SOCIETY FOR QUALITY IN HEALTHCARE IN NIGERIA

TRANSCRIPT OF 1ST MEMORIAL LECTURE

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Prof. Elebute's legacy has been affirmed through the establishment and the conduct of this Memorial Lecture. Prof. Elebute encouraged us to focus on the quality of healthcare in Nigeria during my service in the Federal Ministry of Health. He was a great source of inspiration. At that time we developed a Clinical Governance Initiative that lead to the National Quality Strategy, we also engaged SafeCare to work with Private Sector Health Alliance in Lagos State to do quality care collaborations in several primary healthcare centers in Lagos State. It is therefore no surprise that I continue in this line of work even after voluntarily resigning from the Federal Government in July 2013. The continuation of this work led me to Co-Chair with my Colleagues at Harvard, a Global Commission on High Quality Health Systems which was published in early 2018. The focus of this lecture is ***Reimagining the Future of Healthcare in Africa – A Healthcare Quality Perspective.*** I would draw much on the work we published in the Lancet Commission High Quality Health Systems, I will also draw from some of the recent works that we are undertaking on the Future of Health and Economic Resiliency in Africa. I will highlight the global challenge of quality in healthcare systems across countries, diverse incomes, why the global quest for universal health coverage is unlikely to lead to health outcome improvements without balancing the access with quality especially here in Africa. I will then end my lecture with a few recommendations for placing quality at the center of health systems in Africa, Nigeria as a starting point.

Firstly, I will start with a story published in The Nation Newspaper on April 12th 2016, The story of Mr. Udegu who accused Medical Doctors here in Lagos of professional misconduct resulting in the death of his 46 year old wife, Ngozi on March 20th 2016. Apparently, Mr. Udegu's wife had complained of severe stomach pain and she was rushed to the teaching hospital around 9pm at night where she underwent tests, scans, and the results were ready before 7am the following morning. Mr. Udegu took the results to the doctors and was asked to wait until the doctors were ready for ward rounds. The doctor turned up after about 90 minutes, checked the woman and said the scan revealed some Ulcer. The doctor prescribed Gascol and an injection that was unavailable in the teaching hospital. Mr. Udegu bought the drugs outside the facility, but no relief. The doctor later prescribed an intravenous medication and Mr. Udegu bought it, which was administered to the wife. The husband quoted that the emergency unit where his wife was had no light, no fan and no good ventilation. *"Daddy don't go"* were the last words his wife said. He was forced out of the word at 11pm that night. When he and his eldest daughter got to the hospital the following morning around 6am, he got the news that his wife had died. The doctor in charge said the woman died of Ulcer, yet an autopsy showed that she died of asphyxia (lack of oxygen in tissues). She died as a result of lack of quality in the system of care that she has been able to access.

The last 20 years have been the golden era of global health for those of us in Health. We have seen the world witness expanded access to the various social determinants of health and health services such as vaccination, anti-natal care, HIV, Tuberculosis, Malaria, and several millions of virus from infectious diseases and Maternal and child conditions. There has been less attention to non-communicable diseases, complex conditions such as cardiovascular diseases, diabetes and Cancer, and even less attention to the quality dimension in healthcare systems. Healthcare systems can drive significant reductions in pain and suffering, improve survival and promote the wellbeing of populations. The system comprises entities, processes and resources in the organized health sector, both public and private including frontline and community health services, the infrastructures, the finances whose primary purpose is to provide Healthcare for populations. The systematic examination of healthcare quality has also had a very long history. Many of the healthcare quality experts here know that it largely started from the work of Donabedian in 1966 who in an article proposed a framework for quality as assessment of medical care. He described quality along the dimensions of structure, processes and outcomes of care. Then later, Donabedian defined structure as the settings where care is provided, providers themselves and the organization of care with the process comprising of all the technical quality and the interpersonal care given to patients and the outcomes must be mortality reductions, disability reduction, deformity reduction and patient satisfaction. A few years later in the Institute of Medicine in the United States, the work that was led by Donald Berwick produced two influential quality reports; Crossing the Quality chasm and to Err is Human, which further spurred the examination of quality in the United States and other advanced countries.

Health services should be technically competent and include good communication, shared decision-making with the patient and also cultural sensitivity. The Institute of Medicine in those reports noted that 21st Century health systems should seek to improve performance on six dimensions of Quality, Safety, effectiveness, patient centeredness, timeliness, efficiency and equity. The Health System lens emphasizes that quality and particularly safety which Prof. was very passionate about is the responsibility of the entire health system.

In our work at the Lancet Global Commission on High Quality Health System, we took off on the back of the Institute of Medicine reports and put forth a definition of a high quality health system as one that optimises health in a given context by consistently delivering care. We saw health systems as social institutions rather than a collection of health services that are very discrete and fragmental; I believe the systems have the responsibility to offer consistent care to improve health and to adapt to changing societal needs. A high quality health system is underpinned by four values; People focus, Equity, Local specificity and Resilience. It also implies that the element of quality selected for measurement should be ones that matter to people. We have not done as well in terms of measurement of quality. At the health systems we have different instruments and different cultures. Our effort to build high quality health systems must be contextualized and we must realistically plan for improvement.

Our systems, traditionally, have been looked at as static entities, yet health needs and expectation are shifting sometimes very quickly, and you see that everyday especially in our country. We have seen how health crises like the Covid-19 pandemic acutely bring out the issue of resilience in health systems, lots of disruption of services seen in this country is huge. What we planned to do in Lancet Commission was to take the quality importance at the facility and also to look at it from a systems perspective. The definition that we laid out in that work led to a new perceptual framework. The framework that we put together said that health systems should be judged based on their

performance in the processes and impact of care and not only their capacity of care. The foundations of high quality health systems are critical prerequisites but are not direct measures of quality themselves. The foundation begins with the population; individuals, communities and families. Those should shape how the health system responds. At the system level, people should receive safe and timely care and be able to trust that their conditions will be detected and managed in an integrated manner. As such, systems should also be easy to navigate with very short waiting times and should pay attention to people's values and preferences. When people visit healthcare providers, they should be able to expect to receive basic care including detailed assessment, the correct diagnosis, appropriate treatment as well as counseling. Healthcare providers should treat all patients with dignity, communicate clearly and provide autonomy and confidentiality. High quality health systems also require strong governance particularly policies to regulate providers in both public and private sectors and also Accreditation which is part of what you are doing at the Society (SQHN). They should institutionalize accountability as part of these overall governance construct, using financing to promote desired outcomes.

Health systems that are of high quality would have the hardware, the medicine, all of those things that are necessary, and the soft stuff which is the quality mindset, supervision, feedback and the ability to learn from data. The story of Mr. Udegu and his late wife Ngozi is very sobering but it is the reality faced by millions of people all over the world and millions in our country and in the continent. The missed opportunities are seen in the domains of assessment, diagnosis, prevention, treatment and palliation. At our commission, we measured the maternal and child care across 18 countries. Findings showed that only 50% of history questions, tests and examination that were recommended by the WHO Guidelines were fulfilled during 81,000 patient consultations in those countries. Only about half of the women who were attended to, in terms of care given by skilled providers, across 29 low income countries reported having their blood pressure checked. This is very telling in terms of the gaps in assessment. It is not limited to basic frontline, reproductive, maternal and labour health. It extends to diagnosis of infectious diseases, tuberculosis, other cardiovascular diseases and screening for cancers. Poor quality laboratory testing and lack of adherence to recommended assessments by healthcare providers contributes to misdiagnosis and overall poor quality of care. Poor quality assessments may result from poor provider knowledge, poor effort or even short consultation time. At best, we can say that the quality of assessments in healthcare systems tend to be mixed, which is a huge issue. Diagnostic accuracy is often low with huge consequences for the patients and for their confidence, leading to delays and loss of time for serious conditions. When it comes to infectious diseases, wrong diagnosis can be fatal.

Quality care requires providing appropriate treatments, adhering to clinical guidelines. There are widespread evidences in many low income countries showing that many individuals who seek care in facilities do not get the appropriate treatments. Poor quality care is wasteful care from at least two angles; firstly, use of care that is not needed or from receiving care that leads to death or does not lead to improvement in patient outcome. Beyond the content of care, competent care also requires a range of system functions. There are five core domains of system functioning; safety as a domain itself, detection within the system, the continuity of care, integration. Safety concerns are pervasive in many of our health systems with lots of adverse events and unsafe care. I remember Prof. was very keen on the aspect of safety. Overall, unsafe care leads to lots of complications like urinary tract infections, Pneumonia which results in thousands of disabilities in low and middle income countries. Covid-19 has shown us the importance of hand washing all over the world, and I hope it stays because infections can be prevented by that. User

experience on care is also a fundamental element, in our commission we look at measurement of user experience; there are huge issues there as it is not convenient to measure, often times you might get a positive response because they do not want you to penalize them. It is really important that we are listening and being able to access the user experiences. The impact of poor quality in health systems is that population health outcomes will not improve. To improve health outcomes, the formula is Access multiplied by Quality. Not only can there be very harmful care, but also poor quality care leads to avoidance of care because they do not trust what they would get. Low confidence and trust undermines the ability to improve professional hazards. We estimated the main issue of medicine in our commission based on the work that Margaret coon had done which showed that the mortality burden in low and middle income countries was 7 million annual deaths globally, 2.6 million of those deaths are people who do not access the health system because they perceive low quality or other reasons, while 4.4 million people are estimated as those who showed up but received poor quality care. Based on the analysis that was done, there is a wide range of SDG conditions with 81% of poor quality deaths coming from cardiovascular diseases, communicable diseases. We estimated the lack of access to high quality healthcare will cost low and middle income countries in Africa cumulatively almost $11 Trillion in lost economic output between 2015 and 2030 which is representing a loss of nearly 3% of annual GDP in low income countries. With this as a background, the question of the state of health systems in Africa, I think we all will have a sense of where things are.

The reality is that many of our health systems are underfunded, what we put as investment in our health is really small. As a consequence health systems are poorly equipped, poor infrastructures and not well trained workers. To reimagine healthcare systems in Africa, I will like to put forth a few recommendations which can apply to Nigeria, as an example, to use the quality angle for transforming our health system at a structural level. The recommendations I would like to put forth for discussion are:

- National health policies must focus intentionally on both access and quality. Have deliberate strategies to measure and improve quality at scale. I mentioned what we did in the National Quality Strategy, which was an initial output to guide Federal Ministry of Health. The relevance of such a strategy I think remains and I think it should be financed from domestic sources, implemented by the Federal and State government and the Private sector. Where there are gaps, improve it. As part of the effort to improve governance, transparent, efficient and regulatory framework should be in place not only for medical products and services. The role of accreditation is very vital, but there are a whole lot of issues around regulation.

- Quality should be embedded within all pre-service and health work force training and continued professional education with a team-based and multidisciplinary approach. Measurement of quality, tracking and continuous improvement must be at the top of mind for health professionals and managers in our health system. Such training should include large doses of interpersonal element such as empathy.

- Increased domestic financing for health should be prioritized. Government should use those resources to invest in health infrastructure, ensuring adequate arrangement for maintenance, using digital technology to improve diagnostics and continuity of care in this day and age and to enable patients to be more active participants. Quality is not cheap; a country must invest in it.

- We must professionalize health systems management. Training clinicians with broader management and leadership skills, to be equipped to harness all potential areas of input, to manage processes and inspire the right attitudes among the team of health workers.

- Patient or health client must be repositioned to be at the center of the health system, we should listen to the voice of the patient and their experience in our healthcare facilities and respond accordingly. Respecting the view of the patient will restore their trust, it will also give our politicians the value of true appreciation of the population.

- Improving quality of health systems require robust public and private sector collaborations. Each bringing its complementary strengths and capabilities with health outcomes as a tune off. Constructive public private collaboration with the patient at the center with health outcomes is key to transform the system that we have, which is clearly not at the level that we want it to be.

In conclusion, healthcare access without quality is wasteful and also dangerous. It is unlikely to lead to improvement in health and it can make things worse. Focus on quality can be an arrowhead for transformation to realize a different future for health systems in Nigeria and in Africa.