

PATIENT CENTERED CARE: FOCUS ON LOW AND MIDDLE INCOME COUNTRIES (LMICs) AND PROPOSITION OF NEW CONCEPTUAL MODEL

Said Bensbih ¹, Amine Souadka ^{2,3}, Amalia Giuliani Diez ³, Otmame Bouksour ¹

1. Laboratory of Mechanics, Production & Industrial Engineering (LMPGI), Hassan II^d University, High School of Technology of Casablanca (ESTC), Casablanca, Morocco.
2. Mohammed Vth University, Rabat, Morocco.
3. Digestive Surgical Oncology Department, National Institute of Oncology, Rabat, Morocco.

ABSTRACT

The health system is a fundamental building block of a country's social project. Approaches and strategies differ but some concepts such as Patient Centered Care (PCC) seem to be more and more popular nowadays as the customer centric advocated in the industry. The research has focused on this trend of PCC with several different definitions but without having a particular focus on the context of Low and Middle Income Countries (LMICs). The objective of this study is, through an extensive literature review, to analyze this concept, to unify the dimensions described by different authors, to define a concept that can be proposed to LMICs and to determine facilitating factors as well as obstacles for its implementation.

Keywords: Conceptual model, Health system, Low and middle income countries (LMICs), Patient Centered Care.

Corresponding Author:

Said Bensbih,

Address: Laboratory of Mechanics, Production and Industrial Engineering (LMPGI), Hassan II^d University, High School of Technology of Casablanca (ESTC), Casablanca, Morocco.

E-mail: saidbensbih@gmail.com

Tel: +212 661 2037 66

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INTRODUCTION

Nowadays worldwide life expectancy is increasing. However the top ten causes of death are diseases which still require complex and multidisciplinary interventions such as: heart disorders, cancer, chronic diseases, road accidents, tuberculosis and maternity conditions (WHO 2019). To face these challenges, which concern all regions of the world to different degrees, the United Nations has set among 17 objectives that aimed at good health and well-being. This goal, however, is to be correlated with others in order to converge towards global development, which is a major challenge for decision-makers (Nilsson 2016). Furthermore, as Donkin et al. (2018) remarked, politicians need to be more than ever aware of the importance of integrating social determinants of health (SDH) into

their policies. These integrations are complex actions, because health care priorities demand the need to include a patient-centered care approach (PCC) in global health policies.

Therefore, in recent years, we have examples demonstrating that this approach has become a priority for governments regardless of their level of development (Agyepong et al., 2017, Almalki et al., 2011, Peters et al., 2008, Reibling 2010, WHO 2017, Wu et al., 2010). This orientation takes into consideration the importance of a Patient Centric Care in order to improve the outcomes of healthcare systems. However, this PCC approach is subject to different definitions and interpretations leading to confusion in its implementation because success factors and bottlenecks depend on the context and level of development of each country. Although the literature is abundant on the specific sense of PCC

meaning (Constand et al., 2014), they are only few authors that were concentrated on facilitating factors and barriers of implementation of PCC in health strategies in Low and middle income countries (LMICs).

The study's aim

Due to the importance of this topic among all other crucial topics that should be integrated in health policies and in order to offer a better patient care, the main aim of our study is to propose a large literature review of all PCC concepts and its actual application worldwide. Secondary we proposed a unique integrated model adapted to LMIC with further perspective of implementation of this concept at more adequate manner.

PATIENT CENTERED CONCEPT IN HEALTHCARE

Definitions

Patient Centeredness, a confused concept!

A systematic literature review from 1990 to 2012 produced by Constand et al. (2014) in an attempt to frame the PCC concept concluded that there is no unified model for this approach, however they are three main components that emerge from the practice: the health promotion, partnership and communication. The authors of this work insisted on the need to develop measures for these three components.

This is a first synthetic definition of the PCC, consisting primarily on a two-way communication with the patient to better identify their needs and preferences with the necessary empathy and commitment. Secondly, the partnership dimension involves sharing information with the patient and his family to gain their commitment and trust. This partnership aims also to provide a context-specific care while ensuring collaboration between the various stakeholders. The health promotion, as specified by the authors, consists of having the more efficient management of resources in order to better treat the patient, based on an evaluation of the results obtained in previous cases.

Patient Centric Care may be located between Patient Participation and Patient Empowerment

Based on another literature review, Castro et al. (2016) also concludes that PCC is a confusing concept. For these authors, PCC is rather a strategy from a care provider perspective and is halfway between two multi-level organizational concepts:

patient participation (PP), more oriented patient experience, and patient empowerment (PE) that would bring together the two concepts.

Patient Participation, which would be a prerequisite for PCC, is considered by the authors as an individualized care, planning and development of services with their evaluation, and finally addressing the health policies component. This concept recognizes the right of patients to individually and collectively influence decision-making about the care they receive. Patient participation is thus a prerequisite for the PCC.

As for patient empowerment, it is approached by Castro et al. (2014) from different perspectives (the patient, the caregiver or the health system). It is seen as a metaparadigm resulting in a process that allows the patient to influence individually and collectively his health and increase his ability to have more control over aspects that he considers important for his well-being.

Patient Centric Care which is a bio- psychosocial approach that emphasizes respectful individualized care and empowers patients to decide their health in an empathic and knowledge-sharing environment would thus be a logical continuation of PP and a prerequisite for PE. Patient participation would be a strategy to reach PCC which in turn allows the promotion of PE.

Patient Centric Care and Health System

Levesque et al. (2013), through a systematic review, proposed a framework for patient centric accessibility. This framework is a proposal to integrate the factors characterizing the demand for care and their provision by making it possible to make access to the health system operational throughout the process in order to benefit from its services. They declined this accessibility centered patient in 5 dimensions: approachability, acceptability, availability and accommodation, affordability, appropriateness. There are five components corresponding to these dimensions: ability to perceive, ability to seek, ability to reach, ability to pay, and ability to engage, which allow people to benefit from this approach, called Patient-Centered Access.

An integrated model for Patient Centric Care

In another study, Scoll et al. (2014) while also highlighting the variability of definitions that do not facilitate the implementation of PCC, conducted a systematic review with the aim of proposing an

integrated model that allows different stakeholders to adopt the same language and thereby facilitate the implementation of political guidelines. The model lists 15 dimensions divided into 3 sections:

- 1- Principles: essential characteristics of clinician, clinician-patient relationship, patient as unique person, bio- psychosocial perspective.
- 2- Facilitators: clinician-patient communication, integration of medical and non-medical care, teamwork and teambuilding, access to care, coordination and continuity of care.

- 3- Activities: patient information, patient involvement in care, involvement of family and friends, patient empowerment, physical support, emotional support.

Accessibility is cited as a facilitator for a timely access to the health system, which must demonstrate coordination, continuity of service and a degree of decentralization to provide patient-centered care. The authors note, however, that this study was limited to: North America and Europe and examples of definitions adopted in Australia, New Zealand, Asia, and South Africa.

Table I: Summary of definitions of PCC dimensions and their association according the 4 systematic reviews (Castro et al., 2016, Constant et al., 2014, Levesk et al., 2013, Scoll et al., 2014) with declination on the proposed 3 axes.

Author	Association	Dimensions	Axes		
			Accessibility	Communication	Quality
Constand	Components	Promotion			+
		Partnership	+	+	+
		Communication		+	
Castro	Levels	Patient Participation		+	+
		Patient Centered		+	+
		Patient Empowerment	+	+	+
Levesk	Framework	Approachability		+	
		Acceptability	+		
		Availability and accommodation	+		+
		Affordability	+		
	Principles	Essential characteristics of clinician			+
		Clinician-patient relationship		+	
		Patient as unique person			+
		Bio- psychosocial perspective			+
	Facilitators	Clinician-patient communication		+	

	Integration of medical and non-medical care		+
	Teamwork and teambuilding	+	+
	Access to care	+	
	Coordination and continuity of care	+	+
Activities	Patient information	+	
	Patient involvement in care	+	+
	Involvement of family and friends	+	
	Patient empowerment	+	+
	Physical support		+
	Emotional support		+

PCC AXES

By analyzing these different PCC approaches, we consider that despite the apparent variation in definitions, there is a common need to converge the proposed dimensions to what we consider PCC axes (**Table I**). With this convergence, we propose an integrated PCC approach around the 3 illustrated axes: communication, accessibility, quality. These axes are interdependent with the goal of providing care on time and tailored to the needs and preferences of the patient.

The definitions that we have adopted for these three axes are the following:

Communication

According to Ratzan (2001), communication means getting the right message to the right people, at the right time, with the intended effect. It requires both the science and the art of communicating health. It is an approach that adds value to health, not only to disease, but also to decision-making on the subject of sound science and theory.

Accessibility

Four main dimensions of access were described by Peters et al. (2008):

1. Geographic accessibility: the physical distance or travel time from service delivery point to the user.
2. Availability: having the right type of care available to those who need it, as well as having the appropriate type of service providers and materials.
3. Financial accessibility: the willingness and ability of users to pay for those services.
4. Acceptability: the match between how responsive health service providers are to the social and cultural expectations of individual users and communities.

Quality

Donabedian (1988) described quality into three parts approach: "structure", "process", and "outcome":

1. Structure: includes the attributes of material resources, human resources and organizational structure.
2. Process: includes the patient activities in seeking care and carrying it out as well as the medical activities.
3. Outcome: denotes the effects of care on the health status of patients and populations.

It is based on these definitions that we propose to integrate the different dimensions and reflections,

expressed in the various PCC undertaken works, around the three axes: communication, accessibility and quality (**Table I**).

PROPOSAL OF A CONCEPTUAL MODEL PCC

For us, access to care requires prior and sufficient communication so that the patient can benefit from the nearest services available and adapted to their cultural context. The service offered must be of quality with a perceived beneficial effect for the population that has accessed it. This quality, combined with effective and efficient communication will capitalize on this first interaction of the patient with the system and ensure that he remains in the circuit. Hence our proposal for a conceptual model (**Figure 1**) which relates the interdependence of the 3 PCC axes.

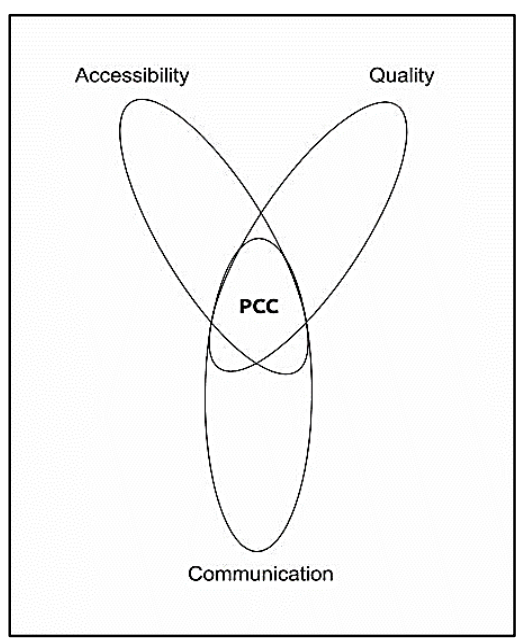


Figure 1: Conceptual Model with PCC Axes interdependence.

However, the three axes cannot be isolated from the context that they integrate and this is what we will try to discuss through the examples below.

Western Countries

A study of a sample of 16 Western countries focused on the different typologies adopted by health systems regarding the accessibility dimension (Reibling 2010). Based on the fact that these health systems were built on a public private mix in the

three areas of funding, provision and regulation, it stressed the importance of access to care from the perspective of the patient. This access is defined as the conditions under which its services can be obtained, the measures put in place to use them and their availability.

The study highlights 4 groups of countries adopting differentiated systems of access to care:

- The first group (Austria, Belgium, France, Sweden, and Switzerland) advocates shared responsibility for funding to regulate access to doctors.
- The second group (Denmark, Netherlands, Poland, Spain, and the United Kingdom) do not have cost sharing measures but have strong regulation for access to care.
- The third group (Czech Republic, Germany and Greece) have a very weak regulation of access to care with a particular characteristic: a high number of doctors.
- The fourth group (Finland, Italy and Portugal) is characterized by a mix of access regulation and shared financial responsibility.

It is mentioned that in most of these countries it is necessary to have a reference before accessing a specialist. However some health systems offer the possibility to the patient to "skip & pay" the reference system. Nevertheless, the coverage rate of health expenditure exceeds 99% and efforts continue to reduce informal payments and "out-of-pocket" health expenditure.

It goes without saying that these typologies are implemented in correlation with the GDP of the countries concerned and their level of development allowing them to manage health expenditure related to their social projects. This accessibility to care, an essential component of the PCC, is clearly facilitated.

In another study conducted by Wendt et al. (2009), the authors also confirmed that for European countries accessibility to public health systems was high and there was little difference between countries in this sense. The study also mentioned the importance of having a model for analyzing health systems from three dimensions: financing, provision and regulation. Three systems are being suggested: state healthcare systems, societal healthcare systems, and private healthcare systems, and various permutations of mixed systems of this three.

However, Thomson et al. (2012), in an analysis of international profiles of health systems whose scope covered developed countries (Australia, Canada, Denmark, England, France, Germany, Iceland, Italy, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States) noted

that there is still margin to improve accessibility and communication. Mackenbakh et al. (2013) also point in this direction and mentions that significant gains can be achieved if countries remove barriers at will and resources. Variations in health policies and attempts at comparison are the subject of research with a view to assessing their different scope (Béland 2010, Bureau et al., 2006).

We note that for western countries, given their level of socioeconomic development and the important place of their health expenditure, PCC approach is handled with a sufficient margin of success to apply the three axes as defined above.

Low and Middle Income Countries (LMICs)

For LMICs, it is fundamental that health policies can enable poor people to have access to quality health care that can provide them with good health, which in return will give them the opportunity to improve their situation (Peters et al. 2008). The author, in an extensive analysis of the health policies adopted by the LMICs around the world and based on studies and reports elaborated by international organizations, NGOs, concerned countries themselves, demonstrates the importance of the financial support to ensure this access by emphasizing the imperative of making the health budget a priority, especially in a context where economic objectives are the center of concern. This would involve encouraging disadvantaged and vulnerable people to participate in the development of health strategies, their implementation and evaluation. While universal coverage trials have been attempted requiring complex financial arrangements, improvements in the health system also depend on the development of human capital (knowledge, education) and should take into account individual and community expectations.

Thus it appears clearly from this study that for LMICs, in order to better adopt PCC, not only accessibility and quality are urgent axes to consider at health system level, but also the communication by promoting a local medicine, would be able to adapt the offer of care to the communities concerned. The financial aspect, however, remains one of the major constraints to face as several development priorities are in competition with the health system.

Sub-Saharan Africa

Agyepong et al. (2017) has made a large analysis of all sub Saharan health systems and specifically their population-centered approaches adapted to the needs of each country. And conclude that these countries have two main challenges to address:

- A double burden of traditional, persistent health challenges, such as infectious diseases, malnutrition, and maternal mortality.
- Emerging challenges of an increased prevalence of chronic conditions, mental health disorders, injuries, and health problems.

The study also confirms that better health would contribute to achieving the other Sustainable Development Goals (SDGs). For this purpose it is recommended that a change of mind be made at all levels of society, all sectors of government and institutions. The commission that produced this study and of which the author is a part encourages the adoption of strategies encompassing the promotion of health and prevention of the disease but also access to treatment. It highlights eight determinants as success factors for these strategies: people-centered health systems, universal health coverage (UHC), social determinants of health, and health outcomes, leadership, stewardship, civil society engagement, and accountability at public health systems, public health systems, health workforce development, research and higher education, innovation in products, service delivery, and governance.

The authors note that models that rely only on hospitals and individual care provision would have a low probability of success. An African population-centered approach focusing on prevention, primary care, public health and supported by a referral system and quality tertiary care provision is required to move towards better health.

This approach is justified by the fact that at the heart of any health system there are people with interdependent roles, interactions and relationships. Health systems are essentially human systems. The reason why values such as respect, dignity and compassion are critical to this approach. The central elements of this approach are: a strong focus, patient and community engagement, and a chain of accountability.

Abimbola et al. (2014), illustrate how a multi-level governance framework offers a people-centeredness on the governance of public healthcare in LMICs. To achieve people centered health systems, there is a need for an approach to governance which incorporates the roles and relationships of all health system actors.

Our conclusion from these analyzes is that in Sub-Saharan Africa, in addition to the common factors described in the LMICs example, of which they are part, the epidemiological, political and demographic context suggests a PCC approach where the

accessibility axis is to develop. There is also a need that quality is ensured and communication is adapted to cultural aspects and local values.

GLOBAL PERSPECTIVE

The Universal Health Coverage (UHC) Forum Held in Tokyo in December 2017, organized by WHO with Japanese government, World Bank, UNICEF, UHC2030 and JICA, Japan International Cooperation Agency, (WHO 2017), reiterate the importance of:

- Sustainable Development Goals (SDGs) in Target 3.8 seeks to provide all people with access to high-quality, integrated, "people-centered" health services.
- Including promotive, preventive, curative, rehabilitative and palliative health services, as well as safe, effective, quality and affordable essential medicines and vaccines.
- Ensuring that people do not suffer financial hardship when accessing services.
- Emphasizing the importance of protecting all people from health risks such as outbreaks, and responding rapidly to outbreaks and crises.
- Reaffirming the commitment to accelerating progress towards UHC, and to achieving health for all people, whoever they are, wherever they live, by 2030.
- Recognizing the integrated and indivisible nature of the Sustainable Development Goals (SDGs), which balance the economic, social and environmental dimensions of sustainable development.
- Acknowledging that health is a human right and that UHC is essential to health for all and to human security.
- Adhering to the principle of Leaving No One Behind, which requires special effort to design and deliver health services informed by the voices and needs of people.

This statement corresponds well to the PCC concept on two axes: accessibility and quality of care. However communication is mention as critical axis which has an equally important role. This emphasizes the importance of the health system in a comprehensive approach to development.

PATIENT CENTRED CARE: PROPOSITION OF NEW CONCEPTUAL MODEL IN LMICs

As shown before, the diverse and contextual definitions of PCC concept have been the focus of

work in Western countries. Research on this concept in the Low and Middle Income Countries (LMICs) is very rare and highlights the accessibility, quality and communication as dimensions of health policies and strategies.

Indeed, for LMICs, several political and economic objectives are as important as the social aspects of education, health and employment.

Cultural aspects, literacy and demographic characteristics also play a major role in the development and implementation of health systems. It should also be noted that the LMICs have a rather limited financial margin to be able to implement PCC-oriented health approaches because the material, human and financial resources suffer from a shortage often cited in the various studies and research.

From all these conclusions we propose a new conceptual model that will integrate the context to the definition in **Figure 1**. Indeed the degree of implementation of the PCC concept may vary from one country to another but the main thing is to find a balance for the 3 integrated axes. This balance, that needs to be contextualized, will allow coordinated and concrete actions to arrive at the desired PCC model (**Figure 2**).

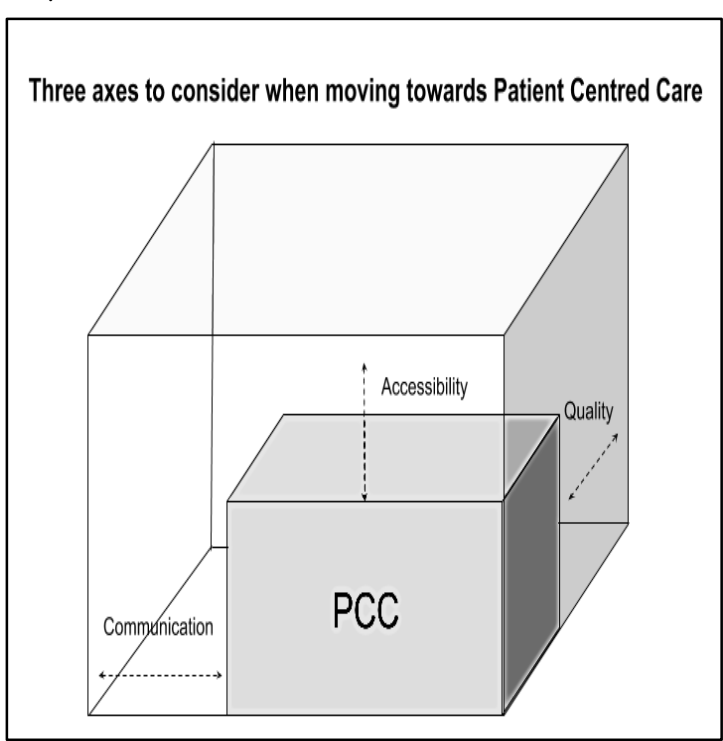


Figure 2: PCC Revisited Model.

Through this conceptual model revisited we want to highlight and insist on the need of integration of the 3 PCC axes which will allow the health systems, through their various reforms, to consider

convergent action plans towards the universal coverage.

As for each axis we have to consider the following:

1. Accessibility is one of the primary objectives of health systems and its level of implementation varies from country to country but should be emphasized particularly in "underprivileged" regions.
2. Quality of care is also a major challenge in that the hospital supply chain suffers from a shortage of material, financial and human resources and needs to be well distributed.
3. Communication, at its patient level, is supposed to be delivered by a disproportionate number of professionals compared to a growing number of care seekers. This third dimension seems to be one of the more challenging items especially in the absence of a common medical file and collaboration between the various stakeholders.

The sociocultural strands that paradoxically would require more effort to integrate the context of each patient, constitute an additional difficulty for the participation and commitment of the patient for his health.

FURTHER RESEARCH & CONCLUSION

As shown before, there are different PCC approaches around the world and also a general confusion in the definitions. However, this is the first summarizing study that propose a conceptual model in three integrated PCC axes (accessibility, communication, quality). This model if contextualized to specific demands will allow to consider serenely the convergence towards a universal coverage of health. This approach is more adapted and oriented to LMICS, of which Morocco is a part because the economic, political, cultural and social context requires deciding on basic priorities. We consider this work as a contribution towards the path to frame the concept of PCC, but at the same time we believe it is necessary to continue with the research in order to deepen aspects such as its implementation and necessary actions to achieve it.

ABBREVIATIONS

JICA: Japan International Cooperation Agency. LMIC: Low and Middle Income Country.
PCC: Patient Centred Care.
PE: Patient Empowerment.
PP: Patient Participation.
SDG: Sustainable Development Goal.
SDH: Social Determinant of Health.

UHC: Universal Health Coverage.

UNICEF: United Nations of International Children's Emergency Fund.

WHO: World Health Organization.

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