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Comments

Evaluation of quality or qualitative evaluation of health care?

ABSTRACT

The paper presents a theoretical exercise regarding health care evaluation in an effort to define several concepts. The multi-dimensional aspects of quality in health are emphasized in addition to the differences between quality evaluation and qualitative evaluation. The implications of not distinguishing between these two concepts are also discussed. Health care is analyzed as a material expression of interpersonal relations in this field and as an object of evaluation, highlighting its intricate relation with integrality and humanization. It is affirmed that quality evaluation and qualitative evaluation are not interchangeable labels, but rather political choices connected to health policies that can not be juxtaposed. Therefore, understanding this distinction is necessary for constructing evaluation proposals that surpass traditional and exclusionary perspectives.

KEYWORDS: Delivery of health care. Health services evaluation. Health care quality, access, and evaluation. Health policy, planning and management.

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INTRODUCTION

The evaluation of health actions has stood out among planning and management actions. Currently, there is a tendency to consider the specificities of each context, including the relations that process and produce direct reflections in the operationalization of health practices. In light of the current situation, varied and multidimensional methodological strategies have been generated, suggesting an inclination for overcoming positivist surroundings that mark their history.

Despite the variety of meanings, at times antagonistic, the term evaluation has been referred to in ways that separate it from its polysemy. Its application in the field of health policy and programs reveals a dilution of consensus regarding its meaning because, in this area, evaluation can assume various designs, in the effort to adjust itself to the scope of the intervention or to the scientific rationale that supports the study.

When the concept evaluation is associated with another polysemic – quality – giving way to new constructions, the question becomes even more complex, as they turn into explicit semantic tensions and the difficulties of using this concept, highlighting its intrinsic or extrinsic multidimensional character and reaching objective and subjective dimensions.[5,14]

The difficulty of recognizing the polysemy results in the weakening and narrowing of the breadth of the concept, due to the fact that some dimensions of quality predominate in traditional evaluation models. In this field, the paradigm that orientates evaluation of *quality* of programs focuses in an accentuated, if not exclusive way, on objectable[12] dimensions, or rather those that allow themselves to be quantified, excluding the intersubjective human dimension.

Some authors, of whom Ayres[3] stands out, transcend this position by incorporating the subjectivity present in health care practice in the evaluation of programs and services, identifying two modalities of evaluation: *normative evaluation* and *formative evaluation*. The first refers to the verification of the technical success of health actions, including the products of the work in health. In simplified terms, normative evaluation limits itself to a quantification and prioritizes the formal elements of an intervention, admitting a perfect juxtaposition with what is referred to as evaluation of formal quality.[14] Formative evaluation[3] is directed at judging the practical success of a health action. This implicates in recognizing the "*projects of happiness* that justify and elucidate the realization of care that they want to judge," or rather, they are directed at the subjective nature of quality, an analogous approach to the conception of *qualitative evaluation* postulated in the present article.[14]

In this sense, evaluation studies with more classic design are directed at an analysis of the efficacy and/or efficiency of a certain program. Given the nature of the method which they utilize and the understanding of reality through the optic of objectification, they would be appropriate for an analysis or measurement of the technical success of a program, or rather, of its *formal quality*.[8] On the other hand, evaluative studies directed at the subjective dimension of quality, propose a revelation of the sense of the phenomenon, respecting their complexity, richness, and depth.[14] Such studies would be adequate for analysis of practical success, or rather, the analysis of the effectiveness of a health program, as they consider the expectations and symbolic universe of the stakeholders, in particular, the users to whom the actions are directed.

As such, it becomes essential to delineate in what sense the concepts are being applied, as qualitative evaluation corresponds to an analysis of dimensions which escape from indicators and numeric expressions. This analysis is directed at the subjective production that permeates health care practices inscribed in programs and services, with direct repercussions in the nature of the material collected and produced, of which cannot be restricted to structured instruments with exclusively numeric responses.[5] Such a definition is distinguishable from an evaluation of quality, although it does include, given the elements previously pointed out that allow objective expressions to be made within this framework, such as those directed at the dimensions of quality that admit objectification.

This distinction does not, necessarily, imply dichotomous positions, but rather complementary ones. In other terms, *evaluation of quality* proposes to emit a judgment of the value of programmatic actions or health service, through the uncovering of their aspects or components, in accordance with the classic proposition of Donabedian,[10] independent of the fact if they are able to be quantified or not. In this sense, *qualitative evaluation,* for contemplating aspects circumscript to the plane of subjectivity, incorporates itself into the *evaluation of quality*.

It is worth pointing out that both planes – objective and subjective – correspond to inherent dimensions of complex phenomena such as health. As such, the idea is not to exclude one of the polarities, nor to defend the predominant one over the other, but rather contribute to a broadened conception of evaluation,

so that the necessary rigor in applying the concepts and selecting the adequate approaches for what is intended to be evaluated.

Transporting the present reflection to an actual health system context, the model of care consolidated as part of the implementation of the National Health System (SUS) stands out, as it exercises an unquestionable amount of influence on the definition of the scenario, whose specificities impose that the initiatives of evaluation be recognized and considered, indicating the need for the construction of a theoretical-methodological model that will give it support. Such a model stimulates an expanded understanding of health and prioritizes the construction of care practices which have integrality and humanity as pillars.[9]

Care as an object of evaluation in health

The notion of care adopted for the present reflection is founded in the proposition that care transcends the technical environment of treatment or level of attention in health,[2] although it represents the material nature of the interpersonal relationships that are established in this field.

This perception of *care* is intimately related to the notion of *integrality*. Integrality constructs one of the philosophical pillars of the SUS in Brazil, and in the center of the conceptual matrix of some programs, exercises a multi-dimensional omnipresence that requires an expanded vision of man, health, and care, translated in the need for many visions of a certain object.[1]

Still the is a clear interface with another presumption worth reflection – humanization – as its appropriation has been banalized and inadequate. Not uncommonly, the term humanization is invoked as if it had a clear and singular significance. In the same way that this happens with other allusive concepts discussed in the present paper, they count on the possibility of various readings, sustaining different practices.[4,7]

Human refers to the plan of intersubjective relations that are processed in social practices, in this case, in reference to the health field having as their base the capacity of symbolism and construction of meanings in relation. Intersubjecitve relation, while a space of humanization of practices, is not limited to the contact between individuals or isolated subjectivities, but rather it is established as a symbolic relationship between historically situated subjects.[3] In other words, the human is constituted *in relation* and does not exist beyond this intersubjectivity. Therefore, to humanize signifies the possibility of this re-encounter, implying in comforting and dialogue.

It refers to taking a fundamentally ethical position. An ethical condition giving in contact, an opening for the other, the condition of the possibility of complete subjectivity.[11]

It is crucial to emphasize that dialogue cannot be reduced to a speech or a conversation. Genuine dialogue is an attitude from which the other assumes a precipitates an encounter.

Evidently, this approximation, corresponding to what Buber[6] refers to as the attitude Me-You, cannot be maintained indefinitely, due to its alteration with distancing – attitude Me-It. However, it is worrisome that in the era of super-communication, in which time and space barriers are constantly transposed, that this dialogue is disappearing.

The human is therefore eliminated, dehumanizing social practices and in health by reducing the relationships between people in relationships Me-It. Such a mechanism resonates in many of the instruments/technologies used in traditional evaluation in the way in which it restricts or impedes listening and dialogue.

The recognizing of the dialogue plane as a space of humanization of practices does not refer only to rescuing subjective, affective demands, in the plane of singularities. It refers, still , to the construction of new horizons for health evaluation practices through the recognition of the subjective demands put to sleep by distance and alienation.

Synthesis

The evaluation of health actions, in a context of reflection and practice, involves a subjective and objective network, through which various challenges and possibilities are brought to light.

As discussed in the present paper, *evaluation of quality* and *qualitative evaluation* cannot be reduced to interchangeable frameworks, as they constitute political options rooted in health projects that cannot be juxtaposed and demand rigorous conceptual demarcation. To understand this distance can represent a first step in constructing alternatives and evaluation proposals that break with traditional and exclusionary perspectives and, in a dialectic way, overcome them.

To speak about humanization and integrality in health care, and reflect about the incorporation of these principals in the area of evaluation implies accepting the polysemic nature of quality. As such, qualitative evaluation of programs is that which, with-

out damaging the insertion of other dimensions, *necessarily* includes the actors involved in the production of the practices, their subjective demands, values, feelings, and desires.

The polysemy of quality requires recognizing and considering the centrality of symbolic processes and discursive practices of the actors involved – especially the users, for the evaluation of the nuances of quality of the actions developed, understanding, overall, these perceptions not as decontextualized subjectivity, like those idealistic perspectives, but rather as a sign of complex experiences, materialized in the relationships established with certain health practices. The interfaces between two planes-the subjective and the material with which it is related – constitute a guiding principle for evaluative processes that consider formal aspects of quality and include subjects whose needs and demands, as well as their interactions between themselves and with their structures, play a decisive role in the production of care in health.

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