Patient's Satisfaction as a Subjective Criterion for Assessing the Quality of Work in Primary Level Healthcare Protection Units in Bosnia and Herzegovina

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Background: The quality of healthcare and therefore primary healthcare and its measurement is a theoretical problem. However, its practical performance turned out to be even greater. However, we must always keep in mind the importance of not only primary healthcare as one of the key branches of the healthcare system, but above all its quality. Quality assessment is the first step in quality assurance and includes the analysis of structural, process and outcome variables. Objective: This article deals with that issue - assessment of the quality of work is one of the key elements in primary healthcare. Methods: This is cross-sectional study about quality assessment of patient's satisfaction in PHC units in Bosnia and Herzegovina regarding AKAZ standards and rules. Results and Discussion: Namely, primary healthcare, which operates at the municipal level and serves 10,000 to 50,000 inhabitants, must be carried out with quality, in order to raise the health standard in the country to a higher level. All countries, including ours, strive to provide high-quality healthcare services to residents with the available resources. With this idea, the Agency for Quality and Accreditation in Healthcare FBiH (AKAZ) was formed with its headquarters in Sarajevo. It is the competent authority in the field of improving the quality and safety of healthcare services. AKAZ offers a unique program to improve the quality and safety of healthcare services for healthcare centers, family medicine teams, hospitals and private health institutions in the Federation of Bosnia and Herzegovina. The agency was established to work in cooperation with healthcare professionals and help them improve standards of quality and safety of healthcare. The manner in which we will collect the data we need to assess the quality of work is in the form of a questionnaire. This directly addresses residents, healthcare service users. Only from them will we receive appropriate information on the functioning or non-functioning of the healthcare system. Conclusion: More precisely, we can directly conclude whether a problem that has appeared is a problem of the entire healthcare system (at the level of the municipality, canton, entity, state), or whether it is a problem of a narrower nature. Namely, the problem can also be at the level of the healthcare center or even the practicing doctor. Such data are of great use to us in order to improve the entire healthcare system, starting from the practicing doctor, the family medicine team, and so on all the way upward to the competent political authorities.

Keywords: Quality assessment, PHC, patient’s satisfaction, AKAZ.

1. BACKGROUND

In order for the complete healthcare system to function as well as possible, and to be able to perform all tasks, it is necessary to introduce a unique system for assessing the quality of work of primary healthcare. Namely, healthcare is considered high-quality if it provides adequate healthcare to those who need it, but at the same time has low organizational costs. The quality of healthcare and therefore primary healthcare and its measurement is a theoretical problem (1-5). However, its practical performance turned out to be even greater. However, we must always keep in mind the importance of not only primary healthcare as one of the key branches of the healthcare system (if not the main one), but above all its quality. Quality assessment is the first step in quality assurance and includes the analysis of structural, process and outcome variables (6-10).

Quality medical care is the complete fulfillment of the needs of those who need healthcare services the most, at the lowest cost to the organization, and within the limits and guidelines set by health authorities and financiers. (Ovretveit J. Health Service Quality. An introduction to Quality Methods for Healthcare services. Blackwell Science, Oxford 1998:2.) (11-16).
QUALITY DEFINITION

Quality is one of the fundamental philosophical concepts (lat. qualitas) that denotes the determination of an object or phenomenon by which it differs from other objects or phenomena, by which it specifically relates or reacts to other objects or phenomena (1, 2). Specifically, in our case when it comes to the quality of primary healthcare, the quality of healthcare services means the degree to which users received certain healthcare services according to established standards. There are other definitions of quality healthcare that formulate the same idea in a different way. One of these is Lohr’s definition, which defines the quality of healthcare as: “the degree to which healthcare services for individual patients and populations increase the likelihood of desired health outcomes and which is consistent with current professional knowledge” (1, 2).

Grant defining quality as “The capacity of an object to achieve a goal by means of its characteristics” (1).

Considering that in medicine and healthcare, the wishes, needs and demands of healthcare users should be met first and foremost, we adhere to the following definition of quality healthcare: “Quality medical care is the potential of the elements of that care to achieve justified medical and non-medical goals of patients and doctors”. WHO: definition: Good quality means healthcare that meets the needs of an individual, family or community and is provided under the most acceptable and appropriate conditions (2).

It is very difficult to define quality in the context of healthcare. This is why many theorists have focused on defining quality in relation to different dimensions of protection rather than creating a single general definition.

Maxwell’s six dimensions of quality (2):
• Admissibility;
• Effectiveness;
• Efficiency and economy;
• Access;
• Impartiality (fairness);
• Connection with the requirements (of the whole society);

Donabedian’s seven pillars of quality (2):
• Success: The ability to improve health with the best care;
• Effectiveness: The degree to which realizable improvements in health are achieved;
• Efficiency: The ability to achieve the greatest possible improvement in healthcare at the lowest cost;
• Optimality: The most favorable balancing of costs and earnings;
• Acceptability: Alignment with patient priorities regarding affordability, patient-doctor relationship, benefits, outcomes, and costs of care;
• Legality: It concerns all of the above;
• Impartiality: Fairness in care delivery and its impact on health.

2. PROJECT FOR MEASURING THE QUALITY OF HEALTHCARE SYSTEM AND HEALTHCARE PROTECTION IN BIH

The committee or project team has overall responsibility for managing the quality and safety improvement process, such as AKAZ’s accreditation program (17, 18). Depending on the type and size of the institution, representatives of project working groups (PWG) may be included in the work of the quality committee. The number of PWG is determined by the Commission according to groups of standards and the horizontal connection of standards/criteria. A multidisciplinary composition of PWG with no more than 12 members is recommended (the absolute minimum is 3 members per one PWG). For participation in PWG, volunteers and several small groups are preferred, rather than several large ones, so that one person can be a member of more than one PWG. Management representatives also participate in self-assessment and improvement of quality and safety.

The mission of the PWG is to perform a self-assessment, by answering questions about the fulfillment of the criteria in the self-assessment forms. After the distribution of the standards, the Commission gives clear tasks to each PWG, coordinates the self-assessment and collects the completed self-assessment forms. The responsibility of each PWG is to provide credible answers about the fulfillment of standards/criteria (“shared condition diagnostics”). One of the commission’s tasks is to prioritize the corrective and preventive activities of all PWGs in order to improve quality in the institution (for other obligations of the commission and the quality coordinator in the health institution, see the Methodological Instruction). Management (or the Commission) should develop a Project Staff Information Plan (PSIP). The reason for this is that the entire staff of the institution participates in the quality project, so PSIP also applies to staff who do not directly participate in the project. Informing about the quality project includes the involvement of local media in monitoring the development of the quality project. Informing is achieved through the distribution of minutes, notices on bulletin boards, newsletters, e-mails, web pages, etc.

Project planning techniques include:
• analysis of project tasks;
• delegation of tasks to PWG members and creating a Gantt chart.

Task analysis is the division of the entire project into smaller parts and identifying the people who are responsible for completing the tasks in a defined timeframe. In doing so, all tasks are divided into parallel and dependent. As their name suggests, parallel tasks are those that can be done at the same time as one or more other tasks. Dependent tasks are those that cannot be started until the previous task has been completed (for delegating tasks there is a special ready-made form that needs to be filled). Gantt charts are used to show the overall flow of a project. They arise from the anal-
ysis of tasks and the planning of specific goals in relation to a defined time plan. At the same time, they show which tasks are “parallel” and which are “dependent”. They are useful to look back at activities in relation to a given time. Other details on quality improvement project management can be obtained by management and health professionals through training.

3. SELF AND INTERNAL ASSESSMENT

Today, the systematic improvement of the quality of healthcare and services is the professional duty and responsibility of service providers, which is implemented in a friendly climate of non-punishment for sporadic poor performance and which becomes part of routine work. The emphasis is on good organizational leadership, establishment of appropriate structures and functions for safety and quality, management commitment to quality improvement, teamwork that crosses the boundaries of a department and/or organization, self-evaluation, self-regulation, incentives for good performance and adequate resources.

Healthcare institutions cannot enter the demanding accreditation program without the Agency’s help, which, of course, implies a previously established quality improvement system. For this purpose, when concluding contracts with agency, they undertake to provide them with all assistance, including the engagement of a more experienced health professional or more in the role of facilitator. Facilitation can last from 6 to 12 months or longer, which depends on the success of the institution that enters the accreditation program.

When you register your participation in the accreditation program, you will receive a comprehensive set of standards related to the systems and processes in the provision of healthcare services in your organization. Before that, it is necessary to appoint a quality coordinator (in this case he has the function of project coordinator) and establish a committee for improving quality and safety. The Quality Coordinator coordinates all service improvement activities in your institution and establishes links with agency and is in constant communication with the Facilitator. The agency provide training to help the facilitator implement the local project, covering issues such as: starting the project, gathering staff, organizing meetings, preparing documentation and training internal evaluators. The training uses materials related to project management, which together form a useful resource package for facilitators.

There are three key stages in the accreditation program (17, 18):

- internal self-assessment according to standards;
- action planning (development of action plans);
- and the development of services that follows external collegial evaluation.

During the process of preparing for the external evaluation on a collegial basis, the health facility is assisted by a facilitator from the Agency, who is an experienced health professional and who advises and interprets the standards and helps in the management of the quality improvement project. The facilitator will know the health facility well and can be an invaluable source of information and significant support to the health facility.

4. THE CONCEPT OF QUALITY AND VARIABLES FOR ITS MEASUREMENTS AND EVALUATION

The concept of quality includes at least three dimensions and therefore has three different meanings (18):

- Comparative meaning in terms of degree of enforceability;
- Quantitative meaning in terms of level reached;
- Suitability of something for certain purposes, or feature to satisfy certain needs.

In our specific case, this means that we have three dimensions of quality healthcare (18):

- Quality for the user: what users and carers want from the service;
- Professional quality: doctors and other experts assess whether the patient’s needs are met; whether the services are technically correctly provided; and whether appropriate procedures have been applied to meet the needs of users;
- Quality of management: medical care is evaluated in relation to efficiency; efficiency and productivity, within the given limits and guidelines prescribed by political and financial decision-makers in the healthcare system.

In order to assess the quality of primary healthcare, it is necessary to obtain quality health information. For this purpose, we primarily use primary medical information. They arise from the direct contact of health professionals with the patient, non-medical professionals working in healthcare with the patient, mutual communications between health professionals, health workers and healthcare financiers, health professionals with non-medical workers working in healthcare, etc. By definition, primary medical information is created in elementary patient-doctor communication and is of inestimable importance for the needs of solving medical problems and for decision-making. However, most of the primary information is oral and remains only in the memory of health professionals as observed changes in the patient’s condition. Secondary medical information is created from primary by selection and summarization - reports on medical procedures, assessment and quality assurance of the professional work of healthcare personnel and organizations, monitoring and evaluation of programs by administrators in health insurance, analysis of the health status of the population by public health experts. Tertiary medical information is scientific research health information.

Poor quality of healthcare can be categorized as excessive, weak and inadequate use of resources, as weak technical or interpersonal skills and beliefs, which
can ultimately lead to increased risks for patients and user dissatisfaction with the services provided or the overall healthcare system. That's why quality assessment tends to create such a system of standards that can show when the provision of healthcare services has fallen below the permissible limits resulting from those standards.

Quality assurance includes assessments of the current level of quality and corrective actions aimed at eliminating observed deficiencies. Quality assessment is therefore the first step in quality assurance, and includes the analysis of structural, process and outcome variables. It is quite clear that the idea of using information technologies in the quality control of healthcare in general, and therefore also of primary healthcare, arises here. But, not only in our country, but also in many developed countries, that idea is still an idea of the future. The reasons for such a situation are as follows:

- The data needed for assessment and quality assurance are only a byproduct of routine data in existing health information systems;
- Sensitive quality indicators are still not clearly defined;
- There is often a high degree of errors in data collection, as well as difficulties in connecting data on one patient across different levels of protection;
- Financial resources for information support in quality assurance are lacking in many departments;
- Computers prove useful only in some links of the quality assurance cycle, such as the area of data collection, their analysis and interpretation, and as reminders, while they are not useful in the formation of quality control groups, choosing priorities, setting standards and choosing methods.

At the conference on primary healthcare held in Alma-Ata in 1978 and promoting the goals of "Health for all by the year 2000", the need for quality assurance and assessment emerged. According to the international specification (ALPHA Standards for Accreditation Bodies), in May 2003, the development of accreditation standards for primary and hospital healthcare was initiated. In our country, the assessment of quality assurance in primary healthcare mainly referred to the share of professional work in health institutions, including the quality of health personnel such as the level of education, length of service, working conditions, equipment, etc. Initial attempts at quality assessment in PHC were made by creating a pilot model with a point scale for the proposed variables and indicators. The choice of variables related to structural, process and outcome elements. In this way, the model connected all three approaches to quality measurement. Based on the proposed variables, a proposal for the point value of each variable that represents the rank of importance in the process of providing healthcare services was given. The defined indicator for the assessment of structural, process and outcome elements were thus classified. Comparison of the obtained sum of points for the provided health service with the index of high-quality healthcare (total value is 100 points) gives an answer to the level of achievement of the provided health service.

There are many conceptual models of quality assessment, and the most commonly used is Lang's model (1976), which is modified and adapted to the quality assurance program by those who use it.

**Stages in the implementation of the quality assurance program according to the revised Lang model:**

- Determine and accept the value of healthcare;
- Study professional literature, known quality assurance programs and funding sources;
- Analyze existing programs;
- Determine the most acceptable quality assurance programs;
- Establish standards and criteria for outcome, process and structure;
- Adopt standards and criteria;
- Evaluate the existing levels of protection according to the adopted standards;
- Determine and analyze factors that are important for results;
- Select appropriate activities to maintain or improve protection;
- Application of selected activities;
- Evaluation of the quality assurance program.

It is impossible to assess the quality of healthcare if it is not presented in detail through measurable terms, therefore it is necessary to determine criteria and standards.

**QUALITY CRITERIA**

They describe the activities to be performed, while the standard indicates at what level these activities must be performed.

**Criteria:**

- Measurable - describe the standard and offer local benchmarks;
- Specific - provide a clear description of behavior, desired or required action, situation or funds;
- Relevant - represent items that are easy to determine and that are necessary in order to achieve the established level of performance;
- Easy to understand - and each one should contain only one main theme or idea;
- Clearly and simply presented - so as not to be misunderstood;
- Achievable - because it is important to avoid unrealistic expectations of work methods or results;
- Clinically reliable - which means that they were chosen by general practice doctors who follow developments in medicine and whose knowledge is based on reliable research or documentation;
- They must be reviewed periodically to ensure that they reflect good practice based on existing
They reflect all aspects of the patient’s or client’s condition, i.e., physiological, psychological and social.

We divide quality improvement methods into internal and external quality reviews.

Internal quality reviews are:

- Interviews with patients, families or doctors;
- Studying medical records;
- Peer review;
- Medical audit;
- Track tracking;
- Patient satisfaction;
- Prospective methods; clinical practice guidelines, clinical pathways, protocols, algorithms and decision trees;

External quality inspection methods are:

- Accreditation;
- Adherence to ISO standards;
- Acting on EFQM recommendations;
- Visits.

**DIMENSIONS OF HEALTHCARE QUALITY**

Each of the dimensions of quality can, to a greater or lesser extent, help the planners and developers of certain types of healthcare with the aim that the final outcome, i.e., a specific health service to a healthcare user shall be (1-3, 5):

- rational,
- efficient and
- economical.

These are the three basic attributes of healthcare quality.

The most important dimensions of quality are the following:

- **AVAILABILITY OF HEALTHCARE SERVICES**, which means that primary healthcare should be equally accessible.
- **ADEQUATE HEALTHCARE**, which means that the appropriate patient, in the given working conditions of health professionals, should be provided with appropriate quality healthcare in accordance with legal and by-laws in the competent primary healthcare institution, and according to the adopted standards and norms of healthcare.
- **EFFECTIVENESS OF HEALTHCARE**, a dimension that assumes that the provided healthcare services can be measured in accordance with the prescribed valid standards of healthcare services.
- **SAFETY OF HEALTHCARE** means that every patient must be sure of the health service provided.
- **EFFICIENCY OF PROVIDING HEALTHCARE SERVICES** implies “minimization of expenditure, maximization of effect”.
- INTERSECTORAL COOPERATION implies that patients themselves, individually or through appropriate institutions and agency, participate in creating and making decisions in the provision of healthcare.

**INDICATORS FOR ASSESSMENT OF QUALITY**

Indicators are an effective tool for monitoring the performance, enable comparison with previous periods, with different territories, with established norms, and signal when it is necessary to carry out more detailed research. They are not essential for continuous quality improvement (1, 2).

**Structural indicators:**

- Characteristics of health insurance;
- Level of education;
- Level of continuous education;
- Organization of work;
- Work technology;
- Level of remuneration.

**Process indicators:**

- Doctrinal positions for a specific health problem;
- Process technique of doctors for setting diagnosis and therapy for certain diseases;
- Health records as a source of requested information about the procedural technique of the doctor’s work.

**Outcome indicators:**

- Examining the degree of patient satisfaction with the provided healthcare services;
- Examining the level of satisfaction of patients, that is, healthcare staff;
- Monitoring the effect of the applied treatment.

If we apply these points to individual areas of primary healthcare, we get the following:

**Indicators for measuring the quality of healthcare for mothers and children:**

- Frequency of care (number of women who had at least three examinations before childbirth),
- Timeliness of care (number of women who started examinations before 16 weeks),
- Content of care (number of women who measured their blood pressure, urine control and received two doses of tetanus anatoxin),
- Instructions for further treatment (bleeding during pregnancy, neonatal jaundice, hypertension,...),
- The percentage of staff who have spent a certain amount on specific trainings in this area,
- The quality of the material resources used to provide primary healthcare in this area.

Quality can also be assessed based on the number of referrals that are technically incorrect compared to the number of referrals received.

**Indicators for examining the quality of perinatal healthcare:**

- Timely provision of care (number of births that started in the initial phase),
- Content of care (number of cases in which a physical examination of the pregnant woman was performed),
- Newborn care (number of cases in which new-
borns were correctly examined and treated - correctly tied cord),
• Number of cases where pregnant women were given advice on childbirth, breastfeeding,...
• BMI of children
• Percentage of children with a birth weight of less than 2,500 g.

Indicators for measuring the quality of healthcare for children:
• Frequency of examination of children;
• Percentage of children whose body weight and height were measured;
• Percentage of children with anemia;
• Percentage of immunized children;
• Indicators for measuring the quality of home care:
• Number of home visits in which inadequacy of food preparation conditions was determined;
• The number of cases where the presence of insects was found in the room where children under 5 years;
• Number of follow-up visits where a high degree of risk of illness was detected.

Patient satisfaction with healthcare services as a subjective criterion for quality assessment in healthcare

In dictionaries, we can find a whole range of alternative definitions, the most suitable of which are “satisfaction of a desire or need” and “ensuring the necessary conditions for the fulfillment of a desire or need”. In terms of the quality of healthcare, this means that the patient feels that his wishes or needs are met.

Pascoe defines patient satisfaction as a “recipient of healthcare” as a reaction to important aspects of the context, process and results of his experience. Patients may express a low degree of satisfaction with a doctor who, according to certain technical standards, provides quality healthcare, simply because they do not share his opinion about what is considered quality healthcare.

5. AGENCY FOR QUALITY AND ACCREDITATIONS IN HEALTHCARE FBiH-AKAZ

Most of the methods for improving the quality of healthcare originated in the USA and were adapted to the needs of the countries where they are applied. On the other hand, indicators and methods of assessment, assurance and improvement of quality in primary healthcare cannot be directly downloaded and exchanged between countries with different healthcare systems, clinical practice and cultures. Scarce data in the archive of general practice, considering the possibility of their use as well as their availability, represents a significant difficulty in the assessment of quality in primary healthcare. Without major investment in healthcare information systems at the national level, quality assessment will always be expensive, time-consuming, unreliable, and of dubious value. Only good information technology enables the progress of the quality assurance improvement program.

The Agency for Quality and Accreditation in Healthcare FBiH (AKAZ) was established with its seat in Sarajevo (17, 18). The Agency was established on the basis of the Law on the System of Quality Improvement, Safety and Accreditation in Healthcare (Official Gazette of the Federation of Bosnia and Herzegovina No. 59/07), which was adopted by the Parliament of the Federation of Bosnia and Herzegovina at the session of the House of Representatives on April 13, 2005, and at the session of the House of Peoples on July 29, 2005 year (attached). The Law on the System of Quality Improvement, Safety and Accreditation in Healthcare was published. The law cannot prescribe quality, nor is it possible to carry out quality inspections in healthcare institutions. Quality can be assessed only by health professionals equal in rank to those they assess (doctors, nurses, managers). That's why the accreditation of medical institutions is, in essence, a process of peer review and joint work of trained assessors and the evaluated health institution. An adequate patient satisfaction scale must meet three requirements: it must be reliable (provide robust results), qualitative (assess what needs to be examined), and demonstrate transferability (18).

• It is in the interest of the family doctor/general
practice to find out to what extent patients are satisfied with the services provided to them.

• In order to determine the degree of the patient in a meaningful way, it is important to establish quality and reliable criteria that provide the offices with the information they need to evaluate the quality of the process and results of healthcare.
• An adequate scale for measuring the degree of patient satisfaction implies internal reliability, quality content and transferability.
• The Patient Satisfaction Questionnaire is a useful tool for determining how satisfied patients are with the services provided, and it allows family physicians to determine how successfully they are meeting the needs of their patients.

FUNCTIONS OF AKAZ
The main functions of AKAZ are:

• development and revision of accreditation standards: organizational and clinical
• development and revision of clinical guidelines based on evidence-based medicine
• definition, development and revision of execution indicators, i.e., quality parameters for the purpose of stimulating financing of health institutions together with other actors (line ministries, public health, health insurance institutes
• collection, processing and analysis of data from health institutions and providing information to health institutions for the purpose of education and comparative analysis (for example, fulfillment of quality parameters, incidents)
• resource center: AKAZ provides access to appropriate databases, professional and “grey” literature, collects information on good practice from the country and abroad, exchanges it and compares it with information from other countries
• education and training: AKAZ organize education and training in the field of quality and safety of healthcare services for health and other professionals
• Facilitation in raising the quality and safety improvement system in healthcare institutions based on the requirements of the accreditation standards
• external assessment of health institutions for the purpose of accreditation
• domestic and international cooperation in the field of quality and safety of healthcare services.

The application of accreditation standards leads to the development of services and the improvement of quality and safety in the entire health institution. Today, many advantages of accreditation have been proven both for healthcare institutions and for doctors, patients and healthcare financiers. AKAZ can currently offer the following products and services in the form of four packages:

Package 1 - Accreditation standards for healthcare centers, family medicine teams and hospitals

Package 2 - Education and training for the quality and safety of healthcare services - basic and advanced

Package 3 - Facilitation of health institutions in establishing systems, improving the quality and safety of healthcare services

Package 4 – External examination of the health institution for the purpose of accreditation

Accreditation is a model of external evaluation of healthcare organizations on a collegial basis and a formal process in which an independent, usually non-governmental agency defines, evaluates and monitors the fulfillment of explicit and published quality standards in healthcare institutions, compares the institution’s performance with the standards, recognizes and/or recommends measures for quality improvement. Accreditation is usually voluntary and, in some countries, legally required (e.g., in France).

In the period from 2005 to 2010, the accreditation standards for healthcare centers underwent a new revision (17, 18). The basic concept has not changed, the same way of numbering the standards/criteria has been retained, but the numbers have been changed for correspondence and deletion of certain criteria.

6. ORGANIZATION OF STANDARDS FOR HEALTHCARE CENTERS
Standards form the backbone of shaping organizational quality. Standards are statements of expectations or some values that describe the level at which the service will be provided, taking into account that they must be significant, objective, understandable, desirable, realistic, measurable, achievable, flexible, acceptable, adaptable, and professionally and consensually accepted. Accreditation standards are statements of expectations of patients, health professionals, managers and other actors, based on which health institutions self-assess to improve the quality and safety of the services they provide and to earn accreditation recognition after external peer review (16, 17). Standards define not only the necessary resources and organizational agreements, but also various criteria, policies and procedures, for example qualifications of clinical and support staff and acceptable levels of performance of the procedure itself, instructions on the circumstances and conditions of performance, etc.

Based on the harmonized accreditation standards, each organization defines its policies in more detail by which they determine the offer of services, the place and time of service provision, and who is eligible to provide and receive such service; working procedures and protocols, which direct and determine daily tasks (detailed description of the procedure, who provides the service and to which clients; forms and other supporting documentation). Procedures are essentially psychomotor tasks that are broken down into steps in the form of an algorithm or flowchart, or the work processes are described narratively.
According to the level, the standards can be divided into minimum, optimal and excellence standards. Minimum standards must be 100% met, since anything below the agreed minimum means an unacceptable service or product. The standards for various government inspections are usually minimal. Optimal standards, the usual standards for the accreditation of healthcare institutions, indicate the best possible level that can be achieved with the available resources under the given conditions. Therefore, they do not represent a theoretical maximum, but care is taken to ensure that these standards can be met in most cases even in an average healthcare facility. Finally, standards of excellence indicate maximum requirements and usually refer to tertiary healthcare centers, especially reference health institutions.

According to the type, the standards are divided into structure, process and protection outcome standards. The standards of the structure define the necessary resources – human, financial and physical; process standards define activities and processes in a healthcare institution, while outcome standards refer to the results of those activities. Previous research shows that more resources do not ensure better care outcomes, but it becomes evidence that the fulfillment of process standards and criteria leads to better results of patient treatment.

According to the focus, the standards are divided into organizational and clinical. That division is quite artificial, since these sets of standards must be harmonized in order to be operational.

The standards for healthcare centers are divided into 6 parts (16, 17):

- Management of healthcare centers
- Risk management
- Quality improvement system
- Focus on the patient
- Organization and provision of healthcare services
- Technical services

Within each part, statements of standards are formulated that describe the desired performance that can be achieved by satisfying a number of criteria (18). For the sake of clarity, the criteria are gathered under the names of specific chapters. Each of the criteria has its own weight in order to determine those that are associated with essential practice and those that are associated with best practice that the healthcare center should emulate. Essential criteria include the requirements set before the healthcare center by legislation, professions or ministries of health, then patients’ rights, potential risks for patients, users and staff, and accepted written or unwritten standards of good organizational and clinical practice (20). Quality practice criteria are those that go beyond basic good practice and represent a real challenge for every healthcare center to achieve the highest level of quality (18-20). In this phase of testing the accreditation program, it is yet to be determined which criteria are essential and whether they can be met, which criteria are essential but for various reasons cannot yet be met, and which met criteria really represent quality practice that goes beyond the usual requirements.

At this point it should be stated that health professionals from hospital healthcare they did not develop standards for all functions of a healthcare center, since British standards are higher managerial and generic oriented. In order to fill that gap, AKAZ is together with health professionals formulated more standards and criteria from the sixth part Specific clinical services, which is an incentive for commenters to review and comment first those proposals, and then to give their suggestions for filling in new criteria that will be better reflect existing practice. Commentators are left free to add new ones standards and criteria that they consider to be indispensable in each of the parts of this draft standard. This should not be surprising as we are in the phase where it is being tested first accreditation program whose core is these standards.

As it was said, the first part contains management and management of healthcare centers, or part for the management of the healthcare center. The task of top management is to determine and obtain resources for the implementation of the quality improvement strategy, quality management, patient and staff satisfaction and experience surveys, and - in general - for the achievement of organizational goals.

The second part is designated for risk management. Local risk management systems are designed to help healthcare organizations manage risk effectively and reduce the chance of adverse events occurring. Patient safety is a key component of risk management and should be integrated with staff safety, complaints management, litigation and financial and environmental risk assessment. There are clinical and non-clinical risks with corresponding performance indicators to be monitored and controlled. The reporting system generates information and enables proactive risk assessment.

The third part is designated for the improvement and monitoring of healthcare standards and the quality of service for which the healthcare center is responsible. It consists of clinical audit, implementation of evidence-based practice, a program of research and development in the domain of healthcare services, and continuous professional development.

The fourth part is designated for the patient and contains patient rights and information for patients. Research shows that patients accept bad news if it is communicated to them in a timely, complete and respectful manner. Patients expect an honorable attitude of medical teams towards them, and this openness minimizes and alleviates the trauma they have and feel. Patients who are not apologized to or explained by staff are more likely to complain and seek financial compensation. The organization should have a policy on dis-
closure of adverse events to patients that could lead to harm or death.

In the fifth part, health promotion and disease prevention are emphasized. In addition, the criteria of integrity and continuity of healthcare, treatment of chronic patients, pediatric services, dental services, family medicine services, palliative home care and dispensaries and counseling centers for the protection of mothers and children are described. In the fifth part, the criteria for minor surgical procedures, palliative home care, emergency services, mental healthcare center are also described (17).

In the sixth part, there are regulations on the maintenance of the facility, the apparatus, the staff who perform it, then the work of the kitchen and its staff, cleanliness maintenance and the staff who perform it, the transport service and the reception.

7. REVIEW OF PHC STANDARDS IN HEALTHCARE CENTERS

- Part I: Management and management of the healthcare center (1A.1 – 1N.574) (17).
- Part II - Risk management (2A.1 – 2G.221)
- Part III - Quality improvement system (3A.1 – 3C.77)
- 3A.: Elements of a quality improvement system
- 3B: Medication Management
- 3C: The opinion of the staff about the quality of their own work
- Part IV - Focus on the patient (4A.1 – 4J.289)
- Part V - Organization and provision of healthcare services (5A.1 – 5M.470)
- Part VI - Technical services (6A.1 – 6E.99)

The measurement of satisfaction should be carried out so that the obtained information can be incorporated into the model of the quality of services in primary healthcare and healthcare in general (16, 17). Several scales for measuring patient satisfaction with healthcare have been defined and applied in practice, of which the most cited are the Likert scale, by the author of the same name, and the EUROPEP scale, recommended by the Expert Group of the World Health Organization. In Bosnia and Herzegovina, the EUROPEP scale and the scale by Mašić et al. have been used the most so far (21-23). The latter was tested in the Research Studies of Selim Toromanović et al. Also, an expert group at the Vrazova Family Medicine Education Center, which is part of the Sarajevo Healthcare center in Sarajevo, tested the EUROPEP questionnaire for researching user satisfaction with family healthcare in the Sarajevo Canton (21).

INVESTIGATION OF THE QUALITY OF PHC WORK

It is necessary to continuously examine the satisfaction/experience of the patient, which is one of the basic parameters, although not the only one, of the quality of the work of the medical staff. The reason for this is that today’s patients are better informed than before; they are true partners in debates regarding optimal control; they know more about the outcome of medical care, especially for patients with chronic diseases, and because their experiences very often remain unknown to doctors.

One of the interesting spontaneous ways of getting the patient’s opinion about the work of his doctor, without directing the answer, is the Book of Impressions. The book provides the opportunity to freely and anonymously express satisfaction with the services provided. Unfortunately, the Book of Impressions is poorly or not at all used in Family Medicine units, either it is not there or it is not available to the patient.

In 2004, the Ministry of Health of FBiH using the EUROPEP questionnaire. Otherwise, the EUROPEP questionnaire is a standardized instrument, designed in such a way that the variables from this questionnaire could be used to make an international comparison of the satisfaction of healthcare users in Family/Family Medicine. The questionnaire contains 23 questions on a Likert scale from 0 to 5 points, and additionally defined questions related to demographic data (respondents were offered three documents: written information about the research, written consent and a questionnaire). The sample consisted of 300 consecutive patients out of a total of 2,600 registered in the Education Center at the Vrazova Healthcare center (21).

Questions that the questionnaire contained (21):

1. Does the doctor devote enough time to you during the examination?
2. Does your doctor show interest in your problem?
3. Does the doctor allow you to tell him your problem?
4. Does the doctor introduce you to the necessary treatment and lifestyle?
5. Does the doctor listen carefully when you present your problem?
6. Does the doctor care about the confidentiality of your health problem/health data?
7. Does it relieve your discomfort quickly?
8. Does it help you feel better and get back to your daily work?
9. Do you have the impression that the doctor does his work thoroughly?
10. Does a doctor examine you?
11. Does the doctor invite you for systemic examinations and vaccinations?
12. Did the doctor explain the purpose of the examination and the procedure?
13. Did the doctor explain your illness to you?
14. Does the doctor help you solve problems or concerns arising from your illness?
15. Does the blacksmith indicate to you the need to accept his advice?
16. Do you remember what the doctor told you at the last visit?
17. Does the doctor prepare you for what you can expect from a specialist examination or hospital...
treatment?
18. Do you feel that you can turn to your sister for help?
19. Is the date of your next examination determined with your cooperation?
20. Can you simply make an appointment over the phone?
21. Can you talk to the doctor by phone?
22. Do you wait a long time in the waiting room?
23. Do you get rapid health service for urgent problems?

The results of the study showed that there is no significant difference between the EUROPEP survey conducted in the Vrazova Educational Center and the results conducted in BiH and in other European countries using the same method and questionnaire, except in the medical care segment.

The main reasons for patient dissatisfaction with services in family medicine clinics are mostly technical in nature or related to the human factor:
1. difficult to order by phone
2. restrictions on the prescription of medicines
3. a long wait for an examination or service
4. poor communication between healthcare professionals and patients
5. patients do not receive an explanation about their illness
6. they do not receive an explanation about the way to use medicines or the necessary hygiene and diet regime
7. frequent visits due to prescribing prescriptions for chronic diseases
8. frequent visits due to control of blood pressure, sugar, etc. (these services can also be performed at home by a polyvalent visiting nurse)
9. the highest degree of dissatisfaction expressed by the surveyed respondents was related to the length of waiting for the examination, which varied from 0 to 60 days.

The highest degree of satisfaction was expressed for the variable of the possibility of ordering a patient by phone, but also the highest degree of dissatisfaction was expressed with the same variable among those who did not have the possibility of ordering.

8. CONCLUSION

Not only drugs are important for the outcome of treatment, but also the doctor’s personality, his approachability and respect for the patient. Patient satisfaction is an important element of healthcare quality assessment. Improving quality is one of the priorities of the reform in the field of healthcare in the Federation of Bosnia and Herzegovina, and the final result of the entire process of improving the quality and safety of healthcare services should be the improvement of the health of the entire population, patient satisfaction and economy in healthcare.

Assessment of the quality of work is one of the key elements in primary healthcare. This article deals with that issue. Namely, primary healthcare, which operates at the municipal level and serves 10,000 to 50,000 inhabitants, must be carried out with quality, in order to raise the health standard in the country to a higher level. All countries, including ours, strive to provide high-quality healthcare services to residents with the available resources. With this idea, the Agency for Quality and Accreditation in Healthcare FBiH (AKAZ) was formed with its headquarters in Sarajevo. It is the competent authority in the field of improving the quality and safety of healthcare services. AKAZ offers a unique program to improve the quality and safety of healthcare services for healthcare centers, family medicine teams, hospitals and private health institutions in the Federation of Bosnia and Herzegovina. The agency was established to work in cooperation with healthcare professionals and help them improve standards of quality and safety of healthcare.

The manner in which we will collect the data we need to assess the quality of work is in the form of a questionnaire. This directly addresses residents, healthcare service users. Only from them will we receive appropriate information on the functioning or non-functioning of the healthcare system. More precisely, we can directly conclude whether a problem that has appeared is a problem of the entire healthcare system (at the level of the municipality, canton, entity, state), or whether it is a problem of a narrower nature. Namely, the problem can also be at the level of the healthcare center or even the practicing doctor. Such data are of great use to us in order to improve the entire healthcare system, starting from the practicing doctor, the family medicine team, and so on all the way upward to the competent political authorities.

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