. Kruk et al. The Lancet Global Health Commission on High Quality Health Systems in the SDG Era. 2018.

Annex 3: Overview of some quality measurement frameworks

	HQSS	PHCPI	HCQI
Full name	High Quality Health Systems in the SDG Era	The Primary Health Care Performance Initiative	Health Care Quality Indicator
Developed by	Lancet Global Health Commission on High Quality Health Systems in the SDG Era	Bill & Melinda Gates Foundations, WHO, WB, Ariadne Labs, and Results for Development	OECD
Introduced in	2018	2015	2002
Objective	To describe quality across health system platforms, its variation, and the impact of poor quality care on health outcomes	To measure primary health care quality for its improvement	To measure and compare the quality of health service provision in the different countries
Scope/Theme	Health systems to be judged primarily on their impacts, not inputs. Focus in LMICs.	Primary health care performance	Primary care, prescribing, acute care, mental health care, cancer care, patient safety, and patient experiences
Conceptual Framework for Quality	<p>Quality impacts</p> <p>Better health</p> <p>Confidence in system</p> <p>Economic benefit</p> <p>Processes of care</p> <p>Competent care and systems</p> <p>Positive user experience</p>	<p>C5. High-Quality Primary Health Care</p> <p>a. First contact accessibility</p> <p>b. Continuity</p> <p>c. Comprehensiveness</p> <p>d. Coordination</p> <p>e. Person-centered</p>	<p>Focus on Quality</p> <p>Effectiveness</p> <p>Safety</p> <p>Responsiveness</p> <p>Patient centeredness</p> <p>– Individual patient experience</p> <p>– Integrated care</p>
Country dashboard	HQSS Dashboard	Primary Health Care Vital Signs Profile	Health at a Glance 2017 (comprehensive report)
Data availability	Some data available for 137 countries	Some data available for 136 countries, with 12 trailblazers globally (Nepal and Sri Lanka in SEAR)	35 countries OECD + Singapore, Costa Rica, and Malta

Endnotes

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