

Mid-level providers online forum

Digest of day 9 (regulation and accreditation MLP)

Responses by Andrew Brown

Thank you to all those who took the time to contribute to this session. The variety of responses reflects the range of approaches that exist across countries, highlights the work that needs to be done and demonstrates the need for a systematic approach that ensures appropriate regulation and accreditation frameworks exist to support MHW.

What country specific legislation is required to enable mid-level providers to practice in your country?

World wide there are a range of approaches to legislation that could be used to cover the involvement of MHW either under government departments or through independent "boards". For example in Ethiopia there is specific legislation that supports an autonomous nursing regulatory body while in Malaysia there is a Nursing Board for nurses and a Medical Assistant Board for Assistant Medical Officers which define the scope of practice and the registration requirements.

It is important that all cadres of practicing MHW have their scope of practice defined by appropriate legislation in a way that suits the specific country environment. In a number of countries legislation covering MHW is state based, not national which adds a level of complexity in those environments.

How is pre service training for mid-level providers accredited in your country?

This question generated the most interest from participants who shared that although many countries have approaches for accrediting MHW many still do not. Significantly the ongoing dimension of accreditation was raised which is very important not only when considering the accreditation of training institutions but the accreditation and registration of MHW themselves;

"First, a critical requirement for achieving the intended impact of quality regulation is that the approach must build in mechanisms to ensure that the desired performance or competence is sustained over time. Licensing and certification only at the point of entry into the healthcare market are insufficient to provide assurance to the public and to health sector institutions that providers maintain competency throughout the span of their careers. Time-limited licenses and certificates and clear requirements for renewal are thus essential."

In resource poor environments the need to appropriately fund accreditation is often overlooked. If appropriate funding and suitably trained staff are not available to monitor and enforce regulations associated with accreditation then... "Regulations that are not enforced, or that are enforced with mild sanctions, do little but contribute to a general disregard of the regulatory authority of the government (World Health Organization 2000)." A further complicating factor can be the "will" of authorities to enforce not only accreditation standards but health legislation.

The absence of enforcement for any reason reduces the quality of the health care system.

Is there a need to register specific cadres to ensure quality?

It is commonly agreed that most cadres that have the ability to influence patient care should be registered and that this registration should require renewal and where possible a demonstration of current practice or evidence of post service continuing education. Departments who have this responsibility are reminded that "for quality regulation to be effective, regulatory bodies must have the resources and mechanisms needed to exert regulatory authority and must regularly collect and act on monitoring data to verify compliance."

Summary of postings by participants.

Navin Chugh (India) reports that registration with the Nursing Council and the Medical Council is mandatory. Pre-service training is not accredited, and there are no specific accreditation criteria used for quality improvement.

Abdurahman Ali, (Chief Executive Officer Ethiopian Nurses Association, Ethiopia) explains that in Ethiopia there is an autonomous nursing regulatory body and specific legislation, and that the Ministry of Health sets standards for training of nurses.

Marco Gomes (Center for Health Policy and Innovation, South Africa) suggests that a number of challenges affect the efficacy of regulation and accreditation systems. “First, a critical requirement for achieving the intended impact of quality regulation is that the approach must build in mechanisms to ensure that the desired performance or competence is sustained over time. Licensing and certification only at the point of entry into the healthcare market are insufficient to provide assurance to the public and to health sector institutions that providers maintain competency throughout the span of their careers. Time-limited licenses and certificates and clear requirements for renewal are thus essential.” “A related issue is the need for enforcement of sanctions or consequences for loss or reversal of quality evaluation status. Regulations that are not enforced, or that are enforced with mild sanctions, do little but contribute to a general disregard of the regulatory authority of the government (World Health Organization 2000).” Gomes then explains the main characteristics of accreditation systems, and their role in improving quality of care. He concludes that registration of MLP is necessary, but cautions that “for quality regulation to be effective, regulatory bodies must have the resources and mechanisms needed to exert regulatory authority and must regularly collect and act on monitoring data to verify compliance.”

In a separate message, Gomes discusses issues related to training, curricula and methods to ensure quality of care among nurse-practitioners in the Pacific region.

Kumar Gopal (India) reports that uniform accreditation criteria are not in place in the country, as there are variations across states. Gopal however believes that “registration and accreditation of specific cadres is necessary, and should be one of the key strategies to improve quality of care. Registration should be done upon completion of pre-service training, but then there should be a process for regular re-licensing of health workers, to ensure they maintain and upgrade their skills.”

Sarasivathy Eddiah (Malaysia) reports that the Malaysian Nursing Board for nurses, and the Medical Assistant Board for Assistant Medical Officers Board define the scope of practice and the registration requirements. “Accreditation is done by the Malaysian Qualifications Agency under the Ministry of Education. All programmes are accredited by this agency via the teaching institution. Assessment for accreditation is not only done on the curriculum, but the staffing requirements and the necessary structure.”

Mininder Kaur believes that the lack of uniform accreditation criteria “is common in the developing world, and that it is sometimes an absence of policy, but more often it is a combination of a lack of will and/ or lack of enforcement .”

Hela Kochbati (Researcher, Afard, Tunisia) highlights the functions played by her country's Government to ensure quality care through accreditation, regulation and investments.



Mohamed Hussein (Ethiopia) stresses the importance of regulatory mechanisms and reports that in Ethiopia health workers are accredited upon completion of training and re-licensed every 5 years.

Kenneth Wind-Andersen proposes as a model framework for MLP a bill introduced in Montserrat in 2007.

Full text of contributions received on day 9 (regulation and accreditation MLP).

1

Hi

My Inputs are:-

1. Registration with Indian Nursing Council and Medical council of India ,Dental council of India is a must, along with registration under the foriegners act.

2.Pre service training is not accreditaed in India.

3. No there is no specific registration criteria for quality improvement

Thanks

Dr Navin Chugh

India

2

What country specific legislation is required to enable mid-level providers to practice in your country?

Autonomous nursing regulatory body and Nursing legislation.

How is pre service training for mid-level providers accredited in your country?

Ministry of education is mandated to set standards for higher education program in Ethiopia.

Is there a need to register specific cadres to ensure quality?

Nursing profession has been one of the regulated profession in the country

Abdurahman Ali,MPH(C),BSCN,Dedu,RN

Chief Excutive Officer

Ethiopian Nurses Association

3

Dear Colleagues,

It is a disappointment that this discussion will be approaching its end soon. However, we must not forget the knowledge, challenges and lessons learned and shared in the fora. Lessons learned and country stories will be imbedded in me for years to come and guide the work which I

do in health and development. Please find below my comments to day 9 topic of the discussion on mid-level providers.

1. What country specific legislation is required to enable mid-level providers to practice in your country?

Worldwide experience with quality regulation points to a number of challenges that countries face in implementing these three approaches. First, a critical requirement for achieving the intended impact of quality regulation is that the approach must build in mechanisms to ensure that the desired performance or competence is sustained over time. Licensing and certification only at the point of entry into the healthcare market are insufficient to provide assurance to the public and to health sector institutions that providers maintain competency throughout the span of their careers. Time-limited licenses and certificates and clear requirements for renewal are thus essential to create an impetus for providers to remain current through continuing education and for organizations to maintain physical infrastructure and capacity (Miller 2000).

A related issue is the need for enforcement of sanctions or consequences for loss or reversal of quality evaluation status. This includes procedures for disciplinary action against licensees who fail to maintain the conditions of licensing as well as procedures for reporting and handling impaired or incompetent providers and facilities. Regulation is only as effective as the power and mechanisms that governments and other regulatory bodies have to enforce it. Regulations that are not enforced, or that are enforced with mild sanctions, do little but contribute to a general disregard of the regulatory authority of the government (World Health Organization 2000).

2. How is pre service training for mid-level providers accredited in your country?

Accreditation is a formal process by which a recognized body—either governmental or nongovernmental—assesses and recognizes that a healthcare organization meets pre-established performance standards. Accreditation standards are usually regarded as optimal yet achievable and are designed to encourage continuous improvement efforts within accredited organizations. The standards used to assess performance for accreditation are commonly developed by expert committees working with the accrediting body and revised periodically to reflect advances in technology, treatment regimes or policy changes. Accreditation has attracted great interest in recent years as a comprehensive approach for improving and maintaining healthcare quality. The key difference between accreditation and other forms of quality regulation is that by focusing on optimal or desirable, rather than minimum standards of care, accreditation has a strong performance improvement orientation, stimulating healthcare organizations to pursue increasingly higher levels of quality of standards beyond the minimum

needed for licensing. Another difference is that accreditation has traditionally been a voluntary process in which organizations choose to participate, rather than one required by government regulations; more recently, however, some countries have made participation of healthcare organizations in accreditation programs compulsory (Shaw 2004).

Accreditation tends to be a participatory approach rather than a “top-down” process from the government, as it requires agreement upon standards, criteria, and policies among participating parties. Standards and criteria for accreditation are generally developed through consensus among healthcare providers and other stakeholders such as medical associations, Ministries of Health, and nongovernmental organizations (NGOs). Accreditation programs are generally funded through survey fees, member fees, publications, educational programs, grants, consulting fees, and government support. Evaluation for accreditation is performed by a group of surveyors that carry out a variety of assessment techniques, such as a review of documents and records, interviews, observation, inspections of the facility, and evaluation of achievements. Based on the results of this thorough evaluation, the survey team recommends whether or not the facility should be accredited or should implement further improvements and be re-evaluated in the future. Renewal of accreditation status is usually required every two to three years. Participation in accreditation programs is voluntary, though some countries have tied accreditation systems to financing mechanisms, thereby creating a strong incentive to achieve and maintain accredited status. Another incentive to participate in accreditation programs is public demand for accredited services as a result of the dissemination of accreditation results. Sharing accreditation results helps a facility or department to gain recognition for its accomplishments and be recognized as a quality institution.

3. Is there a need to register specific cadres to ensure quality?

Yes, there is a need to register cadres to ensure quality. With registration there are challenge for all quality regulation programs keeping standards current with changes in technology, scientific evidence, and medical practice. Any changes in standards need to be communicated to organizations and individual providers as well as to the public, to ensure transparency of quality evaluation criteria. Providing sufficient resources to effectively implement any quality regulation approach is also critical. Decision makers need to address the funding sources and financial sustainability for each phase of a program as part of its design. For quality regulation to be effective, regulatory bodies must have the resources and mechanisms needed to exert regulatory authority and must regularly collect and act on monitoring data to verify compliance.

Best wishes,

Marco Gomes

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4

India does not have a uniform regulation and accreditation requirement framework for mid level providers to my knowledge, and there are variations among state. also the term mid level is not officially used or does not correspond to well defined existing cadres, even though nurses and other workers informally or sometimes more formally assume functions that go beyond those traditionally associated with nurses. so I can't really answer questions 1 and 2

on question 3, I strongly agree that registration and accreditation of specific cadres is necessary, and should be one of the key strategies to improve quality of care. registration should be done upon completion of pre-service training, but then there should be a process for regular re-licensing of health workers, to ensure they maintain and upgrade their skills. this is not specific to MLP, but it is crucial also for this cadre, especially if - as I gather from many colleagues in Africa - they provide life-saving and potentially high-risk services, such as management of labour and emergency obstetric care.

Kumar Gopal

India

5

1 What country specific legislation is required to enable mid-level providers to practice in your country?

The Malaysian Nursing Board for nurses, the Medical Assistant Board for Assistant Medical Officers Board. There are also boards for physiotherapists and pharmacists. But the strongest of this is the Malaysian Nursing Board which controls the influx of nurses into Malaysia. It defines the scope of practice of nurses and their registration requirements

2. How is pre service training for mid-level providers accredited in your country?

Accreditation is done by the Malaysian Qualifications Agency under the Ministry of Education. All programmes are accredited by this agency via the teaching institution. Assessment for accreditation is not only done on the curriculum, but the staffing requirements and the necessary structure.

3. Is there a need to register specific cadres to ensure quality?

Sarasivathy Eddiah (Malaysia)

6

Dear Mr Gopal,

Could you elaborate on the reasons why you think there isn't a regulation and accreditation Framework. I believe (please correct me if i am wrong) this is common in the developing world. In my observation it is sometimes an absence of policy but more often it is a combination of a lack of will and/ or lack of enforcement .

best wishes

Mininder Kaur, M.D

7

1. What country specific legislation is required to enable mid-level providers to practice in your country?

The focus of specific legislation is related to requirements and offers in the practices for health care system for served populations in the institutions and will administer educational, preventive, palliative, therapeutic, and restorative services.

2. How is pre service training for mid-level providers accredited in your country?

In Tunisia, The preservice trainning is supported by the ministry of health, which has taken the lead legislation, services and communication in advocating, this effort let mid-level providers accredited to have international recognition and evolution in their careers.

3. Is there a need to register specific cadres to ensure quality?

The health register specific cadres to ensure quality in two parts. Firstly, Tunisia spend whatever is required to ensure quality of good health for every child, women and man. Second, but equally important, that spending the money effectively and with accountability, and high-qualified professionals for our nation's growth in health and best international recognition in this sector.

Hela Kochbati

Researcher, Afard, Tunisia.

8

Dear all

Every country have to have the capacity of regulatory mechanism for every level of health cadres within the country. For instance, Ethiopia has strong human resource for health regulatory mechanism. Every graduate from any level of health science teaching institution has to be licensed before starting practicing as public health or clinical practitioner in the country. The provided license will be renewed every 5 years with out any unethical health practice. Therefore, Ethiopian Ministry of Health established health care worker Regulatory Agency to protect and save public from unethical non professional practice and licensure is mandatory for independent practice in public, private and NGO institutions in Ethiopia.

Thank you so much

Mohammed Hussein, MPH in Health Service Managment
Ethiopia

Dear Colleagues,

I send this my last response to the final day of questions of the mid-level provider discussions.

1. What country specific legislation is required to enable mid-level providers to practice in your country?

Education of nurses as mid-level practitioners

Nurse practitioners have, in most cases, completed a formal post-registration training course to prepare them to provide comprehensive clinical primary care services in medically under-served areas. Nurse practitioner education programmes require at least one year of intensive, clinically oriented, supervised training. In Pacific island countries, upon completion of their training, registered nurses who have successfully completed advanced training programmes may be awarded either a certificate, diploma or advanced diploma.

Nurses practising in rural/remote areas with some additional primary clinical care skills

Many nurses in rural areas of the Pacific *function* as nurse practitioners, diagnosing and treating conditions as best they can. However, most have not been specifically trained for this function in their basic education programmes, although many basic nursing education programmes in the Pacific try to include some content on the assessment and management of common primary health care problems. It was for this reason that nurse practitioner training courses were initially established—to fill the gap between the training nurses received in their traditional programmes and the clinical services they were expected to provide in areas where there were few if any doctors. Many nursing education institutions have tried to include some basic medically-focused *content* in their curricula (such as the signs and symptoms and treatment of common diseases), and some forward-thinking health departments have produced standard treatment guidelines. While these help, they are not a substitute for supervised clinical training in the *process* of clinical decision-making, such as how to take a proper

patient history; how to conduct a good physical examination; how to assess the findings of the examination and how to make a differential diagnosis.

2. How is pre service training for mid-level providers accredited in your country?

The quality of services mid-level practitioners provide depends very much on the quality of their training. If health workers are to be taught in one year to handle health problems that doctors learn to manage with four or more years' training, a different approach has to be taken, even if the students have a nursing background. It is not good enough to rotate them through the various clinical services. It is not good enough to slot them into regular medical training programmes or to give them a watered down version of a medical education. The approach requires a highly skilled and clinically expert faculty to facilitate, both in and outside the classroom, adult-learning in a participatory and interactive way, focused on critical thinking and problem-solving. Teachers must also provide intensive and mentored clinical learning experiences which promote diagnostic reasoning and clinical decision-making skills.

3. Is there a need to register specific cadres to ensure quality?

Mid-level practitioners need written standard treatment guidelines or protocols, training in how to use them and monitoring and evaluation of their use. These evidence-based guidelines should be developed (or generic guidelines adapted) by national multidisciplinary committees, which should include a national pharmacist, and national medical and nursing experts. The guidelines should reflect the realities of the situation in the country, including availability of drugs, and should be consistent with essential drug lists and other existing nationally approved treatment guidelines or protocols. All countries using standard treatment guidelines reported that these had been very useful as clinical references. Some countries had made provision for prescriptive authority for mid-level practitioners to ensure that they have the protection of the law when providing medications within their scope of practice, as guided by approved protocols. WHO has provided technical support for a number of countries in the development of treatment guidelines or protocols.

Best wishes,

Marco Gomes

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