The Chilean legacies in health care quality

STEPHANE LEGROS¹, RASHAD MASSOUD² AND ORLANDO URROZ³

¹Maternal and Neonatal Health Program, JHPIEGO, Baltimore, MD, ²Quality Assurance Project, University Research Co., LLC, Bethesda, MD, USA, ³Costa Rican Ministry of Health, Costa Rica

Abstract

Objective. The Chilean quality assurance (QA) program evaluation took place in July 1999, at the request of the Chilean Ministry of Health. The main objectives of the evaluation were to identify key aspects of the 8-year-old Chilean QA program that could be considered by other countries and to make strategic recommendations.

Setting. In 1991, the Ministry of Health of Chile launched a national QA program. A national-level team initiated countrywide training of health care providers in QA skills, the development of quality committees at facility levels to direct local quality improvement activities, and training of quality monitors to provide technical support for training and quality improvement activities.

Design. The evaluation team, consisting of two international consultants and a regional consultant from the Costa Rican Ministry of Health, visited six regions and seven health 'servicios' (geographically defined administrative units within a region). The regions and servicios were purposefully chosen to represent different geographic areas, types of facilities, and levels of performance of QA activities. The evaluation was based on a framework developed and applied by the Quality Assurance Project (Center for Human Services, USA). Group and individual interviews with staff complemented document and record reviews.

Results. The evaluation team found that Chile's QA program had been successful in achieving sustainability and institutionalization. Factors contributing to this success included the enabling environment, management and leadership, technical functions, and support functions.

Conclusion. The Chilean QA program constitutes an interesting experience for consideration by other countries. Key features include its sustainability, nationwide coverage, decentralization, and alliance of quality improvement and regulation. Training results are impressive: almost 20% of Ministry of Health personnel received training, and 19 training modules are in use. Coaches are active and technically sustaining quality assurance activities nationwide.

Keywords: Chile, decentralization, health sector reform, leadership, quality assurance

An evaluation of the Chilean quality assurance (QA) program took place in July 1999, with the agreement of the Chilean Ministry of Health (MOH). The main goal was to identify the key ingredients and lessons learned from the program's sustainability that could be considered for use by other countries. A second task was to make strategic recommendations to enable the 8-year-old program to re-orient and strengthen its main activities. The evaluation focused on essential factors identified by a group of QA project experts as important for sustaining a national QA program, such as the enabling environment, QA management and leadership, and QA technical and support functions.

From July 1991 to 1994, the Quality Assurance Project (Center for Human Services, USA) worked in Chile to help launch a national QA program by building a nationwide network of quality coaches and quality committees. The MOH appointed staff at the Primary Health Care Department to direct the QA program. The Quality Assurance Project was funded by the US Agency for International Development (USAID), with a budget of $500 000 to assist the Chilean QA program.

The Chilean authorities established the following guiding principles at the outset of the program's implementation:

1. The effort would be national in scope
2. Participation in the QA program would be voluntary
3. Improvements would be achieved at all levels of the system
4. A broad array of health personnel would be involved
5. Existing technical and administrative lines of authority would be respected

Address reprint requests to Stephane Legros, JHPIEGO, 1615 Thames Street, Suite 200, Baltimore, MD 21231, USA. E-mail: slegros@jhpiego.net
Phase II emphasized decentralization and institutionalization of QA in the health services.

(3) Phase III: Quality and Norms Unit of the Ministry of Health (March 1995 to March 1997). External technical assistance ended in December 1994, and the QA program moved to a third stage: continued decentralization and the permanent incorporation of QA functions within the MOH through the creation of a Quality and Norms Unit.

(4) Phase IV: Quality and Regulation Unit (March 1997 to present). In March 1997, in the context of the health sector’s reform process, the Quality and Norms Unit was re-named the Quality and Regulation Unit. The new unit assumed the responsibility of developing the regulatory role of the MOH with a quality focus.

Evaluation design and methods

The evaluation team consisted of two consultants from the Quality Assurance Project and a regional consultant from the Costa Rican MOH. There was also a close collaboration with the national QA director. Six regions (out of 13) and seven health services were visited (out of 29 services in the country). There are several ‘municipios’ (municipal districts) in each servicio. The team studied both ministerial and municipal health care networks, as well as four different types of hospital. The regions visited and evaluated were chosen purposefully after discussion and consensus with the Quality and Regulation Unit in order to obtain a balanced sample of regions, facilities, and QA performance (representing both the north and south of the country, all four types of facilities, and strong and weak QA programs).

The evaluation plan was based on an evaluation framework that had been developed by the Quality Assurance Project, and tested and refined in previous evaluations. The logical framework of evaluation was divided into technical quality assurance areas, support areas for the QA program, and environmental factors linked to the success or failure of the program. It included specific questions for each area, data sources, methods of data collection, and recommended indicators.

The evaluation team conducted an extensive document review at the Quality and Regulation Unit of the Chilean MOH, and conducted site visits using structured and unstructured interviews. In addition, two new tools were introduced: appreciative inquiry and self-assessment (for details of the evaluation framework and tools, see [1]).

The evaluation was conducted in the context of the goals of health reform and the QA program’s role in supporting it (national-level indicators). For example, decentralized program implementation resulted in different local quality plans and indicators that were taken into consideration. Also, because the QA program had grown rapidly and was considered successful by many, the evaluation looked for factors that might be associated with any successes that might be considered for replication by other countries. To this end, document and record reviews were complemented by group
and individual interviews with staff at all levels of the health system. The team did not evaluate specifically the impact on quality of care, but attempted to gather anecdotal evidence that quality of care had improved within services.

Results

The evaluation team found that Chile’s QA program had been successful in achieving sustainability and institutionalization. This can provide important lessons for other countries. The evaluation noted several key factors that contributed to these achievements: the enabling environment, QA management and leadership, QA technical functions, and QA support functions.

Enabling environment

Historically, Chile has been a health care leader in Latin America, emphasizing promotion of healthy behaviors, prevention of illness, primary care, and high quality medical education. The evaluation team believed that the political, social, and health environment surrounding the program contributed significantly to its success, as explained below.

Health sector reform worked synergistically with the initiation of QA

During 1997, the health sector identified priority public health problems in Chile for the 1997–2000 period, and defined program priorities, strategies, and activities to be carried out [2]. The intent was to reposition the role of public health in health care administrative and financial decisions operating in a decentralized environment. National health priority setting targeted rational use, social participation, equity, improvement in quality, and user satisfaction. The management of health care delivery throughout the country was to be conducted on the basis of 28 specific administrative agreements (see Figure 2 for an example) with the central level of the Ministry. The evaluation team found that while only one agreement addressed quality of care issues directly, approximately 60% of them included quality issues. The evaluation team considered inclusion of quality in health management agreements to be important evidence of the institutionalization of QA.

Other entities supported the MOH in seeking quality

For several years prior to the evaluation, the majority of Chilean universities (e.g., Chile, Católica, Valparaíso, Concepción) had been developing pre-service training modules in QA. The National Health Fund (FONASA) had edited a patient’s rights booklet (Carta de Derecho del Paciente) and was certifying facilities that applied these principles. The MOH created the Norms and Regulations Department in 1992 as an accreditation unit. The accreditation process began in 1998 and the accreditation of specific programs started in 1999.

Furthermore, in 1998 the MOH created the Servicio de Atención al Usuario (SATUS). This central unit focuses on user satisfaction and functions independently of the QA unit. SATUS financed and conducted a national survey on patient satisfaction; the survey also collects information on patients’ wishes for infrastructure improvement. An inter-ministerial committee for ‘public management modernization’ defines quality policy, determines the public services orientation, and fosters citizens’ participation in health care. The committee manages the National Quality Award for Public Services.

QA management and leadership

Formal QA organization and leadership is decentralized to the level of the health servicios and municipalities. Central-level MOH leadership focuses on regulation and has an indirect, administrative relationship with the servicios and the municipalities. In regions where the health leadership of the servicio or municipality has chosen to collaborate closely with the Quality and Regulation Unit, the relationship and collaboration are strong, and vice versa.

The evaluation team determined that the more powerful aspects of leadership were the informal ones. Interestingly, interactions among the QA professionals were quite independent of the formal health system organization and leadership. The glue holding the Chilean QA effort together extended far beyond the formal QA structure and organization. In Chile, QA is a movement of highly committed public health specialists led by a charismatic leader. Chilean QA professionals have a strong sense of responsibility for quality improvement and patient satisfaction. However, this leadership still resides mainly with nurses and other non-physicians. Physicians should play a greater role so that clinical issues will be addressed more effectively.

QA program technical functions

Quality improvement (QI)

Chilean QI efforts have consisted mainly of small-scale projects focused more on infrastructure problems and less on clinical issues. Over 630 QI projects have been completed or are underway, although the work has not been documented systematically. If disseminated, such documentation of both successful and unsuccessful efforts would contribute to general knowledge of QA and innovations. Spontaneous development of QA activities at the facility level may not necessarily target key health priorities or complex organizational problems. A sample of problems addressed in Chile are organized in four classes and presented in Table 1.

Quality assessment and monitoring

The QA program is officially called the Quality Assessment and Monitoring Program, reflecting the MOH QA unit’s commitment to these two major QA functions. But quality assessment in Chile seems to be mostly synonymous with client satisfaction, frequently measured through local surveys, and used by decision makers to define strategies and select QI problems. With few exceptions, teams regularly create and use indicators. In fact, using indicators has become part of the culture. Administrative agreements have management indicators; QI projects have process and outcome indicators. New norms published by the MOH propose a series of related indicators.
Administrative Agreement No. 25 (1999)
“Orient the public management to the satisfaction of users”

Objective: Quality-of-care improvement in relation to national and local health priorities

Activities:
- Develop an orientation for the implementation of projects and activities of quality improvement consistent with national health priorities
- Produce and disseminate documents with methodologies to measure quality and patient satisfaction
- Monitor project development and quality improvement activities within health servicios

Figure 2 Sample administrative agreement. Administrative agreements were negotiated within the central level of the Ministry of Health to articulate national health care priorities and to define quality standards and indicators to guide the regions, servicios, and facilities in planning how to achieve those priorities. The agreements specified levels of responsibility for adequate and timely provision of priority health care services, and the requisite resources and technical and administrative support.

Table 1 Examples of topics of quality improvement projects (1998–1999) by type of problem

<table>
<thead>
<tr>
<th>Type of problem</th>
<th>Topic</th>
</tr>
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<tbody>
<tr>
<td>Structural</td>
<td>Inadequate signage</td>
</tr>
<tr>
<td></td>
<td>Need for better patient waiting areas</td>
</tr>
<tr>
<td></td>
<td>Lack of proper hygiene and cleanliness standards</td>
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<tr>
<td></td>
<td>Absence of patient information office</td>
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<tr>
<td></td>
<td>Registration forms poorly filled out and maintained</td>
</tr>
<tr>
<td>Organizational</td>
<td>Under-utilization of operating room</td>
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<tr>
<td></td>
<td>Inadequate information network between hospital management and the Intensive Care Unit</td>
</tr>
<tr>
<td></td>
<td>Unclear admission process, policies, and procedures for emergencies</td>
</tr>
<tr>
<td>Technical/clinical</td>
<td>Inefficient ambulatory surgery ward management</td>
</tr>
<tr>
<td></td>
<td>Inconsistent care for patients with hypertension and diabetes</td>
</tr>
<tr>
<td></td>
<td>Inadequate dissemination of technical nursing norms in the Intensive Care Unit</td>
</tr>
<tr>
<td>Mixed</td>
<td>Delay exceeding 24 hours to receive blood exam results</td>
</tr>
<tr>
<td></td>
<td>15% of patients rejected for visit</td>
</tr>
<tr>
<td></td>
<td>High average number of patient days in the Intensive Care Unit</td>
</tr>
<tr>
<td></td>
<td>High number of surgery cancellations</td>
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</tbody>
</table>

Standards and regulations
Major progress has occurred in Chile in the development and use of standards. Since 1997, one objective of the MOH QA unit has been to provide an inventory of the existing health standards and other regulations, and to promote expert work on new clinical standards, norms, and manuals as needed. Ten books that included the National Health Priorities regulatory documents were printed and distributed to the entire public health system, with the purpose of facilitating supervision and monitoring of health worker performance. A special assessment instrument is also used to integrate evaluation, monitoring, and regulation.

In August 1998, the MOH published its official document: Criteria, Standards and Indicators for the Assessment and Monitoring of National Health Priorities [3]. Since 1998, new standards and norms have been developed under the authority of the QA unit that follow a specific framework. The new edition of norms now consistently includes two complementary documents: a supervision instrument (checklist) for efficiently evaluating processes, and a monitoring plan with a complete set of indicators (input, process, sentinel, and impact).

QA program support functions
Training
Training, focusing on QI techniques, was a fundamental strategy for the QA program from its inception. Overall, >11,000 individuals—20% of the MOH work force—have been trained in QA through 300 workshops (see Table 2). During the 5 years before the evaluation, local health authorities assumed QA training responsibilities, contributing greatly to program sustainability.
Problem selection, operational problem definition, and the initiation of a problem-solving cycle generally occurred during the 4-day basic QA course, with the support of the coaches. At the end of the course, trainees frequently committed themselves to fully implementing a QI project. The coaches follow up with the QI teams (trainees who pursue their commitments) to support them and ensure completion of the cycle. The central QA unit has developed a set of 19 QA training modules. QI teams use them, especially the ones on the QA conceptual framework, quality improvement cycle, user satisfaction, group work and leadership, quality plan development, training of coaches, and supervision. The QA training also strengthened the management skills of Chilean health managers, especially at the peripheral levels.

Coaching

The evaluation team viewed coaches as a key element in the decentralization of the program and its sustainability. The program has created a countrywide network of 784 coaches, who evaluate and monitor the QI teams continuously. At the time of the evaluation, 75% of the coaches who had been trained were still active.

Dissemination/communication

Starting with the QA unit of the MOH, there is constant communication with all sectors of the health system. The QA unit provides feedback through formal and informal communication. The evaluation team found that the unit provides timely responses, recommendations suited to the needs of the quality projects that the teams are addressing, and fosters openness and leadership of participants. Both regional and central efforts promote the program through participatory forums, such as: (1) The National Conference on Health Services Quality; (2) The ‘month of quality’; and (3) incentives.

(1) The National Conference on Health Services Quality. The QA program has conducted a 1-week long conference to publicize different quality projects annually since 1994. This effort has had a great impact on the development of the program and on involving new participants, including politicians, mayors, and representatives of municipalities and other administrative bodies. All of the QA projects presented at the conference are documented and disseminated throughout the country through the central QA unit. The conference has received very positive evaluations from participants. Additional mechanisms should be used to allow local health teams to share, visit, and compare successes (benchmarking).

(2) The month of quality. Since 1998, 367 different activities, comprising conferences, mural exhibits, and leaflets, for both internal and external clients, have been held or disseminated during the annual month of quality: 24 of the country’s 29 health servicios participate in these.

(3) Incentives. Chile has implemented a number of rewards or incentives. These include a National Prize for Quality in Public Services, The Day of Excellence in Health, the Zepeda Award (an incentive for monitors who participate in training), and local recognition of individuals and teams.

Institutionalization and sustainability

The evaluation team found that quality assurance and quality of care issues are central to the health system in Chile. To a large degree, this is due to the strengths of the MOH’s QA program. The typical sequence of activities observed to ensure the institutionalization of QA within the region are:

(1) Creation of quality committees at the regional, servicio, and facility levels
(2) Implementation of a quality assessment at the facility level
(3) Development of a quality plan at regional and facility levels
(4) Setting up and maintaining functioning quality improvement teams
(5) Developing quality projects
(6) Evaluating and monitoring quality projects

QA is effectively implemented through a decentralized process in 13 regions and the 29 health servicios. At the time of the evaluation, 80% of the servicios had defined quality plans and quality committees. Most of the quality plans are included within the health plans developed by servicio management.

The program experienced a turning point at the end of the Quality Assurance Project’s technical assistance in December 1994. Enabled by the decentralized system and...
QA activities, the 13 regions and 29 health servicios agreed to assume the support for current and newly proposed QI projects. Most projects were financed mainly by the health servicios, although hospital, municipal, or even private spon- sors (e.g. pharmaceutical companies) also collaborated.

At the same time, wide variations were observed among the regions. For instance, most hospitals in Chile have significant debts, and therefore have difficulties justifying financial participation in any quality project. Because there is no budget item for quality improvement, health managers often finance QA activities from the training budget. The central QA unit did not have a specific budget for technical assistance to local QI activities, so it had to rely on funds supplied from local health agencies to provide any on-site support that was needed. Since 1997, most central quality resources were allocated to regulation and only sporadically to the QA program itself. The QA program needs additional staff and budgetary support to carry out its mission effectively.

Conclusions and recommendations

The Chilean QA program achieved significant results during its first 8 years in terms of institutionalization and general organization. Sustainability, nationwide coverage, de- centralization, and alliance of quality improvement and regulation are key features. Administrative agreements and new standards systematically include supervision criteria and different types of quality indicators.

Training generated impressive results in terms of the large cadre of coaches trained who are active and sustaining QA activities with technical support. Almost 20% of the MOH staff has received basic QA training, and 19 QA training modules have been developed. Certain dissemination activities are in place, including an annual QA conference and the month of the quality. Incentives exist, and provide recognition and specific awards.

There is, however, room for improvement. QI teams should select more problems linked with the health priorities, emphasizing technical and clinical topics rather than predomi- nately infrastructure issues, and they should compare their progress with a baseline, which is rarely performed. More physicians should be involved. Dissemination would be even more successful if a systematic benchmarking system of the successful and efficient QI projects was in place. The informal QA leadership would benefit from additional resources and more formal support.

Despite its achievements, the ability of the MOH central Quality and Regulation Unit to influence the general direction of the MOH is not as strong as expected by the evaluation team. Although the unit enjoys some political support, it still lacks adequate budgetary and human resources. The unit will need to re-examine its future direction and strategic objectives. A strengthened QA unit would help meet the need at the MOH level to integrate and coordinate the multiple QA activities being implemented, thereby avoiding inefficiency, omission, and inequity.

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References


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