

Quality Health Care: Comparison between U.S. and Nigeria

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Introduction

The target of a healthcare system is to employ healthcare, social and other resources to meet people's health needs within a given area (Kerleau and Pelletier-Fleury 2002). Ideally, a healthcare system should encompass everyone, from the person who is ill and in need of care to the paramedic who brings the person to a hospital, from the nurses who attend to the sick person to the doctors who diagnose the patient, from the pharmacist who dispenses drugs for the patients 'use to the surgeon who performs surgery on the patient (Wei et al. 2007). In many countries, the health care system also includes the insurance agencies (social or private) and insurers make decisions based on the type and extent of care to be administered. Large differences in healthcare systems exist between countries. These variations are even more evident between developed nations for example United States of America and developing nations like Nigeria. This paper compares the quality management structures and processes commonly found in United States healthcare organizations with that of Nigeria's healthcare organizations. According to Varkey (2010), the Institute of Medicine (IOM) defines quality of care as the degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge. The Agency for Health Research and Quality (AHRQ) also describes quality of care as doing the right thing at the right time for the right individual to get the best possible results (Varkey, 2010 p.1). Avedis Donabedian created the structure, the process, and the outcome paradigm for assessing quality in healthcare that had profound influence than The is often thought of as the modern founder and leader of the quality field (Varkey, 2010; Graham, 1995). This paper will base the comparison between the quality of United States healthcare organizations and Nigeria's healthcare organizations on the Donabedian model. According to Graham (1995), the structure denotes the attributes of the settings in which care occur this include the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure (such as medical staff organization, methods of peer review, and methods of reimbursement). The process is what is actually done in giving and receiving care which include patient's activities in seeking care and carrying it out as well as the practitioner's activities in making a diagnosis and recommending or implementing treatment. Outcome denotes the effects of care on the health status of patients and populations.

A brief description of the health system in nigeria

Nigeria is a West African country, sharing borders with Benin, Cameroon, Chad, and Niger and having a coastline on the Gulf of Guinea. Nigeria is the seventh most populous nation in the world, and the most populous in Africa, with an estimated population of 170.1 million as of July 2012 (Boslaugh, 2013). The population growth rate in 2012 was 2.6% (the 27th highest in the world), the net migration rate negative 0.2 migrants per 1 ,000 population, the birth rate 39.2 births per 1 ,000 (the 14th highest in the world), and the total fertility rate 5.4 children per woman (the 13th highest in the world)(Boslaugh, 2013). In Nigeria, national legislative recognizes the right to health. The national health system is divided into a three tier structure with responsibilities at the federal, state, and local government levels. All three tiers are involved in all the major health functions: stewardship, financing, and service provision. The local governments are responsible for providing healthcare to the population at the most basic levels and institutions, including primary health care and child vaccination centers as well as local and community health clinics. Secondary healthcare services include institutions

such as state general hospitals and private specialist hospitals. This level of health care provides medical services at a level higher than that obtained from the primary healthcare facilities. Healthcare at this level is provided by the state government and basically provide specialized services to patients referred from the primary healthcare level through out-patient and in-patient services for general medical, surgical and community health needs. Support services such as laboratories, diagnostics, and blood banks are provided. Tertiary health care services comprise health care services that are provided by highly specialized institutions and thus represent the highest level of healthcare services in the country. This level of healthcare provides highly specialized healthcare services in many areas including orthopedic, psychiatric, maternity, and pediatric specialties. Institutions at this level include university teaching hospitals, federal medical centers, and other national specialist hospitals (Aigbokan, 2000).

Nigeria's public health infrastructure comprises a Federal Ministry of Health (FMOH), 37 State Ministries of Health, and approximately 1,300 primary health centers serving 774 Local Government Areas. At the policy level, the FMOH develops and implements policies and programs that should deliver quality care that is effective, efficient, and affordable (Society for Quality in Health Care in Nigeria (SQHN), 2014). The FMOH and the federal parastatals play a key role in influencing many aspects of quality delivery within the health care arena. As a policy maker and implementer, the FMOH provides healthcare at the tertiary level through the department of hospital services. As a regulator, parastatals such as the Medical and Dental Council of Nigeria (MDCN), the Medical Laboratory Scientist Council of Nigeria (MLSCN), Pharmacists Council of Nigeria (PCN), and the Nurses and Midwifery Council of Nigeria (NMCN) accredit and regulate health care professionals and facilities. The federal tertiary hospitals that provide the tertiary health services are directly supervised by the department of hospital services, which directly reports to the Minister at FMOH. The department of hospital services directly appoints chief medical directors at the tertiary hospitals and develops policies on nursing, coordinates training programs for nurses, and supervises health research. While the department of hospital services monitors and holds tertiary hospitals accountable, the degree to which tertiary hospitals deliver patient-centered, safe, effective and efficient care is largely up to the individual hospital itself. For example, one tertiary hospitals working to institutionalize a high quality laboratory management system that improves supply chain management and reduces waste (SQHN, 2014).

Comparison of U.S. and Nigeria public health structure

In United States, the Affordable Care Act seeks to increase access to high quality, affordable health care for all Americans. The Act set a national strategy for quality improvement in health care (the National Quality Strategy) which was established by the secretary to the Department of Health and Human Services (AHRQ, 2011). The AHRQ (2011) stated that the National Quality Strategy was established to pursue three broad aims that are used to guide and assess local, state, and national efforts to improve the health care delivery system. The aims include: improving the overall quality by making health care more patient-centered, accessible, reliable, and safe; reducing the cost of quality health care for individuals, families, employers, and government; improving the health of United States population by supporting providing interventions to address behavioral, social, and, environmental determinants of health. Even though the definition and measurement of quality in health care are not as clear-cut as they are in other industries, the delivery sector of health care has come under increased pressure to develop quality standards and demonstrate compliance with those standards. There are higher expectations for improved health outcomes at the individual and broader community level. The concept of continual quality improvement has also received much emphasis in managing health care institutions. The structure of the health care in U.S. shows more advancement than most other countries of the world. In 2004, the United States had 2.67 physicians per 1,000 population; in 2005, they had 9.82 nurses and midwives per 1,000; and in 2000, they had 0.88 pharmaceutical personnel per 1,000,

2.28 laboratory health workers per 1 ,000, and 1 .63 dentistry personnel per 1 ,000 (Boslaugh, 2013 p.496). A huge difference when compared to that of Nigeria.

In 2008, Nigeria had 0.40 physicians per 1 ,000 population, 0.13 pharmaceutical personnel per 1 ,000, 0.17 laboratory health workers per 1 ,000, 2.51 health management and support workers per 1 ,000, 0.03 dentistry personnel per 1 ,000, 0.14 community and traditional health workers per 1 ,000, and 1 .61 nurses and midwives per 1 ,000 (Boslaugh, 2013 p.340). Also the health care facilities in U.S. are accredited by the Joint Commission who inspects for condition of licensure and receipt of Medicaid reimbursement (Shi & Singh, 2015). Joint Commission ensures that certain quality standards are met by these health facilities. In Nigeria, the Society for Quality Health care in Nigeria(2014), has advocated that health facilities in Nigeria should be assessed under the quality improvement program on health care infrastructure, skills set, and expertise of personnel, and safety processes for both patients and health care workers. Due to the political problems in Nigeria, the health care system has been declining since 1980s. Paradoxically while health care facilities have been declining, the cost of acquiring health care has been growing. With the decline in facilities and the increasing cost of health care, the problems of geographic and economic barriers to quality health care have worsened. The situation is compounded by the living condition of the population, which was aptly captured by Aigbokan (2000). He found that, between 1985 and 1996, an increasing number of Nigerians, 38% in 1985, 43% in 1992 and 47% in 1996, were living in absolute poverty. This state of affairs gave room for people to use less expensive, but clearly inferior, medical care, compared to the one provided by medical outlets approved by government. Among such alternative providers could be found spiritual homes, traditional health clinics and self-medication, many of which are of sub-standard quality and inherently unsafe. In a bid to promote the use of quality health care systems, the government, by Decree No. 35 of 1999, established the National Health Insurance Scheme (NHIS)with the broad objectives of ensuring that every Nigerian has access to good quality health care service at affordable cost (Ibiwoye & Adeleke, 2008).NHIS subsidizes the cost of health care for the citizens in order to increase access to quality health care. Perhaps the weightiest factor in the impediments to accessibility to quality health care is cost. Because of the prevalence of poverty, many people who reside in areas that are only a walking distance from a health facility may fail to use such facility because they cannot afford the cost (Ibiwoye & Adeleke, 2008).NHIS is seen as a means of promoting access to health care by reducing or subsidizing the cost. Similarly in United States the Affordable Care Act also advocates uninsured Americans to get insurance so as to increase access to health care.

Physicians need to know their patient's past health and medical problems, and their family's medical history as well to provide quality care. Often times, patient information is contained in a paper medical files that maybe incomplete, lost, and illegible. Electronic health records (EHR) and other information systems can help prevent medical errors and improve treatment decisions and quality and efficiency of care by helping caregivers understand what treatments work, what drugs to prescribe and what other care a patient might be receiving (NCQA, n.d). Both physician clinics and hospitals have adopted the electronic health records and over half of physicians in United States now use EHR systems which the Department of Health and Human Services referred to as a tipping point (Shi & Singh, 2015).

Interpersonal relationship between the health care provider and the patient is a vital component of quality health care (Graham, 1995). It involves the interpersonal exchange, the patients communicates information necessary for arriving at a diagnosis, as well as preferences necessary for selecting the most appropriate methods of care. In Nigeria, PloS (2005)examined the treatment of patients with HIV/AIDS in a survey on 1 ,021 professionals in 111 urban hospitals over 4 states of the federation. It was found that only a few members of staff comply with professional ethics but that the majority showed discriminatory attitudes to patients, in addition to many other forms of stigmata, discrimination, and unfair treatment of patients face in their families, communities, and places of work. Among reasons suggested for the behavior were inadequate education, decay of infrastructure, decay and scarcity of

protection materials. The study called for enforcement of ethical obligations and antidiscrimination policies. United States has advanced so much in the technology that aid the technical aspect of quality of care. Sophisticated diagnostic procedures have reduced complications and disability, new medical cures have increased longevity, and new drugs have helped stabilized chronic conditions. Advancement in medical technology is one aspect Nigerian health care lack, only few hospitals (tertiary hospitals and advanced private hospitals) can provide few of these medical technologies hence, the reason for medical tourism to developed countries for those that can afford it.

In United States, many hospitals are putting new rules in place that require doctors, nurses and other employees to report errors and “near misses “as soon as they happen (NCQ A,n.d). As simple as it sounds, hospitals are making sure doctors, nurses and others wash their hands before treating patients. Patients are given ID bracelets with a bar code to help ensure that they get the right treatment. And surgeons are marking body parts to be operated on so that the right procedure is done on the right part. In Nigeria, there are reports of adverse event systems being embedded in some facilities, there is no nationally endorsed list of serious adverse events(as in the United States where the National Quality Forum has such a list)that facilities can leverage as a standard by which they can measure their performance in reducing preventable harm (SQHN, 2014).

Health care in Nigeria is free for some particular groups of people: the elderly, pregnant women, and children under five years. Most of these patients are illiterates and usually don't participate in the care given to them. Major difficulties facing clinicians in helping their patients understand the importance of quality management include poverty or low income levels in some patients 'populations, often results in problems with accessing quality health care organizations, especially in the private sector. According to NCQA(n.d), patients who actively participate in their care usually get a better results. Activities like asking questions about their conditions and recommended treatments, keeping a list of all their medications and informing doctors of medication allergies or prior adverse reaction. Patients' understanding of their health and the medical care available to them is very important to their ability to get quality care. The ability to understand and follow a doctor's advice can always make the difference between getting well or staying sick.

Challenges of quality health care

Management of primary health care (PHC)systems in less developed countries is always impeded by factors such as poorly trained personnel, limited financial resources, and poor worker morale. A study by Zeitz et al (1993)explored the ability of local-level PHC supervisors in rural Nigeria to use quality assurance management methods to improve the quality of the PHC system. PHC supervisors introduced a checklist implemented during monthly visits to facilities to monitor how workers managed cases of diarrhea. With the introduction of the checklist, performance in history-taking, physical examination, disease classification, treatment and counselling improved over the evaluation period. A health information system audit found that a variety of reporting forms were used at PHC facilities. Quality assurance management methods were used by PHC supervisors in Nigeria to improve supervision and the health information system. Quality assurance management methods are appropriate for improving the quality of the PHC in Nigeria and in other less developed countries where at least a minimal PHC infrastructure exists (Zeitz et al. 1993).

Society for Quality in health care in Nigeria identified some challenges facing quality health care in a survey report in 2014. Lack of uniform cross collaboration between health care organizations for example high patient, doctor ratios and substandard facility infrastructure. Also severe resistance to change from health workers is a major hurdle necessitating massive culture and attitudinal change. Lack of awareness of quality management by health care professionals and financial constraints were also noted as impediments to quality management implementation. SQHN (2014)proposed solutions to reduce the identified barriers these include need for training program addressing the basic

principles of quality management systems, specific discipline related trainings (e.g. customer service, environment of safety, environmental infection control and waste management topics, clinical safety topics, etc.), leadership training is also needed to improve resource development. Multidisciplinary round table discussions where representatives from government, professional licensing agencies, professional associations, HMOs, outpatient facilities, a few patient representatives who have experienced preventable health care related illnesses are necessary.

Improving the quality of health care

According to National Committee on Quality Assurance (NCQA), most payments for health care in United States relate to how many services (also known as the volume of care) are delivered. Efforts are under way to change the way Americans pay for care so that it rewards quality instead of volume of care. Some insurance companies reward doctors for improving care for diabetes and other chronic conditions. Others reward higher patient satisfaction, better access to care, the use of more preventive care services and the appropriate use of emergency services. This approach, known as pay for performance, tries to create a system in which everyone has a reason to improve care for all patients. Health plans, medical organizations, employers and others are using payment linked to performance to improve the quality of care (NCQA, n.d). In Nigeria, financial incentives are linked to improved quality while this is growing in popularity, there is no evidence that shows this is a sustainable solution to improve quality (SQHN, 2014).

Non-financial incentives have been adopted to reward and recognize health personnel. A secondary hospital in Lagos, for example, highlights employee of the month with a photograph displayed in a prominent part of the hospital. This type of recognition sets model behavior there by hoping to increase motivation across the workforce (SQHN, 2014).

Improving health care quality can occur only if all stakeholders, individuals, family members, payers, providers, employers, and communities, make it their mission. In United States, members of the health care community can align to the National Quality Strategy by adopting the three aims (better care, healthy people/community, and affordable care) (AHRQ, 2011). To advance these aims, there is plan to focus on six priorities. These priorities are based on the latest research, input from broad range of stakeholders, and examples from around the country (AHRQ, 2011). These priorities have potential for rapidly improving health outcomes and increasing the effectiveness of care for all populations. These priorities include: making care safer by reducing harm caused in the delivery of care, ensuring that each person and family are engaged as partners in their care, promoting effective communication and coordination of care, promoting the most effective prevention and treatment practices for the leading causes of mortality, working with communities to promote wide use of best practices to enable healthy living, making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models (AHRQ, 2011).

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