Assignment: TF010746

KCPII - Quality of Care in Health Markets: Supply and Demand-Side Perspectives

KCPII - KNOWLEDGE FOR CHANGE PROGRAM II

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Approving Manager: 00000063803 - Adam Wagstaff

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This GRM report includes the following sections: Overview, Program(KCPII), Processing.
OVERVIEW

Overall Assessments and Ratings

Grant Objectives:
We propose a set of studies to measure the quality of clinical interactions in primary health care settings in 3 diverse contexts # rural India, Serbia, and rural Cambodia # and to assess the extent to which quality is determined by explicit contractual incentives and health market attributes, such as the degree of competition, the demand for quality, and the social identities of patients. In addition, we propose systematic support to the Africa region in their scale-up on measures of quality in several Sub-Saharan African countries. The objectives of this work are therefore to (a) expand quality of care work to additional settings; (b) to test innovative methods to measure quality, discrimination against patients from marginalized groups, and the demand for quality; and (c) to build capacity within the Bank and within client countries to conduct similar studies in the future.

Overall progress from 06/01/2011 to 05/31/2012 with regard to Achieving Grant Objectives:
Rating: Satisfactory
Comment:
During this period, the study has focused on exploring opportunities in different countries and putting in place studies that can be completed over the next 3 years. The broad strategy with these studies is to (a) describe quality in health care in terms of access and discrimination and (b) assess different paths to achieving higher quality. Within the latter, we are focusing on ways to improve quality through customer accountability, which includes incentives to providers, peer accountability, which includes non-price norm and peer-based approaches and training. There are three studies that are currently underway and on which we have made progress in differing degrees. These studies are in Tanzania (where we explore customer accountability) and Serbia (where we explore training and discrimination). Furthermore, we are in early conversations regarding a training-based intervention in India as well.

We have made considerable progress in Tanzania and India. In Serbia, we ran into an unfortunate roadblock when the government decided to put the study on hold pending elections, after the team had spent a lot of time training standardized patients and putting study protocols in place. We describe each in turn.

Tanzania
In 2008 and 2009 a research project funded by the World Bank collected data on 87 clinicians practicing in urban and peri-urban Arusha region. That project encouraged clinicians to increase the quality of care provided to their patients and found that two months after the encouragement visit, clinicians were providing substantially improved quality of care. The gains were almost a full standard deviation in quality, and there was no evidence that the gains were falling with time. To understand the long term gain of this project and to see if the simple activities of the study would sustain the quality of care, we replicated the process of collecting regular data from patients who visit outpatient clinics and using personnel to provide some peer encouragement to clinicians. As the process does not use medically trained personnel it has the potential to be a relatively inexpensive quality assurance innovation.

Between February and June 2012, we collected data on patients who sought outpatient health care services from consented Clinicians manning sampled facilities during the data collection period. For each Clinician, each data collector interviewed at least 5 patients in a day from a Clinician after obtaining their consents. Data was collected on several occasions per Clinicians, the maximum being 5 occasions. The number of occasions depended on availability of the Clinician. For the majority, data were collected for at least three occasions.

Preliminary data analysis based on already entered data was done and we find positive effects in this preliminary analysis, results of which are described further below.

India
In India we are continuing with the analysis of a large data collection effort in rural India, with a country-wide collection of information on provider availability and quality, combined with a detailed look at one Indian state. One paper has been resubmitted to the journal Health Affairs and other papers are currently underway. We are also currently exploring a potential project with the Government of West Bengal to look at the effects of a program that trains unqualified providers. The India study, which is primarily funded by the Gates Foundation provides the first set of data on the availability and quality of providers country-wide.

Serbia
During the last reporting period, the Serbia team (Alaka Holla, Ethan Yeh, Ana Holt, and Marijana Jasarevic) drafted and
finalized the scripts for implementing a standardized patients study among general practitioners in Serbia, assembled a team of international experts to assist with training, recruited and trained 36 standardized patients, and obtained the support of various stakeholders in health and governance-related issues more generally (e.g. the doctor's association and the public ombudsmen). Unfortunately, immediately after training, the Ministry of Health expressed reservations about going through with the study since a controversial pay-for-performance for physicians bill had just passed in Parliament, and they were especially wary of the component to detect disparities across Roma and non-Roma SPs. They did this in a climate of severe distrust between the MoH and the larger World Bank health team and requested the Quality of Care team not to try anything before the general elections in May 2012.

Overall progress from 06/01/2011 to 05/31/2012 with regard to Implementation of Grant Financed Activities:
Rating: Satisfactory
Comment:
Tanzania: Fully completed implementation, currently in analysis stage
India: Fully completed implementation for one study; second study currently in scoping stage.
Serbia: The study has been put on hold until the new administration takes power (September 2012) and a new Minister of Health has been announced. Regardless of who becomes the new health minister, the team has decided to modify the study in order to allay any fears that the standardized patients will be spying on doctors and to inform implementation of the new pay-for-performance rules. During field visits, general practitioners decried the pay-for-performance bill since it imposed high standards of quality without providing doctors any training on how to meet such standards. Therefore, the Quality of Care team has decided to embed the former study into a randomized evaluation of the standardized patient methodology as a training tool. In particular, standardized patients will be used to teach treatment doctors the new clinical guidelines that have been developed for certain cases (e.g. diagnosis of diabetes, management of stable angina). Then treatment and comparison doctors will be visited at a later date by different standardized patients presenting the same cases to test whether the training had any impact. In this way, the Quality of Care team will be able to measure a baseline quality measure (the comparison doctors), test for disparities between Roma and non-Roma patients, and evaluate the standardized patient method has a tool to improve physician quality (the difference between treatment and comparison doctors).

Grant follow-up and structure
Description and context of Grant:

Expected follow up (if any): Follow up Bank project/loan/credit/grant

Comment on follow up:
Tanzania: Analysis and writing-up to be completed this year.
India: Analysis and writing-up of completed study to be finished this year. The new study will be in the field this year if it goes as planned.
Serbia: The larger Serbia health team will start engaging with the new Minister of Health in September, and the Quality of Care team will propose the revised study during the winter (when no field work can take place) and offer to send one or two government counterparts to the University of Toronto's Standardized Patient Program to observe how the standardized patient methodology can be used to improve the quality of clinical care. Then in early spring of 2013, the SP-based training will take place across a sample of public health clinics in Serbia, and the former cadre of SPs (with whom the Quality of Care team has maintained contact) will be retrained and deployed to measure the quality of general practitioners and to test for disparities between Roma and non-Roma patients.

End Date of Last Site Visit:

Restructuring of Grant:

Activity Risk
Rating: Modest Risk (Original Risk Rating is Negligible or Low Risk)
Comment:
Tanzania: No further risks or conflicts of interest.
India: Completed study has no risks or conflict of interest. New study that is currently being scoped has support from the government of West Bengal, but has a risk of non-completion due to changes in the health secretariat.

Serbia: There is a risk that the new Minister will not be interested in the study, despite the support that the study has received from other stakeholders (Health Insurance Fund, the Chamber of Doctors, the Chamber of Nurses, the Serbia Medical Ethics Committee, the Public Ombudsmen, the Agency of Accreditation, and the National Roma Council). The Quality of Care team will try to mitigate this risk by making sure the revised study directly informs current reforms (namely, the pay-for-performance rules and the new clinical guidelines) rather than simply providing estimates of quality.

Critical Issues and Pending Actions for Management Attention
There are currently no issues and actions for Management attention.

PROGRAM

Program Specific Ratings

1. Rate local capacity building impact. - Highly Satisfactory
2. Rate country participation and ownership. - Satisfactory
3. Rate innovation and/or new knowledge creation. - Highly Satisfactory
4. Rate impact of pilot/demonstration. - Not Applicable
5. Rate applicability to another country or region. - Highly Satisfactory
6. Rate cooperation with research partners. - Satisfactory

Program Specific Questions

1. Is the budget realistic? If not, explain. Are the disbursements on schedule? Additional resources leveraged?
Every one of these studies requires large-scale data collection efforts, since there are limited/no secondary data to work with. Consequently, we are using the KCP funds to leverage funding from other sources to fund these studies.

2. Progress - are we doing what we said we would do? If not, why not?
We have made considerable progress in Tanzania and India and are confident that by the end of the grant, we will have a set of high-value papers and research that have the potential to be extremely influential in ongoing debates. In Serbia, the project is again very high-value, but the relationship with the government needs to be carefully managed moving forward. The team is highly competent, and it is our belief that the project will work out well.

3. Are there any changes in project design, objectives or timing? Explain and comment on the impact.
Both the India and the Tanzania projects have been completed in terms of implementation and data collection and are now in the analysis stages. For the Serbia project, due to last-minute problems with government permissions, the scope and timeline of the project had to be altered. In Serbia The Quality of Care team has decided to embed the former study into a randomized evaluation of the standardized patient methodology as a training tool. In particular, standardized patients will be used to teach treatment doctors the new clinical guidelines that have been developed for certain cases (e.g. diagnosis of diabetes, management of stable angina). Then treatment and comparison doctors will be visited at a later date by different standardized patients presenting the same cases to test whether the training had any impact. In this way, the Quality of Care team will be able to measure a baseline quality measure (the comparison doctors), test for disparities between Roma and non-Roma patients, and evaluate the standardized patient method has a tool to improve physician quality (the difference between treatment and comparison doctors).
4. Any lessons learned at this point? Can these lessons be applied for future work?
There are two main lessons that have been learnt from the exercise thus far in terms of project implementation. The first is that the team in Serbia completed the selection of standardized patients and their training at a stage when the conversation with the government was 90% complete, but the final signatures were pending. Because the conversations fell through and the project was delayed, we will have to reselect and train the standardized patients again. One big lesson from here was to not start the training for such exercises until the final go-ahead is received.

A second lesson has to do with the retention of staff, for which we have no good solution. Specifically, there is high demand for this work, but (A) it takes time and (B) it requires considerable time from our side as PIs to recruit and train people who can take the work forward. Because there is really no framework within the institution to retain these people (the full training for a person to do such a project on their own is around 1 year, and we can hire an ETC for 2 years), we are constantly in a chicken-and-egg problem where we cannot cope with demand because we cannot decentralize the work to trained staff and every time we do train staff, the maximum retention of 2-3 years creates problems. Our conversations with others on this same issue suggest that this is a problem that many teams face. One way that they have tried to address this is to train staff in another institution, but this carries its own problems. In essence, we end up creating monopolies outside the Bank who then charge monopoly rents despite having received free training from us and institutional support to setup. Any suggestions on how to handle this would be very welcome!

5. Give a brief account of the activities this year. Comment on surprises and difficulties, if any.
During the year we have:
1. #Implemented a full intervention and study in Tanzania that has been described in detail in the overview of this GRM.
2. #Completed the India survey and readied the data for analysis. Produced a paper on standardized patients that has been re-submitted to Health Affairs.
3. #Recruited and trained a team of standardized patients for the work in Serbia.

6. Highlight any success stories and preliminary findings.
We are making considerable progress in understanding the quality of care issues in both India and Tanzania, and the two-fold path we are taking—customer and peer accountability—are both yielding important results. In India we are finding large differences in public and private sector performance, with the private sector performing at higher standards despite lower training. When we control for training by using provider fixed effects (that is, doctors observed both in their public and private sector) we find very large and significant differences along all dimensions of care. For instance, diagnosis rates for heart attacks go up by 50 percent—a change that in the U.S. would require a multi-billion dollar program! The fact that the private markets are largely unregulated and unsubsidized suggests that this improvement is entirely due to the accountability pressures that arise from consumers. Notably, such customer accountability measures, by hypothesis, cannot work well in public settings where providers are typically paid a fixed salary independent of the number of patients that they see. The work in Tanzania then builds on the previous work by Leonard to explore whether an alternate mechanism of peer monitoring can improve quality. Preliminary data analysis based on already entered data was done. The following are highlights of the results. There were 103 doctors in the first study sample (2008-2010), and we estimate that 113 were examined in the present (year 2012) round of data collection (the names of newly enrolled clinicians have not been fully cleaned and there might be some duplicates). Thirty six (36) clinicians were examined in both rounds of the data. In the first round, the average adherence to protocol in the baseline was 75.02%. These clinicians were enrolled in experiment designed to increase their adherence to protocol. At the end of that first study, 76 of the original clinicians were visited and their subsequent adherence to protocol was 83.07%. This 8 point increase in adherence is significant and represents a policy relevant impact.

The goal of the second data collection effort was to see where these clinicians stand, about two years later. 36 clinicians were observed in the baseline and follow up of the first round and the second round. The baseline adherence for this group was 72.42% and their adherence at the end of the study was 81.45% (for a gain of 9 percentage points). In the second round of data (collected almost two years later) their adherence to protocol is 81.07%, negligibly different than where they stood at the end of the first round and significantly different from where they originally stood.

In contrast, the average adherence to protocol for newly enrolled clinicians is 76.84%, which is slightly higher than the baseline adherence to protocol in the first round (75.02%). Thus, the secular trend in quality is, at most, 2 percentage points whereas the clinicians who were part of the experiment 2 years ago exhibit a gain of 8 and half percentage points.

We have thus, across these two studies, started highlighting alternate pathways to improving the quality of health care in low-income settings. This will help identify the pre-conditions for either state expansion in health care or the use of tools like
public-private partnerships.

**PROCESSING**

**Manager's comments on this GRM report:**
Date: 07/31/2012  User ID: WB63803  Name: Mr Adam Wagstaff
Operation performed: Approved by Manager
Shame about Serbia and take your point about being unable to retain staff. Look forward to seeing results. A.

**GRM report history - Requested on 05/17/2012, due on 06/15/2012**

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