Quality assessment and assurance in Primary Health Care

Programme Statement

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Introduction

Why Quality in Primary Health Care?

The implementation of primary health care at national and at district levels is meeting with different levels of success. One aspect that has not been given the necessary importance is the quality of the care provided. This may be due to a misunderstanding of the concept of quality care as being exclusive and expensive. In the context of the global strategy for health for all, quality assurance is exactly the opposite: it means compliance with appropriate standards of the services provided to all people, at the required levels of care and when needed. In the medium and long term, good quality may even yield economics, because of the increased effectiveness and efficiency of the services. Therefore, quality performance is most relevant in situations of limited resources.

Quality in the delivery of interventions is essential for them to achieve an impact on the health status of the population. Therefore, quality is also most crucial in communities with a poor level of health.

Another factor that should not be overlooked in regard to quality in primary health care is the fact that its assessment and assurance, where it has existed, has usually been piecemeal: it has been and is being applied only in individual components of the system. Therefore, an important task for WHO now is to promote the strengthening of the quality aspects in all the activities at the various levels of the system. This implies the raising of awareness, the development of relevant methods and skills, and the broadening of supervision and evaluation processes to include and integrate the quality concerns.

This document sets out in some details the present situation as well as the outline of WHO activities designed to promote and support quality assessment and assurance in primary health care.
Origins of the programme

Concerns with quality are embodied in the Alma Ata definition of Primary Health Care as being based on “scientifically sound and socially acceptable methods and technology”. This principle is reflected in the “Health for All Series” and other publications of WHO. In its 20th Session, the Global Programme Committee of the Organization expressed that: “Quality assurance in the delivery of health services was becoming an issue of importance, not only in the industrialized countries but in many of the developing countries as well”. The WHO Programme for the biennium 1988-1989 reiterates that “the assurance of quality of primary health care will receive greater attention”. The Eighth General Programme of Work of WHO (1990-1995) emphasizes the need “to improve the quality ... of support ... from the district to the community”. The relevance of the subject has also been strengthened by statements from a number of experts from developing countries. The gist of these comments is summarized in one of them: “quality assessment of PHC is one of the areas requiring urgent support”. This is considered valid for the industrialized countries as well.

A systems approach is expected to be developed to enable the experience of specific programmes in the countries and WHO to be brought together in the broader areas of integrated prevention and of day-to-day outpatient and in-patient care.
Main issues and problems

Some health managers in developing countries still hesitate when confronting the quality issue. They have the impression that the assessment of quality is a complicated affair and that, if it is to be done, it may uncover problems that are even more complex and impossible or very costly to solve. Those who are conscious of the imbalance in favour of the urban population and of large hospitals fear that attention to quality may accentuate that imbalance: is it not true that until very recently the quality of care in the industrialized countries was the exclusive concern of hospitals?

However, quality problems are easy to recognize in the developing countries. In hospital wards there may be an accumulation of garbage and insects. In dispensaries there may be ninety seconds of consultation time per patient. Sterilization of syringes and needles may be merely symbolic. And although precisely documented observations from these countries are relatively scarce, those that exist are sufficient to prove that such appalling situations are widespread.

Concerning the quality of activities at the primary level, one known example refers to the inadequate prescription of drugs. In a representative sample of doctors working for the Ministry of Health of one Latin American country (1987) less than 33% of prescriptions were within the Ministry’s Basic Drugs List and only 63% were accompanied by any information to the patient. An (externally supported) team evaluating rural health care in one African country reported: lack of patient examination, lack of health information, education and follow-up of patients, long waiting periods and no community participation. In the same area the referral system did not function and in about half of the rural centres studied the temperature of the refrigerator was far above the recommended one for vaccine storage. In a special programme providing rural health care in another African country, the community health workers — trained for four to six months — were found in an auditing exercise to perform a physical examination in only 11% of diarrhoea cases; this proportion dropped to zero for the health workers that dedicated less than five minutes to each patient. In a third country, the average time for one consultation by a medical assistant in a hospital outpatient department (OPD) was approximately two minutes.
At secondary level the results of quality assessment of activities are also quite sobering. For instance, in one Latin American country it was found that 50% of the patients in the internal medicine wards of one large hospital had no justification for being there. In one of the Caribbean countries an audit performed in a group of hospitals resulted in quality scores ranging between 38% and 87% for two conditions, namely, appendicitis and incomplete abortion. The same audit revealed at least one avoidable factor in 68% of maternal deaths.

The quality of resources also leaves much to be desired, particularly at the primary level. In some Latin American and African countries a high proportion of rural health facilities is reported to lack an appropriate water supply and sanitary facilities. One report reads: “None of the rural health centres studied had electricity ... the toilet rooms were often locked ... the walls, ceilings, doors and windows were generally dirty ... cotton wool and bandages were not available at any rural health centre ... in one health centre there were only two syringes and three needles ... in the majority of the rural health centres there were no mattresses and no linen in the delivery room, no sterile gloves, no antiseptic solution, no sanitary pads, no suture material nor needles for episiotomies”.

Many of these urgent problems can be solved with existing resources, ingenuity, better management, and the participation of motivated and informed personnel. For example, within the same geographical area there is a range of variation in quality among different health care units of the same category. Deficiencies in the quality of resources, such as the absence of sphygmomanometers in an urban health centre or the lack of first-line anti-tuberculosis drugs in a rural health centre have recently been documented in a country that is classified in the upper-middle income bracket by the World Bank: therefore, not a problem of poverty, but of inadequate allocation of resources. Indeed some of the more glaring quality deficiencies in some developing countries consist of an excess of services which are unnecessary and unsafe: in some States of several Latin American countries the proportion of caesarean sections ranges between 25% and 50% of deliveries.

In all these cases, the resources used — large or small — are inefficiently spent, since no positive health effects can be expected from their use in the low quality conditions described. On the other hand, in the few areas in which
the organization and management requisites for quality – such as teamwork and community and intersectoral participation – have improved, a positive change in health status has followed, even in the absence of budget increases.

The demonstration of concrete quality problems should not allow the quality issues of a broader nature to remain out of sight: the under-use of effective and safe interventions, the inappropriate use of unnecessary or unsafe technologies, the lack of attention to the human dimension and to the ethical aspects of care, the absence of community involvement and of an integrated effort of all health-related services in favour of community health improvement. Yet the solution to these more far-reaching quality shortcomings would also be fully affordable.

In fact, ignoring the quality issues that affect the health care of the majority of the population leads to the perpetuation of a state of inequity where quality exists only for a small minority of the population and in some specific interventions.

In summing up, the following pointers may serve as a guide to those striving for quality assurance in Primary Health Care:

- There can be no health improvement without effectiveness of action; nor effectiveness without quality of interventions (health and other sectors); nor quality of interventions without sufficient resources of sufficient quality; neither can there be optimum efficiency without quality of interventions.
- Quality is: compliance with national or district standards.
- Quality as defined by local standards should be for all, all the time.
- Quality is not necessarily dependent on technological sophistication.
- Quality does not always cost more – it may cost less.
- Quality is unachievable without quantitative coverage.
Examples of initiatives in Countries

Standards

Both the assessment and the assurance of quality require the setting of standards for the relevant resources and activities. Some of these are rather obvious, such as the requirement that every health facility be supplied with potable water. Very complete sets of standards have been produced by the Joint Commission on Accreditation of Health Care Organizations (USA) and are a good reference source. Indonesia has produced instruments for classifying health centres according to various characteristics, including quality, and these instruments contain implicit standards. One way of presenting standards for diagnosis and treatment is through “logical trees” or “pathways”: examples of these, intended for use in developing countries, have been published by the African Medical and Research Foundation and by WHO.

Assessments of the compliance of the prescribing practices of physicians with known standards have been carried out in Mexico and Colombia. A national evaluation of the quality of procedures in the immunization programme was published in Chile.

Methods

Instruments for assessing the quality of resources – facilities, personnel, equipment, supplies – and of some activities in health centres have been utilized in Tanzania, first as part of an overall evaluation of the health sector and afterwards in the context of a report on bilateral cooperation for health development. Similar tools have been elaborated in Mexico and Haiti. The Ministry of Health of Malaysia is monitoring the quality of care in the 94 government hospitals by means of a “National Indicator Approach”.

Auditing of clinical activities, using tracer conditions, has been reported by national health workers jointly with external consultants in Jamaica and Ghana. These exercises, however, do not seem to have been followed up for purposes of continuous quality assurance.
A WHO-supported study in the Republic of Korea employed user satisfaction as an indicator of quality. The findings were that 83% of the users were very satisfied with the performance of the community health practitioners (CHPs). A similar study was carried out in regard to the performance of public health nurses in the Philippines.

Support Services

In order to produce effective direct treatment or prevention activities, the supporting services – technical and administrative – must also be of appropriate quality. Great importance has been given to this aspect in Mexico: the Ministry of Health uses a simple monitoring system that aims at improving the following essential points at all levels: supplies, maintenance, personnel management, in-service training, community participation and supervision.

Implementation of the PHC Strategy

At the present stage of transformation of the health care systems, compliance with the basic principles of “health for all” should be seen as an essential quality aspect of health care activities and resources. As such, it is an important subject of quality appraisal and assurance for primary health care. Thailand, for example, has experience in evaluating the application of the principle of community participation in health and development. Some states of Mexico are beginning to monitor and improve another principle, namely the use of intersectoral mechanisms such as development committees and “integrated development centres”. Assessments of appropriateness in the use of health technology have been undertaken in Colombia: the results in regard to the use of the internal medicine beds of one of the Social Security Institute Hospitals are drawing the attention of decision-makers. A recent PAHO intercountry study of the quality of maternal and child health services of the public sector showed that the incidence of caesarean section reaches 50% in some countries – while in the same districts there are no caesarean deliveries among the women that do require the procedure. The same study revealed low quality levels of antenatal care, with a corresponding
lack of effectiveness; proper qualifications in obstetrics of the doctors supervising the deliveries were shown to be associated with a significantly better perinatal outcome. *Continuity* is a characteristic of care that makes it more effective and efficient: simple indicators have been used for measuring it in health centres of *Finland*. While the quantitative coverage of the population with primary health care is beginning to be monitored in an increasing proportion of developing countries, its *equity* is still not regularly assessed. As far as developing countries are concerned, the same applies to another qualitative feature: *satisfaction* of the population with the services provided.

Assessment of the application of the primary health care approach has received increased attention in the Western Pacific Region, where criteria related to its application have been incorporated in research and development activities in countries: the outcomes of these studies are expected to contribute to the assurance of quality care.

**Corrective mechanisms**

*Training*, continued education and supervision carried out in the context of a well balanced health care system and supported by appropriate regulations, constitute the basic elements of quality assurance. Such elements exist, to a variable degree, in all countries. However, in order to be effective, they should: a) have explicit quality assurance objectives, expressed in terms of quality indicators; b) be oriented by quality assessment and c) be supported by adequate structural mechanisms. Very few, if any, countries, have a complete system for quality assessment and assurance for all essential health care resources and activities. However, partial experiences do exist. *Zimbabwe* has a national board for quality assurance in the health sector and *Malaysia* has set up a Quality Assurance Programme implemented by the relevant Divisions of the Ministry of Health. Some programmes both in WHO and countries are directly concerned with "quality control": for example *drugs, biologicals, devices, diagnostic support and environmental health*. Such programme-specific experience exists in a number of developing countries and may be utilized by them as a starting point for a more comprehensive approach that addresses the whole of primary health care.
Recent initiatives by WHO and other international organizations

In 1981 the European Regional Office of WHO launched a programme on “Model health care programmes and quality assurance” and in 1982 it issued a publication* on the subject, which was followed by a series of meetings, culminating in the Technical Discussions of the Thirty-eighth session of the Regional Committee (1988). It is worthy of note that even in European countries “the topic of quality assurance remained (at the beginning of the eighties) a novel and often nebulous concept”. Quality assurance is being studied by health authorities in several European countries, notably Belgium, the Netherlands and the United Kingdom, and legislation already exists covering quality assurance in Spain, Yugoslavia and all the Eastern European countries. The WHO European office helped launch the International Society for Quality Assurance in Health Care (ISQA) which has already organized five international conferences.

In 1988 the American Regional Office/Panamericán Health Organization held a Workshop on Accreditation and Evaluation of Hospitals in Latin America. Besides the experiences and agendas of several Latin American institutions, those of the Joint Committee on Accreditation of Health Care Organizations and of the American Medical Association were presented. Most important, the meeting also recommended the development of quality assessment and assurance programmes in district health systems.

The Western Pacific Regional Office has experience in supporting countries such as Malaysia and Singapore in the appraisal and improvement of quality. Here, as elsewhere, the initial focus has been on hospital services.

In 1985, WHO Headquarters distributed a document on the application of the concept of quality to the implementation of the primary health care strategy, with emphasis on the developing countries. The reactions from both developing and industrialized countries indicated that this was a timely initiative and that document became an official WHO publication**.

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*Quality Assurance of Health Services, EURO/WHO, Public Health in Europe No. 16, Copenhagen, 1982.

Objectives of WHO activities for improvement of quality in primary health care

General objective

To support countries in the process of integrating quality assessment and assurance in their systems’ organization.

Specific objectives

To promote understanding of the importance and feasibility of quality assurance in the context of the primary health care strategy particularly in developing countries.

To assist in developing practical methods for quality assessment and assurance in primary health care.

To support the development of skills in quality assessment and assurance, for application in national and district health systems based on primary health care.

To collaborate, as necessary, in the implementation of health care quality assessment and assurance by countries.

To promote the mobilization – at national and international level – of the essential resources to achieve the above objectives.
Approaches

The activities outlined in this statement are based on the WHO Programme for the biennium 1988-1989 and on the General Programme of Work of WHO for the period 1990-1995. Their aim is to promote mainly the development of national capabilities in implementing and monitoring quality assurance in primary health care.

Maximum use will be made of relevant national experiences: these will be synthesized and disseminated. The Organization will work with national and district health systems and with national health development institutions in order to learn from the application and evaluation of their activities and add these lessons to the international pool of knowledge. Publications on the subject are being reviewed and annotated bibliographies will be made available.

The integration and use of the existing experience of the WHO programmes dealing with specific subjects of quality control will be sought.

The programme will emphasize collaboration with other organizations concerned with the subject, such as the International Hospital Federation, the International Society for Quality Assurance, and others. The experience of quality assessment and assurance in the private sector and in other, non-health sectors, will also be sought and shared with Ministries of Health.
Future Action by WHO

Given the fact that overall health care quality is an essential but very new subject for a large number of countries, action to be taken by WHO in this field is urgent and multi-faceted.

Promotion of awareness

The interest of decision-makers in quality assessment and assurance in primary health may be aroused by making its importance and feasibility understood through interventions in the form of seminars, congresses and other suitable gatherings. Every opportunity should be utilized by WHO to encourage and support the inclusion of the quality issue in primary health care development and upgrading activities in countries and at regional and interregional levels. The contribution of international non-governmental organizations (NGOs) such as the International Hospital Federation, the World Federation of Public Health Associations, the World Federation of Medical Education, the International Council of Nurses, and others, should be decisive for creating awareness on the subject.

In view of the need to stimulate further awareness, an interregional Meeting on Quality Assessment and Assurance in Primary Health Care is now considered essential. By bringing together experienced health managers, representatives of governmental and non-governmental agencies and WHO staff such a meeting would contribute to formulate the global strategy of the programme and to orient the activities enumerated below.

Development of methods and guides

The WHO publications, “Quality assessment and assurance in primary health care” and “Quality Assurance of Health Services” may serve as a basis for the selection of indicators and other methodological tools. New guides on quality assessment and assurance for the integrated delivery of health services through community agents, health posts, health centres and hospitals are required. Mechanisms for applying such methods in districts
and on a countrywide basis should be designed and implemented. The country experiences referred to above, as well as those of a number of specific programmes, may be adapted and serve as starting points. For this, the collaboration among the programmes concerned in the countries and WHO is essential.

Support to training activities

International training activities addressed mainly to educators in health schools or institutes and to health system managers are required. These activities should consist of courses and workshops covering the following subjects: the concept of quality in primary health care; determinants of quality; assessment of quality; setting of standards; and assurance of quality (methods, tools, organization and support mechanisms). After their participation in these activities, the educators or trainers would be expected to incorporate the subject of quality in the basic courses and in the continued education programmes for health personnel. The managers would be expected to plan and implement quality assessment and assurance programmes at their level of responsibility and to extend their experience to the largest possible number of district health teams. It is envisaged that WHO, in collaboration with other agencies, should support such activities, as exemplified by the Course on Quality Assessment and Assurance in Primary Health Care proposed for 1990, which DANIDA has expressed interest in supporting.

Collaboration in launching quality-related activities in countries and districts

WHO, in collaboration with other agencies and NGOs, may collaborate in the preparation, implementation and follow-up of quality assessment and assurance. For example, it may help to introduce these aspects in national health care review, planning and reorganization processes; or in district health systems that already conduct collaborative activities with WHO. The establishment of national, provincial or district committees for quality assurance may be supported. The ensuing experiences should be documented and exchanged within and among countries.
Support in the use of appropriate quality standards and regulations for the application of appropriate technologies.

This activity should be initiated gradually in each country on the basis of the requirements that arise from the first experiences in developing methods and operations in the field of quality. Permanent mechanisms for broadening the sets of national standards and for updating them will be necessary; groups of national experts may be formed for this purpose, and their work and the publication of standards should be supported by WHO.

Support to action research

It is foreseen that the initial activities in quality appraisal and assurance should raise questions that require research for clarifying which are the best approaches for improving quality in a given primary health care situation. This is an area which the WHO Advisory Committee on Health Research, in its twenty-ninth session (October 1988), considered as a relevant subject for future research.

Mobilization of resources

The allocation or reallocation of the essential resources, both human and financial, required to ensure quality according to the standards of a given country and for each particular level of its health system, is an obvious requirement and its cost in monetary terms may be within the reach of many administrations. Supplementary resources should come from the international community — particularly for the take-off and development aspects of this programme. Relevant institutions in both developing and developed countries will be stimulated into forming a network of technical cooperation, and amongst them WHO Collaborating Centres will be designated.

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The reality of primary health care as envisioned in Alma Ata lies in the quality with which its components are provided in every country and district. International collaboration in this field should help to overcome the problems identified, thus ushering in a phase of greater authenticity and reliability in the implementation of the strategy.