Improving the quality of care in the public health system in Bangladesh: building on new evidence and current policy levers

Policy Note

Bangladesh Health Systems in Transition

Asia Pacific Observatory on Health Systems and Policies

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[1] The Asia Pacific Observatory Policy Note series builds on challenges identified during the writing of country reports on health systems in transition (HiTs) and applies the general lessons from evidence reviews in policy briefs to provide specific policy recommendations for action by country policy-makers.

Objectives

Review the current policy framework for regulation and improvement of quality of care in Bangladesh from a systems perspective.

In the light of international evidence, provide recommendations to address the identified gaps and systems issues in the current Bangladesh policy on quality of care.

Rationale

Improving the quality of care in public health facilities in Bangladesh was identified as an ongoing challenge in the 2015 Health systems in Transition (HiT) report on the Bangladesh health system (*1*). Recent publications in the international literature have emphasized the importance of improving the quality of care in the public sector in order to drive improvements in the private sector (*2*). This policy note takes advantage of new insights emerging from international thinking and research on quality of care to identify potential policy opportunities in the evolving landscape of health policy in Bangladesh.

Key policy opportunities

1. Clarify the institutional roles and responsibilities for implementation of the National Quality Strategic Plan.
2. Strengthen the linkage to quality in the essential services package (ESP) by including reference to the quality-of-care standards in the plans for implementation of the ESP.
3. Provide increased management autonomy to upazila health and family planning officers to manage resources across the upazila network of facilities.
4. Increase clinician engagement and responsibility for quality of care by establishing a clinician task force/support group to work with the Ministry of Health and Family Welfare (MoHFW) to provide technical inputs into quality-of-care standards, policy and implementation plans.

A. Review of the current policy framework

(1) Quality-of-care problems

Quality-of-care problems can be categorized as undertreatment and overtreatment as, for example, described by Das and Hammer (*3*), and recently in relation to maternal care by Miller et al. (*4*).

- Undertreatment: failure to access or receive essential care or elements of essential care, or receiving essential care late
- Overtreatment: provision of unnecessary or inappropriate or ineffective services, particularly diagnostic tests, procedures and medication.

Bangladesh experiences both types of quality problems, and these problems play an important role in the country's lack of substantial progress towards universal health coverage, as demonstrated by recent evidence. Several studies have shown that problems range from inappropriate prescription of medicines by drug retailers and village doctors (*5*), to low levels of patient satisfaction during interactions with providers (*6,7*), and provider complaints of lack of staff and supplies, lack of training and supervision, and large volumes of patients constraining quality (*8*).

As summarized in the recent Bangladesh HiT report (*1*), poor-quality service is strongly associated with low utilization of services, especially by low-income groups. Major problems affecting

utilization are lack of sufficient drugs, supplies and equipment; staff shortages and absenteeism, and low levels of competence; poor prioritization of spending; and pervasive problems of management and coordination. All these are indicative of weak governance. Improving the quality of services will require significant reforms to increase the health budget to ensure the provision of drugs, decentralize health services for faster service, reduce fragmentation and increase accountability to users (*1*).

(2) Current policy framework

(a) Health sectoral policy

The Health Nutrition and Population Strategic Investment Plan (2016–2021) (*9*) has as its aim the delivery of a "package of high quality essential health services … through various health delivery outlets in a holistic way". Quality is described as the first key guiding principle of the plan "to ensure that all citizens have access to high quality services, whether these are obtained from the public or private, modern or traditional providers".

The Plan states that "a major focus would be on achieving improved service integration, while ensuring individual services are of a high quality and accessible to all". A key strategy to achieve this is the revision of the ESP. "This proposed version of [the] Essential Service Package is intended to encourage care seeking for common ailments at lower levels, help in establishing a referral system to the higher level facilities, and improving the quality of care at each tier of service delivery" (*9*).

(b) Quality-specific institutional arrangements and recent policy initiatives

Quality Improvement Secretariat

The Quality Improvement Secretariat (QIS) established within the Health Economics Unit (HEU) has developed a National Strategic Plan on Quality of Care for Health Service Delivery in Bangladesh in 2015 (*10*).

The Strategic Plan provides a comprehensive set of interventions based around a shift from the previous quality assurance approach towards a quality improvement (QI) concept. Key elements include: introduction of consumer-focused services; a focus on patient safety; improvements in clinical practice; and strengthening leadership and management. The Plan also proposes the establishment of quality improvement committees at national, district and upazila levels.

Discussion with the focal person of the QIS and review of a recent publication describing activities undertaken under the Strategic Plan demonstrate progress on the development of QI teaching materials and standard operating procedures (SOPs), and piloting of QI activities in one medical college hospital and one district hospital. Other pilot activities include the use of clinical management protocols in the pilot social health protection scheme (SSK) facilities, and a trial of a score card monitoring of private health facilities in Sylhet city.

The QIS has also developed national health-care standards, and a proposal for a hospital accreditation programme, which has been submitted to the MoHFW, and is currently being reviewed by other ministries at the national level.

Quality initiatives in the Directorate-General of Health Services (DGHS)

The Total Quality Management (TQM) unit under the DGHS also undertakes activities to improve the quality of care, including introduction of the TQM process in five medical college hospitals and 22 district hospitals with funding from the Japan International Cooperation Agency (JICA). Some of the results include the introduction of breastfeeding corners, improvement in sanitation facilities, and the establishment of separate queues for women.

The Director of Primary Health Care reported on a mother-friendly hospital initiative, which functions as a hospital accreditation programme with a focus on the area of maternal hospital services. Another area of focus is the development of SOPs for antenatal care (ANC), postnatal care (PNC) and safe delivery care, which are being piloted in districts where the maternal voucher scheme is running.

Quality initiatives in the Directorate-General of Family Planning (DGFP)

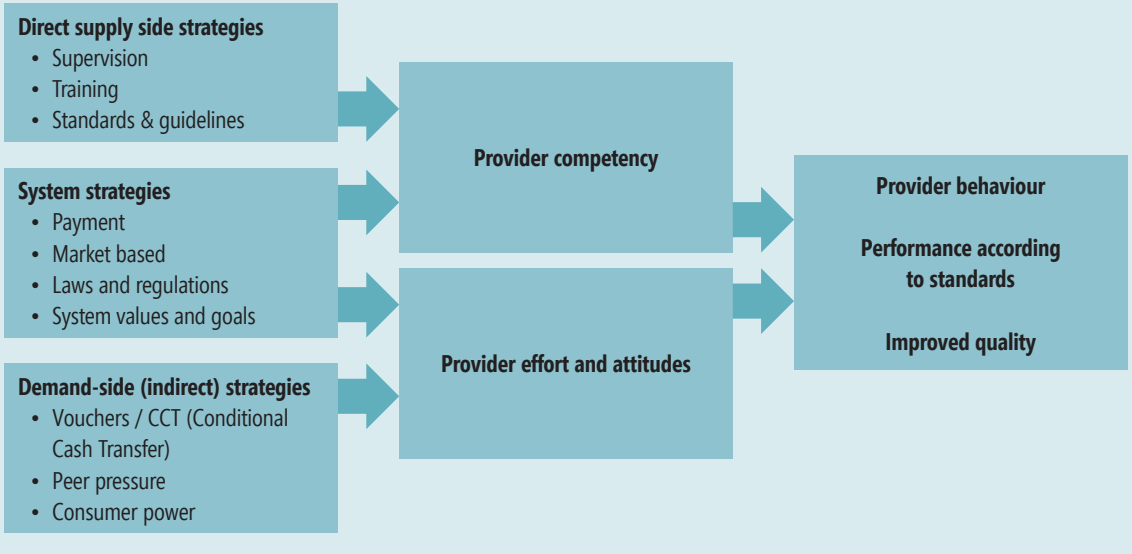
From the experience of the previous sectoral plan (2011–2016), the DGFP has identified the need to develop a structured referral system from community and satellite clinics to higher facilities at the Union and upazila levels, in close conjunction with the DGHS. The DGFP proposes to focus on client satisfaction and basic rights to information, choice, safety, privacy and confidentiality, dignity, comfort and continuity through the Clinical Contraceptive Services Delivery Programme. Ten family planning clinical supervision teams (quality assurance teams) provide technical supervision and capacity-building to service providers in public and private facilities. These teams will contribute to the TQM approach being introduced by the QIS, and link with the national-, regional- and district-level quality improvement committees.

B. International evidence

Fig. 1 summarizes a review of the evidence on effective policy options for governments in low- and middle-income countries (LMICs) to improve and regulate the quality of ambulatory care.

According to the review of the evidence (*11*), the motivation and attitudes of providers are key to improving the quality of care, while strategies that provide training, supervision, standards and

Fig. 1. What is the evidence on how to improve quality?



Source: Dayal P, Hort K. Quality of care. What are effective options for governments in low- and middle-income countries to improve and regulate the quality of ambulatory care? Asia Pacific Observatory on Health Systems and Policies, Policy Brief Vol. 4, No. 1. Manila; World Health Organization Regional Office for the Western Pacific; 2015 (http://apps.who.int/iris/bitstream/10665/208217/1/9789290616955_eng.pdf, accessed 29 July 2017).

guidelines have only a modest impact, if any. System strategies, particularly using financial incentives, market-based mechanisms and regulation appear to offer the most promise in LMICs. In contexts where a large proportion of care is provided by low-quality underqualified private providers, "effectively subsidised health services... of adequate quality... can drive out the low quality element of the private sector in a process of regulation by competition".

Key policy lessons for the government from the review of international evidence (*11*) are as follows:

1. Define and measure the quality of care: establish national standards to demonstrate the expectations of health-care providers.
2. Ensure the availability and quality of resources in public sector services, including facilities, equipment and staff competencies, to enable public service providers to achieve quality standards.
3. Engage providers in addressing quality and motivate them to provide quality services; continuous quality improvement depends on obtaining provider commitment.
4. Use financing and market-based strategies to generate incentives to support motivation.

These recommendations indicate that a coordinated approach using multiple strategies is needed; and that measurement, monitoring and reporting are key to improving the quality of care. Experience in a number of countries suggests that an initial focus on the patient safety element of quality can provide a more easily comprehended and politically salient approach to what can be a complex concept.

C. Key policy gaps

Quality of care is not just the product of interaction between an individual provider and patient, but is an outcome of the operation of the health-care system. The health-care system determines the resources, capacities and incentives available to the provider on the supply side, and the choices and incentives that the consumer faces on the demand side. In a mixed public–private system such as Bangladesh, these choices include both public and private providers.

Key elements of health system function that impact on the quality of care in Bangladesh can be categorized as follows: stewardship and institutional responsibilities for policy-making; management autonomy and accountability; and the service delivery model and how it operates.

(1) Stewardship and institutional responsibilities for policy-making

The allocation of institutional responsibilities for policy-making is a function of the governance and stewardship of the health system. Governance refers to the rules – formal and informal – that govern the distribution of responsibility and accountability within a health system, while stewardship refers to the determination of direction, and the policies and strategies to guide the health system in the desired direction (*12*).

Currently, institutional responsibilities for quality of care are divided between two units within different directorate-generals, resulting in some duplication and lack of coordination. While the QIS has the role of policy analysis and strategy development, implementation requires coordination between the QIS and implementing directorate-generals (DGHS, DGFP).

(2) Management autonomy and accountability

Quality improvement requires facility or system managers who have the capability and authority to assess and identify problems in service delivery, make plans to address them, provide or realign resources to implement the plans, and are held accountable for the results. Despite some discussions on decentralization of authority to upazila level, and on reforms of public financial management, in practice, the capacity and authority of upazila-level managers is limited and focuses on individual facilities rather than the upazila network, while central levels retain control of human resource allocation, and provision of supplies and drugs.

(3) Service delivery model and operation

Until recently, policy has focused more on equity and efficiency objectives, and tends to view quality of care as a separate and secondary issue. The national Quality of Care Strategic Plan focuses on the implementation of quality improvement, but does not situate quality of care within a whole-of-system perspective. A systems perspective recognizes that the allocation and use of resources to achieve equity and efficiency also constrains or enables the quality of care.

The recently revised ESP provides a model of care that allocates service functions to facilities at different levels within the system, sets out the resources and capabilities required for each level of facility, and takes an integrated approach to service delivery. This provides a basis for the allocation of resources across facilities consistent with their service function, but does not explicitly link the services to be provided with the expected standards of care.

However, the level at which services are provided, the extent of coordination among them, the operation of the referral system, and the resources available at each level also have significant impacts on quality.

D. Key policy opportunities

(1) Clarify stewardship and institutional responsibilities for policy-making

Effective stewardship requires close coordination of the responsibilities for quality of care between the programmes implemented by the QIS in the Directorate-General Health Economics Unit (DG HEU), and those implemented by the DGHS and DGFP.

Opportunity 1

Review and clarify the institutional roles and responsibilities for implementation of the National Strategic Plan; in particular, consider mechanisms to enable closer coordination between the QIS and TQM units. Clarify the role of the HEU in providing strategic and policy oversight to implementing units, and the coordination mechanism between the HEU and the implementing DGs.

(2) Strengthen the linkage to quality in the Essential Services Package

There is potential to leverage quality improvements from the current discussions on the implementation process for the ESP.

Opportunity 2

Ensure that plans for implementing the ESP include explicit reference to standards for quality of care, building on the management guidelines developed by the QIS. Such standards should include indicators for the measurement of quality, which can be collected and reported through the district health information software (DHIS-2); as well as specifications for the process of referral between different levels of service and different levels of facility.

(3) Provide increased management autonomy

Upazila health and family planning officers should be given the autonomy to manage resources across the upazila network of facilities

Opportunity 3

Develop and/or review public financial management (PFM) and other guidelines to provide increased management autonomy

at upazila level, and commence a phased implementation of the reforms and guidelines. Ensure that upazila health and family planning officers receive adequate support in terms of capacity-building and mentoring during the transition towards more autonomy.

(4) Increase clinician engagement and responsibility

Experience internationally has demonstrated that clinician involvement is essential for advancing quality-of-care initiatives, and that small groups of committed clinicians can make a significant difference in driving a quality-of-care programme (*13*).

Opportunity 4

Engage with the Bangladesh Medical Association and other health professional groups for the establishment of a clinician task force/support group to work with the MoHFW in terms of developing policy and indicators, and the technical capacity to support facility managers and service providers in implementing quality improvement programmes (including motivational interventions). Such a group could seek funding from development partners, and also from private sector facilities, and provide a nucleus to develop an accreditation programme.

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