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Quality in Primary Health Care Services in Sub-Sahara Africa: Right or Privilege?

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ABSTRACT

The Primary Health Care (PHC) system has been the foundation for the operation of the health system in most of Sub-Sahara Africa following the Alma Ata Declaration in 1978. Quality of care is an important determinant of health services utilization, and is a health outcome of public health importance. It is known that the perception of the users about the quality of service offered in a health facility is a determinant of patient's choice of provider and willingness to pay for the services. This paper discusses quality of primary health care services with focus on perspectives of the users and the need for a user driven and business minded delivery of PHC services in Sub-Sahara African nations.

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INTRODUCTION

The Primary Health Care (PHC) system has been the foundation for the operation of the health system in most of Sub-Sahara Africa following the Alma Ata Declaration in 1978. The design of the system integrates at the community level all the factors required for improving the health status of the population.[1] Though the PHC is about the people it serves, very often the people's perspectives do not feature during design and implementation of services.[2] Moreover, there is often ignorance amongst users of services about their rights and what they can expect from their health care providers. Experiences of being shouted on, being ignored, having to wait for long hours before getting attention and the like abound.[3] Issues like unavailability of health workers on duty, lack of drugs in the pharmacy/dispensary and other related factors all lead to people's dissatisfaction with the services rendered.[4] This paper discusses quality of primary health care services with focus on perspectives of the users and the need for a patient (read 'customer') driven and business minded delivery of PHC services in Sub-Sahara African nations.

What is Quality of Health Care?

The concept of quality in health care may have originated from clinical medicine with its focus on specific diagnosis, therapy or results of these actions.[5] There are however broader perspectives beyond this narrow view of quality of health care. Avedis Donabedian defined quality care as "that kind of care which is expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend the process of care in all its parts".6 This implies a technical and personal component concerning which Brown et al.[7] wrote that "…quality must be defined in the light of the provider's technical standard and patients expectation." In relation to quality of health care, Roemer and Montoya-Aguilar[5] wrote that "it concerns the degree to which the resources for healthcare or services included in health care correspond to specified standards...". The American Medical Association used the term high-quality and defined it as such care "which consistently contributes to the improvement and maintenance of quality and the duration of life".[8] The Institute of Medicine (IOM) defines healthcare quality as the extent to which health services provided to individuals and patient populations improve desired health outcomes and are consistent with current professional knowledge.[9] This care should be based on the strongest clinical evidence and provided in a technically and culturally competent manner with good communication and shared decision making, implying that the concept of quality of care is comprehensive and multifaceted.[7]

The technical component of care can be referred to as 'observed' care. Observed care depends on a normative definition of quality which judges services as of good quality once they reached defined standards.[10] The distinction between perceived and observed quality of care is that while the observed focuses merely on structural and process measures, relates to professionally defined standards of care, and refers to whether health services adhere to these standards, the perceived relates to the views of patients.[11] Thus quality is both a relative and an empirical term.[12] The user's satisfaction can be considered as the patient's judgement on the quality and the goodness of care; what patients feel, are saying or have to say about the services they are offered should be respected.[6] This is because the perception of quality affects utilization of services: the patients discriminate well between the various dimensions of quality and they make sensitively different judgement about different health centres.[11] Non-utilization of services is a major issue in several developing countries which is often traced to a perceived lack of quality.[10]

Quality Assessment and Primary Health Care

PHC was envisioned as a new centre of the public health system; an inter-sectoral approach to health; and a part of a social and political movement for development.[13] Evaluation of its quality is critical to ensure that it is achieving its aims and objectives. According to Sitzia and Wood[14], "health care evaluation involves defining the objectives of care, monitoring health care inputs, measuring the extent to which the expected outcomes have been achieved and assessing the extent of any unintended or harmful consequences of the intervention". They also alluded to the definition of quality assurance as "measurement of the actual level of the quality of services rendered plus the efforts to modify when necessary the provision of these services in the light of the results of the measurement". It is incumbent on healthcare providers, healthcare administrators and those responsible for health care policy to seek input from the users and to use that information to improve services and create innovative strategies that meet and exceed expectations.[15] The information from patients on the perceptions about the services should be used to provide feedback to users, feedback to health planners and healthcare workers and for setting standard of care.[14]

Quality of care is an important determinant of health services utilization, and is a health outcome of public health importance.[16] The health indices in Africa nations still remain poor despite investments into health[17] over the past years. Maternal and infant morbidity and mortality rates are high; and life expectancies very low, compared with other regions, the disparities between low income and high income countries are huge.[18] The World Health Organization (WHO) reported that about 536,000 women died in 2005 due to complications of pregnancy and childbirth, 400 mothers died for every 100,000 live births. The unfortunate ratio is 9 in developed countries, 450 in developing countries, and 900 in sub- Saharan Africa, suggesting that 99% of women who died in pregnancy and childbirth worldwide were from developing countries. Globally, maternal mortality ratio fell by 5.4% in the 15 years between 1990 and 2005, an average reduction of 0.4% each year.[19]

It is known that the perception of the users about the quality of service offered in a health facility is a determinant of patient's choice of provider and willingness to pay for the services.[4] Several challenges have faced the provision of health services in Sub –Saharan Africa including poor funding, poorly motivated staff and high cost of services. These challenges must be tackled with the contribution of feedback from users of the services.[20] In a study in Northern Nigeria, Katung[21] identified major factors that caused non-attendance of the available health services to include the high costs of drugs and service charges, easy access to alternative (traditional) healers and difficulty in getting transport to a health facility. He however noted that the unfriendly attitude of the health workers and the long waiting time patients endure at the facility did not constitute serious constraints to attendance of facilities.

Stakeholders' roles and responsibilities in ensuring good quality in health care

In order to bring healthcare to people where they live and work, the PHC system has a very strong community component and is aptly described as health for the people by the people. Different groups have different reasons for assessing the quality of healthcare hence different criteria and emphases for measuring quality of care.[22] Three main stakeholders are identified as having roles and responsibility in the quality of health care. These are the health care users, the health care providers and the health care policy planners and implementers. For the health care users they primarily want services that effectively relieve symptoms and prevent illness, therefore they focus on effectiveness, accessibility, interpersonal relations, continuity, and amenities as the most important dimensions of quality. The role they have to play, therefore, is identifying their own needs and preferences, and in managing their own health with appropriate support from health-service providers. There is a paradigm shift from seeing the users of healthcare services as just patients – that signifies passivity and dependence – to such as customers, consumers, clients or services users.[14]

For health care providers, quality implies skills, resources and condition necessary to improve the health status of the patient and the community. They want to ensure that the services they provide are of the highest possible standard and meet the needs of individual service users, their families, and communities.[16] For the health care planners and implementers, they are not directly involved in provision of health care. Their role consists of supervision, and financial and logistics management. Thus they view quality more from a population approach and would consider first how many people will benefit on an economies of scale. Their role and responsibility is to keep the performance of the whole system under review, and to develop strategies for improving quality outcomes which apply across the whole system.[16] Decision-makers cannot hope to develop and implement new strategies for quality without properly engaging health-service providers, communities, and service users. Health-service providers need to operate within an appropriate policy environment for quality, and with a proper understanding of the needs and expectations of those they serve, in order to deliver the best results. Communities and service users need to influence both quality policy and the way in which health services are provided to them, if they are to improve their own health outcomes.

As a global measure of quality, the perception of users of a service can serve as basis for adapting services to the peculiar needs of the users because there is a link between satisfaction of patients with services they use and their perception of the quality of the services.[23] In developed countries there has been a strong focus of measurement of patient satisfaction and consumer behaviour. This is because of increased awareness of the rights of users of health services as well as availability of several alternatives where to receive healthcare. People are more likely to opt for services they perceive as having better quality and thus able to meet their needs. Patients may be thought to be satisfied to the degree to which they feel they have received high-quality health care.[24]

Quality in PHC: Right or Privilege?

Health is a fundamental human right and every nation has the duty to provide the best quality of care for her citizenry. However for a lot of Sub–Sahara African nations the provision of health care services could be highly politicised, often policy maker driven and features neglect of demand side.[25,26] Also in many of these nations, minimum care is considered the best that can be provided and quantity is often substituted for quality. Public health facilities lack basic amenities such as restrooms yet politicians boast about how much they have spent on health care. Patients are not treated in this fashion in for-profit health facilities where the patient ('customer') is treated as king simply because health is provided here as a commercial product. This is unlike the public health facilities where patients are treated as though they are being done a favour. There is the

phenomenon of by-passing of government health facility when the potential patients perceive them as offering low quality services.[4] Kahabuka et al[27], in their study in Tanzania, found that more than half of their respondents had bypassed the nearest PHC facility to them during their child's/ward's current sickness episode. The reasons given for bypassing included: lack of diagnostic facilities at such facilities (particularly lack of equipment to test for malaria and blood hemoglobin level); lack of drugs (drugs were out of stock and therefore given prescriptions to buy them elsewhere); and lack of qualified personnel at such facilities or that the trusted health worker was no longer available at a given facility. One of the major challenges of PHC services is that the quality of care is low. Also the health workers are poorly remunerated and are often overworked.

The perception of quality is patients' assessment of the services offered. When patients are the focus of health care reforms then the quality of the services will improve and concomitantly the perception of quality of the services. This will be the indication that health is not merely a privilege but the right of every one in the communities and in the countries at large. There is now increasingly seen in Sub-Saharan Africa literature on users' perception of quality of care.[11,28-32] Of note is the work of Haddad et al[31] who developed a 20-item validated tool for measuring users' perception of quality of care far back in 1998 in Guinea Bissau. Also to be noted is the work of Baltussen et al in Burkina Faso in 2002 (Professor Haddad was also part of this team).

CONCLUSION

A lot of the change that is needed to make significant change in the quality of primary health care lie in political will. When governments are willing to provide the best quality of care with their limited resources then the true spirit of the Alma Ata declaration is being demonstrated. However, when governments see investment into health care as a means for political advantages and not as an end for improved healthcare outcomes, quality of PHC services will remain a privilege and not a right; and only the privileged few will have access to quality health care services. Also, users' perception of quality of primary health care is still insufficiently investigated in the sub-region and has not benefited optimally from rigorous research efforts. Review of literature suggests that authors have often not provided adequate evidence of validity and reliability for their studies. There is a potential for further studies in this area to generate evidences for influencing policy with regards to quality of care in Sub-Saharan Africa.

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