Improving the quality of health care in Latin America

The Journal published a group of country reports recently on quality improvement experiences in Argentina, Brazil, Chile and Ecuador [1–5]. Including Mexico, this group of five countries is in the vanguard of making the measurement and the improvement of the quality of health care an integral part of the process of providing health care services in Latin America. These five countries represent only 15% of the Latin American and Caribbean countries but represent 68% of their population. A comparative analysis based on and limited to the country reports shows that differences in approach, emphasis, national commitment and resources allocated to Quality Assurance (QA) are more obvious than similarities. Common to all countries is the recent origin of Quality Improvement Programs. Systematic and sustained efforts to initiate and develop programs to improve the quality of health care in the Latin American and Caribbean countries are a 1990s phenomenon.

The evolution in Chile and Ecuador – two countries with similar population size (14.6 million and 12.5 million respectively) – shows an interesting contrast. External funding was the spark plug in both countries for initiating a quality assurance program. Gilda Gnecco Tassara [4] reports that outside funding in Chile ended 2 years and external technical assistance ended 4 years after start-up. The first quality improvement project was a joint effort between the Ministry of Health (MOH) and the USAID’s Quality Assurance Project. Strong leadership in the Ministry of Health in Chile ensured allocation of its own resources in 1993 as well as the institutionalization of QA functions. QA activities were permanently incorporated in MOH’s structure in 1995. Under the new title of ‘Quality and Regulation Unit’, the original focus on improving the quality of primary health care was broadened to measure the quality of all national health priorities. Indicators were developed to measure and improve the quality of 16 national health priorities. As implied by the Unit’s name it also assessed the regulatory role of MOH in developing and promoting standards and monitoring compliance with standards.

External funding in Ecuador has been a major financing source of QA activities and the contents and areas of application have been defined by mutual agreement between donors and the country. A national effort was started 4 years ago. Technical assistance from the USAID’s Quality Assurance Project had been provided prior to 1996 to improve clinical case management of acute diarrhea and cholera in two small rural areas. Jorge Hermida [5] reports that a ministerial decree ‘institutionalized’ a national QA program in 1996. By placing it in a parallel position to the MOH structure it was not incorporated into its formal organizational structure. Noteworthy is that both Chile and Ecuador ‘institutionalized’ the QA programs but in one case it became an integral part of the organizational structure and in the other it was put on a parallel track. The well-intentioned proposals of the Ecuadorian Government elected in 1998 had a slow start but advanced the agenda in three areas: (i) it included QA in the health sector reform program which emphasizes decentralization with more autonomy for health service delivery units; (ii) the focus of QA expanded from primary health care, especially essential obstetric care (partly financed by USAID), to hospitals; and (iii) preliminary activities to develop hospital accreditation schemes were started. Following mass demonstrations in January 2000 a new Government was installed with sector leadership less committed to QA and a slowing down of the initiatives of the previous 18-month-old government.

The lack of continuity and stability in sector leadership and the negative economic growth in Ecuador contrast sharply with Chile’s record in institutionalizing, financing and expanding the scope of quality improvement efforts. Stable political leadership willing and able to make decisions is a key ingredient but so is availability and willingness to allocate resources to quality improvement programs. A perennial question that the development community ponders is: does external funding delay national funding? Or is donor financing the seed money – as it is intended to be – to encourage the start-up and institutionalization of programmatic activities? There is evidence, for example from primary health care programs in the poorest countries in the world, that governments deliberately do not allocate resources to rural primary health care activities, as they are confident that the donor community will finance them. It would seem that in Chile donor funding fulfilled its intended goal of providing seed money whereas in Ecuador donor funds may have delayed the allocation of government resources to QA.

Hugo Arce [1] reports on the Argentine experience and Jose Maria Paganini [2] in a separate report complements it with the description of two QA initiatives. A value added feature of the Arce article is a brief review of the evolution of hospital accreditation in Latin America highlighting the development role played by WHO/PAHO since its first regional meeting in 1990. Two facts stand out in the reported Argentine experience. First is the creation in 1993 of a non-governmental non-profit technical institute (TTAES) grouping the major stakeholders that included national scientific societies, provincial physician associations, and the Certification Council of Medical Professionals. External funding did not...
play a role in financing QA programs. Second is the strong focus for quality improvement on hospital accreditation by an external body. Adoption of the hospital accreditation approach was influenced by the use of the hospital oriented PAHO accreditation manual and the expansion into Latin American countries of Joint Commission on Accreditation of Healthcare Organizations (JCAHO) activities that are also hospital based. Once a hospital has met the preliminary requirements to be surveyed, a team of trained surveyors visits the hospital and uses an evaluation form with 40 standards. The 675 questions that cover the 40 standards are in a closed and binary (yes/no) format. The closed nature of the questions allows computerized tabulation to reach a final survey decision. The hospital focus is now being widened to include health care networks and is assisted by Washington-based INTECH with W. K. Kellogg financing.

Brazil started a national program in 1995 pulling together several initiatives that had started in the early 1990s. Jose Carvalho de Noronha at the State University of Rio de Janeiro and Ana Maria Malik at the University of Sao Paulo [3] have promoted a ‘Five Tracks Strategy’:

- the use of outcomes indicators (mainly in pediatric and obstetric care);
- creating a national consortium for accrediting health care systems and services;
- developing selective quality improvement tools;
- producing clinical guidelines to decrease individual clinical practice variations;
- legislating consumer rights and protection (1990 law).

A larger number of approaches in Brazil may be justified as a better fit because of its population size (about 160 million), geographic size, cultural diversity and large socioeconomic differences. Brazil has relied on a public/private sector mix to develop its QA programs. Two of the five tracks have been developed and promoted in the public sector: the use of outcomes indicators in maternal and childcare programs, and the consumer protection legislation. The government has been an active partner in developing accreditation standards but a private sector consortium is the leading actor now. Clinical guidelines are developed and used by medical societies. The use of quality improvement tools [quality prizes, quality awards and mentions, International Standards Organization (ISO) certification] is a mix of private and public initiatives.

Argentina and Brazil are using different methods and approaches. The hospital accreditation approach in Argentina focuses on structure. It measures the quality of inputs by determining the presence or absence of a large number of standards deemed critical to quality hospital care. The presence—absence model clearly reveals the absence of a standard but hides the degree to which a standard is present—or should be present—and whether the standard is applied appropriately and consistently. Good quality of inputs—acceptable physical, financial, staffing and organizational structures—is conducive to good care but does not assure good care. They are necessary but not sufficient conditions. When followed up by intensive field surveys the input data can also be used as a guide for inquiring into and assessing process and outcome dimensions of the care provided.

Brazil’s approach is broader and encompasses the structure of care (accreditation, consumer protection), the process of providing care (clinical guidelines, quality improvement tools) and the results of providing the right inputs and using the correct process (outcome indicators). The report implies a vertically fragmented use of the structure, process and outcome measures. A weakness is not bringing to bear simultaneously the three elements of the widely accepted structure–process–outcome trilogy on the same health problems. Tackling health problems synergistically would yield superior results.

The country reports on Chile and Ecuador do not present information in a format that allows extending the Argentina and Brazil comparison of methods and approaches. The Chile report usefully documents the strategies used for institutionalizing QA and making it appropriate for Chile: (i) a technically strong central level team; (ii) decentralized implementation; (iii) developing appropriate training materials; (iv) training a large number of quality monitors; and (v) collaborating with Chilean professional associations and universities. A similar strategy could have worked in Ecuador but political and economic conditions did not provide the needed stability in leadership to do so. The Ecuador report ends with a useful feature listing 10 lessons learned during the first 5 years of attempts at establishing, integrating and institutionalizing QA activities.

In summing up, what can we learn from the experiences of Argentina, Brazil, Chile and Ecuador as reported in the country reports published by this journal?

First, we need to acknowledge that the systematic and sustained use of quality assurance and quality improvement methods is in an early stage of introduction and development in Latin America with start up and implementation in the 1990s.

Second, hospital accreditation seems to have developed and taken a stronger foothold in the two countries (Argentina and Brazil) that have a large private hospital sector.

Third, QA programs tend to be initiated and promoted by the public sector—often with external seed money financing—except for hospital accreditation where the private sector seems to assume the leadership. Medical schools, scientific societies and professional associations have been more involved in Argentina’s national QA program than in the other three countries reviewed here.

Fourth, external funding by bilateral and multilateral agencies has helped in starting up and building support for QA programs; however it is the allocation of a country’s own resources that ensures expansion and institutionalization of the measurement and the continuous improvement of the quality of health care services.

Fifth, there seems to be a relationship between health sector leadership and especially continuity of leadership at the top and the allocation of internal financial resources for quality assurance and quality improvement programs.

Sixth, the incipient development and use of QA in Latin
America merits support from the international QA community to ensure that Quality Assurance and Improvement become permanent and sustainable parts of each country’s health care delivery system.

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References


