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TECHNICAL REPORT
**IMPROVING HEALTH
CARE AT THE
NATIONAL LEVEL**



Insights from the
Amman, Jordan
International
Policy Seminar



Health Care Accreditation Council
Quality Health Care Conference
& Exhibition

Amman, Jordan | June 29, 2010



FEBRUARY 2011

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TECHNICAL REPORT

Improving Health Care at the National Level: Insights from an International Policy Seminar

**Health Care Accreditation Council Quality Health
Care Conference and Exhibition 2010**

Amman, Jordan, June 29, 2010

FEBRUARY 2011

Shawn Dick

DISCLAIMER

The views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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Acronyms and Abbreviations

EMRO	Regional Office for the Eastern Mediterranean
GCC	Gulf Cooperation Council
HCAC	(Jordanian) Health Care Accreditation Council
HCI	USAID Health Care Improvement Project
IHI	Institute for Healthcare Improvement
JHAP	USAID Jordan Health Care Accreditation Project
MENA	Middle East North Africa
MOH	Ministry of Health
MOPH	Ministry of Public Health
NGO	Nongovernmental organization
NHS	(Scottish) National Health Service
PA	Palestinian Authority
PDSA	Plan-Do-Study-Act (cycle)
QI	Quality improvement
UNFPA	United Nations Population Fund
URC	University Research Co., LLC
USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organization

Box 1: Participants in the International Policy Seminar

Dr. Daoud Hanania, Chairman of the Health, Environment and Social Development Committee of the Upper House of Senate, Jordan

Dr. M. Rashad Massoud, Director, USAID Health Care Improvement Project, Senior Vice President, Quality and Performance Institute, University Research Co., LLC, USA

Dr. May Abu Hamdia, Chief Executive Officer, Health Care Accreditation Council, Jordan

Dr. Jason Leitch, National Clinical Lead for Quality Improvement, Scottish National Health Service, United Kingdom

Mr. Sven-Olof Karlsson, former CEO, Jonkoping County Council, Sweden

Dr. Sameen Siddiqi, Regional Advisor, Health Policy and Planning, WHO/EMRO, Egypt

Dr. Yacoub Neyaz, Director General, Quality Assurance Department, Ministry of Health, Jordan

Dr. Rami Farraj, Director of the Medical Office at the Royal Hashemite Court, Jordan

Dr. Attallah Issa, Representative of the Royal Medical Service, Member of the Health Care Accreditation Council Board of Directors, Jordan

Dr. Hana Slosubaie, Hospital Director, Ministry of Health, Qatar

Dr. Aziza Khalfan Amri, Hospital Director, Ministry of Health, Oman

Dr. Buthaina Al Muddaf, Director of Quality and Accreditation Directorate, Ministry of Health, Kuwait

Dr. Awni Al Bashir, President, National Hospital Association, Member of the Health Care Accreditation Council Board of Directors, Jordan

Dr. Ali Shaar, National Program Officer, UNFPA, Palestine

Dr. Jorge Hermida, Associate Project Director for Latin America, USAID Health Care Improvement Project, University Research Co., LLC, Ecuador

Dr. Rajna Al Mus'abi, Coordinator of Quality Improvement and Patient Safety, Ministry of Health, Yemen

Dr. Azman Abu Bakar, Director and Public Health Physician, Institute for Health Systems Research, National Institutes of Health, Malaysia

Dr. Salman Rawaf, Professor of Public Health, Imperial College, United Kingdom

Dr. Abdelaziz El-Anezi, Health Attaché, Government of Jordan

Dr. Tawfiq Khoja, Director General, Gulf Cooperation Council, Health Ministers' Council, Saudi Arabia

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Dr. Safa El Qsoos, Quality Director, Ministry of Health, Jordan

Dr. Nagwa Hussaini, Consultant for Quality, Ministry of Health, Egypt

Dr. Nael Edwan, President, Jordanian Hospital Association, Jordan

Dr. Fathi Abumughli, Minister of Health, Palestine

Dr. Faisal Nasr, Senior Policy Advisor, University Research Co., LLC, MENA Region

Dr. Malak Al Ali, Head of Indicators and Standards at the Quality and Accreditation Directorate, Kuwait

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Executive Summary

This paper summarizes the major insights shared during the Policy Seminar on Improvement Strategies and Infrastructure for Improving Health Care at the National Level, which was convened at the Health Care Accreditation Council Quality Health Care Conference & Exhibition 2010 in Amman, Jordan on Tuesday, June 29, 2010. The meeting was held to share experiences and develop lessons learned across multiple national level health care quality improvement initiatives, and was organized by the United States Agency for International Development (USAID) Health Care Improvement Project (HCI) in an effort to encourage global knowledge sharing about quality improvement (QI) approaches and their effectiveness.

The Conference was organized by the Jordanian Health Care Accreditation Council (HCAC) from June 28–30, 2010. University Research Co., LLC (URC) established HCAC in 2007 through the USAID Jordan Health Care Accreditation Project (JHAP); HCAC has since guided six hospitals in Jordan through the accreditation process and had distributed awards to those hospitals earlier in 2010. HCAC subsequently hosted the conference to both showcase the achievements of those hospitals and encourage continued improvement across the Jordanian health care system. Global experts presented on a variety of health care improvement methods and tools, opening up discussion on their strategies and successes to participants from Jordan and other countries in the region.

Prior to the Conference, the HCI project organized a Round Table Meeting on the National Improvement Strategy and Infrastructure for Improving Health Care in Afghanistan in Kabul on January 10, 2010. The Round Table provided an opportunity for two days of thoughtful conversation among members of the Ministry of Public Health (MOPH) of Afghanistan, partnering organizations, and a panel of experts. The purpose of the Round Table was to share relevant international health care improvement experiences with the MOPH. Instead of the usual focus on prepared presentations, Dr. M. Rashad Massoud, HCI Director, designed the meeting as a forum for thoughtful dialogue in which both local and international expertise could be brought to bear in approaching Afghanistan's unique issues of quality.

The Policy Seminar in Jordan was designed after the successful experience of the Round Table Meeting to draw on the experience of leaders of health care quality improvement efforts from countries in the Gulf region and beyond. By sharing the experiences from each of their sectors and countries, the seminar hosted thoughtful conversation on national level strategies for quality improvement in health care unique to the Gulf region.

The chairperson for the Policy Seminar was Dr. Daoud Hanania, Chairman of the Health, Environment and Social Development Committee of the Upper House of Senate, Jordan. The seminar was designed and moderated by Dr. M. Rashad Massoud, who is both Director of HCI, and Senior Vice President of the Quality and Performance Institute, University Research Co. LLC, USA. Participants in the Policy Seminar are listed in Box I.

Throughout the day, participants shared their experiences with national level quality improvement efforts. The examples discussed were from Jordan, Palestine, Egypt, the Gulf Cooperation Council, Kuwait, Bahrain, Oman, Yemen, Malaysia, Scotland, Sweden, Iraq, Ecuador, and Chile.

Each country had its own story, timeline, methods, and challenges; however, a number of common lessons, barriers, and drivers of change were discussed. Several common themes emerged among the valuable insights suggested by the participants' experiences.

Access is the primary problem many systems recognize, due to varying geographic, financial, and cultural barriers. However, once access has been addressed and people join the system, outcomes are not improved on their own. One must also have a focused effort on **improving the quality of services** to which people now have access. This improvement effort must be holistic, involving public,

private, and quasi-public sectors along the full continuum of care (patient-level, primary care, secondary, and tertiary).

The initiative must be started at a national level with a **national mandate and vision** that is effectively communicated all the way down the line to the frontline workers. This fosters inclusion and tangible support, including resources and efficiencies of standardization of guidelines, use of common standards and data systems, and one common leadership committee that brings together all stakeholders for unified leadership.

Good governance at both the national and local level is necessary to support quality improvement. At the national level, it is essential to emphasize the centrality of health to the macro economy. Leaders must understand that health is dynamically connected to all other sectors and increase its share of the national budget in line with the strategic framework and vision for the health sector. Resources must be budgeted to support not only the operation of the health system, but also investment in its infrastructure for the future. At the local level, all stakeholders must learn to function as best as possible regardless of the amount of available resources. By functioning well within existing constraints, they pave the way for the best use of future resources while making the case for the allocation of additional resources.

Leadership must be developed at every level. Whether at the national, local, or even individual facility level, individual leaders will leave a vacuum if they have not developed leaders below them to continue driving improvement.

Everyone must **choose the improvement tools and methodologies that work for them**. There is no one-size-fits-all improvement path. Accreditation is not a final goal, but rather a means to an end. It is just one of the many tools available to improve the quality of health systems.

Quality improvement requires a **culture change** in which all members of the health system start to see themselves as having two jobs: one where they provide health services and one where they work to improve the quality of those services. Leaders must show a commitment to quality improvement and encourage everyone throughout the system to be committed to change.

In order for change to be continuous and not lose momentum, workers and leaders alike must be able to see what they have **achieved** through improvements in outcome data and must be **recognized** for their contribution to improvement. This recognition does not have to be financial, but should be acknowledged publicly by others in the system.

The health system must be equally **transparent** about its failures as its successes, both within the system and with the public. Only by acknowledging failures can they be addressed. A system that seeks to hide its shortcomings prevents both **accountability** of politicians to the public and the ability of health workers to benefit from critical analysis of real data. Public support, encouraged and guided through honest assessment of issues, is a major driving force for improvement.

In addition to these key points, participants also shared lessons and valuable insights related to their specific experiences in sustaining their quality improvement efforts.

I. Introduction and Background of the HCAC and the Policy Seminar

The Health Care Accreditation Council Quality Health Care Conference and Exhibition 2010 was organized by the Jordanian Health Care Accreditation Council (HCAC) and took place June 28–30, 2010. The Conference theme was “Good, Better, Best: Moving toward Quality in Health Care in the Middle East.”

The Conference included workshops and presentations from Jordanian and international experts in health care accreditation and quality improvement in health care. Participants were drawn mainly from Jordanian health care professionals currently engaged in accreditation and improvement work. The content of the workshop covered a wide ground, from various tools and methodologies, to sharing of results from recent initiatives, to discussions on strategies and policies for ongoing work.

The Conference host, the Jordanian Health Care Accreditation Council, was established in 2007 by University Research Co., LLC through the USAID Jordan Health Care Accreditation Project (JHAP). HCAC has since guided six hospitals in Jordan through the accreditation process and had distributed awards to those hospitals earlier in 2010. HCAC hosted the conference to both showcase the achievements of those hospitals and encourage continued improvement across the Jordanian health care system.

Jordan is a middle-income country and spends approximately 9.5% of its GDP on health services. There are many established health care providers in Jordan, but they are very fragmented. In the public sector, the Ministry of Health (MOH) oversees primarily preventative medicine, but also provides some curative services by running a number of hospitals throughout the country. The Royal Medical Service is responsible for about a third of health services and is highly regarded among the public. The private health care sector is also strong, as shown by the large number of international visitors who come to Jordan for its services. The sector of health services provided by international nongovernmental organizations (NGOs) and other donors primarily provides services for refugees but also runs some teaching hospitals.

In Jordan and other countries in the Arab Gulf region, accreditation and quality improvement have become an increasing priority for the national agenda. Several countries in the region have embarked on efforts to improve health care, including developing policies and plans for improvement as well as structures to implement and support it.

Leaders from these quality improvement efforts were invited to participate in the Policy Seminar on Improvement Strategies and Infrastructure for Improving Health Care at the National Level at the HCAC Conference. The seminar was organized by University Research Co., LLC (URC) through the USAID Health Care Improvement project (HCI) in an effort to foster international dialogue to advance the global knowledge base for health care improvement strategies. The seminar brought together high-level health care leaders from around the world to share their experiences in implementing quality improvement efforts in their respective countries. The goal of the workshop was for all present to share their experiences in order to provoke a thoughtful conversation around this topic area to help health care leaders learn from each other and make informed decisions for their countries.

The Policy Seminar drew on the experience of the Round Table Meeting on the National Improvement Strategy and Infrastructure for Improving Health Care in Afghanistan, conducted in Kabul, Afghanistan, on January 10, 2010. Also organized by HCI, the Round Table Meeting brought together high-level health care leaders from around the world in order to share experiences and lessons that could be applied to the burgeoning national level quality improvement initiative in Afghanistan. The proceedings and findings from the Round Table were published and distributed prior to the Policy Seminar to inform invitees of some prior lessons in advance of the discussion.

Immediately preceding the Policy Seminar, Jason Leitch, the Clinical Lead for Quality in the Scottish National Health Service, presented a session entitled “Leadership Challenges in Quality Improvement: The Scottish Example.” In this session, he shared the Scottish government’s experience instituting a nationwide initiative in quality improvement for health care and development of the Scottish Patient Safety Programme to spearhead improvement efforts aimed at reducing preventable deaths system-wide in Scotland. That experience thus further set the tone for the Policy Seminar.

II. Design of the Policy Seminar

The chairperson for the Policy Seminar was Dr. Daoud Hanania, Chairman of the Health, Environment and Social Development Committee of the Upper House of Senate, Jordan. The seminar was designed and moderated by Dr. M. Rashad Massoud, MD, MPH, FACP, Director of the USAID Health Care Improvement Project and Senior Vice President of the Quality and Performance Institute, University Research Co. LLC, USA.

The specific objectives of the seminar were to:

- Share experiences and ideas from different countries on successful models for leading and providing support for improving health care at the national level, including developing policies and plans for improvement;
- Exchange ideas on appropriate infrastructures that enable Ministries of Health to lead and support health care improvement; and
- Stimulate a thoughtful conversation around this topic area that would be helpful to participants in their work in their respective countries.

Prior to the Seminar, the following questions for discussion were distributed to invitees to guide the proceedings:

- How did the improvement effort(s) you have experienced start? What infrastructure was created to support improvement?
 - Who championed it?
 - How were improvement priorities set?
 - How was commitment sustained?
 - How did it work?
 - How did you communicate and coordinate activities?
- What improvement approaches were used?
 - How and why did you choose particular approaches?
 - How did they work?
 - How did you review progress?
- If you were to undergo this experience(s) again,
 - What was important that you would want to see repeated?
 - What proved not important that you would not want to see repeated?
 - What would you do differently?

The following recommended readings were distributed to invitees. Full bibliographical information for these documents and other related readings is in the Bibliography.

- Quality Assurance in Malaysia in Health Care Quality: An International Perspective
- Round Table Meeting on the National Improvement Strategy and Infrastructure for Improving Health Care in Afghanistan: Proceedings

- The Niger QAP/ BASICS Joint Project: Technical Report Summary
- Making a Commitment to Quality: Development of a National Quality Assurance Program in Chile, 1991–1998: Country Report
- Jönköping County Council. High Performing Health Care Systems: Delivering Quality by Design
- Quality of Care: A Process for Making Strategic Choices in Health Systems
- Upgrading the Palestinian System: Improving Quality and Management. In *Separate and Cooperate; Cooperate and Separate: The Disengagement of the Palestinian Health Care System from Israel and Its Emergence as an Independent System*
- The Health Care Quality Strategy for NHS Scotland
- Scaling Up and Institutionalizing Continuous Quality Improvement in the Free Maternity and Child Care Program in Ecuador

At the Policy Seminar, welcome remarks were given by its chairperson, Dr. Hanania. He expressed his high hopes for the results of the Conference in advancing the field of quality improvement (QI) in health care for both Jordan and other countries in the region.

Participants introduced themselves, and Dr. Massoud outlined the purpose of meeting, reviewing the questions to guide discussion and background documents distributed to participants before the seminar. Dr. Massoud emphasized that the goal of the meeting was not for invitees to give presentations or for outsiders in any way to teach concepts or lessons to the Jordanian leaders, but rather for all participants to share their experiences, listen to those of their colleagues, and take what is useful for them. He encouraged all participants to share their good experiences and challenges to enrich each other to return and feed that knowledge into their own countries to help improve their own health care systems.

Before beginning to answer the questions set forth, participants spoke to clarify some of the terminology and context of the discussion. The term “health care” itself can be restrictive if limited to a “health care system”: the term limits people’s thinking to hospitals and disease management and makes them focus on the small portion of issues relating to acute care. When referring to health care, one should instead talk about “health services” in a broader context.

Similarly, the word “infrastructure” means something different to everyone. It can mean human resources and the systems that support them, the physical presence of a quality improvement division within the Ministry, existence of external QI bodies, or simply the means by which a country approaches QI (the tools and methodologies that have been implemented). Depending on the context, everyone has his or her their own way of defining the infrastructure needed to support QI, and Dr. Massoud expressed hope that this would become clearer through the discussion.

The first major issue brought up with regard to national QI efforts and the establishment of infrastructure to support it was the frequent turnover of Ministers of Health in most countries. Each new Minister comes with a new vision and new priorities, frequently diverging from his or her predecessor. This is not unique to the region, nor is the resulting question of how to have systems that build on existing ones, instead of demolishing previous systems and starting anew every time a new Minister is appointed.

A second major underlying issue is that, when it comes to quality and patient safety, the entire system must be addressed. One cannot ethically have a patchy approach that creates inequity within a system, achieving accreditation and other gains for a small number of hospitals while ignoring the rest of the system.

After the Seminar, the proceedings were summarized and shared in summary form with participants and other colleagues working in the field of QI. From the proceedings, portions of the discussion were grouped into categories, and the resulting major insights are presented in this paper.

III. Insights on Improving Health at the National Level

A. Access in Relation to Quality of Care

Quality of health care services and access to those services are inextricably linked. Regardless of the quality of services that a health care system is able to provide, if not all patients are able to access to those services, the system will not succeed in providing quality care to every potential patient. Likewise, it is not sufficient for a health care system to provide complete access to care if the quality of that care is not very good.

Problems with access and quality also have the potential to compound themselves. For example, if patients encounter poor care, they may choose not to access that care in the future, reducing demand for health services, which is a key driver of QI efforts. Lack of public access to services reduces the system's ability to deliver preventative medicine and other public health interventions that are key to both quality of care and efficiency of care delivery.

Egypt's experience with QI in health care is long-standing, from the establishment of its public health sector 40 years ago through focused reform efforts that started in 1994. Egypt's first goal for improving its health system was to increase access to care, improve preventative medicine at primary health care, and improve the referral system to secondary units. Geographic access to care was not a major obstacle, but most people face financial barriers to accessing care. While these barriers still exist, Egypt also established a quality department within the MOH in 1998 and an accreditation department in 2000 to work on improving the quality of services that are provided. Now, Egypt has over 5000 primary units with standards in place and 1900 units with accreditation, and is working to ensure access to those services by virtually all people in the country.

Access is also a major challenge for the Palestinian health care system. They are currently grappling with a number of questions related to access: Has access be secured for all people, how can this be known, and what does access really mean in this context? Is more tertiary care needed or should the focus remain on primary care and public health? Should the focus be on primary care, striving to improve services and really reach all people before moving on to referral systems? Every country has different questions and different answers to them, but securing access to care and defining what we mean by that should be a priority for everyone. Each country needs to define its specific goals and priorities at each level. In Palestine, the decision has been to focus on investing in infrastructure, both in people and systems, at all levels of the system at the same time.

In Scotland, the two biggest problems and main focus areas for their QI efforts are low lifetime expectations and access. Like the Gulf States, their problems with access are caused by very similar barriers, such as poverty and demographic hurdles. When they began addressing their issues with quality of care, they, too, quickly learned that they had to improve access before they could move on to improving quality. They concentrated on access, yet once that was improved, their problems with patient safety persisted because the quality of services that people gained access to was still poor. Some people familiar with the health system had criticized that even though everyone had access: "The health care is free, and so are the infections." As a result, there were even stronger drivers behind the subsequent patient safety and quality movements in that country.

Across Latin America, many health systems had efforts to improve access to care that preceded QI efforts. Early on, the phenomenon began to emerge in which stakeholders increased access without improving health care outcomes. For example, the Dominican Republic increased access to services by 90% without significantly reducing maternal mortality. After seeing this problem face to face, many countries in Latin America began to question what exactly they were providing access to, and QI became even more significant as seen in other countries. However, the new gap that still persists is the dichotomy between countries having recognized this importance by paying attention and taking some action, but without giving the funding and budget allocation necessary for those actions to succeed.

In each of these national level QI examples as well as those of others the Policy Seminar, access issues needed to be addressed. Whether by choosing deliberately to include access as a focus at the beginning of the effort or by realizing soon after initiating QI efforts that access was being neglected, access to health care became a key early component of successful QI initiatives.

B. National Mandate and Vision

The decision of how to address access along with other key concerns regarding a national QI effort must be clearly articulated throughout a health system with enough authority behind them to drive changes. Policy leaders, system managers, front line workers, and other stakeholders all need to be well informed of what initiatives are being undertaken for what reasons and using what methods. Support for and understanding of strategy foster success of efforts. A lack of buy-in from stakeholders will even make efforts that are successful in the short term unsustainable. Without sustaining both the results of improvement efforts and the momentum for future initiatives, ongoing QI is not possible.

In Malaysia, stakeholders' experience in QI began alongside the nation's independence in 1957. At first, the Ministry focused only on providing access to basic services and vaccinations, and it wasn't until later that quality was examined. Their QI efforts received their mandate in Vision 2020, in which Mahatya Mohammed said that "quality must be an integral focus of everything in life." He required every Ministry, including the MOH, to come up with its own vision for quality. He underlined the importance of leadership support and having a mandate that flows down from the top. Quality was emphasized as a vision within one's self, as an individual goal. Rather than trying to be like other people, one should try to improve quality by him- or herself. The Ministry further encouraged QI efforts with quality awards. These awards extended both within the public system and across the public and private sectors so service providers would begin to compete across all sectors for better quality.

Mahatya Mohammed wrote Vision 2020 while in exile in Britain. It has since been translated into many national plans under the overarching vision that Malaysia will be a modern country by 2020. The major effects of these plans can already be seen. People now immediately talk about outcomes instead of dwelling on processes. Outcomes are ultimately most important, and it is not useful to keep discussing better processes forever without looking at the tangible outcomes seen by the people. Malaysians are still in the middle of their quality journey. As it continues, sustainability and financial support are the major challenges. The overarching vision continues to evolve to fit their current situation as improvement efforts continuously improve that situation.

Palestinians' QI efforts had to overcome the legacy of transition from colonialism to occupation to state building. When the Palestinian Authority (PA) inherited its system from the occupation, it was damaged and fragmented and very far from providing quality services. When Dr. Massoud established its quality improvement team in 1994, the vision was to create the critical mass of experts who could drive the quality movement. While that critical mass was being built, they started to dissect the system and to see all the real problems. Long waiting times, waste in labs, poor diabetes services, and so forth were all identified by the experts who were encouraged as part of this vision, and this in turn drove subsequent QI.

In Scotland, the National Health Service (NHS) is led by a Minister much the same as in Gulf States. In order for NHS to put forth the aim and vision for the system, it needed to have documented successes and clear goals to illustrate to the government and the public. To have such documented successes, clear goals were expressed even in newspaper headlines, such as "We will reduce mortality by 15% in 5 years." At the same time as setting up a clear outcome goal, NHS didn't ignore the inputs and processes leading to that outcome. The Minister established jobs, allocated resources, and brought in outside experts in QI. The outcome made for splashy headlines, and NHS used that to build support and to engage the clever people within the system to figure out how to achieve their goals.

Most political leaders don't care about processes and pay attention only to the outcomes. Health care leaders are the ones responsible for thinking through the processes and determining how they achieve the outcomes. In order to effectively link these groups so that the right changes are made to the right processes to produce the right outcomes, communication is key. From the top-most levels down to the grassroots, the vision needs to be well communicated while acknowledging workers' contributions and recognizing their efforts and successes, ensuring that goals are both understood and committed to all levels. If primary care providers don't understand what the Ministry is talking about and what its vision is, they cannot and most likely will not do anything about it. Communication and leadership are deeper issues that should be addressed more fully in future efforts and may be the subject of future conferences hosted by the HCAC.

In Kuwait, the MOH is the main provider of health care, with the remainder being provided by the Ministry of Defense, the oil sector, and the private sector. The care in the public sector is provided through six health districts, which include 15 general and specialized hospitals and 90 primary care clinics. QI practices were adopted in Kuwait's public health care system in 1987 with the establishment of the central Directorate of Quality Assurance and Infection Control. For many years, however, the interest in health care quality was random, individualized, and unstructured, and the main concentration at the time was on infection control because it led to tangible outcomes.

It wasn't until early 2001, when the need for assessing and improving the quality of health care was becoming a global phenomenon, that Kuwait established a separate Quality Assurance and Accreditation Directorate. The Directorate's main function is to design, train for, and monitor the implementation of quality and safety programs in all MOH sectors. The Directorate started the preliminary phase of the national accreditation program in which a set of quality and safety standards were developed and compulsorily implemented in all MOH hospitals. More recently in 2008, a two-year contract with Accreditation Canada was signed in order to give technical support to the MOH in developing its national accreditation program.

While these developments are forming the basis of a national vision and mandate, challenges remain in the implementation of a quality program due to the absence of a clear national strategic plan for quality with involvement and commitment from top-level management. Without this vision, they also lack basic training in quality and incentives and recognition built in to the program. Another significant barrier to promote the QI activities is the current information system, which is not yet fully developed to meet the needs of the QI program; however, a reporting system has recently been introduced.

In spite of the remaining barriers and challenges, the guidance provided by the central Directorate has led to some excellent achievements, such as the establishment of a national accreditation program and a well-recognized indicators (generic and clinical) program. Additionally, the patient safety program is working on developing safety policies and following the mandatory implementation of the World Health Organization's (WHO's) Nine Patient safety solutions and the Safe Surgery Saves Lives challenge.

In Palestine, political commitment had to be built in support of a vision of QI in health. The MOH Quality Director directly addressed the Prime Minister in order to convince him of the reliance of a healthy economy on having a healthy population. After striking this understanding, the Prime Minister gave his full support to QI in health care.

Political commitment is a necessary precursor to a successful vision and mandate, and the appropriate leadership needs to be identified early in the process. After that, a partnership with all stakeholders will further contribute to a successful vision: Government hospitals, private clinics, NGO facilities, and others all need to be a part of it. Together, parties can build an ultimate goal that defines a common goal and a common path to that goal. In Palestine, the overarching goal is "to provide safe and sustainable health services for our people."

The first step that stakeholders identified was then to take assessment of the physical infrastructure, including numbers of beds, capacity in different types of surgery, and a national health account system. They also began to look at how much people actually pay out of pocket versus how much the government is paying for services, thus addressing access issues as part of the vision. They subsequently formed a voluntary body that includes all stakeholders and headed by the Minister of Health. Their first conference focus was “right to health,” then “patient safety.”

Now, they are looking to build a national health information system for access to data for planning and management. They are advocating and doing outreach for awareness among the population and have begun to talk about creating a culture of improvement so providers understand it and its importance. Recently, they have even begun acting to reduce the number of patients referred abroad, with the resulting increase in local health care income to put back into infrastructure. They intend to build hospitals and the capacity of staff and to bring in more expertise from abroad to stay in Palestine, as well as to buy state-of-the-art equipment, such as new incubators. Only after all of this effort and achievement did they start to think about how to build their accreditation system, because they knew they needed a certain level of improvement first.

In the same manner, the national vision that guided QI in Malaysia started with a national indicators approach to establish common terminology and understanding. After aligning all of the stakeholders, the specific goals were able to evolve, and an accreditation approach was introduced approximately eight years later with the support of all parties.

With an overarching vision that keeps the goals of many stakeholders aligned over time, a health system can successfully introduce not one set of interventions, but an evolving strategy over time that involves many individual and interconnected interventions. The direction and support provided by a national vision and mandate for QI provides a framework in which well-governed systems can succeed dramatically in the implementation of QI.

C. Good Governance at National and Local Levels

Once a clearly articulated and well-supported vision is established for a health system, the execution of policies depends on good governance at both the national and local levels.

Policy has many layers, and it is critical to begin at the national level as a total sum of all regional needs. In Iraq for the last few years, actors have been working with the MOH toward achieving that objective. They emphasized the centrality of health to the macro economy while recognizing and taking into consideration various regional needs and postures in all Iraqi provinces. Health started as a low priority sector but slowly but surely emerged as a top priority, strengthening the perspective that health and education are at the very core and foundation of sustainable economic growth. Oil and electricity were considered the most important as the energy base of the Iraqi economy. They worked with the MOH to precipitate a significant awareness for health, as the foundation for a healthy and productive labor force and population, thus equating its importance to oil as the generator of revenues in the short and long runs, while the health sector guarantees health human resources capable of working productively in all sectors, including oil and electricity. The Iraqi Minister of Health worked diligently with the MOH in Baghdad and the Directorates of Health (DOHs) in all provinces to affect a greater role for the MOH and to move toward evidence-based policy making and was recognized by the Council of Ministers for his success in steering the health sector toward greater efficiency and productivity. A lot remains to be done by developing and sustaining evidence-based policy making and policy-driven programs in pace with the national strategic plan and the changing health needs of the Iraqi people. They also worked closely with the MOH to enhance the awareness of the role of the private sector in advancing the health economy. This requires further policy input at the level of the Council of Ministers to open the channels of private sector development in health and other key sectors of the economy, thus

strengthening economic growth while maintaining the role of government as the watchdog to enforce fairness and justice to all producers and consumers of services in the Iraqi economy.

Parallel to this is the importance of micro/macro linkages and local governance. They worked with the MOH to extend the impact to all provinces in Iraq in building capacity for training and assessing regional needs along with the critical budget preparation skills for the objectives envisioned by the national strategic plan. By focusing on doing the best they can with what they have and producing results, they can further encourage the government to allocate more funds and utilize the allocated financial resources in the most efficient way.

The national budget has two elements, the operating budget and capital (investment) budget. The operating budget covers salaries and day-to-day operating costs, including maintenance. The investment budget covers spending on projects to rehabilitate existing infrastructure and to add to it through the construction of new hospitals and primary health clinics as needed in Baghdad and the provinces. In the last few years, Iraq has been working hard to strengthen performance of the public sector through capacity building and system reform leading to the threshold of sustainability beyond the stage of donor assistance, which HCI has been providing on numerous USAID-funded projects in Iraq.

In Jordan, medical tourism is a significant part of the health system and substantial sums into the economy. Whether it is being invested into the health infrastructure or is just a part of the hospitals profit is a question of governance. If directed into the former and not the latter, it is a very strong asset for improving the quality of care delivered across the system.

Another side of medical tourism is what happens to the low-income economies that people are coming from to get care. The money coming into Jordan is not going into other medical systems. The health systems of the low-income economies are suffering even worse as a result of medical tourism. For example, while Jordanian patients might gain from services that their system provides to visiting Yemeni citizens, ideally, Yemenis should be able to get quality care in Yemen, not have to go to Jordan. So, even if medical tourism income benefits from being governed well in one system, it still represents a barrier that another system in the region will face in achieving its own high-quality health care.

While implementing QI in Malaysia, actors saw they needed a dedicated budget in order to continuously train people and create awareness. They depended on national steering committees, program committees, and hospital- and city-level committees to drive QI and collect and review data, fueling the national initiative. These committees contributed to good governance of sites and QI initiatives because they had financial and other support from national governing bodies. However, if done over again, they would have merged all the committees nationally instead of having multiple different committees with different foci (accreditation, QI, standards). This would instead bring all stakeholders together and make them work out their differences and find better overall solutions for everyone.

In each of these cases, the initial decisions and guidance provided at the national level set the direction and goals of national QI efforts. These efforts then relied on good governance systems in order to execute the policies and plans inspired by the national vision. In turn, the success of governance systems and their sustainability depends largely on the leadership of individuals within those systems.

D. Leadership Development at Every Level

Successful national QI efforts require good systems to implement policies and achieve goals, and good systems require leaders to make them successful and ensure their continuity. Movements are created and driven by high-level leaders. Leaders from different stakeholders at different levels are needed to implement those movements. If any of these leaders are absent or become absent, a leadership vacuum can lead to the demise of essential parts of an improvement movement or even the entire movement itself. In order for future leaders to be available to fill these vacuums and maintain momentum in a movement, they must be identified and nurtured on an ongoing basis.

Momentum has been maintained in Egypt largely because its Ministers serve for at least five or six years and have lower turnover; they are able to keep the same vision longer. The current Minister is trying to improve whole system instead of individual sectors. He is focused on changing the way people think about their work to begin to think that the work should be different and that they should not continue doing things the same way. However, they are still worried that a lot may still be lost if he leaves, because there is no guarantee that the next Minister will support QI in the same way.

Jordan has faced the same problem with turnover of Ministers, but has addressed it with the establishment of a higher health council chaired by the Prime Minister and including other Ministers concerned with health and major service providers from each sector. The council's purpose is to sustain policies and reduce changes as new Ministers are appointed.

Jordan's experience with QI in health started with the introduction of the King Hussein Medical Center in 1973. This hospital was ahead of its time in many ways and the notoriety around the quality of care caused other facilities to attempt to catch up. It was driven most forcefully through cardiac surgery. At the time, it was accepted that no one in the region had the capacity to perform cardiac surgery well. The international medical community even said it would be dangerous; however; it worked and patients did not die. When this medical center proved everyone wrong, the additional international acclaim raised the profile of health care quality in Jordan even further. In this manner, an entire center and not just an individual acted as a leader for the system, leading by example in order to inspire others to keep the movement going.

Due to this and other factors, political leadership strongly championed health care quality issues. The late King Hussein himself sustained this actively. He also looked at how many medical professionals went abroad for training and took measures to increase that and build Jordanian expertise. King Abdullah is continuing to push for that and provide that top-level leadership.

Across the Gulf States, the Gulf Cooperation Council (GCC) started some years ago to look at health systems in the region and identify gaps. One of the most important ones they saw was in the leadership support to QI. The concept of leadership for QI is not yet universally understood in this part of the world and is not given enough weight for its role in guiding health care improvement. As a result, Dr. Tawfik Khoja, Director General of the Gulf Cooperation Council, has been focusing on the importance of leadership. He has asked other Ministers what portion of their budget is allotted to leadership, and it has been very low, close to 0.02 %.

Dr. Khoja insists that this needs to change and that "When you have a good leader, you will have improvement." However, when that leader is gone, the improvement cannot be sustained if you have no "second line" of leaders. After he left Saudi Arabia, colleagues told him that the quality movement he had established collapsed because there was no leader left behind to sustain it. The lesson he took from this is that role of the top leader should be to teach other leaders to lead improvement, not to lead improvement on his own and try to teach it to everyone at once. It is important to invest in leadership, not just the program activities. Many of the leaders today are the same people who were working on QI 15 years ago. This is dangerous, and leaders and champions need to be developed at every level, from the King on down to the front line worker. In order to nourish this leadership, it is necessary to provide model examples of successful improvement initiatives to government leaders. By showing them pilots that work and other successes, they will better understand and thus better support and replicate them.

In developing leaders, health providers and others in the system should not be the only ones considered. Many QI champions arise out of crisis, and many come from the general public. If people are engaged in their own health, they will have major influence on the way their health services are delivered. They will drive change by leading the health system. Many of the biggest QI champions come to the table as lay

people who become health care quality leaders. People should be engaged and the seeds for their involvement planted.

In Sweden, improvement started with very interested employees, from the ground-up. However, they quickly saw that if the leadership didn't support their actions and efforts, they would not succeed in the long run. A central role of leadership is to give strong signals in support of employees' improvement efforts. Sweden's leadership board was not supportive at first and frequently asked why the QI initiatives were taking people out of the system for training instead of staying on the front line to provide care. Mr. Sven-Olof Karlsson, former CEO of the Jonkoping County Council, had to negotiate with them to continue setting aside time and resources for QI until he had the results to show them. This patience paid off and now health leadership is fully supportive of QI efforts.

In Palestine, they saw the importance of having a critical mass of middle-management leaders in addition to top-down and ground-up leadership. Their support is also critical in guiding higher level leaders as well as in actually implementing changes.

In Malaysia, leaders at all levels were also integral to their movement. These leaders need to act as QI champions, acting at every level to advance QI. It was important that they were identified early to increase their involvement, ownership, and contribution to the movement.

A major challenge and disappointment for many Ministers is that major resolutions and pronouncements often stay on paper and are not implemented. Some leaders may learn from others while abroad; however, their plans do not see life after they return and are among others who are still unaware of quality issues. Leaders may believe in quality and accreditation in principle, but the lack of understanding among colleagues is a major barrier to implementation. Getting them on board when they don't understand is a major challenge and yet another reason why multiple leaders at multiple levels are necessary to build and maintain a QI movement.

Actors in Yemen also had some difficulty getting the Deputy Minister on board and had to work hard behind the scenes to get support for accreditations. Now, they see things differently and consider quality health care to be a human right. Yemen is a recent starter on its quality journey, and actors there have learned to start modestly and work within their reality, with a focus on the people who are delivering services to the community. They found that you need to give providers more power and to be consistent and patient with the system. QI takes time, but on the ground, they are now seeing some results. On the political level, it was very challenging. If they were to do it all over again, they would have built better consensus at the political level and at the same time taken better advantage of diverse expertise by coordinating everyone's contribution better and with better consensus on overall direction.

In each of these cases, lack of leadership has been associated with difficulties and unsuccessful QI efforts. The importance of good leaders cannot be overstressed at any point in the life of a QI movement through the choices they make, direction they provide, and the momentum they maintain throughout the execution and ongoing redesign of long-term strategy.

E. Choosing Appropriate Tools and Methodologies

National QI efforts have numerous different tools and methodologies that actors can choose among and adapt for their situations. No one tool or methodology provides a perfect answer for every health system. Also, tools such as accreditation should not be confused with the overarching goals and should be viewed as one of many means by which a system can achieve those goals. The recognition of the achievement is an important driver to encourage continuity of a QI movement, but it should not be mistaken for the end of the movement.

Dr. May Abu Hamdia, Chief Executive Officer of Jordan's Health Care Accreditation Council, commented on HCAC's role in QI in Jordan. Council staff are primarily observers, involved with both national leaders and workers. This allows them to see both sides of the coin. Like a diagnostician, they

need to see both sides in order to best diagnose the problems. In order to improve quality, one must be able to put a finger on exactly where it hurts, and HCAC's position gives them the ability to do so. Development of standards is important and accreditation is a great reward and form of recognition for QI implementers, but it is not the end product, not the be-all-and-end-all. HCAC must continue to be critical and properly identify local needs. There is no one-size-fits-all solution, all methods for QI are not the same, and even the same tools are not always applicable over time. Within health systems, one should segment all markets and apply different stresses and different treatments for the system in different sectors.

Achievement of accreditation does not mean that there is quality care. Quality processes mean there is quality care. While accreditation may be valid for a hospital if it was recently achieved, it does not mean that services are still being provided at the same level after longer periods of time. There is a cut-off point for accreditation, though conditions can change and deteriorate long before that is reached. Like accreditation, there needs to be a cut-off point for the recognition of external rewards by other methods and tools to encourage people to maintain processes and quality over time.

Many public systems are receiving too many messages, priorities, standards, and goals, such as from the WHO, the United Nations, national-level MOHs, and others. If public systems try to follow all of them at once, it will be too many and will be a strain on the system. Leaders and managers have to decide for themselves what is necessary for them to utilize and what would be unattainable or would function as a distraction.

Some say that accreditation is popular in Jordan only to support medical tourism, but in reality it should be for the benefit of the Jordanian people. HCAC would like to revisit itself to ensure that they are serving the Jordanian people in this manner. There will be an ongoing need to do so in the future to reinvent themselves again over time and make sure they have the right priorities.

In Palestine, the quality movement is now looking at how to build their own accreditation ability. For years actors there have chosen other foci and methods that were more appropriate for their situation. Now that they have realized the successes of earlier efforts and their situation has changed, they have chosen to begin using accreditation in order to continue improving their system. They want to benefit from the Jordanian experience and how Jordan built its quality indicators and checklists for accreditation in both primary- and secondary-level facilities. The Palestinians believe the levels cannot be separated, and they need to look at both levels of service at the same time.

Other leaders present acknowledged that methodologies not only must change over time, but they also cannot be universally applied across a system. If methods are organization-based (designed, one hospital at a time), those designs may not be appropriate or applicable in other hospitals. The wider system may not allow and support organization-based design, so it is important to consider a variety of methods and the system's ability to support a variety of systems when designing interventions.

Also, accreditation established for an individual hospital can remain valid even though new doctors come in under the authority of the accreditation won by previous doctors despite a possible decline in quality. Without a system for ongoing training and support for quality, new doctors often have a "license to kill" given to those who came before them. An organizational framework for improvement without a national framework can lead to this situation.

The Scottish learned that accreditation is necessary for QI but not sufficient on its own. They required a certain level of basic standards that everyone must live up to and that was served by accreditation. However, that would not take them to the next level to achieve excellence. For them, excellence was measured as the ability of all patients to come in to a hospital and not be infected and receive the right care the first time; excellence was not defined as the number of advanced magnetic resonance imaging (MRI) machines and other expensive equipment.

To achieve excellence defined as the right care for every patient every time, they choose the Institute for Healthcare Improvement's (IHI's) model of improvement that encourages complete transparency followed by testing of big changes on a small scale. Some locales in Scotland are also using lean methodology, which works for them, but the national effort primarily relies on the IHI model. They are seeing major successes, which to them still doesn't necessarily mean they are fancy and have elaborate machines, but rather the absence of infections and errors.

In Jordan, many feel that "accreditation" as a term is indeed being magnified beyond what is actually meant by it and achieved by it. Jordan is still in an infant stage of accreditation. They have a very small percentage of hospitals accredited, and accreditation is still our main focus. However, in other countries where 90% of hospitals are accredited, they have ceased to talk about accreditation and now talk about quality and transparency. Once quality is better, they start talking more and more about competition over outcomes and publicity for them. At that point they can compete and more widely publish their adverse events because they are more rare and significant, and as a result it is more productive to do so.

As with some other tools and methodologies, misuse of accreditation can be rampant and used too commercially. This is also evidence that local accreditation standards are in place, but facilities are still focusing on international standards because they serve commercial goals that local standards do not. There should be a human focus that emphasizes common goals and outcomes and not a commercial focus that distracts from them. We also need to get away from a political focus; political support is necessary but political ownership of QI can be as dangerous as overt commercial influence.

Whatever approaches, methodologies, and tools are employed for QI, they should not be parachuted approaches. They must instead come from within the system and be adapted to the local context by the local stakeholders with the right priorities aligned to the right goals.

F. Culture Change

QI requires a culture change to come about within a health system. At the national level, this culture change reflects a realignment of priorities. Policies and resources must be realigned to support changes that drive quality as well as the people and systems that implement those changes. At the local level, practitioners must begin to see themselves as being responsible for implementing QI. At levels in between, the culture must otherwise evolve so that QI efforts receive the necessary support.

Mr. Karlsson agreed on the importance of leadership as seen by other countries. However, in Sweden, he noticed that there are a lot of different approaches and people don't always do what leaders want them to do. Usually, people are satisfied with what we are doing and the way we are doing it now. They may acknowledge that they hurt a lot of people, but since they always have, many people think it is acceptable. This is wrong and we need to change the culture so that health workers see themselves as having two simultaneous jobs: providing care and improving the quality of the care they provide. All companies in competitive markets see it that way; Toyota, leading hotels, and more and more companies are addressing QI because they have realized that it is necessary. He worked for a long time to change this culture in health care in Sweden and has seen only some progress in getting health care providers to also see QI as necessary. Lately, he also visits schools to look at their classrooms. On a recent visit, he found a Plan-Do-Study-Act cycle (PDSA) wheel in a classroom. A seven-year-old boy was able to explain PDSA cycles and how they used them in class. This kind of culture change from the beginning will eventually foster a wide and permanent culture change in which all participants accept their role in improving the system.

The Palestinian leaders have also recognized that training is an important foundation; if you train people in QI from the very beginning, people will understand from the beginning that QI means lower costs for the system, not higher costs.

In the Malaysian experience, actors worked with the WHO collaborating center for QI, giving them a regional focus. They worked on the premise that quality is about changing work processes and improving systems. They pursued incremental change, not immediate improvement from A to Z. Quality is about changing peoples' attitude and putting a better work culture in place. They learned that one has to dislodge people from their comfort zones carefully. The most important thing is having a national leadership mandate that trickles down and a vision that is transferred right down to the practitioner level. When they did it at first, they found that it didn't get transferred down very well. People didn't understand that they had a part to play in the vision, and without that culture change, the effort was ineffective. To correct this, senior management commitment must be shown, not just expressed. So they made sure senior management attended all activities to make them high profile and show their commitment and appreciation to those participating. The resulting culture change was a major driver in later successes.

In Egypt, the Minister's longer term of service has allowed him to realize the importance of culture change and act on it. He is focused on changing the way people think about their work to begin to think that the work should be different and that they should not continue doing things the same way. While they still depend on his leadership, the culture change is in progress.

Other than leadership instigation and management support, this kind of culture change also needs a system designed to encourage it. Systems that ensure acknowledgement of people's efforts and recognition of their achievements best serve this purpose.

G. Acknowledgement and Recognition

Systematic acknowledgement of people's efforts and recognition of their successes is an integral part of successful and sustainable QI movements. Without proper encouragement, workers who put in the extra effort and adapt to the culture change of increasing their workload to include QI will not do so indefinitely. Not only must they receive external rewards, but they also must see the value of their work for themselves. Managers and front line workers should be able to see their own data and outcomes, empowering them to make the best decisions in care delivery while also providing the motivation for them to do so.

The Palestinian leaders started with pilot projects to address the problems they identified in their system. Within a few years they started to see the results of the actions taken by the heroes they supported within the system, and those heroes started to see those results themselves. This acknowledgement of the gains inspired people at all levels to continue. Low-paid frontline workers were still overworked and overloaded, but they started to see better satisfaction from customers and that motivated them to continue. Through achievement of improvements and recognition of their contributions, they are still seeing a commitment to quality despite the thousands of patients who have been piled on the system in the last 10 years of fighting. Things have gotten considerably more difficult since the intifada and conditions have deteriorated, but people are still committed and there is both the willingness and the leadership to bring the system back to level it was at 10 years ago despite the hardships. In order to maintain this leadership and support, they would like to establish a formal system of rewards and recognition while encouraging further thinking about quality and streamlining of processes.

Jordanian leaders saw that there also needs to be a challenge involved, and the challenges must be designed well. Goals must be attainable, but auspicious. The target must be hard to reach, but not so far that it cannot be reached.

In Malaysia, leaders also saw the importance of appraisal and recognition systems for QI initiatives. Rewards don't necessarily have to be monetary, and an official "pat on the back" can go a long way to motivate employees. At the same time, one should avoid a "bad apple" system that singles out low performers or is overly critical of performance. Once they started placing blame or negative

recognition through judgmentalism, it became very detrimental to QI efforts. It was also very difficult to get rid of that way of thinking once it started.

Bahrain has been working on improvement for a long time before moving on to accreditation in 2010. One issue that came up in accreditation was that the enthusiasm and teamwork at the beginning amongst staff (52 teams across the MOH) was good at first, but over time, it faded. After a while, when they went back to look again at the teams, they found that there was no recognition given to them. The QI work was mandatory, and they were expected to give results, but no recognition was given to them along the way. Everyone was being asked to do more and more without acknowledgement of their increased workload.

Fortunately, the highest levels acknowledged this problem and have been trying to fix it by giving more recognition and support to teams. Ministry leaders then made it mandatory that higher levels give weekly feedback and recognition of the work. The new problem was that the managers and leaders were getting recognition, but the front line staff were not. Getting the frontline workers to work on improvement after all that time was like trying to get a cold diesel engine to start. Fortunately, they did get teams working again, but it was very hard. It helped that their leaders had mostly been primary health care providers and family physicians, so they understood the frontline workers and created effective programs to support them.

A system for acknowledgement and recognition of individuals provides them with the motivation to act within the system. For their actions to be effective, they must also have access to information about the system and have the authority to make changes that keep the system accountable to its overarching QI goals.

H. Transparency and Accountability

Ultimately, the purpose of a national health care system is to serve the needs of the public. As with all other sectors of government service, the transparency of government agencies and their accountability to the public is a cornerstone of their effectiveness. Transparency is important both within and outside of the system. The availability of data and being fully informed about the system around them allows frontline workers to make better decisions in the delivery of care, managers to make better decisions while running the system, and top-level leaders to design better policies. The availability of service statistics and other health care information to the public allows it to be better engaged in health care at the personal and political levels while also holding policy leaders accountable for their support or lack of support to improving the quality of health care.

In between sharing of experiences, participants began to ask critical questions about each others' accounts of their own systems. Some countries have claimed big improvements in the quality of services in recent years despite continued public criticism of their health systems. Most every country is also experiencing increasing costs, including out of pocket costs to the public for health services. Major mistakes create big newspaper headlines while certain statistics about costs and infection rates fuel loud public debates. Sometimes, the resulting outcry can be seen as counter-productive, and in some cases that may be true if it is not responded to properly by the Government.

The health care leaders present all acknowledged the ongoing problems that persist within their health systems and the particular challenges of responding to public criticism and dissatisfaction. The proper response advocated by the group is that the headlines and public dissatisfaction can be a good thing if not ignored or covered up by health care leaders. All systems need to learn from their mistakes and failings. Only by openly acknowledging the problems can those problems be properly addressed. Instead of denying statistics on cost, Governments should investigate the claims of those statistics and ensure that they have actual data to work from themselves. Instead of denying major mistakes or covering up events, they should be open about them in order to have free discourse on how to solve those problems and prevent those problems in the future.

As a result, not only can everyone learn from mistakes, but also these problems will drive future changes and improvements, giving additional fuel to national mandates to improve quality.

It is well known that there are problems in every health care system, no matter how developed. The biggest issue is being transparent. Being transparent about what is really going on and acknowledging mistakes is key to improving quality. Even in the U.S. health care system, the recent 100,000 lives campaign has made massive improvements to the health care system only by first acknowledging that the deaths were being caused by the system and that the system needed to be changed and improved to prevent them. As with other countries, there was a lot of defensiveness by system practitioners; however, those who accepted that the system needed to be changed made truly spectacular improvements to the system.

In Kuwait, actors continue with and build on their performance indicators program as a driving force behind QI. The program started in 2002 with the training of doctors and specialty council members, followed by the development of sets of indicators, including generic indicators, clinical indicators, safety indicators, and primary health care indicators. Periodical reports of indicators are submitted to directors and heads of departments, which has had a positive effect on improvement. This project should be continued and performance measures should be built on to help health care providers and leaders monitor performance and improvement efforts.

In Jordan, King Abdullah wanted to take health care to another level, so he met with Ministers across the Government. Everyone had his or her own idea how to do it, but they all agreed on one thing: they could not move without data. However, they did not have the data. Getting the data was a difficult process with no computers and no standard hospital information systems. Building all of that from scratch from paper records was a very long and hard process. They tried to pass that through the establishment of a single hospital information system. The aim was to get data across all 6 million people in Jordan, including data on clinical decisions in order to find out how to provide better data.

The lesson they learned is that once you have the data, it is the lower quality hospitals that benefit the most. He thought they would focus on getting the best hospitals to be even better and that low-quality facilities would not be interested in accreditation. Those of low quality saw less of a need to improve when they had no data to look at, but that changed when they had data. Their exercise of grading and comparing hospitals on every indicator drove improvement. Accountability and transparency were critical. There is no need to have accreditation first, and everyone should work on getting data right away.

In two major hospitals, they have pilot project to establish this information system. After the pilot, they will have one database that all hospitals can contribute to. Everyone should build one system from the ground up and get all hospitals on one system sooner rather than later. If you have to integrate different systems from each hospital, it will be very costly and difficult.

In Scotland, leaders likewise were able to make the major systemic changes that were needed only after they admitted openly that there were problems within the system and were able to openly discuss the data related to them.

In Latin America, the interest and involvement of Governments and MOH support for QI came hand-in-hand with another social phenomenon: the increase of civil society participation in government. As Latin American countries transitioned from military regimes to democratic governments, people began to participate more and more in government in general. This also led to public involvement in the Ministries of Health and renewed interest in access and quality by the government. In Chile in the early 1990s, URC gave technical assistance to the Government Ministry to improve quality. The public health sector was very deteriorated at that point and the Government's acceptance of this led to the identification of the needed assistance.

In Ecuador, the women's movement in the mid 1990s identified the quality of health services as an important issue for women, and they worked hard to enact legislation in support of improving the quality of care for women. This in turn led to increased priority for QI across the board.

Changes like these, whether driven entirely by the public, by people within the system, or by some combination of the two, only happened because of increased transparency and accountability in the health system.

I. Other Major Insights

As national QI efforts continue over time, a number of new issues arise and the QI efforts must evolve to address them. Many different choices, actions, and preparations can contribute to the sustainability of QI, and the leaders present at the policy seminar have had widely varying experiences over the years.

In Egypt, the accreditation system is now automated for primary health care, but the question is how to link with secondary, tertiary, and referral systems. They are also working on reform of the insurance system to address this and link units together through the referral system. The goal is to extend insurance coverage to everyone (currently at only 44%), and this has been their greatest challenge. They have also started a pilot program for second and tertiary facility accreditation and have developed a system of inspection and regulation for the MOH to assist individual hospitals to reach 0-level. After reaching 80% at inspection on their own efforts, the Government will then help them make additional improvements in order to reach full accreditation.

WHO recently commissioned a multi-country study on the prevalence of adverse events. The results were astonishingly high, and such high rates should not be overlooked. When common issues are faced across an entire region, countries should not be left on their own to address them. Programs should be created to support countries to help prevent adverse events together.

Another underlying issue with improvement and the role of health systems is that health systems around the world only contribute directly to 10–15% of the overall health of their populations. A recent Canadian study showed this, and a study from the GCC also showed that improvement in health of the population mostly came from improvement in other areas, such as public infrastructure, sanitation, housing, etc. In order to truly affect the health outcomes for a population, QI efforts should also address public interventions that may not be in control of the health system.

In order to make their efforts sustainable in Ecuador, leaders are still working on three critical factors: developing a critical mass of leaders at the national and sub-national levels who have knowledge and commitment to QI, establishing policies at different levels in support of QI, and introducing quality of care with all various stakeholders: Government, private providers, insurance companies, universities, and social movements.

In the GCC countries, they are now or at one time were grappling with where to start—with primary, secondary, or tertiary care. The conclusion in most places is that they need to do all at the same time and ensure a certain minimum quality of services at each level, as Scotland did. However, having fancy hospitals and machines is also important for long-term improvement. Reducing mistakes is important, but increasing capacity to treat in advanced ways is also important.

In Palestine, the diabetes scare taught them the need to reach out to patients more. By reaching out to those who own the process and giving them the power to control it and guide improvement, they will also see more effective outcomes. A few years ago, the definition of health management was increasing people's ability to influence the outcomes of their own treatment. Engaging with patients actively is important for improvement. There is a need for general systemic change, but practitioners should also go one step further and empower patients to improve their own outcomes. This was a big shift in paradigm by going one step further to make the client a player in the game. This paradigm shift could also prove essential in the long-term sustainability of health systems.

Some countries also identified doctors' role as managers as a source of problems in some systems. For better long term results, the administration and management capacity of doctors should be built in medical school so that they have some managerial skills when they start. As it is, doctors move up through the ranks and without intentional building of managerial skills along the way. A sustainable system requires good managers, so good managers should be both brought into the system as well as developed early within the system to prevent many problems.

IV. Conclusions

After the Policy Seminar, many valuable lessons for the successful establishment of national QI efforts in the region were summarized, including:

- Access to services and improving the quality of those services is a dual goal.
- A national mandate and vision must guide improvement.
- Good governance at the national and local level must support improvement.
- Leadership must be developed at every level.
- Appropriate tools and methodologies must be selected locally.
- Quality improvement requires a culture change.
- Workers and leaders are motivated by achievement and recognition.
- The health system must be transparent and held accountable.

Access is the primary problem many systems recognize, access that is limited by varying geographic, financial, and cultural barriers. However, once it is addressed, and people participate in the system, outcomes do not improve on their own. One must also have a focused effort on **improving the quality of services** to which people now have access. This improvement effort must be holistic, involving public, private, and quasi-public sectors along the full continuum of care (patient-level, primary care, secondary, and tertiary).

The initiative must be started at a national level with a **national mandate and vision** that is effectively communicated all the way down the line to the frontline workers. This fosters inclusion and tangible support, including resources and efficiencies of standardization of guidelines, use of common standards and data systems, and one common leadership committee that brings together all stakeholders for unified leadership.

Good governance at both the national and local level is necessary to support quality improvement. At the national level, it is essential to emphasize the centrality of health to the macro economy. The council of ministers must understand that health is dynamically connected to all other sectors and increase its share of the national budget in line with the strategic framework and vision for the health sector. Resources must be budgeted to support not only the operation of the health system, but also investment in its infrastructure for the future. At the local level, all stakeholders must learn to function as best as possible regardless of the amount of available resources. By functioning well within existing constraints, they will both pave the way for the best use of future resources while making the case for the allocation of additional resources.

Leadership must be developed at every level. Whether at the national, local, or even individual facility level, individual leaders will leave a vacuum if they have not developed leaders below them to continue driving improvement.

Everyone must **choose the improvement tools and methodologies that work for them**. There is no one-size-fits-all improvement path. Accreditation is not a final goal, but rather a means to an end. It is just one of the many tools available to use to improve the quality of health systems.

Quality improvement requires a **culture change** in which all members of the health system start to see themselves as having two jobs: one where they provide health services and one where they work to improve the quality of those services. Leaders must show a commitment to quality improvement and encourage everyone throughout the system to be committed to change.

In order for change to be continuous and not lose momentum, workers and leaders alike must be able to see what they have **achieved** through improvements in outcome data and must be **recognized** for their contribution to improvement. This recognition does not have to be financial, but should be acknowledged publicly by others in the system.

The health system must be equally **transparent** about its failures as its successes, both within the system and with the public. Only by acknowledging failures can they then be addressed. A system that seeks to hide its shortcomings prevents both **accountability** of politicians to the public and the ability of health workers to benefit from critical analysis of real data. Public support, encouraged and guided through honest assessment of issues, is a major driving force for improvement.

In addition to these common themes, there was much more that participants had to offer regarding the creation, longevity, and continued work of their QI efforts. Their experiences provide a wide range of suggestions and insights applicable to the development of other successful national strategies.

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