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Health Quality Assessment in Family Medicine and Primary Care in Ibero America

Avaliação da Qualidade em Saúde na Medicina de Familia e na Atenção Primária na Ibero-América

Evaluación de la Calidad en Salud en la Medicina Familiar y en la Atención Primaria en Iberoamérica

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Abstract

The purpose of this study is to contribute to the development of the concept and the assessment of Quality in Primary Care, under the perspective of Family and Community Medicine (FCM). The study was based on texts reading, discussion in a working-group, and a survey with the application of a semi-structured questionnaire to FCM and other professionals from 19 countries. Information about PC services, as well as the perception of its evaluation processes, including those related to permanent education, motivation and work overload was obtained. The results suggest that the quality assessment of PC in Iberoamerica is still a very incipient process. In addition, with the exception of a few countries, there is not even a universal PC with FCM in the health teams. Considering the principles and practices of the FCM, it seems that there is a limitation of the instruments commonly used to evaluate the quality in PC. It is concluded that to achieve a better quality assessment in order to conduct continuous improvements in the PC services, it is necessary to include indicators related to the concepts and tools of FCM. Considering the competences of the FCM, a quality concept in PC is proposed and dimensions to be included in the evaluation processes are indicated.

Keywords:
Health quality
Family and Community Medicine
Primary Care

Resumo

O objetivo deste estudo é contribuir para o aperfeiçoamento do conceito e dos processos relacionados à avaliação da qualidade na Atenção Primária à Saúde (APS), sob a perspectiva de Médicos de Família e Comunidade (FCM). O estudo foi realizado com base na leitura de textos, discussão em grupo de trabalho e uma pesquisa com a aplicação de um questionário semi-estruturado a MFC e outros profissionais provenientes de 19 países. Foram obtidas informações sobre os serviços de APS e das percepções sobre seus processos de avaliação, incluindo os relacionados à educação permanente, motivação e sobrecarga de trabalho. Os resultados sugerem que avaliar adequadamente e sistematicamente a qualidade da APS na Ibero-América ainda é processo muito incipiente. Além disso, com exceção de alguns países, não existe sequer uma APS universal com MFCs nas equipes de saúde. Por outro lado, se considerarmos os princípios e práticas de MFC parece ser uma limitação dos instrumentos utilizados para avaliar a qualidade em APS, Conclui-se que para alcançar uma avaliação de qualidade que possa ser condutora de uma melhoria contínua dos serviços de APS é necessário incluir indicadores relacionados aos conceitos e ferramentas da MFC. Um conceito de Qualidade na APS é proposto e são indicadas dimensões para ser incluídas nos processos de avaliação, considerando-se as competências da MFC.

Palavras-chave:
Qualidade em Saúde
Medicina de Família e Comunidade
Atenção Primária

Resumen

El propósito de este estudio es contribuir al desarrollo del concepto y de los procesos relacionados a la evaluación de la Calidad en la Atención Primaria de Salud, bajo la perspectiva de Médicos de Familia y Comunidad (MFyC). Fue basado en la lectura de textos, discusión en grupo de trabajo y en una investigación con la aplicación de una encuesta semi estructurada a MFyC y otros profesionales provenientes de 19 países. Fueran obtenidas informaciones acerca de los servicios de AP y de las percepciones de sus procesos evaluativos, incluyendo los relacionados a la educación permanente, a la motivación y la sobrecarga de trabajo. Los resultados sugieren que evaluar de forma sistemática y adecuada la calidad de la AP en Iberoamérica aún es un proceso muy incipiente. Además, excepto por algunos pocos países, ni siquiera existe una APS universal con MFyCs en los equipos de salud. Por otro lado, si consideramos los principios y las practicas de la MFyC, parece haber una limitación de los instrumentos utilizados para evaluar la calidad en AP. Se concluye que para alcanzar una evaluación de calidad que pueda ser propulsora de una mejora continua de los servicios en la AP es necesario incluir indicadores relacionados a los conceptos y herramientas de la MFyC. Un concepto de Calidad en AP es propuesto y se indica las dimensiones a ser incluidas en los procesos evaluativos, considerando las competencias de la MFyC.

Palabras clave:
Calidad en Salud
Medicina Familiar y Comunitaria
Atención Primaria

Introduction

From Alma Ata - the World Health Assembly carried out in 1978 - there have been important advances in the establishment and implementation of Primary Care (PC) models, especially in countries with a more developed economy, but the world is far from achieving the goal set in that conference.[1] In countries with a fragile economy, low implementation of qualified PC is seen as a relevant problem due to a series of conceptual, political, financial and professional obstacles.[2] There is not even a national or international standard regarding concepts and comprehensiveness of the health services that must be taken to get quality in PC. In these countries, different models of PC coexist, and most of the times are focused on specific illnesses control and implemented by means of vertical programs and protocols.[3]

In Latin America, Family Medicine, the specialization by excellence to develop a quality PC, shows different stages of development. With the exception of Cuba and Mexico, it is not necessary to have the specialization to work in PC, contrary to what happens in countries with a more developed economy like England, Canada, Portugal and Spain.[3] But times are changing, and some Latin American countries are experiencing real reforms in their health models, even inside the countries themselves, such is the case of the city of Rio de Janeiro, Brazil.[4]

In this context, when a qualified PC model replaces a non-qualified one, professionals involved in its practice should reflect about it to review its objectives. In this case assessment processes must be re-considered to achieve excellence in the professional practice and to offer new services. To review assessment process in these circumstances should be considered positive, especially when it is suggested in a collaborative way, involving the specialists in PC and their associations. Assessment must be considered in this context a key instrument for the continuous quality improvement in Primary Care.[5]

Furthermore, the concept of quality in health, itself, must evolve. With humanity development and advances in medical biotechnology, it is necessary to make a call to re humanize health care and offer higher quality services from a holistic standpoint, including human resources, commitment and the political it is required to offer good health care. The concept of Quality must be thought from a multi disciplinary perspective,[6] with the right professionals and accessible and equal health services.[7] Quaternary Prevention concept must be included (avoiding, reducing and palliating the damage brought about by medical interventions).[8] Patient's satisfaction and expectations with the services received must be evaluated as an active and relevant part of this process.

It is important to highlight that quality has a historical and cultural connotation, that is to say, specific for a given society. Subjective, psychological and social factors are important among individuals, professionals and the community (believes, values, etc).[9] In other words, PC quality improvement must be a permanent goal and adjust to the new challenges, in the growing complexity of people's health needs as to the epidemiological and demographic transition and the current social and political context.[10]

Bárbara Starfield[11] studied many health systems (mainly from the 90's during the XX century) and evidenced that the main characteristics to define a quality PC is related to seven attributes. Four essential attributes: 1) first contact/ access, 2) longitudinality, 3) comprehensiveness and 4) coordination; and three derivate ones: 1) family orientation, 2) community orientation and 3) cultural competence.

Considering the hypothesis that PC quality evaluation is insufficiently developed in Latin and Ibero America, this research has the purpose of contributing to concept and practices of Quality in health from a Family and Community Medicine perspective.

Metodology

Exploratory research with quali-quantitative approach, developed by a task force for pre, per and post activities of the 6th Family Medicine Summit, that took place in San Jose, Costa Rica, in April 2016. As part of the working process, the first step involved creating a group of representatives from Family and Community Medicine Associations in Ibero America in October 2015. Then, literature data collection directed to PC evolving processes, highlighting the ones used at a country or regional level was carried out. During January and February 2016, with the help of the task force, a semi structured survey was created and used with Family and Community Medicine (FCM) and other interested professionals coming from 19 countries who answered through an online mode. The survey searched for the characteristics on the services surrendered by PC in those countries, as well as perceptions on their assessment processes. The information obtained covered: profession, specialization, knowledge on quality assessment in their countries; the assessment characteristics included: professionals participation, frequency, national adoption or not; used indicators, unit activity planning, type of services rendered to the society as well as feeling overwhelmed or motivated to work. Next the task force met to analyze and debate on the data, taking survey results into consideration for later recommendation on the subject.

Results

PC quality reasearch

Research was conducted with the following search words: quality, primary care and family medicine with the objective of finding information to evidence a country or region perspective, specially in Latin or Ibero America. A systematic literature review carried out in Brazil was identified,[12] with the purpose of identifying national or international instruments for PC evaluation. This article found 3048 studies, published between 1979 and 2013. Validated and highlighted instruments translated to Portuguese, Spanish and English were: (1) WHO Primary Care Evaluation Tool (PCET); (2) ADHD Questionnaire for Primary Care Providers (AQ-PCP); (3) General Practice Assessment Questionnaire (GPAQ), PACOTAPS (Applied to APS); y (4) PCA Tools (Primary Care Assessment Tool), (5) EUROPEP (European Task Force on Patient Evaluation of General Practice Care and (6) PMAQ (National Program for Access Quality improvement and Quality in Primary Care) used in Brazil.

Among these, we must emphasize 3 for having a wider nature including, necessarily PC organization and practice and for committing health teams in the assessment process. Besides, they are being used in an international or in Latin American countries such as Brazil:

a) PCA Tool based on health services quality assessment model suggested by Donabedian[13] - structure measurement, process and results - developed by Starfield's team at John Hopkins University is composed of 77 questions (items) within the 7 PC attributes and allows, by means of Likert type answers, a punctuation from 1 to 4 for each attribute. It is directed to health professionals and the population they served. There is no distinction between general physicians or family doctors or any other specialization, not even if the professional is a nurse. It does not include specific approaching techniques or tools centered in people, family or community.

b) PMAQ-AB (2011), used in Brazil to evaluate and foster family health strategy advance/APS,[12] it has been specially elaborated and implemented for the PC context. It also includes health professionals that integrate teams, users and local and central health managers. It was the result of governmental initiative. The goal is to widen the access and improving the quality of PC, assuring a comparable pattern of national, regional and local quality to allow higher transparency and effectiveness of government actions directed to PC. It is based among others, mainly on:
   - Health Team Self Evaluation. Based on the answers from the participants, even users, fosters the group to review the working process and the way to change it to overcome problems and reach the goals set for that group.
   - Monitoring: attention indicators record and social demographic data.
   - Permanent Training: Fostered by team/community local needs demanding from their actors (workers, agents and users) higher analysis skills, intervention and autonomy for setting transforming practices.
   - Besides Professionals evaluation, it is an external assessment based on:
     - A process of incremental, continuous and progressive improvement of patterns in quality and access indicators covering: management, work process and results achieved.
     - Transparency at every stage, allowing permanent follow up for the actions and results.
     - Voluntary Participation: in PC teams as well as in municipal agents, success depends on motivation and the pro activity of the actors involved.

c) EUROPEP - devoted more specifically to explore PC quality from the user's perspective, it is a patient's evaluation system on the services provided by family physicians. EQUIP[14] developed it during the 90's with

collaboration from different European countries. Its objectives are improving practice, performance and assistance of family physicians in PC. EUROPEP is made of 3 parts:

1. Key Indicators (relation and communication, health care, information and support, continuity and cooperation and new services organization.)
2. Satisfaction indicators specific areas: (consultation, programmed agenda and access, professional characteristics, health centers conditions and rendered services).
3. Users information: (social, economic and health data and attitude after the service).

It does not discriminate doctors' specialization either.

Survey's result

81 professionals from 19 countries answered the survey: Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Spain, Mexico, Nicaragua, Panama, Paraguay, Peru, Portugal, Puerto Rico, Uruguay, Venezuela; two came from other regions: India, and US. The professionals that answered the questions were considered key informants once they represent Ibero-American Family Medicine Associations and/or had been indicated by them. Distribution, complying with their working activity, was as follows: Family and Community Physicians: 87.7% (71 participants); FCM Residents: 9.9% (8); Health Agents: 2.5% (2).

Regarding whether there was systematic evaluation at PC level, 41% responded negatively. In the cases of positive answers, there was criticism on the quality of the tool used, as it would not reflect precisely whether there is quality service or not (Figure 1).

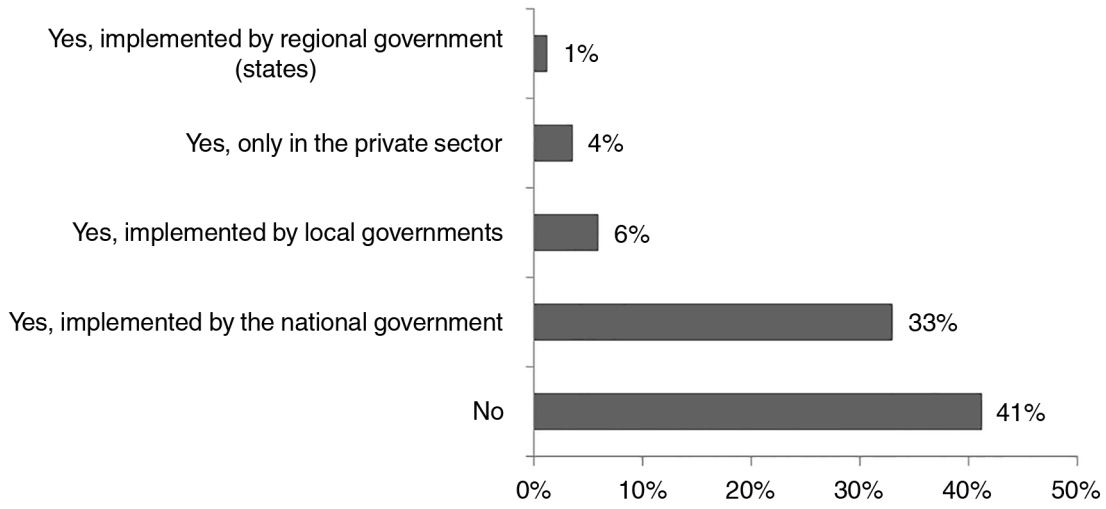

Figure 1. Does your country systematically evaluate quality in PHC?
Source: CIMF Survey - Quality in Family Medicine, Sub-Group, 2016.

Regarding frequency: 41% reported it is performed once a year and 39% said it was every six months.

Regarding perception on motivation and professional work load, 91% said it is not systemically assessed. Whether Family and Community Physicians (FCPs) are motivated (Figure 2), 80% thinks that FCPs in their countries feel overwhelmed with the work load (Figure 3).

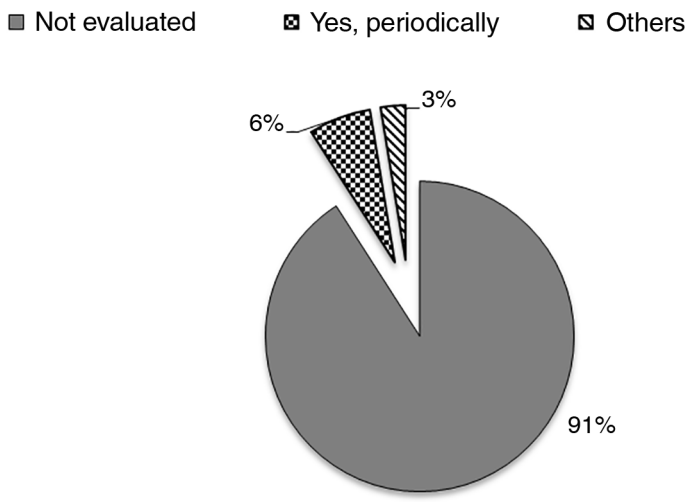

Figure 2. Does your country systematically evaluate if FCP are motivated to work? (77 answers)
Source: CIMF Survey - Quality in Family Medicine, Sub-Group, 2016.

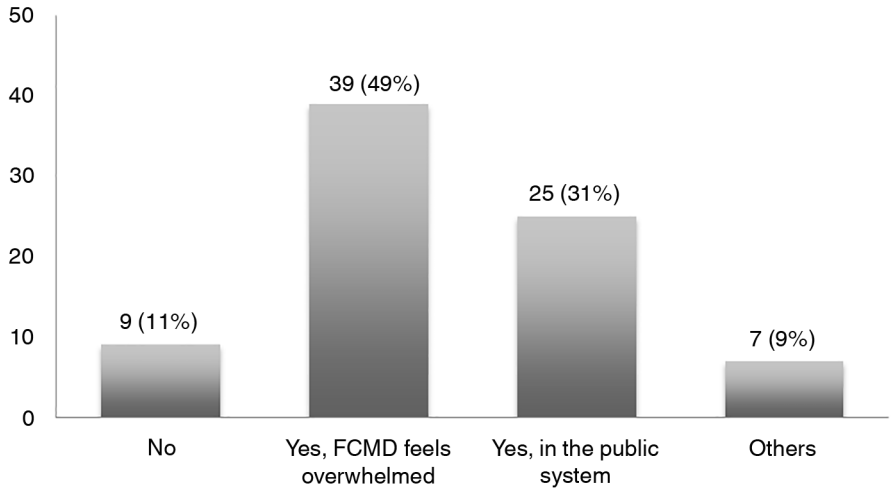

Figura 3. Do FCMDs in your country feel overwhelmed with the work load?
Source: CIMF Survey - Quality in Family Medicine, Sub-Group, 2016.

Health Professionals direct participation in PHC units on quality assessment processes

Around 67% reports they do not participate directly and around 29% stated they assess the services themselves.

Health Action Planning and/or work process organization

35% said there are not frequent meetings with this purpose. For those who meet, they have a monthly frequency for 43% of the cases, weekly for 27% and six monthly for 22%.

Health professionals' continuous training performed according to local population health needs

Around 70% answered positively. Round this topic, some reported that many times FCPs do not feel interest in getting training and others said that FCPs participate in training but the rest of the professionals in the unit, do not.

PC assessment indicators

Regarding PC quality assessment indicators, quantitative ones are the most used (50%) - illnesses prevalence and incidence (29%). Only 23% states that their country use process indicators to assess PC for example: (Body Mass Index decreasing rate - BMI) in obese people and smoking interruption rate, among others).

Among PC essential and derivate attributes according to Barbara Starfield, the most used indicators to assess the participants within the survey were: access ones (34%) and care coordination (19%). Cultural competence, community and family approach, and longitudinal reach less than 15% (Figure 4).

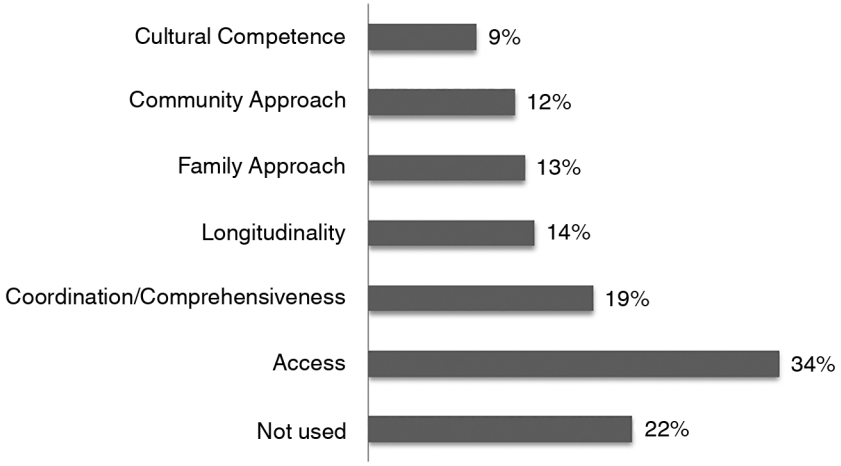

Figure 4. Considering essential and derivate attributes in PC (according to Barbara Starfield) mark indicators frequently used in your country.
Source: CIMF Survey - Quality in Family Medicine, Sub-Group, 2016.

Services rendered in PC

For most participants (78%) there is a PC assistance package, but 43% thinks this is not equal all over the country. On the other hand, there seem to be important restrictions to access some services in health units: Electrocardiogram (ECG) is available in 48% of the cases, X Ray imaging testing in 38%, Eco Scan in 4% and other diagnostic tests in 46%. At the same time, there are barriers to access TSH measurement (thyroid stimulating hormone), Glycated Hemoglobin or Myocardial Scintigraphy.

Regarding services provided at PC, 69% reported childcare is not performed within the services. Home visiting, genre and sexuality approaches and mental health services are performed in 60% of the cases. Social participation and health educational group activities only in a 38% and 25% respectively (Figure 5).

Discussion

This research shows the limitations of an exploratory investigation. Thus, it has a problematized perspective and invites to a deeper reflection on health care practices and PC assessment processes from FCP's standpoint in different Latin American countries. It raises potentially relevant problems in the process, such as the possible limitations on existing assessment tools and even the mere lack of processes on quality assessment.

Based on the previously mentioned PC quality assessment revision article, it can be said that on PC quality research there is no specific consideration on the existence or need of having Family Physicians in the teams as a quality parameter. Probably because most of the research is done in countries where FM is a compulsory specialization, required to work in PC, thus no need to explain it. But that is a potential problem when the research is done in

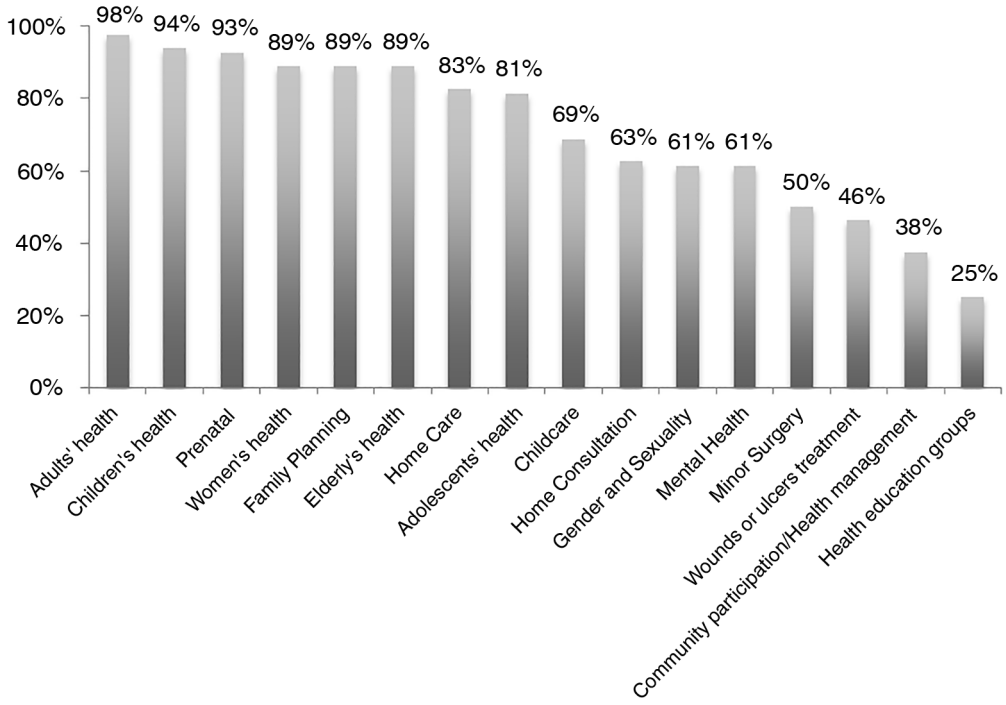

Figure 5. Services rendered in PC units according to participants.
Source: CIMF Survey - Quality in Family Medicine, Sub-Group, 2016.

countries where the specialization is optional, there might be the chance of mistakenly attributing PC, per se, with or without the FM, the good or bad results.

It is important to say that research does not generally cover specific tools used every day in clinical practice on people, family or community centered approach, like genogram, Eco map, technics of community diagnosis, etc. These dimensions are assessed on the user's or on the health professional's general impression. It is possible that is a limited perception because of local conceptions on what FCM is, thus the use of specific tools during practice is generally placed on common sense.

The fact that there is little systemic investigation on PC organization or performance and no critical vision of institutional mechanisms for its monitoring it is really a worrying problem.

Regarding survey results, it is relevant, for example the fact that there is no research on FCM's professional motivation or work overload, not even on user's satisfaction.

Most people reported that there is no direct participation of health professionals in PC units on quality assessment. It is worrisome that evaluation indicators are mostly quantitative with very little attention to process indicators.

It is surprising the limitation or even the lack of existence itself, of some PC basic services, including childcare, home visiting, mental health approach and topics such as genre and sexuality. Social participation and health education groups activities do not take place as expected or required.

At the same time, there seems to be little interest in evaluating PC essential or derivate attributes such as coordination, longitudinality, cultural competencies and family and community approaches. There are still obstacles to access evaluations; and although there are PC packages available, they are insufficient or heterogeneous even inside the countries themselves.

We can mention as positive results, the existence of health actions planning and the organization of PH working process in most of the answers, as well as the existence of a continuous professional development process for health professionals.

Conclusion

Implementing a universal PC in Latin America with FCPs inside the teams represents a challenge. Evaluating PC quality in Ibero-America is under development and there is still much to be done. In order to achieve it with efficiency, respecting current health quality standards as well as FCPs' ones, it is essential to involve FCPs to create, review and suggest improvements for the existing tools. It is necessary and strategic to include tools and specific aspects of FCM practice. Maybe they are not frequently approached or correctly included when quality parameters are created only by other professionals or specialists.

FCPs should be involved in practical activities related to PC quality evaluation either in an assessment role or as active health professionals. It is crucial to point out the need to specify the existence or lack of existence of FCPs inside the health teams as one of the most relevant factors to consider quality in any PC.

As contribution to this work, from the proposals and considerations obtained, we believe that:

- QUALITY in Family and Community Medicine as a specialization and PC as a strategy must be interdependently assessed.
- It must be a process of continuous improvement based on a quantitative, qualitative, systemic and dynamic assessment.
- It should retro feed and perfect health actions developed and directed to a given population assigned to a PC unit.
- It should cover self regulatory and self evaluating mechanisms, involving professionals from the health teams, people, families and the assisted community.
- It must be related to a role of principles and actions which must be evaluated in a systemic, permanent and dynamic mode having in mind that the target is the development and continuous improvement of:
  - The Essential Attributes (Access/Access gate; Health Coordination, comprehensiveness, longitudinality) and PHC Derived Attributes (Family Orientation, Community Orientation, Cultural Competency);
  - The strategies and tools derived from FCM (Biological, psychological and cultural approach of the health-illness process, Person centered approach, family and community oriented care; independently of their gender, age group of health state;
  - The Clinical practice with high responses to the most frequent health problems presented in a given population.

It must necessarily cover multi dimensional indicators related to 10 groups of essential elements:

1. PC essential and derivate attributes.
2. FCM tools, with the biological, psychological and social paradigm as basis and a systemic perspective, including that used for the People, Family and Community Centered approach - for example, genogram and community diagnostic instruments among others.
3. Health Care considering health problems and needs along people, families and a given community life cycles.
4. Basic health team for a given population group, minimally with a family physician, a nurse and health technicians.

5. Effectiveness and equity in the health services offered, considering the inverse care law and patients safety, based on quaternary prevention principles.
6. The social and health team participation in the diagnosis of health problems as well as on the planning of the services to be offered.
7. Health team members' continuous development of professional and personal competencies, including their work motivation and satisfaction.
8. PC role inside the health system, considering integration, coordination and reference and counter reference among the different health care levels and considering other inter sectorial actors as well.
9. Adjusting the diagnosis and therapeutic process according to health needs, assuring the necessary resources, including structure and functional conditions in the health unit.
10. People, families and communities safety and positive experiences in relation to the professional care humane treatment and provided health services.

Considering the presented and discussed concepts in this task force, we have the following guidelines:

1. Suggesting a model for assessing quality in FCM and PC in Ibero America taking into account the characteristics and concepts proposed in this document; and considering existing and available instruments, specially PMAQ and PCATOOLs. both already translated into Spanish and Portuguese.
2. Organizing and implementing regional research so as to stablish a base line that allows achievement assessment and goes hand in hand with continuous improvement of quality in PC and FCM in Ibero-America.
3. Standing for the implementation of an assessment model suitable for PC and FCM within health systems in Ibero-America and maybe at an international level.

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