KINGDOM OF CAMBODIA

Nation-Religion-King

MINISTRY OF HEALTH

MASTER PLAN

FOR QUALITY IMPROVEMENT IN HEALTH

2010 - 2015

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ACRONYMS

ACC	Accreditation Committee for Cambodia
AGREE	Appraisal of Guidelines for Research and Evaluation
CAR	Council for Administration Reform
CBHI	Community Based Health Insurance
CDHS	Cambodian Demographic Health Survey
CME	Continuing Medical Education
CPA	Complementary Package of Activities
CPG	Clinical Practice Guideline
DDF	Department of Drug and Foods
DPHI	Department of Planning and Health Information
EBM	Evidence Based Medicine
GTZ	Deutsch Geselschaft für Technische Zusammenarbeit
HCMC	Health Centre Management Committee
HEF	Health Equity Fund
HI	Health Insurance
HRD	Human Resource Development
HRH	Human Resource for Health
HSD	Health Service delivery
HSP	Health Strategic Plan
HTA	Health Technology Assessment
IMR	Infant Mortality Rate
ISQua	International Society for Quality in Health Care
MBPI	Merit Based Performance Incentive
MMR	Mother Mortality Rate
MOEF	Ministry of Economic and Finance
MOH	Ministry of Health
MPA	Minimum Package of Activities
MTR	Mid Term Review
NGO	Non Government Organisation
NIPH	National Institute of Public Health
NMCHC	National Maternal and Child Health Centre
PHD	Provincial Health Department
PMG	Priority Mission Group
QAO	Quality Assurance Office
QI	Quality Improvement
QIWG	Quality Improvement Working Group
RTC	Regional Training Centre
SOA	Special Operating Agency
UF	User Fee
UHS	University of Health Sciences
VHSG	Village Health Support Group

FOREWORD

The Second Health Strategic Plan 2008-2015 (HSP2) designates five strategic cross-cutting areas for the implementation of three health program areas in which health service delivery is the first strategy. The National Policy for Quality in Health outlines the roadmap towards an accreditation system, in which minimum standards and benchmarking are mainstreamed into the public health system. In line with the policy vision, a multidisciplinary approach to building up the quality of health services is important in order that all Cambodians are able to achieve the highest level of health and well-being.

With the development of Social Health Protection Programme, especially, coordination among all stakeholders is crucial to the process of quality improvement. For example, insurers participate in determining the minimum acceptable quality of health care to purchase for their clients, while policy makers seek the appropriate balance of incentives to the community and providers to harness pressure on the system to improve. The private sector must also be actively involved, as they are also subject to a common minimum quality of care, by participating in the development of guidelines to which will they are ultimately accountable. Besides monitoring the implementation of the Code of Conduct, coordination bodies such as professional councils are also tasked for a key role in ensuring patient safety in both public and private sectors.

The Quality Improvement Master Plan defines key milestones and activities to be carried out in a long journey towards accreditation by 2015. Many institutions due to their related activities and objectives have a stake in the success of achieving the vision, goals and objectives of the master plan.

The Ministry of Health strongly believes that the Quality Improvement Master Plan provides clear direction for developing a dynamic and responsive system which delivers continuously improving health services for all Cambodians. Thank you for contributing to the achievement of the Cambodian Millennium Development Goals.

Phnom Penh.....January 2010

CHAPTER 1: BACKGROUND

The pursuit of quality improvement has been moving at a slow but steady pace in Cambodia for the past couple of years. The current Health Strategic Plan 2008-2015 mandates the health sector to "*to provide stewardship for the entire health sector and to ensure supportive environment for increased demand and equitable access to quality health services in order that all the peoples of Cambodia are able to achieve the highest level of health and well-being*."

This mandate however was first explored in the 2005 National Policy for Quality in Health which is further guided by a roadmap (2006), for institutionalizing quality improvement in the health sector in Cambodia. Given the wide range of possible key result areas in quality improvement, the biggest challenge for the MOH and its development partners has been to arrive at a consensus on the priorities for action.

This is further aggravated by the fact that many of these key result areas for QI are indeed interconnected to various extents, e.g. development of clinical standards in the form of clinical practice guidelines with evidence-based medicine, links with development of an accreditation system in the same way that professional development links with institutionalization of quality, etc.

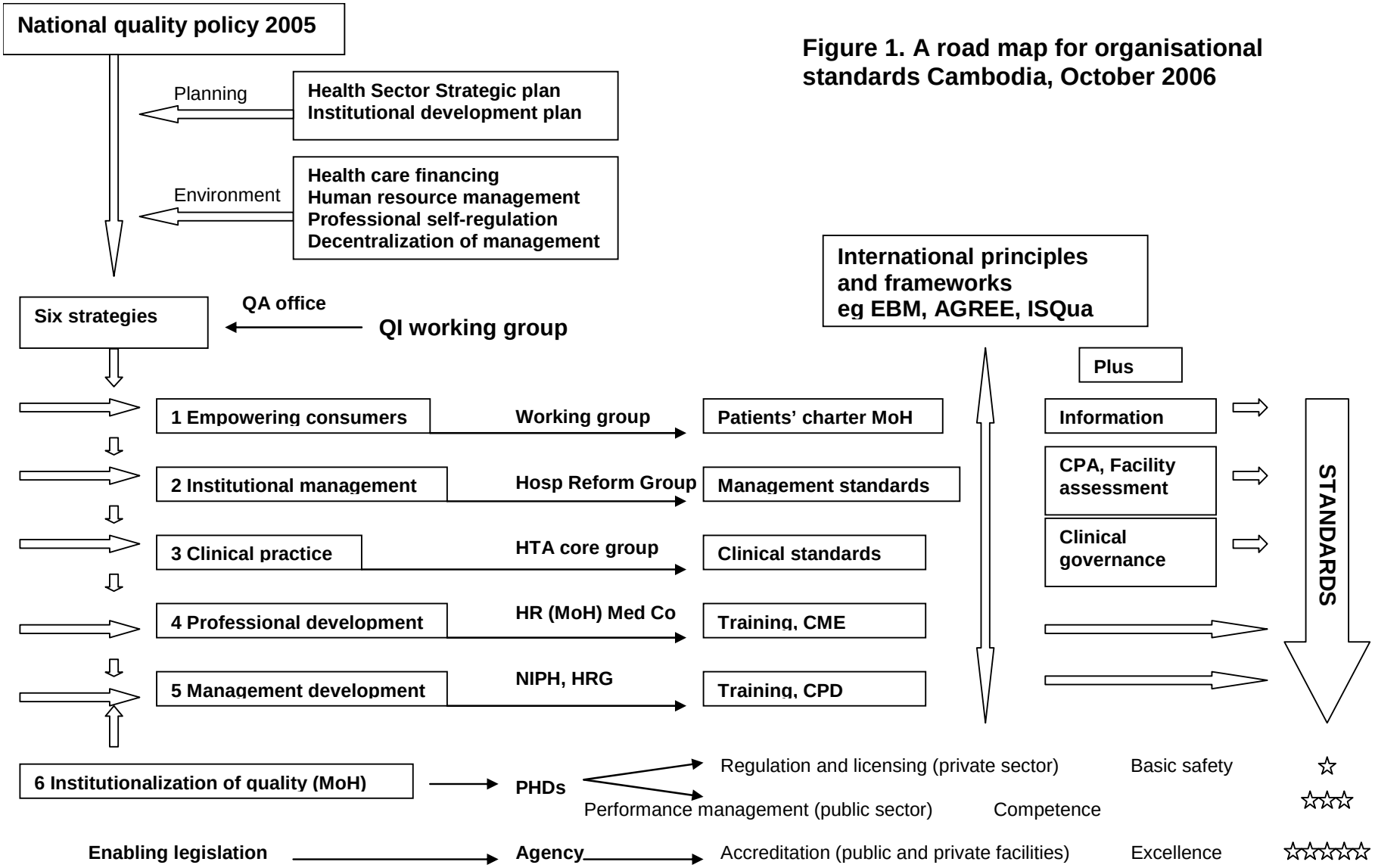
Given these huge tasks that can test the perseverance of a QI advocate matched with the targets proposed by the new health sector strategy and a growing need for regulation and assurance of quality for social health protection, the MOH rightfully considered the development of a Master plan for Quality Improvement as a guide for implementing the National Policy on Quality in a systematic manner.

The mandates of the National Policy for Quality are embedded within the strategies in HSP 2, albeit in different sections, as seen in the table below. Quality improvement falls under the strategy of Health Service Delivery (HSD 4) -- ***develop and apply consistent standards of quality across entire health sector (public, private and non-profit) --*** and is further elaborated under the Human Resource for Health (HRH 2) –***strengthen staff professionalism, ethical conduct and quality of work.***

Table1. Matching the National Policy Objectives with the Strategies of HSP2.

Objective	Strategic Ideas	
1. Empower consumers to foster appropriate health seeking behaviours and to understand the value improving the quality of health services.	***HSD 4.4***	*Monitor client satisfaction in public health service through regular client surveys; and improved communication and coordination between health facilities and Health Centre Management Committees (HCMC), VHSGs, Health Equity Fund implementers and Commune Councils.*
2. Institutional regulation and management to ensure that health services providers have the necessary systems in place to respond to the needs of the population.	***HSD 4.2***	*Develop and implement routine facilities survey procedures and reliable systems for follow-up to ensure that appropriate medical supplies, basic equipment and infrastructure are in place according to MPA and CPA guidelines.*
	HSD 4.5	*Strengthen institutional regulatory mechanisms for licensing in the private sector followed by implementation of an accreditation system as a step-up after compliance to licensing requirements. This process will be introduced gradually in the public sector as well.*
3. Clinical practice management to assure that timely and appropriate care processes are available.	***HSD4.1***	*Strengthen the implementation of the National Policy for Quality in Health (October 2005) to provide care with quality; safety; efficacy; focused clients; timely; and equity by greater emphasis on clients' rights; institutional regulations and management; clinical practices; professional development and supportive environment for quality improvement.*
4. Professional development to ensure that the individuals providing care to the population remain updated with the necessary knowledge and skills to discharge their functions.	***HRH 2.1***	*Encourage self-regulatory bodies for health professionals such as Medical Council, Dental Council, Midwife Council and other professional associations, etc.*
	HRH 2.2	*Develop and implement professional accreditation and licensing system for health workforce in public and private sectors.*
5. Management development to ensure that people tasked to manage health facilities programmes and projects have the necessary management qualifications.	***HSD4.1***	*Strengthen the implementation of the National Policy for Quality in Health (October 2005) to provide care with quality; safety; efficacy; focused clients; timely; and equity by greater emphasis on clients' rights; institutional regulations and management; clinical practices; professional development and supportive environment for quality improvement.*
6. Institutionalisation of quality to foster a culture of continuous quality improvement within the health sector.	***HSD 4.3***	*Establish incentive mechanisms for high quality, such as facility bonuses and recognition/awards for high achievement with involvement of consumers.*

Figure 1. A road map for organisational standards Cambodia, October 2006



CHAPTER 2: STRATEGIC APPROACH AND ROLES OF STAKEHOLDERS

1. DEFINITION OF QUALITY IMPROVEMENT

Quality and quality assurance is defined in HSP 2008-2015 as a general term for actions and systems for monitoring and improving quality. It involves measuring and evaluating quality, but also covers other activities to prevent poor quality and ensure high quality.

Quality management is the degree of excellence of a service or a system in meeting the health needs of those most in need at the lowest cost, and within limits, directives and/or regulations. This means looking at issues including equity, accessibility, effectiveness, efficiency, appropriateness and responsiveness.

Quality in service delivery refers to quality prevention and care, which is measured to a great extent by clinical audit. To move towards higher quality prevention and care, more and better information is commonly required on existing provision, on the interventions offered and major constraints on service provision. Information on numbers and types of providers is a basic requirement. An understanding of provider attitudes and practices and on client utilization patterns is also needed.

2. VISION, GOAL AND GUIDING PRINCIPLES

2.1 Vision:

To ensure a supportive environment for building up the quality of health services in order that all the peoples of Cambodia are able to achieve the highest level of health and well-being.

2.2 Goal:

To develop and set into motion sustainable quality improvement measures within the health system that will ensure:

- A conscious appreciation of and feeling of responsibility for providing quality care to Cambodians; and
- A systematic approach of putting into action the plans for improving quality at all levels of health care.

2.3 Guiding Principles:

The Ministry of Health reiterates its commitment to provide quality health care that is safe, effective, patient-centered, accessible, efficient, equitable and continuous.

- **Safe:** Health care ensures that the patients and staff do not suffer undue harm from the treatment itself and from the manner it was given.
- **Effective:** Any form of treatment or patient care will be based on guidelines that follow current scientific evidence.
- **Patient-centered**: Health care will be responsive to and respectful of the patient's values and choices to ensure patient satisfaction at every health care encounter.

- **Accessible:** This refers to care that is timely and affordable. Efforts will be made to ensure that no unnecessary delays occur in providing care. Likewise the cost of providing health care will be reasonable and within the financial capacity of the majority of the population.
- **Efficient:** Wastes are avoided and resources are used appropriately to ensure optimum benefits for the patients and the health care providers.
- **Equitable:** Health care is accessible and is provided to all who need it regardless of gender, ethnicity or socioeconomic status.
- **Continuous:** Efforts will be made to ensure that care is coordinated within the health care provider organization itself and with other providers, including the community, to ensure that the health needs of patients are met.

The provision of quality care will be guided by the following principles, as guided by the National Policy for Quality (2005):

- **Transparency:** Stakeholders will be given the opportunity to participate in the development of policies, standards and guidelines that impact on the provision of health care. Results of performance assessments will be made available to the general public.
- **Code of Ethics:** The provision of care shall be guided by the code of ethics of respective professions.
- **Evidence-based:** Current professional knowledge shall guide organization management and the care rendered to patients.
- **Top-down, bottom-up approach:** The MOH shall ensure proper coordination of central level regulation and peripheral level developments in pursuing improvement activities.
- **Shift from blame to improvement:** The MOH shall lead the change from a culture of placing blame on individuals for poor performance to that which recognizes “problem areas” as opportunities for improvement.
- **Accountability:** All health care providers, direct and indirect, shall be held accountable for their actions or inactions.

3. STRATEGIC APPROACH FOR IMPLEMENTING THE MASTERPLAN

Quality is a broad concept. Varied approaches to integrate it in the health sector have been tested in many countries with equally varied outcomes (PAHO 2002, Downie 2007, Ito 1998, Kim 2000, Birkner 1998, IOM 2001).

Similarly, quality improvement has been an ongoing challenge in the Cambodian health sector. Government and its partners have been continuously advocating for measures that aim to enhance its existing systems, creating policies and authorizing activities which contribute to the end goal of improved quality of health care for its population.

To attain the vision for quality in health, the following strategic approach will be implemented for this master plan for quality improvement:

3.1 Consolidate Existing Policies and Key Documents

Key documents on quality improvement needs to be consolidated in order to provide a clearer direction for its implementers.

- **Health Strategic Plan (2003-2007)** lays out the commitment of the Government of Cambodia, through the Ministry of Health, to improve the quality of health interventions for the good of the population. It listed quality improvement as one of 5 key pillars in health sector reform.

- **National Policy for Quality in Health Care (2005)** provides the framework which guides efforts for quality assurance and improvement in health care by streamlining and setting the direction for activities of government, NGOs and other stakeholders. It mandates that health care in Cambodia needs to be *safe, effective, patient-centered, accessible, efficient, equitable and continuous*.

- **Road Map for Quality Improvement (2006)** provides a snapshot of the key components and directions necessary for implementing the national policy.

- **Mapping of QI activities, version 1 (2006)** compiled by the QIWG, it lists the key players in quality improvement in Cambodia and their key areas of work on QI.

- **Roundtable Discussion on Master Plan (2007)** provides options for implementing the various components of the national policy.

- **Ministry of Health's Policy for Clients' Rights and Providers' Rights-Duties (2007)** is a national standardised package for clients' rights and providers' rights and duties and is addressed to consumers and managers of health services, and all health partners.

- **Health Strategic Plan (2008-2015)** provides the mandate for integrating quality improvement among key intervention areas of the MOH. It guides the direction for offering services with emphasis on affordability and acceptability of services, client rights, community participation and partnership with the private sector. It further requires the provision of comprehensive health care services including preventive, curative and promotion in accordance with nationally accepted principles, standards and clinical guidelines, such as MPA and CPA, and in partnership with the private sector.

3.2 Create (or Strengthen Existing) Dedicated Units

Dedicated units perform key tasks of developing the necessary systems for implementing quality improvement.

- **Standards Working Group -**
  - *Clinical Practice Guidelines Working Group* – already existing, this group reviews and updates existing clinical guidelines, as well as creates new guidelines for emerging needs.

- *Working Group on professional standards for practices (midwifery, nurse, medical doctors, etc.*) – these groups define the standards for acceptable clinical practice suitable for and according to the current state of health capacities and technology for Cambodia.
- *Working Group on Private facility organisation standards* – this group will identify the basic safety requirements for operating a health facility in the private sector.
- *Accreditation standards Working Group* -- this group develops the organizational performance standards which will be required for the accreditation system, over and above the existing CPA and MPA. These standards will be equally applicable to both public and private sector facilities.

- **Accreditation System Working Group –** shall develop the comprehensive system of accreditation (apart from the standards themselves)such as necessary legal requirements; identification and planning for training needs and training sources for surveyors and providers; selection of potential surveyors; decide on costing implications of implementing an accreditation system.

- **Accreditation Body --** This group is created at a later time for overall programme management of the accreditation process. Among its tasks include deciding on the schedule of evaluations; authorizing surveyors to conduct assessments in specific provinces; deciding on the accreditation status of providers which undergo assessments; deciding on administrative issues such as the cost of accreditation fees.

3.3 Capacity Building

Build up capacity among stakeholders to reach the critical mass of people with an understanding of quality improvement in order to sustain the gains.

3.4 Financial and Technical Support

Ensure financial and technical support from government and from health partners, as needed, to ensure that resources will be available to carry out the planned activities for quality improvement.

3.5 Feedback

Ensure adequate feedback to stakeholders for coordination and continuing ownership.

4. ROLES AND RESPONSIBILITIES TO IMPLEMENT THE MASTERPLAN

The levels of responsibility and engagement among stakeholders will be guided by their roles in implementing this master plan. There will be three levels:

Main Stakeholder is primarily responsible for the overall implementation of the master plan. This role falls on the **Ministry of Health (MOH), Health Care Providers,**

Professional Councils and Associations. Their tasks will include, among others, the following:

- **Ministry of Health**
  - Oversight of master plan implementation;
  - Set the policy direction for QI according to the HSP2;
  - Ensure that planned activities are carried out according the agreed timelines and are managed appropriately by the stakeholders assigned to accomplish the tasks;
  - Develop the standards for quality;
  - Design a monitoring and evaluation framework to evaluate progress and impact of the master plan implementation.

- **Health Care Providers**
  Translate quality policies and strategies into action in both public and private sector, implementing quality improvement innovations in the provision of care to the population.

- **Quality Improvement Working Group (QIWG)** is responsible for organizing and facilitating dialogues on the various quality improvement activities and harmonising efforts in implementation and monitoring of the impact of the Master Plan. It will identify key individuals and/or organizations which have the potential to contribute to the discussion on QI interventions. It is also the responsibility of the QIWG to leverage financial support from development partners to complement government funds.

- **Hospital Services Department (HSD)** is responsible for authorizing the identified key individuals and/or organizations which have the potential to contribute to the discussion and implementation of QI interventions. Further, the HSD will also take the lead in monitoring the progress on the master plan and report this to the QIWG.

- **National Institutes of Public Health (NIPH)** and sub-technical working group of laboratory are responsible for ensuring continuing mentoring on quality principles both in in-service and post-graduate training for laboratories. More over, it plays main roles to develop guideline for the development of standard operating procedure for medical laboratory services and update laboratory equipment standard list according to scientific and technology development.

- **University of Health Sciences (UHS)** is responsible for ensuring the application of the principles of evidence-based medicine in the medical and paramedical curriculum in order to promote the best practice at the basic training of professionals.

- **Department of Human Resource Development** is responsible for the quality of pre-and in-service training for midwives and nurses especially at RTCs level. Its involvement in curriculum development will be instrumental in upgrading the technical capacities of the health workforce. The **National Maternal and Child**

Health Centre (NMCHC) also links closely with the HRD Department for in-service midwifery related training programs. In collaboration with health professional councils and associations and other relevant stakeholders, its involvement is important to set up health professional licensing and registration.

- **Department of Personnel and Administration** is responsible for staff deployment according to job specifications.

- **Department of Budget and Finance** responsible for allocation and disbursement of budget needed for implementation of the quality improvement activities based on the annual operational plan.

- **Professional Councils and Professional Associations** their mandate is to ensure quality of health care services provided by health care providers. These bodies actively involve in the development of clinical standards, legislation of health sector, including code of conduct and practice.

Enabling Stakeholders lend to the implementation of the master plan. Without their cooperation and collaboration it will be very difficult to carry on the planned activities. It is crucial that the MOH has regular dialogue with these stakeholders to ensure their continuing commitment to agreed plans.

- **Ministry of Economy and Finance (MOEF)** - specifically, the Budget Department is responsible for assuring timely and adequate disbursement of funds for operation as well as for the provision of key needs such as drugs from central to the provinces.
- **Provincial governors** – responsible for assuring timely and adequate disbursement of funds for operation and the provision of key infrastructure needs of hospitals and health centres.
- **Third Party Payers** – contribute valuable inputs for quality improvement interventions and monitoring quality of health care in ensuring that health service delivery is appropriate and acceptable to agreed standards.

Supportive Stakeholders further support the MOH and its providers in attaining the targets for QI.

- **Consumers**, both individual and interest groups, as recipients of care, provide the feedback about quality interventions and health care services to the providers and ultimately to the policy makers.

- **International Development Partners** involved in improving the quality of health service delivery are responsible for providing technical and logistic resources to support and attain the goals of this Master Plan.

- **Civil society and NGOs** are responsible for cooperating in raising local awareness in demanding quality health care from providers and assist health facilities to improve quality of care.

- **Accreditation Committee for Cambodia** (ACC) responsible for accreditation for university education.

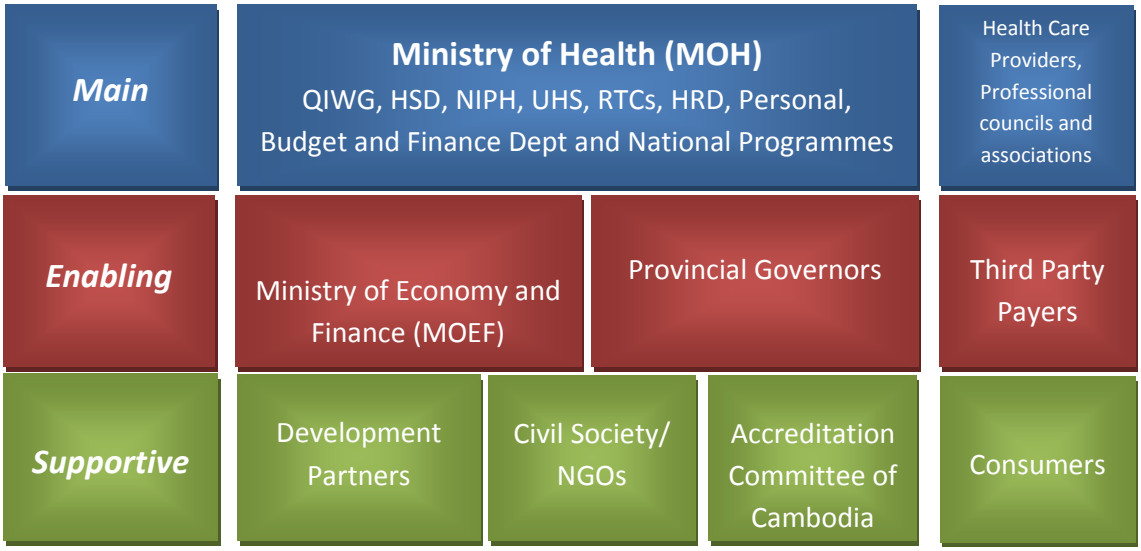


Figure 1: Stakeholders in QI

5. LINES OF ACCOUNTABILITY

The best way to illustrate the relationships of these various stakeholders is by looking at their interaction as each contributes to the final end goal which is to improve health outcomes in Cambodia①.

For a health outcome to happen – lower IMR and MMR, for instance – an interaction has to happen between health care provider and health care consumer. This interaction ② is called health care utilization. Health care utilization is affected by both quality of provision by the health care providers, and the actual demand for better health care by the consumers. This quality is in turn influenced by the interactions of the various players in the health sector.

The quality of health care provision is influenced primarily by the MOH ③ through its core units -- QIWG, HSD, NIPH, UHS, RTCs, HRD, Personal Department, Budget and Finance Department. It is the MOH which provides guidance to health care providers how to provide safe and effective care to its clients as well as professional associations, councils and NGOs working to improve quality of care. Likewise, it is MOH that has the responsibility to inform and educate health care consumers on proper health seeking behavior. If MOH falls short in these two important roles, the interaction – health care utilization – will not occur and desired health outcomes will not be achieved.

The MOH, in turn, is further supported by MOEF ④, the UHS and national programmes, and professional councils and associations ⑤ to ensure that it has the necessary resources to carry out its functions.

Development partners⑥, the provincial governors and 3rd party payers ⑦ also have huge potential to significantly influence the performance of providers by further facilitating

and/or providing the much needed logistic support for operational costs. They are also conduits through which the challenges of hospitals are transmitted back to the MOH.

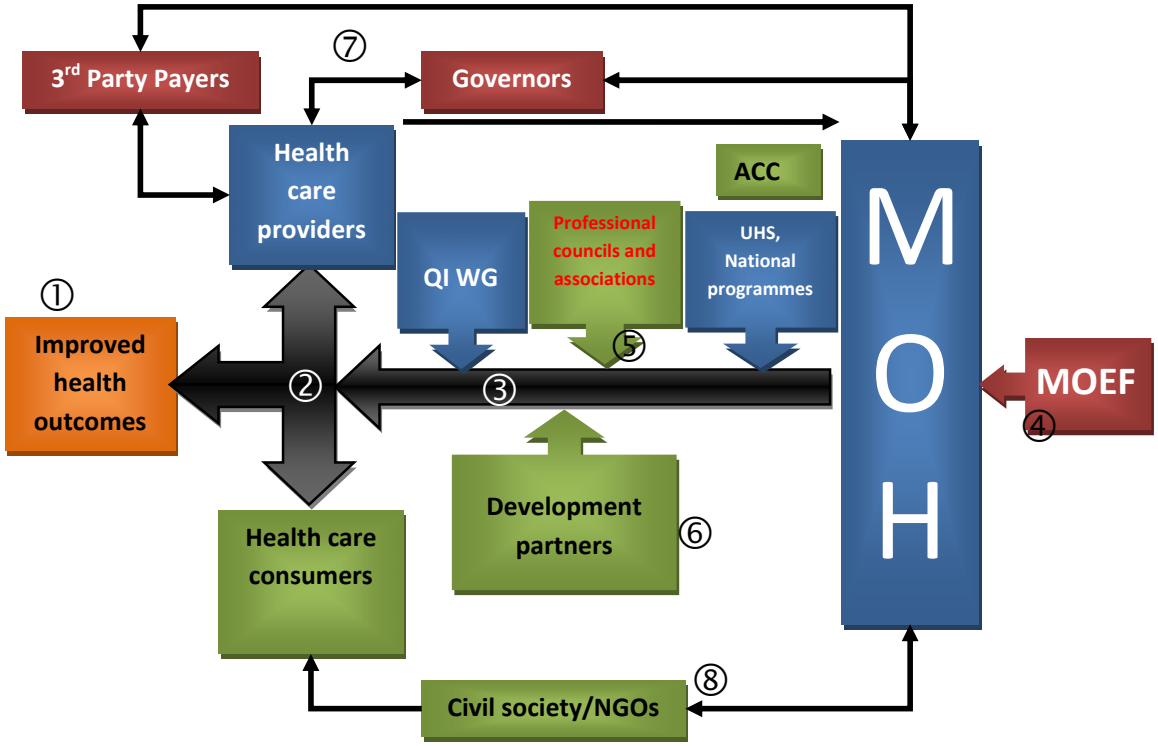


Figure 2: Inter-relationship of Stakeholders

From the consumer side, the MOH is assisted by civil society/ NGOs ⑧ and also development partners in influencing and promoting better health seeking behaviour. They also serve as feedback routes to the MOH.

It is strongly recommended that over time, the MOH fosters a more regular and structured guidance and feedback mechanism for its assistance to both health care providers and consumers, either directly and through its many partners, to ensure that each is able to act according to what is necessary for the achievement of desired health outcomes.

CHAPTER 3: QUALITY IMPROVEMENT IMPLEMENTATION PLAN

The approach to quality improvement in Cambodia will have to be multi-faceted and activities done in parallel, whenever possible. Key activities are described below according to the health service delivery strategies (4.1-4.5) and human resource strategies (2.1-2.2) of the Health Sector Strategy 2008-2015.

1. HEALTH SERVICE DELIVERY STRATEGY 4.1

Strengthen the implementation of the National Policy for Quality in Health (October 2005) to provide care with quality; safety; efficacy; focused clients; timely; and equity by greater emphasis on clients' rights; institutional regulations and management; clinical practices; professional development and supportive environment for quality improvement.

To ensure the quality of care provided to patients is of a minimum standard the following need to be in place. Standards are developed in the following:

- Infrastructure of health facilities
- Equipment and supplies for health facilities
- Health professional standards – for doctors, nurses, midwives, laboratory technicians, radiographers, dentists, physiotherapists, pharmacists, housekeepers etc

Clinical guidelines and pathways should be developed and updated regularly.
SOP are developed and introduced to facilities (for all disciplines and national programmes). Staff adheres to standards, SOP and guidelines

- In order to widen the knowledge base on quality and facilitate productive discussions on issues, a **series of technical seminars or more formal training courses** will be initiated for targeted groups such as policy makers, technical staff, doctors and paramedical people, and frontline staff. Topics may include concepts such as quality improvement, accreditation, clinical practice guidelines and pathways, governance, patient safety, and clinical audit.
- **Development of clinical practice guidelines (CPGs)** promote evidence-based practice and when applied properly may consequently address the issues of over-prescription and inappropriate management of patients.
- Promotion of **clinical audit systems** allows the MOH to monitor and evaluate the clinical competence and performance of its providers. Audits may be done on fixed schedules throughout the year. This will entail the creation of tools such as **clinical pathways** which can measure variance or deviation from the proposed CPG. It will further require engagement of doctors, paramedical staff and other staff in the creation of tools, promotion of the idea of clinical audit, and involvement in the actual evaluation of clinical performance.
- **A clinical pathways manual** will be developed to provide a template for health care providers to create their own pathways suitable for their local settings (and guided by national CPGs).

- **Review of the hospital management training programme** gives an opportunity to assess existing management programs for enhancing capacities of managers. The management section of the level 1 hospital assessment and health centre assessment tools can be used to follow trends in management capacities of managers.
- Standards for laboratories need to be developed which include standards for infrastructure, equipment and supplies, standard operating procedures and protocols for tests, quality control etc

2. HEALTH SERVICE DDELIVERY STRATEGY 4.2

Develop and implement routine facilities survey procedures and reliable systems for follow-up to ensure that appropriate medical supplies, basic equipment and infrastructure are in place according to MPA, CPA guidelines and CPGs.

- **Training of health facility assessors** is a pressing issue that needs to be discussed further by the QIWG. There are already a significant number of assessors trained and actively engaged in surveys. Certification of assessors will help determine reliability and validity with assessments

- Given the constraints in resources and limitations of the survey process itself, a **two-year cycle of assessments** is recommended with continuous quality improvement mechanism as routine process; unless there are special programming needs (e.g. health financing annual assessments for contract criteria). In addition to this assessment, internal/self assessment should be conducted regularly and through an ongoing process throughout the year to ensure continuous quality improvement.

3. HEALTH SERVICE DELIVERY STRATEGY 4.3

Establish incentive mechanisms for high quality, such as facility bonuses and recognition/awards for high achievement with involvement of consumers.

Providing payment based on the attainment of quality targets have been used in various countries using variable modes (Rosenthal et al 2004, Marshall 2006). To some extent this has been tested in Cambodia in the equity fund sites. Results are limited however facilities do not yet understand the necessity of institutionalizing quality of patient care and often prepare for assessments and do not continue the practices and good behaviour once the targets have been attained. To address this issue, spot checks have been introduced and in the future it is hoped to link spot checks and self assessment results with incentives on a quarterly basis rather than annual assessment results.

Health financing documents specific to the Cambodian setting have been developed including:

- Social Health Protection Master Plan(draft), Social Health Insurance Committee, 2009
- Strategic Framework for Health Financing, 2008-2015, Ministry of Health, 2008
- Health Strategic Plan 2, 2008-2015, MOH (2008)

- Report and Recommendations of 1st National Forum on Social Health Protection, MOH, December 2006
- Report and Recommendations of 2nd National Forum on Social Health Protection, MOH, November 2008
- "Promoting sustainable strategies to improve access to health care in the Asian and Pacific Region" UNESCAP Report, 2008
- National Equity Fund Implementation and Monitoring Framework, MOH, September 2005
- Health Equity Fund Financial Manual, MOH, 2008
- Health Equity Fund Implementation Guidelines, MOH, 2008

To date, there have been many discussions about linking health financing (HEF, CBHI, etc) to quality performance however other non financial incentives such as capacity development, career advancement etc. need to introduced. Ultimately, an MOH Prakas may be signed which requires a certain level of quality performance integrated into the contracts of health finance options.

4. HEALTH SERVICE DELIVERY STRATEGY 4.4

Monitor client satisfaction in public health service through regular client surveys; and improved communication and coordination between health facilities and Health Centre Management Committees (HCMC), VHSGs, Health Equity Fund implementers, health insurance agencies or HI committee and Commune Councils.

- A standardized **client satisfaction tool** will be developed and used to draw an assessment of provider performance. This can be done as internal improvement tool on a regular basis.
- The **Client satisfaction baseline study** should be conducted in 2010.
- Based on the results of the national study, a **review of the Implementing Guideline of Clients and Providers Rights and Responsibilities** will be done.

5. HEALTH SERVICE DELIVERY STRATEGY 4.5

Strengthen institutional regulatory mechanisms for licensing in the private sector followed by implementation of an accreditation system as a step-up after compliance to licensing requirements. This process will be introduced gradually in the public sector as well.

Regulation of institutions is underpinned by valid standards which are widely consulted with stakeholders.

5.1. Development of Standards for Private Health Facilities

The CPA of the MOH is applicable only to public hospitals. However with the proliferation of private health facilities, the MOH recognises the need to have standards and a methodology to evaluate the safety and competence of the private sector.

Development of organizational standards for private health facilities may be done, as proposed, by a Standards Working Group. For licensing purposes, basic safety

requirements are obligated; for accreditation, system performance requirements are required.

5.2. Development of Accreditation

Overview documents on developing accreditation (Shaw 2008, Evangelista 2008) have been prepared and discussed for the guidance of the QIWG on next steps. Shaw (2008) provides a detailed step-by-step guide on how to proceed. The key elements to the accreditation process include:

- Creation of the standards which will underpin the assessments – drafting, validation and finalisation of the standards will take 2-3 years
- Creation of the survey tools and survey guides
- Selection and training of surveyors
- Costing of the entire process
- Creation and operationalizing the Accreditation body
- Conduct initial survey

6. HUMAN RESOURCE FOR HEALTH STRATEGY 2.1

Encourage self-regulatory bodies for health professionals such as Medical Council, Dental Council, Midwife Council and other professional associations, etc.

Professional bodies are envisioned to participate in discussions, define and enforce standards and negotiate contracts on improving quality health care. International experiences show that professional associations provide a venue for exchange of clinical best practice.

7. HUMAN RESOURCE FOR HEALTH STRATEGY 2.2

Develop and implement professional accreditation and licensing system for health workforce in public and private sectors.

Regulation of professionals begins with appropriate evaluation of competence through national examinations for all new graduates of medical and paramedical schools. A national entry examination for doctors, pharmacists, dentists and bachelor of nursing in sciences was initiated in 2008 and will be done annually. Examinations for paramedical professionals will follow.

Further promote quality, an accreditation system for professionals will also be developed. A current practice of registration at Cambodian Medical Councils needs to be strengthened to maintain competency of health care providers in both public and private sectors. A national body needs to be set up with defined criteria and mechanism required for implementing this activity. Health professional councils and associations play crucial role in the implementation.

8. TIMELINE FOR IMPLEMENTATION

Key Milestones – provides a summary of the detailed activities according to timelines

Activities	Timeframe					
	2010	2011	2012	2013	2014	2015
1-Develop client satisfaction tool						
2-Develop 2nd level assessment stool for RHs						
3-Develop standards for private facilities						
4- develop the most prioritised CPGs (including National Programmes)						
5- Capacity building (Technical forum/CME)						
6- Develop quality standards for health service delivery						
7-Develop Clinical pathway manual						
8-Revalidate Level 1 tool RH assessment tool						
9- Conduct baseline survey on client satisfaction						
10- Update Management textbook						
11-Develop Incentive mechanism & tool to monitor performance - incentive						
12- Clinical audit and reporting system						
13- Management audit						
14- Develop guideline for the development of Lab. SOP and update equipment standard list						
15- Review of implementation guidelines of Client and provider right						
16- Conduct CPA/MPA facility survey						
17- Review of the progress on the QI Master Plan						
18- Develop accreditation standard						
19- Advocate for the creation and strengthening of professional councils and associations						
20- Update and develop remaining CPGs.						
21- Develop accreditation tool						
22- Select accreditation surveyors and training						
23- Create accreditation body						
24- Conduct accreditation survey						
25- Conduct 1st cycle of hospital accreditation						
26- Evaluate impact evaluation of the Master Plan implementation						

9. DETAILED ACTIVITIES

Strategy	Activity	Target indicator(s)	Target Completion Date	Responsible Unit
HSD 4.1 Strengthen the implement-ation of the National Policy for Quality	Series of Technical seminar (1-2 days) on QI for individuals at (1) policy-level, (2) technical-level, and (3) implementer-level.	Series of forum conducted (input indicator) Informed discussion at working group level observed (output indicator)	2015	HSD, MOH
	Strengthen national body within MOH to discuss, approve and register clinical practice guidelines.	Guidelines are standardized countrywide	2015	HSD, MOH
	Develop clinical practice guidelines (CPGs) which comply with AGREE principles.	CPGs published and systematically disseminated to intended users and implemented.	Ongoing beginning 2009	HSD, MOH
	Develop a Manual on *How to Create Clinical Practice Guidelines (CPG)* for Cambodia.	Manual created, tested and published	2010	HSD, MOH
	Develop a Manual on *How to Create Clinical Pathways.*	Manual created, tested and published	2010	HSD, MOH
	Conduct training and provide assistance for hospital staff on *How to Create Clinical Pathways* suitable for their respective settings.	Each trained hospital has a set of clinical pathways	2011	HSD, MOH

Strategy	Activity	Target indicator(s)	Target Completion Date	Responsible Unit
	Develop a national audit and reporting system which show compliance with clinical guidelines (using pathways) and improved outcomes for patients and/or populations.	National reporting system developed (including report forms and flows, analysis of data and feedback)	2010	HSD, MOH
	Conduct training for clinical auditors.	Auditors selected and trained	2011	HSD, MOH
	Conduct annual audit of compliance to CPGs (using pathways).	Nationally validated measures of clinical performance routinely provided to local clinical teams	Annually beginning 2012	HSD, MOH
	Develop quality standards for health services delivery (nursing care, midwives, radiology, pharmacists, physiotherapists, operating room etc.).	Quality standards for health service delivery	2015	NMCHC, HSD, National Programmes, Professional councils and associations
	Develop guideline for the development of laboratory standard operating procedure and update laboratory equipment standard list.	Standard operating procedure and equipment for laboratory	2011	NIPH, sub-technical working group and Lab. Bureau of HSD
	Enhancement of health management training pre and in-service.	NIPH textbook for management training adapted to national standards for private and public health facilities	2010	HSD, NIPH, HRD, Admin Dept, Personnel Dept.

Strategy	Activity	Target indicator(s)	Target Completion Date	Responsible Unit
	Enhancement of clinical skills training in-service for health staff.	Specific required training programme for in-service / on the job training	From 2010 onwards	HRD (MOH) Professional councils and associations
	Conduct management audit as reflected in MPA/CPA compliance.	Up-trend in management scores on surveys	Annually beginning 2011	HSD, MOH
		Each facility can demonstrate a functioning QI structure	2010	HSD, MOH
HSD 4.2 Implement routine facilities surveys	Update responsiveness of current compliance tools for CPA/MPA → Revise/update tools every three years (to comply with MOH standards).	Revised compliance tools (whether level 1, 2, so on)for measuring compliance to basic requirements – both CPA and MPA	2010 - onwards	HSD, MOH
	Conduct training of facility assessors for level 1 tools nationwide.	Trained assessors available at each province	2010	HSD, MOH
	Conduct 2-year cycle audit of compliance to CPA/MPA with follow-up system.	Nationally validated measures of compliance routinely provided to facility managers	2010 - 2012	HSD, MOH
	Develop criteria for certifying assessors (CPA and MPA tools).	Standard criteria for assessors' competencies developed	2010	HSD, MOH

Strategy	Activity	Target indicator(s)	Target Completion Date	Responsible Unit
HSD 4.3 Establish incentive mechanisms for quality	Initiate discussion and gain consensus among stakeholders about the linkage of quality to current health financing schemes (HEF, CBHI, UF).	Approval of MOH and MOEF MOH Prakas requiring a certain level of quality performance which is integrated into the contracts of health finance options Guidelines for an incentive mechanism for quality, including Contracts.	2010	HSD, Personnel Dept, Financing Dept, PDHI, Health Partners
HSD 4.4 Monitor client satisfaction	Develop and endorse a client satisfaction tool for facility level.	Tool developed and endorsed	2010	HSD, MOH, Health partners
	Client satisfaction baseline survey.	Baseline report	Q2- Q4 2010	HSD, MOH
	Each facility conducts valid, regular surveys of patient experience.	Annual report on advocacy and complaints	2011 - onwards	HSD, MOH
	Review and revision of Implementing Guideline of Clients and Providers Rights and Responsibilities.	Guidelines revised and republished	2013	HSD, MOH, Preventive Medicine Dept
HSD 4.5 Strengthen institutional regulatory mechanisms	Develop standards and assessment tools (clear definition) for private facilities.	Standards and assessment tools for private facilities developed and validated (reflect accreditation)	2010	HSD, MOH, DDF, Professional bodies

Strategy	Activity	Target indicator(s)	Target Completion Date	Responsible Unit
	Develop standards of performance for accreditation (beyond the requirements of CPA and MPA).	Performance standards developed and validated.	2012	HSD, MOH
	Develop accreditation tools for public and private and surveyor guides.	Accreditation tools validated.	2013	HSD, MOH, Health professional councils
	Develop process for selection and training of accreditation surveyors.	Surveyors trained to conduct accreditation surveys	2014	HSD, MOH
	Creation of accreditation body which decides on accreditation status of providers.	Accreditation body operational	2013	HSD, MOH, Professional councils
	Conduct initial accreditation survey.	Providers are awarded accreditation status	2015	HSD, MOH, Professional councils
HRH 2.1 Encourage [creation] of self-regulatory bodies	Advocate for the creation and strengthening of professional councils and associations.	Professional council and associations participate in discussions on improving quality health care	2012	HRD, MOH, UHS
	Technical forum for doctor and nurses on audit (see series of forum in HSD 4.1).	Doctors participate in systematic clinical audit in hospital/HC	Annually, beginning 2012	HRD, MOH, UHS and Health Professional Bodies

Strategy	Activity	Target indicator(s)	Target Completion Date	Responsible Unit
HRH 2.2 Develop and implement professional licensing and accreditation	Establish law/ regulation on professional licensing for health professional practices.	Law/Regulation of professional licensing institutionalised	2010	MoH, Professional Boards/Councils, Training Institutions, HDPs
	Develop professional Registration and licensing system for health practitioners, including Licensing and Registration Board.	Registration and licensing system for professionals developed and institutionalised	2011-onwards	MoH, Professional Boards/Councils, Training Institutions, HDPs
	Implement professional Registration and Licensing System for health practitioners, in public and private sectors.	Health professionals are licensed and registered	2012 onwards	MoH, Professional Boards/Councils, Training Institutions, HDPs

CHAPTER 4: ADVOCACY PLAN AND REVIEW OF THE MASTER PLAN

To ensure the vividness of the master plan, responsibility for advocacy within the Ministry of Health need to be defined. Based on current mandates, the most appropriate department for this task is the Hospital Service Department. They are responsible for coordinating, monitoring and evaluating the implementation of the master plan.

They will make sure that the QI master plan is translated in to action appropriately and they will coordinate with the Department of Planning and Health Information to ensure that QI activities are reflected in the Annual Operational Plan.

Consistent with the phased-in planning of the HSP2, implementation of the master plan will also be reviewed following the consolidation and scaling-up phases of HSP2 below.

Track	Consolidation 2008-2010	Scaling-up 2011-2015
1 Decisions over a package of key policies		
a. review/develop sub-sector strategic plan	◆———	
b. develop implementation tools for existing policies/strategies	◆———◆———	
c. define "Policy Package"	◆———	
2 Institutional development with capacity strengthening		
a. Institutional arrangement	◆———	
b. capability strengthening	◆———◆———	
3 Implementation and preparation for scaling-up		
a. mobilize financial resources	selected ODs	All ODs
b. prepare for scaling up	CDHS2010 MTR	HSP3

Midterm review of progress on the master plan will be done on 2011. Timelines, targets and resources will be adjusted as necessary.

Impact evaluation of the master plan will be done in 2015. Results will be used to guide proposals for HSP3.

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Annex 1: Task Force on the Master Plan for QI

1.	HE.Prof. Thir Kruy	Under Secretary of State
2.	Dr. Chi Mean Hea	Deputy Director General for Health
3.	Dr. Sann Sary	Director of Hospital Service Department
4.	Dr. Sok Po	Deputy Director of Hospital Service Department
5.	Dr. Phum Sam Song	Deputy Director of Human Resource Development Department
6.	Dr. Chorn Sinuon	Chief of Quality Assurance Office
7.	Mr. Ros Chhun Eang	Chief of Economic Health Financing Office
8.	Ms. Lim Khankryka	Deputy chief of Quality Assurance Office
9.	Phr. Va Sok Kea	Deputy chief of Essential Drug Office
10.	Dr. Voeung Vireak	Deputy Chief of Quality Assurance Office
11.	Representatives:	GTZ, URC, RHAC, BTC, RACHA

Annex 2: Some parameters to be considered for assessment of assessment tools

The tool

Do the hospitals or the assessors consider any of the criteria to be irrelevant, unclear, unmeasurable, unachievable, and unnecessary?

Is the structure easy to understand; would an index help?

The findings

Which criteria were most/least compliant?

What key messages emerged – for hospitals, OD, PHD, MoH?

What plans, actions followed at hospital level?
What implications for annual planning?

How has evidence of need to change central systems (eg drug procurement, data management) been presented to MoH?

The experience

How was it for?

- The hospitals: induction, preparation, costs, self-assessment, external assessment, challenges and benefits?
- The external assessors: training, the tool, the visit, timescale, team function, analysis and presentation?

Effectiveness – what does it do?

- Provide credible assurance for funding hospitals – for contracting, HEFs, SHI etc (who will define what is credible? What thresholds required?)
- Identify resource needs of individual hospitals – for local action
- Identify needs for system development in hospitals generally – for PHDs, MoH
- Identify needs for training and facilitation for hospitals in general – who will provide?

Conceptual questions

- What proportion of effort of assessment teams should be spent in diagnosis as opposed to treatment of hospital problems
- Separation of two elements (diagnosis and treatment)– implications for staffing, training required
- Separation of hospital guidance/self-assessment doc from external/peer review assessment doc
- Reduction of tool and procedures to focus on most discriminating diagnostic elements
- Economy of cost and time; is sophistication justified; is full assessment needed every year; which elements are stable, which are most liable to relapse

- Should awards given for achievement (static), or for effort and improvement (dynamic); see South African model of “graded recognition”

Technical questions

- Validation of scoring and weighting ie sensitivity within and between criteria
- Diagnostic capacity of questions ie ability to identify underlying problems and potential solutions eg ambulance, dosimeters, radiation exposure tables score 10 or 0; some adjustments have been made already to the use of the tool
- Validation, aggregation and application of key indicators eg 10 referrals from HC, 11 patients receiving antibiotics, 12 mortality; how have these been used
- Should teams directly audit eg CPGs or seek evidence of internal systems
- How are assessments of individual hospitals moderated
- Statistical data from HIS and hospital profile could be provided in advance
- How are comments from assessors used; what changes resulted

Development and migration

- Transfer from QAO to internal self-assessment and external peer review
- Recruitment and training implications
- Full-time or part-time assessors
- Integration of existing complement of PHD supervisors into assessment teams
- Development pathway for trained assessors towards hospital standards
- Alignment of assessment training and methods between Hospital Assessment Tool (HAT) / HC Assessment Tool (HCAT) and “accreditation” model

Practical questions

- Timescale for roll-out; how determined; how phased between sites
- Projected workload (training, assessment) and rate of growth
- Recruitment implications
- Funding and its provision

Annex 3 List of Persons Consulted and Contributed

Ministry of Health	1. HE Prof Thir Kruy 2. Dr Chi Mean Hea 3. Dr Sann Sary 4. Dr Phum Sam Song 5. Dr Sok Po 6. Dr Chon Sinoun 7. Mrs Limkhankryka 8. Dr Voeurng Vireak 9. Mr Va Sokea
Provincial Health Department	1. Dr Khlem Sokun 2. Dr Va Luong Khun 3. Dr. Meas Sokha
Calmette Hospital	1. Dr. Kong Sonya
UHS	1. Chea Kim Ly
GTZ	1. Dr. Bernd Schramm 2. Dr. Chhom Rada 3. Anja Papenfuss 4. Dr. Yath Yathy 5. Nathalie Abejero 6. Olivia Nieveras
PSI	1. Mao Matha
RACHA	1. Dr. Sun Nasy 2. Phy Maly 3. Dr. Lim Nary
RHAC	1. Ping Chutena 2. Suon Bophea
URC	1. Dr. Christophe Grundmann 2. Dr. Huong Vuthy 3. Dr. Hun Ratana 4. Dr. Tan Chanthy 5. Dr. So Phat 6. Frances Daily
WHO	1. Dr. Paul Weelen 2. Anne Robyns
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