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REGIONAL POLICY AND STRATEGY FOR ENSURING QUALITY OF CARE, INCLUDING PATIENT SAFETY

Introduction

1. Quality^{*}, including patient safety, is an aspect of health care essential for attaining national health objectives, improving the health of the population, and ensuring the sustainability of the health system. However, despite the efforts of the Member States, major challenges in quality persist in the more developed and developing countries alike (1-4). This document proposes five strategic lines of action for improving the quality of health care and patient safety, with emphasis on the most vulnerable population groups. It also proposes the creation of a regional quality observatory to monitor the preparation of a consensus-based regional quality strategy.

Background

2. Poor quality health care imposes a very heavy burden on society and health systems. The Annex presents selected indicators of the quality of health care and patient safety in the Region of the Americas. Lack of quality is manifested in many ways, including:

- (a) Ineffective health services; that is, services that do not obtain the expected health outcomes. This problem is expressed in unjustifiable inconsistencies in clinical practice, inappropriate or unnecessary care, and a high percentage of care inconsistent with current knowledge in the profession. In the most extreme cases, lack quality makes the health services unsafe, causing physical or human harm--a

* The Institute of Medicine of the United States defines quality as the degree to which health services for individuals and populations (1) increase the likelihood of desired health outcomes and (2) are consistent with current professional knowledge. To this definition should be added the subjective component of quality, which is users' perception of quality.

- situation that has led to an increase in lawsuits against health professionals and health services alike. At the regional level, examples of the lack of quality are the excessively high rate of maternal and neonatal mortality, hospital infections, irrational use of drugs, and surgical errors.
- (b) Inefficient health services; that is, services with higher costs than necessary for obtaining the same outcome, a phenomenon that contributes to an excessive increase in health expenditure without a corresponding improvement in health service performance. This implies an opportunity cost for the health service, siphoning off resources that could be invested, for example, in expanding service coverage to the most unprotected populations. The limited response capacity at the first level of care is a paradigm of inefficiency because of the pressure it puts on hospital emergency rooms and consultations at higher levels of complexity.
 - (c) Poor quality is also expressed in limited access, marked by administrative, geographic, economic, cultural, and social barriers and indifference about employing the gender perspective in health service delivery.
 - (d) This situation is manifested in long waiting lists, clinic hours out of synch with users' schedules, excessively long distances to health centers, lack of drugs in health centers, and services inappropriate to the cultural and social context/preferences of citizens.
 - (e) Finally, another expression of the lack of quality is the dissatisfaction of users and health professionals with the health services. Citizens complain, for example, about abuse, lack of communication, and the inadequacy of health facilities. Moreover, health professionals and health workers suffer from a lack of motivation, excessive work loads, and in the most extreme cases, burn-out, which further contributes to a deterioration in the quality of the service provided.
3. Lack of quality has many causes and involves failures at the systemic level and in the delivery of personal health services.
- (a) At the systemic level, the following contribute to poor quality: (1) failure to give quality priority and make it part of the health sector reform agenda; (2) deficiencies in the frameworks for quality regulation; e.g., technical regulations and standards, accreditation, certification, and licensing systems, and posters indicating patients' rights and responsibilities; (3) insufficient material, human, and financial resources or their complete absence; (4) lack of information systems for adequate resource management; (5) financial transfers or provider payment mechanisms that are not linked to performance and health outcomes, and (6) low

technical, ethical, and human standards in undergraduate and graduate training programs.

- (b) In the delivery of personal health services, poor quality is caused by: (1) lack of motivation among health workers; (2) weak competencies and technical skills; (3) the absence of teamwork and trust; (4) a paternalistic model of care in which users are not involved in decision-making; (5) poor working conditions, and (6) lack of professional programs and programs to update professional skills.

Progress Report

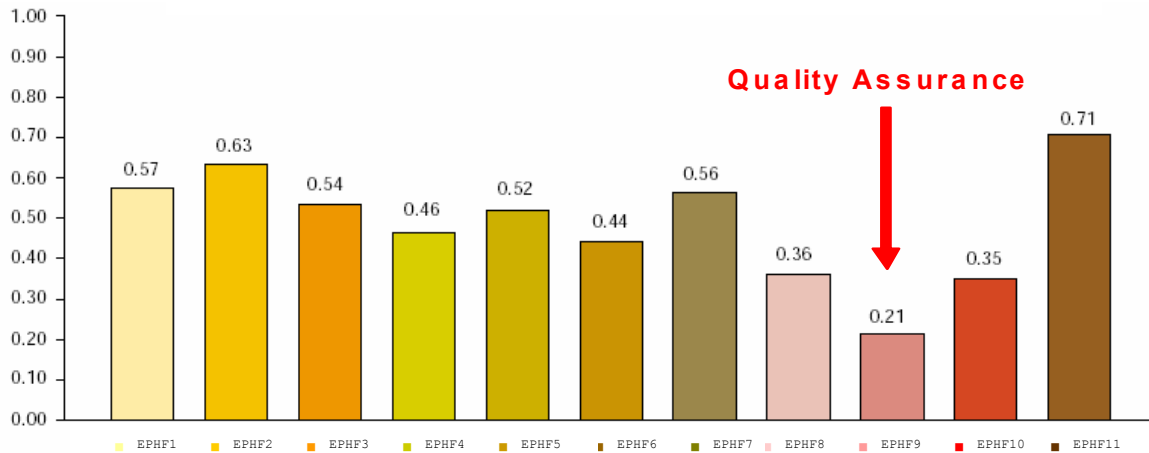
4. In recent decades, several countries in the Region have launched major quality and patient safety initiatives. For example:

- In February 2001, Mexico launched its “National Quality Campaign,” aimed at improving the quality of services and raising it to acceptable levels throughout the country.
- Peru has introduced a national accreditation system for health centers, with a new initiative to be implemented in 2007.
- Argentina has numerous institutions dedicated to improving quality and a national program for “licensing by category.”
- Costa Rica has spearheaded the commitment to patient safety activities.
- Brazil has carried out important quality assessment exercises and promoted improvement strategies in areas ranging from accreditation to the promotion of patient safety.
- Colombia has a system for reporting adverse events in health care.
- Chile has a wide range of initiatives for controlling infections associated with health care.

5. PAHO/WHO activities to promote quality include the 1992 publication of the manual *Hospital Accreditation for Latin America and the Caribbean (5)*, which was widely accepted and used in the countries of the Region. In 2000, a ninth function was added to the essential public health functions (EPHF) initiative: “Ensuring the quality of personal and population-based health services.” This was significant at two levels. First, it gave the State responsibility for safeguarding the quality of care in both the public and private sector. Second, it outlined the specific components for the performance of this function, including the continuous quality monitoring, health technology assessment, the development of standards, and application of the scientific method in evaluating health

interventions. In the 2002 evaluation of the EPHF, the ninth function received the worst marks (6) (see figure below).

Figure 1: Performance of the EPHF in the Region of the Americas (6)



6. In May 2002, the 55th World Health Assembly (WHA) adopted resolution WHA55.18 “Quality of Care: Patient Safety,” which urges to the Member States “to pay the closest possible attention to the problem of patient safety” and to “establish and strengthen science-based systems, necessary for improving patients’ safety and the quality of health care...” In response to this resolution, in 2004 the 57th World Health Assembly proposed to the creation of a World Alliance for Patient Safety (WAPS), which was launched by the Director-General of WHO in October of that same year at PAHO/WHO Headquarters in Washington, D.C.⁴

7. In response to this global initiative, PAHO/WHO has aligned its quality improvement strategy with the objectives of WAPS. In May 2006, the First Regional Workshop on Patients for Patient Safety was held in San Francisco (USA); here, professionals and patients from the Region formed an initial network of regional leaders. In March 2007, the first regional workshop of WAPS’ first Global Patient Safety Challenge, “Clean Care is Safer Care”, was held in San José, Costa Rica. Also in March 2007, the first working meeting of the IBEAS, Research for Patient Safety Project was held in Buenos Aires, Argentina; the project’s objective is to determine the frequency of adverse events in a sample of over 20 hospitals in Argentina, Colombia, Costa Rica, Mexico, and Peru. The IBEAS study is a collaboration between AMSP, PAHO/WHO, and the Ministry of Health and Consumer Affairs of Spain.

8. Other regional initiatives include the Iberoamerican Cochrane Network for evidence-based medicine, the Iberoamerican Network for Quality guides, the Central

American EPQI Network for continuous evidence-based quality improvement, and the Expert Nurses Group on Patient Safety.

9. Despite the progress cited earlier, quality improvement still poses a real challenge for the Region, not only because of the persistence of the problems associated with the lack of quality, but because of the multiple concepts and approaches for improving it (1-7). This heterogeneity, combined with the lack of available information, hinders the development of a shared conceptual framework and the setting of intervention priorities. Moreover, the limited evidence on the cost-effectiveness of quality improvement strategies poses a dilemma for decisionmakers regarding which policies and strategies will have a greater impact on health outcomes (1).

Proposal

10. The current context and regional situation call for a regional strategy to improve the quality of care and patient safety. This strategy should include continued health care for patients, families, and communities and target the most vulnerable population groups and health priorities outlined in the Millennium Development Goals (MDG). Designing this strategy will require an exhaustive situation analysis together with a regional consultation. The strategic lines of action for this effort are defined below:

(a) Make the quality of health care and patient safety sectoral priorities

- Political dialogue with national authorities to make quality and patient safety part of sectoral policies and health sector reform processes;
- Active participation and advocacy in global and regional forums;
- Signing of political commitments for action (By December 2008, at least 20 Latin American and Caribbean countries are expected to have signed the commitment to the first Global Patient Safety Challenge, “Clean Care is Safer Care;”
- Identification and orientation of leaders—“ambassadors”—for quality and safety in health care;
- Advocacy to include quality and patient safety in the curriculum for training health workers.

(b) Promote citizen participation in matters related to quality

- Encourage definition of the rights and responsibilities of citizens and health professionals in the areas of quality in health care and patient safety, including the handling of privacy, confidentiality, and emotional security;
- Use of tools for evaluating user satisfaction with the health services;

- Encourage the creation and strengthening of citizen initiatives to improve quality and patient safety, as well as their links with decisionmakers, managers, and professional societies (By December 2007, at least five countries are expected to have participation initiatives of this type.)

(c) *Generate information and evidence on quality*

- Production and pilot testing of a tool for measuring quality and patient safety in health centers (Final report anticipated in December 2008.);
- Compilation of information on quality and patient safety and its availability through virtual media;
- Development and encouragement of priority lines of research:
 - Status of quality initiatives in Latin America and the Caribbean through a literature review and survey of key informants (Anticipated publication of results: October 2007);
 - Patient safety (IBEAS study) (Anticipated publication of final report: March 2008);
 - Effectiveness of hand-washing solutions (Final report expected in June 2008); PICK strategy for the prevention of kernicterus, and retinopathy prevention in premature infants (Final report expected in December 2008).

(d) *Develop, adapt, and support the application of solutions in the field of quality*

- Compilation and dissemination of the existing material, models, and tools for improving quality, including continuous improvement and quality assurance models, in addition to the publication of a manual of methodologies for quality and safety in health care and specific manuals on hospital infections;
- Training in the use of quality models and instruments through online courses such as those of the Iberoamerican Network of Quality Guides, on-site training activities in collaboration with WAPS, quality courses from the Spanish Agency for International Cooperation, and creation of the Central American EPQI Network, promoted by the University of Tohoku, Japan, etc;
- Technical assistance in the formulation, improvement, and implementation of the national quality and patient safety programs of the Member States;
- Promotion of the sharing of experiences among Member States.

(e) *Develop a Regional Strategy for improving the quality of health care and patient safety with a 10-year horizon. The methodology will be based on a regional consultation that will involve health authorities, leaders in the field of quality,*

experts, and other relevant actors. The plan will include the development of a consensus-based conceptual framework for quality and patient safety and a regional plan of operation at four levels: country, groups of countries, corporate, and multiagency. The strategy is expected to be finalized in December 2008.

11. The aforementioned strategic lines will prioritize the most vulnerable population groups, especially those specified in the MDGs. The areas selected for the maternal and child group include maternal mortality, neonatal infections, prevention of retinopathy in premature infants, and the prevention of kernicterus. Priority will also be given to various health issues, such as hospital infections (the objective of the First World Challenge of WAPS 2005-6); safe surgery (the objective of the Second World Challenge of WAPS 2007-8); and safe technologies and drugs (based on PAHO/WHO's current work in these areas).

12. This proposal also includes the creation of a regional observatory of quality in health care and patient safety, made up of the national authorities responsible for quality, academicians, citizens' representatives, international cooperation agencies, and other NGOs. This observatory, whose activities are slated to begin in December 2007, will have the following functions:

- Generate, analyze, and disseminate information and solutions with respect to quality;
- Help make quality fundamental to the effectiveness and sustainability of health systems;
- Promote the sharing of experiences and solutions between the Member States of the Region and other regions of the world;
- Mobilize resources for quality initiatives;
- Support development of the regional strategy on quality and patient safety.

13. This proposal is part of the AMPES THS.0051 project "Improvement of Quality Services" in the Biennial Budget 2006-2007 of PAHO/WHO, designed to focus efforts on helping the Member States to raise the health status of their populations and individuals and overcome access barriers with respect to quality goods and services, particularly in vulnerable populations. The proposal, moreover, is part of the Proposed Strategic Plan 2008-2012 under Strategic Objective 10 (SO10), "To improve the organization, management, and delivery of health services," and the first Region-wide Expected Result (RER) is "Countries supported to provide equitable access to quality health care services, with special emphasis on vulnerable population groups, and with health services that reflect recognized standards, best practices and available evidence".

14. Total confirmed net resources for development of the strategy during the period June 2006 to 2008 come to US\$ 839,000. Some 98% of the funds are from extrabudgetary financing, with the sources as follows: 52% from AMSP/WHO, 42% from Spanish cooperation (as a component of the Health Program in Ibero-America 2005-2007), and 4% from other agencies (Joint Commission-Joint Commission International, Parents of Infants and Children with Kernicterus-PICK). Spanish cooperation is also financing the hiring of a full-time associate quality expert. Finally, efforts are under way to mobilize additional financial resources, again with Spanish cooperation and also with AMSP/WHO, the U.S. Government's USAID, the Government of Japan (JICA), and the Mériex Foundation.

15. This proposal also involves collaboration with several national and international centers. Some of the most important are:

(a) The Joint Commission-Joint Commission International, the official collaborating center of the AMSP/WHO for the design of solutions in patient safety.

(b) Other centers with whom activities are under way and/or we have active relations, such as:

- The Quality Agency of the Ministry of Health and Consumer Affairs of Spain, and its collaborating institutions (the Universidad Española and regional health services);
- The International Society for Quality (ISQua);
- The Latin American Federation of Hospitals (FLH);
- The Argentine Society for Quality Care (SACAS);
- Argentina's Technical Institute for the Accreditation of Health Facilities (ITAES);
- EPQI Initiative of the University of Tohoku, Japan;
- Quality Assurance Project (QAP), University Research Co., LLC.

Action by the Executive Committee

16. The Executive Committee is requested to consider these strategic lines of action and support the creation of a regional quality observatory, and also to recommend steps that could be taken to improve the quality of care, including patient safety.

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Annex

**Selected indicators of quality in health care and patient safety
in the Region of the Americas**

| Functions and Indications of quality | Selected indicators |
|---|--|
| State regulatory function in quality assurance ^a | <ul style="list-style-type: none"> - Only 49% of the countries indicate that they have national policies on quality; only 30% have an agency that regulates health technologies, and only 22% autonomous accreditation bodies. ^a - Only 43% of the countries apply quality standards. ^a - Only 27% of the countries have measured progress in quality improvement. ^a |
| Indications of ineffectiveness | <ul style="list-style-type: none"> - In Brazil, the proportion of deliveries via caesarean section was 41.8% in 2004.^b - A productivity analysis of some hospitals in the Americas found that the number of laboratory tests per discharge ranged from 2.1 to 22.8 per discharge. |
| Indications of inefficiency | <ul style="list-style-type: none"> - 51% of hospitalizations are for problems that could be handled on an outpatient basis or at the first level of care. ^d - The cost of nosocomial pneumonia associated with mechanical ventilation in a Guatemalan hospital was US \$1,758 per case, or 2.5 times higher than cost of care for a patient who does not contract this infection. ^e - In Brazil, Passarelli et al ^f report that hospitalization was prolonged by 10 days in cases of adverse reactions to drugs. |
| Indications of a lack of safety | <ul style="list-style-type: none"> - At a university hospital in Brazil, 61% of elderly patients admitted experienced at least one adverse drug reaction. In approximately one-quarter of these cases, inappropriate drugs had been administered. ^f - At a third-level hospital for respiratory pathologies in Mexico, 9.1% of hospitalized patients suffered adverse events associated with the care received. Of this group, 17% suffered temporary disability and 52% required a longer hospital stay; in 26%, these adverse events were a contributing cause of death. Some 74% of these events were considered potentially preventable. ^g - At the Teaching Hospital of Honduras the prevalence of hospital infections in services under surveillance was 10%.^h - In Peru, Ministry of Health hospitals, the incidence of surgical wound infection is 2.1 for every 100 deliveries by caesarean section,, and puerperal endometritis, 1.19. ⁱ |
| Indications of lack of access | <ul style="list-style-type: none"> - In the Central American Isthmus, only 59.1% of deliveries are attended by trained professionals. ^j - In municipios in northeast Brazil, at least 10% of the women who used the health services in the three months prior to the evaluation were dissatisfied with the access. ^k |

^a PAHO/WHO. Public Health in the Americas: New Concepts, Analysis of Performance, and Basis for Action. Scientific and Technical Publication No. 589; 2002. ^bPAHO/WHO. Draft of the ECP of Brazil. OPS/OMS; 2007. ^cOPS/OMS.ACODESS. Ministère des Affaires Étrangères. République Française. La Transformación de la gestión de hospitales en América Latina y el Caribe. Washington, D.C.: OPS/OMS; 2001. ^dPAHO/WHO, Estudio Regional sobre e Assistência Hospitalar e Ambulatorial Especializada na América Latina e Caribe. Document THS/OS/04/2; 2004. ^eSalvatierra-González, R.M. Costo de la infección nosocomial en nueve países de América Latina; Washington, D.C.: PAHO; DPC/CD/271/03; 2003. Available at: <http://www.paho.org/Spanish/AD/DPC/CD/eer-amr-costo-infec-nosocomial.htm>. ^fPassarelli MC, Jacob-Filho W, Figueras A.; Adverse drug reactions in an elderly hospitalised population: inappropriate prescription is a leading cause. *Drugs Aging*. 2005; 22(9):767-77.

^gHerrera-Kiengelher L, Chi-Lem G, Baez-Saldana R et al. Frequency and correlates of adverse events in a respiratory diseases hospital in Mexico city; Chest. 2005 Dec;128(6):3900-5. ^hKafati R. Informe de actividades de vigilancia de infecciones intrahospitalarias 2006. In: I Regional Workshop on Clean Care is Safe Care. San José de Costa Rica, Costa Rica. 2007. ⁱCárdenas F. Infecciones intrahospitalarias en el Perú. In: I Regional Workshop on Clean Care is Safe Care. San José de Costa Rica, Costa Rica. 2007. ^jPAHO/WHO, Health Situation in the Americas. Basic Indicators. PAHO/HDM/HA/06.1; 2006. ^kAtkinson, S. and D. Haran, Individual and district scale determinants of users' satisfaction with primary health care in developing countries. Soc Sci Med, 2005. 60(3): p. 501-13.

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