The Challenge of Quality Improvement in Our Health System

Prof. Dr. Isuf Kalo

Quality in health as a concept, as a demand and as a measurable indicator of success has long been forgotten or underestimated. Just a few decades ago, it has entered in its dictionary and programs. Yet it is still perceived as an optional innovation, but not as a necessity and priority to it.

The same thing happens in our health system. The challenge of structured quality improvement, security and performance started too late, in 2006 with the establishment of QKCSA-ISH. Thereafter, it began to be mentioned more often in political, managerial and professional rhetoric; but mainly as a sermon and desire, not in a concrete way and not in a consistent manner with the major objective of the health reform.

In fact, health systems are not perfect nowadays. They have impressive achievements but also serious defects and serious deficiencies. And there is a need for quality review and improvement. They almost do not differ from each other by the universal principles and their guiding values. But they differ from the architecture of functionality and especially from their performance and quality. And this from one country to another, and also strangely between countries of the same community as those of EU.

Interest for the quality was added to health sector when its unjustified variations emerged in services of the same type. And even differences between analogue institutions within the same state and even within the same city. The comparison, for example, carried out by QKCSA for the quality of the same services in the two maternity hospitals of Tirana, having the same mission and the same resources resulted in some of the best quality in one maternity and some others to the other maternity.

This proved the existence of subjective factors and the unequal utilization of available resources and potentials. The improvement of quality in health was due to

the need to recognize and eliminate such barriers and at the same time to maximize the use of resources at the institutional and system level.

The philosophy of improvement is based on a progressive positivist paradigm: not merely correction of defects and blaming for the consequences the ones who caused it, but the identification and promotion of the demonstrated and certified practice as the best. And its reward. First of all, the "champion" examples of quality should be identified, discovering their success secrets and then spreading them to other institutions in and out of the country. The same paradigm is proposed recently in the Security field, where the "Safety 1" method focusing on identifying and correcting mistakes and failures is being replaced by "Safety 2", which instead utilizes, disseminates and promotes proven and successful practices that are actually many times larger than the first one.

This is not an original method of health system. It is borrowed by the industry, which has implemented it many years before it. In a simplified form, healthcare quality means "doing what it takes properly, to the right patients, at the right time and price". Applied in different fields and populations, this philosophy created in itself great aspects and great research methodology. Currently, quality improvement in healthcare sector has gained scientific character as a new field of study in terms of health systems with architecture and different opportunities.

Trust or measurement?

It is a fact that quality has traditionally been somewhat a naïve approach based on access a priori to white coats professionals. Trust based on the diploma they possess and a code of ethics known as the Hippocratic Oath, in which the doctors vow to do the best for the patients. So they left the "best possible" thing in their hands neither measured nor verified. The quality of services was judged based on opinions, rumors, or advertisements.

Meanwhile, the unified metering tools ("meters", "scales") were both missing (as unnecessary) as for quality and performance, which made it impossible to evaluate and compare objectively the quality among analogue institutions. As a consequence of the reckless, unrecognized and unpublished, good quality and bad quality services of analogue institutions, are still treated and rewarded equally in public healthcare sector.

Parameters that were measured, reported and rewarded in health system generally referred only to the quantity, volume and spectrum of health activity, but not to their quality. One of the reasons was that the measurement and evaluation of the quality was not liked neither by the professional elite nor by the leadership and managerial elite. A priori trust was by itself more preferred than measurement.

They could put the real results of the qualitaty in front of the mirror in relation to expectations by the population.

The situation was changed by the free health market. In its demand-offerings apart from the quantitative side, consumers also rightly ask for the "label" of the quality, cost and security of the services they pay. The unmeasured "good" it is not a without fail good thing. In our healthcare market the quality is still unverified and its "label" is generally absent. This leaves room for abusive advertising which lead to the disorientation of consumers. Establishing them and regulating new free market relations with quality and real cost remains for us a heavy burden like Sifiz.

Illusion and resistance

It should be said that one of the most widespread illusions regarding the goodness of the general health is that money is the only way forward. It is not quite so. The best quality is mainly given by people themselves, as passionate and motivated individuals, or more often in programmed interaction with partners and other interested parties. Medical care is the human product that is created and offered mostly by man to man. Undoubtedly, quality improvement, both at institutional and system level, requires an initial financial investment. It is necessary to create the concepts, the strategy, tools, methods and culture of measurement and improvement. But this investment returns a few years later by reducing unnecessary excessive expenditures, lost from incorrect quality practices and not effective. Health systems, including ours, are like a container with many holes, from where too much money flows in vain. The most frequent current barriers to quality improvement in our health come from: conservative thinking, indifference, lack of recognition, arise from resistance, inertia of the inherited routine, wrong subjective decision making and unfounded in scientifically evidence. They also come from discouragement and disbelief for success. They appear whenever it is attempted to move from a lower quality level A to the highest quality B.

Regardless of how they disguise it, such resistance is encountered both at local and central policy and decision-makers, elite health professionals, managers, hospital and ambulatory medical staff, health insurance agencies, patients and our passive citizens. While in principle and rhetoric they are all in favor of quality, they virtually expect it as a gift from someone else and not as one of their own duties.

The best quality efforts in our healthcare context were not limited to making it possible to measure and verify. Measurement only gives figures. The goal of quality movement is not just photography but continuous improvement, not just one episode. Improvement is created only if it is acted upon. It begins with the creation

of the first good quality embryos and examples. Not acting like it will fall from the sky; either wait to be imported or donated by someone.

The first action step is consensus with all stakeholders and partners of the "good quality" definition according to our understanding and expectation. What will be the targeted values and parameters ?

According to the American Institute of Medicine, "good quality" consists of 6 basic features or values: **Health Care** safety (minimizing mistakes and risks during medical practice), clinical effectiveness (in diagnosis and treatment), patients at the center (respect their rights), efficiency (maximizing results with the available resources) and equality (non-discrimination, unbiased) in the provision of services. No health system can accomplish those at once and should therefore be selected and focused on those selected as priority.

Standardization without implementation

In this context in 2005, thanks to the cooperation with WHO and the World Bank, a consensual strategic document for quality development in our healthcare was produced. The focus was on three main features selected: safety, effectiveness, and center-based patients. Based on this strategy, the QKCSA-ISH (National Center for Quality, Safety and Accreditation of Health Institutions) was established as a new structure that would lead the process, provide concepts, vision and create quality measurement tools and at the same time improve its methods. At the same time, they would encourage, coordinate and support the expertise of their institution-building activity under the leadership and executive authority of the Ministry of Health.

The QKCSA activity has been successful in the strategic conceptual aspects and the creation of tools and methods for improving quality and its progress is evident.

It is worth mentioning here apart from the national strategy, that for the first time (even the first in the region) of a set of standards, for measuring the quality and institutional performance necessary for licensing and accreditation of hospitals and primary centers, dental services, pharmaceutical and laboratory services. Also, the establishment of the first network of specifically trained institutional coordinators and the drafting of a methodological strategy for designing UPK and PPK best clinical practice. CBSA-ISH has produced and distributed a considerable number of materials, methodological documents, books and toolkits, rights charts and methodologies, instructive documents and structures to promote its concepts to healthcare staff and empower patients and citizens as the best quality active partner. It has organized national and international conferences every year with recent issues regarding quality of our health and beyond, where achievements and problems are presented, also challenges for the future.

Unfortunately, the implementation process from healthcare institutions, in terms of using and implementing these methods and concepts, tools and materials has been sluggish and deceptive. QKCSA-ISH has promoted, trained and produced but had no executive and enforcement powers in the center and or institution level. The Ministry of Health has them.

Lack of Quality Mechanisms and Culture

The inactivity in the implementation of available tools and methods highlighted the need to develop a culture of quality and responsibility and motivational mechanisms for its development, both in white coat professionals and our local institutional leaders and managers. The culture of quality means the disagreement with the bad quality and the conscious commitment to improving it within everyone's reach in the daily practice of healthcare links.

It has already been proven that measuring and evaluating quality in healthcare institutions can be technically correct from the outside, but its substantial and continuous improvement can only be accomplished and achieved by inside actions from the dedicated and motivated staff.

The European Association of Physicians in 1994, in its resolution, recognized the responsibility and protagonism of white coat professionals towards "quality" as the leader of the movement towards the best. "Providing health care with the highest possible quality,- it is said in it,- constitutes an obligation of the health profession ". Whereas WHO, in 1998, proclaimed the continued assurance of the best possible quality as a "healthcare obligation to a legitimate right of the sick people".

But quality improvement also requires innovative methods and specific tactics, which should be recognized and applied scientifically and creatively under the specific conditions of each institution. One of the essential principles is stop sporadic actions and say no to propagandistic campaigning with the quality as a façade, but with a plan and seriousness, with stages in order to achieve the best targets. The next condition is the creation of a favorable, intra-institutional climate with a motivation for better quality. Prior to the preparation of the terrain, the lack of the necessary devotion to quality towards excellence in institutions, it shows that numerous attempts do not yield fruits. QKCSA is offered to help with expertise in them but unfortunately institutional receptivity is not in its best place. The ringer of the quality clock has still not ringed to them. And not only to them.

Experiences prove that good quality is achieved not by decrees or by dictates, nor by preaching or by fear and punishment. Commitment for it arises first in the mind, in the heart and in the professional and institutional attitudes, mainly

as an ethical and cultural element. Then It is furtherly developed through the example of the best practices, demonstrated as “champions”, which inspires and then encourages imitation and race to overcome qualitative levels among them.

The father of quality in healthcare A. Donabedian insisted that “Quality is Love”. According to him nothing qualitative cannot be realized unwillingly, without love and passion and without feeling inwardly the need for it. But the success or failure of quality programs is also determined by a pragmatic element such as the existence of correct or incorrect use of incentives, motivating and rewarding to “militant” and enthusiastic individuals, be they ethical incentives, honorific, career promoters, or why not even financial.

From the network of first volunteer quality coordinators formed by QKCSA-ISH through special trainings in hospitals and health centers of our country, unfortunately only in very few places, they kept the enthusiasm still heated. Most of them were “extinguished” in the ice of the indifference of the leaders of the institutions, who changed one after the other without being acquainted neither with the dictionary of the quality, nor with the merits, efforts, achievements and precious values of these first admirable pioneers.

Still far away from the desired quality

However, it has come the time that our quality health should be seen not as a luxury or as a secondary issue, but as an unfulfilled debt and obligation to our patients and our citizens. Unfortunately, it has not been rated as such. Out of the three strategic objectives of quality, **safety, efficiency and patient satisfaction**, selected since 2006: none has been achieved. Even though there have been taken some steps forward, our health system remains far from the objectives of a qualitative system.

One of the causes has been that the cause of quality has generally been misunderstood, sometimes even misused. Variations and all-around activities often serve as quality enhancing equivalents. Under the name and with the cause of quality, projects and initiatives without real connection with quality have been fabricated. Quality means moving towards the verified best. Not every “change” turns out to be such. Some of them concede towards regression.

Obstacles to a long-term process of inconsistent continuity such as quality improvement have been also the politicization or more precisely the “politically lead” of our health system expressed by the heavy circulation of heterogeneous leaders with unusually subjective and nihilistic attitudes, among them that turn everything useful at reaching the zero point of resumption. The shine in our health looks like it has walked on the tango forward and backward like the knit – unknit process of Penelope’s fabric...

Some recommendations aimed for improvement would be:

- Our current healthcare steps towards the best quality should be preserved without drawbacks.
- Tracking the predetermined milestones in the strategic document. Walking slowly is more justified than hurrying and changing the direction of the new wrong paths.
- The focus of improvement should be on the processes of internal “soft” aspects of the activity and not in the structure, in the drugs and in the technology acquired as it has been so far.
- The direction needs to be decentralized and based on multi-partnership. Systematic accountability and institutional autonomy should be installed. Participation and contribution of patients and citizens should be strengthened. And the provision of medical care and “decision making technology” at all levels of the system should not be based on subjective “expert” or administrative and political opinions, but on scientific evidence.
- Today’s health system is offers multiple risks for patients. Minimizing risks, mistakes and damaging is urgent in order to avoid unsafe medical practices.
- Accreditation of quality in institutions, especially of hospitals, should not be done with campaign, without the preparation of its success in achieving the required standards. The culture of quality and security in our institutions is still very low. Leaders and staffs are not motivated.
- Accreditation should not produce fictitious certificates, but true, verified, deserved quality level. The Ministry of Health should not interfere and patronize the accreditation process. The Accreditation Council should be autonomous in decision-making and not under the tutelage of the Minister of Health. Otherwise, the QKCSA will have to become independent, as a self-financing public good.
- Actually, our public health institutions, as well as private ones, need to be urgently and compulsorily subject to the licensing process, meeting minimum mandatory standards to be allowed to function. Their condition makes them ineffective and risky, therefore unsafe for the life and health of citizens.
- The “Quality Label” (Accreditation) should be transformed into the key instrument of our healthcare market, in serving citizens’ (customers) to give them the possibility to select and perform the best, safest, most cost-effective healthcare purchases for them.

Bibliography

1- Charles D Shaw & Isuf Kalo :A backgraund for national quality policy in health systems, 2002
2- World Health Organisation :Quality of care :A proces for making startegic choises in health system,2006
3-WHO-Eastern Mediterranien:Quality Improvement in primary health care, 2004
4-National Department of Health :National Core standarts for health establishements in South Africa, 2011
5-Andrea Gardini : Verso la Qualita ,modeli per migliorare l'assistenca sanitaria, 2004
6-Juliette Malley:Measuring the quality of long term care in England , Eurohealth, 2, 2010
7- QKCSA-ISH : Standartet e Cilesise per Akreditimin e Spitaleve , Kujdesit paresor, Sherbimit Framaceutik , Stomatologjise dhe Laboratoreve klinik ne Shqiperi , 2008
8-Anne L.Rooney, Paul R.Van Ostenberg: Licensimi, Akreditimi dhe Certifikimi,1999
9- US Institute of Medicine : To Err is Human , 1999
10- US Institute of Health :Crossing the Quality Chassme , 2001
11- Isuf Kalo e bp :Toolkit per zbatimine standarteve te cilesise ne kujdesin shendetesor
12-Isuf Kalo : The current Albanian health system : pains and hopes , 2005
13. Charles D Shaw,Helene Crisp ,Isuf Kalo ; National Strategy for quality improvement in Albanian Health system , 2006
14- Anne Lacroix, Jean Philippe Assal: Aftesimi per vetmjekim i pacienteve me semundje kronike , 2003(i perkethyer ne shqip)
15- WB Project :A National Strategy for development of clinical gudlines in Albania, 2008
16- Isuf Kalo : Shendetesia jone si do e doja , 2015
17-Marck Suhrcke , and coll:The economic costs of ill health in the Europian Region,2008
18-Bruno Bouchet:Monitoring quality of primary care , 2006
19-QKCSA-ISH : Karta Shqiptare e te drejtave te pacienteve , 2008
20-ACER –Albania 2008 :Annual Review of Health sector Performance and Financial cost estimationfor HSS Implementation (2007-2013)

Focus On Health Or Illness?

Promotion and Prophylaxis Reports with Diagnostics and Measurement

Prof. Dr. Eduard Kakarriqi

The two "kingdoms" of medicine are **community medicine (or public health or preventive medicine**) and **clinical medicine**. While in **clinical medicine** the actor is the clinician and his client is an individual-patient, in the community medicine, he is an epidemiologist and his client is the community, that is - the population, *understood not as a numerator of only individuals-patients, but as the plural of all individuals community or population components*.

Clinical and community medicine differ essentially between them. While clinical medicine decides the diagnosis through anamnesis and physical examination of the individual, community medicine determines the diagnosis through estimation of population patterns. On the other hand, while clinical medicine treats (cures) the individual, community medicine uses programs for the treatment of specific population groups. These differences dictate the undertaking of efforts to achieve the equiliber (balance) between the community and the individual.

The basic question "The focus should be on health or the disease?" of this talk is a question, the answer to which would essentially embody questions such as "What is health and what does healthy mean " and "what is the disease and what does 'sick' mean related to the 'natural history of the disease'? "; "What is community medicine (or public health) and clinical medicine, and what is the relationship between them: controversy or interaction?"; "What is the 'gnosis' process in public health (community medicine) and clinical medicine related to etiology or causality ('diagnosis'), and prognosis?"; as well as "What is the prevention of the" natural history of the disease "and what is its relation to public health (community medicine) and clinical medicine?". These questions, which actually express the reports of health promotion and prophylaxis of community medicine, i.e public health, diagnosis and treatment (cure, treatment) of clinical medicine, and vice versa.