MEETING ON STRENGTHENING QUALITY IN HEALTH CARE TO LEAVE NO ONE BEHIND

24–25 August 2017
Kuala Lumpur, Malaysia
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MEETING REPORT

MEETING ON STRENGTHENING QUALITY IN HEALTH CARE
TO LEAVE NO ONE BEHIND

Convened by:

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REGIONAL OFFICE FOR THE WESTERN PACIFIC

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NOTE

The views expressed in this report are those of the participants of the meeting and do not necessarily reflect the policies of the conveners.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for Member States in the Region and for those who participated in the Meeting on Strengthening Quality in Health Care to Leave No One Behind in Kuala Lumpur, Malaysia from 24 to 25 August 2017.
SUMMARY

Advancing towards universal health coverage (UHC) is about increasing equitable access to health services for all. Member States increasingly recognize the importance of improving people’s access to quality, people-centred services. However, translating plans and policies into practical actions remains a challenge in many countries.

Improving health-care quality is linked to improving access. Quality, either perceived or real, affects people’s trust in health systems and influences their inclination to access care and services. The goal of “leaving no one behind” requires health services that are delivered in a way that is responsive and inclusive, engaging all population groups, especially those most vulnerable and hard to reach.

Interventions are needed on both the supply and demand sides. On the supply side, quality can be improved by changing provider practices, institutions and systems. It requires an institutional culture that values accountability and competent health-care providers who deliver safe and responsive services respectfully. On the demand side, strengthened health literacy and engagement of patients, families and communities, especially from disadvantaged groups, are key.

Building on policy dialogues held in the two preceding years, this meeting brought together policy-makers and experts to discuss ways to strengthen quality dimensions that foster equity-focused health services. The meeting coincided with the International Forum on Quality and Safety in Healthcare (BMJ Forum), jointly organized by the British Medical Journal (BMJ) and the Institute for Healthcare Improvement (IHI), in Kuala Lumpur, Malaysia. This enabled the World Health Organization (WHO) to benefit from venues, opportunities to engage Forum delegates and access of meeting participants to the Forum.

The meeting was organized over two days and was attended by policy-makers (country participants) from Australia, Cambodia, China, the Lao People’s Democratic Republic, Malaysia, Mongolia, the Philippines, Singapore and Viet Nam, along with invited experts, including academics, health-care providers, patient advocates and representatives of international organizations. The first day involved interactive discussions on ways to strengthen health-care quality that foster equity-focused health services. The second day involved meetings between WHO and country delegates to consider country-specific actions to improve quality and enhance equity in access so as to leave no one behind.

The meeting generated key recommendations for countries and WHO for strengthening systems and services to improve the quality of and access to health services that are inclusive and people-centred.
1. INTRODUCTION

1.1 Background

To advance universal health coverage (UHC), countries increasingly recognize the importance of improving access by all groups of the population to services that are safe, of good quality and people-centred. However, translating plans and policies into practical actions remains a challenge. The goal of leaving no one behind requires health services that are delivered in a way that is responsive and inclusive, engaging all population groups, especially the most vulnerable and hard-to-reach. On the supply side, actions are needed to improve quality by changing practices by providers, institutions and systems. Important quality dimensions of health services that improve equity include an institutional culture that values accountability as well as competent health-care providers who deliver safe and responsive services respectfully. On the demand side, strengthened health literacy and engagement of patients, families and communities, especially from disadvantaged groups, are key.

Since 2015, the World Health Organization (WHO) Regional Office for the Western Pacific has collaborated with the British Medical Journal (BMJ) to organize events on the side of the International Forum on Quality and Safety in Healthcare (BMJ Forum), jointly organized by BMJ and the Institute for Healthcare Improvement (IHI). At the BMJ Forum 2015 (in Hong Kong) and the BMJ Forum 2016 (in Singapore), the WHO Regional Office for the Western Pacific convened policy dialogues on quality in health services and on strengthening people-centred, integrated health services, respectively.

Building on policy dialogues held in the two preceding years, this year’s meeting brought together policy-makers from Asia to discuss ways to strengthen quality dimensions that foster equity-focused health services. Participants discussed how to bring about a culture change among institutions and providers to enable respectful and compassionate service delivery and engaged patients, families and communities.

1.2 Meeting organization

The meeting on Strengthening Quality in Health Care to Leave No One Behind took place in Kuala Lumpur, Malaysia, from 24 to 25 August 2017 at the Kuala Lumpur Convention Centre, coinciding with the BMJ Forum 2017. The meeting was the result of collaboration between the WHO Regional Office for the Western Pacific, WHO Malaysia Country Office and the BMJ with support from the Malaysian Society for Quality in Health (MSQH). The meeting was attended by 29 policy-makers and experts from 14 countries (Australia, Canada, Cambodia, China, Hong Kong SAR (China), Japan, Lao People’s Democratic Republic, Malaysia, Mongolia, New Zealand, Philippines, Singapore, United Kingdom of Great Britain and Northern Ireland, and Viet Nam). The Secretariat for the meeting included WHO staff from both the Regional Office and the Malaysia Country Office. The list of participants is available in Annex 1 and the programme of activities is available in Annex 2.

1.3 Meeting objectives

The objectives of the meeting were:

1) to share experiences and good practices on strengthening important quality dimensions of health services that improve equity in health service delivery;

2) to explore entry points for implementing policies and practical actions to engage health-care providers and institutions as well as patients, families and communities in this goal; and

3) to agree on next steps for implementation.
2. PROCEEDINGS

2.1 Opening session: Improving quality for equity of access to health care

The meeting commenced with Ms Anjana Bhushan delivering the opening address on behalf of Dr Shin Young-soo, WHO Regional Director for the Western Pacific (Annex 3). Ms Bhushan then set the scene for the meeting by providing an overview of the work of the WHO Regional Office for the Western Pacific on the Sustainable Development Goals (SDGs) and UHC, the contexts in which health systems need to be strengthened for health-care quality improvement.

UHC is a target within SDG3. Countries’ efforts to achieve the SDGs and UHC are progressing and professional bodies’ and communities’ awareness of these efforts has increased. To facilitate the translation and implementation of these policy goals into practice, the WHO Regional Office for the Western Pacific has developed action frameworks (SDG1 and UHC2) to guide country implementation. Universal Health Coverage: Moving Towards Better Health – Action Framework for the Western Pacific Region (2016) presents a menu of actions that countries can consider implementing, depending on their individual contexts, to improve the performance of the health system along five key attributes – namely quality, efficiency, equity, accountability, sustainability and resilience – as the foundation for accelerating progress towards UHC. Although all the attributes are interrelated, this meeting focused more specifically on quality and equity, aiming to identify ways to transform institutional culture towards more inclusive health services delivery, so as to leave no one behind.

Quality encompasses safe and effective services at both individual and population levels as well as a satisfactory experience for patients and their families. Poor quality can manifest as overuse, underuse or misuse of health services and resources (e.g. provision of unnecessary injections or medical imaging, avoidance of follow-up diabetic care due to poor quality), often coexisting in the same system. Improving quality requires a people-centred and integrated service delivery system.

Health inequities continue to pose challenges to the health-care system, with certain disadvantaged groups (e.g. older people, those from ethnic minority groups, women, children, those living in rural or remote areas, the urban poor, etc.) at risk of being left behind. Reducing health inequities requires engagement with policy-makers and practitioners to foster mutual learning and share good practices to reduce barriers to access to good quality health services and improve the experience of patients from disadvantaged groups. There is no one-size-fits-all solution and the interventions need to be tailored to the specific context.

2.2 Sessions

2.2.1 Experience and practices in strengthening quality to improve equity in access to health services

This session involved group work in which small groups of participants discussed their experiences and perspectives about health care quality improvement in their countries, especially those that are equity-focused.

1 Regional action agenda on achieving the Sustainable Development Goals in the Western Pacific. Manila: World Health Organization Regional Office for the Western Pacific; 2017 (http://iris.wpro.who.int/handle/10665.1/13553).
Ms Nittita Prasopa-Plaizier introduced the session by illustrating the concept of the “golden triangle” of health care: cost, quality and access. Equitably improving people-centred service delivery requires appropriately balancing between the trade-offs involved in increasing both access by all to and the quality of services while containing their costs. When cost is well managed and access is high, equity of access is improved. Quality also affects how people seek health services, which in turn affects costs. An example of the 2014 Ebola outbreak in West Africa illustrated how perceived poor quality and safety of health services led to people not seeking and receiving timely health care, which had significant implications on the management and control of the outbreak. People may also bypass primary health care and seek services from hospitals directly, if they perceive the quality of hospital services as superior. Improving quality by delivering people-centred services can promote equity in access, especially for disadvantaged groups. Timely access and appropriate use of services improves the efficiency of the system and reduces costs. Robust health financing helps manage costs while maintaining adequate quality. Achieving UHC is therefore about finding the optimum balance of quality, access and cost to ensure that people are able to use affordable, good quality health care when they need it. Participants were asked to share their experiences in efforts to improve health-care quality so as to leave no one behind, based on the following two guiding questions:

- What are your biggest challenges in improving quality in health services?
- How are you overcoming challenges to improving quality in health services?

Key discussion points

- Perceived unsafe or poor quality health services lead to situations whereby people bypass primary health care or local health care providers in preference for hospital services, resulting in higher costs for patients and their families, underuse of local health services and overburdening of hospital services.

- Misperceptions about the quality of health services or inappropriate care-seeking from traditional healers can also delay timely access to services. Seeking health care late when disease has advanced or complications have developed can, in turn, negatively affect patients’ health outcome and increase health care costs.

- Health service quality improvement entails making services more people-centred, culturally appropriate and focused on meeting the needs of patients and their families. Involving affected communities, civil society, health professionals and academics in planning and budgeting contributes to this goal.

- Good quality primary health care can empower communities with the health-relevant knowledge, skills and resources to enable good preventive health practices that build healthier communities.

- New technologies can enable health services to improve both access to and quality of health services for disadvantaged groups as well as provide a useful means for health information sharing and health education.

- Health-care providers need to engage better with patients, families and communities and listen to their feedback. Open channels of communication can resolve misunderstandings and prevent issues from escalating. Open sharing of health-care quality information must take into account the readiness of the community to interpret the information, understand the context and indicators and engage in constructive dialogue.
2.2.2 Fostering leadership and management capacity for sustainable quality improvement

Ms Anjana Bhushan introduced the session and the moderator, Ms Debbie Sears Barnard. Two presenters then shared their experiences on this topic.

Dr Lui Siu Fai, using the Donabedian model, shared his perspective on how improvements in structure, process and outcome can enable providers to deliver inclusive and people-centred health services. The new five-year strategic plan of the Hospital Authority in Hong Kong SAR (China) includes patient-centred care as a key focus, with the strategic plan report dedicating 32 pages to this topic. Factors critical to changing the organizational culture include infrastructure, policy support, role modelling, and building new skills and capability in the workforce in line with the new ways of working.

Dr Lavanh Vongsavanthong shared the experiences of implementing people-centred health services in the Lao People’s Democratic Republic. Leadership is a key enabling factor. Simple but effective steps that can be used in low-resource settings include being more attentive to patients’ needs, showing empathy and being a good listener. Educating health-care providers in professional ethics is critical. The health insurance system in the Lao People’s Democratic Republic is being strengthened and it is expected that insurance payments to providers will better resource them to improve the quality of service delivery.

Key discussion points

- Enabling health-care providers to deliver care that is respectful and compassionate requires high levels of trust between stakeholders. Building trust is a slow process, while losing it is often rapid and sometimes unrecoverable. Health service leaders and managers need to be sensitive in building and managing these trust relationships.

- Training of health-care professionals needs to be grounded in ethics and values – these help build trust between providers and communities, a key component of building respectful health services. Seeing the patient as a person and taking the time and effort to understand their individual health journey is a key element of people-centred care.

- Delivering more people-centred services requires a combination of enabling structures for engagement and relevant, appropriate information for stakeholders to make informed choices.

- Progressing towards people-centred health services may lead to increased demand in the short to medium term, but can help reorient services towards improved prevention, thus increasing the overall efficiency of the health system.

2.2.3 Transforming governance to improve equity and quality

Ms Nittita Prasopa-Plaizier introduced the session and the moderator, Dr Kamran Abbasi. Three presenters then shared their experiences on the topic, guided by the following three questions:

- How can regulation (accreditation, certification, licensing) improve hospital governance and management?
- How can institutional policies foster inclusive, people-centred care?
- How can civil society, the community, professional groups and academia contribute to organizational accountability?
Ms Margaret Banks shared that, as part of its corporate governance, the Australian Commission on Safety and Quality in Health Care (ACSQHC) has four strategic priority areas: (1) patient safety, (2) partnering with patients, consumers and communities, (3) quality cost and value, and (4) supporting health professionals to provide safe and high-quality care.

Clinical governance is a joint responsibility between the organization and health-care providers. For people-centred care, ACSQHC goes by the adage “Nothing about us without us” – that is, health-care consumers are at the centre of ACSQHC’s work. Consumers are frequently engaged in the governance, design, evaluation and decision-making for health services planning and quality review. Strengthening population-based health literacy enables improvements in people-centred health care. It helps people, especially disadvantaged groups, to understand health issues and participate meaningfully in the dialogue. Vulnerable populations are sometimes at risk of being neglected in the planning of services and budgets. To reduce potential neglect of the needs of disadvantaged groups, ACSQHC requires organizations to perform a needs assessment to understand the diversity of their catchment population.

Dr Duong Huy Luong shared that, in 2013, Viet Nam’s Ministry of Health set regulations requiring all hospitals to establish a quality division or team. Building on this, in 2016, the Ministry issued a set of criteria to assess hospital quality towards improving services and patient satisfaction. Of the 83 criteria, 19 are related to patient care, 14 to work force development, 38 to professional quality, 8 to quality improvement and 4 to professional knowledge – scored using a five-level ranking system. From 2013 to 2015, the Ministry trialed the implementation of these criteria and results showed that hospital scores generally improved across the three years. Since their establishment, the hospitals’ quality divisions have completed numerous quality improvement projects, using process tools such as LEAN, 5S and Six Sigma. For example, hospitals conduct regular patient surveys, using a common format to reduce the data collection burden and enable comparisons across hospitals. Several improvements in the quality of infrastructure, processes and services were introduced based on feedback from patients and their families.

Dr Oyuntsetseg Purev shared that Mongolia has introduced a series of laws and regulations that have gradually improved patient safety and the quality of services, using a combination of mandatory licensing, and voluntary accreditation and certification. The 2016 Mongolia State Policy on Health includes people-centred health care as a key focus. A key challenge is the predominance of hospitals and tertiary care services – akin to an inverted triangle. Mongolia’s strategic goals are to increase the resources to expand primary health care as the foundation of the service delivery system and improve the capacity of family doctors. This will increase both the quality of and equity in access to health services. Mongolia has leveraged mobile technology, using telehealth services to reach populations in geographically remote areas. Dr Purev provided examples of community engagement and advocacy on health issues of public concern, such as air pollution.

Using Juran’s Quality Trilogy, Dr Helen Bevan shared that increasing health service quality requires a delicate balance between quality planning, quality control and quality improvement. High-income countries often overemphasize quality control, losing the spirit of quality improvement, due to increased data collection and reporting requirements.
Key discussion points

- Regulations can help initiate a process of continuous quality improvement for health services, but need effective implementation through appropriate policies and resources. Regulatory staff need the knowledge, skills and tools for good implementation.

- Progress towards people-centred health services requires the appropriate institutional policies and commitment and support from organizational leaders, as well as strengthened staff capacity. Feedback from patients and their families can help ensure that the practice accurately reflects the policy.

- Using the feedback and experiences of stakeholder improves accountability and efficiency, raises awareness of issues, and improves the knowledge and skills of health-care providers. Feedback and participation mechanisms should be embedded in the process of service delivery and organizational governance.

2.2.4 Reorienting care delivery to improve access and leave no one behind

This session was organized in a “marketplace” format, with four moderators facilitating discussions on given questions. Participants took turns to visit each “market” in groups. The moderators were Drs Helen Bevan, Andrew Jamieson, Kadar Marikar and Lui Siu Fai.

Key discussion points

1) How can health-care providers and managers engage patients, families and communities, especially disadvantaged groups, to understand their needs and expectations?

Engaging communities starts with understanding their needs and situation. Avenues for engagement are context- and country-specific, but can include, for example:

- connecting at points of care, such as for illness, childbirth, primary health care or population health services (e.g. immunization);
- connecting through religious and community leaders and their gatherings;
- connecting through mobile health networks, home health services and community health workers; and
- connecting through interviews, questionnaires, focus group discussions and observation.

Sustainable and effective engagement, especially of disadvantaged groups, requires both an enabling environment and the intrinsic motivation of health leaders and service providers. Building a positive mindset in the community, making structural improvements and creating change agents can empower communities to overcome their disadvantage. Creating supportive structures and networks – for example, setting up a community health centre, building networks of “healthy communities” and “healthy cities” – can help sustain these changes.

2) How can hospitals be a key driver for strengthening primary health care and improving service coordination?

To drive the changes indicated in the discussion question, hospitals must first have the capacity and willingness to invest in the change process. Hospitals can collaborate with identified primary care providers through direct partnerships or networks, whose structures may vary from a loose network of independent providers to providers as part of shared governance. The networks need strong two-way
referral processes and common medical records, for better information transfer, care coordination and patient handovers. Hospitals, being the largest institutions within the networks, offer the economies of scale needed for common training and continual professional education, health workforce planning, provision of specialized services (e.g. radiological investigations, extended medication formularies, etc.) and can facilitate the use of new technologies (e.g. telehealth initiatives or common electronic medical records).

Good monitoring and measurement are needed of the quality of network relations, communication, coordination and partnership, patient outcomes, and patients’ and carers’ experiences. As services become more integrated, innovative financing mechanisms, such as activity-based funding that spans providers, can support these new ways of service provision.

3) What skills (core competencies) must health-care professionals have to deliver people-centred services?

To deliver people-centred health services, health-care professionals must combine the needed clinical with social competencies. The relevant social competencies include empathy, sincerity and genuine care for patients, families and communities. They also need skills in communication, listening, problem-solving and conflict resolution as well as knowledge of quality improvement and patient safety practices, the ability to work in team-based approaches and the willingness to learn new things. Both pre-service as well as in-service education must reinforce these competencies.

The skills of individual providers need to be complemented by supportive institutional policies and organization levels that can foster collective cultural competencies, and the resilience to adapt to the changing health-care environment and new technologies.

4) How can providers and managers know that they have made a difference in improving access to services?

It is essential to have a baseline with agreed indicators, definitions and criteria on access and the mechanism to measure outcomes. Patient waiting times (e.g. the number of hours waiting at the hospital emergency department or number of months to see a specialist) are a commonly used measure. While useful, however, these purely quantitative measures are limited and should be supplemented with qualitative information, including surveys of patient experiences and patient-reported outcome measures. Qualitative information, such as that obtained through feedback from patients, carers, families and communities on quality of and access to services, can provide deeper insights into what and how to improve. In resource-limited contexts, health-care planners and providers can hold candid discussions with stakeholders on the appropriate targets for improved access and quality.

2.3 Country-specific sessions

As countries are at different stages of the UHC journey and have different priorities, depending on population health needs, resources or partnerships, there is no one-size-fits-all solution. Day 2 of the meeting was dedicated to country-specific discussion sessions between WHO and participants from Australia, Cambodia, China, the Lao People’s Democratic Republic, Malaysia, Mongolia, the Philippines, Singapore and Viet Nam. Dr Clive Tan, who also served as a temporary adviser, also participated in these discussions.
Key messages

Countries have included quality and patient safety in one or more of their national plans. *Universal Health Coverage: Moving Towards Better Health – Action Framework for the Western Pacific Region* (2016) is helpful in facilitating countries’ strategies and plans for safety and quality. Countries have implemented several initiatives, though they are at varying stages of progress. These include:

- improving the management of health-care facilities within health system reform;
- enacting laws and regulations to guide the use of licensing and accreditation;
- establishing standards for monitoring and measuring health-care quality;
- reorienting services to become more people-centred; and
- planning for or conducting patient experience surveys;

Key areas of support requested from WHO include:

- Provide guidance, translated into local languages. Policy guidance from WHO can serve as a beacon guiding the country through its political cycles.
- Facilitate a country-level technical meeting on improving health service quality and provide technical assistance to translate high-level policies into programmes and interventions.
- Facilitate the sharing of experiences, good practices and lessons to develop country capacity.
- Source international experts to conduct field studies and offer relevant solutions to address challenges in improving quality and patient safety.
- Raise the awareness of health sector leaders on the importance of safety and quality improvement and good practices from other countries, including through relevant leadership and management training.
- Increase high-level support and commitment by sharing concepts and current knowledge with policy-makers and health care sector leaders.
- Develop attribute- or country-specific health system policy briefs that suggest strategies and offer tools relating to quality, safety and improving equity in integrated health service delivery, and translate these into local languages.

The WHO Regional Office for the Western Pacific and WHO country offices will provide support to Member States on the identified issues and challenges to strengthen quality in health services so as to leave no one behind. Member States acknowledged that the Regional UHC Action Framework was useful for advancing the agenda and provided good guidance to health sector leaders on actions to advance towards UHC.
3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

The meeting provided a forum for Member States and experts on patient safety, health care quality, health care management and accreditation, integrated care, and institutional transformation to share experiences, discuss issues and identify solutions. Member States and experts actively engaged as topic presenters, session facilitators, group work moderators and rapporteurs.

Key conclusions included the following:

- Participants acknowledged that discussions on improving access to health services generally focus on financial barriers. This meeting raised their awareness of the relationships between access (people), quality (services) and costs (affordability) and how improving quality can improve service access.

- *Universal Health Coverage: Moving Towards Better Health – Action Framework for the Western Pacific Region* suggests ways to strengthen health system performance across five key interlinked attributes: quality, efficiency, equity, accountability, and sustainability and resilience. Member States have implemented several efforts to improve patient safety and quality and advance UHC. The discussions helped clarify how these initiatives can improve health system performance across these attributes.

- The experiences shared suggested that health-care quality can improve at little or no cost and this in turn can improve access to services. Reducing physical barriers, such as by building ramps for wheelchair access to hospitals, as well as providing respectful and culturally appropriate services can improve acceptability and uptake, especially by disadvantaged groups.

- Member States are at different stages of efforts to improve quality and safety, with varying needs for technical support from WHO. Common areas for technical support include:
  - engaging health-care leadership and management;
  - supporting health-care leaders and managers to develop or implement laws, regulations and policies that support equity and quality of health care;
  - strengthening the capacity of health-care leaders and providers to become more competent, compassionate and accountable;
  - providing tools and guidance for health-care professionals to better engage patients, families and communities; and
  - supporting the creation of country focal points for quality and safety to strengthen care continuity and coordination, as well as its quality and equity.

Participants supported the idea of creating national networks of participants of relevant WHO training sessions and meetings to facilitate information sharing and coordination, leveraging resources and maximizing impact.
3.2 Recommendations

3.2.1 Recommendations for Member States

Member States are encouraged to:

1) Facilitate the coordination of initiatives and programmes relevant to quality improvement and patient safety within overall efforts to strengthen health systems and advance UHC.

2) Facilitate collaboration between policy-makers, health-care providers, civil society and patient groups in policies and actions to foster inclusive, culturally appropriate, quality and people-centred health services.

3) Document and monitor initiatives and programmes to improve equitable access to quality health services including through participation by patients, communities and civil society groups.

3.2.2 Recommendations for WHO

WHO is requested to:

1) Support Member States in strengthening health-care leaders and managers’ capacity in quality and safety improvement and equitable care provision by creating opportunities for and facilitating training.

2) Support the coordination of efforts by facilitating the creation of “focal points” at the country level and strengthening their capacity.

3) Develop and disseminate tools and policy briefs on practical ways to implement equitable, people-centred integrated service delivery models that appropriately balance the trade-offs between cost, quality and equitable access.

4) Provide technical support on reorienting and implementing people-centred health care services and approaches for patient, family and community engagement, especially on measures and indicators of patient experiences.

5) Facilitate country-level policy dialogues, technical meetings and or training workshops on strengthening quality and equity in health systems.
ANNEXES

Annex 1. List of participants, temporary advisers, observers, Secretariat and resource persons

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Dr Samsiah AWANG, Head of Quality Assurance, Institute for Health Systems Research, National Institute of Health, Ministry of Health, Selangor, Malaysia. Telephone: +603 3 346 6400 ext 472, Email: samsiah.a@moh.gov.my.

Dr Kenichiro TANEDA, Chief Senior Researcher, WHO Collaborating Centre for Integrated People-Centred Service Delivery, National Institute of Public Health, 351-0104 Saitama Prefecture, Wako, Minami, 2 Chome-3-6, Japan. Email: kentaneda@gmail.com.

4. SECRETARIAT

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## Programme of activities

### Day 0: 23 August 2017

**17:00 – 18:00: Secretariat meeting and meeting with session chairs and rapporteurs** (Coffee shop, Impiana Hotel)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Moderator</th>
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<tr>
<td>Day 0:</td>
<td>23 August 2017</td>
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<tr>
<td>17:00</td>
<td>Secretariat meeting and meeting with session chairs and rapporteurs</td>
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<td>17:00</td>
<td>– 18:00: Secretariat meeting and meeting with session chairs and rapporteurs (Coffee shop, Impiana Hotel)</td>
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### Day 1: 24 August 2017, Room 310 KLCC

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<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>08:00 –</td>
<td>Registration</td>
<td>Ms Anjana Bhushan</td>
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<tr>
<td>08:30 –</td>
<td>Opening session</td>
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<tr>
<td>09:00 –</td>
<td>Welcome remarks, administrative announcements, meeting objectives, and introductions</td>
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<tr>
<td>09:00 –</td>
<td>Session 1. Scene setting: experience and practices in strengthening quality to improve equity in access to health services</td>
<td>Ms Anjana Bhushan</td>
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<tr>
<td>10:30</td>
<td>Regional Action Framework on Universal Health Coverage: Moving Towards Better Health (10 mins.)</td>
<td>Ms Nittita Prasopa-Plaizier</td>
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<td>10:30</td>
<td>Video on people-centred health services (5 mins.)</td>
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<td>10:30</td>
<td>Introduction to group work: quality, costs and equity in access (5 mins.)</td>
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<td>10:30</td>
<td>Group work (30 mins., see Annex)</td>
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<td>10:30</td>
<td>Key questions:</td>
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<tr>
<td>10:30</td>
<td>o How can improving quality help improve equity in access to health services (countries' experiences)?</td>
<td>Ms Nittita Prasopa-Plaizier</td>
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<tr>
<td>10:30</td>
<td>o What are countries' experiences in engaging stakeholders (civil society, health professionals, academics, communities, etc.) to improve equity in access to health services?</td>
<td>Ms Nittita Prasopa-Plaizier</td>
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<tr>
<td>10:30</td>
<td>Group reporting (20 mins., 5 mins. per group)</td>
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<td>10:30</td>
<td>Discussions (20 mins.)</td>
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<td>11:00</td>
<td>Group photo and break</td>
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<td>11:00</td>
<td>Session 2. Fostering leadership and management capacity for sustainable quality improvement</td>
<td>Ms Debbie Sears Barnard</td>
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<tr>
<td>11:00</td>
<td>Presentations (5-7 mins. each)</td>
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<td>11:00</td>
<td>o Prof Lui Siu Fai, Chinese University of Hong Kong</td>
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<td>11:00</td>
<td>o Dr Lavanh Vongsavanthong, Lao People's Democratic Republic</td>
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<td>12:00 – 13:00</td>
<td><strong>Lunch</strong></td>
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<td>13:00 – 14:30</td>
<td><strong>Session 3: Transforming governance to improve equity and quality</strong></td>
<td><strong>Dr Kamran Abbasi</strong></td>
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<td>Key questions</td>
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<td></td>
<td>o How can regulation (accreditation, certification, licensing) improve hospital governance and management?</td>
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<td>o How can institutional policies foster inclusive, people-centred care?</td>
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<td>o How can civil society, the community, professional groups and academia contribute to organizational accountability?</td>
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<td>Presentations (10 mins. each):</td>
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<td>o Ms Margaret Banks, Australia</td>
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<td>o Dr Duong Huy Luong, Viet Nam</td>
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<td>o Dr Oyuntsetseg Purev, Mongolia</td>
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<td>Commentators:</td>
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<td></td>
<td>o Dr Helen Bevan, NHS Horizons, England</td>
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<td>o Dr Kadar Marikar, Malaysian Society for Quality in Health</td>
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<td></td>
<td>Discussions</td>
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<td>14:30 – 16:00</td>
<td><strong>Session 4: Reorienting care delivery to improve access and leave no one behind</strong></td>
<td><strong>Ms Nittita Prasopa-Plaizier</strong></td>
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<td>Topical overview (10 mins.)</td>
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<td>Market place: Discussions on four topics, with facilitators and rapporteurs (20 mins.)</td>
<td><strong>Dr Helen Bevan</strong></td>
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<td>Key questions</td>
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<td></td>
<td>o How can health care providers and managers engage patients, families and communities, especially disadvantaged groups, to understand their needs and expectations?</td>
<td><strong>Dr Andrew Jamieson</strong></td>
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<td></td>
<td>o How can hospitals be a key driver for strengthening primary health care and improving service coordination?</td>
<td><strong>Dr Kadar Marikar</strong></td>
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<td>o What skills (core competencies) must health care professionals have to deliver people-centred services?</td>
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<td>o How can providers and managers know that they have</td>
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<td>made a difference in improving access to services?</td>
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<td>• Reporting back to plenary (20 mins., 5 mins. each)</td>
<td>Dr Lui Siu Fai</td>
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<td></td>
<td>• Summary of key experiences and messages (10 mins.)</td>
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<td>16:00 – 16:30</td>
<td><strong>Afternoon break</strong></td>
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<td>16:30 – 17:30</td>
<td>Session 5: Summary and conclusions</td>
<td>Ms Anjana Bhushan</td>
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<td>Take home action – What will you do when you get home?</td>
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<td>19:00</td>
<td><strong>Dinner (Tonka Bean, Impiana KLCC Hotel Lobby)</strong></td>
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<tr>
<td>08:00 – 10:00</td>
<td>Participants attend the Forum’s opening</td>
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<td>10:00 – 10:30</td>
<td>Break</td>
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</table>
| 10:30 – 12:30| Action planning: Participants from Cambodia, Lao People’s Democratic Republic, Mongolia, Viet Nam  
  Dr Loun Mondol (KHM)  
  Dr Sim Sansam (KHM)  
  Dr Lavanh Vongsavanathong (LAO)  
  Dr Phisith Phoutsavath (LAO)  
  Dr Baigali Tumurbataar (MNG)  
  Dr Oyuntsetseg Purev (MNG)  
  Dr Tham Chi Dung (VTN)  
  Dr Duong Huy Luong (VTN)  
  Key questions:  
  o What key messages have you learned from the meeting?  
  o What more will you do when you go home?  
  o How can WHO support you? | Ms Anjana Bhushan,  
Ms Nittita Prasop-Plaizier,  
Dr Clive Tan |

*Transfer to Impiana KLCC Hotel: Afternoon session is at Jasmin Room (Level 1)*

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<th>Time</th>
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<tr>
<td>12:30 – 13:30</td>
<td>Lunch (Tonka Bean, Impiana KLCC Hotel Lobby)</td>
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| 13:30 – 15:00| Action planning: Participants from China, Malaysia, Philippines  
  Dr Wang Fei (CHN)  
  Mr Ye Liang (CHN)  
  Dr Noridah Mohd Saleh (MYS)  
  Dr Paa Mohamed Nazir Bin Abdul Rahman (MYS)  
  Ms Ligaya Catadman (PHL)  
  Dr Rio Magpantay (PHL)  
  Key questions:  
  o What key messages have you learned from the meeting?  
  o What more will you do when you go home?  
  o How can WHO support you? | Ms Anjana Bhushan,  
Ms Nittita Prasop-Plaizier,  
Dr Clive Tan |
| 15:00 – 16:30| Action planning: Participants from Australia, Macao SAR (China), Singapore  
  Ms Margaret Banks (AUS)  
  Dr Felicia Hong (SGP)  
  Key questions:  
  o What key messages have you learned from the meeting?  
  o What more will you do when you go home?  
  o How can WHO support you? | Ms Anjana Bhushan,  
Ms Nittita Prasop-Plaizier,  
Dr Clive Tan |
<p>| 16:30 – 17:30| Secretariat meeting and debriefing                                        |                                                                          |</p>
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<th>Group 1</th>
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<tr>
<td>Ms Margaret Banks (AUS)*</td>
<td>Mr Ye Liang (CHN)</td>
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<td>Dr Wang Fei (CHN)</td>
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<td>Dr Shinsuke Murai**</td>
<td>Dr Tham Chi Dung (VTN)</td>
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<td>Dr Kadar Marikar</td>
<td>Dr Andrew Jamieson*</td>
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<td>Dr Soo Chun Paul</td>
<td>Dr Kenichiro Taneda**</td>
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<td>Mr Ye Liang (CHN)</td>
<td>Dr Samshah Awang</td>
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<td>Dr Sim Sansam (KHM)</td>
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<td>Dr Oyuntsetseg Purev (MNG)</td>
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<td>Dr Andrew Jamieson*</td>
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<td>Dr Kenichiro Taneda**</td>
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<td>Dr Samshah Awang</td>
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<td>Ms Anjana Bhushan</td>
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<th>Group 3</th>
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<tr>
<td>Dr Phisith Phoutsavath (LAO)</td>
<td>Dr Lavanh Vongsavanthonh (LAO)</td>
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<td>Dr Noridah Mohd Saleh (MYS)</td>
<td>Dr Baigali Tumurbaatar (MNG)</td>
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<td>Dr Duong Huy Luong (VTN)</td>
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<td>Ms Debbie Sears Barnard*</td>
<td>Mr Manvir Jesudasan</td>
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<td>Dr Shinichiro Noda</td>
<td>Dr Kamran Abbasi**</td>
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<td>Dr Azhar Ali</td>
<td>Ms Nittita Prasopa-Plaizier</td>
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<td>Dr Lui Siu Fai**</td>
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<td>Dr Clive Tan</td>
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* Moderator
** Rapporteur
Annex 3. Opening remarks on behalf of Dr Shin Young-soo, WHO Regional Director for the Western Pacific at the Meeting on Strengthening Quality in Health Services to Leave No One Behind

Good morning.

1. I am very pleased to welcome you all to the Meeting on Strengthening Quality in Health Care to Leave No One Behind.

2. Dr Shin Young-soo, WHO Regional Director for the Western Pacific, regrets not being able to join us due to previous commitments. He has asked me to send his regards and deliver these words.

3. As the title of this meeting suggests, it has a dual but linked focus—quality, as well as the idea of leaving no one behind, or equity.

4. Both quality and equity are key attributes of a well-performing health system. In turn, a well-performing health system is critical to accelerating progress towards universal health coverage, or UHC – which is a key target of the Sustainable Development Goals. Indeed, the SDGs emphasize a more integrated approach to well-being and thus offer a major opportunity to accelerate progress in health. Leaving no one behind is a core principle of the SDGs.

5. UHC is defined as all people having access to quality health services without suffering the financial hardship associated with paying for care. This definition gives emphasis to access and quality. To achieve UHC, countries need to improve access by all groups to services that are of high quality, safe and people-centred. Despite improvements, and with the shifting burden of disease, people from all groups have growing expectations about health services related to quality, safety and the patient experience. How to translate this policy goal into practical actions remains a key challenge for many countries.

6. Factors like discrimination and unconscious bias by facilities and providers lead to poor access, poor quality and poor satisfaction. Leaving no one behind requires health services that are responsive and inclusive. It also requires engaging all population groups, especially the most vulnerable and hard-to-reach—including, for example, people with disability, migrants, ethnic minorities, older people, and so on.

7. Interventions are needed on both the supply and demand sides. On the supply side, practices need to change towards an institutional culture that values accountability, as well as competent healthcare providers who deliver safe services responsively and respectfully. On the demand side, strengthened health literacy and engagement of patients, families and communities, especially from disadvantaged groups, are key.

8. WHO’s regional action framework Universal Health Coverage: Moving Towards Better Health suggests ways to maximize five inter-related attributes of a high-performing health system, namely: quality, efficiency, equity, accountability, and sustainability and resilience. The framework suggests policy options and practical actions to maximize these attributes. More broadly, WHO’s Regional Action Agenda on Achieving the Sustainable Development Goals in the Western Pacific aims to guide Member States on achieving the SDGs by 2030 through whole-of-systems, whole-of-government and whole of society approaches.
9. In line with these frameworks, WHO has been supporting Member States on UHC through policy dialogue, capacity-building and technical support. WHO has set up a UHC Technical Advisory Group meeting, which, at its first meeting held in December 2016, discussed how to strengthen equitable service delivery and governance.

10. This Meeting on Strengthening Quality in Health Care to Leave No One Behind marks the third in a series that we have been organizing, to coincide with the annual BMJ International Forum on Quality and Safety in Healthcare in Asia and the Pacific. In 2015, WHO organized a policy roundtable on quality in health services, in Hong Kong; and in 2016, we organized one on strengthening people-centred, integrated health services, in Singapore. These roundtables brought together policy makers to share experiences, build networks with experts, and identify entry points for policies and action.

11. I hope this meeting will build strongly on the previous roundtables, helping strengthen quality dimensions that foster equity-focused health services.

12. Your conclusions and recommendations will inform WHO’s efforts to support Member States in strengthening health-care quality and patient safety.

13. I wish you fruitful discussions.

14. Thank you.
APPENDICES

Appendix 1. Summary of discussions with country participants

On the second day of the meeting, WHO met with country participants to review the proceedings, discuss relevant good practices, and discuss the Member States’ current plans for improving quality and equity in health services and their associated implementation challenges. The following summaries are informed by these country-wise discussions.

Cambodia

Cambodia has developed a Quality Policy and Action Plan (2016–2021), which is pending endorsement by the Ministry of Health. In addition, the Cambodia Health Equity Plan (2016–2021) aims to improve overall health equity and reduce financial barriers to access to health services. Cambodia receives financial and technical assistance from partners including KOICA, GIZ and the World Bank to improve health care quality, patient safety and health equity. There is increased emphasis on strengthening the management of health care facilities to improve the quality of services and the level of patient satisfaction. Since health workforce competency is recognized as a key enabler, the Ministry has increased training opportunities for health workers. Participants suggested that WHO could facilitate a country-level technical meeting on improving quality in health care, and provide technical assistance to implement the existing policies through programmes and interventions.

China

Ensuring that health care providers provide quality and safe services is an important part of China’s health care reform. China’s 13th Five-Year Plan for Health Sector Development (2016–2020) emphasizes public hospital reform as a key priority, and aims to improve accountability, quality and regulation. As government spending on health has steadily increased, recognition of the need to improve health service quality has also increased. Current initiatives include: (1) strengthening policy design and regulation by developing mechanisms for quality monitoring and control; (2) establishing health care quality standards—for example, 1020 clinical pathways have been published; (3) using evidence-based quality management tools (such as total quality management) to strengthen processes within the system; (4) building a national diagnosis-related group system to enable better reporting and financing; and (5) planning to implement patient satisfaction survey in over 10,000 hospitals.

WHO can share relevant guidelines, success stories and important health system development lessons, and bring international experts to China to conduct field studies and suggest solutions to challenges in quality and patient safety.

Lao People’s Democratic Republic

The Lao People’s Democratic Republic’s Policy on Quality, approved in 2016, includes 5 ‘Well’ areas, and 1 ‘Satisfaction’ area. To ensure equity, families as well as agencies such as the Poor Help Foundation, the Ministry of Labour and Social Welfare, and the Lao Red Cross provide social support to disadvantaged families in times of need. Lao People’s Democratic Republic is also expanding the health insurance system to improve financial protection. Key challenges include resource constraints and limited health workforce capacity in health care quality improvement. Participants acknowledged the usefulness of WHO-supported training courses for health leaders. The Policy Roundtable on People-Centred Integrated Health Services (Singapore, 2016) introduced participants from the Lao People’s Democratic Republic to the concept of people-centred health services. Upgrading of health
service facilities and providing training opportunities for health workers are important future priorities for improving the overall quality of health services.

**Malaysia**

Strengthening primary health care is the key strategic focus for Malaysia in improving equitable access to quality health services. The idea of having a designated family doctor and a multi-disciplinary team assigned to cover a specific population and geographical area is being piloted, for more inclusive and integrated service delivery to tackle chronic noncommunicable diseases (through early screening, clinic-based and community-based interventions and community empowerment programmes) on a tailored basis, so as to leave no one behind. Early reports point to improved satisfaction for patients and providers, with 50% of patients having managed to see the same doctor again in follow-up. Trust, communication, values, community engagement: are important qualities to include in clinical practice. Health professionals have a relatively good understanding of quality and patient safety strategies, but weaker understanding of the concept of people-centred health services. WHO can conduct policy advocacy on this concept with policy-makers and health care leaders. Future priorities in moving towards more people-centred health service delivery include better measurement of the clinical experience by patients and their families.

**Mongolia**

Through a series of laws and regulations, Mongolia is using a combination of licensing (mandatory) and accreditation and certification (voluntary) to improve health service quality and patient safety. The country’s strategic long-term plans to improve quality and patient safety, especially for disadvantaged groups include expanding primary health care, leveraging mobile technology and telehealth services and improving the capacity of family doctors. Many initiatives have been introduced to improve quality and patient safety in recent years, which now need to be aligned and integrated. Recent political volatility and the 2-year strategic planning cycle have posed challenges in sustaining changes. Policy dialogue on UHC and people-centred health services, based on translation of WHO’s guidance into Mongolian, is an area for future WHO support.

**Philippines**

As a result of devolution, the local government units (LGU) are responsible for planning and delivering health services through hospitals, rural health units and barangay health stations in the Philippines. In recent years, the Department of Health has worked to strengthen the service delivery network, better equip health centres and hospitals, and build referral systems between hospitals and primary care providers. Leadership and management training for health leaders (e.g., newly appointed chiefs and senior managers, especially in smaller hospitals) is an area of possible support by WHO that can help improve the quality of health services as well as coordination between hospital and primary care. To make services more people-centred, country participants agreed to consider replacing patient satisfaction surveys with patient reported experience measures, as learned at this meeting.

**Viet Nam**

In recent years, policy-makers and senior health leaders in Viet Nam have recognized the importance of strengthening the quality of health services, resulting in some steps forward. WHO’s framework *Universal Health Coverage—Moving Towards Better Health: Action Framework for the Western*
Pacific Region (2016) can be useful in advancing Viet Nam’s progress towards UHC. The challenge is to translate its suggestions into policy and practice. The private sector provides a significant proportion of health services. Regulatory tools need to be developed to improve the quality of these services. The Ministry of Health is exploring financing mechanisms that link quality and payment, providing incentives to encourage the appropriate changes in provider behaviour. WHO can provide support through policy briefs and related information products relating to quality, equity, and health care financing for UHC, preferably in Vietnamese.
Appendix 2. Presentations

Universal Health Coverage: Moving Towards Better Health

SDGs, UHC and health system

Action framework

UHC: moving towards better health

Adopted at 69th CPM, October 2015
## Common UHC challenges

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<th>Attributes</th>
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<td>Regulation – standards</td>
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<td>Engagement – patient and community</td>
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<td><strong>Efficiency</strong></td>
<td>System architecture – primary health care, public health</td>
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<td>Resource allocation – payment incentives</td>
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<td>Management – systems and capacities</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td>Financial burden – impoverishment</td>
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<td>Access – financial, geographical, disability</td>
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<td>Exclusion – discrimination</td>
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<td><strong>Accountability</strong></td>
<td>Leadership and coordination – within and outside health sector implementation</td>
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<td></td>
<td>– role of law, participation information – access, reliability, currency</td>
</tr>
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<td><strong>Sustainability and resilience</strong></td>
<td>Public health capacity – preparedness</td>
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<td>Community capacity</td>
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<td></td>
<td>Resource deployment flexibility – readiness and fragmentation</td>
</tr>
</tbody>
</table>

## Quality

- Key attribute of a high-performing health system, which is the foundation for progress towards UHC.
- Encompasses safety and effectiveness of both individual and population-level interventions.
- Also implies a satisfactory experience for users.
- Poor quality includes overuse, underuse or misuse of health services and resources, often co-existing in the same system.
- Improving service quality requires a people-centred and integrated health service delivery system.

## Leaving no-one behind

- Even where gains are made at the population level, inequities pose challenges to health and development.
- The SDGs call for equity-focused policies and actions within and beyond the health sector.
# Health system attributes and action domains for UHC

<table>
<thead>
<tr>
<th>Health System attributes</th>
<th>Action domains for achieving UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>QUALITY</strong></td>
<td>1.1 Regulations and regulatory environment</td>
</tr>
<tr>
<td></td>
<td>1.2 Effective, responsive individual and population-based services</td>
</tr>
<tr>
<td></td>
<td>1.3 Individual, family and community engagement</td>
</tr>
<tr>
<td><strong>EFFICIENCY</strong></td>
<td>2.1 System design to meet population needs</td>
</tr>
<tr>
<td></td>
<td>2.2 Incentive for appropriate provision and use of services</td>
</tr>
<tr>
<td></td>
<td>2.3 Management, efficiency and effectiveness</td>
</tr>
<tr>
<td><strong>EQUITY</strong></td>
<td>3.1 Financial protection</td>
</tr>
<tr>
<td></td>
<td>3.2 Service coverage and access</td>
</tr>
<tr>
<td></td>
<td>3.3 Non-discrimination</td>
</tr>
<tr>
<td><strong>ACCOUNTABILITY</strong></td>
<td>4.1 Government leadership and rule of law for health</td>
</tr>
<tr>
<td></td>
<td>4.2 Partnerships for public good</td>
</tr>
<tr>
<td></td>
<td>4.3 Transparency, monitoring and evaluation (M&amp;E)</td>
</tr>
<tr>
<td><strong>SUSTAINABILITY AND RESILIENCE</strong></td>
<td>5.1 Public health preparedness</td>
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<tr>
<td></td>
<td>5.2 Community capacity</td>
</tr>
<tr>
<td></td>
<td>5.3 Health system adaptability and sustainability</td>
</tr>
</tbody>
</table>

## 1. Quality

**Action domains:**

### 1.1 Regulations and regulatory environment

- a. Enforce workforce regulation
- b. Strengthen national regulatory authorities for medicines and technologies
- c. Adopt service standards for health facilities and infrastructure
- d. Legislate to protect patient rights

### 1.2 Effective, responsive individual and population-based services

- a. Build and maintain a competent workforce of multi-disciplinary teams
- b. Implement evidence-informed protocols and interventions at individual and population level
- c. Use individual and population-level health information for health improvement

### 1.3 Individual, family and community engagement

- a. Improve health literacy and capacity for health decision-making
- b. Adopt a systematic approach to monitor patient experience for service improvement
- c. Empower patients and families through self-efficacy and peer-support groups
2. Efficiency

Action domains:

2.1 System design to meet population needs
a. Define core service packages and delineate roles of health institutions at different levels of health system
b. Make more resources available for public health, primary-level services and disadvantaged groups
c. Guide service delivery providers for public health

2.2 Incentives for appropriate provision and use of services
a. Use provider payment mechanisms and other incentives to set appropriate incentives
b. Leverage price and benefit package design to encourage provision of desired services by providers and curb unnecessary use of services
c. Improve management and rational use of medicines and health technologies

2.3 Managerial effectiveness and efficiency
a. Encourage all providers to be efficient through managed autonomy
b. Improve overall management capacity and skills to meet requirements in the changing environment
c. Strengthen information systems and effective use of information and communications technologies (ICT)

3. Equity

Action domains:

3.1 Financial protection
a. Reduce financial and non-financial barriers to access
b. Strengthen appropriate connections between health financing and other social protection schemes

3.2 Service coverage and access
a. Foster equitable access to services
b. Catalyse appropriate demand for services

3.3 Non-discrimination
a. Foster respectful care
b. Provide legal protection
c. Create opportunities for vulnerable groups to have a voice

4. Accountability

Action domains:

4.1 Government leadership and rule of law for health
a. Set the vision for health sector development and ensure sufficient resources for health
b. Strengthen the rule of law and regulatory institutions
c. Build leadership and management capacities

4.2 Partnerships for public policy
a. Secure intersectoral collaboration across government
b. Work with non-state partners on shared interests for health
c. Empower communities to participate in decisions and actions that affect them

4.3 Transparency, monitoring and evaluation
a. Develop efficient health information systems and streamline information flows
b. Foster open access to information
C. Strengthen institutional capacity for health policy and systems research and translation of evidence into policy
### 5. Sustainability and Resilience

**Action domains:**

**5.1 Public health preparedness**
- a. Detect and respond to a disease or condition with the potential to become a public health concern or emergency
- b. Develop cross-sectoral partnerships and plans for disaster risk management
- c. Design and test business continuity plans

**5.2 Community capacity**
- a. Enhance community capacity for disease management and health promotion
- b. Promote community participation and readiness for disaster risk management

**5.3 Health system adaptability and sustainability**
- a. Develop foresight capabilities
- b. Leverage resources for health through cross-programme and inter-institutional linkages
- c. Institutionalize participatory governance

---

### Improving quality

- Strengthening legislation and regulation, and its enforcement
- Continuing professional education
- Evidence-informed protocols, processes to review how well services are delivered
- Service models designed around needs of patients and communities
- At institutional level: culture of continuous quality improvement using sound information about individual and population health
- Engaging, empowering individuals, families and communities to ensure appropriate service use and improved satisfaction
- Promoting health literacy
THANK YOU
Session 1. Experience and practices in strengthening quality to improve equity in access to health services

Group work (30 min)

Key questions:

- How can improving quality help improve equity in access to health services (countries’ experiences)?

- What are countries’ experiences in engaging stakeholders (civil society, health professionals, academics, communities, etc.) to improve equity in access to health services?

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Group 2</th>
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</thead>
<tbody>
<tr>
<td>Ms Margaret Banks (AUS)**</td>
<td>Ms Ye Liang (CHN)</td>
</tr>
<tr>
<td>Dr Wang Fai (CHN)</td>
<td>Dr Sim Sanam (KH)</td>
</tr>
<tr>
<td>Dr Louis Monod (KH)</td>
<td>Dr Oyunatsag Purev (MNG)</td>
</tr>
<tr>
<td>Dr Pas Mohamed Nazir Bin Abdul Rahman (MYS)</td>
<td>Dr Felicia Hong (SGP)</td>
</tr>
<tr>
<td>Dr Shinbil Murali*</td>
<td>Dr Tham Chi Dung (VTN)</td>
</tr>
<tr>
<td>Dr Kedar Markar</td>
<td>Dr Andrew Jelinek***</td>
</tr>
<tr>
<td>Dr Soo Chan Paul</td>
<td>Dr Kenichi Tanoda*</td>
</tr>
<tr>
<td></td>
<td>Dr Samsiah Awang</td>
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<td>Ms Anjana Bhushan</td>
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<tr>
<th>Group 3</th>
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<tbody>
<tr>
<td>Dr Phoeth Phousavath (LAO)</td>
<td>Dr Lavanh Vongsavath (LAO)</td>
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<tr>
<td>Dr Noridah Mohd Suleh (MYS)</td>
<td>Dr Bagail Turubat (MNG)</td>
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<tr>
<td>Dr Hoc Mogensen (PHL)</td>
<td>Ms Lignos Catzufski (PHL)</td>
</tr>
<tr>
<td>Dr Duong Hoy Loong (VTN)</td>
<td>Dr Helen Bevan***</td>
</tr>
<tr>
<td>Ms Dible Barea Bernard**</td>
<td>Dr Karmen Abasai***</td>
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<tr>
<td>Dr Lee Hu Pei**</td>
<td>Mr Nanra Jesudan</td>
</tr>
<tr>
<td>Dr Azhar Ali</td>
<td>Ms Nittita Prasopa-Plaizier</td>
</tr>
<tr>
<td>Dr Shervino Noda</td>
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<tr>
<td>Dr Gwee Tan</td>
<td></td>
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</tbody>
</table>
Quality, Costs and Equity in Access to Health Care and Services

Three ways to enhance quality

1. Quality planning (QP)
   - All three are necessary for quality outcomes
2. Quality improvement (QI)
3. Quality control (QC)
   - All three need to be aligned

Three ways to enhance quality

- Identify the needs of the population, create aims & metrics for outcomes & set out steps for meeting our aims
- Achieve better outcomes through a systematic change approach with strong leadership, improvement culture and people who are skilled in QI methods
- Ensuring high quality care through monitoring, inspecting, regulating

Source: [Add Source Information]
What keeps happening

![Diagram showing Quality Planning (QP), Quality Improvement (QI), and Quality Control (QC) intersecting]

Adapted from the Danish national quality strategy

Further information

Education and Capacity Development for Health Professionals in WPPO
http://www.who.int/hpr/dgs/downloads/en/

Universal Health Coverage: Moving Towards Better Health
Action Framework for the Western Pacific Region

Regional action agenda on achieving the sustainable development goals in the Western Pacific
http://iris.cdc.gov/irispub/44931/489305417563_598

Contact
WPPO Integrated Service Delivery: wppdb@who.int
NITPPO.Pacific: pacificpfd@who.int
Session 2. Fostering leadership and management capacity for sustainable quality improvement

- Presentations (5-7 mins. each)
  - Prof Liu Sia Fa, Chinese University of Hong Kong
  - Dr Laveth Vongsaavithong, Lao People’s Democratic Republic

- Moderated panel discussion: (30 mins.)
  Panelists:
  - Mr Mohd Jasudasa, Patients for Patient Safety, Malaysia
  - Dr Rico Maguigad, Philippines
  - Ms Helen Bevan, NHS Horizons, England

- Key questions:
  - How can leaders or managers enable health care providers to deliver inclusive, people-centred services?
  - How can leaders or managers change organisational culture to provide respectful and compassionate care?

How can leaders or managers enable health care providers to deliver inclusive, people-centred services?

- People-centred care (individual)
  vs. System-centred care (organization / population)

- Public sector (population service)
  vs. private sector (customer service).

- All (frontline staff) want to provide better quality care
  vs. Management perspectives

- Barriers:
  - resource (manpower, time, funding)
  - culture, existing practice

How can leaders or managers enable health care providers to deliver inclusive, people-centred services?

<table>
<thead>
<tr>
<th>Structure</th>
<th>Process</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Define</td>
<td>Monitoring</td>
</tr>
<tr>
<td>Organisation set up</td>
<td>Agree on</td>
<td>Patient experience survey</td>
</tr>
<tr>
<td>People - Leader - Middle management - Frontline</td>
<td>Planning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enable (resource)</td>
<td></td>
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<td></td>
<td>Promulgate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Execute</td>
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</table>
Values

People-centred Care

This concept extends beyond providing patients with the best possible services, although that is always our top priority. It also acknowledges the importance of having a caring heart, even when we are busy or a patient is demanding, as well as good two-way communication, which is indispensable for understanding and meeting a patient's needs.
**Strategic Goals**

We aim to achieve our corporate vision by adopting the following five strategic goals under three strategic foci:

- Provide Patient-centered Care
  - Improve service quality
  - Optimise demand management

- Develop a Committed and Competent Workforce
  - Attract & retain staff
  - Enhance staff training and development

- Enhance Financial Sustainability
  - Drive accountable & efficient use of financial resources

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**STRATEGIC FRAMEWORK**

From the consultation process and analysis of our environment, three main strategic foci pertaining to the service, workforce, and financial aspects of HA were crystallised along with an array of strategies which map out the corporate priorities for HA to work towards in addressing the key issues. The three strategic foci are as follows:

- **Provide patient-centered care** - Ensuring patients have timely access to high-quality and responsive services which place patients firmly at the heart of their care. This is carried out through multi-faceted strategies that are geared towards improving service quality and optimising demand management. Core to this will be a fundamental transformation in the way we deliver care, streamline care processes and improve care efficiency and effectiveness, and engage patients as key partners in healthcare.
Our Strategic Goals

To ensure our patients receive safe, high quality, and compassionate care through the entire continuum of care, we aim to improve the following key areas:

2. Improving service delivery: enhancing service delivery, reducing wait times, and improving accessibility.
4. Advancing technology: integrating technology to enhance patient care and efficiency.
5. Building community partnerships: fostering strong relationships with our communities.

Key Challenges the Strategies will Address

Through these strategies, we will address the following key challenges:

- Enhancing service delivery by reducing wait times and improving accessibility.
- Improving communication and collaboration among all levels of care.
- Enhancing patient satisfaction through improved service delivery and outcomes.
- Building strong community partnerships and collaborations.
- Investing in technology to advance patient care and efficiency.

In keeping with the mission of "Helping people live healthy," we recognize that every patient is a unique individual with their own needs and preferences in care. Our dedication to improving patient care continues with the following initiatives:

- Treating patients with dignity, compassion, and respect.
- Offering convenient and personalized care according to patients' needs.
- Communicating with and engaging patients in the care process.
- Procuring and delivering care in a timely and efficient manner.
- Supporting patients' access to necessary care.

However, effectively achieving our strategic vision, there is much room for improvement in delivering the type of patient-centered care that we aspire to. In particular, our current service models in our facilities and our care model for patients with common chronic conditions like hypertension, diabetes, and asthma do not fully meet patients' needs. We will require a comprehensive approach to address these challenges, including improvements in the way we deliver care, the way we communicate with patients, and the way we engage them in decision-making about their care.

For instance, primary care providers across our services have noted that much effort has been put into expanding our capacity. There are no longer waiting times for new patients in our service. Challenges with access to patients with chronic conditions are minimized and patients are followed by the primary care provider. Similarly, more resources are...
Alignment of vision mission values,
• Supported by policy and structure
• Define what is patient centered Implement in stages
• Engaging staff and patients
• Patients to join hospital committees and take part in decision making Patients to take part in monitoring progress towards patient centered
• Resources to support Role modeling Incentive system: how to reward good behavior
• People centeredness comes before patient centeredness.
• The whole organization must respect people including staff, before the organization can move to become truely patient centered

Dr. CT Hwang, Ex-Cluster Chief Knockhers, NHIC
How can leaders or managers change organizational culture to provide respectful and compassionate care?

- Not change organization culture per se (as high failure rate) but when bringing in changes to the organization, take the chance to change the organizational culture (integrated approach)
- Infra-Structure and policy to enable and support changes in organizational culture.
- Role of leadership: role modeling
- Engagement, especially middle managers
- Develop skilled and capabilities needed for the new way of working
- Measure impact of culture change
- Need to consider balance of survival anxiety versus learning anxiety
- Engagement, engagement and engagement

![Diagram]

Empowering and engaging people

Coordinating services within and across sectors

Creating an enabling environment

Strengthening governance and accountability

Reorienting the model of care
Meeting on Strengthening Quality in Health Care to Leave No One Behind, 24-25 August 2017

Lavanh Vongsavanthong MD.; MPH.
Department of Health Care, MOH.

Outline

☐ Profile of Lao PDR
☐ MOH Lao PDR., Department of Health Care.
☐ Health Care Situation in Lao PDR
☐ Key Questions

Profile of Lao PDR
General Information

- Country Areas: 236,800 (Sqkm²)
- Districts: 148
- Villages/Household: 8,507/1.2 Million
- Capital: Vientiane Capital
- Population (Million): 6.492/3.237 F
- Citizen density (one/Sqkm²): 27
- Age groups (%): 0-14: 32.0, 15-64: 63.7, 65+: 4.2
- Ethnic groups: 49
- Religion (%): Buddhist 64.7, Christian 1.7, Other 33.6

(Source: Lao Statistics Bureau, 2015)

General Information

- Total fertility rate per 1,000: 25.10
- The death rate per 1,000: 8.20
- Natural growth rate (%): 1.90
- Life expectancy: 63.5 (Men 62, Women 65)
- Mortality rate of infants under 1 year per 1,000 live births: 57
- Mortality rate of children under 5 per 1,000 live births: 86
- Seasons: Rainy (May-November) and Dry (December-April)

(Source: Lao Statistics Bureau, 2015)

Age Group
MOH Lao PDR,
Department of Health Care.

Organization Chart of Department of Health Care
Health Care Level in LAO PDR

Health Care System in Laos

- Public (Predominant)
  - Primary Care
  - Intermediate Care
  - Secondary Care
  - Tertiary Care
- Private (Tendency increase)
  - Hospital (General, Special)
  - Clinics
- Public cooperation with Private
  - Infrastructure, equipment, technical
  - Private clinic in public hospital

Number of Health Care in Laos

- Central Hospital: 05
- Special Treatment Central: 03
- Provincial Hospital: 17
- District Hospital: 135
- Health Centers: 1,020
- Village Health Workers: 5,250
- Private
  - Hospital (General, Special): 19
  - Clinics: 1,050
Number of Health Care Service

<table>
<thead>
<tr>
<th>N.</th>
<th>Item/Content</th>
<th>Central hospital and special treatment center</th>
<th>Rural hospital</th>
<th>Private hospital</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>OPD</td>
<td>485,265</td>
<td>2,022,025</td>
<td>66,714</td>
<td>2,574,004</td>
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<td>2</td>
<td>IPD</td>
<td>70,086</td>
<td>334,628</td>
<td>2,195</td>
<td>406,909</td>
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<tr>
<td>3</td>
<td>Death in hospital</td>
<td>775</td>
<td>1,278</td>
<td>6</td>
<td>2,059 (0.5%)</td>
</tr>
</tbody>
</table>

(DNC Report, 2015-2016)

Health Care to Leave No One Behind Situation in Lao PDR

To leave no one behind

- It is not big problem in Lao PDR.
- According the Lao culture/traditionally, we can say that family care are very strong in Lao culture.
- To leave no one behind care in the hospital are not specific service they are similar general patients service.
- Poor Help Foundation in MOL, Lao Red Cross.
Challenges

- Human resources are limited
- Fund are limited
- Technical are not strong
- Coordination is not good
- Linkage is not well
- Lack of data

Key Questions

1. How can leaders or managers enable health care providers to deliver inclusive, people-centred services?

2. How can leaders or managers change organizational culture to provide respectful and compassionate care?

1. How can leaders or managers enable health care providers to deliver inclusive, people-centred services?

- Increased attention to high responsibility duties
- Offer sympathy and listen to the patient’s press release
- Educate the employees to have ethics
- Develop and implement the Policy on Quality Approve of “Five Good One Satisfy” for Healthcare at All steps and all Levels in Countrywide, No. 1801 / MOH, 05 Aug 2016.
  - Five Good:
    1. Well Warm Welcome
    2. Well Cleanliness
    3. Well Convenience
    4. Well Accurate Diagnosis
    5. Well and Quick Treatment.
  - One Satisfy:
    1. Satisfaction of Patient
1. How can leaders or managers enable health care providers to deliver inclusive, people-centred services? (Cont)

- Improve and develop the health insurance system by Universal Health Coverage
- Provide the sufficient personnel, equipment and budgets to improve service quality.

2. How can leaders or managers change organizational culture to provide respectful and compassionate care?

- First of all, leaders need to change and constantly develop
- Leaders must have a good vision and a professional manager
- Provide encouragement and fairness to employees or colleagues
- Educate the employees to work by responsibility and ethically
- Provide the employees with good quality of living, such as adding a monthly salary

Thank you for your kind attention
Strengthening quality in health care to leave no one behind
WHO, Kuala Lumpur

Margaret Banks
National Standards Program Director

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Setting the scene - Australia

- How can regulation improve hospital governance and management?
- How can institutional policies foster inclusive, people-centred care?
- How can civil society, the community, professional groups and academia contribute to organisational accountability?

Hospital governance

- National Safety and Quality Health Service (NSQHS) Standard has clinical governance as overarching standard
- NSQHS Standard are assessed during mandatory accreditation for all hospitals and day procedure services
- Developed a range of supporting document and tools
- Developed a national model Clinical Governance Framework based on the NSQHS Standards

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**People centred care**

- Partnering with Consumer Standard
- Developed tools and resources to support health services partner with consumers
- Research and developed a national statement about health literacy
- Tools and information for consumers
- Assessed at accreditation

**Organisational accountability**

Society and communities
- NSQHS Standards require organisations to report on performance
- Require organisations to understand the diversity of catchment population
- Involve people of different backgrounds in organisational processes

Professional groups
- Include partnering with consumers in education and professional development programs
- Include expected behaviours in professional codes of conduct
- Provide feedback to organisations and review reports about organisation performance

Academic
- Use evidence on service use, effectiveness and variation in practice

**AUSTRALIAN COMMISSION on SAFETY and QUALITY in HEALTH CARE**

- safetyandquality.gov.au
- twitter.com/ACSQHC
- youtube.com/user/ACSQHC

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QUALITY IMPROVEMENT IN VIETNAM 2012 - 2017

MINISTRY OF HEALTH

Health Care in Viet Nam, 2017

- Total 1365 hospitals, ~ 32.3 bed/10,000 population

- Private
- 205 hospitals
- ~ 30,000 clinic

REGULATION

- Circular 19/2013/TT-BYT on guidance of quality management in hospital
- - Request all hospital need to establish Quality division/team
- - Apply quality standard, criteria to improve quality
- QD 4858 Pilot Hospital quality Criteria (83 criteria) in December 2013
- QD 6858 Official Hospital quality Criteria (83 criteria) in December 2016
- All public and private hospitals apply the Hospital Quality Criteria and conduct self assessments followed by Ministry of Health validation (start from 2019)
Hospital Quality Criteria Components

83 Criteria Framework

- Patient Orientation
- 46
- Specific Criteria (Obstetric & Pediatric)
- 4
- Human Resource Dev.
- 14
- Quality Improv.
- 6
- Technical Quality
- 38 (7)

Conceptual framework of Hospital Quality Criteria
Ministry of Health (for all 83 criteria)

LADDER OF HOSPITAL QUALITY CRITERIA IN VIETNAM

GRADE 1
- NOT AWFUL
- HOSPITALS OF ARMS
- NO IMPROVEMENTS QUALITY

GRADE 2
- COMPLETE STRUCTURE
- PROCESS STABILIZED

GRADE 3
- COMPLETE STRUCTURE
- PROCESS STABILIZED

GRADE 4
- GOOD OUTCOME
- PATIENT SATISFIED

GRADE 5
- VERY GOOD OUTCOME
- PATIENT VERY SATISFIED

SOS

PRIORITY TO FIX

83 Quality criteria as Measurement for Hospital to know where they are...
3.1 Experience Quality Improvement 2013 – 2015
Of Tu Du hospital in HCM

QI 2013 - 2015

1 criteria related breast feeding is pushing all hospital need to apply 10 steps of WHO–UNICEF on breast feeding
Skin to skin: mother to baby

Skin to skin (not mother)!

How can institutional policies foster inclusive, people-centred care?
In Vietnam, MOH set up a Satisfaction survey system for patient and health care staff, applying for 100% hospital, start from 11/2016
Type of regulations (accreditation, certification, licensing) the hospitals, Mongolia

- Legal arrangements
- The Law on Licensing of Business Activities approved in 2001
- The licensing system was established in 1998, accreditation system regulated by Health Law in 2001, and amended in 2015
- In 2001, Contracting health service program developed and approved by Government resolution No. 72 (FOP)
- Accreditation system implemented in private hospitals and incentives from HIF in 2003
- In 2015, developed hospital Health care service Law (Certificate of needs, No licensing.)
- In 2017, developed State policy on Health approved by the Government resolution.

Accreditation - Continuously improving quality

- Independent accreditation (Independent organization or Professional society and associations)
- Accreditation not only by institution, in line with the types of care
- Performance based accreditation, not input
Licensing and certification for health organization

- Health needs and demand of the population

Licensing:

- Prioritization of licensing - every 3 years
- Need to link Certificate of needs
  - Undertaking core health activities:
    - Purchase high-cost medical equipment and high cost repairs;
    - Increase current capacity of health organizations by 30% or more
    - To build, expand, and renovate designated facilities of health organizations

- MOH - Health organizations who is providing health care in nationwide and foreign investment health organization

- Ministries, city governors – other health organization

How can institutional policies foster inclusive, people-centred care?

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Systemic Learning from 2019-2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Involving and empowering patients and communities;</td>
<td>in the public healthcare area</td>
</tr>
<tr>
<td></td>
<td>in the medicine area</td>
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<td>2.</td>
<td>Strengthening governance and accountability;</td>
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<td>in the public healthcare area</td>
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<td>3.</td>
<td>Reorienting the mode of care;</td>
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<td>4.</td>
<td>Good-serving services within and across sectors;</td>
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<td>5.</td>
<td>Creating an enabling environment;</td>
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<td>in the area of the sector management, organizational arrangements and transparency</td>
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</tbody>
</table>
How can institutional policies foster inclusive, people-centred care?

Some examples:
- Improve capacity of SCH, EGP-tended package of medical care (rehabilitative, palliative and nursing care), increase funding, improve environment
- To reach the people in rural, remote areas – mobile technology, telemedicine
- To protect of financial crisis – high cost medical care funding from health insurance (up to 70 %), private, and public hospitals network for service delivery by geographically, administratively, capacity.
- Improve organizational arrangements and transparency: joint management and semi-autonomous governance into state-owned hospitals;

How can civil society, the community, professional groups and academia contribute to organizational accountability?

<table>
<thead>
<tr>
<th>No.</th>
<th>Type of contribution</th>
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<tbody>
<tr>
<td>1</td>
<td>Civil society</td>
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<tr>
<td>2</td>
<td>Community</td>
</tr>
<tr>
<td>3</td>
<td>Professional groups</td>
</tr>
<tr>
<td>4</td>
<td>Academia</td>
</tr>
</tbody>
</table>

- Participate policy and decision-making
- Monitoring and evaluation process
- To deliver health care services (public health)
- Organization and management of health care (administration)
- Designing and training (deterrence, audit, monitoring)
- For the decision-making processes (implementation of new technology, and investment)
- Supervision of health organization and health professionals
- To organize consultation meetings and seminars
- Develop clinical guidelines and standards
- Coauthorship, academic publications

How can civil society, the community, professional groups and academia contribute to organizational accountability?

- Social accountability project – 4 aims,
Initiatives of communities

Thank you for your attention
The pursuit of quality in healthcare was a major concern since early days of Independence, especially Equity.

Health was made a federal responsibility in 1958.

In the 60 years since Independence, the Malaysian healthcare system has been transformed from a simple one to the modern equitable system that we have here today.

This is thanks to the foresight of our founding fathers who incorporated health as an important agenda in the nation's development.

Health was included in the First Malaya Plan (1956-1960) and Second Malaya Plan (1961-1965) and henceforth. These are 5-year rolling plans for socio-economic development in our quest for nation building.

The Government adopted a holistic approach to health – gave high priority to poverty eradication and economic development, education infrastructure development and social & community services - the Social Determinants of health including improved sanitation, water supply, and nutrition.

All these have been shown by researchers such as Thomas Mckelown many years later to have a significant impact on population health.
Social Determinants of Health

Ministry of Health Operational Definition of Quality
(incorporates views of key stakeholders of health care)
Facilities and services are of high quality if they are:
- Safe
- Effective
- Timely
- Equitably accessed
- Patient-centred and consumer-friendly

Malaysia has one of the best healthcare systems in the world
Improvement in our health status (1957 - 2013)

<table>
<thead>
<tr>
<th>Country</th>
<th>% female in cohort [1960]</th>
<th>Life Expectancy at Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>55.1</td>
<td>51</td>
</tr>
<tr>
<td>Australia</td>
<td>8.7</td>
<td>63</td>
</tr>
<tr>
<td>France</td>
<td>31.9</td>
<td>81</td>
</tr>
<tr>
<td>Japan</td>
<td>71.8</td>
<td>74</td>
</tr>
<tr>
<td>China</td>
<td>64.4</td>
<td>79</td>
</tr>
<tr>
<td>Denmark</td>
<td>9.9</td>
<td>89</td>
</tr>
<tr>
<td>Italy</td>
<td>55.1</td>
<td>74</td>
</tr>
<tr>
<td>Mexico</td>
<td>46.1</td>
<td>73</td>
</tr>
<tr>
<td>Thai</td>
<td>52.0</td>
<td>79</td>
</tr>
<tr>
<td>Singapore</td>
<td>4.5</td>
<td>82</td>
</tr>
<tr>
<td>Philippines</td>
<td>5.5</td>
<td>78</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2.3</td>
<td>60</td>
</tr>
</tbody>
</table>

**Equity**

✓ "A fair share for all the community (including minority and disadvantaged groups)" - Maxwell

✓ "Equity in health status vs equity in access (informational, cultural, geographical, financial)"

✓ "The publically-funded healthcare system has an open door policy – anyone who needs healthcare will be given the care that is needed"
The Rural Health Team

- A referral system of ascending complexity
  - Rural clinics
  - KK Districts
  - District hospitals without specialist services
  - Specialist hospitals-centres of excellence and national referral centres

Where do we go from here?
WHO'S 3 HEALTH SYSTEM GOALS
- Health status
- Responsiveness
- Fair Financing

RESPONSIVENESS OF A HEALTHCARE SYSTEM
- This concept encompasses the non-health enhancing, non-financial aspects of healthcare system
- the outcome that can be achieved when ... respond to the universally legitimate expectations of individuals (~ the user as a consumer who needs to be responded to, safeguarding rights of patients to adequate and timely care i.e. people-centred

RESPONSIVENESS OF A HEALTHCARE SYSTEM
- Dignity
- Autonomy
- Confidentiality
- Prompt Attention
- Quality Of Basic Amenities
- Access To Social Support Networks During Care
- Choice Of Care Provider
ADOLESCENT HEALTH PROGRAMME

Introduction

Reasons to introduce Adolescent Health Programme were the significant contribution to the growth of population in the country which is a bread and butter of the nation's economy and health wellbeing.

- Adolescent Health Policy
- National Adolescent Health Policy
- National Adolescent Health Policy
- Adolescent Health Policy

HEALTH SERVICES

- Adolescent Friendly Health Services in all government clinics
- Training for Healthcare Providers:
  - Non-judgemental
  - Confidentiality
  - Respect
  - Empathy
  - Trust

Principles:
- The Best Interest Of The Child
- Harm Reduction

KOSPEH
Komuniti Sihat, Perkasa Negara

Collaboration between KOSPEH, NZH in community empowerment for healthy lifestyle

1. Knowledge
2. Translating knowledge into practice
3. Facilitating change for HLS

Target: 34,000 volunteers
Opening: 18 October 2023

Scope of healthy lifestyle:
- Tobacco
- Alcohol
- Healthy eating
- Healthy exercise
- Safe sex
- Early detection of NCD

65
KOSPEN

- A community-based intervention program for NCD and its risk factors (educating and prompting people to change)
- Aggressive steps taken by MOH to tackle the problem of NCD
- Health volunteers as the functioning units
- Started in Oct 2013 at 3 states with 100 locations
- In 2016,
  - 7,000 KOSPEN facilties developed
  - 40,000 volunteers trained

Basis of KOSPEN - Ottawa Charter

- Build Healthy Public Policy
- Create Supportive Environments
- Strengthen Community Actions
- Develop Personal Skills
- Reorient Health Services towards NCD
ROLES OF COMMUNITY IN KOSPEN

- Setting for intervention
- Target of change
- As agent with development capacity
  - Infrastructure
  - KEMAS and RT Program
- Resource – ownership and participation

Implementation Strategies
- Increasing awareness & knowledge
- Health Policy adoption and Health-promoting environment
- Translation of knowledge into sustainable actions

The Scopes
1. Healthy eating
2. Active living
3. Smoke-free
4. Weight management
5. Early detection of NCD risk factors

ROLE OF VOLUNTEERS

- FUNCTIONING UNITS OF KOSPEN
  - Promotes and Advocates for healthy policy adoption related to scope of KOSPEN
  - Health promotion to local KOSPEN community (KOL at KOSPEN Localities)
  - Facilitate establishment of healthy environments that enable practices of healthy lifestyles
  - Screening for BP, RBS and BMI
  - Referrals to nearest Health Clinics
  - Interventions - Weight Management Program
**IMPLEMENTATION TARGETS**

**BY YEAR 2022**
- 10,000 KISPEN localities
- 50,000 volunteers trained
- 1.5 adults screened by 2022

**CURRENT STATUS**
- 7,000 KISPEN localities
- 30,000 volunteers
- 400,890 adults screened
- Referrals and Community Interventions for Weight Management Programs

**REFERRALS**
- 70% for Diabetic confirmatory test
- 36.2% BP ≥ 140/90 mmHg
- 6.5% for BMI ≥30 kg/m²
THANK YOU