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ABSTRACT The rapid demographic and epidemiological transitions occurring in Latin America and the Caribbean have led to high levels of noncommunicable diseases in the region. In addition to reduced risk factors for chronic conditions, a strong health system for managing chronic conditions is vital. This study assessed the extent to which populations in six Latin American and Caribbean countries receive high-quality primary care, and it examined the relationship between experiences with care and perceptions of health system performance. We applied a validated survey on access, use, and satisfaction with health care services to nationally representative samples of the populations of Brazil, Colombia, El Salvador, Jamaica, Mexico, and Panama. Respondents reported considerable gaps in the ways in which primary care is organized, financed, and delivered. Nearly half reported using the emergency department for a condition they considered treatable in a primary care setting. Reports of more primary care problems were associated with worse perceptions of health system performance and quality and less receipt of preventive care. Urgent attention to primary care performance is required as the region's population continues to age at an unprecedented rate.

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Countries in the Latin America and Caribbean region have experienced considerable improvement in population health measures over the past two decades but still face many challenges.^{1,2} The rapid demographic and epidemiological transitions occurring in these countries have led to high levels of noncommunicable diseases, particularly cardiovascular disease, stroke, cancer, and depression.^{3,4} Such diseases are now the leading causes of death and morbidity in the Latin America and Caribbean region, accounting for 74 percent of deaths and 69 percent of disability-adjusted life-years there. Within countries, the burden of noncommunicable disease is often highest in poor communities.⁵ The costs of treating these diseases and associated losses in economic productivity are staggering:

Annually, cancers cost the region up to US \$150 billion, and diabetes is estimated to have been responsible for 9–14 percent of health care spending in 2000 alone.⁶

Over the past decade, consensus has been reached that reducing the toll of noncommunicable diseases requires not only a strong policy environment for reducing risk factors (such as the use of tobacco products) that cause chronic conditions, but also a robust health system for managing chronic conditions once they occur.⁷ In particular, the importance of strengthening primary care and integrating it with other levels of the health system has become a rallying cry in many countries.^{8,9} However, few studies have been carried out to evaluate the quality and availability of primary care services throughout Latin America and the Caribbean, or the degree to

which such care is integrated into a larger health services network.

One approach to measuring health system performance and the role of primary care across countries is the collection and analysis of data on user-reported experiences. The Commonwealth Fund has conducted a variety of such surveys in a number of high-income Organization for Economic Cooperation and Development countries since 1998.¹⁰⁻¹² These International Health Policy Surveys have found significant differences in population access to, cost of, and receipt of preventive services, depending on how health systems are financed and delivered.¹³ The surveys have also shown that, compared to the general population, patients with chronic conditions have lower levels of access to care, worse coordination across providers, and lower satisfaction with the care they do receive.¹¹ In Latin America and the Caribbean, however, there is no standardized way to assess how well different national health systems have strengthened primary care, or how they have responded to the challenge of noncommunicable diseases.

In this context, beginning in 2013 the Inter-American Development Bank financed the collection of nationally representative data on patient-reported measures of primary care access, use, and quality across middle-income countries in each region of the Americas. The countries were Brazil and Colombia (in South America), El Salvador and Panama (in Central America), Jamaica (in the Caribbean), and Mexico (in North America). Together, these countries account for nearly three-quarters of the region's estimated 2012 population of more than 500 million. Descriptive data on each country and its health system are presented in the online Appendix.¹⁴

This article reports results of these surveys in the six countries listed above, describes the extent to which different Latin American and Caribbean populations view their receipt of primary care, and assesses whether users' receipt of better primary care is associated with their perceptions of overall health system performance.

Study Data And Methods

Under the authors' supervision, Nielsen (formerly Harris Interactive)—in collaboration with local country researchers—translated, adapted, and pretested the 2013 Commonwealth Fund International Health Policy Survey; designed the sampling strategy; and conducted all interviews, using a standardized protocol.

In each country, telephone interviews were conducted among a national sample of the adult noninstitutionalized population taken from a

nationwide list of households. Both mobile and landline telephone numbers were included, which allowed for representative samples of both rural and urban populations in each country. Data were weighted based on city, age, sex, socioeconomic status, education, and household size.¹⁵ Surveys lasted from an average of twenty minutes in Brazil to an average of twenty-seven minutes in Colombia. The overall response rates varied from 29 percent in Colombia to 44 percent in El Salvador.

MEASURING PRIMARY CARE EXPERIENCES To assess people's primary care experiences, we adapted a section of the International Health Policy Survey that contained sixteen self-reported primary care items, following our previous work.¹⁶ These items represent attributes of effective primary care (accessibility, continuity, patient-centeredness, problem resolution, and coordination of care).¹⁷⁻¹⁹

Primary care experiences on the list were dichotomized and coded to represent problems or negative experiences. To better capture the latent variable that reflects users' overall primary care experiences, we then used tetrachoric factor analysis and extracted the main resulting factor, which showed high internal reliability (coefficient omega was 0.86).²⁰ The resulting primary care problem scale was then divided into tertiles, with the respondents reporting the fewest problems (tertile 1) used as the reference group.

MEASURING HEALTH SYSTEM PERFORMANCE Outcome variables were selected based on existing frameworks.^{21,22} The variables were satisfaction with and trust in the health system (respondents' agreement that the health system needs major reforms and assessment of the quality of care received); specialty care coordination and availability (waiting eight or more weeks for a specialist appointment); technical quality of care (receiving health advice from a health professional); use of the emergency department (ED) in the past two years for a condition that was treatable in a primary care setting; being readmitted to a hospital for the same condition, among those admitted to a hospital in the past two years; and whether the person was up to date with preventive exams—that is, having had blood pressure and cholesterol checked within the past year and the past five years, respectively.

STATISTICAL ANALYSIS Because the outcomes analyzed were binary but had relatively high prevalence (generally over 10 percent), we used robust Poisson regressions to test the association of the primary care problem scale with all outcomes.²³ Our models controlled for the following characteristics: sex, age range, educational attainment, the individual's main health care coverage (national health service, social se-

Citizens in each country report considerable gaps in the way primary care is organized, financed, and delivered.

curity or social insurance, or private health insurance), and health needs (self-reported health status fair or poor—compared to good, very good, or excellent—and the number of chronic conditions on a list of eight common conditions).

Country fixed effects (with Mexico as the reference category) controlled for unmeasured time-invariant country characteristics.²⁴ To take into account the fact that primary care problems may manifest themselves differently within different country contexts, we included an interaction term between the primary care problem scale and the country fixed effect. All results took into account the sample design and included final sample weights.

LIMITATIONS Our study had several limitations. First, since it was a cross-sectional study based on self-reported data, we could not assess true causal relationships between people's experiences of primary care and aspects of their health systems. Additionally, we had no baseline data for comparison, so some results might be highly sensitive to events taking place at the time of the study.

Second, the survey had reasonable but still low response rates. Although survey weights ensured that our final results were representative of each country's demographic characteristics, respondents might have been systematically either more favorable or less favorable to the overall health system, and such strong likes or dislikes might well have been a factor in people's willingness to participate.

Third, although our primary care problem scale exhibited good internal reliability, it might not be completely independent of all outcome measures. However, sensitivity tests that included randomly deleting up to three different items from the scale did not significantly change its relationship with the outcomes reported here. This suggests that the scale was probably not being driven by any single aspect of primary care.

Fourth, country comparisons might be complicated by different perceptions of the need for health care. Even though our analyses controlled for health needs, the predicted probability of seeing or needing to see a specialist varied from nearly 45 percent in Brazil and Colombia to 25 percent in El Salvador and in Jamaica (data not shown). Higher demand for specialist services (independent of need) could be an additional explanation for longer waiting times.

Study Results

Roughly one-fifth of the population of each of the six study countries was in each of the three youngest age groups, while only about one-sixth of respondents were age sixty or older (Exhibit 1). (For more detailed results, see the Appendix.)¹⁴ El Salvador had the highest share of respondents in the youngest group, while nearly one-fifth of the respondents in Panama were age sixty or older. Slightly more than half of respondents were female.

Overall, 37 percent of respondents reported having at least one chronic condition, with the highest prevalence (52 percent) in Jamaica. Almost one-fifth of respondents rated their health as fair or poor, with no significant differences across countries. Forty-two percent of respondents overall were covered by the national health system, 40 percent reported being covered by social security, and the remainder reported having private insurance. Respondents in Brazil and Jamaica had the highest rates of national health system coverage; social security systems predominated among respondents in Colombia, Mexico, and Panama; and Jamaica and Brazil had the highest rates of respondents with private health insurance. There were also considerable educational differences across countries.

Slightly more than a third of respondents overall thought that their health systems needed major reform, ranging from a low of about one-quarter in Mexico to a high of over one-half in Brazil. About 40 percent of respondents overall rated the quality of care they received from their general practitioners as very good or excellent. On average, slightly less than one-third of respondents reported having received health advice (the lowest ratings were in Jamaica and Colombia), and slightly more than one-third of respondents reported being up to date with basic preventive exams.

Almost half of the respondents overall had an ED visit for a condition they considered treatable in an ambulatory care setting, ranging from a low of 30 percent in Brazil to a high of nearly 60 percent in Jamaica. Nearly one-quarter of respondents overall reported being readmitted

EXHIBIT 1

Population characteristics and outcome measures in six Latin American or Caribbean countries, 2013

Characteristic	Brazil	Colombia	El Salvador	Jamaica	Mexico	Panama	Overall
Unweighted number	1,501	1,501	1,500	1,506	1,503	1,501	9,012
DEMOGRAPHIC CHARACTERISTICS							
Age (years)							
18–25	20.13%	19.43%	26.67%***	22.83%	24.30%	19.55%	22.15%
26–34	23.97	24.11	23.50	23.01	24.67	20.14	23.23
35–44	21.55	22.49	18.18	19.28	21.89	19.86	20.54
45–59	19.97	22.47	17.57	18.87	21.91	20.61	20.23
60 and older	14.38	11.51	14.08	16.02**	7.23***	19.85***	13.84
Female	51.33	51.22	53.39	52.80	51.50	51.44	51.95
Education							
Less than high school	64.41***	26.19***	45.97***	25.30***	28.99***	48.64***	39.91
High school	23.77***	52.39***	31.35***	55.50***	54.00***	24.70***	40.30
College	11.82***	21.41	22.67***	19.20	17.01	26.66***	19.79
HEALTH STATUS AND COVERAGE							
1 or more chronic conditions	34.22	32.82	30.51***	51.68***	34.88	38.22	37.06
Self-reported health status fair or poor	16.60	18.38	19.32	19.79	21.71	18.96	19.13
Source of insurance coverage							
National health system	76.99***	23.73***	43.10***	60.27***	30.67	13.66***	41.63
Social security	— ^a	66.55***	46.67***	12.51***	50.51***	64.89***	39.87
Private insurance	23.01***	9.72***	10.23***	27.21***	18.82	21.45***	18.51
HEALTH SYSTEM PERFORMANCE							
System needs major reform	54.75***	30.68**	36.93	35.47	27.35***	30.05***	35.87
GP quality very good or excellent ^b	32.38**	30.07***	46.24***	53.06***	37.70	33.84	38.97
Received all health advice	26.99**	24.27***	33.88	23.63***	42.38***	38.62***	31.62
Preventive exams up to date	35.30	35.76	27.95***	42.52***	45.87***	29.48***	36.15
Visited ED for PC-treatable problem ^c	30.36***	52.29***	45.78	59.03***	36.84	39.54	45.04
Needed hospital readmission ^d	18.07	27.01	23.41	25.98	32.59	11.72	24.93
Waited 8 or more weeks to see specialist ^e	43.41***	22.96	32.27**	16.35***	19.44	29.99	28.47

SOURCE Authors' analysis. **NOTES** Results include survey weights. Significance refers to difference between the individual country and overall, using Bonferroni-adjusted *p* values. Preventive exams are explained in the text. PC is primary care. ^aNot applicable. ^bAmong those who reported having a regular general practitioner (GP) or place of care (*n* = 6,431). ^cAmong those who used the emergency department (ED) in the past two years. ^dAmong those who were admitted to a hospital overnight in the past two years (*n* = 899). ^eAmong those who saw or needed to see a specialist in the past two years (*n* = 3,002). ***p* < 0.05 ****p* < 0.01

to the hospital, and almost one-third reported having to wait eight weeks or more to see a specialist—with the highest proportion reported in Brazil.

PRIMARY CARE EXPERIENCES Around one-fifth of respondents overall reported having skipped a doctor visit or prescribed treatment because of its cost, or an appointment because of problems in scheduling (Exhibit 2). One-third of respondents said they had to wait more than five days for a primary care appointment. Forty-five percent reported communication problems with their provider, 39 percent said that they could not schedule an appointment by phone, and 75 percent said that it was difficult to receive primary care on weekends.

More than half of respondents said that they had no regular primary care provider. One-third said that their primary care provider did not know their medical history, 28 percent said that the provider gave them no opportunity to ask questions, 26 percent reported that the provider did not explain things well, 31 percent said the

provider did not solve most health problems, and 61 percent said the provider did not help coordinate their care.

Overall, respondents experienced 4.5 out of 16.0 primary care problems, with the highest average of problems (5.1) in Brazil and the lowest (4.0) in Mexico. These differences were also apparent when the list of primary care problems was transformed into a scale and divided into tertiles. A significantly higher percentage of respondents in Mexico and Colombia were in the lowest tertile (corresponding to an average of 1.7 problems) than in one of the two higher tertiles. Panama and El Salvador had the highest shares of respondents in the second tertile (corresponding to an average of 4.5 problems), and Brazil had the highest share in the third tertile (corresponding to 8.7 problems, on average).

PRIMARY CARE AND HEALTH SYSTEM PERFORMANCE Compared to respondents who reported the fewest primary care problems (the lowest tertile), respondents in the middle tertile had a 64 percent higher chance and those in the high-

EXHIBIT 2
Prevalence of primary care problems in six Latin American or Caribbean countries, 2013

	Brazil	Colombia	El Salvador	Jamaica	Mexico	Panama	Overall
ACCESSIBILITY OF CARE							
Skipped doctor visit because of cost	15.82%**	12.64%***	29.32%***	31.49%***	19.54%	13.44%***	20.41%
Skipped prescribed treatment because of cost	16.48	13.09***	26.58***	28.98***	18.33	18.26	20.32
Unable to schedule appointment	21.49	18.43	22.31	24.78***	15.13***	17.04	19.87
Transportation difficulties	8.17	9.42	15.97***	10.41	10.43	7.56**	10.33
Waited 5 or more days for PC appointment	31.55	40.15***	52.11***	24.05***	20.76***	32.79	33.56
No PC appointment by phone	64.09***	15.97***	75.8***	25.82***	41.18***	22.11***	38.59
Difficult to receive PC on weekend	74.09	79.82***	83.05***	60.07***	74.25	77.50	74.87
CONTINUITY OF CARE							
No regular doctor	65.96%***	66.12%***	63.82%***	37.08%***	35.31%***	41.95%***	51.69%
PC doctor doesn't know medical history	56.78***	26.14***	31.46	39.76***	23.79***	26.07***	33.64
PATIENT-CENTEREDNESS—PRIMARY CARE DOCTOR:							
Is difficult to communicate with	45.18%	49.43%	58.37%***	23.31%***	49.72%**	51.07%***	44.96%
Gives no opportunity to ask questions	38.59***	23.50	28.84	35.37***	19.75***	23.72	28.12
Doesn't spend enough time	65.31***	26.79**	38.81	40.25	25.68***	46.33***	39.97
Doesn't explain things well	33.01***	21.13**	27.61	31.14***	21.10**	23.84	26.17
PROBLEM RESOLUTION							
Long time for diagnosis	15.12%***	22.58%	23.39%	26.37%***	17.43%	23.45%	21.41%
PC doctor doesn't solve most health problems	44.40***	27.44	28.24	40.62***	18.84***	25.10**	30.65
CARE COORDINATION							
PC doctor doesn't help coordinate care	74.14%***	52.74%***	57.11%	66.38%***	50.55%***	62.10%	60.54%
PRIMARY CARE PROBLEM COUNTS AND SCALE (TERTILE)^a							
No. of problems (out of 16)	5.11***	4.17***	4.94***	4.75	3.96***	4.29**	4.53
Percent of population in tertile 1	22.19%***	41.92%***	21.77%**	30.64%	43.42%***	27.79%	32.47%
Percent of population in tertile 2	25.89***	28.98**	39.21	27.03**	34.89	41.91**	32.97
Percent of population in tertile 3	51.93***	29.10***	39.02	42.33**	21.69***	30.30	34.56

SOURCE Authors' analysis. **NOTES** Results include sample weights. Significance refers to difference between the individual country and overall, using Bonferroni-adjusted *p* values. The term "doctor" is used here for brevity, but responses include services or consultations provided by either a physician or another health care professional. PC is primary care. ^aTertile 1 of the PC problem scale (explained in the text) is the lowest; tertile 3 is the highest. ***p* < 0.05 ****p* < 0.01

EXHIBIT 3
Prevalence ratios of primary care problems, health system perceptions, and receipt of timely and effective care in six Latin American or Caribbean countries, 2013

Outcome	PC problem scale (compared to lowest)		Country (compared to Mexico)				
	Middle	Highest	Brazil	Colombia	El Salvador	Jamaica	Panama
Health system needs major reform	1.64**	2.09***	1.99***	0.85	1.40	1.52**	1.77***
GP quality rated very good or excellent ^a	0.58***	0.25***	0.93	0.92	1.10	1.31***	0.88
Received all health advice	0.76***	0.52***	0.90	0.70***	0.92	0.53***	0.93
Preventive exams up to date	0.82***	0.78***	0.77***	0.85**	0.82***	0.82***	0.66***
Used ED for PC-treatable problem ^b	1.13	1.60**	0.65	1.97***	1.14	1.80***	1.53
Needed hospital readmission ^c	0.81	1.28	0.62	1.22	1.16	0.84	0.26**
Waited 8 or more weeks to see specialist ^d	2.54	4.12***	3.24**	1.69	2.92**	1.18	2.08

SOURCE Authors' analysis. **NOTES** Results are survey-weighted prevalence ratios from robust Poisson regressions that controlled for age, sex, health, chronic disease, health system coverage, primary care (PC) problem scale (explained in the text), country fixed effects, and interactions between country and PC problem scale. For the PC problem scale, significance refers to difference between the tertile shown and the lowest tertile. For each country, significance refers to difference between that country and Mexico. In both cases, we used Bonferroni-adjusted *p* values. ^aAmong those who had consulted with a general practitioner (GP) in the past year. Preventive exams are explained in the text. ^bAmong those who used the emergency department (ED) in the past two years. ^cAmong those who were admitted to a hospital overnight in the past two years. ^dAmong those who saw or needed to see a specialist in the past two years. ***p* < 0.05 ****p* < 0.01 *****p* < 0.001

est tertile had double the chance of reporting that their health systems needed major reform (Exhibit 3). Brazilians were twice as likely as the reference group (Mexicans) to agree with this statement. Respondents who reported the most problems were 75 percent less likely to report that the quality of their primary care providers was very good or excellent, and only Jamaicans exhibited a significant difference in this outcome from the reference group.

Compared to respondents reporting the fewest primary care problems (the lowest tertile), respondents in the highest tertile had a significantly lower probability of reporting receipt of health advice and of having all of their preventive exams up to date. Compared to Mexicans, respondents from all other countries reported lower rates of receiving advice and of having exams up to date.

Also compared to respondents in the lowest tertile, those in the highest had higher rates of having used the ED for a problem that respondents believed could have been treated in a primary care setting and a higher probability of having to wait eight weeks or more to see a specialist. And compared to Mexicans, Colombians were the most likely to report having used the

ED, while Brazilians and Salvadorans were most likely to report having waited for a specialist.

However, the primary care problem scale was not associated with the risk of hospital readmission. Only Panama had a significantly different rate (about 74 percent lower) from that of Mexico.

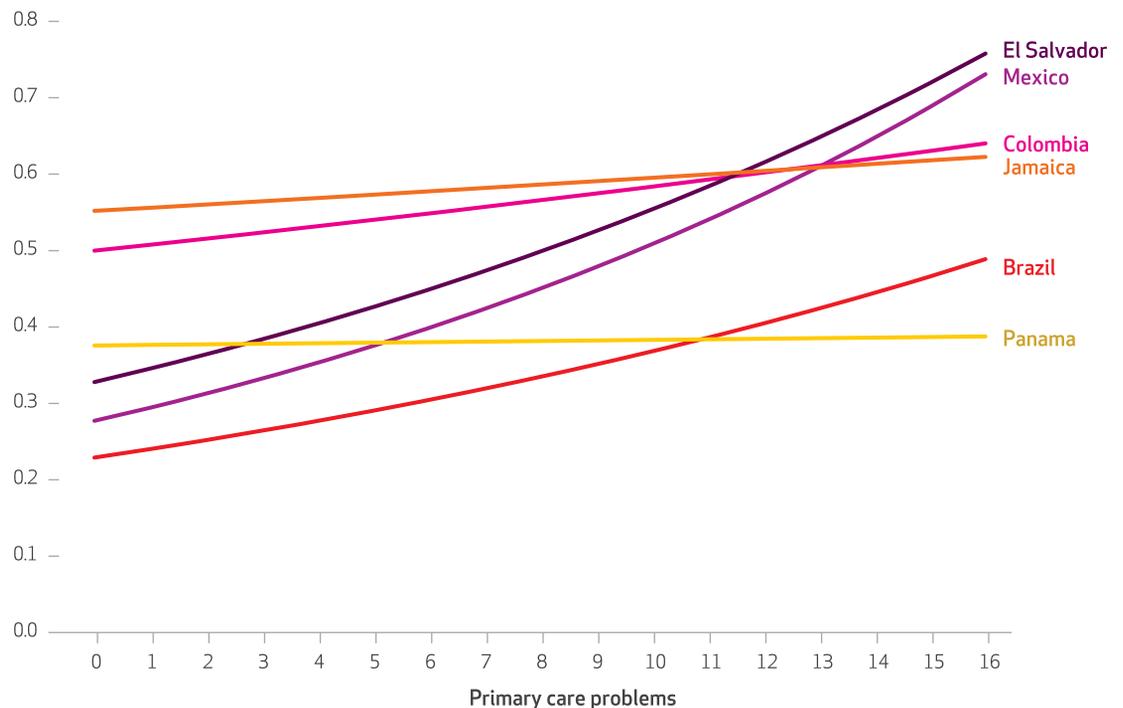
Exhibit 4 provides more detail than Exhibit 3 about the association between reporting a greater number of primary care problems and the probability of using the ED for a condition treatable in primary care. The largest initial values for the association were observed in Colombia and Jamaica (Exhibit 4). The steepest slopes were seen in El Salvador and Mexico. For respondents reporting the highest number of problems, the probability of using the ED in El Salvador and Mexico was nearly double that predicted in Brazil and Panama.

Discussion

We found great variation in the reported number of primary care problems and consistent associations between reports of such problems and worse health system performance measures across six middle-income countries in Latin

EXHIBIT 4

Predicted probability of reporting use of an emergency department for a primary care-treatable condition, by number of reported primary care problems



SOURCE Authors' analysis. **NOTE** Results are from robust Poisson regressions that controlled for age, sex, health, chronic disease, health system type, primary care problem scale (explained in the text), country fixed effects, and their interactions.

Most countries showed substantial room for improvement in the area of patient-centeredness.

America and the Caribbean. Our findings suggest that citizens in each country report considerable gaps in the way primary care is organized, financed, and delivered and that the presence of these gaps is associated with worse health system performance—including the receipt of less effective and timely health care.

Our objective was not to compare countries to each other. However, an examination of common indicators across different countries' health systems can provide insights into the comparative effectiveness of different strategies for organizing and delivering primary care.

In terms of access, countries presented very different scenarios. Countries with relatively low levels of financial barriers (such as Brazil and Colombia) tended to have somewhat higher levels of organizational barriers. Continuity of care also varied significantly across countries, in somewhat surprising ways. For example, in Brazil (where more than half of the population is assigned to a specific primary care team based on residence) reports of having a regular provider were much lower than in Mexico (where there are no required provisions—such as patient lists—to ensure continuity of care).

Most countries showed substantial room for improvement in the area of patient-centeredness. This poses a significant challenge, given that as the number of patients with one or more chronic conditions increases, the time available for each patient might continue to decrease—even further limiting consultation time.

Coordination of care was a problem in all six countries. That fact reflects the ongoing challenge in all of the countries to successfully incorporate secondary prevention and enhanced diagnostic services into primary care.

COUNTRY-SPECIFIC IMPLICATIONS In addition to these general findings, the study also revealed specific challenges for each country. Brazil had the highest reported number of primary care problems, and these assessments were reflected in its poor performance on most health system outcomes. However, the high levels of reported

financial barriers in Brazil were unexpected, given that all public services are free at the point of service and levels of catastrophic health expenditure have been found to be quite low.²⁵ The primary care problems in Brazil may at least partly reflect the country's ongoing financial crisis. Indeed, negative perceptions about the health system may be related to widespread dissatisfaction with the government in general, shown in protests that took place in the country in 2013—the same year that this study was fielded.

For Colombia, very high levels (over 50 percent) of ED use for a problem that was treatable in primary care may be a logical consequence of users' reports of very low accessibility for primary care on weekends, long waiting times for primary care appointments, low levels of having a usual source of care, and poor coordination of care. Compared to the other countries, Colombia was relatively strong in other domains, such as patient-centeredness.

In general, Mexican respondents reported fewer primary care problems, had relatively more confidence in their health system, and reported better quality indicators, compared to respondents from the other countries. These results may be because 51 percent of Mexican respondents were beneficiaries of their country's social security services. The results may also reflect results from recent health reforms, such as those involving Seguro Popular—which at the time of the study covered nearly half of Mexico's previously uninsured population. The implementation of Seguro Popular has been associated with reduced catastrophic expenditures and improved access to care.²⁶

Across the countries, Panama had consistently low levels of reported problems in accessing primary care and high levels of reported receipt of health advice. But it was also among the lowest in terms of people reporting that they were up to date with preventive exams, and it had relatively low levels of patient-centeredness, which suggests several areas in need of attention in that country's health system.

Nearly one-third of respondents in Jamaica and El Salvador reported having skipped a doctor visit because of the cost, even though user fees in the public sector were formally eliminated in 2008 and 2009, respectively. Indirect costs related to transportation or charges for medications could partially explain these findings. Another possibility is that overcrowding of public services could be pushing part of the population to use the private sector, which would require greater out-of-pocket spending. These two countries also had high proportions of respondents reporting having skipped treatments because of

cost and relatively high levels of access barriers. These data suggest the need for experimenting with additional ways to enhance access to care, such as improving transportation, phone access, and weekend care in El Salvador and improving the affordability of medicines through the Drugs for the Elderly Program in Jamaica, among other approaches.

IMPLICATIONS FOR HEALTH SYSTEM REFORMS

There are several additional implications of these results for strengthening primary care in the Americas. First, access barriers are not just financial. Organizational barriers may be even more complex, and thus more difficult to resolve, than financial ones because they vary across organizational contexts and may manifest themselves at multiple levels in the health system.

Second, the considerable degree of skepticism reported by respondents about whether primary care is capable of resolving people's health problems may be a result of primary care's failure to serve as an effective medical home when people seek care from other sources—whether they seek care elsewhere because of perceived levels of better access or greater convenience in terms of hours of operation, compared to primary care.

Third, continuity of care requires the development of a long-term relationship between a person and his or her primary care provider. Clinic-level interventions such as the use of patient lists can strengthen the ties between individuals and their health care providers, which can lead to better medication adherence and management of chronic conditions. The use of community health workers can also enhance outreach from the clinic to the community, although this strategy needs to be developed with adequate infrastructure and management support.

Fourth, care coordination is a challenge for most of the world's health systems. Improving coordination may require sustained investments—for example, in integrated electronic health records. Reducing fragmentation across different levels of care and across different owners or operators of specialty and diagnostic services may require further refinements to the ways in which such services are financed and organized. Lack of coordination and long waiting times are likely related to insufficient supplies of specialists—a problem that extends

Lack of coordination and long waiting times are likely related to insufficient supplies of specialists.

beyond primary care and remains a major challenge in most countries. Payment system reforms may also be necessary to improve the alignment of incentives for having primary care serve as people's medical homes, coordinating care from other providers, and integrating sources of patient health information.

Fifth, the lack of patient-centered primary care was a major complaint of respondents in most countries. This suggests the need to implement additional strategies, such as the use of patient navigators or case managers, and it illustrates the potential for shifting tasks from physicians to other health providers, among other strategies.

Conclusion

Overall, we found substantial gaps in primary care performance across six very different health systems in the study countries. Moreover, respondents' reports of primary care experiences were strongly associated with assessments of how their health systems function, protect them from financial hardship, and deliver high-quality and appropriate health care. These gaps require urgent attention as the population of Latin America and the Caribbean continues to age at an unprecedented rate. Comparative studies such as this are intended to provide benchmarks for performance, assess country-specific challenges, identify best practices, and foster collaborative efforts to exchange information about them. ■

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NOTES

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