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Plan for Technical Assistance in Quality Assurance

**A Project of the Ministry of Health of Chile
and the Quality Assurance Project**

January 1991

**Michael H. Bernhart
Management/Operations Research Specialist**

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IN QUALITY ASSURANCE**

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Prepared for USAID/Chile under the
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University Research Corporation
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**TECHNICAL ASSISTANCE
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AND

THE QUALITY ASSURANCE PROJECT

Prepared:
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EXECUTIVE SUMMARY

The Ministry of Health (MOH) of Chile, in an effort to redress some of the consequences of policies pursued by the former government, will undertake with AID assistance a project to improve the quality of primary health care. Primary care in Chile extends beyond the acute maternal-child diseases typically found in developing countries to include the chronic and degenerative diseases associated with an advanced economy and aging population.

There is already considerable interest and activity directed toward improving the quality of services. However, in the decentralized administrative structure of the country, dissemination is difficult and the peculiarities of the financing system are a constant distraction and introduce distortions inimical to high quality service.

The objectives of the project would be:

- to increase the quality of medical care as assessed by improvements in indicators such as tracer diseases for primary health, health knowledge of clients and direct observation of clinical practice;
- to increase the quality of service to clients by reducing the reject rate and waiting time for service; and
- to improve client perceptions of the comprehensiveness and accessibility of health care.

The project would be overseen by a unit within the MOH which would establish methodologies for assessing quality of care, provide training, propose experiments to improve quality, and organize dissemination activities.

At the field level three or four Health Service Areas (HSAs) would be selected that represent geographic spread and operating diversity. They would implement and assess quality improvement projects developed by the central office, support quality enhancing experiments in neighboring HSAs, and provide training in their geographic region.

In addition to the MOH and the selected HSAs, a US cooperating agency and one or more Chilean research organizations would participate in the project.

A closer examination will be required to identify the types of interventions that might be tried to improve the quality of primary health care. It may be anticipated that the

interventions could include changes in supervisory practices, training, incentives to providers and clients, and information retrieval and flows.

Given the extremely decentralized structure of the public health system, the success of the project will ride on the dissemination mechanisms that are developed.

The project will begin in March 1991 and continue for 18 months.

The project's rationale, objectives, and activities are outlined in this consultant report. Annex A provides an illustrative list of quality assurance interventions that may be appropriate for the project. Annex B provides descriptions of a sample of Chilean institutions with appropriate capability to assist in implementing quality assurance activities. Annex C contains a draft scope of work for the US Cooperating Agency for the project, the S&T/Health-funded Quality Assurance Project. Annex D lists the persons contacted during the consultancy.

TECHNICAL ASSISTANCE IN QUALITY ASSURANCE

Problem

The experiments undertaken in the social sector by the military government of Chile produced consequences which the current democratically elected government is attempting to redress. In the health field some of those consequences are:

- a) a shift in emphasis from preventive to curative care;
- b) a shift in emphasis away from primary health care;
- c) a relative neglect of health education;
- d) incentives for health care providers to focus on health care activities, not on outcomes;
- e) incentives to process large quantities of patients rather than to provide quality care; and
- f) distortions in costs for health care.

These changes were the by-products of experiments tried in the areas of de-centralization, financing and costing of services, and a strong preference for private sector provision of services.

The net effects on service quality in primary health are the following:

- a) limited health education,
- b) overcrowded facilities,
- c) long waiting times for services,
- d) the rejection of some clients (ten to 15 percent of the total requesting care) not in immediate need of health service,
- e) run down primary care facilities, and
- f) client dissatisfaction with primary health services.

Response

The current government, with assistance from AID, wants to improve the quality of primary health care services. This includes not only technical quality, but also client

satisfaction which is influenced by fees charged, time lost waiting, continuity of provider, access to services, and perceived comprehensiveness of care. It should be noted that given the disease profile found in Chile, primary health care extends beyond the typical maternal-child interventions of less developed countries. In Chile primary health also includes prevention, early detection and management of degenerative diseases and improvements in health knowledge and practices to reduce the diseases of a country undergoing an epidemiological transition. A listing of the leading causes of mortality in 1980 and 1988 is instructive:

Disease	1980	1988
Cardiovascular	26.6%	27.9%
Cancers	15.4	18.0
Accidents, traumas	11.9	12.1
Respiratory	9.5	12.0
Ill-defined causes	9.6	7.1
Digestive tract	8.1	6.5
Infectious and parasitic	4.8	3.5
Perinatal causes	4.3	2.5
Genito-urinary tract	2.3	2.4
Others	7.5	8.0

These percentages indicate that the degenerative diseases of an aging population have been dominant for the past decade and their prevalence is becoming even more pronounced.

The Ministry of Health believes that an effective program to improve the quality of medical attention will have to address the relatively complex medical services demanded by the profile just listed. While the experience gained in developing countries through PRICOR I and II in defining standards of medical attention will provide a useful starting point for quality assurance (QA) in Chile, work done to improve service quality in the US and Europe may also have relevance here. The Ministry believes that improvements in the quality of health services is not only an ethical response but it is also a practical one as it is anticipated that over the long term improved service quality will lead to a reduction in demand for services and reductions in overall operating costs.

Context

Several comprehensive analyses of the Chilean health system have been recently prepared by careful researchers in the MOH, AID, and World Bank; taken together those reports would be difficult to improve upon and the reader is directed to those sources for background on the Chilean health system (note that the MOH has questioned some aspects of the World Bank draft report). Three aspects of the public health

system influence the design of this project, however, and merit special comment:

1) Organizational structure. The MOH was progressively de-centralized during the '80's. Primary health care facilities, Consultorios and Postos Rurales, were spun off to the Municipalities which nominally report to the Ministry of Interior. There are some vestiges of the old MOH supervisory structure still in place but no one appears to be fully satisfied with the the current structure.

At present the Ministry can supervise through Health Service Areas (26 plus on environmental area for Santiago). The HSAs are in the line of command over hospitals but have no authority over the clinics and rural posts. A section of each HSA, the Department of Primary Attention (DAP), is charged with technical supervision of clinics but has few staff, often no transport, and no clear authority to mandate changes, take corrective action, or move resources. Any influence the HSAs might have rests on the bases of fading precedent and personal acquaintanceships.

There are 13 Regional Ministerial Secretariats (SEREMI) which are in the chain of command over municipal health facilities. These bodies are part of the regional Intendencias which execute Ministry of Interior policies and programs at the regional level. The Health SEREMIs appear to command even fewer staff and resources than the HSAs; their primary advantage is that they are linked into the present administrative structure and might influence policies or resource allocations.

In sum, the current structure of the public health system effectively prohibits implementation of changes by fiat. The MOH can only establish norms and only very general norms of medical attention at that. Health Service Areas can add specificity to those norms but they lack the manpower to supervise and monitor compliance (some resources to improve the capacity of HSAs to supervise are budgetted by the MOH for 1991). The upshot of this structural feature is that this project will have to rely on widespread promulgation of results, training, and providing incentives for adopting changes if service quality is to be improved nationally.

2) Innovation. There are many experiments being run within the system already as managers and staff attempt to overcome the problems of delivering services. These efforts often approximate operations research as data are frequently collected to assess the impact of the

changes introduced. Because of the de-centralized nature of the health service, dissemination of positive results is difficult. The project would attempt to encourage this spontaneous innovation and disseminate proven interventions.

3) Financing. The financing of public health services has been under continual change for over a decade. Financial responsibility was passed to municipalities beginning in 1982. The municipalities lacked the resources to support health services and a reimbursement scheme was introduced that paid each municipality, out of central revenues for health, according to the type and quantity of services provided. The unfortunate by-products of this system were: a) an explosion of health care attention provided to patients, b) emphasis on provision of those services that received the highest reimbursement, and c) full utilization of only those providers (i.e., physicians) for whose services the highest reimbursement was paid.

The rapid increase in reimbursable billings led, in 1988, to imposition of a ceiling for each facility. Since then a facility's budget has been determined by its historical ceiling, its negotiating power with the MOH, the wealth of the municipality, and its negotiating power with the municipality. The current government recognizes that there are significant distortions and the budget available to a given health facility may bear little relation to its costs or the demand for health services.

Objectives

The project would have the following three objectives:

- a) An increase in the quality of the provision of medical care as assessed by improvements in the following indicators:
 - i) Tracer diseases for primary health care (PHC).
 - ii) Level of health knowledge of PHC practices by clients of public clinics.
 - iii) Level of health practices by clients of public clinics.
 - iv) Direct observation of the provision of medical care by trained supervisors using standardized protocols for common presenting complaints.

The degree of improvement for each category will be established early in the project after baseline levels have been documented.

b) An improvement in the quality of service provided to program clients in the following areas:

i) A reduction in the number of clients seeking medical attention who are rejected by clinics.

ii) A reduction in waiting time as measured by the time elapsed from hour of appointment to provision of service.

iii) A reduction in the percentage of revisits required of patients for initial diagnosis and treatment of a health complaint.

iv) Improvements in access to clinical and medical services as measured by client reports.

c) An improvement in client perceptions of the care provided in the areas of:

i) General satisfaction with the service.

ii) Perceptions of the comprehensiveness of care.

iii) Perceptions of the accessibility of care.

Project Overview

The quality assurance project/Chile would be implemented along the following approximate lines:

a) A central office would oversee a QA project conducted in three or four distinct areas of the country. The central office would provide training, establish methodologies for assessing quality of care, propose specific experiments to improve quality, conduct periodic checks on the quality of services throughout the country, and organize national and regional meetings to disseminate the results of QA improvement projects.

b) At the field level three or four HSAs -- referred to as QA/HSAs in this document -- would be selected that represent geographic spread and operating diversity. They would perform three principal functions. First, they would implement and assess QA improvement projects developed by the central office through clinics within the QA/HSA. Second, they would review proposals from clinics within their geographic

area for QA projects; the QA/HSAs would have a small budget (US\$10,000) for supporting QA projects proposed by clinics and would assist with QA assessment methodologies. Third, the QA/HSAs would be responsible for training and dissemination within their geographic area of proven changes that improve the quality of care.

The purposes of this two level approach are a) to overcome the barriers imposed by the unique geography of the country and the lack of formal channels through which the Ministry can mandate changes; and b) to tap the interest in improving services and innovativeness already present in clinics throughout the country. Detail on the implementation of the project is found below.

Kinds and Sources of QA Interventions

Interventions to improve service quality would emanate from two sources:

1. The MOH would select interventions in the areas of supervision, incentives, information management, and training to improve the quality of services and client perceptions of same in the QA/HSAs. See annex A for a listing of illustrative interventions. These interventions would be implemented and evaluated in the selected QA/HSAs.

2. The QA/HSAs would solicit proposals from clinic staffs in proximate HSAs for QA interventions -- labeled experiments below -- that such clinics might wish to carry out. The staffs of the QA/HSAs would review these proposals and provide technical and limited resource support to approved QA experiments.

Participants

Four groups would participate in the execution of the project. The groups and a general description of their respective responsibilities follow:

1. US cooperating agency (CA). The US cooperating agency would be the Quality Assurance Project supported by the Agency for International Development under Cooperative Agreement DPE-5992-A-00-0050-00. Three organizations have implementing responsibility for the Project: the Center for Human Services, Johns Hopkins University, and the Academy for Educational Development. These organizations would contribute to the project in Chile on the bases of their comparative advantages to support specific activities in Chile.

The US cooperating agency would be responsible for the following:

- a) Training central MOH and QA/HSA staff in quality assurance issues and methodologies.
- b) Proposing methodologies and interventions to measure and improve the quality of care.
- c) Participating in training activities as requested by the MOH and agreed to by the CA.
- d) Participating in the assessment of results from experiments conducted under the project.
- e) Participating in dissemination activities as requested by the MOH and agreed to by the CA.

2. National contractors. National contractors would carry out specific data collection and analysis activities which the MOH is not staffed to perform. These could include but not be limited to:

- a) Survey of client perceptions, health knowledge, and practices, baseline and follow up.
- b) Review and analysis of facility records.
- c) Analysis of cost information.
- d) Direct observation of provision of clinical services.

There are several organizations in the country which could conduct these activities. As examples: ILADES, CPU, Universidad de Chile/Economics Department, INTA, FLACSO and the Catholic University; see annex B for profiles on a sample of these organizations. It is expected that through participation in the project, the institutional competence of these organizations would be improved so that they could continue to conduct QA work after completion of this project.

3. Ministry of Health. The MOH would bear the primary burden of organizing and sustaining the project. Its first task would be to determine the organizational locus of the project within the Ministry and to provide human and physical resources necessary for execution of the project. As a consequence of its central role, activities not assigned to other participants fall to the Ministry by default. An abridged list of such responsibilities includes:

- a) Designation of counterpart officials.

- b) Selection of participating QA/HSAs.
- c) Selection of training sites.
- d) Approval of training materials.
- e) Organization of training.
- f) Staffing of a central office charged with improving service quality.
- g) Assessing the results of QA experiments and determining which should be disseminated.
- h) Organizing dissemination seminars.
- i) Evaluation of project progress (jointly with CA).
- j) Allocation of special QA project funds among QA/HSAs (jointly with CA).

4. Selected QA/HSAs. The selected QA/HSAs will represent geographic spread and diversity of operating environments. A representative selection might be Antofagasta, Valparaiso, Santiago, and Valdivia. In broad terms these QA/HSAs would

- a) implement and assess changes in their respective HSAs designed to improve service quality,
- b) encourage and support active experimentation to improve service quality in their own and proximate HSAs, and
- c) disseminate the results of changes and experiments to managers and operating staff in their own and proximate HSAs.

Some of the specific responsibilities would be:

- a) Assure mastery by all HSA staff of the basic concepts of QA.
- b) Transmit those concepts to clinic staff through training and supervision.
- c) Participate in the design and conduct of field surveys.
- d) Participate in the design and implementation of changes to improve service quality.
- e) Promote QA experiments in their own and proximate HSAs.
- f) Solicit and review proposals from clinic staff for the QA experiments.
- g) Monitor the progress of all QA experiments in their own and proximate HSAs.

- h) Participate in the evaluation of QA experiments.
- i) Conduct dissemination seminars for clinic staff from their own and proximate HSAs.

Project Chronology

A broad overview of the sequencing and timing of the project follows. A single asterisk * indicates participation by personnel of the US cooperating agency followed by the person-days required; a double asterisk ** indicates participation by a national contractor. Note that the cooperating agency and MOH will have to develop a mutually satisfactory project description and timetable.

Jan-Feb 91

Creation and staffing of MOH unit for QA.

Mar 91

Selection of participating HSAs.

Detailed planning of project by CA and MOH. (* 2 x 5 person days)

Preparation of training activity for MOH/QA staff and QA/HSA staffs. (* 2 x 4 person-days and **)

Training in QA for MOH/QA and QA/HSA staffs. (* 2 x 4 person-days and **)

April 91

Development of QA methodologies. (* 15 person-days and **)

Preparation of training for clinic staffs in QA/HSAs. (* 5 person-days)

May 91

Conduct of QA training for clinic staffs in selected HSAs.

Apr-May 91

Conduct of baseline surveys of service quality in QA/HSAs.**

June 91

Selection of interventions to improve service quality. (* 5 person-days and **)

Initiate implementation of interventions. (* 10 person-days and **)

July 91

Solicitation of proposals by QA/HSAs from clinics for QA experiments in proximate HSAs.

Continued implementation of interventions.

Aug 91

Review of submitted proposals by QA/HSAs.
Assessment of implementation problems encountered in first group of interventions. (* 10 person-days)

Sept 91

Ad hoc evaluation of first interventions. (* 7 person-days)
Review of first interventions. (* 8 person-days)

Oct 91

Dissemination seminar of results from first group of interventions to staffs in proximate HSAs. (* 10 person-days)
Selection of second group of QA interventions. (* 5 person-days)

Nov 91

Initiate implementation of second group of QA interventions.
Ad hoc review of results of experiments undertaken by clinic staffs.

Jan 92

Ad hoc evaluation of second group of interventions.
Solicitation of proposals from clinics for experiments in QA.

Feb 92

Review of results from second group of QA interventions.
Dissemination of results from second group of interventions to staffs of proximate HSAs.

Mar 92

Ad hoc evaluation of results of QA experiments in proximate HSAs.
Review of results of evaluation.

April 92

Preparation of follow up surveys in selected HSAs and in clinics where QA experiments were undertaken. (* 10 person-days and **)

May-June 92

Conduct of field surveys.**

July 92

Analysis of results of field surveys. (* 10 person-days and **)

August 92

Preparation of national seminar on QA project results. (* 10 person-days)

September 92

Conduct of national seminar on QA project results. (* 5 person-days)

October 92

Report preparation.

Planning.

Conclusion

The overriding challenge posed by this project is easy to state: dissemination. Identifying changes to improve the quality of care should be a minor hurdle; clinic staff are bright, well trained, and dedicated. Further, they are already engaged in countless small projects throughout the country to improve service. Good ideas will be easy to come by; however, they will be difficult to implement on a national scale. Given the recent dismemberment of the public health supervisory system and the relative isolation of each primary health care facility, the project should place emphasis on developing mechanisms for lateral and vertical dissemination of quality improving innovations.

Annex A

Quality Assurance
Illustrative Interventions

Alternative aspects of quality include:

Technical quality

- History taking
- Examination
- Treatment
- Patient counseling and education

Client satisfaction

- Wait for services
- Costs
 - Direct payments for services
 - Transport, lost wages, etc.
- Treated with dignity
- Access to services
 - Distance traveled
 - Hours of service availability

Representative interventions that might be undertaken include the following:

Technical quality

The objective of these interventions would be to improve the comprehensiveness of the medical services provided in selected health and disease areas. A list of four groups of projects may convey the range of possibilities. The four general approaches these embody are to address quality issues through supervision, training, incentives, and the MIS.

1. Supervision for quality assurance. This could involve direct observation of the provision of services using standardized checklists (these have already been developed for several disease categories under PRICOR II) and performance feedback to the clinician providing the service. This observation might be conducted routinely:

a) by supervisors housed in the HSA or regional office (advantage: this helps build a professional supervisory cadre);

b) by peers who serve in this capacity on a rotating basis and who receive a brief orientation in the use of the checklists (advantages: this is "democratic", less threatening, and sensitizes the "supervisor" to quality issues while he or she is temporarily assigned to this duty);

- c) by inspectors or supervisors from the Ministry (advantage: this strengthens the Ministry's normative role);
- d) by members of the municipal health committee who are trained to conduct this (advantages: local involvement and sense of control and low recurrent costs once the training has been done); and
- e) by members of the Faculty of Medicine on contract (advantage: physicians may find evaluation of performance by professors most acceptable).

These are not mutually exclusive options; several of them may be tried simultaneously. Note that the intervention itself is also the method for evaluating the success of the intervention; the results obtained by the observer may be analyzed over time to determine if there have been any improvements. Just as there are various ways of collecting the data on technical quality, there are several alternatives for feeding it back to clinicians. These include direct post-observation reports to the clinician, presentation of aggregate data to groups of previously observed clinicians, distribution of aggregate data via periodic publications, and so on.

2. Training in quality assurance. The QA (Quality Assurance) project has training courses of different durations on the shelf that may be adapted. Additional options may be proposed that respond to quality of care issues uncovered in the baseline analysis.

3. Provision of incentives for quality care. There is a local precedent for reimbursing municipalities for improvements in health status (the "Estimulos" based on billing information). This might be extended to any of the following options:

- a) Reimbursement on the basis of health knowledge of community members or patients. This was done successfully in Bangladesh by BRAC. Patients may be quizzed as they depart the clinic or followed up later from clinic records. If community education is the goal, a simple randomized door-to-door survey would suffice.
- b) Reimbursement on the basis of changes in health practices. Indicators might be reductions in smoking and alcohol intake, changes in diet, use of supplementary vitamin A (for ALRI reduction),

use of salt substitutes, weight reduction, increased physical exercise, etc.,.

c) Reimbursement on the basis of changes in health status. Standard morbidity indicators might be selected.

4. Inclusion of quality assurance indicators in the MIS. Illustrative of the possibilities are:

a) Inclusion of "mystery shopper" reports on the quality of clinic services.

b) Systematic collection of supervisory reports (supervisors use a QA checklist).

c) Longitudinal tracing of key indicators such as number of C sections performed, percentage of children classified as malnourished, incidence of low birth weight, etc.

d) Cross-checks on data such as inventory drawdowns vs. reported consultations (e.g. amount of ORS dispensed vs. amount of antidiarrhoeals vs. number of reported consultations for GI problems).

e) Monitoring health status. Some of the preceding indicators (listed under incentives) might help assess community health status on a routine basis. These could be supplemented by longitudinal tracing of morbidity data.

f) Monitoring health practices. Rapid surveys might be the best way to track the prevalence of health practices. When a system is established for conducting rapid surveys they are surprisingly inexpensive.

g) Monitoring health knowledge. Same as above.

Client satisfaction

Presumably several of the improvements in technical quality will lead to increased client satisfaction. Beyond those, specific interventions might be designed to improve areas such as reduction of "rechazos", wait for services, and access. These might be addressed through changes in clinic procedures, moving more of the care outside of the clinic, and increased patient self-management. It may be noted that most of the following examples are directed toward reducing the client load in the clinic, thereby decreasing waiting

times and freeing the clinician for counseling and patient education.

1. Clinic procedures. Illustrative changes would be:

- a) triage; this is an embattled proposition at present;
- b) fuller utilization of paramedical personnel; and
- c) reduction in number of control visits; there appears to be a tendency to require patients to return after completing treatment, whether they suffered from further symptoms or not.

2. Externalization of care. As in so many areas, the Ministry already has long experience in this. The types of care that might be externalized include:

- a) screening for hypertension, obesity, malnutrition, breast cancer, etc; this might be conducted by Mother's Clubs, community volunteers, Nurse Auxiliaries, members of the health committee, and so on;
- b) health education; the list of possible topics is long as is the list of vehicles for this;
- c) case follow up and control; not every control visit following an episode of illness need be seen in the clinic; and
- d) provision of preventive care.

3. Patient self-management. In interviews with patients departing clinics, few were aware of danger signs that should bring them back for care; instead, they were routinely scheduled for a control visit. In this scenario the patient was not expected to do more than follow the regimen; the clinician took full responsibility for managing the cure. It was also noted that the clinicians often lacked an accurate picture of the level of health knowledge of the patients. More time spent on patient education and counseling could reduce the need for control visits and for nuisance visits by concerned parents. Delivery options include:

- a) group education; delivered personally or electronically in the health care facility;
- b) extended personal counseling by the clinician;

- c) extended personal counseling by an auxiliary nurse;
- d) mass education via electronic or print media;
- e) extensive questioning of the patient by the clinician on the former's level of health knowledge; and
- f) outreach education from door-to-door by any or all members of the health team.

The content of the education could cover:

- a) self-examination and early detection -- breast or testicular cancer, hypertension, pneumonia, parasitosis, etc.,
- b) prevention -- environmental sanitation, diet, lifestyle, etc.,
- c) management -- care of the ill person; and
- d) identification of danger signs specific to the illness.

ANNEX B

National Contractors

The following are a small sample of the broad range of Chilean contractors who might work with the project. These are listed as direct contact was made with them.

Corporacion de Promocion Universitaria (CPU)

CPU houses University of Chile and independent researchers who have worked on a wide variety of social problems. Of special significance, CPU has undertaken an interesting series of research projects on quality assurance projects in hospital care under the direction of Dr. Maria Ynes Romero (copies of reports sent under separate cover) who is the contact person (Tel. 274-8869).

University of Chile, Department of Economics

Within the Economics Department a survey group has worked for several years. This group carried out the two CASEN studies on health as well as other surveys on social issues. The group is noteworthy for its ability to quickly get into the field (sampling frames have been developed for most of Chile), get the job done, and produce results. All this at a reasonable price. As examples: A survey of 500 hundred respondents in the capital area costs \$3000 to \$4000, depending on the length of the questionnaire. These prices include questionnaire pre-testing, data analysis and write-up, as well as the survey. The price increases by 40 percent if the survey is conducted in a rural area and by 50 percent if done away from the central regions (five and six) of the country. The contact person is Dr. Esteben Ogradnik.

INTA, University of Chile

Yet another U. of Chile research organization, this one has been involved principally in nutrition research but conducted, for UNICEF, the research that identified the 108 municipalities most in need of assistance. (These municipalities may be the focus of many activities of this project. It is my impression that the group is more comfortable working with secondary data but has collected primary data when needed. The contact person is Dr. Francisco Mardones R. (Tel. 221-4531)

FLACSO (Facultad LA de Ciencias Sociales)

A well thought of group, perhaps strongest in sociology. They have a large number of researchers they can call upon, one of them, Eduardo Morales, with experience in health

policy. Contact person is Dr. Manuel A. Garreton M. (Tel. 225-6955)

ILADES

This group draws in researchers for projects and will conduct a study on primary health care financing and costs. Initially I was told that they would be unable to undertake additional projects in the near future; they then informed Mr. Fritz of AID that they were reversing that position. They may enjoy a strong comparative advantage in research on health financing. Contact person is Dr. Cesar Oyarzo M. (Tel. 698-0046)

SCOPE OF WORK

The cooperating agency, the Center for Human Services and its partners, Johns Hopkins University and the Academy for Educational Development, will be responsible for the following:

- a) Training central MOH and QA/HSA staff in quality assurance issues and methodologies for primary health care. This will include at least one two- or three-day seminar on quality assurance for 20 to 30 senior staff members to be conducted early in the project, preferably in March 1991. The CA will prepare and conduct the seminar. One objective of this training will be to enable the participants to provide similar training to HSA and clinic personnel throughout the health system.
- b) Proposing methodologies and interventions to measure and improve the quality of primary health care. The CA will work with MOH staff and national contractors to create innovative quality assessment methods appropriate to the leading causes of disease in Chile which can be addressed through primary health interventions.
- c) Participating in training activities as requested by the MOH and agreed to by the CA. It is anticipated that the CA may participate in the initial training conducted by MOH and QA/HSA personnel to ensure that these personnel have mastered the concepts and can effectively transmit them to others.
- d) Participating in the assessment of results from experiments conducted under the project. The CA will, with the MOH, review all results obtained from evaluations of the effectiveness of QA interventions introduced under the Project.
- e) Participating in dissemination activities as requested by the MOH and agreed to by the CA. The CA may participate in dissemination activities during the course of the project and will participate in the final national dissemination activity.
- f) Selecting QA interventions for testing in QA/HSAs. The CA will propose to the MOH QA interventions that hold promise of improving the quality of primary health care.

g) Preparing proposal solicitation process for QA/HSAs. The CA will advise the MOH and QA/HSAs on methods for soliciting and reviewing proposals from clinic staffs that wish to introduce QA interventions under the Project.

h) Assessing implementation problems of QA interventions. The CA will review with the MOH and QA/HSAs the experience gained in implementing the first round of QA interventions. The CA will document the more commonly encountered implementation problems and identify the responses, if any, that were successful in resolving those problems.

i) Analyzing project results. The CA will, with the MOH, analyze the final results of the QA project in Chile. The CA will document the more generalizable results and will disseminate them to the international health community.

j) Contracting national research and support organizations. The CA will, with the advice of the MOH, review the qualifications of national research and support organizations and enter into contracts for special studies and services integral to the Project.

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LIST OF PRINCIPAL CONTACTS

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 Mrs. Luisa Martineaux, Midwife
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 Telephone: 36-12-00

Consultorio Municipal De Colina

Dr. Rinaldo Basso, Director
 Dr. Rebeca Misle, Medical Director
 Patients in and leaving the clinic - 14
 Neighbors of the clinic - 6
 Address: Carretera General San Martin 077
 Telephone: 844-1525

Consultorio Anibal Ariztia

Dr. Rodrigo Carrasco, Director
 Nurse Maria Mardini, Administrator
 Dr. Leonor Robres, Staff Physician
 Pharmacist
 Clients in clinic - eight
 Neighbors of clinic - five
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SUMMARY

The Ministry of Health (MOH) of Chile, in an effort to redress some of the consequences of policies pursued by the former government, will undertake with AID assistance a project to improve the quality of primary health care. Primary care in Chile extends beyond the acute maternal-child diseases typically found in developing countries to include the chronic and degenerative diseases associated with an advanced economy and aging population.

There is already considerable interest and activity directed toward improving the quality of services. However, in the de-centralized administrative structure of the country, dissemination is difficult and the peculiarities of the financing system are a constant distraction and introduce distortions inimical to high quality service.

The objectives of the project would be:

- to increase the quality of medical care as assessed by improvements in indicators such as tracer diseases for primary health, health knowledge of clients and direct observation of clinical practice;

- to increase the quality of service to clients by reducing the reject rate and waiting time for service; and

- to improve client perceptions of the comprehensiveness and accessibility of health care.

The project would be overseen by a unit within the MOH which would establish methodologies for assessing quality of care, provide training, propose experiments to improve quality, and organize dissemination activities.

At the field level three or four Health Service Areas (HSAs) would be selected that represent geographic spread and operating diversity. They would implement and assess quality improvement projects developed by the central office, support quality enhancing experiments in neighboring HSAs, and provide training in their geographic region.

In addition to the MOH and the selected HSAs, a US cooperating agency and one or more Chilean research organizations would participate in the project.

A closer examination will be required to identify the types of interventions that might be tried to improve the quality of primary health care. It may be anticipated that the interventions could include changes in supervisory practices, training, incentives to providers and clients, and information retrieval and flows.

Given the extremely decentralized structure of the public health system, the success of the project will ride on the dissemination mechanisms that are developed.

The project will begin in March 1991 and continue for 18 months.

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