Meeting Report

Policy Roundtable on Quality in Health Services

28 - 29 September 2015
Hong Kong SAR (China)

World Health Organization
Western Pacific Region


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WORLD HEALTH ORGANIZATION

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MEETING REPORT

POLICY ROUNDTABLE ON QUALITY IN HEALTH SERVICES

Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

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NOTE

The views expressed in this report are those of the participants of the Policy Roundtable on Quality in Health Services 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 Policy Roundtable on Quality in Health Services in Hong Kong SAR (China) from 28 to 29 September 2015.

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Keywords: Health policy/ Health Services/ Patient Safety

SUMMARY

The introduction of universal health coverage reforms in the Western Pacific Region has directed attention to the problem of low quality care. Strategies are needed to systematically improve and regulate quality of health care.

The objectives of the Policy Roundtable on the Quality in Health Services were to:

1) to identify policy trends and critical issues in assuring the quality of health services
2) to share good practices and lessons learnt in implementation of quality improvement measures
3) to promote actions on quality and safety of health services in countries.

Thirty policy-makers and experts from 14 countries identified and discussed key policy and practice trends, along with critical issues and several good practices, for ensuring quality of health services. Several challenges identified were shared across countries – lack of regulatory oversight and difficulties with monitoring and enforcement, absence of a strong quality improvement and patient safety culture, poorly designed incentive payments schemes, low levels of engagement with patients and communities, care fragmentation in the overall health system, and the need for robust information management systems to monitor quality and patient safety indicators.

Four key policy instruments commonly used to address quality and patient safety issues were discussed extensively: (1) adverse event reporting and monitoring; (2) the utility of clinical guidelines, professional standards and quality committees; (3) regulation of quality in health services; and (4) the use of financial incentives to improve quality.

Adverse event reporting and monitoring systems can be set up beyond institution levels to enable efficient cross-sharing of lessons. They are an important source of data for identifying patient safety challenges, and areas for quality improvement. To encourage and foster a culture of open reporting, a non-punitive and safe environment is critical. The feedback loop must also be closed, with events and near misses analysed and communicated back to the practitioners.

Clinical guidelines, is one of the most widely used tool to ensure quality in clinical services – but there are huge variations in the quality of these guidelines. Development of clinical guidelines requires significant investments of expertise, time and resources, and should be preferably undertaken by professional associations, with support of professional councils and endorsement by Ministry of Health. Quality committees in hospitals and large group practices are useful for maintaining quality standards, but the quality of these committees also need to be strengthened through training and system-level changes.

Regulations should focus on sustaining and improving professional standards, and identifying and addressing poor practices. Regulatory levers include legislation, licensing and registration of health practitioners, accreditation of health facilities, standardized quality assessments, regular quality surveys and other data collection activities that can be built into planning cycles to monitor and improve quality. Accreditation can be done by national agencies or independent organizations, and is a versatile tool to raise the benchmark for quality. Payment incentives can be introduced to act as a driver for regulation and accreditation. Professional bodies can act as co-regulators as long as they demonstrate impartiality.

Using financial incentives to improve quality is a difficult decision to get correct. Poorly designed financial incentives can lead to unintended actions and consequences – and the misuse, overuse or underuse of clinical services. At the institutional level, the use of financial incentives to reward performance can work well if the performance indicators are well-designed and balanced to take into account many facets of a professional's work. Designing financial incentives for institutions and groups of providers is efficient, and can be effective if there are good and transparent measures of performance, and there is a strong information management system.

As health services expand in order to keep up with increasing demand for health services, it is important that systems and processes are in place to ensure access to quality health services. Countries need to ensure that the fundamental issues such as licensing of health practitioners based on

professional standards, accreditation of health systems, and adverse event monitoring and reporting are in place. Providers and governments must work together to create an enabling environment through sound policy and legislative frameworks to encourage good quality and safe practices.

1. INTRODUCTION

1.1 Meeting organization

The WHO-led Policy Roundtable on the Quality in Health Services was held from 28 to 29 September 2015 at the Hong Kong Convention and Exhibition Centre, Hong Kong SAR (China). It coincided with the International Forum on Quality and Safety in Healthcare: Asia conference, organized by the British Medical Journal.

Thirty policy-makers and experts engaged in strategic planning, development of policies and programmes for quality in health-care from the following countries attended: Australia, Brunei, Cambodia, China, Hong Kong SAR, Japan, Lao PDR, Malaysia, Mongolia, New Zealand, Philippines, Republic of Korea, Singapore, and Viet Nam . The Secretariat for the meeting included five WHO staff. The list of participants is available in Annex 1.

The programme of activities is available in Annex 2.

1.2 Meeting objectives

The objectives of the Policy Roundtable on the Quality in Health Services were to:

1) to identify policy trends and critical issues in assuring the quality of health services
2) to share good practices and lessons learnt in implementation of quality improvement measures; and
3) to promote actions on quality and safety of health services in countries.

2. PROCEEDINGS

2.1 Opening session

Dr Vivian Lin delivered the opening address on behalf of Dr Shin Young-soo, WHO Regional Director for the Western Pacific. Dr Sin Young-soo's opening address is available in Annex 3.

Dr Lin shared the recently adopted Sustainable Development Goals (SDGs), highlighting that health is one of the seventeen SDGs, and emphasized that Universal Health Coverage (UHC) is an important area of work. Many countries in the Western Pacific Region have made commitments to achieving UHC, for better health outcomes. Quality is at the heart of UHC, and improving quality in services requires a people-centred and integrated health services approach. WPRO conducted several activities over the past years to assist countries to improve the quality and safety in health services, including joint meetings with the WHO's South East Asian Regional Office (SEARO) and the Organisation for Economic Co-operation and Development (OECD) to discuss quality and patient safety indicators, and training on quality improvement and patient safety in hospitals together with Japan's National Institute for Public Health. This policy roundtable continues the conversation and engagement with both policy-makers and practitioners to foster mutual learning and share best practices across countries in realizing access to good quality health services. It is important that the context specificity of the developments are considered as there is no one-size-fits-all solution.

2.2 Session 1: Overcoming challenges to improving quality in health services: what lessons can we learn from?

Dr Lin introduced the session with the following discussion questions:

- What are your biggest challenges in improving quality in health services?

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

Participants discussed these questions in groups and shared them during the plenary discussion.

Key discussion points raised included:

Leadership

Participants highlighted two key challenges present in many countries: (1) the lack of strong leadership and political will to improve quality in health services, and (2) the absence of a strong quality improvement culture. Good leaders can shape the environment and culture of health service delivery, and promulgate emphasis on achieving high quality, safe care. Elements of good leadership support identified are: leading by example to value high-quality, safe patient care and ethical behaviour, fostering a no-blame safety and quality culture, planning for the adequate provision of resources, supporting ongoing evaluation and set priorities for improved performance improvement of performance, ensuring the availability of overarching policy frameworks to support quality improvement activities. Participants recognised that lack of leadership support is often due to a high staff turnover rate and such turnover may further worsen existing inefficiencies.

Incentive payments and health financing

The way health systems are financed influences both access and quality of care. Fee-for-service models often pay providers based on the quantity of care provided, rather than assessing quality of care. The use of incentives and penalties to change health-seeking behaviours, and set clinical standards, has the potential to greatly improve health outcomes. Incentives may be extrinsic (e.g. monetary) or intrinsic (e.g. professional motivation), or a combination of both. Incentives can also be designed to reward health outcomes rather than processes. However pay-for-performance systems are fraught with trade-offs and may generate unintended consequences. Over-reliance on financial incentives may result in health practitioners behaving as independent contractors and providers of health services, and may erode at the ethos and professionalism of the entire health sector.

Regulation and licensing

There are wide variations across countries in the regulation of health facilities and the licensing of health practitioners. With an emerging private sector, the need to regulate for quality in health services is becoming increasingly important. In several countries, governments are offering private providers a de facto role in pluralistic health systems and using them to alleviate their own funding constraints. In these pluralistic systems, healthy competition between the private and public sectors must be encouraged. Several countries have little or no information about the private sector, which make regulatory oversight, monitoring and enforcement difficult. Hong Kong shared that its legislation on the regulation of the private health-care sector is being expanded to include several aspects of quality, such as presence of quality assurance programs, information transparency and adverse event reporting. Quality improvement initiatives should aim to exceed, and not just meet regulatory requirements. Quality improvement can also be supported through continuing education and training of health professionals. Developing national competency standards and assessment procedures for registration and licensing of health professionals can improve quality of health-care providers and services. In this area, Cambodia is the process of developing a new law for registration and licensing of health-care providers.

Engagement of stakeholders

Information asymmetry affects the ability of patients to make informed decisions, and affects how patients and family perceive their health needs, and the quality of services they receive. In some circumstances, the lack of transparency can create situations where health-care providers promote use of services that may be unnecessary. The concept of ‘perceived quality’ – as the quality of healthcare as perceived by patients, is constituted by health-care providers' attitudes, waiting times, health

facility infrastructure, etc. Patients often consider 'branded' medications and advanced diagnostic tools such as CT-scans, as proxies of high quality health services. Transparent reporting on performance and quality can help inform stakeholders at all levels (patients, families, health practitioners, health-care providers) and facilitate engagement with the quality agenda. The WHO ‘Patients for Patient Safety' programme adopts an approach which incorporates the patient, family and community voice in health care through better engagement and empowerment.

Quality Improvement

Most quality improvement efforts traditionally looked at why things went wrong, and focused on evaluation and analysis of the error, considering both the outcome and the processes, and the changes required to the work processes. A new way of looking at quality is to look at the things that went well, and see if useful lessons can be gleaned, that can be applied to a different situation. Going back to basics, the critical first step to improving quality of health care is to be able to measure it. This requires robust information management system(s), which can identify variation in practice and support monitoring of performance. Health-care quality indicators provide an important tool for measuring the quality of care.

Session Summary

Dr Lin acknowledged the important and difficult challenges shared, including broader issues such the business drivers of modern health care, the delivery of medical education, the changing relationship dynamics of doctors becoming clients of the hospital (both public and private), the use of financial incentives as drivers of provider behaviour, and providers and policy makers not prioritizing quality as core to UHC. On the other hand, several countries in the region have made progress on the quality front, creating national strategies for quality in health services, stating their commitment to UHC, investing in health information systems to support data collection, strengthening regulations, encouraging setting of standards for licensing and accreditation, working on stakeholder engagement, improving media messaging and communications, considering different forms of payment incentives, and developing health sector champions to influence and lead the quality agenda.

Key discussion points for this session were:

- Many health-care systems are fragmented and decentralised, which makes it difficult for patients and their families to navigate the health-care system. Operating in silos prevents health care from being delivered in a coordinated fashion, and negatively affects quality and efficiency.
- In terms of effecting change, strategy and culture are two key issues to address. Amongst the two, it is said that ‘culture eats strategy for breakfast, every day’. Having a strategy that does not address deep-seated culture issues, means that old habits and resistance to change can easily negate the strategic plan.
- There is a need and growing trend to reorient health-care delivery away from hospital-centric models, and towards community-based, primary health care models. Such systems tend to reward care rather than cure, and have a population health focus, which is more sustainable in the long term.
- An open reporting culture should be fostered to recognize, report and prevent adverse events. Leadership needs to create a safe space and trusting environment, where health-care professionals feel safe and motivated to report adverse events and near-misses.
- Public reporting and transparency is essential for accountability and strengthening public confidence. Benchmarking institutions against other similar institutions, when done correctly, can provide motivation for providers to improve quality and patient safety.
- Quality lies in the 'eyes of the beholder', and ‘perceived quality’ varies across countries and settings. Each country must engage stakeholders at all levels (patients, families, health practitioners, health-care providers) to manage expectations and determine what constitutes reasonable and acceptable quality of care.

- Payment incentives should be reoriented to move away from being volume-based, fee-for-service models, towards more value-based health care, focused on health outcomes rather than inputs and processes.
- Low resource countries have an opportunity to leapfrog by learning from the experiences of other countries. An important principle highlighted was for countries to focus on strengthening their primary health care systems.
- Monitoring and evaluation is critical to support tracking of health system performance, understand variations in quality, and help evaluate the effectiveness and efficiency when implementing quality improvement initiatives.
- Systems thinking suggests that "every system is perfectly designed to achieve exactly the results it gets" – and that perspective can provide opportunities for system redesign to provide solutions for addressing problems caused by poor system design.

2.3 Session 2: Tools and strategies for quality improvement: what can be used by countries?

Session 2a: Adverse event reporting and monitoring – does it help improve quality and patient safety?

Dr Rasul Baghirov introduced the session, the panel of experts and moderated the discussions.

Prof Shin Ushiro shared the Japan Council for Quality Health Care's (JCQHC) experience in introducing a web-based, nation-wide reporting and monitoring system to collect information on near-misses and adverse events. This system has been in place since 2004 and encourages hospitals (both mandatory and voluntary) to undertake non-punitive and anonymous reporting. To date, some under-reporting has been identified; however the rate of reporting has improved over time. Transparency is encouraged and in order to promote medical safety efforts, information collected on adverse events and near-misses are analysed and published online on a regular basis, through the National Database of Medical Adverse Events. This National Database is freely available online to support knowledge sharing and prevent the occurrence and reoccurrence of adverse events. Prof Ushiro shared that the success of the nationwide adverse event system in Japan was made possible by strong patient safety culture and close engagement and cooperation with medical institutions, government and other agencies.

Dr Kadar Marikar presented on his experience at the Malaysian Society for Quality in Health, a non-government organization that works actively with health-care professionals and institutions to ensure safety and continuous quality improvement through accreditation of health-care facilities. In 2008, legislation was passed – all public and private hospitals are mandated to report all adverse events to the Ministry of Health. However, there still lacks a platform to enable sharing of incidents and lessons learnt at the national level. While regular audits are undertaken to ensure all incidents are reported and root cause analyses are undertaken to identify causal factors, the process of providing this information back to hospital management and clinicians is less clear.

Prof Cliff Hughes shared based on his experiences at the International Society for Quality in Healthcare (ISQua) and the Clinical Excellence Commission in New South Wales, Australia. Reporting adverse events solely, without the necessary analysis and follow-up actions, does not drive change. Prof Hughes used the imagery of holding up a mirror to emphasise the importance of practitioners reflecting on what is happening in their unit, their practice and their institution. Prof Hughes reiterated that more emphasis needs to be placed on what happens after a report is submitted. It is the feedback to the reporter that perpetuates the information and closes the loop. It is critical that clinicians are able to understand what their results are and why – they must own any changes or improvements. Providing feedback to the professionals who reported on the adverse event make the reporting process more meaningful, and helps to engender buy-in from providers.

Key discussion points included:

- Reports on near-misses should be collected in addition to adverse events. It is a valuable source of data for identifying patient safety challenges, can help set priorities, and allow for monitoring and measurement of progress.
- Reported near-misses and adverse events provide a dual pathway for quality improvement: (1) the process of collecting incident data and undertaking root-cause analysis to identify and act on causes, gradually improves the system and leads to better quality and safety; and (2) through the process of reporting, practitioners learn to trust the incident reporting system as a safe means for communication and a tool for gradually improving patient safety. This engagement and familiarization with this communication and quality improvement tool changes culture and behaviour, and is more sustainable.
- The feedback loop must be closed. The perception that reports disappear into a 'black hole' is a barrier to reporting. The information system must be designed to use information from reports effectively, generate awareness and knowledge on safety issues, communicate these issues back to the practitioners, and develop solutions to effectively improve the quality and safety of care.
- A non-punitive and anonymous environment is critical to encourage reporting of patient safety events and foster an open disclosure culture. Building a safe, trusted environment and a culture of opening reporting needs to start at the institution level, taking a bottom-up approach. However disciplinary investigations are still necessary and the system should be designed to separate the processes of corrective investigation and disciplinary investigation.
- Many adverse event reporting system(s) rely on voluntary reports by patients and/or clinicians. Depending on the reporting culture, the number of reports collected via these system(s) can be low and may not reflect the real situation on the ground. There must be two different data sources to allow for triangulation of the true incidence.
- Quality improvement training can positively influence practitioner attitudes and behaviours towards quality and patient safety, and should form part of the undergraduate health professional curriculum.

Session 2b: Clinical guidelines, professional standards, quality committees – what works?

Dr Baghirov introduced the session, the panel of experts and moderated the discussions.

Mr David Meates shared the experience of the Canterbury District Health Board in New Zealand in developing HealthPathways to build relationships between general practice teams, specialists and other community health-care providers to deliver integrated care, and get agreement on one another's role in delivering patient care. Mr Meates shared that the transformation journey began in 2008 with a fragmented and disjointed health system. HealthPathways were envisioned as a way to overcome care fragmentation, and the initiative has been strongly successful. There are now over 800 HealthPathways available on the Canterbury HealthPathways site. The HealthPathways have resulted in the transfer of tasks from acute care to the primary health care sector, reduced duplication of tests and improved health outcomes. Mr Meates highlighted that the real value-add is the process, which generated conversation and dialogue is encouraged between different professional groups, which broke down the traditional communication silos. Although clinical guidelines have existed in New Zealand for some time, HealthPathways are being increasingly used as they are suggestive, non-compulsory and can be more intuitively applied support clinical decision making. HealthPathways are also available to patients at the time of consultation and serve as a basis for better doctor-patient communication. This has resulted in improved doctor-patient relations. Financial incentives were not used to increase uptake.

Dr Lee Chien Earn presented on the Singapore Healthcare Improvement Network (SHINe) and its role in bringing together clinical quality experts from various institutions to share lessons and best

practices. Dr Lee recounted an important historical milestone for SHINe where the senior leadership of all the public health institutions came together to prioritise the national quality improvement agenda for the next two years. Three important areas of work, where tangible and measurable improvements could be made, were identified: (1) hospital associated infections, (2) medication errors and (3) surgical safety. Over the next two years, a large scale initiative was developed to work on these priority areas, where the principle is to develop a localised and contextualised approach – focusing on what should be done, where and by whom. Dr Lee shared the 1,3,5 method[1] of rolling-out and scaling-up of a program at the institution level. Site visits were encouraged to facilitate sharing of data, cross-learning and understanding the unique context in which the solutions were developed. These actions allowed health practitioners at the coalface to realise they are not alone in experiencing these challenges. SHINe recognized the process of "forming, storming, norming, performing" as a model for developing of a sense of community. Dr Lee shared four key components that can be used to encourage health-care leaders and providers to think about opportunities for quality improvement in their place of work:

1) Ideas – what alternatives are there to the status quo?
2) Will – is there desire to improve the system?
3) Execution – how can we make it real, create ownership, and contextualise the solution to local practices?
4) Measurement – how can we know if there have been changes and improvements to the system?

Dr Donald Li shared insights from his experiences at the World Organization of Family Doctors (WONCA) and the Hong Kong Academy of Medicine. The Hong Kong Academy of Medicine is the statutory body responsible for training, assessment and standards, it provides policy support and continued professional development for both clinical and specialist registries. Hong Kong has a number of clinical guidelines which closely references international guidelines; however there were four guidelines or reference frameworks were developed specifically by Hong Kong for use in primary health care, which take into consideration local and cultural differences and patient expectations. These four are: hypertension, diabetes, elderly care and paediatric care. The Food and Health Bureau's primary health care office is responsible for publicizing and promulgating these clinical guidelines. Financial incentives are not used to encourage compliance with guidelines, other than government funded support in the form of health vouchers for preventative care for those who follow the reference frameworks. A number of factors need to be considered when developing clinical guidelines:

- Are there are any commercial interests?
- Are the guidelines are practical and user-friendly, or too idealistic?
- Are the guidelines written to be binding or suggestive, and does it limit or challenge professional autonomy?
- How can adherence to these clinical guidelines be promoted?
- How can the effectiveness and utility of the guidelines be measured?

Dr Li shared that in Hong Kong SAR (China), clinical guidelines are not used for registration and accreditation, but practitioners are encouraged to use them as reference documents to support continuous professional development and delivery of quality health-care services.

[1] The 1,3, 5 method as described by Dr Lee is implementing a pilot in one ward, for example, tackling hospital acquired infections. If it works in that ward, it should be expanded to 3 wards to see if it is scalable. Some solutions do not work well in different context (e.g. a method may only work in a medical ward, but not in a surgical ward). If the method is successful in 3 wards it should be extended to 5 wards, and this can include the emergency department and specialist outpatient clinics. If the method is successful across 5 wards it can be scaled up at the institution level.

Key discussion points included:

- Development of clinical guidelines requires investment of expertise, time and resources. To encourage ownership, these should be preferably undertaken by professional associations, with support of professional councils and endorsement by Ministry of Health.
- Clinical guidelines should be written and used as guidelines – incorporating well-evidenced recommendations and suggestions to assist practitioners with clinical decision making, but not be overly prescriptive or directive. Patient assessment and treatment needs to be person-centered and individualized, and practitioners should not blindly adhering to guidelines and practicing 'cookbook' medicine.
- Professional and ethical standards serve a licensing function, and are different from guidelines. While often unintended, clinical guidelines have been used in litigation as legal standards. When developing guidelines, committees should consider the legal status of these documents, and whether the guidelines can be used in legal proceedings.
- Clinical pathways are structured multidisciplinary care plans that detail essential steps in the care of patients with specific diseases and conditions. They are designed like clinical practice guidelines but are used differently; often developed by translating guidelines into local protocols for application in clinical practice. Clinical pathways are used by multidisciplinary teams and encourage communication, teamwork and care planning and they also create transparency in the system for patients and their families.
- It is useful to have quality committees in hospitals and large group practices, but the quality of these committees need to be strengthened through training and system-level changes. At the national level, a platform for sharing amongst institutional quality committees can help more quickly diffuse good practices and lessons learnt.

Session 2c: Regulation of quality in health services – government, insurers or co-regulation?

Dr Clive Tan introduced the session, the panel of experts and moderated the discussions.

Dr Hj Zulaidi Hj Abd Latif presented on Brunei's experience on regulating for quality in health services. Dr Zulaidi shared that the Bruneian health-care system is fully subsidised by the government; there are four government hospitals, two private hospitals and sixteen public and private health clinics. Legislation governs the regulation of medical health practitioners. Private hospitals and private health clinics are accredited under the Malaysian Society for Quality in Health standards. There is currently no accreditation system for government hospitals and health clinics; however a survey has been introduced to encourage self-assessment and quality improvement. An e-health initiative was introduced across all government hospitals and health clinics in 2014, which also has the potential to improve the quality and safety of health systems. Brunei's recent Master Plan for Health addresses key health-care challenges of non-communicable diseases and emerging infectious diseases. The Plan also outlines quality of health care as a key goal, an area that has strong leadership support. Amongst all this progress, determining how quality in health services can be better supported at the hospital level remains a key challenge.

Ms Margaret Banks shared the Australian Commission for Safety and Quality in Health Care's (the Commission) experience in developing the national accreditation scheme and National Safety and Quality Health Service (NSQHS) Standards to drive the implementation of safety and quality systems in Australia. Health care provision and regulation is the responsibility of the jurisdictions. The Commission has no authority to regulate and relies on the referred powers of the states and territories (jurisdictions) to support national coordination in the regulation and accreditation of health services. Accreditation of health services is mandatory. Health departments (the regulators) determine which services must undertake accreditation, with reference to the NSQHS standards. Where possible, standards have been incorporated into the NSQHS standards to reduce duplication and improve

efficiency. In some instances, regulators may wish to refer to other existing standards e.g. national standards in mental health services. The Commission plays a role at three different levels:

- Capacity building and workforce development at the health service level. For example, developing resources such as a series of safety and quality improvement guides and accreditation workbooks to help health practitioners reach the required NSQHS standards;
- Provide standards and advisory services to accreditation agencies across the country. For example, establishing an advice centre as a national source of advice, providing support and if required, mediation between health service organizations and surveyors and expert advice on the interpretation of standards; and
- Partner with state-level regulators to scope the range of health services that will require accreditation and provide advice on the standards to be adopted. For example, providing advice on the regulatory approach and processes to be implemented if standards are not met, and if conditions of significant risk for patient harm are identified. An annual performance review of the standards is undertaken by the Commission in collaboration with regulators.

Ms Banks highlighted that collaboration is the central principle; all stakeholders (health services, accrediting agencies and regulators) must be on board to develop systemic solutions rather than individual solutions. 'Accreditation is not the main game' – it is the quality journey that health facilities take that is important, including how they implement standards, and identify opportunities for improvement.

Prof Sophia Chan shared Hong Kong's experience in the regulation of health practitioners and the role of professional bodies in undertaking professional co-regulation to support quality in health services. Prof Chan noted that Hong Kong has undertaken statutory regulation of medical practitioners since 1957. Since then, regulation of dentists, nurses, pharmacists and five supplementary professions, including occupational therapists, medical laboratory technicians, optometrists, radiographers and physiotherapists, chiropractors and Chinese medical practitioners was gradually introduced. These thirteen disciplines must register, in order to practice in Hong Kong. The statutory/regulatory functions performed by professional bodies are governed under legislation. The key functions include registration of health practitioners, administration of licensing assessments, maintenance of ethics and professional standards, investigation of complaints against health professionals and subsequent conduct of disciplinary proceedings. Hong Kong provides a high degree of autonomy to its professional bodies. Regulatory bodies are expanding beyond physicians, with anticipated involvement from the Hong Kong Academy of Nursing. A strategic review is currently being undertaken to:

- Recommend measures of professional development to maintain the skills of health professionals;
- Provide a regulatory structure for health-care professions, including the functions and composition of regulatory bodies (e.g. boards, councils);
- Examine the existing mechanisms for setting and upholding professional standards; and
- Consider tools to strengthen professional standards.

The report of the strategic review will be published later in 2015.

Key discussion points included:

- Governments need to develop and strengthen both regulations and regulatory capacity, and improve coordination and collaboration with wide range of regulatory stakeholders, to be efficient, improve compliance and change practices. While there is a role for professional bodies to undertake co-regulation, government still hold the stewardship role in ensuring an enabling environment that aids regulatory monitoring and enforcement. By establishing clear standards and transparent regulatory structures, regulators can help promote accountability.
- The way in which a health system is financed (government, private, or insurer dominated) can affect which regulatory levers for ensuring safety and quality in health services are selected.
- Regulatory efforts should be two-fold: focus on sustaining and improving professional standards, and identifying and addressing poor practices.

- Regulatory levers can include legislation, licensing and registration of health practitioners, accreditation of health facilities, standardized quality assessments, regular quality surveys and other data collection activities that can be built into planning cycles to monitor and improve quality.
- Payment incentives can be introduced to act as a driver for regulation and accreditation. However, the issuing of incentives to insurance companies may not result in the betterment of safety and quality depending on whether their goal is to provide a social health insurance system or maximise profit.
- Accreditation can be done by national agencies or independent organizations, and is a versatile tool to raise the benchmark for quality. Professional bodies can act as co-regulators as long as they demonstrate impartiality. A quality improvement culture should be instilled early amongst health practitioners through education and training so they embrace the importance of quality and patient safety.
- Quality assurance and quality improvement are two different principles. While quality assurance involves developing guidelines and implementing risk management strategies, improvement goes beyond minimum quality standards and encourages drivers for excellence.

Session 2d: Relationship between financing and quality – how do you manage payment incentives?

Dr Tan introduced the session, the panel of experts and moderated the discussions.

Dr Zhao Jing shared the Peking Union Medical College's experiences with the use of financial incentives to improve quality of health services and health outcomes. At Peking Union Medical College, quality dimensions are not considered in the determination of salary levels for health practitioners. Health practitioners receive a base salary and a bonus based on volume. A pilot was conducted to include three additional components in order enhance clinical quality: (1) compliance to clinical guidelines, (2) patient satisfaction, and (3) evaluation of clinical outcomes. The Chinese government is working improving quality in health services by developing provincial centres for quality management and indicators for quality management.

Dr Sun Min Kim presented on the role of the Health Insurance Review and Assessment Service (HIRA) as national purchaser of health services to improve quality of health services and clinical outcomes. The Republic of Korea reaps the benefits associated with a single unified nationwide health insurance program to control quality of care that is provided. Dr Kim described the Republic of Korea's journey to applying a pay for performance system based on sound quality indicators. The pilot project, introduced in 2007 targeted acute myocardial infarction and caesarean section indicators as Korea was performing against these poorly in comparison to other OECD countries. In the first year of the pilot project, a penalty threshold was announced considering the quality score of the lower performing group, in the second year financial incentives were provided to top performers, and in the third year financial incentives were provided to top performers, and penalties were provided to lower performing groups. Financial incentives were also given to the quality improvers. The use of financial incentives was shown to improve average quality and narrow the quality gap, though it is not certain if this is attributable to the introduction of the pay-for-performance system or public reporting on performance. Dr Kim highlighted two key components that made a pay-for-performance system possible in the Republic of Korea: a strong information system for measurement and evaluation, including capacity to create linkages with unique patient identifiers, and an established legal mandate since 2000.

Dr Francisco Soria shared how PhilHealth utilises payment incentives for improving quality in health services: each provider must be accredited by PhilHealth to receive reimbursements for services provided. Philippines' health-care system operates in a decentralised environment with different levels of care providers, in the presence of a large private sector, often creating fragmentation and variation in the quality of services across the country. The introduction of the Benchbook accreditation

standards in 2010 shifted the focus from infrastructure, to processes and outcomes. PhilHealth provides reimbursements to providers on the basis of accreditation, and these reimbursements are provided on the top of their base salary, and hence can be considered financial incentives. The distribution of reimbursements within the institution is determined by the institution. Other non-monetary incentives are also applied. Branding rights associated with accreditation as a "Centre of Safety", "Centre for Quality", and "Centre of Excellence" also encourages institutions to improve performance.

Key discussion points included:

- Use of incentives and penalties, as a 'carrot-and-stick' approach can generate unintended consequences. As a 'double-edged sword', incentives and penalties may undermine staff morale and induce stress; incentivize physicians to ‘hunt’ certain goals as delineated by a pay-for-performance system, while neglecting other aspects which are not incentivized.
- At the institutional level, the use of financial incentives to reward performance can work well if the performance indicators are well-designed and balanced to take into account the many facets of the provider's work. These duties can include clinical duties, research, administration and education, amongst others.
- Incentives can also be directed towards patients to encourage preventative and proactive behaviors. For example, if patients undergo regular health screening, they may receive subsidized health services or discounts off their health insurance premiums.
- In low resource settings, careful consideration needs to be given to the misuse and overuse of services associated with low base salaries for health practitioners. With the growing spiral of patient expectations, health practitioners often find themselves climbing the ladder of defensive medicine and inappropriate care. Most commercial pay-for-performance systems use hybrid approaches that combine fee-for-service payment with payment bonuses, or tag aspects of provider performance with specific measures on quality and patient satisfaction.
- Financial incentives work best when carefully targeted to a specific population, set of services, or health condition.
- Payment incentives should not only be based on absolute measures of achievement aimed at encouraging high-performing health service providers to maintain a high level of care, but also focus on encouraging performance improvements at all levels of service providers. Pay-for-performance systems can impact on the dynamics of the patient-provider partnership. The health practitioner making clinical judgment often becomes the client of the institution rather than the patient.
- Current fee-for-service models offer little incentive for providers to deliver efficient care. The model is limited in that it pays for health-care services rendered, but does not pay for care coordination or counselling and health education. Other forms of payment (e.g. capitation) each have their strengths and limitations. Ideally, payments should be designed based on health outcomes rather than inputs and volume, with due consideration to productivity and ensuring that access to health-care services is not compromised.

2.3 Country-level discussions

Recognizing that each country is at a different stage of the quality journey and subject to different path dependencies, there will not be a one-size-fits-all solution. Day 2 of the policy roundtable comprised of in-depth discussions with participants from each of the six Member States that participated in the policy roundtable, and they include: Cambodia, China, Lao PDR, Mongolia, Philippines and Viet Nam . There was WHO Country Office participation from Cambodia and China.

A short summary on the in-depth discussions is provided in Annex 4.

WHO and WHO Country Offices will work together on the highlighted challenges and issues with Member States to provide country support, and assist to help improve quality in health services and patient safety. It was recognized that WHO can support sharing of good practices for quality by

sourcing for and documenting country case studies for sharing and publicising at both regional and international platforms.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

Countries in the Western Pacific Region have shared challenges in improving the quality of health services. Overall there was consensus on the need to improve the quality of health services. While there are commonalities identified across countries, especially those at similar stages of development, countries must ground their assessments based on their specific context and challenges, their population profiles, the human and financial resources available, priorities for health and determine their own national quality agenda.

Key policy and practice trends, along with critical issues and several good practices, were identified. The four key policy instruments used to address quality and patient safety issues discussed were: (1) adverse event reporting and monitoring; (2) the utility of clinical guidelines, professional standards and quality committees; (3) regulation of quality in health services; and (4) the use of financial incentives to improve quality.

1) Adverse event reporting and monitoring. Several countries who have established a national level adverse event reporting and monitoring platform and system shared the challenges they faced during the development journey, which provided insights to other countries in the midst of the development process. A few key challenges were common to many:

- The culture of open reporting requires trust, and trust takes time and effort to build up, but can be easily breached and undone. This form of culture-building needs to start at the institution level, in a bottom-up approach.

- Lack of a good information management system to help ensure that professionals, who report errors, maintain anonymity, and separate the two processes of corrective investigation, and disciplinary investigation.

2) The utility of clinical guidelines, professional standards and quality committees. There are several options to ensure quality in clinical services. Clinical guidelines, is one of the most widely used tool – but there are huge variations in the quality of these guidelines. Sometimes a lot of effort is spent in developing guidelines, which are subsequently not used or referred to. Other tools that can be used are: professional standards, set by professional councils or health-care institutions; and the use of quality committees within hospitals or large primary care providers, to set context-specific standards and guidelines. Quality committees can serve as useful second-layer to review cases where quality of care is poor or unsafe. Some key takeaways from the discussion were:

- Development of clinical guidelines requires investment of expertise, time and resources. These should be preferably undertaken by professional associations, with support of professional councils and endorsement by Ministry of Health.

- Professional and ethical standards serve a licensing function, and are different from guidelines. When developing guidelines, committees should consider the legal status of these documents, and whether the guidelines can be used in legal proceedings.

- It is useful to have quality committees in hospitals and large group practices, but the quality of these committees need to be strengthened through training and system-level changes. At the national level, a platform for sharing amongst institutional quality committees can help more quickly diffuse good practices and lessons learnt.

3) Regulation of quality in health services. Regulations for quality can be addressed at various levels of the health system, from national level regulation by the government, to co-regulation by professional councils, to internal workplace regulations, to regulation by national insurance agencies. Regulations at various levels need to be coherent and work together to achieve good quality in health services. Licensing and accreditation of health facilities and providers are important tools in regulation. A few key themes emerged during the discussion:

- Governments need to develop and strengthen both regulations and regulatory capacity, and improve coordination and collaboration with wide range of regulatory stakeholders, to be efficient, improve compliance and change practices.

- Accreditation can be done by national agencies or independent organizations, and is a versatile tool to raise the benchmark for quality.

- Establishing clear standards and regulatory processes aids with regulatory monitoring and enforcement.

4) The use of financial incentives to improve quality. How to use of financial incentives to improve quality is a difficult decision to get correct. Poorly designed financial incentives can lead to unintended actions and consequences – and the misuse, overuse or underuse of clinical services. Sometimes the financial incentives are not a deliberate part of the system design, but they exist, and a situation analysis is needed to effect change. A few key discussion points:

- At the institutional level, the use of financial incentives to reward performance can work well if the performance indicators are well-designed and balanced to take into account many facets of a professional's work. These duties can include clinical duties, research, administration and education, amongst others.

- Designing financial incentives for institutions and groups of providers is efficient, and can be effective if there are good and transparent measures of performance, and there is a strong information management system.

As health services expand in order to keep up with increasing demand for health services, it is important that systems and processes are in place to ensure access to quality health services. Even with financial protection, there is no assurance for better health outcomes if not enough attention is given to quality in health services.

Everyone has a role in achieving UHC and quality in health services – patients, families, communities, practitioners and provider organizations must all be engaged. Countries need to ensure that the fundamental issues such as licensing of health practitioners based on professional standards, accreditation of health systems, and adverse event monitoring and reporting are in place. Providers and governments must work together to create an enabling environment through sound policy and legislative frameworks to encourage good quality and safe practices.

3.2 Recommendations

1) WHO is recommended to assist and work closely with Member States to:

    a. Develop system(s) for adverse event reporting and monitoring of medical errors and near-misses.

    b. Strengthen regulatory capacity and capability for quality in health services and patient safety issues.

c. Strengthen professional councils and associations and enable them to co-regulate health-care professionals.

2) WHO is recommended to engage with Member States and regional experts to further develop the evidence base for best practices in regulation for quality and patient safety, with a specific focus on clinical standards, licensing and accreditation.

3) Follow up with a similar flagship regional meeting on quality and patient safety, involving policy-makers and technical experts, to review issues discussed during this policy roundtable, and raise new trends and issues on quality and patient safety for discussion and sharing.

Annex 1: List of Participants

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Annex 2. Programme

POLICY ROUNDTABLE ON QUALITY IN HEALTH SERVICES

WPR/DHS/ISD(1)/2015.1
25 SEPTEMBER 2015

Hong Kong SAR (China)
28-29 September 2015

ENGLISH ONLY

PROGRAMME OF ACTIVITIES

TIME	SESSION	MODERATORS
Monday, 28 September 2015		
7:45–8:00	**Registration**	
8:00–8:30	**Welcome, Opening Remarks and Introductions** [30 min] *Welcome / Administrative Announcements* *Opening Remarks & Objectives of the meeting* *Introductions*	Clive Tan Vivian Lin
8:30–8:35	Group photo [5 min]	
8:35–10:20	**Session 1: Overcoming challenges to improving quality in health services: what lessons can we learn from?** [105 min] *Group discussion with group sharing at plenary.*	Vivian Lin
10:20–10:40	*Mobility break [20 min]*	
10:40–12:40	**Session 2: Tools and strategies for quality improvement: what can be used by countries?** [120 min] Session 2A. Adverse event reporting and monitoring – does it help improve quality and patient safety? [60 min] Session 2B. Clinical guidelines, professional standards, quality committees – what works? [60 min] *Moderated panels for each topic [60 min per topic].*	Rasul Baghirov
12:40–13:40	*Lunch [60 min]*	
13:40–15:40	**Session 2: Tools and strategies for quality improvement: what can be used by countries?** [120 min] Session 2C. Regulation of quality in health services – government, insurers or professional self-regulation? [60 min] Session 2D. Relationship between financing and quality – how do you manage incentive payments? [60 min] *Moderated panels for each topic [60 min per topic].*	Clive Tan
15:40–16:00	*Mobility Break [20 min]*	
16:00–17:00	**Session 3: Summary and Conclusions** [60 min]	Vivian Lin
Tuesday, 29 September 2015 Secretariat discussion with country participants. Cambodia, China, Lao People's Democratic Republic, Mongolia, Philippines, Viet Nam		

Annex 3. Summary of discussions with country participants

WHO secretariat met with country participants on the second day of the policy roundtable to review proceedings of the policy roundtable, discuss the good practices that may be relevant for country, discuss implementation challenges and current plans for improving quality in health services. The following summaries of countries is informed by a desk review of available literature, and discussions with country participants at the policy roundtable.

Cambodia

Cambodia's health system is in a period of transition. Recent health reform efforts have focussed on strengthening the Ministry of Health's capacity to manage health-service delivery and move towards UHC. Cambodia's Master Plan for Quality Improvement 2010-15 outlines the roadmap towards an accreditation system, in which minimum standards and benchmarking are mainstreamed into the public health system. Given the wide range of possible areas for quality improvement, the biggest challenges for the Ministry of Health are the limited resource allocation for quality improvement programs, and the system capacity for implementation.

Discussion on current challenges for achieving quality in health services:

- Without an enforced government health regulatory framework, the rapid expansion the private health sector can lead to wide variation in quality of health services.
- While government funding for health care has increased significantly, it remains at only 1.4% of GDP. Out-of-pocket payments consist of 61% of total health expenditure. Most of these payments are made to private providers.
- Improvements in the collection and use of health care data can be made. Currently, there is no standardised reporting system for quality indicators. There is little publicly available information on the quality of care in both the public and private sectors.
- High dependence on donor funding, about 20% of Cambodia's total health expenditure. Donor funds may less sustainable once Cambodia's economy improves.

Opportunities for moving forward identified during discussion:

- The Complementary Package of Activity (CPA) establishes the service package and resource requirements for public hospitals. It can be built upon to include standards for quality and safety. With the growth of private health facilities, there will be need and opportunity to strengthen institutional regulatory mechanisms for licensing, quality and safety standards, and methods to evaluate the safety and competence of the private sector.
- There are opportunities to build upon some early analysis work being prepared on the feasibility of developing an accreditation system, as a step-up for health facilities to improve standards, after meeting the basic licensing requirements.
- Health professional councils such as Medical Council, Dental Council, Nursing Council, Midwifery Council, Pharmacy Council and other professional associations can take on more responsibilities and act as co-regulators to define and enforce standards to improve quality health care.

China

China's 13th Five-Year Plan for Health Sector Development (2016-2020) emphasized public hospital reform as a key area of work, and states that it is working to address challenges of accountability, quality and regulation. In terms of quality, health administrative departments at all levels and medical institutions focus primarily on the management of medical malpractice and medical safety. Comprehensive and integrated statistics at national level on health care quality are required to inform quality improvement activities. A Medical Service Management and Guidance Center was newly established in 2015 to promote standardised quality and safety standards in hospitals, support inspection and supervision, and strengthen data collection and analysis.
Key discussion points included:

Discussion on current challenges for achieving quality in health services:

- A large population and wide geography with variation in the level of developments in health services. The process of changing behaviour and introducing new concepts is slow and takes time, more so in a big country.

- Data collection for quality indicators at hospital-level has been introduced since 2008, but data collection is still incomplete, and not reliable.

- While acknowledging that quality is important, there are concerns that over emphasis on quality may negate gains made in improving access.

- Historically, the strong central government leads change; as a result, non-government organizations (NGOs) and civil society organizations are relatively weak. However moving forward and in the face of increasing complexity, government needs to partner with NGOs and societies to make sustainable improvements to the system. Currently the government is working closely with the Chinese Medical Association (CMA), Chinese Medical Doctor Association (CMDA), Chinese Hospital Association (CHA) and Chinese Dental Association (CDA) in moving forward with agenda.

Opportunities for moving forward identified during discussion:

- Quality may be a good entry point for looking at the health sector reform that ties together key issues of public hospital reform, primary care strengthening, financing for better access and quality.

- Developing mandatory adverse event monitoring and reporting system(s) to cover both public and private healthcare providers. National oversight of near-misses and adverse events allows for learnings to be shared.

- Engaging with stakeholders at all levels (patients, families, communities, health service providers, governments) to generate awareness and knowledge of quality and patient safety and build a shared understanding of quality issues. Alignment between government agencies is required.

- Strengthening data collection and information management system(s) to support monitoring of performance and design of payment incentives.

Lao People's Democratic Republic

Lao People's Democratic Republic has seen health gains due to strong political commitment to develop the health system. The results, however, have been mixed and gaps remain between policy intentions and effective implementation. Quality of care and healthcare provider responsiveness has

yet to improve substantially. There is ineffective coordination and management, particularly at the district and sub-district levels. Funding for health is heavily reliant on out-of-pocket payments. Expansion of social health protection schemes to all informal workers remains a significant challenge for government.

Discussion on current challenges for achieving quality in health services:

- While the 'Law on Health Care' (2005) sets out the legal and regulatory framework for quality of health care, operationally there are challenges of low awareness of regulations among the population and lack of enforcement.

- A policy aimed at improving the quality of private health services through accreditation and licensing has yet to be fully implemented. The emerging private-sector providers are currently only loosely regulated by the Government, and dual practice is common among public sector doctors.

- Currently there are no policies to ensure quality at hospitals; some better hospitals have their own organization-level policies to ensure quality.

- Changing how hospitals work is difficult, partly due to the financing structure. Hospitals work with line item budgets. Ministry of Health needs to approve any budget re-allocation, and the process of policy approval at the Ministry-level can take a long time .

- Government does not have funds for quality related work and developments, so most of these work are donor-funded and donor-driven.

Opportunities for moving forward identified during discussion:

- For 2016 to 2025, the government plans for more emphasis on quality, establishing stronger networks in healthcare, upskilling of the health workforce and strengthening of healthcare regulations.

- Accreditation standards for health professional education are currently being considered. A regulatory mechanism to manage health care providers and health professional education is also being planned for.

- There is an existing quality improvement project in Vang Vieng district that is pending evaluation, and can be scaled up if feasible.

Mongolia

Within the context of overall health reform, Mongolia has been emphasizing the development of quality systems to improve management, efficiency and clinical outcomes and processes. Quality of services is considered one of the health sector’s main directions in the Health Sector Strategic Master Plan for 2006–2015. Mongolia has established a framework for quality assurance, with the Ministry of Health taking a lead role in developing and promulgating materials and organizing training. A key focus has been on creating a governing system for quality in the health system with processes instituted at the hospital level and upwards in the health structure. In addition, the Mongolian framework has developed a range of indicators to guide the quality process. In 2015, the national strategic plan on hospitals, which covers quality and patient safety issues, was approved.

- Ministerial Orders were issued to establish quality committees in hospitals (2000), mandatory internal monitoring for quality of medical services by hospitals (2010) with oversight by the National Committee for Quality Assurance and mandatory national adverse event reporting to Ministry (2012).

Discussion on current challenges for achieving quality in health services:

- While government has mandated that all hospitals must have a quality committee and quality unit, government does not have enough financial resources to provide training for quality and patient safety. There is low level of understanding for quality and patient safety issues – and there is a need to help build shared understanding and common language in this area.There is also no system for sharing of quality and safety issues across institutions.

- A national adverse event collection system was established in 2012. There were 300+ errors reported in 2013, but only 190 reports in 2014, and only 30 reports in 2015 by September. There is a lack of trust in the system, and many hospitals do not report. Also there is no system to close the feedback loop: ministry also does not analyse the reports and provide feedback to the hospitals.

- Changing how government funds quality is difficult because of the lack of good data on quality and costs, and such changes need high-level approval by parliament.

Opportunities for moving forward identified during discussion:

- Strengthening data collection and information management system(s) to support monitoring of performance and design of payment incentives. There may be opportunity to consider how data collection by insurance agencies can assist in providing costing information.

- Developments to change funding mechanism and governance structure of hospitals to become more semi-autonomous hospitals. Hospitals are provided line item budgeting and case-based insurance payment based on DRGs (currently there are 115 categories).

- Quality training for hospital staff to maximise use and build on established quality committees. Sharing of quality and safety issues should also be facilitated across institutions.

- In Ulaanbaatar city, Ministry is exploring how public-private-partnership (PPP) models in health can work better to improve outcomes and efficiency.

Philippines

Health sector and hospital reform programs instituted by the government have yielded some positive results. In 2008, the Department of Health established a national patient safety policy which mandates that hospitals must have patient safety committees. In progressing towards UHC, PhilHealth has been important for improving coverage for the general population, and in particular, the vulnerable population groups. PhilHealth accreditation standards – the Benchbook – provided a push for quality improvement among hospitals as it emphasizes not only structure, but also process and outcome. In the Philippines, there are high rates of post-graduate training for hospital managers and health leaders. The Department of Health provides funding support for hospital managers to go for further training, and there are strong education institutions that provide courses in this subject.

PhilHealth has also started the adoption of clinical practice guidelines, developed by specialty societies, Department of Health, or international organizations, for the most common causes of members' reimbursements. To date, PhilHealth has adopted clinical practice guidelines on the following conditions: hypertension, pneumonia, urinary tract infection, asthma in adult and children, dengue fever, diarrhoea, dyspepsia, and acute bronchitis.

Discussion on current challenges for achieving quality in health services:

- Since 2008, safety incidents are reported to the hospital management, but there is no national level reporting, and no cross-sharing with other hospitals.

- Philhealth faces the long-standing issue of paying for unnecessary admissions and over-use of services, which is a difficult area to regulate.

- Despite the presence of social insurance, more than half of the total health expenditure still comes from household out-of-pocket.

Opportunities for moving forward identified during discussion:

- Despite the limitations at the national level, good practices exist at the hospital level to improve quality of care, which can be shared, if the right platform can be developed. For example, the Philippines Children's Medical Center has 3 committees to manage its patient safety issues:
    - Patient Safety and Occupational Committee
    - Pharmacovigilance Committee
    - Blood Products and Adverse Event Committee

- Department of Health has a Quality Scorecard which forms the basis of allocating subsidies. It can be further developed to track hospital performance indicators, and potentially used to incentivize quality.

- Indicators for hospital performance are of interest to the Department of Health, Philhealth and hospital leaders.

Viet Nam

Viet Nam faces strong challenges in ensuring quality in health services in the face of strong private sector growth. The government has made significant strides: In 2013, a Ministry of Health circular mandated that hospitals must have a quality management system, and established that the hospital director will be the chair of the quality committee. Hospitals are also provided with non-monetary incentives for quality improvement – there is an annual award for the 10 best hospitals in Viet Nam , highlighting hospitals with comprehensive quality improvement developments, with smaller awards in smaller, individual categories. Viet Nam has established a national hotline for the public to provide feedback on any issue with regards to the health system[2]. There is now a system for collecting and monitoring data for quality indicators, comprising of 84 standards, and 1,500 sub-indicators.

Discussion on current challenges for achieving quality in health services:

- On registration and regulation of health workforce, the current system allows for local registration by local health authorities, and registration is based primarily on academic qualifications. Registration only occurs once, and does not require renewal. This creates challenge for regulation for better standards and quality.

- There is concern about the drop in quality of undergraduate education, due to system incentives. Anecdotally there have been reports that patients do not want to be examined by medical students due to lack of trust, and clinical tutors are not keen to teach medical students due to the incentive structure.

- Quality in health professional training is an area of concern. Qualifications of teachers, methods and teaching facilities are often inadequate. There is no consensus on standard performance indicators to serve as benchmarks for appropriate training objectives and program development.

Opportunities for moving forward identified during discussion:

- Viet Nam plans to develop a national health accreditation system within the next five years. There are decisions that have not yet been made – whether to make it a government agency or an

[2] The top three reasons for feedback are: (1) Human relations, (2) lack of communications, and (3) provider does the wrong thing.

independent agency. While currently there is a provision for hospitals to be accredited by international accreditation bodies, such as the JCI, setting up a national accreditation system will ensure better coverage and make accreditation more accessible to more providers.

- Strengthening Social Health Insurance System and changing how hospitals are funded is a key area of work. Viet Nam aims to have 80% of its population covered by insurance by 2020, with plans to shift away from line item budget for hospitals, and moving towards funding insurance which will disburse money to hospitals using a case-based system. The system will need a strong review mechanism to prevent misuse and over-provision by providers.

- There are plans to set up a mandatory adverse event reporting system to cover both public and private healthcare providers. A new unit in Ministry of Health will oversee this, and Viet Nam is being advised by NICE UK for this development.

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