Global Healthcare Quality in an Urban Setting

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Aims of the Session

- Relevant global health policy context.
- Definition of healthcare quality.
- Methods for assessing care quality in LMICs.
- Problem of provider quality in LMICs – key research.
- Share details about my on-going research.

Sustainable Development Goals[1]

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Primary Healthcare in LMICs

- Global policies (**1978 Alma Ata Declaration[2], 1988 Bamako Initiative[3], and 2018 Declaration of Astana[4]**) – primary care to be moved from hospitals into a primary healthcare setting.

- Strengthening primary healthcare in LMICs – WHO priority for 2019-2023, as part of the 13th General Programme of Work[5].

- A 5-year strategic plan focusing on *"ensuring that 1 billion more people benefit from access to universal health coverage; 1 billion more people are protected from health emergencies; and 1 billion more people enjoy better health and well-being."*

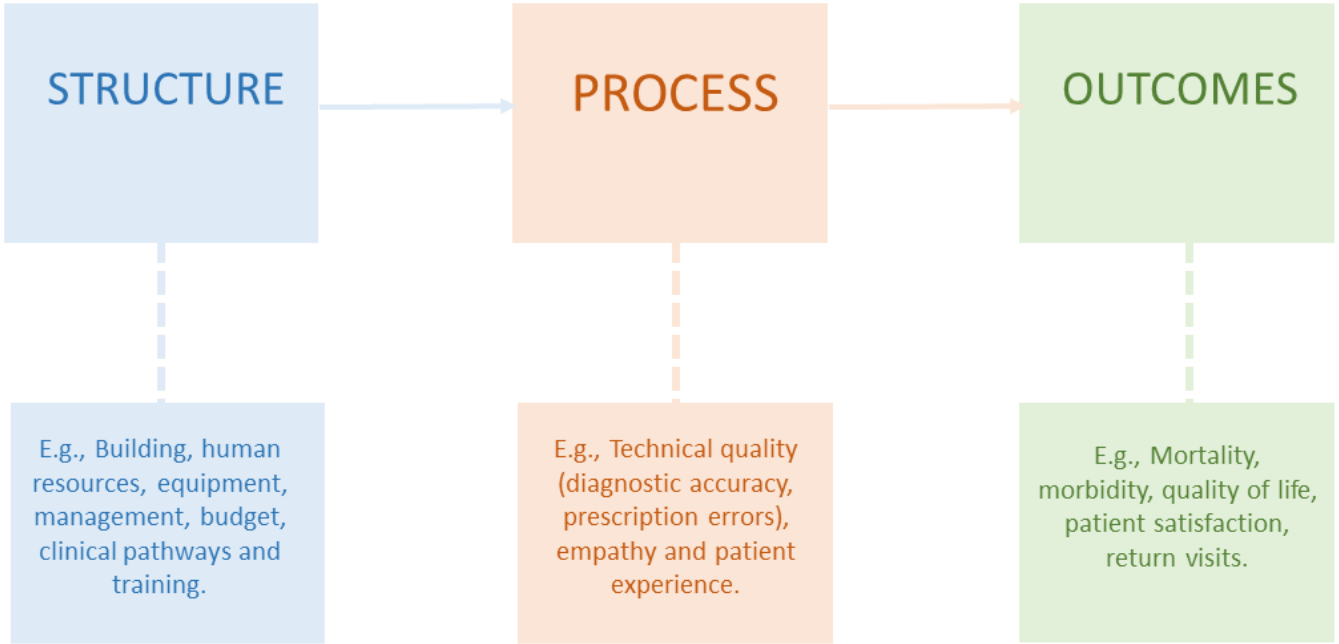
What is Healthcare Quality?

- WHO definition[6]:

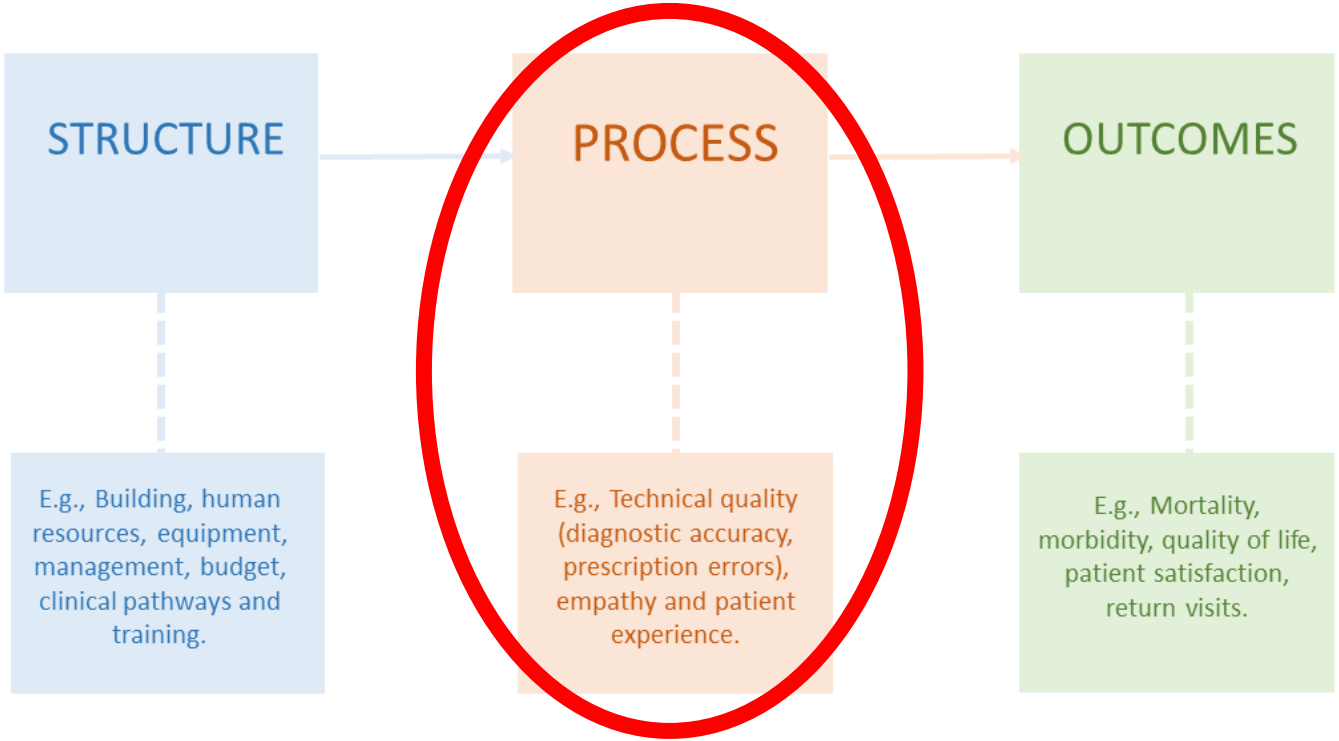
*"The extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be **safe**, **effective**, **timely**, **efficient**, **equitable** and **people-centred**."*

- ***Safe*** – Minimises risk and harm to patients.
- ***Effective*** – Evidence-based services.
- ***Timely*** – Reduces delays.
- ***Efficient*** – Maximises resource use and avoids waste.
- ***Equitable*** – Same quality of care for all.
- ***People-centred*** – Considers person's preferences and culture.

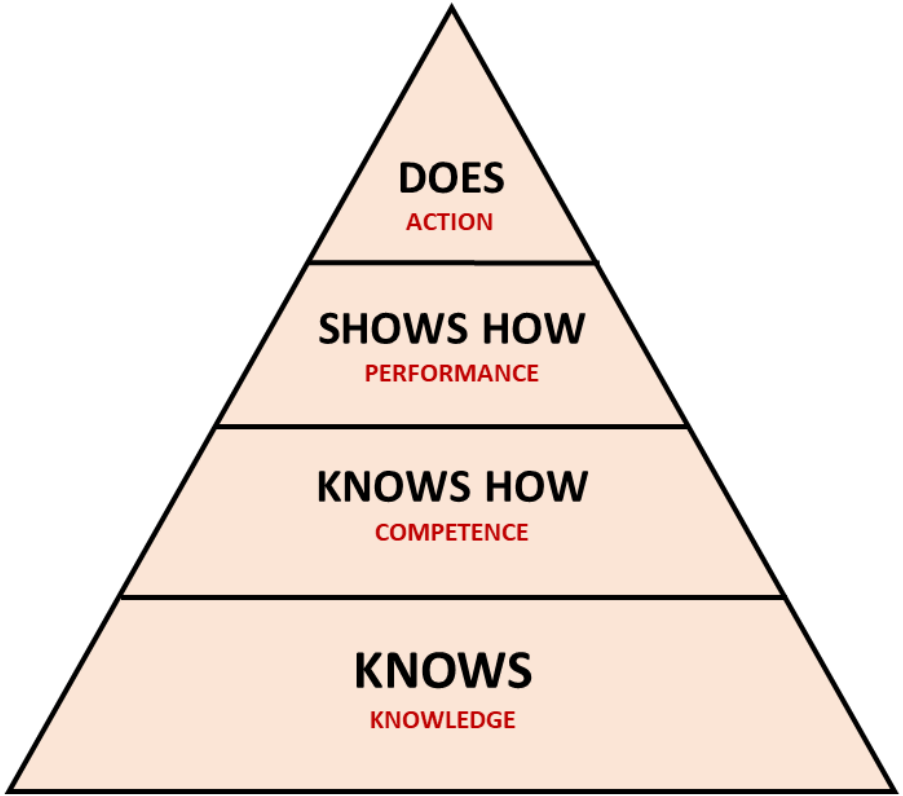
Dimensions of Healthcare Quality[7]



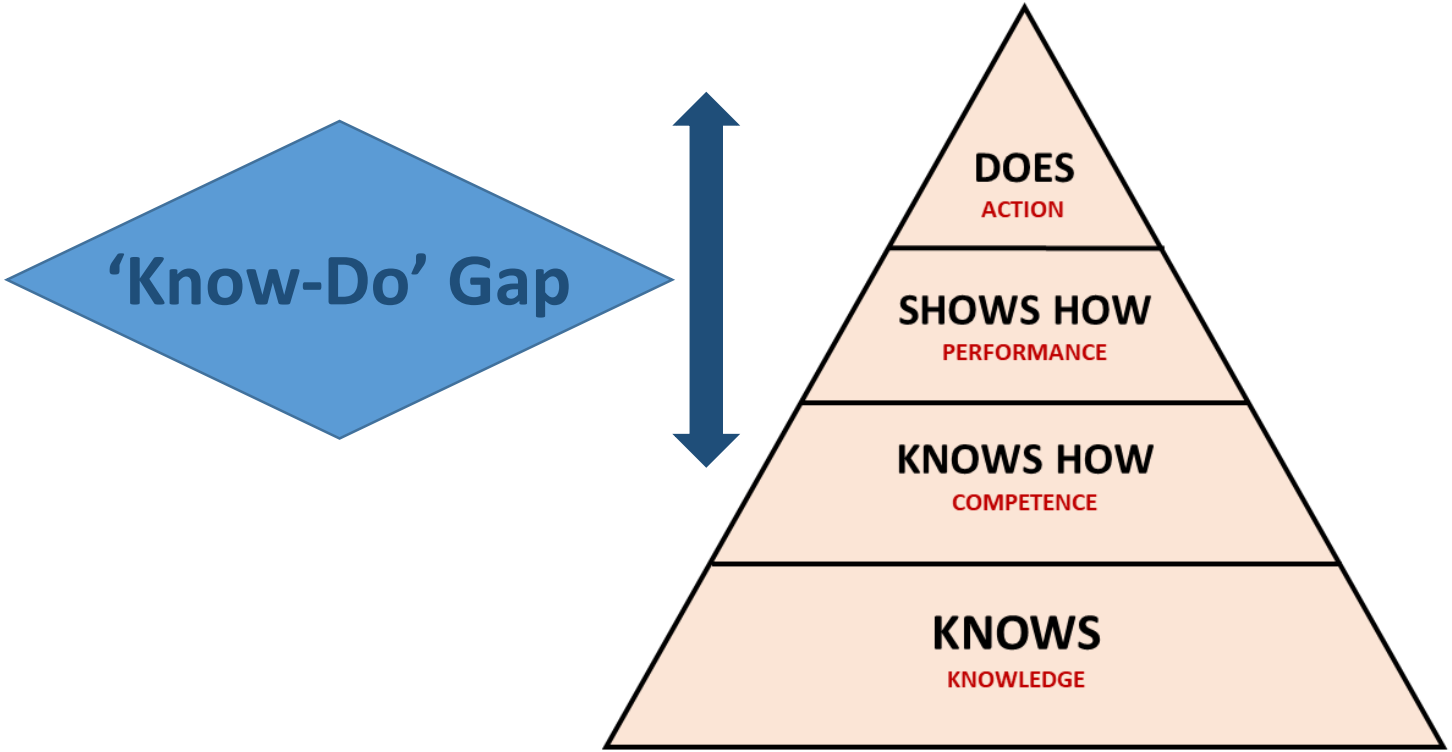
Dimensions of Healthcare Quality[7]



Miller's Pyramid[8]



The ‘Know-Do’ Gap



Methods for Measuring Provider Quality

- Main methods:

- ***Vignettes –*** written case descriptions.

- ***Direct observation*** – first-hand observation of clinical practice during consultations or via video- or audio-recording.

- ***Simulated/standardised patients (SP)*** (announced or unannounced) – actor or patient trained to act as a real patient and simulate a set of symptoms or portray a particular case.

- ***Exit interviews/questionnaires*** – patients/carers asked post-consultation about their experience of care provision.

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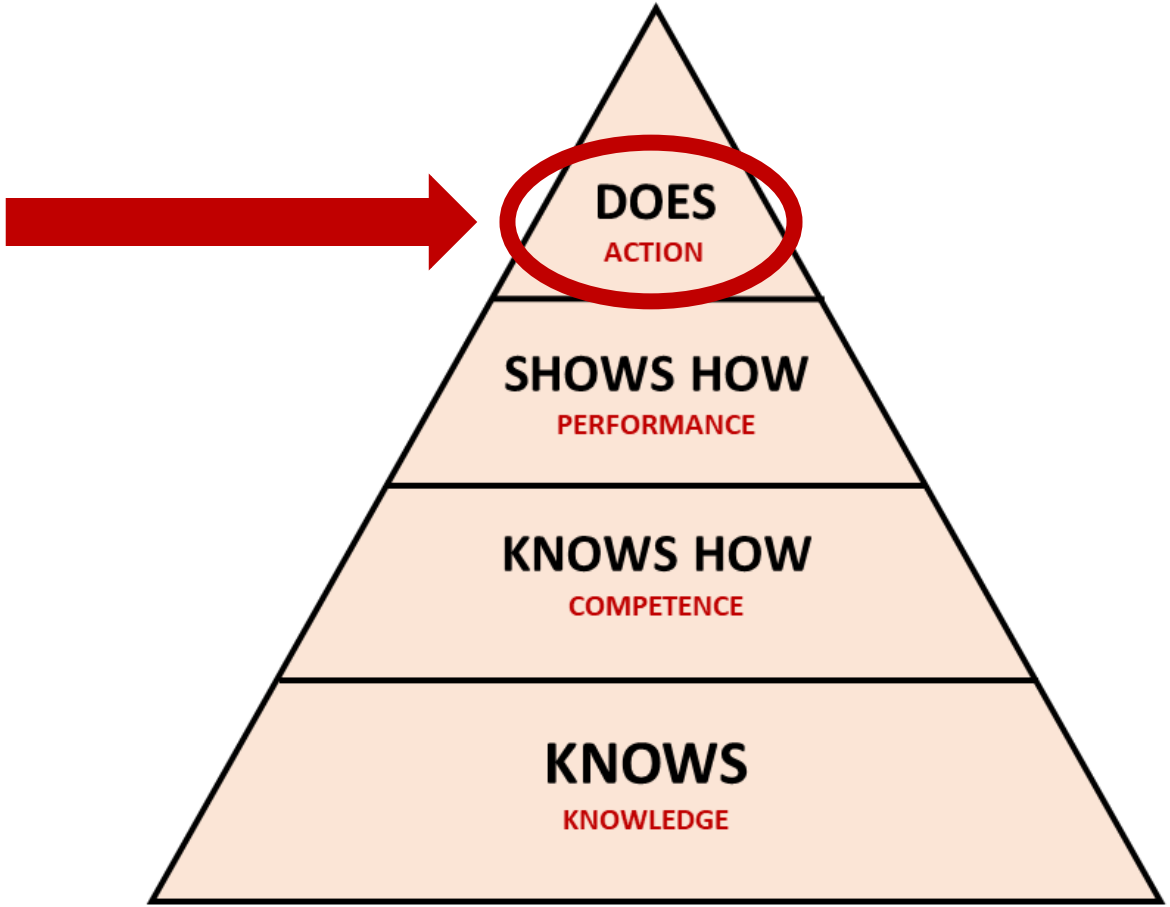
DOES
ACTION
SHOWS HOW
PERFORMANCE
KNOWS HOW
COMPETENCE
KNOWS
KNOWLEDGE

Our Current Work

Component of clinical encounter	General Assessment Criteria	Symptom-Specific Assessment Criteria			
		Cough	**Fever**	**Diarrhoea**	**Abdominal Pain**
Interviewing/history-taking	• Greeted patient/carer • Solicits what the problem is and allows patient to fully elaborate presenting problem • Exhibits well organised approach to information-gathering • Gave due attention to patient/carer (looking and listening)	• Asked duration of cough • Asked about difficulty in breathing • Asked about wheezing • Asked about presence of fever • Asked about sputum production • Asked about TB history and exposure	• Asked about duration of fever • Asked about localising symptoms suggesting site of infection if not obvious (headache, neck stiffness, skin, mouth and pharynx, lungs, urinary tract, gastrointestinal tract)	• Asked duration of diarrhoea • Asked about presence of blood or mucus in stools • Asked about vomiting • Asked about HIV status/CD4 count	• Asked about duration and progression • Asked about presence of fever • Asked about weight loss and appetite change • Asked about blood or mucus in stools • If female, asked about last menstrual period; chance of pregnancy
Physical Examination & Investigations	• Washed hands • Number of minutes spent examining patient behind the screen (XX minutes)	• Listened to lung	• Site of infection obvious (Yes/No) • If yes, examined for localising symptoms if site not obvious (neck stiffness, skin, mouth&pharynx, lungs, urinary tract, GI tract)	Checked for dehydration: • Checked abdomen • Pinched skin examining for signs of severe dehydration • (If infant) checked for sunken fontanel	• Examined abdomen for location and nature of pain, and distension • (If acute abdominal pain) checked for rebound tenderness

Current Problem of Low Quality Care in LMICs

- Methods allow quantification of the healthcare quality problem in LMICs.

- Lancet Global Health Commission on healthcare quality in LMICS[9]:

  - *Poor adherence to clinical guidelines;*
  - *Incomplete history-taking, examinations and investigations;*
  - *Incorrect diagnoses;*
  - *Under-use of effective care*
  - *Over-use of unnecessary care;*
  - *Lack of counselling and preventative care.*

Kwan et al (2018)[10]

- Examined the quality of tuberculosis (TB) care provision by trained and untrained providers in India, using SPs.
- 2652 SP-provider interactions across 1203 health facilities and 1288 provider practices Mumbai and Patna – economically disparate but both had a high prevalence of TB.
- Covertly nested within a Government of India initiated TB management improvement programme.
- Trained 24 local actors in 4 scenarios representing various stages of diagnostic and disease progression.

Kwan et al (2018)[10]

- Main outcome: case-specific correct management based on local clinical guidelines.

- Key findings:

  - Medically trained providers were three times more likely than non-medically trained providers to correctly manage cases.
  - Only 25% of encounters demonstrated standards-compliant care.
  - Only 35% were correctly managed.
  - Of these, only 53% of providers ordered a chest X-ray; 36% made a referral; and 31% ordered a microbiological diagnostic test.
  - But, an average of 3 medications per interaction (mostly antibiotics) were prescribed or dispensed.

Summary

- Global health policy context – SDGs, UHC, Alma Ata/Bamako/Astana Declarations.
- WHO definition of healthcare quality and different aspects of individual provider quality that can be measured.
- Current problem of sub-optimal healthcare quality in LMICs.
- Main measurement methods, plus real-life research examples.

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