Revija za univerzalno odličnost / Journal of Universal Excellence, Članek / Article
Junij / June 2019, leto / year 8, številka / number 2, str. / pp. 153–168.

Ensuring and Measuring Quality in Primary Healthcare

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Abstract:
Research Question (RQ): What are the basic postulates of ensuring and measuring the quality in primary healthcare in Europe and Slovenia?
Purpose: The purpose of this article was to study the origin and status of ensuring high quality services in primary healthcare.
Method: Systematic review of existing literature.
Results: The research showed the origin of quality in healthcare and the status of ensuring quality in primary healthcare. Measuring quality indicators in healthcare is deficient. They are monitored only by accredited or certified health institutions.
Organization: Quality indicators shall be publicly accessible data, since this is the only way healthcare service users and doctors are enabled to choose the organisation with best quality indicators.
Society: The ensuring of quality has to start on primary level of healthcare since this level of healthcare deals with prevention, treatment and rehabilitation of diseases for an acceptable quality of life. Thus we can decrease the number of treatments on secondary and tertiary level of healthcare and costs of unnecessary medical care and treatments.
Originality: In the theoretical part, we have presented basics characteristics of healthcare quality. We collected the information on the primary health care quality assurance and measurement.
Limitations: Research is limited with relatively low amount of relevant sources.

Keywords: quality, quality system management, primary healthcare, healthcare, patient safety.

1 Introduction

Improvement of quality level and accessibility of healthcare services is a priority to all countries. Slovenia has adopted National strategy for quality and safety in healthcare (Ministrstvo za zdravje, 2010, pp. 13-21), which derives from National guidance on developing quality healthcare (Ministrstvo za zdravje, 2006, p. 19) and thus taken measures for ensuring quality and safe medical treatment.

Managers of medical institutions are responsible for ensuring quality and safety in healthcare. Quality should not be a separate and special activity of medical institutions; it should be interwoven with everyday activities and processes.

Quality indicators show the quality level of healthcare and are measured by healthcare practitioners in order to get an overview and control over the quality of medical treatments in their own institutions. Healthcare practitioners use the results in order to monitor and improve the quality of services; payers need information on effective use of assets; patients need data

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Prejeto: 5. november 2018; revidirano: 3. december 2018; sprejeto: 5. december 2018. /
Received: 5. November 2018; revised: 3. December 2018; accepted: 5. December 2018.

which can help them choose a practitioner, whereas general population require an assurance of medical system adequacy (Ministrstvo za zdravje, 2010, pp. 21-23).

2 Theoretical framework

Primary healthcare centres are usually situated near patients' home and represent the first level of access to medical care. It includes prevention, health education, cure and rehabilitation (Schäfer et al., 2013, pp. 67-79).

The monitoring of quality in healthcare lacks structure indicators (suitability of equipment, education of employees, satisfaction of employees, etc.) and process indicators (how services are provided to patients, patient satisfaction, etc.). Self-assessment, expert advice, quality indicator measurement and its publishment contribute to the improvement of quality and safety of health (Kringos et al., 2010, pp. 1-8).

The quality of work in healthcare evaluated by means of suitable quality indicators is important both for healthcare practitioners and users (patients). Organisations mostly monitor the success and efficiency of achieving set goals. This enables control and taking prompt measures in case of deviations. The accessibility of this information enables the users to evaluate the quality and safety of healthcare services. Therefore, it is very important that the set quality indicators can be measured, shown with absolute values and compared in time and among individual institutions (Ministrstvo za zdravje, 2010, pp. 13-21).

Primary healthcare lacks information on financial savings and on improvement of population's health state deriving from healthcare quality (Kersnik, 2001, pp. 39-44). Due to poor familiarity with quality management the majority of healthcare workers has a negative attitude towards introducing quality systems, which has negative effects for both patients and practitioners. Thus, the article tries to explain the basis for introducing quality standards on the primary level of healthcare in Slovenia and position this in a wider framework.

Since there is no systematic regulation on national level regarding quality monitoring, individuals and individual institutions have to deal with it on their own. Consequently, there are no financial incentives for high-quality work in healthcare. There are only sanctions provided for (fines) – for example if a practitioner on the primary level of healthcare does not achieve the plan of preventive check-ups, exceeds the average number of referrals, does not prescribe medicine in accordance with regulations of ZZZS (HIIS) etc.

Healthcare institutions at the primary level took own initiative to introduce the system of quality assurance and thus the condition for the ISO9001 certification. Aforementioned is a predisposition to ensure quality of healthcare services, since ISO9001 demands from the healthcare institutions to monitor the quality indicators. Reporting of these results to the Ministry of Healthcare was not requested, which makes comparison among institutions impossible. Thus, the patient has no option to choose the provider of best quality services.

Research question is, which are basics s of quality assurance and monitoring in primary healthcare in Slovenia and in Europe.

In the research, we strive to confirm the thesis, that half of primary healthcare institutions in Slovenia has no system of monitoring of quality assurance and that they are not properly certified, which further means that they do not fulfil basic condition for assuring proper quality of healthcare services and its monitoring.

3 Method

The article is based on descriptive method and focused synthesis. It merges key findings based on the review of literature on quality in healthcare, quality management systems, quality indicators, certification and accreditation.

Data was collected using qualitative methods and literature review. Literature was collected using Google scholar and digital libraries of SICRIS and SCOPUS. Used keywords were quality of primary healthcare services, quality indicators and patient security.

4 Results

4.1 List of literature regarding basics of ensuring and measuring quality in primary healthcare

In the table below, list of literature regarding basics of ensuring and measuring the quality of primary healthcare is provided.

Table 1. Basics of quality assurance in primary healthcare

Author, title	Basics of quality assurance in primary healthcare
Ministrstvo za zdravje. Priročnik o kazalnikih kakovosti	Measuring quality indicators provides overview and control over the healthcare services.
Kringos DS, Boerma WGW, Bourgueil Y, Cartier T, Hasvold T, Hutchinson A, et al. The european primary care monitor: structure, process and outcome indicators	Self-evaluation, peer-review, measuring and reporting of quality indicators leads towards improvement of the quality of healthcare services.
Ministrstvo za zdravje. Nacionalna strategija kakovosti in varnosti v zdravstvu (2010–2015)	Institutions most often monitor effectiveness and efficiency of reaching goals, which enables action in the case of disparity. Due to this, indicators should be measurable in absolute terms and comparable.
www.oecd.org/els/health-systems/health-care.quality-indic ators.htm	Set of quality indicators was developed in order to enable assessment of individual factors on healthcare services quality.

»se nadaljuje«

»nadaljevanje«

Ministrstvo za zdravje Republike Slovenije. Nacionalne usmeritve za razvoj kakovosti v zdravstvu	Healthcare should focus on indicators of healing results.
Commission of the European communities. Communication from the commission to the European parliament and the council on patient safety, including the prevention and control of healthcare-asociated infections	Healthcare treatment mistakes are causing human suffering and high expenses of healthcare system. Due to this, patients should be better secured, by improving healthcare systems.
Sporočilo Komisije – O učinkovitih, dostopnih in prožnih zdravstvenih sistemih,Varnost pacientov in zagotavljanje oskrbe v sistemih javnega zdravstva	Main purpose of quality assurance systems in healthcare are: high level of deviation in medical procedures, ineffective use of medical technologies, high expenses of medical treatment, patients' dissatisfaction, and long waiting lists.
Zagotavljanje vzdržnosti zdravstvenih sistemov Evrope	To grade and asses the patients' safety quality indicators should be developed.
Brubakk K, Vist EG, Bukholm G, Barach P, Tjomsland O. S systematic review of hospital accreditation: the challenges of measuring complex intervention effects	Certified organisations are monitoring the quality indicators.
Saut AM, Tobal Berssaneti F, Moreno MC. Evaluating the impact of accreditation on Brazilian healthcare organizations	Certification has significant effect on financial results; therefore, organisations should measure the quality indicators, evaluation and improvements.

4.2 International grounds in the field of quality in healthcare

In 1997 the Council of Europe adopted Recommendation No R (97)17 to unify measures in the field of healthcare, to ensure fair accessibility to healthcare and to prioritise the improvement of healthcare quality in all member states (Svet Evrope, 2001, pp. 7-31). Based on the recommendation of the Council of Europe all member states had to draft political guidelines to support the development and implementation systems for improvement of healthcare quality on all levels. (http://eur-lex.europa.eu/legal-content/SL/TXT/HTML/?uri=LEGISSUM:sp0009&from=SL).

In 1999 the World Health Organisation introduced the document *HEALTH21 – Health for all in the 21st century*, which focuses on results as the final assessment of healthcare (WHO, 1999).

In 2002 the project OECD for healthcare quality took place, with the aim of measuring and comparing the quality level of ensuring medical services in different countries. Within the framework of the project numerous indicators on the level of health system were developed, enabling us to estimate the effect of individual factors on the quality of health services (www.oecd.org/els/health-systems/health-care.quality-indicators.htm).

The project of healthcare quality indicators was managed by a group of representatives of OECD countries. In 2006 following countries participated in the project: Australia, Austria, Canada, Czech Republic, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Japan, Mexico, the Netherlands, New Zeeland, Norway, Portugal, Slovakia, Spain, Sweden, Switzerland, the United Kingdom and the United States of America (Kelley & Hurst, 2006, pp. 1-3).

By 2010 all OECD member states had to ensure that healthcare focuses on the results of medical treatments on all levels. The emphasis was placed on determining the success of public health strategies, which was determined based on medical results, cost efficiency, establishment of mechanisms for monitoring healthcare quality for at least 10 medical states, improvement of medical results after at least five years and improved satisfaction of patients due to questionnaire results (Ministrstvo za zdravje, 2006, p. 19).

Medical errors result in patient's suffering and high costs in healthcare; therefore, the European Commission draws attention of OECD member states to the importance of patient safety and the establishment of systems for the improvement of patient safety

(http://eur-lex.europa.eu/legal-content/en/TXT/?uri=CELEX%3A52008DC0836).

On the initiative of the ministers of health the Council of Europe has published recommendations for the establishment of quality management systems in healthcare. The cause for recommendations for improved patient safety lies in high level of medical treatment rejection, unsuccessful/inefficient use of medical technologies, high costs of poor quality, dissatisfaction of patients, inequality in accessibility to healthcare services, patient waiting period and high prices of medical services, which the society cannot afford (http://eur-lex.europa.eu/legal-content/SL/TXT/?uri=celex:52014DC0215, http://eur-lex.europa.eu/legal-content/SL/TXT/?uri=LEGISSUM:2901_5).

Healthcare practitioners in EU member states shall establish authorities for quality, efficient internal and external audit, ensure constant quality improvement (clinical guidelines and paths, measuring of and reporting on quality indicators, reporting on medical errors) and introduce trainings for quality management. Thus, the practitioners could gradually introduce

a method of balanced indicators and thereby consider all dimensions of their effects (Ministrstvo za zdravje, 2006, p. 19).

For healthcare systems to ensure high quality healthcare the European Commission has established recommendations for: the enhancement of service efficiency with the help of results of success evaluation, better accessibility to healthcare and better adjustment of healthcare systems to changed conditions. The emphasis was placed on the development of more efficient systems, processes and tools in the field of healthcare safety and introduction of a special approach for the promotion of safe practices in order to prevent most common complications related to medicines, infections related to healthcare treatment and complications related to surgical interventions. Furthermore, systems shall be developed, which would encourage healthcare workers to make reports on all safety complications. Since the healthcare workers play an important role in improving patient safety they have to participate in trainings and educations related to patient safety in undergraduate and post-graduate programmes, in professional trainings and further professional training at workplace. It is also necessary to develop the classification and assessment of patient safety, which requires defined and comparable indicators (http://eur-lex.europa.eu/legal-content/SL/TXT/HTML/?uri=LEGISSUM:2901_2&from=EN).

Accreditation and certification have positive effects since these organisations monitor quality indicators. Seven most commonly monitored quality indicators are put forth: patient satisfaction, number of patients treated with medicines, accessibility to medical data, soundness of medical records, completeness of pre-surgical notes, marking of sick-leave data and the assessment of toilets in hospitals. A research among healthcare workers and patients has shown that accredited and certified organisations are more successful than non-accredited and uncertified institutions. The quality and safety management analysis was carried out in 89 hospitals in seven countries: Belgium, Czech Republic, France, Irelands Poland, Spain, the Netherlands and the United Kingdom. The aim was to define systematic differences between accredited or ISO-certified hospitals and those which are neither accredited nor certified. In Europe hospitals apply for certification predominantly due to European framework of quality and safety management and mainly voluntarily due to their commitment to development, self-regulation and marketing. The comparison between accredited/ISO-certified and non-accredited/uncertified hospitals showed that accredited or certified hospitals reach much higher scales of quality indicators and are much safer than hospitals without accreditation or certification (Shaw, Groene, Mora & Sunol, 2010, pp. 445-451). Key findings of the study revealed that the easiest way to measure the effect of accreditation and certification is by comparing accredited/certified organisations with non-accredited/uncertified ones (Brubakk, Vist, Bukholm, Barach & Tjomsland, 2015, pp. 1-10).

Accreditation is a means of organisational development and health system regulation. Numerous healthcare reform programmes in countries with medium and low incomes include introduction or enhancement of accreditation or certification of healthcare organisations (Shaw et al., 2013, pp. 222-231).

The certification of quality management systems is the assessment of conformity with one of international standards, conducted by third parties (Slovenski inštitut za standardizacijo, 2015, p. 11).

Certification and accreditation are useful for healthcare organisations regardless of the chosen external assessment. Both systems encourage structures and processes which support patient safety and thus achieve higher quality level than organisations without an external assessment (Shaw et al., 2014, pp. 100-107).

Between 2010 and 2013 a study of quality, fairness and primary healthcare costs in Europe was performed. 31 countries participated in the study (27 thereof EU member states). The aim of the study was to determine the efficiency of primary care and is related to project »Health 2020«. Demographic changes, technological development and increasing expectations of the population are the biggest challenges for healthcare systems (Schäfer et al., 2011, pp. 1-9).

In the past, Portugal has faced numerous problems related to quality of healthcare services, inter alia lack of patient safety, high costs, unsatisfied patients, inequality in access to healthcare safety and long waiting periods. A healthcare reform in Portugal in 2003 linked all units of healthcare in a network of health institutions, which is aimed at expectations of the public. Based on this reform Family Health Units (FHU) were established in 2007 in order to ensure better accessibility to healthcare, shorter waiting periods and higher quality of healthcare services. Healthcare practitioners started introducing quality management systems first in hospital and gradually also in primary healthcare. The goal of introducing quality management systems in healthcare institutions was to optimise work processes, identify critical processes and determine quality indicators (Duarte & Fonseca, 2017, pp. 251-264).

The research of the DUQuE project included 74 hospitals in seven countries (Czech Republic, France, Germany, Poland, Portugal, Spain and Turkey) where the relations among different measures are being studied. It has been revealed that hospitals with self-assessment and quality indicators evaluate maturity of their own system and thus improve the quality of their services. However, an external assessment (certification or accreditation) enables a wider reflection of organisation maturity related to quality (Wagner et al., 2014, pp. 66-73).

In the United Kingdom quality indicators have been established from the recommendations of clinical guidelines in primary healthcare, which are measured based on routine data collection. 17 success indicators have been developed which focus on chronical diseases, however, do not measure the quality of patient treatment (Rushforth et al., 2015, pp. 1-10).

It has been revealed that healthcare costs, adverse events, complexity of new technologies, aging of population and spreading of transmissible diseases all contributed to the main reasons for implementing quality improvement programmes in Brazil. There are not sufficient evidence of correlation between patient safety and accreditation. Patient safety is prescribed in Brazilian legislation, which requires an obligatory monthly report on adverse events. Furthermore, it wasn’t confirmed that accreditation had impact on financial result of

healthcare organisations; therefore, healthcare organisations should focus on monitoring and measuring of quality indicators, evaluating and taking measures (Saut, Berssaneti & Moreno, 2017, pp. 1-9).

Working system has a huge impact on safety of patients and healthcare workers, in particular lack of expertise, poor applicability of information technologies, inappropriate workspace, hierarchical culture and avoiding guidelines. It is strictly necessary to balance the working system in order to increase the safety of patients and staff (Carayon et al., 2014, pp. 14-25).

4.3 The quality of healthcare system in the Republic of Slovenia

The state of the quality in healthcare in Slovenia was defined in Quality of the healthcare system in the Republic of Slovenia (Kersnik, 2001). In National program of the healthcare in the Republic of Slovenia – health up to 2004 was introduced, which enhances the development of professionals and quality improvement, promotes healthcare system adjusted to the needs of patients and emphasises the importance of efficient use of assets. However, interested parties could not reach an agreement, therefore, a national authority wasn't established. Consequently, in 2004 Department for quality and safety was established within the framework of the Ministry of Health, which should implement above mentioned tasks of a national authority (Ministrstvo za zdravje, 2010, pp. 13-21).

Based on guidelines for quality development numerous activities for improvement of quality in healthcare took place between 2006 and 2016. Furthermore, a number of measures have been taken and documents drafted in order to ensure higher patient safety. A more detailed overview of documents and measures in the field of Slovene healthcare system are gathered (Tušar, Kociper & Zupančič, 2016, pp. 1-6).

In November 2010 a Manual on quality indicators was published (Ministrstvo za zdravje, 2010). The manual introduces indicators applicable mostly for secondary and tertiary level of healthcare practice; only 20 thereof are useful for the primary healthcare level.

Firm primary healthcare ensures an accessible, fully continuing and coordinated treatment in outpatient clinic, which is supported by proper healthcare management and competent staff. An important driving force of primary healthcare is better responsiveness to the needs of population and improved cost efficiency. Primary healthcare significantly influences the functioning of all medical systems, therefore, the majority of needs for curative and preventive medical services should be satisfied on the level of primary healthcare (Schäfer et al., 2011, pp. 1-9).

Following countries are known for having the broadest set of medical services on the primary level of healthcare: Belgium, France, Bulgaria, Finland, Lithuania, Norway, Portugal, Spain, Sweden and the United Kingdom. The question regarding the development of the primary healthcare in the future remains open since there are significant differences in accessibility to

primary healthcare services (decentralisation of community healthcare centres), financing and medical treatment quality (Kringos et al., 2013, pp. 742-750).

Between 2011 and 2013 a research was conducted among patients in 34 countries during their visit at the doctor's focusing on possibilities of improving primary healthcare. Patients were asked to rate the accessibility/availability, continuity, integrity, the involvement of patients and the communication between patients and doctors. The results of the research showed medium to high potential of improving primary healthcare in 26 countries. The highest potential for improvement was evidenced in the field of patient involvement during medical treatment and the integrity of medical treatment (Schäfer et al., 2015, pp. 161-168).

Primary healthcare represents the basis of healthcare systems in many parts of the world. OECD measured the quality of general practice in 34 countries (31 European and 3 Non-European: Australia, Canada, New Zeeland) within the framework of four dimensions: continuity, coordination, focus on community and integrity of the treatment. Doctors considered the continuance of medical care as the most important quality dimension. The coordination of the treatment was proven to be the least important quality indicator. It is significant for patients with chronic diseases since the results of the treatment of such patients in countries with good-coordinated healthcare proved to be much better, mainly at the discharge from the hospital or at transition among different levels of healthcare as the doctors are far more coordinated The continuance of medical treatment is closely linked to the organisation of primary healthcare, which should not be fragmented (Rotar Pavlič, Sever, Klemenc-Ketiš & Švab, 2015, pp. 1-11).

For organisational changes to take place the willingness of employees is of key importance. In Lebanon 108 medical centres participated in a study, which showed that 66 % of the interviewees are willing to report on quality indicators. Doctors are not prepared to report on adverse events due to fear of sanctions although these might by system errors. The willingness of nurses to make reports is the lowest due to personal valence (the benefits of reporting on quality indicators), as they are overworked, therefore, a restructuring is of the highest importance in order to ensure them more time for reporting (Alemeddine, Saleh & Natafgi, 2015, pp. 1-14).

»Information communication technology and paperless work can improve work processes and represent an important part of modern primary healthcare. (Iljaz, Meglič, Petek, Kolšek & Poplas Susič, 2014, pp. 42-54)

There is a coordinator for ensuring quality in each hospital in Australia. The quality coordinators are responsible for improving the level of quality of patient treatment and for the encouragement of efficient use of funds and sources and for ensuring administrative, technical and educational support in quality development. They are also responsible for defining the method of clinical work (Wilson, 2000, pp. 127-130).

Prevention of adverse events should become general perception in healthcare since only the identification of potential risks and recording of mistakes can help predicting and preventing and thus minimizing damages for patients and lowering costs in healthcare. Efficient organisation management manifests itself by:

- Documented processes with efficiency indicators and documented quality policy,
- Clearly defined and measurable performance indicators,
- Implementing regular certified audits,
- Processes, implemented according to defined methods on a daily basis, not only during audits (Dotan & Koski, 2017, pp. 1-10).

"Safety culture is a concept which describes how relations between managements and personnel, their standpoints, processes and practice protect patients against harmful events due to mistakes in healthcare." (Klemenc-Ketiš, Tveter Deilkas, Hofoss & Bondevik, 2017, pp. 203-210)

The expectations and needs of community are the most important quality indicators in primary healthcare, in particular patients' accessibility to healthcare and relationship between a patient and a doctor (Krczal & Mock, 2016, pp. 1-8).

The Minister of Health in OECD emphasizes the importance of investments in measures for assessment regarding whether healthcare systems ensure the satisfaction of population's needs and expectations. Patients' reports on measures are supposed to become new currency for measuring healthcare system performance and for the comparison of performance rate among individual healthcare systems (Coulter, 2017, pp. 1-2).

Quality assurance indicators are measured only in certified institutions of primary healthcare, since this is the requirement of ISO9001 standard. Our research showed that only 33 out of 59 all primary healthcare institutions is certified and monitors the indicators. Almost half of primary healthcare institutions do not monitor quality assurance indicators, which shall be basis for quality of healthcare services and for security of the patients.

Table 2. Certification of community healthcare centres in Slovenia

Health Insurance Institute of Slovenia branch offices (BO)	SIQ*	BV*	Uncertified
BO Celje	2	1	4
BO Koper	0	6	0
BO Kranj	0	0	1
BO Krško	0	0	3
BO Ljubljana	3	7	8
BO Maribor	1	1	3
BO Murska Sobota	1	1	2
BO Nova Gorica	2	1	1
BO Novo Mesto	2	2	0
BO Ravne na Koroškem	0	3	4
Total: 59	11	22	26

Note: Personal research based on information of HIIS (ZZZS) (Zavod za zdravstveno zavarovanje Slovenije, 2017, pp. 15-30), SIQ, Bureau Veritas, own source

5 Discussion

Rejections of medical treatment are the main reason for ensuring high quality of healthcare services. The improvements based on collected data can be made after the measurements have been made. Quality indicators must be publicly accessible data so that healthcare service users and doctors have the possibility to choose a suitable healthcare service practitioner.

Certified or accredited organisations are more successful in introducing new changes (Shaw, Goene, Mora & Sunol, 2010, pp. 445-451). The majority of healthcare institutions get accreditation or certification based on their focus on development, self-regulation and marketing (Brubakk, Vist, Bukholm, Barach & Tjomsland, 2015, pp.1-10), as it is very difficult to justify the amount of money and time used for quality management systems, although both systems support higher patient safety (Shaw et al., 2014, pp. 100-107).

By introducing quality management systems we often encounter resistance of healthcare workers, who lack knowledge on quality management system. The consequence thereof is false perception of self-assessment of the organisation (internal audits, internal professional audits), external audits, non-conformity and recommendations. In most cases healthcare workers consider audits as supervision, control and search for errors. Therefore, introducing obligatory trainings on quality and safety for all healthcare workers would be very meaningful. Everyone should be aware of the fact that errors in healthcare are often system errors, which can be prevented by better communication and better cooperation of team co-workers.

In many parts of the world primary healthcare represents the basis of healthcare systems. A research conducted in 34 European countries has shown defective coordination of healthcare at transition of healthcare service users through different levels of healthcare services since the treatment results of patients with chronical diseases proved to be much better in countries with well-coordinated healthcare (Alemeddine, Saleh & Natafgi, 2015, pp. 1-14).

The starting point for quality insurance should be on the primary level of healthcare since it deals with prevention, treatment and rehabilitation of illnesses for an acceptable quality level of life. Thus we can decrease the number of treatments on the secondary and tertiary level of healthcare and lower costs of unnecessary medical treatments. In addition, patients remain independent in their basic life functions. Introducing quality management systems in primary healthcare should be considered as one of priority tasks of the government and managers of healthcare institutions.

Healthcare service users and healthcare workers, who are often overburdened to deal with quality, are put at the centre. Healthcare organisations have applied for certification or accreditation, gained a quality management system administrator and started monitoring quality indicators. In 2010 the manual Priročnik o kazalnikih kakovosti (Handbook on Quality Indicators) within the framework of the Ministry of Health was published. The manual defines quality indicators useful on the secondary level of healthcare services. On the other hand, indicators (first 20 indicators) listed as suitable for primary healthcare are not useful on the primary healthcare level. Thus, primary healthcare is losing its position as it deals with prevention, treatment and rehabilitation of illnesses, which lowers the costs of subsequent treatment and enables higher quality life for each individual.

Medical errors result in suffering of patients and high costs, therefore, it is necessary to increase patient safety and establish systems for the improvement of patient safety. Additional reasons for introducing systems for quality management are as follows: inefficient use of technology, dissatisfaction of healthcare service users, inequality in accessibility, long waiting periods and expensive services (Ministrstvo za zdravje, 2006, p. 19).

By entering the European Union, Slovenia has accepted common responsibility for citizens of EU member states, which includes requirements for comprehensive management and coordination of quality on the level of individual countries. Healthcare practitioners are responsible for cooperating in national quality indicator programme and in the program Quality in Healthcare. Besides this, they are responsible for using quality indicators in order to improve systems, clinical paths and processes. Therefore, healthcare practitioners should gradually introduce the method of balanced indicators and thereby consider all dimensions of their effect (performance indicators, patient safety indicators, clinical indicators, indicators of experiences and patient satisfaction and satisfaction of other users and healthcare workers (Ministrstvo za zdravje, 2006, p. 19).

Our research, among primary health care centres confirms the thesis that almost half of the institutions are not certified. This means that they have no system of quality assurance implemented. Among total of 59 primary healthcare centres in Slovenia, 33 are properly certified, while another 26 are not.

Main consumer of healthcare services is ZZZS, which unfortunately does not require proper certification form healthcare centres and thus, higher quality of services. Healthcare workers, especially medical doctors, consider the quality assurance system as control and search for the mistakes; at the same time state does not provide additional financial sources or other initiatives for healthcare institutions, which decided for proper certification, which is rather significant expense.

As long as certification will not be legally mandatory, there will be healthcare organisations, which will, due to pressure of medical doctors or due to financial reasons, skip the introduction of quality assurance system.

6 Conclusion

The focus of comprehensive quality management and coordination is placed on patient safety as this lowers high costs of medical treatment, dissatisfaction of healthcare service users, inequality in accessibility to healthcare services and long waiting periods. Therefore, healthcare practitioners should be obliged to introduce and establish quality management systems on all levels of healthcare. For healthcare services users the primary healthcare represents the entrance into healthcare system and includes both prevention and treatment, therefore the development of quality management systems on primary healthcare level should be of highest importance. Primary healthcare level affects all other healthcare levels. Consequently, a coordinated cooperation and functioning of all healthcare levels is very important because this can ensure a possibility of successful treatment results for patients, which is a significant quality indicator of healthcare services.

Healthcare institutions on primary level should follow unified indicators of quality and they should be reported to the higher level. Quality indicators should be public since they enable doctors and patients to choose among healthcare practitioners with best indicators of treatment results. Unfortunately, quality indicators are measured only by certified institutions. These indicators are not comparable and no further reporting on higher instances are organised.

Quality indicators shall be publicly accessible data, since this is the only way healthcare service users and doctors are enabled to choose the organisation with best quality indicators.

The ensuring of quality has to start on primary level of healthcare since this level of healthcare deals with prevention, treatment and rehabilitation of diseases for an acceptable quality of life. Thus we can decrease the number of treatments on secondary and tertiary level of healthcare and costs of unnecessary medical care and treatments.

Quality assurance indicators are measured and controlled only in certified healthcare organisations and they are not unified. It would be appropriate and needed to develop unified quality assurance indicators for primary healthcare, which should be monitored by all organisations in question. Results should be reported. Only in this perspective the comparison would be possible and proper steps could be taken in order to improve primary healthcare services.

Research is limited with relatively low amount of relevant sources.

References

1. Alemeddine, M., Saleh, S., Natafgi, N. (2015). Assessing health-care providers' readiness for reporting quality and patient safety indicators at primary health-care centres in Lebanon: a national cross-sectional survey. *Human Resources for Health*,13 (*37*):1–14. doi: 10.1186/s12960-015-0031-5
2. Brubakk, K., Vist, E.G., Bukholm, G., Barach, P., Tjomsland, O. (2015). S systematic review of hospital accreditation: the challenges of measuring complex intervention effects, *BMC Health Services Research*, 1–10. doi: 10.1186/s12913-015-0933-x
3. Carayon, P., Wetterneck, T.B., Rivera-Rodriguez, A.J., Schoofs Hundt, A., Hoonakker, P., Holden, R. (2014). Human factors systems approach to healthcare quality and patient safety, *Applied Ergonomics*, 45,14–25, doi: 10.1016/j.apergo.2013.04.023
4. Coulter, A. (2017). Measuring what matters to patients: OECD Health ministers commit to patient reported measures of performance. BMJ, 356 (*j816*),1–2, doi: 10.1136/bmj.j816
5. Commission of the European communities. (2008). *Communication from the commission to the European parliament and the council on patient safety, including the prevention and control of healthcare-asociated infections*, 836 final. Accessed February 24th, 2018 at: http://eur-lex.europa.eu/legal-content/en/TXT/?uri=CELEX%3A52008DC0836
6. Dotan, D.B., Koski, K.J. (2017). How Predictive Analytics Will Prevent the Cost of Harm: A Practical Approach for Hospital Management Systems. *Pegwin*, 1–10. Accessed February 24th, 2018 at: www.pegwin.io
7. Duarte Sonia, S., Fonseca, A. (2017). Portuguese primary healthcare – sustainability through quality management. *International Journal of Quality & Reliability Management*, 34(*2*), 251–264. doi: 10.1108/IJQRM-05-2015-0066
8. Iljaz, R., Meglič, M., Petek, D., Kolšek, M., Poplas Susič, T. (2014). Adherence factors to paperless primary healthcare: a focus group study. *Zdravstveno varstvo*, 53, 42–54. doi: 10.2478/sjph-2014-0006
9. Kelley, E., Hurst, J. Healthcare Quality Indicators Project: Conceptual Framework Paper. (2006). *OECD Health Working Papers*, 23, 1–3. doi: 10.1787/440134737301
10. Kersnik, J. (2001). *Kakovost v sistemu zdravstvenega varstva v Republiki Sloveniji: pregled stanja in bodoče usmeritve*.
11. Klemenc Ketiš, Z., Tveter Deilkas, E., Hofoss, D., Tschudi Bondevik, G. (2017). Patient safety in Sovenianout-of-hoursprimary care clinics. *Zdravstveno varstvo*, 56 (*4*), 203–210. doi: 10.1515/sjph-2017-0028
12. Krczal, E., Mock, T. (2016). People-Centred Quality Indicators for Primary Care Centres. *International Journal of Integrated Care*, 16 (*6*), A300, 1–8. doi: 10.5334/ijic.2848
13. Kringos, D.S., Boerma, W.G.W., Bourgueil, Y., Cartier, T., Hasvold, T., Hutchinson, A. (2010). The european primary care monitor: structure, process and outcome indicators. *BMC Family practice*, 11(*81*), 1–8, doi:10.1186/1471-2296-11-81
14. Kringos, D., Boerma, W., Bourgueil, Y., Cartier, T., Dedeu, T., Hasvold, T. (2013). The strength of primary care in Europe: an international comparative study. *British Journal of General Practice*, 742–750
15. Ministrstvo za zdravje. (2010). *Nacionalna strategija kakovosti in varnosti v zdravstvu* (2010–2015), 13–21.

16. Ministrstvo za zdravje Republike Slovenije. (2006). *Nacionalne usmeritve za razvoj kakovosti v zdravstvu*. 19.
17. Ministrstvo za zdravje. (2010). *Priročnik o kazalnikih kakovosti*.
18. *Priporočilo - Varnost pacientov in preprečevanje okužb povezanih z zdravstveno oskrbo*. Accessed May 21th 2018, at: http://eur-lex.europa.eu/legal-content/SL/TXT/HTML/?uri=LEGISSUM:sp0009&from=SL
19. Rotar Pavlič, D., Sever, M., Klemec-Ketiš, Z., Švab, I. (2015). Process quality indicators in family medicine: results of an international comparison. *BMC Family Practice*, 16 (Suppl 172):1–11, doi: 10.1186/s12875-015-0386-7
20. Rushforth, B., Stokes, T., Andrews, E., Willis, T.A., Mc Eachan, R., Faulkner, S. (2015). Developing »high impact« guideline-based quality indicators for UK primary care: a multi-stage consensus process. *BMC Family Practice*. 16 (*156*), 1–10. doi: 10.1186/s12875-015-0350-6
21. Saut, A.M., Tobal Berssaneti, F., Moreno, M.C. (2017). Evaluating the impact of accreditation on Brazilian healthcare organizations: A quantitative study, *International Journal for Quality in Healthcare*, 1–9, doi: 10.1093/intqhc/mzx094
22. Shaw, C.D., Braithwaite, J., Moldovan, M., Nicklin, W., Grgic, I., Fortune, T. (2013). Profiling health-care accreditation organizations: an international survey, *International Journal for Quality in Healthcare*, 25(*3*), 222–231. doi: 10.1093/intqhc/mzt011
23. Shaw, C.D., Groene, O., Botje, D., Sunol, R., Kutryba, B., Klazinga, N. (2014). The effect of certification and accreditation on quality management in 4 clinical services in 73 European hospitals, *International Journal for Quality in Healthcare*, 26, 100-107. doi: 10.1093/intqhc/mzu023
24. Schäfer, W.L.A., Boerma, W.G.W., Kringos, S.D., De Maeseneer, J., Greß S, Heinemann, S. (2011). QUALICOPC, a multi-country study evaluating quality, costs and equity in primary care, *BMC Family Practice*, 12 (*115*),1–9. doi: 1471-2296/12/115
25. Schäfer, W.L.A., Boerma, W.G.W., Murante, M.A., Sixma, J.M.H., Schellevisa, G.F., Groenewegena, P.P. (2015). Assessing the potential for improvement of primary care in 34 countries: a cross-sectional survey. *Bull World Health Organ*. 93, 161–168. doi: 10.2471/BLT.14.140368
26. Schäfer, W.L.A., Boerma, W.G.W., Kringos, D.S., De Ryck, E., Greß, S., Murante, A.M. (2013). Measures of quality, costs and equity in primary healthcare instruments developed to analyse and compare primary care in 35 countries. *Quality in Primary Care*, 21(*2*), 67–79. Accessed May 20th, 2018 at: https://www.ncbi.nlm.nih.gov/pubmed/23735688
27. Shaw, C,, Groene, O., Mora, N., Sunol, R. (2010). Accreditation and ISO certification: do they explain differences in quality management in European hospitals?. *International Journal for Quality in Healthcare*, 22 (*6*), 445–451. doi: 10.1093/intqhc/mzq054
28. Slovenski inštitut za standardizacijo. (2015). *Slovenski standard SIST EN ISO/IEC 17021-1*.
29. Sporočilo Komisije – O učinkovitih, dostopnih in prožnih zdravstvenih sistemih. Accessed February 25th 2018, at: http://eur-lex.europa.eu/legal-content/SL/TXT/?uri=celex:52014DC0215
30. Svet Evrope. (2001). *Razvoj in izvajanje sistemov izboljševanja kakovosti v zdravstvenem varstvu.* Priporočilo št. R (97):7–31.
31. Tušar, S., Kociper, B., Zupančič, V. (2016). Pogled ministrstva na zadnjih 10 let kakovosti v zdarvstvu.10 let vodenja kakovosti v slovenskem zdravstvu: izkušnje, dobre prakse. In*: 9th dnevi Angele Boškin. Jesenice*: Splošna bolnišnica, 1–6
32. *Varnost pacientov in zagotavljanje oskrbe v sistemih javnega zdravstva*. Accessed February 20th, 2018 at: http://eur-lex.europa.eu/legal-content/SL/TXT/?uri=LEGISSUM:2901_5
33. *Zagotavljanje vzdržnosti zdravstvenih sistemov Evrope*. 2014. Accessed February 24th, 2018 at: http://eur-lex.europa.eu/legal-content/SL/TXT/HTML/?uri=LEGISSUM:2901_2&from=EN
34. Zavod za zdravstveno zavarovanje Slovenije. (2017). *Kako do zdravnika in drugih zdravstvenih delavcev*: *Seznam izvajalcev zdravstvenih storitev in dobaviteljev medicinskih pripomočkov iz obveznega zdravstvenega zavarovanja,* 15–30. Accessed January 13th, 2018 at: http://www.zzzs.si/
35. Wagner, C., Groene, O., Thompson, A.C., Dersarkissian, M., Klazinga, N.S., Arah, O.A. (2014). DUQuE quality management measures: associations between quality management at hospital and

pathway levels. *International Journal for Quality in Healthcare*, 26(*1*), 66–73. doi: 10.1093/intqhc/mzu020.
36. Wilson Lionel, L. (2000). The Quality manager. *J. Qual. Clin. Practice*, 20, 127–30.
37. World Health Organization. (1999). *Health 21. Regional Office for Europe*. Copenhagen. www.oecd.org/els/health-systems/health-care.quality-indicators.htm, Accessed February 24th, 2018

Povzetek:
Zagotavljanje in merjenje kakovosti v primarnem zdravstvenem varstvu

Raziskovalno vprašanje (RV): Katere so osnove zagotavljanja in merjenja kakovosti v primarnem zdravstvenem varstvu v Sloveniji in Evropi?
Namen: Namen članka je raziskati izvor in stanje zagotavljanja kakovosti storitev v primarni zdravstveni dejavnosti.
Metoda: sistematični pregled obstoječe literature.
Rezultati: Raziskava je pokazala izvor kakovosti v zdravstvu in stanje zagotavljanja kakovosti v primarni zdravstveni dejavnosti. V zdravstvu je merjenje kazalnikov kakovosti pomanjkljivo. Spremljajo jih le akreditirane ali certificirane zdravstvene ustanove**.**
Organizacija: Kazalniki kakovosti morajo biti javno dostopni podatki, saj le tako omogočajo uporabnikom storitev in zdravnikom, da izberejo organizacijo z najboljšimi kazalniki kakovosti.
Družba: Zagotavljanje kakovosti se mora začeti na primarnem nivoju zdravstvene dejavnosti, saj je ta namenjena preventivi, zdravljenju in rehabilitaciji obolenj za še kakovostno sprejemljiv nivo življenja. S tem lahko znižamo število obravnav na sekundarnem in terciarnem nivoju zdravstvenega varstva in stroške nepotrebnih zdravstvenih obravnav ter zdravljenja.
Originalnost: V teoretičnih izhodiščih smo strnjeno predstavili spoznanja o izhodiščih kakovosti v zdravstvu. Pridobili smo informacije o zagotavljanju in merjenju kakovosti v primarnem zdravstvenem varstvu.
Omejitve: Raziskava je omejena z manjšim številom obstoječih virov, ki so uporabljeni.

Ključne besede: kakovost, sistemi vodenja kakovosti, primarna zdravstvena dejavnost, zdravstveno varstvo, varnost pacientov.

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