Towards evaluation of the quality of care in health centres

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There is wide acknowledgement that quality assurance is desirable in primary health care. Considerable success has been achieved in this field by the Iberian Programme of Training and Implementation of Quality Assurance Activities in Primary Health Care, the basis for which is outlined below.

When a strategy for quality assurance in primary health care is being devised it is necessary to decide whether programmes should be voluntary or compulsory and what the balance should be between internal and external initiatives.

Mandatory quality assurance programmes are likely to be developed in systems where the provision of health care services is fundamentally private. Where the state both owns and provides most health care organizations, and where health personnel are salaried, as is the case in Spain and Portugal, mandatory requirements laid down by government are less likely to succeed. In these circumstances, quality assurance programmes can be introduced voluntarily as part of a system of managerial objectives on the basis of a clearly defined strategy in which professionals and institutions freely decide to commit themselves to quality.

Mandatory programmes usually give most attention to external approaches and relatively little to the means of implementing internally assumed activities. It is vital that professionals delivering health care be motivated and involved in quality assurance, and this is possible only through commitment to internal programmes. External programmes may support or mandate quality assurance, which, however, has to involve an internal effort if improvement in quality is to be achieved.

In accordance with Spanish and Portuguese conditions a strategy was designed for the implementation of quality assurance in health centres on a voluntary basis with particular attention to internal involvement. The main elements of what became known as the Iberian Programme of Training and Implementation of Quality Assurance Activities in Primary Health Care were as follows:

- training, involving problem-solving, learning-by-doing, a phased approach, and the use of real cases;
- internal commitment;
- professional leadership;
- teamwork;
- external support;
- intrinsic professional incentives.

Training was the most important strategic factor. Also significant, perhaps, was adequate
ad hoc implementation of the principles of planned change (1, 2), including:

- building on strength (starting small, demonstrating success before attempting to grow, considering the strengths of persons and institutions and using them to help in the introduction of quality assurance);
- analysing systems (in order to assess who or what might impede or assist the introduction of quality assurance);
- using reinforcement models (practising professionals performing quality assurance as part of their everyday work);
- identifying influential persons (who could be expected to give active support to the innovation);
- adopting a voluntary approach;
- fostering a sense of the need for quality assurance (through training and the demonstration of successful examples).

Overall, a high degree of reliance was placed on the intrinsic motivation and self-determination of professionals (3).

Training

Preliminary training seminars were held in Portugal in November 1986 and May 1987. The overall programme began in December 1987, and within the next two years four

more training seminars were offered in Portugal and five in Spain. The participants were always drawn from various regions of both countries, and presentations based on actual experience were made by previous participants. Training activities continued at the same intensity during the period 1991–92, under local initiatives, but active support and follow-up by the Ministry of Health of Spain ceased in May 1990.

The complete programme reached 213 professionals attached to 203 health centres. Of the 51 multicentre quality assurance projects that were drafted, 42 were fully implemented after intervals averaging 12 months from the date of entry into the programme.

A five-day intensive seminar on quality assurance methods in primary health care was offered to selected professionals working in health centres. It was intended that they should implement quality assurance activities and pass on their experiences to other professionals and health centres.

Problem-solving

The problem-solving approach (4, 5) having been selected, all the concepts and methods taught had to meet the participants’ needs for designing projects with a view to evaluating and improving the quality of care in specific areas or for dealing with potentially problem-atic issues. The advantages of this approach were enhanced by asking the participants themselves to propose problems that existed in the environments where they worked.

The topics selected by the participants for evaluation and improvement covered almost the full range of the health centres’ work, as detailed below.

- Management of acute conditions
  - Use of antibiotics for common cold
  - Diagnosis and treatment of acute urinary infections
  - Care of patients with skin pressure ulcerations
- Use of intramuscular and intravenous drugs in primary care
- Knowledge of patients about management of fever in children

Management of chronic conditions
- Health care for patients confined to their homes
- Health care for patients with high blood pressure
- Health care for patients with ischaemic heart disease
- Health care for stroke patients
- Health care for patients with diabetes
- Health care for patients with terminal cancer
- Use of chronic drug prescription forms
- Use of laboratory test in patients with high cholesterol levels
- Use of prescriptions for chronic patients

Preventive care
- Immunization of children aged up to two years
- Well-child care
- School health programme
- Health care for pregnant women
- Tetanus immunization in adults
- Influenza immunization
- Cancer screening in women
- Detection and control of cardiovascular risk factors
- Early detection and control of alcoholic patients

Structural and organizational issues
- Organization of primary care team
- Information system and use of productivity indicators in primary health care
- Quality of medical records
- Quality of referral documents from health centre
- Quality of interclinic reports

Perceptions of patients and their contribution to health care
- Knowledge of patients about administration of prescribed drugs
- Knowledge of diabetic patients about self-care

The participants undertook to discuss the specific projects with the rest of the personnel at their health centres and to perform evaluations. Implementation of the full quality assurance cycle, including problem identification, study design, intervention design, implementation of remedial actions and re-evaluation, was considered to be part of the training experience, a kind of supervised learning-by-doing with follow-up and methodological support provided by the organizers. Teachers were available throughout the learning experience to give advice on matters raised by the participants.

Phased approach

An evaluation cycle begins when a problem connected with quality has been identified and ends when data confirm that a solution has been found or that a satisfactory degree of improvement has been achieved. The means to these ends include problem analysis, the definition of criteria on the quality of care, study design for improved understanding of the quality problem, implementation of the study, and application of the results to the design and implementation of remedial actions. Occasionally, intervention design may follow problem analysis, in which event there is no need for new data or study design. If re-evaluation reveals no improvement a reassessment of causes and probably a new study design may be required. An evaluation
cycle requires most, if not all, of the skills associated with quality improvement.

Monitoring, on the other hand, essentially includes the selection of indicators and periodic measurements, possibly leading to the identification of problem areas requiring evaluation. It may follow an evaluation cycle in order to verify whether an improvement has been sustained.

The relationship between monitoring and evaluation activities is shown in the figure.

A full quality assurance cycle was performed and training was then given in the establishment of indicators and the methodology of monitoring. Performing a full evaluation cycle is the most essential activity in any quality assurance programme, regardless of the methods used to identify improvable areas, design the evaluation study or implement remedial actions.

Monitoring activities were not the starting point for training for the following reasons:

- the establishment of indicators is easier and can be more readily understood after an attempt has been made to evaluate and establish criteria;
- monitoring alone cannot improve quality; it is a tool for the identification of problems or a means of ascertaining that products and services are of adequate quality; when a problem is detected a more detailed evaluation is necessary;
- to suggest that participants should monitor several services or potentially problematic areas could lead them to feel overwhelmed; motivation for further activities is more likely if a single service or product is understood and improved initially.

The main objectives of the second phase of the training programme were to establish indicators and learn monitoring methods.

**Real cases**

Real quality assurance cases were presented and discussed by people who had been involved in them. They served as an additional incentive for the participants to

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**Monitoring and evaluation activities**

![Diagram](image-url)
perform quality evaluations, because they were told at the outset that they would be able to present their examples of full quality assurance cycles in future seminars, and because their professional pride was aroused. Furthermore, discussions about the cases with colleagues who knew the details of implementation were of great practical value to the participants.

**Internal commitment**

The quality assurance activities were internally chosen and implemented, thanks to the fact that professionals were selected from health centre staffs who were directly involved in clinical care. Attention was directed to problems that were both caused and solvable internally.

The relative stability of the positions of professional staff in health centres was another reason for giving the greatest possible strategic importance to these people. Moreover, in primary care and to some extent in hospitals the quality of service is sometimes determined by a team comprising only a physician and a nurse or even by a single health auxiliary. It should also be borne in mind that the scope for offering new services to the population is greater and more decentralized in health care than in most industrial activities, in connection with which the commitment of upper and middle managers may be the first concern.

**Leadership and teamwork**

Beneficial changes in organization and behaviour are most likely to take hold if driven by recognized leaders. Accordingly, training was offered initially only to potential leaders of health centres, including directors and people known to possess the capacity to implement innovations or to be respected by their colleagues and to have the potential for influencing them. It was assumed that the persons selected would take it upon themselves to convince the staffs in their centres that quality assurance should be initiated. Institutional or formal leadership was considered less important than professional leadership, although the best candidates for the seminars had the characteristics of both. Selection was carried out locally by provincial or regional primary care managers. Where the local authorities sent professionals holding purely managerial positions at the district, regional or provincial levels, the organizers indicated that they expected centres to be selected in which efforts would be made to convince the staffs to implement internal quality assurance activities. Although the organizers would have preferred to have two participants, rather than one, from each health centre, this was not usually achieved. The participating professional leaders had either medical or nursing backgrounds.

It is worth noting that although the industrial model of quality assurance pays little attention to professional leadership, there is evidence that, in health care settings where attempts have been made to adopt this model, a lack of commitment among professional staff is an important obstacle to its full development (6).

Since the implementation of quality assurance and the improvement of quality were most likely to be achieved if the whole primary care team was involved, it was decided that internal quality assurance activities in the health
centres should not be a task solely for experts. Projects were encouraged in which the whole team was involved. An attempt was made to reinforce the team approach throughout the training period.

**External support and professional incentives**

The view was taken that the role of external support was to help the centres to initiate internal programmes and to provide whatever incentives could be developed under the structural constraints encountered. External support and stimulus were regarded as very important, given that the centres were trying to add activities to their already busy schedules. Apart from the initial training, this support consisted mainly of methodological aid and supervision of the first quality assurance cycles, with particular reference to practicability. In those instances where the same topic was evaluated in several centres, as was encouraged in the seminars, the organizers helped to coordinate the activities.

Only intrinsic professional rewards were used as incentives. The diffusion of the quality assurance work was encouraged and facilitated, and the projects were used as practical examples in the seminars.

Some centres have progressed towards monitoring and the establishment of stable quality assurance schemes. Some participants systematically fostered and performed local replications of the seminars. The programme is still developing, and a second phase of training is under way following requests at the local level. The continuation of the programme at the local and regional levels suggests that it was well founded. Other countries may well wish to consider what has been achieved.

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**References**