How quality improvement in health care can help to achieve the Millennium Development Goals

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A recent article in *The Lancet* analysed the barriers to reaching the Millennium Development Goals (MDGs) concerning maternal health, child health, tuberculosis, malaria and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).[1] Inappropriate provider behaviour, insufficient case management, limited management capacity, and referral and communication failures were identified at the service delivery level; at the policy and strategic management level, insufficient coordination between actors, weak links between programmes, and inappropriate use of information were mentioned.

Looking at this evidence from a quality improvement angle is particularly interesting. The majority of the barriers described by the authors relate to the classic quality dimensions that define a quality service (in both delivery and management): to be effective, efficient, accessible, timely, acceptable, evidence-based, equitable, safe and client centred. For example, inappropriate provider behaviour often results from a lack of patient orientation, unacceptable and ineffective communication, and the non-application of evidence-based standards.

If the majority of barriers to health-related MDGs can be seen as quality-related, quality improvement approaches may be able to tear down some of them. Quality improvement means any process or tool aimed at reducing the quality gap in systemic and organizational functions according to the dimensions of quality. The basic principles of quality improvement are common sense: customer focus, strong leadership, involvement of people, process approach, system approach to management, continual improvement, factual approach to decision-making, and mutually beneficial supplier relationships.[2] There is evidence that these basic principles can contribute to the improvement of health service delivery in developing countries: an article in this issue of the *Bulletin* describes how some of them have been used to improve the emergency care of children in several countries.[3]

If we accept that quality improvement can make a difference in service delivery and management, we should look at how we can make this happen on a large scale and what the determinants are for the successful introduction of quality improvement approaches. Although quality improvement is already an aim of the vast majority of health sectors, there are still numerous problems linked to the introduction of approaches in developing countries.

In many countries the choice of quality approaches is driven by the attraction of brands and by small lobby groups rather than by a rational decision-making process — consequently, they are often not adapted to the country's reality. As an example, the introduction of sophisticated hospital accreditation brands from competition-driven rich countries to poor district health systems rarely leads to the desired outcome, as rural inhabitants often have no alternative to district hospitals and market forces are limited.[4]

Furthermore, the lack of an overall vision is leading to fragmented quality landscapes in many countries: most pilot schemes have not grown to national coverage and system-deep penetration.[5] Evidence for the impact of quality improvement is sparse and — because of the complex change processes — difficult to create. Transferability and results of approaches are contextual, so decision-makers have to rely on considerable judgement.

The majority of the above-mentioned barriers to the MDGs are linked to process quality and not primarily to a lack of resources. Many of these processes are system functions (e.g. coordination or reference) that can be carried out only by different organizations working together. Recent experiences from Guinea (Conakry) and Morocco have shown that home-grown quality improvement approaches can address these system functions and processes with good results, based on the generic principles.[5–7]

Through system-wide approaches that focus on different types of organization at the same time, the system coherence can be addressed.[6] System coherence can be understood as the capacity of a system to behave "like just one organism" and can be seen as a major determinant of a system's steerability.[8] Steerability is a measure of to what extent management and delivery organizations in a sector are following strategic guidelines. To increase the capacity of a system to absorb major vertical interventions, system coherence and steerability represent important assets.

Systemic approaches to quality improvement should focus on complex capacities such as the integration of different programmes on management and service delivery levels or a "quality culture". In contrast, specialized vertical functions such as disease control programmes should be linked with added-on quality control measures.

Finally, the level of process quality of an organization can be used as an indicator of the capacity to absorb investment measures. In this way, systemic quality approaches may offer adapted mechanisms for resource allocation and donor coordination.

To mobilize the potential of quality improvement in the quest to achieve the MDGs, countries should carry out participative processes to design or choose system-wide approaches fitting their context. This should be done based on the generic principles of quality improvement. WHO is preparing a document to assist countries in the process of choosing interventions to increase quality in health systems. ■

References

Web version only, available at: http://www.who.int/bulletin

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