Perceptions of health care quality in Central America

MOISES LEON
Instituto Centroamericano para la Salud (ICAS), PO Box 6-2010, Zapote, San Jose, Costa Rica

Abstract

Objectives. To examine user perceptions of health care delivery in selected rural and urban areas of three Central American countries.

Design. Three focus group studies were conducted in 1997–98 in Honduras, Costa Rica, and Panama. In each selected region, 10 to 15 groups met to discuss health services available, access to and use of the services, satisfaction with different aspects of care and suggestions for improvement.

Setting. Regions chosen represented the poorest areas in each country and the dominant health care systems in Central America: the Ministry of Health system and the Social Security system based on mandatory contributions.

Participants. 351 residents from rural and urban communities represented different genders, ages, occupations, health, and socio-economic status.

Results. Participants considered private care to be the best, but too costly. Their main preoccupations focused on prompt access to trusted physicians, effective and inexpensive medication, and quality attention in public hospitals. Hondurans favor the personal care offered in public clinics and rural hospitals, and hope for improved medical services. In Costa Rica and Panama, users prefer Social Security clinics for the medical specialties and perceived sophisticated technology, despite delays and poor attention. The rural poor, especially indigenous people, voice basic needs with little regard for quality.

Conclusions. Health care quality is extremely variable in the three regions, requiring increased community participation to improve. Focus groups offered important, confidential and cost-effective information on quality and breadth of health care delivery and should be part of quality monitoring initiatives.

Keywords: quality perceptions, focus groups, Central America

Objectives

Three focus group studies conducted in 1997–98 assessed perceptions of health care delivery held by diverse users in low-income rural and urban communities in Honduras, Costa Rica, and Panama. The studies supported the design of a health quality survey conducted subsequently in the same areas by the Central American Health Institute (Instituto Centroamericano para la Salud, ICAS), aimed at establishing quality assurance systems and improving health care in Central America [1–3].

Groups focused on services available, access to services, use and satisfaction with the different aspects of service delivery, and suggestions for improvement. Groups in Honduras and Panama were facilitated by the author and in Costa Rica by sociologist Sonia Cervantes.

Design

Methods

We assessed quality of health care by studying user perceptions through focus group analysis. In each region, 10 to 15 focus group meetings were held with a variety of community members of different genders, ages, occupations, and socio-economic status, living in rural and urban settings, who are users of the various health services, and who volunteered to participate by invitation of a local private health organization. We applied a protocol with each group during 2–4 hours at a community locale, which was designed by Mexican sociologists for similar work in their country [4].

Address reprint requests to Instituto Centroamericano para la Salud (ICAS), PO Box 6-2010, Zapote, San Jose, Costa Rica. E-mail: icascor@racsa.co.cr
Discussion protocol

After presentation of meeting purposes and introductions by participants, groups discussed the following questions, previously defined by regional experts on the basis of ICAS studies [5]. (1) Where do people in your community go when they are sick and need help? What health services exist in the community? (2) Would you relate any experience you had with any one of the health services in your area, what resulted, and why the outcome? Were you satisfied with the services provided by health staff? The doctor? The treatment offered? The cost of services? What was the most important aspect of the services? (3) What is the most important concern, that which most worries you when seeking health care? (4) What would you change, or would like to see changed, to improve health care in: health centers, hospitals, private health clinics, or medical offices?

Setting

The three regions of the study were selected to represent the poorest areas in each country. They also represent the two dominant health care systems in Central America: the government financed Ministry of Health system (MOH), and the Social Security system (SS) based on mandatory worker-patron contributions. The regions were: (1) the fifth Health District of Honduras (six communities); (2) the Province of Veraguas in Panama (six communities); and (3) the Huetar Atlantica Health Region in Costa Rica (nine communities). The regions present significant socio-economic and cultural differences: Costa Rica and Panama with per capita GNP of $2770 and 2990 respectively, are significantly wealthier than Honduras, with a GNP of $740. Honduras is the most rural with 87% of rural population, followed by Veraguas, Panama, with 79%, and Huetar Atlantica in Costa Rica with 68% [6]. Cultural differences include a predominantly mestizo population in Honduras, with a large indigenous population in rural Veraguas and a significant Black Creole population in Huetar Atlantica. Such social and cultural differences characterize the population throughout the isthmus. Each of the three regions has a particular configuration of public, SS, and private health services, reflecting the social and economic characteristics of each country and the level of development of its health system. Health care in Honduras is provided almost exclusively by the 155 permanent MOH centers, of which 75% are found in rural areas. In Panama, the system in Panama is a combination of public and SS services. Veraguas has two polyclinics of the SS, 17 MOH centers, and 57 rural health posts, which are staffed part-time by local paramedical staff and visited by medical personnel on a weekly or bi-monthly basis. Costa Rica’s system is dominated by the SS with 17 multi-specialist polyclinics based in Huetar Atlantica region and 96 rural outposts visited regularly by SS ‘Basic Integral Health Teams’.

Hospital care in the three countries is provided by a network of regional hospitals located in the main cities. In Honduras this includes small rural MOH hospitals with low admission capacity but a wide spectrum of services and easy access for the rural population. Such hospitals charge variable fees based on income levels. In Costa Rica, and to some extent in Panama, hospitals are part of the SS system and their services are free as they are subsidized by worker-patron contributions that provide financial stability to the system. Panama has MOH hospitals in areas where SS coverage is absent. In the three countries, the population of distant rural communities receives medical attention periodically (once or twice-a-month in remote areas of Honduras and Panama; weekly in Costa Rica), from medical teams based in district health centers.

Study participants

Participants represented the general population of health service users in rural, urban and semi-urban areas, as well as groups with particular interests in health services. Working men and women, the largest proportion, participated in single gender and mixed groups. Others were senior citizens, pregnant women, indigenous women and men, outpatients of a large regional hospital, high school students and teachers of both genders, and paramedical personnel of a small rural hospital. Table 1 presents the number of participant groups by gender in the three regions. Table 2 includes the number of participants in groups defined according to a number of social and health characteristics deemed relevant to the perception of health care delivery.

Interventions

The focus groups provided a special opportunity for participants to formulate, analyze, and define their perceptions and opinions of health services delivery in their region. Results are discussed in order of protocol presentation, drawing on commonalities followed by particular findings for each country.

Preference for services

MOH Community health centers and SS clinics are the most sought after providers in the three regions, routinely attended for their free or low-cost basic health care and preventive health care programs for women and children. Users are predominantly women who also seek care for other members of the household, mostly children and older adults. Special programs, such as adolescent health programs in Costa Rica,
Traditional medicine is the first option of remote indigenous populations and an important source of health care among non-indigenous people in rural and, to a significant extent, in urban areas. Indigenous populations in the three regions, coincidentally concentrated in the most remote locations, consider institutional care a last resort, when other forms of care fail.

**Satisfaction with services**

Community health centers and SS clinics are well regarded for their physical and social accessibility, the vaccination and mother-child programs, and the user-oriented attention particularly regarding service fee policies in MOH centers. Users maintain that health centers are perceived as part of the community, however, in the three regions users expressed generalized dissatisfaction with specific aspects of the services.

The quality of personal attention is foremost among complaints: ‘The doctor often pays little attention, he is not interested in what you have to say, and he just hurries through the appointment; they treat you in a cold and impersonal way’. This view extends to other medical personnel and administrative staff, the latter in particular being blamed for disrespectful attitudes towards users, especially those of modest socio-economic status: ‘I see very humble, poorly-dressed people come in and the nurses use harsh words with them. They leave like children who have just been punished.

Users consider that optimal medical and personal attention can best be obtained in private clinics and offices, despite their limited experience with such services. Costs of private care constitute the major obstacle that makes this option an exceptional practice, particularly in Honduras and Panama, where it is almost exclusively used by wealthy sectors of the population. In Costa Rica, however, an important number of users seek private care on a regular basis, especially when dissatisfied with delays in the SS clinics. This leads to a controversial and popular way to gain access, through special medical referral, to the overcrowded but perceived superior SS services. The mixed use of different services is common in Costa Rica where users look for medical attention at the SS clinics but seek medication at private pharmacies; SS generic medication is disdained in favor of commercial brands, which, although more costly, are thought to be superior.

Users complain of long waiting periods to obtain appointments, especially with specialists, requiring time-consuming, costly travel: ‘Sometimes you have to spend half-a-day getting to the city to obtain the medication, and then you don't have enough money to pay for it; you spent it getting there!’. Users consider that optimal medical and personal attention can best be obtained in private clinics and offices, despite their limited experience with such services. Costs of private care constitute the major obstacle that makes this option an exceptional practice, particularly in Honduras and Panama, where it is almost exclusively used by wealthy sectors of the population. In Costa Rica, however, an important number of users seek private care on a regular basis, especially when dissatisfied with delays in the SS clinics. This leads to a controversial and popular way to gain access, through special medical referral, to the overcrowded but perceived superior SS services. The mixed use of different services is common in Costa Rica where users look for medical attention at the SS clinics but seek medication at private pharmacies; SS generic medication is disdained in favor of commercial brands, which, although more costly, are thought to be superior.

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Main concerns about health care

When in need of urgent health care, the main concern of users in the three regions is to have ready access to a doctor they can trust. This would require increasing the availability of doctors in the health centers during regular working hours, as well as having medical staff available after hours to take care of emergencies. In addition, users would like to be familiar with the medical staff who take care of them, just as they are with other health center staff who live in the community.

In circumstances that require special outpatient attention, such as broken bones and minor accident-related surgery, users worry that emergency attention at the health centers may present a risk, because centers might not be properly staffed and equipped. Private medical attention may be available for such cases at non-ordinary hours, but high costs make it a last option.

Access to any form of health care is the most crucial problem for distant and dispersed populations, which are also the poorest. 'Sometimes we have to walk long distances to catch a bus or get a ride in a passing truck, and when we get to the clinic we are told to come back another day; that there are no more appointments!'. Often voiced in the three study regions, this is a particularly common complaint in Costa Rica among those referred from health posts to the overcrowded SS clinics and hospitals. In the absence of medical attention, users would like to have ready access to effective and inexpensive medication, in the needed quantity, to deal with the problem at hand.

In Honduras and Panama, emergency transportation may mean long hours on horseback for an ill or injured person. Among the indigenous population, the sick and snake-bitten persons may have to be carried in hammocks for long distances with the aid of neighbors recruited along the way, until ordinary means of transportation can be found. Unusual means for those with poor access in Costa Rica may include the use of rural taxicabs in lieu of ambulances, paid by hospitals as part of the SS coverage.

Mobile health teams offer limited attention hours and are not able to provide care for all patients, leading to postponement of medical consultation, sometimes for significant periods. Long waiting periods also apply to obtaining medication. In Costa Rica, users from remote indigenous communities express frustration at not being able to attend the clinic of their choice and feel that a policy of arbitrary assignment of users by mobile team staff limits their capacity to build a much-desired familiarity with the medical staff of a center.

User expectations

Users in general expect increased attention hours, more and better medication, and improved personal attention from physicians. They favor shorter waiting times to be seen by doctors, to receive medication and to have specialist appointments. Users of the SS system in Costa Rica and Panama express a sense of ownership in the institution and hold high expectations, requesting better personal treatment and improved attention by physicians, which includes more information on medical condition and prognosis to the patient, as well as taking care of patient fears and anxieties.

Those outside the SS system, mostly the rural population in Honduras and Panama, consider themselves a disenfranchised sector and are preoccupied almost exclusively with obtaining a basic modicum of health care and medication in their communities.

Conclusions

Quality of health care in the three regions is extremely variable; user perceptions focus on issues of personal medical attention, costs and treatment effectiveness.

(1) In the three regions, health clients are well aware of the need for improved quality of care but are not clear about their rights or how to obtain the desired changes.

(2) As would be expected, the poorest sector of the population has the most difficult access to services, receives the lowest quality of care and has the fewest or no expectations.

(3) Users in the three regions consider that optimal quality of medical and personal care is provided in private medical offices and clinics, but costs make their use prohibitive except for life-threatening emergencies.

(4) The most basic need expressed in the three regions was to have ready access to a doctor that the user could trust; an expression that complements the perception that private medical attention offers optimal quality of care.

(5) Users in the three regions suggest that improved information and education promotes better use of services and reduces insecurities and anxiety, whereas improved doctor-patient relations are seen as encouraging motivation, improving response to treatment and medication and leading to better prognoses. Users not covered by SS would like to see hospitalization time reduced in order to lower costs.
(6) Leaving quality considerations aside, the most basic and widespread preoccupation among the rural poor was how to obtain effective, cheap medication in sufficient quantity.

(7) Public health care users in Honduras consider local health centers part of their communities but regard themselves as passive recipients of services; ownership expressions and active engagement in the system are not expressed. Those in the lowest socio-economic class feel excluded from the system, discriminated against and treated in a non-dignified manner. Users in urban communities also expressed concern that the health care system in general—and users in particular—is exposed to undetermined political pressures. Therefore, criticism and suggestions were sometimes vague and prefaced with words such as: ‘It may be better not to say much, to avoid reprisals from the authorities’.

Defiant attitudes were an exception, in the words of one teacher: ‘I will say what I have to say, no matter what, if I want to see changes take place in my community’. 

(8) Like their counterparts in Honduras, Panama’s non-contributing rural population feels disenfranchised, especially the indigenous groups who only hope that the health system will pay attention to their basic needs; a concern for quality seemed beyond their scope.

(9) Users of the SS system value the medical specialties and the perceived advanced technology available in SS clinics and hospitals, but complain about long waiting periods and the low quality of personal attention. In Costa Rica ownership feelings are an important factor among SS users, who feel confident to criticize and demand better quality of services. For some time there has been a growing demand among users for the right to select their own doctors within the SS system, partly based on the fact that many SS clients also seek attention in the private clinics of SS doctors.

(10) A clear distinction is evident between the attitude of SS users, who are contributors to the system, and those who are fee users of services underwritten by a perceived impersonal and distant government bureaucracy, such as MOH. SS users act more critical and demanding, although the study in Costa Rica shows that SS continues to face serious quality issues and that users need to be more engaged in monitoring the quality of SS services.

(11) Traditional health practices are an important source of health care in rural and urban areas alike. Public health systems in Central America should consider ways to incorporate such practices to improve health coverage when appropriate.

(12) These studies suggest that public health services in Central America may need to include systematic and permanent community participation at the local and regional levels in the design and monitoring of health care delivery. Such participation would benefit from periodic focus group analyses and the application of other qualitative methods. Especially in communities where users do not feel empowered as clients of the health system, group discussions with outside facilitators and a diversity of community representatives may be a very helpful mechanism to find out what clients need and want.

References


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