

Political and technical barriers to improving quality of health care



With the currently renewed emphasis on universal health coverage, the study by Margaret Kruk and colleagues¹ in *The Lancet* is a timely reminder of the need to examine inadequacies in both access to and quality of health care.² Their key finding that poor quality of health care is a major driver of excess mortality in low-income and middle-income countries (LMIC) will not surprise those working in such settings.³ However, the authors' quantitative comparison indicating that improvements in the quality of health services would have a greater overall effect on mortality than expansion of service coverage (without attention to quality) provides new evidence to inform the resource allocation strategies of health policy makers and funding agencies. Indeed, excess mortality is only one of many adverse public health effects of low-quality health care. Other effects of low-quality health care include delays in diagnosis, which can result in transmission of communicable diseases or worse patient outcomes; inappropriate use of antimicrobials, which can cause drug resistance; and the incurrance of unnecessary costs by patients and health systems.^{4,5} There is clearly a strong case for taking steps to tackle provision of poor-quality health care. However, we believe that this issue does not receive the attention it deserves, largely because addressing quality of care is both technically and politically complex.

Health-care systems in LMIC are usually fragmented, and there are often many different types of private-sector and public-sector health facilities operating.⁶ These facilities range from large, modern hospitals to rudimentary for-profit laboratories in the centre of busy cities to rural roadside stalls that sell drugs and petrol. There are two key technical challenges to assessing and addressing the quality of care. First, there are inadequate basic data on the numbers and locations of health-care facilities to be assessed because there are so many health-care facilities and because of their vast geographical distribution. This challenge in compiling data on the range of health-care facilities is compounded by the limited resources available to support information systems in LMICs. Second, there are methodological challenges in assessing quality of care; such assessments would include adherence of providers to relevant

clinical protocols and provider-patient interactions. Research methods into innovative health systems that involve actors performing as patients and behavioural economics-based games are being applied, but the cost and logistical challenges of doing large-scale systematic studies, especially without access to a sampling frame of existing providers, should not be underestimated.^{7,8}

The substantial political challenges in acting against low-quality health-care providers are rarely acknowledged. Quality control issues occur in the public and private sectors, often with different factors driving resistance to change. In the public sector, for instance, replacing insufficiently qualified staff in primary health-care facilities can be met with opposition by powerful local policy makers, who want to have control over allocation of civil service jobs. The politics of controlling human resource management decisions was highlighted by our experience in Pakistan's People's Primary Healthcare Initiative (Sindh), which is a public-private partnership contracted to run almost 1200 basic health units on behalf of the Pakistani Government. In this context, we found that managers received threats to their personal safety for introducing a merit-based job application system.

There is growing evidence from many LMIC settings that for-profit providers often do not follow essential guidelines when diagnosing or treating patients,⁷⁻⁹

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For Pakistan's People's Primary Healthcare Initiative (Sindh) see <http://pphisindh.org/>



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and there is limited information on a way forward that addresses power dynamics and financial interests. Very often, public-sector staff (including senior doctors responsible for influencing policy) will additionally work in or own private health facilities to supplement low government salaries, which can result in a reluctance to shut down or limit the profit-generating services of such facilities.¹⁰ Further, taking strong measures to shut down poor-quality health-care providers could result in some regions having a sudden gap in access to any health-care provider. Local politicians who are aiming to get re-elected will be concerned that such measures could be unpopular with local communities that are unaware of the quality issues of their local providers, and that steps to curtail activities of private health-care providers might result in pressure on the government to improve public-sector services.

The analysis by Kruk and colleagues¹ is therefore an important initial step in providing evidence for the substantial public health benefits of improving the quality of health care in LMICs, but action on this evidence could be impeded by a vicious cycle: there are inadequate data at national and sub-national levels about providers that are operating and about variations in their quality. In parallel, there are political challenges to shutting down or limiting services offered by some low-quality providers, which allows this issue to be deprioritised in terms of evidence generation.

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