



Training of Health Professionals for Quality Health Care

P.T.

Jayawickramarajah*

ABSTRACT

This paper presents an overview of Quality Assurance (QA) movement in health care and education. Initial steps taken to introduce the concept of QA in Nepalese context is outlined. Some specific educational interventions are given as illustrations. Since complex health care systems lose sight of the need for quality of performance in the midst of organizational routines, an attempt has been made to relate quality of training to practice. The need for inclusion of QA in health professional training is emphasized.

Keywords: Quality assurance; Human Resources for Health; Indicators; Training; Problem Oriented Medical Record; Medical Audit; Nursing Standards.

INTRODUCTION

The importance of Quality Assurance (QA) in health care is now of growing interest to many countries, stimulated by the universal problem of increasing costs and concern about access and quality of health care. However, in most instances health care planners and providers are unaware of basic concepts of quality assurance and relatively untrained and ill prepared to participate in quality assurance activities. Even the terminology used in quality assurance varied in detail between different countries.

When one considers the usual models from USA and UK, due to differences in the health care systems quality assurance is also considered in different ways. In USA health care is more commercialized. Quality assurance has been promoted by those who pay for care i.e. government and insurance companies as well as those who make profits. Since it is the doctors who spend the money, their work has come under scrutiny through quality assurance programmes designed for cost containment. In contrast in the UK, the National Health Service is a public service

* MBBS (Colombo), MEd (Illinois), PhD (Groningen), PhD (Southampton), FCollP, World Health Organization, Kathmandu, Nepal

Adapted from a paper presented at the Regional Workshop on "Quality Assurance", Far Western Region, Dhangadhi, Nepal, 9-11 March 1999.

funded by taxation with costs controlled at the source, and the rigor of quality assurance is less intense. In the developing countries, Malaysia and Singapore introduced quality assurance programmes in their health care systems about a decade ago. Quality assurance programmes have been also strengthened in the health care systems in Middle Eastern countries. Since we are still in the initial stages in the development of quality assurance programmes in Nepal, it is important to consider this concept in perspective.

Quality of care encompasses several factors, including patient's comfort, satisfaction, responsiveness to complaints, quality of service and clinical outcomes. Medical Audit is thus a systematic critical analysis of the medical care provided, including procedures used for diagnosis and treatment given. Standards for nursing practice have been set in different countries. Nursing profession has developed a range of analytical, rational and intellectual skills necessary for nursing care. An initial document on Nursing Standards for Nepal was developed in 1991. In addition, there have been a few developments towards QA in Family Planning, Safe Motherhood, Tuberculosis, Laboratory services and quality of Drugs supplied to the health sector. Quality assurance and Medical Audit requires a good Health Management Information System (HMIS) to support it. Nepal has already taken initial steps for development of such a system.

HRH Planning

This paper is focused on training of health professionals for quality health care. The Human Resources for Health (HRH) system is a sub-system in the overall health care system. The health care system involves static and dynamic elements. The static elements involve hospitals, beds, nurses, doctors, population ratio etc. The dynamic elements involve the policy making and decision making process, staffing patterns, performance standards, etc. The flow of information, resources and decision making between the static and dynamic elements is activated by the HRH mechanism involving planning, training and utilization of health workforce.

Nepal is in the process of systematic planning for HRH development. There is increasing recognition that HRH planning is an integral part of comprehensive health planning. The three components; planning, production and management are being brought into closer relationship with each other. There is definite national political will on the part of His Majesty's Government for an integrated process of HRH development. This could be seen from the establishment of HRH unit in the division of HIMDD directed by an inter-sectoral policy making body with key actors from the health and education sectors, proposed to be chaired by the Hon'ble Minister of Health. However, implementation of the Health Policy of HMG, and the HRH Master Plan is not an easy task in a young democracy with inherent and dynamic political uncertainties.

The 1993 HRH Master Plan has all the necessary elements of systematic planning. It provides a situation analysis at a point of time from available data sources, and HRH supply and demand projections (updated in 1996) based on the combination factors including needs, targets, expert opinions and policy statements in the 8th health plan. The development and acceptance of the HRH master plan by the government is a major part of planning, with production of human resources and utilization, as aspects of its implementation. The need for quality assurance in training HRH and health care delivery has been made explicit in the recommendations of the 9th health plan developed in 1998.

In general, quality assurance involves systematic identification and assessment of problems for setting standards towards attainment of better health care. The activities and arrangements comprise of determination of deficiencies in infrastructure, client/patient's needs and performance of health workers. A major reason for non compliance with standards by health workers is lack of knowledge, skill or awareness. Continuing education could reverse this situation (1). In order to improve quality assurance, awareness of the need for improving quality of services, transfer of knowledge and information on quality assurance and enhancement of the ability of professional associations to assume a proactive role is essential (2).

Education and Training

However, it should be noted that unlike planning, production of HRH requires the longest preparation period. This process is subjected to certain inherent inertia, due to rigidity of the health and education systems with vested interests on either side. If quality health care is to be assured HRH should be made available at the proper time, planned for in advance in the right amount and type no more and no less is needed.

Generally the crude population ratio, needs and targets, manpower equipment ratio, and geographic distribution are taken into consideration in deciding the numbers to be trained in the various categories. A careful analysis of all these factors should be considered by the planners in revising HRH projections.

In Nepal the HIMDD has already taken steps to bring education and health institutions closer in taking policy decisions on HRH development at all levels and match service needs to curricula and learning methods;

Utilization of HRH

In order to maximize utilization and management of HRH, a computerized inventorization of HRH programme (HuRDIS) is being completed with GTZ assistance. Training programmes in management are being undertaken with WHO assistance. Coordination of Strengthened District Health System (SDHS) and HRH development is underway to implement and learn from new and modified systems at district level. At the interphase judgements on training and

utilization have to be based on the following factors:

- a. the relevance of training;
- b. the nature of refresher training;
- c. the quality of supervision;
- d. the clarity of job-description;
- e. the scheduling and sequencing of tasks;
- f. the degree of job-satisfaction; and
- g. the availability of supplies and equipment.

Efforts to improve productivity and utilization must depend on the judgement of experienced group of health planners and educators. Career development plans and continuing education activity should be planned on the basis of performance and potential appraisal of programmes.

Quality assurance programmes in this area should consider **staff characteristics**; young/old, male/female, service/ teaching functions, commitment to HMG/ Private practice **staff productivity**; service per unit of time. i.e. number of vaccinations per day, number of teaching session per day etc. and **staff movements** transfer, promotion, deputation etc.

Specific training interventions for quality assurance

It should be emphasized that WHO has been in the fore front of facilitating change towards quality assurance in health professions education from the early 1970s through establishment of satellite Regional Teacher Training Centres (RTTCs). The Reorientation of Medical Education (ROME) movement involving regional consultations by SEARO is an endeavour

towards this goal. The various indicators developed by the ROME group provides the yard sticks for evaluating quality of education(3). A few specific instances on how "quality assurance" could be implemented in the educational system, would be useful to internalise the concept.

In a residency training programme at George Washington University in USA (4) a peer review process focused on:

- a. needs for the programme;
- b. goals, objectives;
- c. evaluation process;
- d. programme status;
- e. status of former trainees;
- f. selection process;
- g. institutional concerns, and
- h. academic training and research.

The review process was undertaken using questionnaire, observations and interviews. Such peer reviews have helped in the quality assurance of different departmental academic programmes in the hospital. To cite an example an internationally recognized department was placed on probation because of the temporary loss of one of the faculties in the department, which decreased effective teaching time and supervision. This example is relevant in the context of programmes conducted by newly established private medical schools, Council for Technical Education and Vocational Training (CTEVT) and Post Graduate Medical Education Programmes in Nepal. The Nepal Medical and Nursing Councils have initiated guidelines for accreditation of educational programmes.

Another example in training undergraduate and post-graduates could be cited from the review of records to evaluate the extent of quality care given to patients. An example of this is Problem Oriented Medical Record (POMR)(5). In this format, medical audit using a standardized format with following components have been used.

- (1) **Problem list:** Identifies all relevant clinical problems including active and inactive problems.
- (2) **Defined data base:** Problem specific information, and routine information relevant to patient management.
- (3) **Plan of action for each active problem:** Investigations; therapy; and patient education.
- (4) **Progress notes for each problem:** Data base; assessment, and plan.
- (5) **Discharge summary:** Follow up, Medication etc.

This format could be considered at the interphase of training and health care.

Implication for HRH development

An important aspect of quality assurance is cost containment in educational programmes. In the recent past educationalists have been advocating (a) Multi professional education (b) multidisciplinary laboratory and (c) library networking to provide quality educational programmes aimed at cost containment. Developing countries should plan their programmes, taking into consideration, factors involving effectiveness and efficiency of educational programmes.

For better health care, medical audit and evaluation of performance of health workers based on set standards should become part of the essential structure of health care provision, leading to an accepted spirit of inquiry among the health professions. Such an attempt should foster spontaneous reflection of their work based on consensus arrived at good practices and an analysis of variations shown in their performance against standards. Health professional schools should therefore include quality assurance activities in their curricula.

QA in educational contexts requires an organizational frame work within an institution which will ensure that operational procedures will be carried out. In higher educational institutes there is a need for a formal committee structure with clearly defined procedures to be followed in relation to:

- planning, approval and review of courses;
- analysis of performance indicators for courses, including the intake characteristic of students, wastage rates and final results, and the follow-up of these statistics;
- obtaining feedback from students on their learning experiences;
- obtaining feedback from the employers of graduates on the appropriateness of the knowledge and skills acquired in the courses;
- analysing external examiners' reports;

- accepting and responding to external inspection from relevant professional institutes or associations, and
- implementing a staff appraisal and development scheme, including the provision of training in teaching;

Quality Assurance is, thus, an operational process which is carried out within an organizational framework that is conducive to , and supportive of, appropriate and effective teaching and learning (6)

There is also a need for training in "quality assurance" for both health care and educational planners. Such programmes could borrow models from other countries for training purposes. But Nepal should devise its own model of quality assurance programme and set standards based on needs, resource availability and feasibility. These regional workshops conducted by HIMDD are essential steps in the direction

REFERENCES:

1. Crosby F, Finnicks M, and Ventura M (1989) A Survey of Educational Needs of Nurses regarding Quality Assurance. *Journal of Nursing Quality Assurance* 3 (4): 72-82.
2. Feirman, H Stokoe P, Kim-Farley R (1996), The Role of Foreign Assistance in the Improvement of Quality Assurance, *Regional Health forum*, 1:1: 63-68
3. Indicators for Monitoring and Evaluation, 1991, WHO/SEARO Regional Publication No. 18, New Delhi
4. Greenberg L.W. (1993), Quality Assurance in Graduate Medical Education: A Peer Review Process, *Medical Teacher*, 15:2; 171-174
5. Jayawickramarajah P.T. (1993), Writing Clinical Notes in General Practice, *Journal of the Institute of Medicine*, 15:1, 100-104.
6. Stewart A, (1998), Quality Assurance: A Framework for Ensuring the Achievement of WHO thrusts in Medical Education over the past 25