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**QUALITY OF CARE IN THE NEW GENERATION OF HEALTH SECTOR  
REFORMS IN THE AMERICAS  
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I have a clear recollection of my initial interest in this subject being stimulated about 40 years ago in discussions with Archie Cochrane after whom the Cochrane collaboration is named. He was an incurable skeptic, but out of that skepticism arose some of the earliest work on the quality of care. He showed with biting sharpness that much of the health care given, particularly in the National Health Service (NHS) was neither effective nor efficient. He gave me a copy of his book “Effectiveness and Efficiency” and I have always been amused by the opening of one of his essays on the NHS. He wrote:

“I once asked a worker at a crematorium, who had a curiously contented look on his face, what he found so satisfying about his work. He replied that what fascinated him was the way in which so much went in and so little came out. I thought of advising him to get a job in the NHS, it might have increased his job satisfaction, but decided against it”.<sup>1</sup>

This apparently flippant approach hid a burning concern to have a system of care that was effective in terms of addressing appropriately the health problem, and at the same time was efficient in the sense of optimal utilization of the myriad of resources that went into the system. My attention to the issue waned somewhat after my early contact with Archie, but has been awakened in the context of the technical cooperation that should come from the Pan American Health Organization (PAHO). Clearly, PAHO as an organization that through its history has been committed to improving the health and well being of the people of the Americas, cannot be insensitive to the quality of care that could make for optimal health.

Over the last three decades we have seen an increasing interest in the topic of quality that goes beyond hospital care. Many early studies evaluated quality of care with the use of normative criteria for the structure and processes around care. More recent approaches have been to see the structure and process through the use of appropriate

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<sup>1</sup> Cochrane AL. Effectiveness and Efficiency. Random Reflections on Health Services. The Nuffield Provincial Hospitals Trust, 1971.

indicators and relate them to results that were also measured against indicators. Of course, it was the seminal work of Donabedian that conceptualized the interrelationship between structure and process in services and related them to results or outcomes.<sup>2,3</sup> These outcomes were to be seen as changes in health status that could be attributed to health care.

I have been struck by the explosion of attention to quality of care both nationally and internationally, and the existence of a vigorous society like this is an indication of that growth of interest. There has been almost a sense of angst in the United States over quality and I am indebted to the publications of the Institute of Medicine for much of the literature in this field.<sup>4,5</sup>

The year 1998 probably represented the high point of concern and as one major report said “The burden of harm conveyed by the collective impact of all our health care quality problems is staggering.”<sup>6</sup>

This affirmation was all the more shocking given that the expenditure on health care in that country is among the highest in the world. The IOM publication “Crossing the Quality Chasm” paints a picture of a system that is bad and has to be changed radically if it is to deliver quality health care. It contends that no amount of tinkering with the current system will suffice.<sup>7</sup> Although I do not wish to focus on American concerns and constructs, I do like the IOM definition of health care quality as “the degree to which health services for the individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” This definition appealed to me also because it made clear that our concern is for quality care not only for individuals.

I have accepted the basic components of health care quality –safety, effectiveness, patient centeredness, and timeliness. But I have often thought it simpler for my own understanding to think of quality of care as having two dimensions. First, there is the capacity of services to resolve the problems of the target population or individual. Implicit in this resolving capacity are the elements of safety effectiveness, efficiency and timeliness. I see the ability of services to respond to the perceived needs of the population or individual as being of a different dimension. Indeed, whereas the resolving capacity

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<sup>2</sup> Donabedian A. Evaluating the Quality of Medical Care. *Melbank Memorial Fund Quarterly*. 44:166-203;1966.

<sup>3</sup> Donabedian A. *Explorations in Quality Assessment and Monitoring*. Ann Arbor, Michigan: Health Administration Press; 1985.

<sup>4</sup> *Envisioning the National Health Care Quality Report*. Committee on the National Quality Report on Health Care Delivery. Hurtado MP, Surfle EK and Corrigan JM eds. National Academy Press, Washington, DC, 2001.

<sup>5</sup> *To Err is Human: Building a Safer Health System*. Kohn LT, Corrigan JM and Donaldson MS, eds. National Academy Press. Washington, DC, 2000.

<sup>6</sup> Chassin MR, Golvin RW and the National Roundtable on Health Care Quality. *JAMA*, 280:100-105;1998.

<sup>7</sup> *Crossing the Quality Chasm. A New Health System for the 21<sup>st</sup> Century*. Committee on Quality of Health Care in America Institute of Medicine. National Academy Press. Washington, DC, 2001.

applies with equal force to both individuals and populations, in the case of responsiveness, this is predominantly a subjective attribute predominantly of individuals.

It is also useful to point out here that, while the concepts of resolving capacity and responsiveness may be applied throughout the life cycle, it is difficult to apply the concept of responsiveness with equal force to infants. Thus, the quality of perinatal care of infants is centered more on the capacity of services to prevent or resolve the problems that may occur. It is not a philosophical point to consider which of the two main approaches constitute the essential goal of the health system and its services. To the extent that the health system exists for the primary purpose of improving the health of people, then considerations of ability to satisfy users by definition have to be seen as important attributes or characteristics rather than primary goals.

Before turning to the relevance of quality of care in relation to the new approaches to health sector reform, I must refer to a question I am sometimes asked. In situations in which there are such gross deficiencies in terms of quantity, is it realistic to think seriously about quality of care? This is an old dilemma, but we come down firmly on the position that advocates for both, and do not see that efforts to extend services run counter to considerations of quality. The fact is that the population is being treated in services that exist, and whatever the treatment in or rather contact with services, the care must be of optimum quality. There can be no acceptance of an approach that pits extension against quality of care, and in any case there is no correlation between quality of care and resources applied to the health sector.

A more fundamental issue is the relation of the nature of health problems to the possibility of offering quality care. Everyone is aware of the demographic transition that is a worldwide phenomenon which, in association with the application of health technology, has changed the epidemiology in our countries. Life expectancy has increased: in the Americas there has, on the average, been an increase of 3.4 years over the past 15 years and noncommunicable diseases are prominent, although we must never forget that the communicable diseases are still and will always be with us. If there was any doubt about this the problems of HIV/AIDS and dengue would be sharp reminders. Particularly in our developed countries, the main problems of health services are now noncommunicable diseases, many of them occurring in an older population.

Although it is perfectly feasible to have care that addresses the aspect of patient centeredness in all countries, it is increasingly difficult, especially for poor countries, to have services that offer the same kind of resolving capacity especially for noncommunicable diseases that is possible in richer ones. Indeed, even in developed countries, the question is being asked whether it is possible to have quality care that accommodates the drive of the technological imperative to save or prolong life at all cost, and at the same time deal with the issue of care for all people throughout the life cycle. This is being framed as a question of ethics and not only one of quality of care.<sup>8</sup> Is it ethically correct to devote such a substantial part of the resources available for health to

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<sup>8</sup> Callahan D. What Kind of Life. The Limits of Medical Progress. Georgetown University Press. Washington, DC;1994.

prolonging life at the end of life with technologies that often fall far short of being patient-centered and at the same time ignore the vast differences in availability and quality of treatment for so many others in the population? This is not an esoteric consideration for less developed countries.

The pervasiveness of the information that comes from the global nature of modern communications makes it possible for all persons to view the technological miracles that stretch the envelope of the possible and to ask why access to these technologies should not be available to them. This spread of information is one of the factors that is fostering an ever widening divide in terms of care between the rich and the poor in less developed countries. The approach to the correction of this growing problem probably falls outside the competence of the health sector, and it is probably seen in other sectors of society as well.

The question is also being asked whether it is possible to have the same focus irrespective of the type of health system that is operative. In any system that is essentially individualistic and market-driven, it will be incredibly difficult to optimize quality of care, or rather legislate for optimization of care. There will always be tension between the providers and the consumers. I assume, as a matter of principle, that physicians and indeed all health care workers would wish to provide care of the highest quality, but this laudable desire is often frustrated by a system that causes them to give precedence to other considerations. In a transaction in which there is not equality in terms of information and knowledge, there is no mechanism for ensuring quality that is intrinsic to the organization. Here I use the term organization to refer to the association of two elements that are unified for a common purpose. One approach to this has been to democratize the information such that both parties have access to the needed information, but I doubt that that will ever be the answer. There is an aspect of individual care that is bound up with Samaritanism that will never entertain equality in the transaction. Indeed, equality would itself destroy the possibility of the care provider satisfying many of the aspects of appropriate responsiveness.

I have always been intrigued by the need to divide or describe health services in terms of coverage and quality of care especially in relation to populations. I have proposed that we differentiate between those services that are supply driven from those that are demand driven. Supply driven services are usually of high quality in the sense that their resolving capacity is usually high, they are well focused and address a specific problem or set of problems. Immunization services are a good example. There is a high resolving capacity of these services, and to the extent that they are usually targeted towards children, the issue of patient responsiveness and satisfaction is of secondary importance, although one could argue that it is the parent satisfaction in this case that is important. For these reasons it is possible to design high quality immunization services. In contrast, in the case of services such as those for family planning or the treatment of noncommunicable diseases that are demand driven, it is inherently more difficult to establish services that satisfy the elements of quality. The countries of the Americas have made significant advances in those areas in which services have been supply driven; the high level of immunization has led to the elimination of poliomyelitis and the virtual

elimination of measles; iodine deficiency has almost disappeared.<sup>9</sup> Of course, in making this distinction between supply and demand driven services or interventions, I make the assumption that they are both effective.

The question remains as to where should be the locus of responsibility for ensuring quality of care. This brings me to the relationship of quality of care to the reform of the health systems, as I do believe that it is much easier to define such a locus in the reforms that are occurring in the countries of Latin America and the Caribbean.

Our involvement in the reform of the health sectors in the Americas took a major leap forward with the declaration of the First Presidential Summit of the Americas in 1994 in Miami. The Plan of Action that came from the Summit called for governments to:

Develop or update country action plans or programs for reforms to achieve child, maternal and reproductive health goals and ensure universal, nondiscriminatory access to basic services, including health education and preventive health care programs. Reforms would encompass essential community-based services for the poor, the disabled, and indigenous groups; stronger public health infrastructure; alternative means of financing, managing and providing services; quality assurance and greater use of nongovernmental actors and organizations.<sup>10</sup>

The Plan went on to establish PAHO's role in promoting and monitoring the reform processes. This mandate has generated considerable work in PAHO in defining the currents of reform that exist in order to situate our technical cooperation appropriately. I cannot go into detail on the state of the reforms in all the countries, but there are some general characteristics that bear noting. Although the concept of equity has been ever present, there is little evidence that the reforms are as yet making a significant dent in the inequalities, especially of access that has plagued our Region for years. There are still major gaps between rural and urban populations and between indigenous and nonindigenous groups, and gender inequality is endemic. Quality of care has been of concern mainly in relation to hospital services, and most attention has been placed on systems of accreditation and licensing. Little attention has been given to the issue of management of human resources as part of the reform process and we often see a disjuncture between the processes of planning, training, and management of the human resources that everyone acknowledges are critical for the success of any reform process.

The reforms that have been traditionally pursued were focused predominantly on the details of the organization of services, particularly personal services and the need for financial efficiency.<sup>11</sup> The last is eminently understandable given that the major concern of our countries in the decade of the eighties was the economic crisis and the need for reduction of expenditure in all sectors of the society. Quality of care, social protection in

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<sup>9</sup> Pan American Health Organization. Health in the Americas. 1998-2002. In press.

<sup>10</sup> Summit of the Americas, 1994. Summit Documents. Plan of Action.

<sup>11</sup> Ross AG, Zeballos JL and Infante A. La calidad y la reforma del sector de la salud en América Latina y el Caribe. Rev. Panam. Salud Pública, 8:93-98,2000.

its broadest sense and concern for public health did not figure prominently in the discussions on reform.

Dr. Daniel Lopez-Acuña and his colleagues have recently described the new generation of health sector reforms in which considerations of quality of care of individuals and of populations figure prominently.<sup>12</sup> They emphasize that previous reforms had concentrated predominantly on individual care and virtually ignored public health. New reforms should have the state at the central intermediate and local levels pay attention to what they describe as the essential functions of public health. These are:

- Health situation monitoring and analysis.
- Public health surveillance.
- Health promotion.
- Social participation and empowerment of citizens in health.
- Development of policy, planning, and managerial capacity.
- Public health regulation and enforcement.
- Evaluation and promotion of equitable access to necessary health services.
- Human resources development.
- Ensuring the quality of personal and population based health services.
- Research.
- Reducing the impact of emergencies and disasters on health.

PAHO is currently engaged in the application of instruments for measuring the extent to which these functions are being discharged and providing support to assist in their discharge.

Another important aspect of the new focus is the attention being given to the steering or guiding role of the ministry of health. While the state may or may not be responsible for the delivery of all services, it should not abrogate its fundamental role of steering the system. There is acceptance of the thesis that the state must assure at least the provision of a certain minimum of services that include those with highest social content and a certain essential package of clinical services that will depend on resource availability, as well as the particular epidemiological characteristics of the country. It is this steering role of the state that is critical for the assurance of quality. This is the only locus that should be so disinterested that it can establish and standardize the quality of care for both individuals and populations and monitor them through appropriate indicators of structure, process, and results.

The exercise of this steering role in the context of quality is even more critical given the tendency towards pluralism in terms of service provision. I am not denying the interest of other actors in improving quality of care, but regardless of the affinity to the various versions of the Beveridge or Bismarckian system or even the individualist market-oriented system, there should, or must, be a critical role for the state in ensuring quality of care. This role is also of crucial importance, given the tendency to see the

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<sup>12</sup> López-Acuña D, Brito P, Crocco P, Infante A, Marin JM and Zeballos JL. Hacia una nueva generación de reformas para mejorar la salud de las poblaciones. Ref. Panam. Salud Pública, 8:147-150, 2000.

whole care system as truly being a system and eliminating the rigid segmentation that occurs between the various levels of care and between the various subsystems for financing and provision of care.

The new reform processes are taking more seriously the concept of health promotion and the possibility of applying its strategies. The growth in this approach has come with the increasing appreciation that health care quality is not synonymous with health cure quality. The quality of care does not turn around cure, and in this context I am always reminded of the essential goals of medicine described by Callahan and his colleagues, and in each one of them the aspect of quality must enter.<sup>13</sup> They identify four goals and refer to them as the forgotten issue in health care reform. They are:

- The prevention of disease and injury and the promotion and maintenance of health.
- The relief of pain and suffering caused by maladies.
- The care and cure of those with a malady and the care of those who cannot be cured.
- The avoidance of premature death and the pursuit of a peaceful death.

The pursuit of these must be a part of the agenda of the new reforms of health services. One of the challenges for all those interested in quality of care will be to establish the indicators of achievement of these goals and the structures and processes of care that will allow their achievement. The one that I always find intriguing in relation to quality is the pursuit of a peaceful death. In this age of aggressive application of invasive technology in the final days, it is well to recall the importance of care in relation to death.

Unfortunately, there is no uniformity of action in the countries of the Americas with respect to measurement of quality of care. Few countries have established systems to evaluate the care at the personal and population levels. Most attention has been paid to assessment of quality in hospitals, and in some cases this has been linked to reimbursement schemes. Such information as exists on measurement of satisfaction of the users of the services has been done through punctual surveys, and there is no indication that the results influenced subsequent practice.

Finally, I will address briefly one other aspect of the work of PAHO in this field. A considerable amount of effort has been expended in trying to collect and codify the information in relation to care and particularly within the context of health sector reform. I believe that the critical weak point has been, and will continue to be, in the area of the information systems to support analysis and action.

I am pleased at the progress our countries have made in this regard. Almost every one produces its basic indicators and the regional compendium produced annually is a major effort that allows us to track a series of health and other social indicators. We now see countries collecting data with a greater degree of disaggregation and the culture of analysis is growing slowly. PAHO has intensified its cooperation in the field of health statistics and we continue to believe that in spite of the great power of analysis that comes

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<sup>13</sup> The Quality of Medicine-The forgotten issues in health care reform. Eds. Hanton MJ and Callahn D eds. Georgetown University Press, Washington DC, 1999.

with computers, basic health statistics are as crucial as they have ever been and that is why monitoring the health situation is the first of the essential public health functions. We must progress in similar fashion in the area of quality of care.

Let me wish you well. I hope your Conference will go well and will result not only in the interchange of information among the like-minded, but will permit the dissemination of good practices that will benefit all.