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User satisfaction through "plural-comprehensive" primary health model

JAIME- Jose*† & VARGAS - Jose

'Universidad de Guadalajara, Centro Universitario de Ciencias Económico Administrativas.

'' Universidad de Zacatecas, Jardin Juarez 147, Centro Histórico, 98000 Zacatecas.

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This paperwork aims to propose the implementation of a plural-complete model of primary health care in Mexico that speeds up the access of people to these services and ensures the satisfaction of users. A review and critical bibliography analysis was carried out on the topic to improve the proposal. In various countries, there have been implemented primary health care-oriented health care systems and better results are on the health of the inhabitants and are more efficient. In order to improve the quality of Primary Health Care (PHC) in Mexico. It is proposed the development of a plural-complete model allowing free choice of the doctor of care system that the patient of family decides. That has public financing or mixed program, depending of the case and has a certified technical quality assurance.

Primary health care, quality of care, satisfaction of users.

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*Correspondence to Author (email: jesusjaimeguzman@hotmail.com)
† Researcher contributing first author.

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1. Introduction

The initiative of this work stems from the perceived need to improve user satisfaction of services of Primary Health Care (PHC) in Mexico, considering it requires greater flexibility in accessing the system using a "Plural" and comprehensive model, which in one hand expedite the entry of people to these services and on the other ensure quality standards and increase their level of satisfaction. So there was a review of existing information on the subject to enable to enter and generate a proposal to change the established paradigms about the traditional supply of PHC services in the country.

The Primary Health Care (PHC) is the most important gateway to the National Health Service (NHS) and the fact that it is a factor of satisfaction of those who access it is an indicator of the quality with which the service is provided in the various institutions and constituent components.

The current model of PHC, existing in Mexico is mainly given by the institutions of Social Security, The Mexican Institute of Social Security (Instituto Mexicano del Seguro Social, IMSS) and the Institute for Social Security and Services for State Workers (Institute de Seguridad y Servicios Sociales para los Trabajadores del Estado, ISSSTE), Mexican Oil Company (Petróleos Mexicanos, PEMEX), Secretariat National Defense (Secretaría de la Defensa Nacional, SEDENA), and for those who do not have social security, they can have access to the Ministry of Health (Secretaría de Salud, SSA) and the IMSS program opportunities.

It is considered that users care systems especially in case of health, represent a niche of opportunities for improvement.

As in the various areas of patient contact with service providers may generate a significant number of cases of dissatisfaction with either the waiting time, with the treatment, or the deferral of specialized care, which may be delayed for two to three months and in some cases longer (Ramírez-Sánchez, Nájera-Aguilar and Nigenda-López, 1998).

To illustrate, in a study conducted in family medicine units of the Mexican Social Security Institute (IMSS) in 2007, it was noted that a health care unit where the first contact was made by telephone appointment concerted up to 85% of cases, was achieved by 66% of users satisfied with the care provided by the family physician and 68% with the waiting time, while other units where only 28% of users had made appointment prior telephone, satisfaction with family physician care was 48% and waiting time 34% (Colunga, López Aguayo and Canales, 2007).

This low percentage of claimants satisfied considered is facilitated by the way in which services are performed, their organization and the capacity to solve them, driven in turn by the time available for conducting medical consultations and the type of standardization thereof.

2. Background

The primary health care (PHC), is the most important focus of the health system and its first contact care, bringing the maximum possible health care to where people live and work (Loyola, 2005).

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The preventive health care and screening tests for the early detection and treatment of diseases are held mostly in the Centers for Primary Health Care (PHC). These centers, where people can come spontaneously, they are also the largest providers of management and continuous care.

An estimated 80% of health care provided at the community level and first contact, where PHC centers are the basis of the health care system. PHC centers are the frontlines of health care and therefore are places that serve the function of providing the initial contact, prolonged and continuous to patients.

The government of Mexico created the Mexican Social Security Institute (IMSS) in 1943 with the purpose of protecting the health of workers employed in the formal sector of the economy.

The ultimate goal of this strategy was to provide 100% coverage population with this system by the end of the twentieth century; however, the maximum coverage is achieved in about 50% of the country's population.

By the early eighties, health authorities had reported that more than 10 million Mexicans lacked access to formal health services, that half of the population used public health services and social security (Nigenda, 2005). Despite this, life expectancy in Mexico increased from 65 to 75 years in the last 20 years, maternal mortality was reduced, as well as infant mortality.

Moreover, the segmented structure of the health system in Mexico has been an obstacle to achieving coverage targets primarily because the existing competition for funds to cover uninsured populations.

The federal government channeled resources 2.4 times more per capita to the population covered by social security to the population served in the Ministry of Health. This reflects corporatist policy even created in the forties that favored the provision of services to people based on their ability to be formally employed (Nigenda, 2005).At present, the public health care and social security institutions face adequacy problems of financial and human resources for their activities.

To illustrate the above in regard to the distribution of health spending, it calls the attention of all of this 15% of the total is intended for health needs of 40% of the population that is socially and economically marginalized and is used compared to 48% of it to meet 10% of the population which has purchasing power (Arredondo López and Recamán Mejía, 2003).

The strategy called primary health care is based on the resolutions of the conference in Alma Ata, Russia held in the year 1977 and that was the basis of the goal of the World Health Organization, "Health for All by the Year 2000" (Hoskins, Kalache, and Mende, 2005; Álvarez Alba, 1991, 65).

The main features of the PHC are: Health promotion, increase preventive actions, attention to more frequent and endemic diseases, supply of food and medicine, maternal and child health, family planning, training and staff development, work equipment, active community participation, appropriate technology and cost, expanding coverage and integration of health services and promotion of basic sanitation.

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To date, the coverage expansion programs have not been able to extend the range of services and the structure of the health system, which inadvertently it has reinforced inequality to the various segments of society.

This is true especially the economically disadvantaged, and more specific in the distribution of financial resources, which already are existing below average in Latin America and the Caribbean who spends on average (7%) of gross domestic product (GDP) on health, while in Mexico barely reaches (5.6%) (Nigenda, 2005).

It is considered that the countries with a health system oriented Primary Health Care (PHC) have better health outcomes of the population and are more efficient (Pujol Rivera, Gene Baida, Sans Corrales, Sampietro-Colom, Pasarín Rua, Iglesias-Pérez, Casajuana-Brunet and Escaramis-Babiano, 2006).

Current trends of PHC involve choice doctor or primary health care system that is preferred as it could be in France or Germany, and this precisely is related to a strategy for improving primary care.

Ortun and Gérvas (1996, p: 97) believe that health and economic efficiency of the primary medical attention (PMA) is based conceptually on longitudinality and the role of patient flow regulator of PMA and comprehensive view of the patient.

The family physician acts as a regulator of the flow of patients to the use of specialized services in countries like Canada, Denmark, Finland, Spain, Holland, Ireland, Italy, Norway, Portugal and the UK. It is emphasized, the importance of recovering the overview of the interaction between patients and the general care and specialized medical-liaison facilitating doctor.

3. Plural-comprehensive primary health care model.

Lara Di Lauro (2011) defined the plural-comprehensive primary health care model as the reform of the health system that is based on the principles of universality, solidarity and pluralism in order to pursue the purposes of equity, quality and efficiency.

The Plural-comprehensive primary health care model is organized by function and not by social groups, separating regulatory functions financing and delivery, looking for efficiency and quality of care, and encouraging the participation of users in their own care.

Thus, the modulation becomes the core mission of the Secretariat of Health. Funding is the core responsibility of social security, extending it to private insurance. The joint function becomes explicit through the administration of payments and coordination of provider networks, through the ISES and finally the provision of a scheme is open to plural public institutions, civil society and private. In order to better meet the public and provide performance incentives to providers, must be recognized freedom of choice for users.

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4. Interrupting the vicious cycle of poor primary care

Countries that have broken this cycle, such as Denmark, the Netherlands and the United Kingdom, began with the creation of a professional association of general practitioners (GP) and powerful family that was inserted into the universities and obtained postgraduate training which became mandatory for the profession.

With the help of regulations determining the GP-family as a filter and coordinating, regulating access to specialists, primary care is the cornerstone of the health system in these countries. In these cases the family physician, is highly recognized, is reasonably well paid which generates the existence of candidates for the exercise of the profession of good quality and the population is broadly satisfied with their services (Ortun and Gérvas, 1996).

There are cases like that of Canada where, operation costs have elements of control by the federal government on the provincial government. Health spending has remained at 8.6% of GDP in 1997, with an annual per capita expenditure of $ 1,836.00 USD. Regarding the payment mechanism, as it has been noted, doctors are paid by the provincial health insurance, primarily through a fee for service. Health care is publicly funded, but private provision. It is based on primary care physicians, and they are the first formal contact users. 60% of practicing physicians in the country are primary care physicians.

They usually work in private, communities and have a high degree of autonomy. Canadians usually go to the doctor or clinic of their choice. They must present their current insurance card to receive care that allows access to the insurance, so they do not need to pay co-payments, deductibles or premiums (De los Santos Briones, Garrido Solano and Chávez Chan, 2004).

Another interesting case is represented commenting Health System in Cuba which, in the eighties prompted the primary health care model, with the Plan Family Doctor and Nurse, which is the protagonist of the health strategy in this country.

The national health system has a network of institutions that provides easy access to 100% coverage of the population. The benefit is primarily focused on primary health care (PHC) model based on the Family Medical and Nurse (FMN), which currently covers 94% of the population. It is Established an office of FMN for every 600 to 700 people and in certain places of work or study (De los Santos et al, 2004, Lopez, Morales, Lara, Martinez, Lau, and Soler, 2009).

5. User satisfaction as a measure of quality of health services

Among the indicators that measure the quality of results, and which is given increasing importance, included patient satisfaction with the care received. That satisfaction is derived from subjective experience of compliance or noncompliance with the expectations a person has about something.

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If we try to offer the highest quality services and build institutions of excellence, then, the evaluation of user satisfaction, families and providers becomes a permanent task and provides dynamic data on how far is it to meet expectations of each other (Massip Perez, Ortiz Reyes, Llanta-Abreu, Peña Fortes, and Infante Ochoa 2008).

A valuable tool to learn about the user satisfaction are the surveys, because they provide information about the user satisfaction regarding the treatment received and can fix or adjust the objectives to be achieved with the improvements made.

The service orientation towards the needs of those who use health services is increasingly present in the proposals of professionals, managers and planners in health. In this sense, the analysis of user feedback incorporates the perspectives of citizens within the overall framework of the evaluation of health programs (Massip et al. 2008).

The appointment at the primary care level, it may be beneficial to user satisfaction because it aims to reduce waiting times for patients and lead to greater user satisfaction with the care provided. Colunga, Lopez Aguayo and Canales (2007), Serrano Del Rosal and Loriente Arin (2008) found that some specialists in the field have shown the high correlation between user satisfaction and service quality, implying knowledge of the need to better understand the first and second boost.

Once it has been known the satisfaction in each dimension of the service received, it can be determined, how they contribute to shaping the global satisfaction.

At first, one might say that overall satisfaction is a sum of all partial satisfactions, but all dimensions equal to weigh in shaping overall satisfaction? In reality, the answer to this question, not to be supported by empirical reality, it would be nothing more than a hypothesis or theory course starting (Serrano Del Rosal and Loriente Arin, 2008). While some earlier analysis concluded that these three variables, the recommendation of the center is the most important to be considered as overall satisfaction with primary care services. Indicators can be grouped into three:

A. Satisfaction with facilities
B. Satisfaction with the organization
C. Satisfaction with the medical treatment.

This grouping together realizes the holistic approaches of structure, process and results that Donabedian (1993) considered necessary for the evaluation of quality. Partial satisfactions, satisfaction with the organizational aspects are those with greater ability to vary the overall satisfaction, with a significance of 51.6%. The satisfaction of the medical act gets 35.2 percent of importance and satisfaction with facilities 11%.

On the other hand the characteristics of supply and the user also affect the overall assessment of their satisfaction.

The three partial satisfaction indicators that more percentage of dissatisfied presented in this study are the evaluation of the waiting time, ease solving procedures and papers, and assessment of the organization of the school in general, all aspects pertaining to the organizational dimension (Serrano Del Rosal and Loriente Arin, 2008).

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Finally, the role of user feedback on services received is key aspects in the definition of quality and its evaluation is essential to provide proper health care. Patient perception therefore becomes one of the principal steps in evaluating how or which improve the quality of care.

The ultimate goal is to detect the presence of attendance problems and develop proposals for improving care through the patient assessment revealing the service received (Granado de la Orden, Rodriguez Rieiro, Olmedo Lucerón, Chacon-Garcia-Escribano Vigil and Rodríguez-Pérez, 2007)

8. Conclusions

It is considered that to achieve the purpose of improving the quality of PHC in Mexico may be worth checking the satisfaction of users of these services, by enabling the patient or her family doctor to choose the medical doctor and the system of the first contact the user prefers.

Then, he/she can select based on proximity to his/her location, affordability (reaching even to propitiate the gratuity based on the principle of citizenship).

Also on the basis that the users count on the necessary organization to simplify administrative procedures for their care and have a support system when required for higher level of medical expertise to solve the most complex health situations efficiently and timely.

All of these should result in achieving a higher level of satisfaction with the health care services received, with the lowest risk for health and a permanent improvement.

In the reviewed literature, it has been shown the feasibility of such strategies especially if it is considered important to clarify the comparison that can be made between different sets of primary health care in several countries and the way that care is provided in Mexico. As part of the proposal representing the Popular Health Insurance, which has been mentioned already that one of its claims is to achieve universal access to health services.

This can be interpreted that there are different funders of health services including existing ones as in the Mexican Social Security Institute (IMSS), the Institute for Social Security and Services for State Workers (ISSSTE) and derivatives from Secretariat of Health (SSA) coupled with the system for Integral Family Development (Desarrollo Integral de la Familia, DIF).

It is intended that a claimant from these institutions or any citizen even if not have any entitlement can go to any unit, clinic, health center, family practice unit, which is accredited to provide this service to request services from PHC.

This would be equivalent to that access to these services is given by citizenship even as there are various lenders, payment of providers of these services would be given by the institution to which is entitled the individual or family.

This system is considered to be an advantage that can be achieved for the user because it creates competition by giving quality services among the various providers of PHC, since when there is a possibility that a user of the IMSS or ISSSTE go with private physician practicing in a colony near their home could facilitate access and service satisfaction.

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It is considered that users will be served preferably where they get greater satisfaction with the service received.

In addition to achieving service standardization, it exists within the Ministry of Health a group of trained professionals to carry out the accreditation of the different type of unit.

Accreditation has a clearly defined evaluation system on granting services health units and has a term of five years for the units that have been accredited.

This system can be generalized to private units and civil society and thus can guarantee uniformity of services provided in PHC in the public and private sector. To provide greater certainty to this type of organization proposal would add the social comptrollership that would be the possibility that this strategy be monitored and audited by various civil society organizations.

Another advantage that can be considered to be achieved with this proposal is that current services would be used and the existing infrastructure of the various institutions.

Thus, to extend the offer to users, the federal and state governments do not require large investments in new units as in most cities, towns and communities have some general practitioners.

With reinforcement in training of these general practitioners, it can be achieved to give primary care services of high quality and highly satisfactory to the user population.

At the end of the day, it can be implemented in everyday practice, the right to health protection with a wide satisfaction for all Mexicans without unjust distinctions fostered by the divergent supply that currently exists of PHC services.

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