

Institutionalization of Minimum Service Standards (MSS) for Health Facilities in Nepal: Exemplary Plan-Do-Study-Act (PDSA) Cycle for Readiness and Service Availability

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ABSTRACT

Access to health facilities alone, without quality services, does more harm than the benefit to the people's health. Nepal has invested more than two decades in expansion of number of health facilities and the journey is still on to balance level of health facilities based on the federal structure. Institutionalization of Minimum Service Standards (MSS) for health facilities in Nepal implemented by Ministry of Health and Population is an exemplary Plan-Do-Study-Act (PDSA) cycle for health facilities readiness and service availability for quality improvement. Thus, it is important to document the process for guiding institutionalization of tools. From its design, development, stakeholders' engagement, implementation to development of action plan makes MSS lively and outcome-oriented tool. MSS for health facilities in Nepal is an effort of government to prepare foundation of readiness and service availability to move ahead with effective quality service utilization. Digitalization of the all sets of MSS, development of MSS to cover the existing type of the health facilities currently present in the country and access of data set for researchers is the way forward. Developing standards for national accreditation system and international collaboration is the next step to embrace. Furthermore, MSS gradually reported through self-assessment of the health facilities with occasional monitoring by the local, provincial and federal government and gap fulfillment through routine annual work plan and budgeting is the future direction. It is high time MoHP moves ahead with service specific quality improvement tools integrated with MSS assessment to prepare them for high quality health systems that can adapt to changing health needs and health shocks.

Keywords: Minimum Service Standards, Quality Improvement, Plan-Do-Study-Act Cycle, Institutionalization, Readiness and Service Availability

ARTICLE INFORMATION			
Source of Support:	No external support		
Received:	6 April 2023	Accepted:	13 April 2023
		Published Online:	20 April 2023
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BACKGROUND

Access to quality health care services is an essential function of health system strengthening and universal health coverage and an instrumental imperative for Sustainable Development Goal 3 (SDG 3).^{1,2} Basic

essence of access is establishment of health facilities in strategic locations and service provision from these facilities based on the need of population.³ In year 2018, the Lancet Global Health Commission on High Quality Health Systems (HQSS Commission) reported

that yearly around nine million deaths occurring due to treatable conditions for lack of good quality care. Among these lives lost, 60% of deaths among those who loose lives from treatable condition for lack of good quality of care were actually occurring among those who had access to care.⁴ This was stark finding which sensitized the global leaders majorly in low- and middle-income countries that care without quality does more harm than no access to care and at the same time gave platform for introspection on lacuna in terms of quality health services in their countries.

Nepal, as a country with difficult terrain, after the launch of National Health Policy 1991, Government of Nepal (GoN) invested more than two decades in increasing the number of health care facilities establishing sub-health posts, health posts and primary health care centers in the grass-root levels to ensure that each lowest administrative level and political division has at least one such primary level health facility.^{5,6} After federalization in the country and mandate of Constitution of Nepal 2015 that enshrines health as fundamental human right, in the year 2017, the Nepal Integrated Health Infrastructure Development Standards envisioned the primary level hospitals at the local government level, secondary level hospital in the provincial level, tertiary, super-specialty and health academia (at least one in each province) in the federal level and promoted the need of the population as the basis of the classification of the type of health services rather than simply number of bed.⁷ This has been revised in the Public Health Service Regulation 2020 Schedule- 7, which classifies these health facilities based on numbers of beds and services provided through them : basic health service centers, basic hospitals (5-15 beds), general hospitals (25-50 beds), general hospitals (100-300 beds), specialized hospitals (minimum 100 beds, multiple of 100 beds), super specialty hospital (minimum 50 beds, multiple of 50 beds), teaching hospitals under health sciences academia (minimum 300, multiple of 100), children hospitals, and in alternative medicine- basic *ayurveda* service centers, *ayurveda* health centers (25-50 beds), specialized *ayurveda* hospitals (minimum 100, multiple of 50 for additional beds), homeopathy hospitals (50 beds).⁸ This classification is assumed to smoothen the service provision, guide the governance and management of the health facility and contribute to the quality of the services provided through these

institutions. The operation and establishment of these health facilities are further guided by the Health Institution Establishment, Operation and Upgrading Standards, 2014/15 (revised 2021).⁹ Backed up with legal framework, policies and strategies in health sector, the policy interventions in the country suffice to build an enabling environment for up taking the direction towards quality health services. Minimum Service Standards (MSS) for Health Facilities at present is one of such initiative from Ministry of Health and Population to build the foundation of readiness and service availability for the quality health services at the point of service delivery.

At present more than 119 different levels of public hospitals- 30 local level hospitals, 78 Provincial level and 11 federal level hospitals have been continuously assessing their readiness and service availability gaps through use of the MSS tools.¹⁰ MSS for health posts is being implemented through local government with leadership of Curative Service Division, Department of Health Services.^{11,12} MSS tools of Ayurveda health facilities and specialized service hospitals- are setting the stage for implementation. And draft of MSS for Homeopathy Hospital and MSS for Tuberculosis Services are drafted and are in the process of finalization.¹² It is clearly seen that MSS is one of the widely owned and implemented tool in health facilities of Nepal. Thus, these editorial aims to cover the process documentation of the journey of institutionalization of MSS. This is the first documentation of its kind and can be an important institutional memory and reference point for the future similar tools and their development.

INSTITUTIONALIZATION OF MSS AND PLAN-DO-STUDY-ACT (PDSA) CYCLE

Literatures show that health interventions that are predefined on PDSA framework for implementation have shown significant health outcome.^{13,14} The process of institutionalization of MSS initiated as a manager-oriented tool in 2014 supported by a development partner to a national level tool owned by the Ministry of Health and Population has some major noteworthy elements that fits it well in the PDSA cycle. Relating it to PDSA cycle also highlights the cyclic nature of the consultation, review, revisions that have been undertaken during the process:

Initiation, Revision and Development of MSS

Managers of the health facilities specifically at the then district hospitals (as of now they are provincial hospitals), who were majorly clinicians requiring balancing their clinical and administrative duties of running the hospitals, felt a strong gap of not having a practical tool for guiding them on management of the hospitals. The identification of this gap was the stepping stone of the initiative taken by the group of health leaders of MoHP and supported by the organization Nick Simons Institute (NSI), which was drafted as the “Hospital Management Strengthening Program (HMSP): A Checklist to Identify Gaps in Minimum Service Standards (MSS) of District Hospitals” in 2014.¹⁵ From the year onwards, Management Division of Department of Health Services allocated flexible grants ranging from NRs 21 to 49 lakhs to all district level hospitals.¹³ In four years span (2014-2018) this MSS tool was scaled up in 83 the then district level hospitals and anecdotes of impressive changes in the hospitals and managerial skills of the clinicians were visibly seen.¹⁶ With federalization and change in the governance of the hospitals through different government level, after 2021, the grant on HMSP has been stopped and activities of MSS need to be budgeted through the budget-item of MSS.

In 2018, Quality Standards and Regulation Division (QSRD) (the then Curative Service Division) Ministry of Health and Population, took on board other partners along with NSI-World Health Organization (WHO) and Nepal Health Sector Support Program (NHSSP) for the stipulation of similar tool for the different level of the hospitals and the task of revision of the existing tool and development of the tools for secondary and tertiary level hospitals was initiated. Technical working group (TWG) was facilitated by technical coordinator (TC) to liaise with MoHP and different stakeholders. Intensive desk review of the national and international documents was done to further strengthen the basis of the components included in the existing MSS and addition of the contextual evidences.¹⁷⁻²⁰

Some noteworthy revisions done to make MSS a comprehensive tool

The framework was based on the WHO six building blocks and people-centered elements were taken into consideration in all the components envisioning an enabling environment to both the providers and the

users.²¹ Along with it patient safety was an instrumental component amplified in the tool in the form of assessment of infection prevention standards as a component of all clinical service standards and continuity was given to the sub-section of quality improvement with key quality indicators.¹⁷⁻²⁰ The presence of relevant human resource was substantially added to all the standards to ensure the component of service availability and delimit the tool of MSS to both health facility readiness and service availability.¹⁷⁻²⁰

During the revision, it was equated that the outlets are the point of service delivery and there is need of revision of the existing MSS of 2014 in terms of its overall scoring framework in order to strengthen the gap identification and improvement in the clinical services at the health facilities. There were eight sections of equal weight in the MSS of 2014 namely- governance, organizational management, human resource management, financial management, information management and medical records, quality management, clinical management, and hospital support services.¹⁵ MSS tool was revised to have three major sections- Section I: Governance and Management Section (20% weightage); which includes the first six above mentioned sections; Section II: Clinical Service Management Section (60% weightage) and Section III: Support Service Management Section (20% weightage).¹⁷⁻²⁰ This revision of the scoring of the MSS demands readiness and availability of the clinical services at the health facility prioritized, however functioning of these clinical services is dependent upon the support service management and most importantly the governance and management of health facility. These three sections are interdependent, selective clinical services’ readiness and service availability shouldn’t be rushed to be seen in fragment without the assessment of the governance and management and support service management for contextual and outcome-oriented investment on readiness and service availability of the health facilities.

After 2018, MSS for Health Posts and MSS for Ayurveda Health Facilities (*Aushadhalaya*, Health Center, Province level hospital and Central level hospital) were developed in a similar template and process followed in the revision and development of MSS taken up in 2018.²²⁻²⁶ Similar steps were taken for developing MSS for special service hospitals-

maternity and gynecological disease hospital, children's hospital, mental hospital and infectious disease hospital in the year 2022/23.²⁷⁻³⁰ The additions to these special service hospitals are elaboration of the standards on patient centered component as each type of hospital addresses its own special group of users or ailments. Also, separate section for infection prevention and control as applicable has been added along with the continuity of the infection prevention component in all clinical services set up to further strengthen the component of patient safety.²⁷⁻²⁹

Stakeholders' engagement, field testing, and consensus development workshop

The leadership of QSRD, MoHP, members of TWG along with TC carried out the exercise of stakeholder mapping, and an extensive list of participants was prepared which consisted subject experts, health leaders, managers, academia, policy makers, professional bodies, administrators, clinical practitioners, clinical nurses, paramedics, technologists, biomedical engineers, technicians, house-keepers, and non-clinical subordinates. Different meetings with subject experts and workshops with all stakeholders were conducted in a period of around nine months that finally gave the product of four sets of the MSS-Primary Hospital, Secondary Hospital (Basic Service and Higher Services) and Tertiary Hospital. After field testing of the tools, the consensus workshop was called in Kathmandu which had the presence of health executives- policy makers, directors of federal and provincial level which was vital to add the accountability towards its implementation.¹⁷⁻²⁰ This exemplary boarding of the stakeholders is one of the contributors for approval of MSS tools without further ado.

Implementation guideline of MSS

The process of implementation of MSS and its management is guided by MSS implementation Guideline-2021³¹ The team was aware of the failure of most tools at the level of implementation at a larger scale with a change in leadership or exit of an external development partner from the program, thus this guideline was envisioned parallel with the development of the MSS tools in 2018. The governance for implementation of MSS has been designed through quality coordination committees at different levels from federal to institutional level to ensure the

participation of the managers from federal, provincial and local government levels, the team from health facilities and health facility management/development committee/ board members, external development partners for both public and private health facilities.³¹

The implementation guideline details on process from preparation to developing resource persons, assessment process, recording, reporting, review, and monitoring and evaluation of MSS. It also has detailed out the terms of references of the committees and the resource persons for MSS assessment. Further to it the guideline also frames about resources that are required during the gap assessment till fulfillment of the gaps.³¹

Dissemination of MSS assessment and stakeholder engagement

Dissemination of MSS assessment is done comprehensively with engagement of stakeholders identified to have potential contribution and influence on health facility management, readiness and service provision. Specific stakeholders are management committee members, representatives from the local/provincial/federal government, locally elected leaders and political party representatives, media personnel, health facility team and team of assessors/evaluators.³¹ Their presence and knowledge on gaps of the health facilities strengthen prioritization of fulfillment of the budgetary gaps during annual work plan and budgeting (AWPB).

Action plan after MSS assessment

After assessment of the health facilities using the relevant MSS tools, the scoring of the health facilities is done and they are given the color codes- White (<50%), Yellow (50-70%), Blue (70-85%) and Green (85-100%).^{17-20, 22-30} The list of standards in which the particular health facility couldn't make optimal score can be segregated in designing action plan after assessment of the health facility. These set of standards are discussed among stakeholders and action plan is developed on prioritized standards which elaborates further steps to be taken to fulfill gaps, person responsible, time frame, tentative cost, type of support (managerial) and type of support (budgetary).³¹ The immediate supplement of data from data entry platform to action plan development is a crucial component of MSS that makes it lively and outcome-oriented tool. The action plan thus formed can help guide further at

institutional level, local government, provincial and federal level priority setting and integration into AWPB to fulfill gaps assessed through MSS tools.

Thus, from initiative taken to start, scale up and further develop MSS tools to the sequential steps adapted in cycle of MSS implementation and thus strengthening of health facilities with prioritized action plan to ensure resource management and action steps; institutionalization of MSS is an exemplary Plan-Do-Study-Act (PDSA) cycle for health facilities readiness and service availability.

WAY FORWARD

MSS prepares the foundation of readiness and service availability to move ahead with effective quality service utilization. There are still more than eight identified special service hospitals, academic hospitals and super-specialized service providing hospitals for which MoHP need to develop MSS tools. The development of the set of MSS tools extensively to cover the existing type of health facilities in the country will help managers at all level to work on the gaps for readiness and service availability of their health facilities. At the same time updating the tools based on classification provided by Public Health Service Regulation 2020 is the immediate short-term action step for QSRD, MoHP.

Each cycle of MSS assessment generate a thick data set. The digitalization of MSS for data recording, reporting and action plan development is one of the crucial steps of informing the higher-level authority on status and gaps of the assessed health facilities. Thus, expansion of the platform to include health posts, *Ayurveda* health facilities and special service hospitals need to be done. The limited access to platform of MSS recording and reporting, keeps the reservoir of MSS

data least explored by the national researchers and thus the platform needs a researcher login access guideline and architecture inbuilt in the data entry platform of MSS. The researcher access needs to be designed having different gates as per the need of the research objectives and the identity of hospitals need to be kept confidential.

MSS gradually reported through self-assessment of health facilities with occasional monitoring by the local, provincial and federal government and gap fulfillment through routine AWPB is the future direction. Development of the standards for national accreditation system and collaboration with international accreditation bodies is the next step to embrace by MoHP.

It is high time MoHP moves ahead with service specific quality improvement tools integrated with MSS assessment to reach the optimal level of quality health services through its outlets and prepare them for high quality health systems that can adapt to changing health needs and health shocks.

Conflict of Interest:

All the authors declare no financial support received for this editorial work and the opinions are their individual opinions and not of the organization that they work for. ATP has worked as technical coordinator, team lead and reviewer in developing the MSS for health facilities. She was procured by NSI, WHO, NHSSP and Divisions for the task. There is no influence of these organizations in any of the content of the article.

MKU is the Chief of QSRD, MoHP.

UP and KA declare no conflict of interest.

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