



Making Health Care Better in Low and Middle Income Economies: What are the next steps and how do we get there?

Monday, April 23, 2012

# SALZBURG GLOBAL SEMINAR

## SALZBURG DIARIES

### Journey's beginning

By: Ezequiel García-Elorrio

**The opening remarks set the scene for a spectacular session in a place where solutions to global problems will be discussed and disseminated.**

The history of the Schloss Leopoldskron and the Salzburg Global Seminar are very impressive; since after World War II this organization has promoted the gathering of people around the world to provide solutions to global problems. The ambience is fantastic – it will surely make participants to give the most of themselves.

During the opening remarks goals were set. The clearest one is to “set an agenda of coming years”. Reviewing where we are and how we got here. Constructing then the action plan for the times to come.

Participants represented a wide variety of settings and realities from around the world. So far just listening to everyone's introductions you can perceive the amount of experience and knowledge in the room. Surely clear objectives and a goal will come from this week-long discussion.

This week-long seminar is described as the “beginning of a journey where we all will go together” confirming that we are “not sitting on plateau but moving ahead”.

The audience is quite diverse, comprising government, patient representatives, international organizations, researchers and improvers. Almost every point of view is represented.

Just to give a sense on the importance of our participation, the questions/debates posted before the seminar were presented to all participants to start the discussion.

Hopefully conversations from Salzburg will reverberate around the world and feedback could be provided.

**Ezequiel García-Elorrio's blog for the ISQua Knowledge Portal can be found online: <http://www.isqua-knowledge.org/activities/salzburg/participate-during/>**



## “Enormous potential” Global healthcare professionals join debate on quality improvement

By: Louise Hallman

**Welcoming over 60 international healthcare professionals from more than 35 countries, Dr. M. Rashad Massoud expressed his excitement at the “wonderful journey” the participants would take over the next six days at Schloss Leopoldskron for the Salzburg Global Seminar session ‘Health and Healthcare Series IV: Making Health Care Better in Low and Middle Income Economies: What are the next steps and how do we get there?’**

The session has been two years in the making, and will follow on from previous sessions' discussions to debate the progress made so far in meeting such targets as the Millennium Development Goals and the role of quality improvement in meeting such public health targets.

Whilst improvements in health care have clearly been made in the past number of years, this progress has since “plateaued”, making it necessary for health care professionals to address the issues and challenges that still lie ahead.

Joining the “crucially important meeting” via a pre-recorded video, Don Berwick, former president and CEO of

the Institute for Healthcare Improvement, USA, highlighted the great opportunity such a global gathering of healthcare experts would experience over the coming week.

“In developed healthcare systems in the Western developed world, we have a crust to drill through,” he said.

“We have an existing legacy production system that for complex reasons has not been orientated around those six aims [safety, effectiveness, patient-centeredness, timeliness, efficiency and equity] for the continual improvement of performance as its primary driver...”

“I have the feeling that low and middle income countries have a thinner crust. There's more opportunity there because in some senses you're building on a relatively less developed platform of management and process thinking. The opportunity in lower and middle income countries is to do it right the first time.

“I think the potential is enormous.”

A ‘Salzburg statement’, along with several reports, will be produced at the end of the week-long intensive discussions.

**Don Berwick's video will be available on the “SalzburgSeminar” YouTube channel.**



**Schloss Leopoldskron was built in 1736 by the Prince Archbishop of Salzburg, Leopold Anton Eleutherius Freiherr von Firmian.** It was restored by renowned theater director Max Reinherdt in the 1920s before being bought by the Salzburg Global Seminar in 1959. It is overlooked by Festung Hohensalzburg, literally “High Salzburg Fortress”.

## TALKING POINT

### Do we need more data?

“Work that is not documented is not done, so definitely documentation would help to improve quality - at the end of the day you have to be able to see what you have done. There are two issues: credible documentation and also making documentation easier... If we have this system where you can plug in the information at the time the activity was going on, or at worst at the close of the day, then you cannot go back at the end of month and change the information for that day.”  
**Charles Nde Awasom, Medical Director, Ministry of Health, Cameroon**

“There’s data for public reporting purposes and there’s data for actual clinical management application. If you connect the two, you have a data source that serves two purposes and is essentially incredibly important to the clinicians themselves... You can’t improve something that you know nothing about. The vast majority of the time [in my research] the data element is collected and sent somewhere on a district level or a regional healthcare system or government’s national health system and the clinic never learns how it’s represented in public health records.”

**Kedar Mate, Director for Developing Countries Programs, Institute for Healthcare Improvement, USA**

“It is helpful [to have more data], but you can do a lot without it, by sampling,

by rigorous independent monitoring, particularly of vaccination programs, and having extensive documentation, like a lot of high income countries do, doesn’t necessarily mean that you use data more intelligently.”

**Sir Liam Donaldson, former Chief Medical Officer, UK**

“It is true that in developing country settings you do have a lack of data...so for sure documentation needs to be improved, but it’s really about what you do with it. In a lot of countries there is tons of data but it’s not developed with clinicians in mind so it’s not relevant and it’s not given to them even if it were relevant so they can do something with it.”

**Ed Kelley, Head of Strategic Programs, WHO Patient Safety, Switzerland**

“A lot of our problems stem from inadequate documentation but more importantly, I think we generate a lot of data that is definitely not used optimally. We don’t have adequate information systems to connect information at community level. If you don’t have a health information system that works well across all levels, you are losing out a lot of vital information that will enable you to put interventions in place that are going to target the community best.”

**Nanthalile Mugala, Director for Technical Support, Integrated Systems Strengthening Program, Zambia**

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you’d like to  
have debated?  
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Making Health Care Better in Low and Middle Income Economies: What are the next steps and how do we get there?

Tuesday, April 24, 2012

# SALZBURG GLOBAL SEMINAR

## SALZBURG DIARIES

### Journey continued

By: Ezequiel García-Elorrio

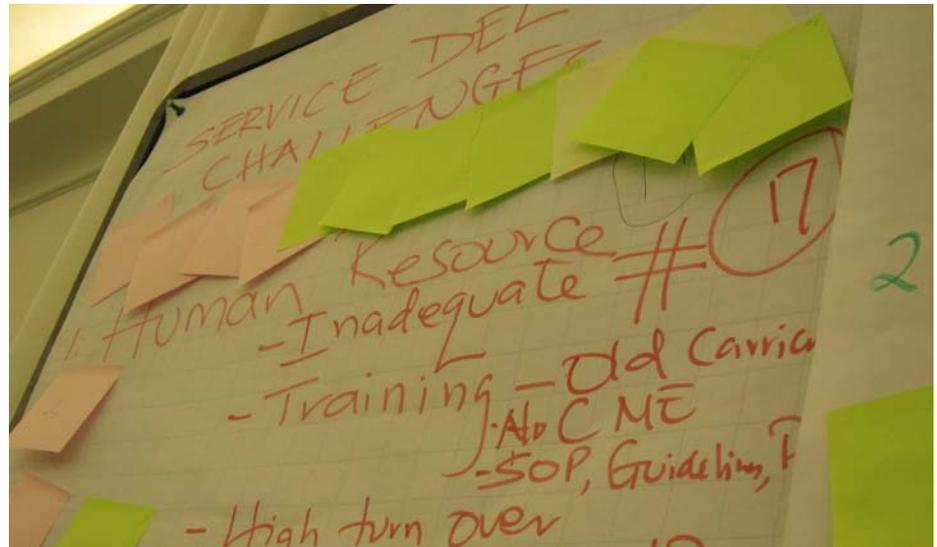
**James Heiby from USAID chaired the Monday morning session where key topics on the present situation of Quality Improvement were discussed.**

After a great warm up, 'the knowledge café' began, with all participants rotating among eight specific topic stations. Experiences and thoughts were shared and finally a facilitator per topic summarized discussions and comments.

Key messages on lessons learnt were:

1. Widely available and simplified data is critical for future QI in LMICs.
2. Cost effectiveness should be included in the QI agenda, stating what should be measured and how it should be done.
3. Organizational structures for quality improvement at the different levels need to be developed to promote capacity building.
4. Knowledge dissemination constitutes a challenge in terms of translation, dissemination and the culture of sharing.
5. Scaling up needs commitment, community involvement, planning and standardized methods.
6. Leaders need to be involved from the inception of the initiative and should receive economic arguments to "buy" interventions and programs, and finally should facilitate the social society involvement.
7. QI methods can and must be applied to processes in healthcare besides clinical care, for example: logistics, human resources and service management.
8. Research is critical to support improvement techniques although mixed methods are needed to create a body of evidence that could be of use for implementers and decision makers. Evaluation also needs a bigger space to disseminate findings beyond the ones generated by research.

A great session and a great methodology. I believe this was an incredible way to share experiences and to leverage an already expert audience.



### HR voted greatest challenge Community involvement close second

By: Louise Hallman

**Human resources – the lack and poor use thereof – topped the healthcare challenge chart, as voted for by Salzburg Global Seminar session participants yesterday afternoon.**

Monday afternoon's session, led by Sheila Leatherman, Research Professor at Gillings School of Global Public Health, University of North Carolina, USA, saw participants to split into groups to identify challenges in two categories: how to improve quality and how to improve healthcare system delivery.

Heated debates arose as participants reported back to the full room. Should "patients' needs" be added to "patients' preferences"? Could the issue of staff competency be considered in the same human resources issue bracket as the inadequate numbers of staff?

Once the participants – from such wide-ranging backgrounds as physicians, academics, government officials and donors – had negotiated and agreed upon the nuances of the challenges, they were then asked to vote on what they believed were the two greatest challenges they faced in improving healthcare.

Coming out resoundingly on top with 17 votes was human resources,

including but not limited to inadequate numbers of health care workers, high turnover, maldistribution geographically, staff morale and unfilled training needs. Community and civil society involvement followed with 16 votes; this issue called for more civil society engagement and client-focus in advocacy, feedback, public protection and responsiveness. In third place was poor planning, encompassing lack of comprehensive operational plans, vertical programs that lack integration and inadequate harmonization of donor programs. Designing a system to meet patient preferences and needs and facilitating the process of addressing different perceptions of quality among providers, policymakers and the public both garnered 12 votes.

Lagging behind were limited capacity and capability to implement QI strategies – 7; leadership behavior – 6; involvement of patients and staff in the process of improving care – 6; absence of QI skills in the head of frontline managers – 6; inadequate information and poor communication – 6; interface of strategy and implementation – 4; optimization of technical skills – 3; poorly articulated arguments to donors and decision makers about the value of improvement and the costs of poor health – 2; and finally inadequate leadership with just one vote.



**Prof. Sheila Leatherman hosted a “fishbowl discussion” as part of the session on Challenges Ahead.** She was joined by Cynthia Bannerman, Head of Quality, Department of Health, Uganda, Natalia Largaespada, Director - Maternal and Child Health, Ministry of Health, Belize, Niaz Mohammad Popal, Ministry of Health, Afghanistan and Robinah Kaitiritimba, Executive Director, National Health Consumers’ Organization, Uganda.

## TALKING POINT

### Donors in healthcare

One issue that was raised in the day’s sessions was that of the role of donors in healthcare improvements. Several participants shared their views with Planning Committee Member *Sylvia Sax*.

“I don’t want donor money because it has strings attached.”

“Donors want short term solutions. When the money is gone after two years, we cannot continue the programs put in place.”

“Donors come with their own solutions and expect them to be implemented.”

“Donors put in parallel initiatives and reporting systems.”

**SGS editor Louise Hallman asked donor representatives for their response.**

“An intrinsic part of what donors are trying to do is support the governments, not to impose a specific agenda. Intrinsicly, improvement has got to be owned by the government, by the country itself. And the solution is a product of dialogue between the donor and the country.”

**Jim Heiby, Medical Officer and Contracting Officer’s Technical Representative, USAID Health Care Improvement Project, Washington, DC, USA**

“Anything we do needs to be something that’s needed by the government and that they would like...”

The role of the donor is several fold: we can provide resources, in the form of money or in the form of technical inputs. But we can also use voice, often at a global level to try and move an entire sector a specific way...

I think the best way we can have an affect and have impact is to support a country’s leadership and to try and leverage each other. We shouldn’t be independently investing here, there or wherever. The whole needs to be greater than the sum of its parts...

So it’s about integrated work, led by governments.”  
**Mary Taylor, Senior Program Officer, The Bill and Melinda Gates Foundation, Seattle, USA**

“One of the important things for donors is to know the real situation of the governments, or what is going on in healthcare, what priorities there are, what exact problems there are, what the priorities of the ministry of health are. And then it’s very important to communicate with them and involve them in the process from the beginning...to help get them on your side while you are implementing something you know will be good for them and it will be easier to transfer to them after you leave.”

**Shirin Kazimov, Health Project Management Specialist, USAID, Azerbaijan**

Who do you agree with?

Carry on the discussion.

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Making Health Care Better in Low and Middle Income Economies: What are the next steps and how do we get there?

Wednesday, April 25, 2012

# SALZBURG GLOBAL SEMINAR

## SALZBURG DIARIES

### Confused.com

By: Ezequiel García-Elorrio

Silvia Sax from Heiderberg University in Germany chaired the Tuesday morning session on Overcoming Issues of Confusion. Another highly participatory methodology was used to allow everyone's opinion. Considering the level of expertise in the room a very interesting topic was brought to discussion and much was said about typical confusions when talking about health care.

From brief presentations made by participants from different regions of the world, we could reflect on the fact that the issue of confusion is keen to everyone, given we all "suffer" from all the contradictions and heterogeneous use of terms.

I participated and witnessed very lively discussions that were very fruitful whenever producing conclusions. Below you can read the topics discussed and some issues of confusion:

*Healthcare QI Terminology:* naming and concepts; differing models using same fundamentals; problems when implementing and using terminology.

*QI Mechanisms:* what are the different mechanisms?; what works in each setting?; role of technical assistance.

*Whose role is to lead improvement in healthcare quality?:* government role; ownership of initiatives and community; role of donors: the advocacy issue.

*Interpreting and acting on results:* data use for decision makers; use and report of data using a common framework.

Overall the group set up a list of recommendations (see ISQua Knowledge Portal for the summary for the session) that will help to construct the final recommendations at the end of the week.

Many contributions were made and this was maybe one the most difficult sessions to narrow suggestions to a short and prioritized list.



Participants vote on matters of confusion in healthcare improvement

## SESSION OVERVIEW

### Seventh and eighth blocks Calls to expand "6 building blocks"

By: Louise Hallman

**Participants the Salzburg Global Seminar called on the WHO to expand its "six building blocks of health systems" in Tuesday afternoon's QI and Health Systems Strengthening session.**

Presented by Ed Kelley, Head of Strategic Programmes and Coordinator, WHO Patient Safety, Geneva, Switzerland, the session considered the existing building blocks inadequate in improving the healthcare systems of lower and middle income countries.

Published in 2010, the WHO "six building blocks of health systems" cover:

1. Service delivery
2. Health workforce
3. Information
4. Medical products, vaccines and technologies
5. Financing
6. Leadership and governance (stewardship)

In his summary, Kelley said, "It is clear that the 'six building blocks'...include major action areas where the application of improvement methods can achieve significant results."

However, common concern amongst the Seminar contested that community mobilization and patient perspective should also be added to the existing list.

Reflecting on all the comments and suggestions made through the group work of the afternoon, Kelley added in his summary:

"Though [its] a broad set of areas to address, key lessons emerged that may form the beginnings of an overarching strategy to more explicitly link quality and safety improvement to the larger health systems strengthening effort."

These key lessons included mobilizing clients and reforming financing systems, strengthening quality in health information systems and building the healthcare workforce.

## FEATURED FELLOW

# Dr. M. Rashad F. Massoud

By: Louise Hallman

**Trying to pin Dr. M. Rashad Massoud down long enough for an interview is no mean feat. The smiling American-based, British-educated Palestinian doctor is seemingly always on the go. The morning sessions start at 9am and he might have been up until 1am, perfecting the next day's line-up, updating the e-conferencing website, or discussing the improvement of quality improvement with other participants into the small hours, but the tiring schedule never shows.**

Dr. Massoud is no stranger to the Salzburg Global Seminar. Now chairing the session 'Making Health Care Better in Low and Middle Income Economies: What are the next steps and how do we get there?', Dr. Massoud first came to Salzburg as a fellow in 2001.

A student of Don Berwick, the outgoing Administrator of the Centers for Medicare and Medicaid Services and the former president and CEO of Institute for Healthcare Improvement in the USA, Dr. Rashad attended a session on Patient Safety and Medical Error. This first visit to Schloss Leopoldskron convinced Dr. Rashad of the value of the Seminar.

"The first seminar I came to," Dr. Massoud explains over a hastily poured coffee, "followed the Institute of Medicine's report 'To Err is Human' in which medical errors were described as between 48,000 and 98,000 errors per year, half of which are easily preventable. And what [Don Berwick, session chair] did, because safety was a poorly developed area generally speaking in healthcare, he brought in experts from aviation, from space, from road traffic accidents, from psychologists to meet with people who are in the area of improvement and that was the beginning of a major thrust in patient safety today. In fact some of the people who were here in 2000 are today some of the leaders in safety and healthcare. That was an amazing experience..."

"The whole patient safety movement – a lot of them were here and that's how the work started. The meeting here was cer-

tainly a significant milestone in the development of the safety effort in healthcare and it really moved things forward."

Dr. Massoud agrees he has similar high hopes for his session this week.

"I'd really like us to take the opportunity of this magnificent setting," he says turning to look out of the Meierhof, across the lake and to the Untersberg mountain.

"The environment we have, the focus that we get out of having 60 people in the same place – not just for the session but for all the interactions outside of the sessions. Having been here already – these interactions were even more valuable than the formal sessions themselves."

Indeed – Dr. Massoud is almost as great an advocate of late night discussions in the Schloss' Bierstube as he is of improving healthcare.

"So if we can put all this together," he continues, "what I'd like to come out with is a thoughtful way that all of us who are representing different groups – host country national governments, improvement efforts, representing implementers in the field, donor agencies, other stakeholders – all of us should think through how do we maximise and leverage everything we have that would enable us to improve healthcare in a different way, take the healthcare improvement effort, which has so far been very successful, to a whole other level."

The session itself has been two years and dozens of hours of Skype conference calls in the making and brings together over 60 healthcare professionals, from physicians, donors, improvement advocates, government officials to civil society leaders, from over 35 countries.

"When John Lotherington [SGS Program Director for Health] approached me with the idea of a seminar on improvement science...my idea was that we probably don't need just another conference or meeting to talk about it, however what we could do is a strategy conversation – something that would enable us to think through what have we accomplished to date, what are the challenges ahead and design an agenda that would take us through the next five to ten years. Everything followed from there. I invited partner organisations, colleagues to join the planning committee. We started to think through what would that agenda look like, what are the themes we have to discuss, who are the people we need to have in the room?"

Much of this week's session has fo-



Dr. M. Rashad F. Massoud

cussed on 'Quality Improvement', and although the physician-cum-Director of USAID's Health Care Improvement Project is a strong advocate of the school of thought (that more isn't always better – more resources, more money, more hospitals – and that healthcare professionals should strive to deliver the best level of care from the resources they have and constantly improve upon that level of care) he is not overly keen on the term.

"If there was one thing I could do here it would be remove the word 'quality'," he laughs.

"Everything we're talking about here is how can we ensure the patients get the best outcomes possible. What is the best medicine that we know? Can we deliver it to them correctly so that they benefit maximally from this? Can we do this in ways that are not wasteful and inefficient? Can we be mindful about meeting patients' needs and expectations? Improvement is what we should be doing in the first place; good quality care is what we should be providing patients anyway."

His enthusiasm for the topic is clear from the outset, driving conversations from the breakfast table first thing in the morning, through the day's sessions, right up to in the Bierstube – the Seminar's own on-site bar – last thing at night.

"He's like this all the time," says his research assistant, Nana Mensah Abrampah. Dr. Massoud just laughs, shrugs, and hurries off for another meeting.

## HEAD TO HEAD

# Patients' needs and preferences Can the two ever be the same?

Sparked by a debate that emerged when establishing the key challenges to healthcare improvement on Monday afternoon, an addition to the program was made to air the views of participants on the matter of patients' needs versus their preferences. Are the two as diametrically opposed as they first appeared in Monday's session? Can one exist without the other? And can they ever be married together? Or should they always be considered separately?

**Louise Hallman spoke to the two main discussants – Robinah Kaitiritimba and Pierre Barker – to try to establish some of these answers.**



**Robinah Kaitiritimba**, Executive Director, National Health Consumers' Organization, Uganda



**Pierre Barker**, Senior Vice President, Institute for Healthcare Improvement, USA

**'Patients' preferences' is the choice that patients make for different reasons and 'patients' needs' is that which is necessary. I think both of them are important. I think patients' preferences are extremely important and patients' rights must be the most important thing. But I think it's important to consider circumstances.**

Where patients' cultures and traditions overrides the freedom to make the kind of choice that would improve life. For instance, woman in the process of childbirth and pregnancy have to make certain because of what culture and traditions demand; you are not allowed to say that you are pregnant...so that means that women will not register with healthcare givers. It is considered brave for a woman to give birth in alone in a room and not make noise, even if she's in pain.

So it's extremely important that those kinds of circumstances are considered in order to be able to serve the needs of patients.

We should begin to think about marrying the patients' interests and the choices they make. The right to choose should be proceed by a lot of information and education and empowerment. The right choice should be the informed choice.

**We still have a lot of work to do, particularly in accessing the needs of people deep in the community. So I think we know what to do, although we don't do it very well, when patients come to see doctors and nurses, but I think we are way behind in our ability to access and respond to the needs of people in the community that are totally determined by context and culture.**

Preferences are culturally determined and needs are medically determined. I think both are absolutely crucial – I don't think it's an either/or issue. I think [patients' preferences and patients' needs] should always be considered together. They both need to be addressed; it's just a question of how you design your response. You have to be very thoughtful about both of them because the needs are going to be addressed through patient education and the preferences are going to be addressed through deep engagement in community structures.

And then there's the personal level; there are preferences that are not totally culturally determined and they all need to be addressed at the point of care.



**Mozarts Geburtshaus, 9 Getreidegasse.** The Mozart family lived here for 26 years, from 1747 to 1773. Wolfgang Amadeus Mozart, was born here on January 27, 1756. It is now a museum and exhibits include Mozart's child violin, his concert violin, his clavichord, his harpsichord, portraits such as the unfinished oil painting "Mozart at the Piano".

## TALKING POINT

What role does consumer choice have in improving healthcare in lower and middle income countries?

“Consumers’ choice is not really only related to the individual’s choice but it relates to the collective’s choice. If the choice for the collective consumer is limited then an individual’s right to choice ends where the rest of the collectivity’s start.”

**Jorge Hermida, Director, HCI Programs - Latin American Region, URC, Ecuador**

“I think it is fundamental if you want to improve healthcare, the quality of healthcare, consumers’ choice is a key element. That implies that first you have to recognise that, and second you have to give elements to the people so that they can make choices - giving information, allowing them to participate, empowerment. This is not an easy thing to do... If they have a choice in selecting a physician for their care, there are some areas with only one physician so they have no choice! ...But you have to it. I see it as a key element for pressing the system to provide quality health services. If that doesn’t happen, the health system won’t be as responsive as it should be.”

**Enrique Ruelas, Senior Fellow, Institute for Healthcare Improvement, Mexico**

“Consumers in most circumstances have less opportunities to make choices about their healthcare. The bulk of the population live below the poverty line and in the remote areas. It is not a matter of choice for them but rather a matter of access to the nearest health facility...”

In cities people have health facilities but then again the poorer tend to be going for public hospitals and they have limited choices. Those with better socioeconomic status and can afford better and higher quality prices for healthcare services, they will go for private hospitals because the perception is the quality is better...

And then we have a small percentage of people who really can afford health services outside the country.”

**Mirwais Amiri, Senior Quality Improvement Advisor, URC, Afghanistan**

“The primary consumer in healthcare is the patient. So when we are talking about low and middle income countries, the only way consumers’ choice can even be an issue is when affordability and access to services are there. And before there is affordability and access, the only choice the consumers have will be to either live or die.”

**Ayman Sabae, Master’s Student, International Healthcare Management, Innsbruck, Austria/Egypt**

Got a question you’d like to have debated? Tweet us! @salzburgglobal



Making Health Care Better in Low and Middle Income Economies: What are the next steps and how do we get there?

Thursday, April 26, 2012

# SALZBURG GLOBAL SEMINAR

## SALZBURG DIARIES

### Hearts and minds for QI

By: Ezequiel García-Elorrio

**On Wednesday the sun was shining and the weather was very mild – the right ambience for a critical discussion on leadership, a key factor for every QI initiative around the world.**

Dr. Bruce Agins, Medical Director of the New York State Department of Health AIDS Institute chaired the morning session; his set of panelists gave their views on the subject.

We first had the chance to listen to a presentation from Rwanda's Health Minister, Dr. Agnes Binagwaho, about situational leadership and the experience from local initiatives; a very instructive description on how to get things done in limited resource settings and changing environments. She seemed like a very committed and strong person, very satisfied with the accomplishments so far.

We then participated in a panel discussion where the panel's views on leadership prompted stimulating discussion.

One of the things that was said and struck me, was something said by Sir Liam Donaldson: "We have to win the heads and win the hearts" in order to succeed.

After the break we had a small group discussion with the following topics:

1. How do leaders effectively carry out the designing of and planning for quality?
2. How do leaders effectively engage community in quality improvement efforts?
3. How do leaders effectively select strategies to communicate initiatives and results?
4. How do leaders implement coordinated strategies at all levels of the public system?
5. How do leaders effectively implement quality improvement efforts?

Several suggestions were made [please read the online summary of the session] and will also be incorporated in the final document of the Session.

Two other comments that impacted me were: "Please never give up" and "Quality Improvement is an evolution not revolution". There was so much wisdom around.



**Rwanda's Minister of Health, Dr. Agnes Binagwaho** joined panelists from Namibia, Thailand, the UK, Uganda and the US to talk about leadership

## SESSION OVERVIEW

### "Leaders must never give up" Wise words from Rwandan MoH

By: Louise Hallman

**Participants at the Salzburg Global Seminar were urged on Wednesday to continue to strive for quality improvement in healthcare by the Minister of Health for Rwanda, Dr. Agnes Binagwaho.**

Dr. Binagwaho joined the Seminar to speak on 'Strengthening Leadership and Policy for Improving Care in Low and Middle Income Economies' via video link from Kigali. She spoke on her own personal experiences of leading quality improvement, particularly highlighting the importance of engaging all stakeholders, including the population, in improving healthcare, as politicians like herself rarely stay in office for more than two years.

The session also saw an international panel - from Namibia, Thailand, the UK, Uganda and the US, as well as Rwanda - convene to share their views and successful experiences of leading healthcare improvements.

Community level engagement was brought

up repeatedly through out the session, with participants during their breakout workshops yet again drawing attention to the limitations in traditional thinking. One of the key suggestions to be made by Salzburg participants addressed the need to lead change through all levels of healthcare systems, not just national, but regional, district and community.

Another suggestion was that leaders must establish clear direction and set priorities that are then communicated to the public, championing transparency in performance and displaying integrity in addressing those promised priorities.

Session chair, Bruce Agins, highlighted in his report: "As they stay attuned to their environment and changing landscape, leaders in particular need to stay attuned to the care provided to those most vulnerable in their nations and drive improvement to meet their needs which may often require specific efforts to ascertain."

All suggestions made by the groups will be incorporated into the Salzburg Statement.



**Sir Liam Donaldson presents the Swiss Cheese Model of Accident Causation.** Presenting the case of Mamma Ses-say, an 18-year-old mother in Sierra Leone, who died due to complications in labor with twins, Sir Liam proposed that Mamma had been failed at several points and efforts were needed to “fill in the holes” to avoid future maternal mortality.

## TALKING POINT

What is the number one most important attribute for a good leader to have?

“Sensitivity to the needs of his staff.”

**Rob Palkovitz, Professor, Human Development & Family Studies, University of Delaware, USA**

“Puts the client first.”  
**Jean Nguessan, Country Director, URC, Cote d’Ivoire**

“To be able to visualize, five, ten years ahead.”  
**Amit Pawal, Consultant, USAID & GTZ, India**

“Effective communication.”  
**Nana Mensah-Abrampah, Quality Improvement Fellow, URC, USA**

“Communication and compassion.”  
**Sylvia Sax, Lecturer, Institute of Health, University of Heidelberg, Germany**

“Be inspiring to the people they lead.”  
**Sarah Byakika, Assistant Commissioner for Quality Assurance, Ministry of Health, Uganda**

“A good team that can point out the real priorities and ensure the strategic ones are being taken and put into the agenda.”  
**Tatiana Paduraru, National Consultant on Foreign Assistant, Ministry of Health, Moldova**

“Tolerance...they have to

work with different donors and organizations... It is important for leaders to understand what other people would like and try to choose key issues.”

**Aigul Kalieva, Chief of Neonatal Services, Ministry of Health, Kyrgyzstan**

“A vision, along with empathy to others.”  
**Shirin Kazimov, Health Project Management Specialist, USAID, Azerbaijan**

“Trust his team.”  
**Anna Korotkova, Deputy Director for International Affairs, Federal Institute for Health Care Organization, Russian Federation**

“Ability to see different sides to an issue.”  
**Carlo Irwin Panelo, Chief of Party, Health Policy Development Program, USAID, Philippines**

“Integrity...straightforward, accountable, be visionary.”

**Baile Moagi, Director, Health Inspectorate, Ministry of Health, Botswana**

“A vision...chart out a path and all other things will fall into place.”  
**Charles Nde Awasom, Medical Director, Ministry of Health, Cameroon**

“Insight...if a leader isn’t able to learn from mistakes and to support people when mistakes are made, they will never reach their potential for delivery.”  
**Tracey Cooper, President, ISQua, Ireland**

“Unflagging dedication and commitment to the goal of improvement.”  
**Bruce Agins, Medical Director, AIDS Institute, New York State Department of Health, USA**



# Making Health Care Better in Low and Middle Income Economies: What are the next steps and how do we get there?

Friday, April 27, 2012

## SALZBURG GLOBAL SEMINAR

### SALZBURG DIARIES

#### Day of action

By: Ezequiel García-Elorrio

**Pierre Barker from IHI chaired a very interactive session on sustainability on Thursday morning covering: “Sustainability in not permanence but integration into the culture of the healthcare system”**

To begin every participant scored on a special designed matrix the way their own country is doing on the different aspects of QI effort implementation and dissemination. The results were the aggregated.

We then explored different perspectives that may help sustainability. They were: Policy, funder and politician’s vision. Alignment of managers and providers, data system adoption, QI capacity needs, role of the technical advisors and the role of the civil society were also topics of discussion.

Some thoughts that come from it were:

1. Demand of quality from the civil society is crucial to give continuity to QI efforts.
2. Tension within current needed systems to collect data for the QI process.
3. Capacity of the community to improve the demand from the civil society
4. Advisors had the challenge of demonstrating the effectiveness of the interventions specially whenever communicating the to the outside world.
5. Harmonization and coordination of donors is the will from the funder’s perspective.
6. Politicians should include quality as a national policy to give QI efforts sustainability.
7. Developing a common language is critical to create a policies across countries.

In the self-assessment of the countries most of them fell in a category where that so far mostly were in the middle of the river or starting to cross it. Not the best scenario but an opportunity to do it the right way considering the gathered experience.

It’s been a busy morning and the best is to come. Lots of ideas and suggestions are consolidating for a productive closure session.



**Senior IHI Fellow, Enrique Ruelas** presented his ‘10 Commandments to deal with politicians’ during Pierre Barker’s ‘Sustaining Execution’ session

### SESSION OVERVIEW

## Preaching to the unconverted “You may lose the battle, but you won’t lose the war”

By: Louise Hallman

**On the penultimate day of the Salzburg Global Seminar on ‘Making Health Care Better in Low and Middle Income Economies: What are the next steps and how do we get there?’, participants were given a new set of commandments to consider: ‘Ten Commandments for Dealing with Politicians’.**

Enrique Ruelas, Senior Fellow at the Institute for Healthcare Improvement, Mexico, shared his commandments with the group as part of the Thursday morning session on ‘Sustaining Execution’ covering introducing QI systems to countries unfamiliar with the methodology and designing sustainability into healthcare initiatives from the start.

Mr. Ruelas’ commandments offered an insight into the psyche of politicians and included selling the concept of QI in

healthcare to politicians, not arguing with them, and also aligning your position with existing initiatives. The full list can be seen overleaf.

Reflecting on the morning’s session, Bruce Agins, chair of the previous day’s session on leadership said: “There clearly is no one way to communicate the benefits or importance of QI... One has to know and read your audience to adapt your message appropriately, i.e. scanning and reading the environment effectively to tailor and craft your message.”

As with previous sessions, all key suggestions made by the group were collated by the session chair to be included in the final session to be held on Friday morning entitled ‘Next Steps’. Participants will not only reflect on the outcomes of the week-long Session but also produce a Salzburg Statement to be shared with key stakeholder groups.



## TALKING POINT

What positive outcome will you take back to your colleagues from this session at Salzburg Global Seminar?

“That the patient matters and quality improvement is all about the patient.”

**Natalia Largaespada Beer, Maternal and Child Health Technical Advisor, Ministry of Health, Belize**

“Quality isn't really my field...I was confused, and I guess I didn't really grasp the importance of quality or the huge impact it has [until now].”

**Michelle Vanzie, Director of Policy Analysis and Planning Unit, Ministry of Health, Belize**

“From this meeting I will have a lot of friends! [I will

have] a lot of challenges. We have discussed a lot of issues on quality so when I go back, I think my vision will be different.”

**Babacar Ndoye, Coordinator, National Program Against Nosocomial Infections, Ministry of Health, Senegal**

“This meeting has brought great light to ideas on what we can share with our country, not to show that QI is a program but a science. I think we can present, we can advocate to leadership that this is the QI methodology.”

**Januario Reis, Clinical Site Monitoring Specialist, USAID, Mozambique**

“The one this is the validation of the enthusiasm around using quality improvement to enhance the healthcare of poor around the world and create a quality movement to really make great progress very quickly in healthcare.”

**Sheila Leatherman, Research Professor, Gillings School of Public Health, UNC, USA**

## THE 10 COMMANDMENTS

### How to deal with politicians

- 1. Politicians always think they know best...**because they are politicians. Do not make them feel otherwise.
  - 2. Politicians always have great ideas...** although maybe their ideas are the ones you gave them.
  - 3. Do not argue with them...sell!** Good sellers always offer a benefit first and then the product as concrete and clear as possible.
  - 4. Align your proposals** with other existing initiatives to add weight.
  - 5. Bring on board as many stakeholders** as possible, this increases your power.
  - 6. Show your power but never say you have it...**that might be interpreted as a threat - politicians will understand you have it.
  - 7. Expose the laggards...**but be kind.
  - 8. Give visibility** to what you are doing.
  - 9. Make quality improvement an inspiring cause to be embraced...**not an argument or a method.
  - 10. Pull, they will push. The more you push, the more resistance you may create.** The more you pull, others will want to join. Make politicians feel that the train is moving and therefore, either they jump in or be left behind.
- Finally, be very enthusiastic, patient and tenacious.** Politicians come and go. Your cause will always be. You may lose a battle but will never lose the war.