



Special Issue / Schwerpunkt

Shared decision making and the promise of a respectful and equitable healthcare system in Peru



Partizipative Entscheidungsfindung und das Versprechen eines von Respekt und Gerechtigkeit getragenen Gesundheitssystems in Peru

Germán Málaga^{1,2,*}, Zoila O Romero^{1,3}, Ariana S Málaga¹, Sofia Cuba-Fuentes^{1,3}¹ Unidad Conocimiento y Evidencia, Universidad Peruana Cayetano Heredia, Lima, Perú² Internal Medicine Attending, Hospital Cayetano Heredia, Lima, Perú³ Family physician, Universidad Peruana Cayetano Heredia, Lima, Perú

ARTICLE INFO

Article History:

Available online: 20 May 2017

Keywords:

shared decision making
health care
medical education
quality assurance
Peru

ABSTRACT

Peru has achieved sustained development in the last two decades. However, despite this achievement, it has not been matched with improvements in the quality of education and health; investment in both sectors is among the lowest in the region. This situation perpetuates huge gaps in infrastructure and also conditions a poor literacy level of the population specifically in health.

Currently, there is a fragmented model of patient care, in which the systems are exclusive of each other. They do not cooperate or communicate with each other; and if there is no vertical communication within the system, preventing referral of patients directly from the basic level to the complex level of care when needed.

In addition, there has been no progress in the development of an empathetic, respectful or person-centered clinical practice; instead, economic, social and educational differences perpetuate a paternalistic clinical practice.

The task of orienting medical training towards the development of humanism is pending. The patient is the center of the medical act and the main objective of doctors' actions. A humanistic care approach will not only empower the person in the clinical encounter – to participate and make decisions related to his/her health care – but it will allow us to move towards an empathetic, caring, respectful and kind model of clinical practice.

ARTIKEL INFO

Artikel-Historie:

Online gestellt: 20. Mai 2017

Schlüsselwörter:

partizipative Entscheidungsfindung
Gesundheitsversorgung
medizinische Ausbildung
Qualitätssicherung
Peru

ZUSAMMENFASSUNG

Peru ist ein südamerikanisches Land, das in den letzten zwei Jahrzehnten von nachhaltigem Wachstum geprägt war. Allerdings konnte das Niveau im Bildungs- und Gesundheitswesen mit dieser Entwicklung nicht Schritt halten, denn die Investitionen in diese beiden Bereiche gehören zu den geringsten in der Region. Dieser Umstand führt zum einen zu einer Verstärkung der enormen infrastrukturellen Defizite, zum anderen ist er auch für die geringe Gesundheitskompetenz der Bevölkerung verantwortlich.

Das peruanische Gesundheitssystem ist derzeit fragmentiert und ineffizient; darüber hinaus schließen sich die Teilsysteme gegenseitig aus bzw. sind voneinander unabhängig. Es mangelt an Kooperation und Kommunikation; findet innerhalb des Systems aber keine vertikale Kommunikation statt, dann kommt es dazu, dass Patienten aus der Grundversorgung im Bedarfsfall nicht auf die komplexeren Versorgungsebenen überwiesen werden.

* Corresponding author: Dr. Germán Málaga, Unidad Conocimiento y Evidencia, Universidad Peruana Cayetano Heredia, Lima, Perú.
E-mail: gmalaga01@gmail.com (G. Málaga).

Darüber hinaus ist der Umgang von Ärzten mit ihren Patienten nicht empathischer, respektvoller und patientenorientierter geworden. Stattdessen hat aufgrund der ökonomischen, bildungsbedingten und sozialen Unterschiede zwischen Ärzten und Patienten der Paternalismus im Praxisalltag nach wie vor Bestand.

Die Entwicklung einer an humanitären Grundsätzen orientierten medizinischen Ausbildung ist eine dringliche Aufgabe. Hierbei steht der Patient im Mittelpunkt der medizinischen Behandlung und der ärztlichen Aufmerksamkeit. Ein humanistischer Versorgungsansatz würde nicht nur den Patienten dazu befähigen, sich an ihn betreffenden medizinischen Entscheidungen zu beteiligen, sondern würde auch Schritte in Richtung einer von Empathie, Fürsorge, Respekt und Zuwendung getragenen klinischen Praxis ermöglichen.

Peru is sadly famous for having promoted the forced sterilization of more than 300,000 women in the 1990s from the government. We are now more aware, human rights institutions have more voice, but the structures of inequality, illiteracy and inequity, have not substantially changed.

Peruvian health care system

Peru is a South American country located in the Andean region, south of the equator line, on the coast of the Pacific Ocean. Its population reaches 31 million inhabitants, with a 78% urban population. Its governmental system is best described as a presidential republic of democratic representation since 1980. It is considered a lower/middle income country, with a life expectancy at birth of 77.7 years for women and 72.5 for men, and an infant mortality rate of 17 per 1,000 live births, which has fallen more than 60% in the last two decades [1].

After two decades of strong economic growth, Peru has made considerable health advances, including reduction in illiteracy and infant mortality [2]. The economic growth has been accompanied by a considerable reduction in the proportion of the population living in poverty, significant migration to urban centers, and a shift in mortality causes from infectious to non-communicable diseases. Unfortunately, these changes in the Peruvian economic and demographic structure have not led to changes in delivery of health services and focus still remains on secondary and tertiary care [3]. Meanwhile, there is a vast and systematized evidence [4] that strengthening primary care results in a better health system and better care, in addition to making the health system cost-effective, which for our low- and middle-income countries (LMIC) would be a notable and necessary benefit [5].

In contrast to Europe, there are few countries in Latin America with a nationwide health system. Peruvian health system is fragmented, with at least five main subsystems, resulting in great variation in the content of care, the type of health coverage, and how the various levels in the system interact with one another. The main subsystems provider of healthcare services is the *Ministry of Health (MINSA)* (70%) and *Social Security (ESSALUD)*, for those who are “employed and salaried” (13%), followed by private health care providers and the *Armed Forces and Police Health Network* [2]. Additionally, other institutions, such as nongovernmental organizations and municipal providers, sometimes offer healthcare services. According to the *National Household Survey*, 29.8% of the population does not have any kind of health coverage [3].

Moreover, Peru offers health coverage known as the “*Seguro Integral de Salud*” (SIS) for citizens living in poverty where they can benefit from a theoretical coverage of 100%, pending budget availability. For example, in 2016, some MINSA facilities had already exhausted their budget by October which led to minimal if not non-existent coverage for care and from then until their new budget in January 2017. Being covered by SIS or ESSALUD does not

guarantee access to healthcare services either. In many cases, due to the economic limitations and services covered by any of these subsystems, citizens choose to seek private services with direct payment to the physician, including those offered as “charity hospitals” by municipalities. For example, it is estimated that less than 50% of ESSALUD policyholders actually use its services [6].

The number of patients assigned to a health facility is variable, as is the number of clinicians and staff members per health facility. There are rural centers where a clinician and his/her team care for 500 people, and there are urban centers where the health care team can be in charge of up to 140,000. In general, MINSA health facilities include three levels: *health posts*, which are usually the smallest and located in the more rural or remote areas, and that might not be staffed by a clinician; *health centers* that are usually staffed by at least one clinician, as well as the rest of the primary health care team, and which may provide urgent care as well as its other services; and *hospitals* which receive the patients referred from the other levels.

Generally, the primary care health team consists of a general/family clinician, a nurse, an obstetrician (midwife), a nurse technician and, in some cases, other professionals such as dentists, social workers, psychologists or nutritionists. In addition, there is the figure of the community health promoter, who is usually a member of the community who has received brief training and serves as a link between the community and health teams; community health promoters work as volunteers.

There is great access variability for patients in the different systems, for example, to see a family doctor in ESSALUD. Appointments are made by telephone and waiting lists of up to 20 days have been quantified [7]. At MINSA, patients go to the health facility closest to their home every day, as early as possible, at risk of not getting an appointment. Patients who cannot or do not want to wait go to the emergency services of the closest health center (if available), go to the hospital or seek care within the private system.

In the public system doctors work 150 hours per month, which are normally distributed in shifts of six hours daily and 6 days per week. Each day, a clinician attends between 16 and 24 patients during the 4 hours of care work; the other two hours are dedicated to administrative tasks, management of health programs or home visits [8].

A large number of health facilities do not have family clinicians, particularly health posts. Moreover, in most health centers, the clinician is a general practitioner who has not received a postgraduate training in Family Medicine. Thus, many patients with problems that could potentially be resolved at the primary care level (social problems, multi-morbidity, mental health problems, etc.) are referred to hospitals [8]. In addition, many referrals are generated for laboratory tests or medications, since many primary health centers are scarcely equipped [9]. For example, MINSA’s primary care pharmacological request does not include insulin, and there is often a shortage of antihypertensive drugs and oral hypoglycemic drugs at health centers.

Download English Version:

<https://daneshyari.com/en/article/5123572>

Download Persian Version:

<https://daneshyari.com/article/5123572>

[Daneshyari.com](https://daneshyari.com)