


National Health Policy Reform for Primary Care in Chile: A Qualitative Analysis of the Health Program Documents

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Abstract

Introduction: Chilean policy makers reformed the national health policy for primary health care (PHC), shifting from the traditional biomedical model to the integral family and community health model with a biopsychosocial approach, to guide the delivery of PHC throughout the country. **Purpose:** To evaluate the implementation of the national health policy for PHC through an analysis of the program documents for PHC; and to identify to what extent the national health policy is expressed in each program document, and across all the documents. **Methods:** A qualitative document analysis with a purposive sample of program documents for PHC. The Chilean Ministry of Health website was systematically searched between October and December 2018 to identify relevant program documents. Thematic and content analysis were performed to identify evidence of the biopsychosocial approach to care delivery with each program document, including the types of interactions between professionals that contribute to person-centered or fragmented care. **Results:** The study included 13 PHC program documents. Three themes and 10 categories emerged from the data. Most program justifications focused on the biopsychosocial approach to care while including biomedical interventions and supporting independent professional work. Only 4 of the 13 programs were consistent in the justification, interventions, and types of stated professional interactions: 2 from the biopsychosocial and 2 from the biomedical perspectives. **Conclusion:** In terms of the national health policy for PHC in Chile, interprofessional collaboration and person-centered care processes and practices were partially aligned with the written content of the health program documents. As such, policy makers and health sector leaders are advised to analyze draft health program documents for consistency in translating national health policies into the written communications that define the actualization of the care model in PHC and direct professionals how to provide PHC to individuals and families.

Keywords

Chile, public health, primary care, health policy, health programs, biomedical, biopsychosocial, interprofessional collaboration, person-centered care, qualitative method, document analysis

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Introduction

For decades, public health leaders have attempted to develop health systems focused on providing universal access to cost-effective person-centered primary health care (PHC), generally regarded as the most efficient and effective model for solving national health problems.^{1,2} Primary care teams (PCTs) are essential to provide the evidence-based, community-delivered, and person-centered care¹ to achieve population health objectives such as reduced morbidity and mortality, decreased chronic disease prevalence, and

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Term (Level)	Definition
Plan (Macro General)	A general idea for an intervention to change the tendency or shift the strategic direction for components of a sector or area of the economy.
Strategy (Macro Focused)	The way plans are defined with a comprehensive and permanent character that identifies and establishes fundamentals actions for insertion into the policy planning process to produce a temporal sequence of events that are viable and feasibility.
Policy (Macro Defined)	The principles by which the governments uses their formal authority and regulatory powers to orient systems and direct behaviors of private entities and public agents to achieve the strategies.
Program (Meso Defined)	A group of projects that point the policy into a defined direction with an organized pool of actions to link resources to actualize the intended outcomes.
Projects (Meso Directed)	The interrelated and coordinated activities that are essential to achieve defined objectives for the programs including the services within the limitations of an approved budget and a defined period of time.

Figure 1. Hierarchy of terminology for national health planning in Chile.

Note: For the Chilean health sector, the government generates documents to actualize the planning process into health programs. The terms with definitions for the levels are translated for clarity of meaning (Reference: <https://repositorio.cepal.org/handle/11362/7316>).

improved child and maternal outcomes.^{1,3-5} Ideally, these teams can provide the first and continued access point for comprehensive primary health care with coordinated interventions. Person-centeredness is an essential strategy to holistically conceptualize health care, including evaluating wellness and diagnosing sickness considering the patient perspective.⁶ As such, PCTs can provide robust person-centered care,^{1,7} guided by the biopsychosocial model,⁸ understanding the biological, psychological, social, cultural, and spiritual interactions in an egalitarian way.^{7,9,10}

The national health policy for primary care has shifted to the biopsychosocial perspective¹¹ principally focused on providing person-centered care delivered by teams^{12,13} in primary health settings. This contemporary approach is more robust than the previous biomedical model where dysfunctional systems and diseased organs are contextualized as biochemical and mechanical disorders.^{9,10,14} The national health policy is implemented into practice through the primary health care programs. Developing these programs requires bringing together a diverse group of professionals working together as a PCT. There need to be organizational guidelines, as well as conditions (eg, team meetings, shared spaces, integrated health records) to facilitate knowledge exchanges, to improve communication about care, to construct a shared perspective about collaboration, and to coordinate care management.¹⁵⁻¹⁷ Thus, the new model selected to guide the national health policy needs to be explicitly written into the health program documents in order to achieve the expected actions that result in achieving the national primary health care outcomes.^{18,19}

When the national health programs are focused on person-centered approaches to providing care, the different professions can work together, or collaborate, as a PCT to provide more efficient and cost-effective health services²⁰⁻²² as compared to the inefficient and fragmented care observed

with disease-centered approaches.²³⁻²⁶ In this regard, collaboration is the sum of professional interactions characterized by mutual goals and values, aligned responsibilities, distributed power, shared decision making, effective communication, and interdependent roles with a shared identity.^{15,27-30} The enactment of policies, procedures, processes, and practices that support collaborative work environment, specially interprofessional collaboration^{27,28,30} has been identified as a facilitator^{24,30}; hence the reason many countries have implemented reforms that foster collaborative work.^{23,24,27,31,32}

Historical Context

The current Chilean PHC system, funded by the national government and managed by the municipalities,³³⁻³⁵ provides health services to nearly 80% of the population principally the low-income population.^{36,37} The PHC provide basic benefits, usually bundled within health programs, as part of the Family Health Plan (*Plan de Salud Familiar* in Spanish).¹² The health programs guide the provision of health services throughout the life span with health promotion, prevention, diagnostic, treatment, and rehabilitation interventions implemented by the Regional Ministerial Secretaries in the PHC centers.^{12,38} The interventions extended from these primary care programs are supposed to be synergistic with the activities at the other levels of the system, including secondary and tertiary. The programs include public health activities ranging from vaccinations to palliative care. Figure 1 provides an overview, with definitions, of the basic hierarchical structures involved in government planning for interventions in the health sector.

Historically, the Chilean Ministry of Health (MOH) has made efforts to solve problems in the national health sector with strategies conceptualized from a biopsychosocial

perspective.¹¹ As such, in 1993 the MOH began revising the national health policy with reforms to the structural framework and organizational processes for delivering PHC.¹¹ With the purpose to achieve a deeper knowledge about the health of the population, a process called “sectorization” divided the health center populations, by geographical reference, into smaller more localized areas to be managed by multidisciplinary PCTs¹¹; called empanelment in the international literature.^{22,25,39} In the past, the PCTs were organized via programs and projects, to address the health and wellness of people, families, and communities. Through the revision to the PHC model, the MOH saw the need to include multiple professionals working in teams to provide better primary care.¹¹ The synergy generated by the multidisciplinary teams working in a collaborative and coordinated manner was expected to address the growing complexity of the national health problems.¹¹

Between 2008 and 2009, the MOH advanced the model to guide to PHC delivery^{40,41} to the Integral Family and Community Health Model (IFCHM), an extension of the Engel Biopsychosocial Model⁴⁰; used from 1993 until the present.¹¹ The resulting policies addressed the challenges associated with implementing the original model by shifting the focus from the traditional disease-centered to family-centered care. Within this context, a 5-stage transformational process (1—*Etapa Consultorio* [Organization of Work]; 2—Motivation and Commitment; 3—Development; 4—Strengthening; 5—Consolidation) was implemented through organizational guidelines that facilitated family-centered care.^{40,41} As a result, the organizational guidelines redirected the PHCs to support multidisciplinary teams^{40,41} to provide transdisciplinary care,^{40,41} or interprofessional collaboration. The health policies focused on developing organizational guidelines that support interactions, based on communication, trust, synergy, interdependency, encourage respect for different roles, and support professional autonomy^{12,40,41} resembling closely to what is internationally called interprofessional collaboration^{3,18,19,27,42}; the perspective strengthened in the 2012 health policy.¹² The consolidated model described in 2012 guideline (*Orientaciones para la implementación del modelo de atención integral de salud familiar y comunitaria*) guides the care in every PHC facility across Chile.⁴¹

Throughout the model development and refinement process to actualize the new primary care strategy, the MOH developed new technical standards and clinical guidelines for the PHC program related activities.³⁵ These changes captured the contemporary perspective for managing health, including consideration for the social determinants of health. Importantly, most programs originated prior to the IFCHM; subsequently updated over the last decade.³⁵ With updates to the programs, professionals are directed to work differently within teams across the PHC system.⁴³ The matrix organization^{44,45} was initially developed in 1993,

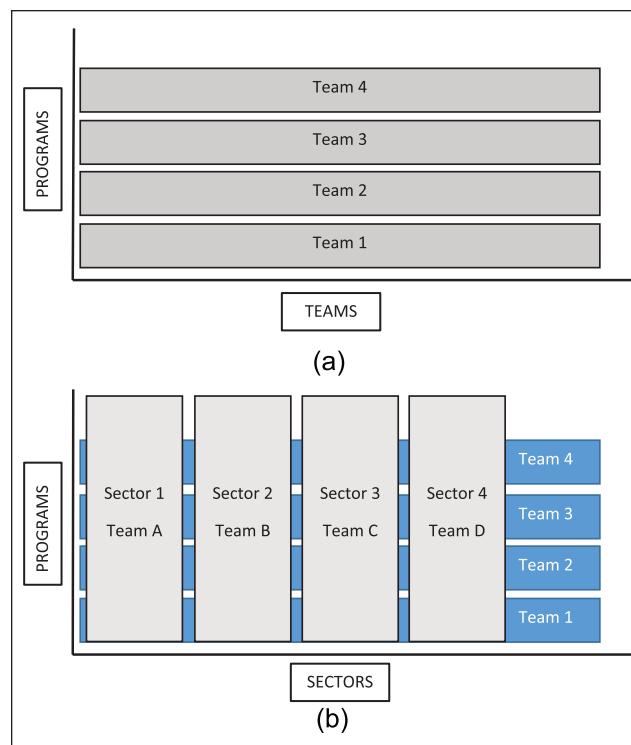


Figure 2. Organizational structures of programs and teams. (a) Program structures and teams without sectors prior to 1993. (b) Program structures and teams with sectors after 1993.

refer to Figure 2, to achieve the program and sectoral/territorial goals.^{11,12,40,41}

Purpose

The Chilean policy makers shifted the national health policy from the traditional biomedical to the contemporary biopsychosocial approach to guide how health services are delivered throughout the country. The purpose of this study was to analyze the content of the national health program documents for primary care (produced by the MOH) to evaluate their alignment with the national health policy. In particular, this study sought to evaluate how the national health policy was implemented through the content of the health program documents for primary care, and to what extent are the elements from the national health policy present within each document, and across all the documents that define primary health care in Chile.

Methods

This qualitative study⁴⁶ applied the method called document analysis⁴⁷ to evaluate the influence of national health policies on the delivery of primary health care through the thematic analysis of the associated health program documents. These program documents formally communicate

the health policy through written directives to guide primary health care professionals. Although this qualitative method is flexible, reflective, subjective, and iterative,⁴⁸ the resulting data analysis is credible, dependable, confirmable, and transferable⁴⁹ as rigor⁵⁰ and trustworthiness⁵¹ are a fundamental objective. The document analysis method for this study is described in the next section, followed by an overview of the 5 phases of the research process.

Document Analysis

Although “qualitative research is many things to many people,”^{52(p8)} ethnographic content analysis⁵³ is a traditional qualitative method⁵⁴ that permits researchers to recruit verbal, visual, and written communication as “participants” for studies to search-out underlying themes in the materials collected for analysis. In the qualitative paradigm, there are four major sources of data, including: interviews, focus groups, observations, and written text/audiovisual materials.⁵⁵ In terms of research using written text, the document analysis method is the most prevalent qualitative approach that is commonly used for public health⁵⁶ and policy research.^{57,58} For this study, a health policy document was defined as the textual evidence of policies focused on health with a governmental origin, cultural persuasion, and contextual uniqueness⁵⁹ that can be recorded and retrieved for description and analysis.⁶⁰

Document analysis has been defined as “an approach of empirical, methodological controlled analysis of texts within their context of communication, following content analytical rules and step-by-step models, without rash quantification.”^{61(p5)} Similarly, social scientists view the method as “an approach to documents that emphasizes the role of the investigator in the construction of the meaning of and in texts.”^{62(p285)} For the purpose of this specific study, document analysis was defined as a systematic process to review and evaluate health policy documents that requires data to be compiled, disassembled, reassembled, and interpreted in order to elicit meaning, gain understanding, and develop empirical knowledge.⁴⁷

Five Phases for Document Analysis

The document analysis was completed in 5 phases: (1) selected the subject of analysis and identifying the documents; (2) defining the search strategy and collecting the targeted documents; (3) scanning the text, coding the data, and organizing the codes; (4) analyzing the codes and identifying the categories; and (5) interpreting the findings and reporting the results.^{46,63-65} In summary, content analysis reduces data into the categories for calculations and comparisons such as descriptive, normative, cross-sectional, and longitudinal,⁶⁶ while thematic analysis examines the relationships and meanings within and between the

categories to identify themes.⁶⁷ As such, this study applied thematic and content analysis to move from data, to codes, to categories, and finally to themes, to answer the same research question.⁶⁸ The 5 phases for this study included

1. *Defining the subject of analysis and identifying the documents.* The research question, supported with a theoretical background, resulted in the identification of the Chilean health program documents for analysis. The health program documents are publicly available through the Chilean MOH website. Each program corresponds to a program document that was developed by the MOH, either at the central or regional level, and applied in every PHC in Chile.
2. *Defining the search strategy and collecting the targeted documents.* The purposive sample⁵⁶ of documents for this study was selected from a systematic search⁶⁹ of publicly accessible official Chilean government websites and databases,⁷⁰ principally the MOH, between October and December of 2018 with the key terms (in Spanish): Programs, guidelines, technical orientations, programmatic orientations, vital cycle programs, transversal programs, support programs and health.⁷¹ Only documents published within the past 10 years, following the health reform, were included in the sample; all other documents were excluded. An additional document verification search was completed at the end of the study, in 2019, to identify potentially missing or important new documents prior to completing the presentation of the results.
3. *Scanning the text, coding the data, and organizing the codes.* Once the sample was completed, the documents were reviewed multiple times by the research team for familiarity with the format, content, and context. The paragraph was adopted as the unit of analysis⁶⁴ for each document. The document review and data collection process focused on identifying and coding the implicit and explicit content evidence, related to the biomedical and biopsychosocial models. In addition, the types of interactions between professionals as well as the relationships that could lead to person-centered or fragmented type care were identified and coded for analysis.
4. *Analyzing the codes and identifying the categories.* Following the organization of the relevant paragraphs, and the highlighting of key sentences, these were organized for the thematic and content analysis.⁷² The analysis process progressed in 10 steps, including (1) review the identified documents; (2) develop the main categories; (3) complete the first coding process; (4) compile the data for each category, look for subcategories; (5) complete the second coding process; (6) category-based

analysis; (7) thematic-based analysis; (8) interpret the findings; (9) Review the work, check the notes, and discuss the findings; and (10) organize and prepare the results.^{65,68,73-76} For developing the codes, a deductive identification process using a “code template” constructed a priori based on the theoretical review.⁷⁷ Demonstrating the rigor using thematic analysis,⁷⁴ the process also included an inductive perspective to allow modification and/or expansion of the prior codes or emergence of new codes.

5. *Reporting the results.* Through a constant comparison technique,⁷⁸ data were organized and sorted into different themes for reporting. These themes are described in detail as an evidence of the researcher rationale.^{65,75} For results presentation, the most representative quotes were selected as exemplars for each code as well as to support the overall analysis.^{49,74} Furthermore, a summary table was constructed to illustrate the frequency in which the codes were present in each document, defined as absent (0) to very present (+++).^{46,74} This process permitted the analysis of internal coherence for each document; making possible an evaluation of congruence between each model, biomedical and biopsychosocial, with the health actions and the professional interaction types described within the documents. Then, the final evaluation was completed to review about the alignment of the study concepts within the national health policy.

Trustworthiness

Multiple strategies and techniques were incorporated into the study design to establish the trustworthiness⁷⁹ of the thematic analysis, including memos, framework coding, audit trails, referential adequacy testing, peer debriefing, and detailed content descriptions for data representation.^{49,80} Memos⁸¹ were maintained throughout the coding and categorization process. The memos provided the previous ideas, insights, and interpretations that aided with the continuously probing of the data and the frequent rechecking of the results.⁸² In addition, the member debriefings and the peer debriefings provided essential pauses for collective reflection to validate the data representation and the derived meaning.⁸³ As recommended,⁸⁴ the categories and themes and were not finalized until all the data were reviewed and the codes were scrutinized multiple times.

The data presented in the quotes throughout the analysis are provided in the original Spanish and the translated English versions (see Supplementary Table 1). In addition, the documents are publicly available to review the raw data.⁷⁴ Finally, the Standards for Reporting Qualitative Research⁸⁵ were followed to improve the transparency for the dissemination of this study, as well as the criteria⁸⁶

outlined for evidence-based research and practice. As the program documents are available in the public domain, without any type of private or confidential information, an institutional review board approval was not required.

Results

The systematic document search strategy resulted in the inclusion of 13 health program documents (see Table 1) for analysis. In addition, the summary for each health program document included in this study (see Supplementary Table 2). From the analysis, 10 categories emerged from the data and organized into 3 themes (see Table 2). The next sections describe the 3 themes: program justification, interventions considered in the program, and types of professional interactions.

Program Justification

The definition for the health problem and the solutions were addressed by each program through interventions. From these 2 components, the health policies were configured with the justification, or background, for the associated program. In defining the health problem addressed in the health policies, elements of both the biomedical and biopsychosocial perspectives were identified. However, the majority of programs, 10 of the 13,⁸⁷⁻⁹⁶ primarily embraced the biomedical perspective. In this regard, they emphasized objective data using statistical and epidemiological measures, generally derived from national epidemiological surveys, to quantified sickness as the central principle that underlies the creation and maintenance of the program.

The National Health Survey (2009-2010) permits a baseline for this proposal (. . .) a complex situation exists for the Chilean population in some areas of health, such as a high prevalence of chronic noncommunicable diseases, which are acquired in the period of adolescence and youth, causing morbidity or mortality during adulthood. (Integrated health for adolescents and youth, p. 8)

In the case of the biopsychosocial approach, 11 programs,^{87-94,96-99} partially defined the health problem using the social determinants of health framework to understand the context and to acknowledge the interactions between the factors, including family relationships, socio-cultural characteristics, environmental situations, and economic conditions. Also, gender, migration, and life course were considered.

The development of all childhood deficiencies is related to several variables, such as mother and father parenting skills, access to preschool, disease prevention strategies and health promotion, environmental conditions, socioeconomic and

Table 1. National Health Program Documents for Primary Health Care in Chile.

No.	Health program documents (English/Spanish)	Publication year
1	Integrated health for children / Salud de la infancia con enfoque integral	2013
2	Integrated health of adolescents and young people / Salud integral adolescentes y jóvenes	2012
3	Older adult health / Salud del adulto mayor	2014
4	Cardiovascular health / Salud cardiovascular	2017
5	Complementary nutrition for children and adults / Alimentación complementaria del niño y del adulto	2011
6	Sexual and reproductive health / Salud sexual y reproductiva	2017
7	Mental health in primary care / Salud mental en atención primaria	2013
8	Home health services for patients with severe dependence / Cuidadores de pacientes por dependencia severa	2014
9	Integrated rehabilitation in the health network / Rehabilitación integral en la red de salud	2014
10	Integrated dental care / Odontológico integral	2018
11	Respiratory health / Salud respiratoria	2015
12	Self-sufficient older adults / Más adultos mayores autovalentes	2015
13	Healthy lifestyle / Vida sana	2015

Table 2. Themes and Categories.

Themes	Categories
Program justifications	Biomedical definition of the problem
	Biopsychosocial definition of the problem
	Biomedical solution proposed for the identified problem
	Biopsychosocial solution proposed for the identified problem
Program interventions	Person-centered intervention
	Fragmented intervention
Types of interactions between disciplines	Intersectoral work
	Interprofessional work
	Multiprofessional
	Uniprofessional work

cultural characteristics in which the child develops, etc. (Integrated health for children, p. 37)

In terms of the proposed solutions, both the biomedical and biopsychosocial perspectives were identified within the data. In the case of the biomedical perspective, seven programs,^{87-89,91,93,95,96} focused on identifying people at risk for the disease, incorporating interventions to address pathophysiologic conditions, and prioritizing health services to address the risk and/or disease severity.

The program focuses on those people who have a high risk for developing hypertension and type 2 diabetes in the future (. . .) there are screening tests that can identify high risk subjects, as well as safe and potentially effective interventions that may decrease the risk factors for developing noncommunicable diseases. (Healthy lifestyle, p. 6)

Regarding solutions from a biopsychosocial perspective, the focus was to address inequalities during critical

development periods for people, an example is the national health program that focused on promoting the integrated development of children⁸⁷ by improving the environment in which they grow and develop.

In 2008, the Comprehensive Early Childhood Protection System was implemented at the national level (. . .) This system is an integrated management model which includes different government agencies, seeking to deliver differentiated conditions for families in order to reduce inequality in the most critical period of development, from gestation to 4 years old. (Integrated health for children, p. 22)

Programs also considered interventions based on the social determinants of health framework, as well as the ecological, cognitive behavioral, and learning models. Ten documents analyzed include solutions with a holistic orientation^{87,89-91,93-97,99} In general, the predominant perspective implied in the proposed solutions were conceptualized from the biopsychosocial model.

Interventions Considered in the Program

The interventions correspond to the actions stated in the programmatic guidelines or programs applied by professionals. The existence of fragmented and person-centered interventions was identified. For example, a classic biomedical/fragmented intervention was related to the diagnosis and treatment of a pathology, with specific actions to manage the acute disease period with periodical medical controls. In this case, the interventions focused on managing symptoms that compromise health status and thus, decrease the perceived quality of life, not necessarily based on the actual experience of having a disease, but rather using preconceived instruments that defines the way to understand quality of life.

Diagnosis and treatment (. . .) evaluation, confirmatory diagnosis, categorization, treatment and follow-up for recurrent obstructive bronchial syndrome, bronchial asthma and other chronic respiratory conditions; periodic visits for chronic respiratory patients with standards and evaluation to control levels; evaluation of quality of life for patients entering the program for acute respiratory infections, with standardized instrument. (Respiratory health, p. 17).

Additionally, person-centered interventions were identified. An example is how the integral home visits were included in several programs to be in closer contact with the person, within the context of their home and surrounding community, to understand their reality. This provides a wider assessment of the environmental context in which the person lives, expanding from the biological to the psychological and social aspects of their health status.

The integrated health services provided in the home focus on high risk groups, considering the family environment through the actions of promotion, protection, recovery, and rehabilitation of health (. . .) allows an interaction with one or more family members, with the caregiver, and the environment; tending to achieve better knowledge and support to confront the biopsychosocial-hygiene problems. . . . (Home health services for patients with severe dependence, p. 6)

Both interventions were identified in all the health programs,⁸⁷⁻⁹⁹ principally with more fragmented interventions in the analyzed documents.

Types of Interaction Between Professionals

In this study, there were interventions supporting different types of interactions that impacted how professionals worked resulting in different levels of collaboration with the patient. The documents describe 4 types of work in terms of these interactions, including (1) intersectoral work (developed with other governmental sectors), (2) interprofessional work (developed in a collaborative way that include different professionals), (3) multiprofessional work (developed independently but in a coordinated way), and (4) uniprofessional work (independent work). In the first case, the different sectors need not only coordinate care, they also needed to plan together with a common goal focused on improving the actual health status of the person, encouraging health coverage, and providing care within the context of the community. This type of work was included in 12 programs.^{87-93,95,97,99}

Working with older adult clubs and office programs related to sports and other education, cultural, and social activities (. . .) can increase the coverage and the proximity of the health team with the community. (Self-sufficient older adults, p.10)

The interprofessional work was observed in 5 programs.^{87,93-95,97}

It will be developed in the community, with the action of the Primary Health Care Team, in particular, with a double Physical-Occupational Therapist or another trained professional. (Self-sufficient older adults, p. 8)

Also, multiprofessional work was described in the documents through teamwork, team leaders (*equipo de cabecera* in Spanish), and/or specialty teams. When the documents indicated clinicians can manage care, either alone or with other colleagues, the interactions were not mandatory. This type of work was included in 9 programs.^{87-91,93,96-98}

One of the actions that must be carried out by the Health Care Team, corresponds to the integrated home visit (. . .) through promotion, protection, recovery, and rehabilitation of health actions that one or more members of the Health Care Team performs at the home of the family or user. (Home health services for patients with severe dependence, p. 7)

When activities related to care were independently performed by specific professionals, these were labeled uniprofessional work. There was a tendency in program documents for multiple interventions that could be performed by several professionals, but were stated to be completed one-to-one manner, usually in an examination/treatment room. Ten programs included this type of uniprofessional interventions throughout the program.^{87-88,90-93,95,97-99}

Reception in the Acute Respiratory Diseases patient area referred from the health network due to an acute respiratory or exacerbation of a chronic respiratory condition, to access a visit with the physical therapist within the deadlines established Explicit Health Guarantees for patients. (Respiratory health, p. 20)

A summary of the findings is organized in Table 3. In general, we observed a predominance of biopsychosocial characteristics for the program justification, as well as fragmented interventions and uniprofessional work. Regarding the alignment between person-centeredness and interprofessional collaboration in the program documents published by the MOH, we only found 2 aligned programs, including the “self-sufficient older adults”⁹⁴ and a partial alignment in “mental health”⁹⁷ programs. However, we found an alignment between the biomedical model with fragmented interventions thru independent or coordinated professional work in the cases of the “respiratory health”⁹² and “rehabilitation health”⁹¹ programs. We also observed a balance between the 2 perspectives with all professional interactions in the “integrated health for children”⁸⁷ and “healthy living”⁹³ programs. Throughout the other programs, we were unable to identify a clear profile. We should also note that only the “integrated health for children”⁸⁷ and “healthy living”⁹³ programs explicitly included the IFCHM within its background, being exposed but not narratively integrated into the different components of the program.

Table 3. Summary of the Results by Health Program.^a

	Justification of the program			Interventions considered in the program		Type of interaction between professionals				
	Biomedical definition of the problem	Biopsychosocial definition of the problem	Biomedical solutions	Biopsychosocial solutions	Fragmented	Person-centered	Intersectoral work	Interprofessional work	Multiprofessional work	Uniprofessional work
Children health with integrated approach of children and adolescents	+	+	+	+	+	+	+	+	+	+
Older adult health	++	++	+	++	+	++	+	0	+	0
Mental health in primary care	0	+	0	+	+	++	+	+	+	+
Home services for patients with severe dependence	+	+	0	+	+	+	+	0	+	+
Integral rehabilitation in the health network	++	+	+	+	++	+	+	0	+	+
Self-sufficient older adults	+	+	0	+	+	+	+	+	0	0
Cardiovascular health	+	0	+	+	++	+	+	+	0	+
Complementary feeding of children and adults	+	+	+	+	++	+	0	0	+	0
Sexual and reproductive health	0	+	0	0	+	+	0	0	+	++
Integral dental	0	+	0	+	+	+	+	0	0	++
Respiratory health	+	0	0	0	+++	+	+	0	0	+++
Healthy lifestyle	+	+	+	+	++	++	+	+	+	+

^a0 = absent (0%); + = present (until 25%); ++ = medium presence (until 55%); +++ = very present (55% or more).

Discussion

The purpose of this study was to analyze the alignment between the Chilean national health policy related to the biopsychosocial model, as manifested through person-centered care and interprofessional collaboration, and the current health program documents developed by the MOH. Overall, the program justifications generally referenced the biopsychosocial model with biomedical interventions performed with independent professional work. Six programs were consistent in their justification, interventions, and type of expected professional interactions, including 2 with a biopsychosocial orientation, 2 with a biomedical orientation, and 2 with a mixed orientation.

In the context of policymaking, the lens used to define the problem results in different solutions depending on the context analyzed.¹⁰⁰ As the IFCHM provides guidelines for the problem definition, proposed solutions, and types of required work, we expected to find a similar perspective in the programs coexisting with the model, especially since all programs were published after 2010 (the years following model implementation). To this point, we expected the health of a person to be defined from a more holistic approach to person-centered care. Instead, we observed the biopsychosocial approach to PHC was not robustly translated into the written program interventions. Instead, the findings were consistent with the interventions resulting in fragmentation historically linked to the biomedical paradigm.¹⁴ Furthermore, we found person-centered interventions that were not accompanied by interprofessional work, demonstrating an inconsistent translation of holistic interventions necessitate by the IFCHM. In this sense, less than half the program documents included interprofessional collaboration.

In terms of the alignment between person-centered care and interprofessional collaboration, we only found evidence in 2 programs (“self-sufficient older adults” and “mental health”). Both programs have a health promotion and preventive approach to delivering health services to a well-defined population. Promotion and prevention activities require a broad vision, for example, in the case of promoting healthy lifestyle there need to be recommendations related to nutrition, physical activity, stress management, and self-care. In this regard, the team needs to include different professionals such as dietitians, nurses, physical therapists, and psychologists. This situation opens more possibilities for different professionals to collaborate in the care management; eliminating the typical limitation related to the specialized medical knowledge that hinders interprofessional collaboration.^{30,101} This can also explain why the “respiratory health” and “rehabilitation health” programs have a clear biomedical stamp as both programs are focused on physiological determinate systems that require specialized medical knowledge or practices that can be applied by one

profession, in this cases by a physical therapist. On the other hand, some interventions included in “self-sufficient older adults” and “mental health” programs are applied in group sessions, which usually requires more than one professional to manage the group. Furthermore, many of the interventions occur in community settings; identified as a facilitator of interprofessional collaboration.³⁰ Finally, every program analyzed included person-centered interventions but only 5 program descriptions included activities performed in a collaborative way by 2 or more professionals.

Contrasting the previous Chilean context, the highly developed countries such as the United States, Canada, and the United Kingdom have implemented health policy reforms supporting interprofessional collaboration through patient-centered care in the medical home context.^{30,102,103} Interprofessional collaboration is viewed as a component of patient-centered care, especially with complex cases that require a broader perspective to plan multiple strategies to tackle the health problems.¹⁰² Nonetheless, different authors have criticized patient-centered care for the focus on transferring responsibility for the health outcomes to the patient instead of proving them with the necessary support for a good decision-making process.¹⁰¹ Yet, organizations continue to promote patient-centered care highlighting the patient satisfaction while not addressing the other aspects to achieving holistic/comprehensive care.^{30,102,103}

Patient-centered care is linked to 3 concepts: (1) expanded view of illness, (2) patient participation in care, and (3) provider-patient relationship.¹⁰² International evidence indicates the focus on the last 2 concepts,^{30,101,104} while largely ignoring the expanded view of health, not only within the context of illness, which is important for Chile due to the national health policy.¹³

An important reason noted in the literature for the focus on patient-centered care is to shift the care responsibility from the health facilities and physicians to the patients and families. As patients become increasing responsible for their own health, there is a risk reduction in legal for deficits in care actions against hospitals, health centers, and physicians.³⁰ In this study, we use *person*-centered concept instead of *patient*-centered care discussed in Starfield’s work.^{39,105} Eklund et al¹⁰⁶ discussed the similarities and differences between these 2 concepts, observing that the *person*- and *patient*-centered care have at least 9 features in common: empathy, respect, engagement, relationship, communication, shared decision making, holistic focus, individualized focus, and coordinated care. However, the 2 concepts also differ in important ways. In the first case, the main goal is a meaningful life for the person, and in the second case, the goal is a functional life for the patient. For this reason, the authors believe the *patient*-centered approach to care replicates the biomedical model.

Despite the efforts made to advance public policy in economically developed countries, the interventions have not

been translated into clear changes in the way health professionals perform their work.³⁰ Although there is consensus about the value of interprofessional collaboration in providing high-quality health services, institutional structures often hinder the implementation of health interventions by collaborative teams.¹⁰¹ The power structures, such as legal, political, and economic, can delay and even obstruct the advancement of care models for interprofessional collaboration.^{30,101} Several authors^{30,102,103} suggested the process is handicapped by maintaining the traditional medical power structures that include defining work only to be completed by physicians, limiting the autonomy of other competent and capable professionals; preserving the fee-for-service payment model that reinforces medical power through only reimbursing physicians for services; and measuring health impact and team performance indicators based on the biomedical model.

The power structure influence can be minimized by applying process indicators that focus on measuring work characteristics specific to teams.¹⁰³ For example, the number of team meetings is relatively simple to measure; however, there should be a group of indicators specific to the care model. This is important as researchers have noted that only implementing team meetings may not achieve the full extent of the expected professional interactions. In this regard, van Dongen et al¹⁰⁴ reported team meetings alone were not successful in developing shared care plans that included the perspectives of different disciplines as well as the patient. Importantly, the researchers noted this reality was unrecognized by the professionals, who individually perceived the meetings to be patient-centered (defined in the study as the care that requires coordinated inputs from a wide range of health care professionals to enhance quality of care). However, in a related study,¹⁰⁷ the amount of interprofessional collaboration to develop care plans was reported to be correlated to a combination of 5 factors, including patient, professional, interpersonal, organizational, and external. As such, the program documents need to include strong, coherent, and concrete language to guide the way professionals work in the PHC centers, as well as to establish the process and result indicators that reflect the chosen care model. This is perhaps one explanation for international health policy initiatives failing to accomplish their primary purpose.

In terms of this study, the interventions that should be independently performed need to be clearly delineated, and by which discipline. Similarly, the way the activity is completed, and the result is communicated to the entire team must be clearly defined. Then, the interventions requiring collaboration between disciplines need to be developed within each program, such as the case for people living with diabetes managed by the physicians, nurses, dietitians, and physical therapists. By focusing on compatibilization, or defining how the 2 models can coexist to increase the quality of care, as the balance between autonomy and interdependence will favor collaborative work.¹⁰⁸

Despite the introduction of innovations to establish new institutional realities,¹⁰⁹ the results demonstrate a tendency to maintain the traditional processes in written documents perceived to be effective. Considering the type of professional interactions necessary to achieve the goal of person-centered care and the incremental nature of policy making, existing policies need to be revised to overcome the unintended traditional barriers to collaborative work. This can be completed by launching new guidelines that enhance communication processes, encourage professional interactions, and clearly define shared responsibility for the disciplines expected to provide person-centered care.^{24,42,110} However, we need to be mindful that on occasion collaboration is not necessary, as some interventions can be implemented better and/or safer as a uniprofessional task.¹¹¹

Finally, the presence of intersectoral work, as a type of interaction explicitly stated in the program documents, was unexpected. Following the Alma Ata declaration “health for all”¹¹² and the current World Health Organization advocacy for “health in all policies,”¹¹³ the health sector needs to work intersectoral, with other economic sectors within and across national boundaries, to widely promote and provide health in an explicit manner.¹¹⁴ The inclusion of intersectoral work as an explicit concept in the program documents appears to be linked to the concepts in this study; however, additional research is necessary to consider the link between the policy and the program, that include the person and practice environment. Yet, we must be mindful that Chile does not have a periodical process to review, identify, and prioritize national health research needs.¹¹⁵

Limitations and Strengths

With a document analysis, three principle limitations need to be recognized.¹¹⁶ First, there is the potential for insufficiency of context as the program documents were not written for research. For example, there were differences in the format of the program documents, which increases the potential for error in extracting the data consistently across documents. Despite this limitation, the inclusion of all the documents prevented the introduction of bias into the document analysis. Second, there could be important program documents, or other related information, missing from the sample due to low retrievability associated with filing methods and storage locations. And, biased selectivity⁴⁷ is possible with errors in search strategy and document selection, and missing documents. However, the database was searched multiple times by the investigators, a comprehensive group of terms was used for the search, and the primary investigators are familiar with the government program documents. In addition, the database was searched independently at the conclusion of the study to seek missing documents; none were identified. Finally, the context of the health policy, the program documents, and the primary care center culture might not be guided by the documents, and there might be differences

between what is written and what is done. Although this is recognized, additional research is necessary to understand this possibility in practice. Despite the stated limitations, the data analysis was credible, dependable, confirmable, and transferable with trustworthiness always the focus.⁵⁶

In terms of strengths, this study is the first step in the path to understanding the impact of health policies on the work resulting from the health programs in Chile. This is a relevant contribution to the literature as few studies address collaborative work in the context of health policy.³² Furthermore, this study address the publication bias that produces a knowledge deficit from alternative cultures and countries with different languages, cultures, and general realities, such as Chile in South America.¹⁰² In addition, this study serves as an example for researchers interested in analyzing policies, efficiently and cost-effectively,⁴⁷ to understand their potential impact on primary and community health programs. The analysis of public policy documents provides an important context for comparing the intended work design with the resulting structures that define the actual work. Unambiguous policies that favor collaborative work make it possible to work this way to achieve an integral approach to caring for individuals, families, and communities. Finally, the Standards for Reporting Qualitative Research were applied to disseminate the results of this (see Supplementary Table 3).

Conclusion

This study provides insight into the relationships between the written structures, elaborated processes, and anticipated outcomes in primary health care. In general, the program justifications principally referenced the biopsychosocial model with multiple biomedical interventions and independent type professional work. Few programs were consistent in defining their justifications, interventions, and interactions in accordance with the national health policy focused on Integral Family and Community Health Model. In closing, health policies in Chile, and possibly other countries, need to be clearly translated into program documents that adhere to the expectations for providing person-centered care within the context of the primary care environment by organizing care processes that encourage interprofessional interactions and collaborative work. As national health policies directly impact the way primary care centers provide primary care services day-to-day to individuals, families, and communities, additional research is necessary to understand the relationship between the findings of this study with the reality of work in the primary care centers. In closing, this study represents the first step in a research journey to evaluate and define these relationships in more depth.

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Supplemental Material

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