CHAPTER II

ESSAY

Quality of care in private health care providers

2.1. Introduction

2.1.1. What is the problem and problem situation?

Quality of care has become an issue of attention in health care system of developed countries since 1980's (Friedman, 1995). Originally quality means having or showing an excellence or superiority (Concise English Dictionary, p. 1092. 1993). Generally quality is the desirable attribute of various products in industrial world. It has a growing interest after booming of market economic system in developed countries. Concept of quality was attached with its benefit because it may accrue saving in many ways, by preventing rework, elimination of waste resulting from manufactural error, and inspection and testing of defective goods. Thus benefit of quality outweighs its cost. Those quality concept and practice spread to the health sector rapidly in recent years (Friedman, 1995).

2.1.2. Definition of quality of care

There is no agreed upon definition in quality of care. But almost all agree that it is multidimensional and difficult to define. Most people are referring to **the technical aspect of quality such as provider behavior and skill in making intervention and applying technology** (Newbrander & Rosenthal, p. 179. 1997).

However Donabedian (1980) pointed out that the quality of care included not only **technical** but also **interpersonal elements**, and **amenities**. **Interpersonal**

elements are judgements about how good or bad the interpersonal process according to social norms, ethical standard and client or patient expectation. It also referred to the responsiveness, friendliness, and attentiveness of the health care providers in interacting with patients. And amenities of care include the appeal and comfort of health care facility. There are also non technical aspects that are referred to as **social elements**. They are **accessibility, efficiency and convenience of service** delivered (Turner & Pol, 1995; Newbrander & Rosenthal, 1997).

However some stated that the definition of Institute of Medicine (IOM) was achieving more consensus among professionals. IOM definition expressed "**the quality of care is the degree to which health services for individuals and population increase the likelihood of desired health outcomes and are consistent with current professional knowledge"** (Friedman, p.4. '1995). It is more reflection on professional point of determination on quality of care and is not an expression on patient perspective.

Although there is no universal definition, many agree that the quality of care has multiple facets. It can be different depending upon the perspectives from professional and technical, or managerial, or experiential point of view of patients or clients. Everybody wants high quality health care. Health care providers want to produce it. Patients want to get it. Health planners and taxpayers want to have value for money provided by them (Vouri, 1994). Thus definition of quality of care should have more comprehensive consideration on quality of care taking all the actors into account.

Lytle & Mokwa, (1992) had proposed a definition on quality of care based on patient perspective. They defined the health care quality **as provider conformance to patient requirements at three different levels; core, intangible, and tangible. The core benefit** is the fundamental benefit that consumer seeks and the provider attempts to offer. It is the nucleus of the total product offering. Intangible product benefits provided by health care providers are trust, reliability, which envelop the core product. **Intangible products** are produced and consumed simultaneously as a result of interaction or encounters between patients and providers. Spectrum of intangible benefit includes reliability, responsiveness, assurance, and empathy. In realm of ambulatory services, Bopp (1990) suggests there are three intangible factors produced by the service provider during encounters; **expressive caring, expressive professionalism, and expressive competence.**

Tangible benefit product is the surrogates or cues to help the patient determine service provider' competence. It is based on the view that physical environment where the process of encounter takes place, has a strong influence on the perception of the patient's satisfaction with service. For example, décor of physician office, physical location of the office, the appearance of the building and the appearance of the professionals involved may influence the quality of care (Lytle & Mokwa, 1992).

Definition of quality of care in hospital setting was developed in a study which involved focus group interviews on patient, doctors and administers. Result of study showed that there were eleven characteristics that contribute to the patient satisfaction and quality of care. Those factors are **tangibles, reliability, responsiveness,**

competence, courtesy, communication, access, understanding customers, caring, patient outcomes and collaboration. These attributes focus on service quality provided to patients who have diverse expectation for the service depending upon educational background, value, and experience. Service quality is also complex and difficult to measure because it has three well-documented attributes inherent in quality of service. These are **intangibility, heterogeneity, and inseparability of consumption and production**. Intangibility of service means that it can not be stored or indented or measured directly. Heterogeneity refers to the involvement of diversity of various providers with different capability and vast difference in individual need of patients varying from minor illness to dying situation. Patient's need and provider capabilities are acting in multiple ways in the different time and circumstance. The final attribute is clear to see and related to first attribute. The service can not be stored because it is consumed simultaneously when it is produced implying the inseparability of consumption and production (Jun, Peterson & Zsidisin, 1993).

Among the different descriptions of quality care, a report of a collaborative WHO / ICM / UNICEF pre-congress workshop held in Vancouver, Canada on May 7-8, 1993 expressed the quality of care in the service provided by them so as to meet the criteria and characteristics such as **effective, efficient, safe, accessible, available, affordable, appropriate, and acceptable** culturally and linguistically. In addition, they also mentioned the high quality of care as an integrated attribute as determined professionally including following criteria.

- Care given by providers with appropriate attitude, adequate knowledge and relevant skills.

- A clean physical environment for cares including safe water supply.
- Adequate basic equipment and medication.
- A care environment that does not stress the mother.
- Agreed standard of care.
- Women taking the responsibility for their own care.
- System in place to identify and correct certain problems, such as infection.
- Continuity of care.
- Home based in use.
- Shared care between traditional birth attendant, midwifes, doctor and mother (World Health Organization {WHO}, 1993).

From above expression on quality of care, we can learn that it relies not only on the provider but also on the client or patient and the physical environmental as well as social environment where the process of care takes place.

2.1.3. Dimensions of quality of care

Despite its diversity in concept and definition of quality of care, there are commonly accepted and excellently appropriate dimensions. Following table provides the various dimension of quality of care (Newbrander & Rosenthal, 1997).

Table 2.1. Dimensions of Quality of Care

1. Technical aspects of quality
   Accuracy of diagnosis
   Efficacy of treatment
   Excellence according to professional standards
   Necessity of care
   Appropriateness
   Continuity of care
   Consistency

2. Interpersonal aspects of quality
   Patient satisfaction
   Acceptability of care
   Time spent with provider
   Attitudes of provider and treatment by staff
   Amenities
3. Social aspect of quality
   Efficiency
   Accessibility

Source: (Newbrander & Rosenthal, 1997.p.179).

2.1.4. Categories of quality of care

Above-mentioned dimensions of quality of care can be placed into different categories: namely **structure, process, and outcome. The structure** refers to relatively fixed characteristics of the medical delivery system such as types, number, qualification of health care providers and facilities. **Process** measures reflect what is done to and for the patients such as application of medical procedures and dispensing of the drugs. **Outcome** can be defined as changes in the current and future health status resulted from medical treatment. For the judgement of quality of care, we can use three bases: criteria, norms and standard. Criteria are the attributes of structure, process and outcome. Norms are general rules of what is good and standard are the specific quantitative measures that define the goodness (Turner & Pol, 1995; Newbrander, & Rosenthal, 1997).

2.2. Why is it important?

After knowing the quality of care from different perspectives and its dimensions we have to consider why it is important, and what consequences are coming out from faulty quality of care.

Quality of care is important because it is one of the major determinants of clinical outcome leading to changes in health status of the patient. Sometimes it may determine life or death. Therefore for the sake of patient it is desirable to improve quality of care. Not only patient and his relatives but also society has an interest in quality of care. Society wants to know that health care providers are taking their responsibility properly according to criteria, norms, and standards in technical as well as interpersonal aspect. Therefore most countries are striving to deliver good quality health care to the society through health sector reform . There are also interests from health care management organizations, government and professional themselves. Organizations are interested in efficient management of resources by improving quality of care. Government has also an interest to protect the right of consumers from provision of poor quality of care in medical transaction process probably resulted from asymmetry in information. Professionals are also interested in quality of care because they want to improve their standard of performance assuming that it is their responsibility and ethics to improve their professional standard (Newbrander, W. & Rosenthal, G., 1997). In the competitive system of health care industry, quality can advance the profitability by reducing cost and firm's competitive position considering the recent trends of consumer are more quality conscious. To achieve the sustainable position, the organization should monitor the customer's perception of service quality and satisfaction, which are positively related to each other. It was also noted that the satisfaction was the function of the patient's expectation and realized performance. Therefore the health care managers attempted to anticipate the customer's expectation and design the service to surpass the expectation of the patient, which is diverse, dynamic and unique according to patient's education, value, and experience and

illness (Turner & Pol, 1995). Then all these notions are reflecting that quality of care issue become everyone's issue.

2.3. Quality of care in private sector

2.3.1. Private sector involvement in health system

Originally health care provision has begun as a private enterprise since prehistoric age. Unsurprisingly every country has a private health care system in addition to government health sector run by public finance. First the meaning of private sector should be defined.

Private sector in health sector has several meanings. It can be viewed from two aspects: provision of service and source of money. The provider of service may be private agent as distinguished from government, or the source of money paying for the health service may be private as distinguished from public. Various combinations of these two dimensions of private and government activities may be involved as shown in the simple matrix of following table (Roemer, 1991).

Table 2.2. The matrix of source of money and provider of service in a health system, classified by private and public sectors

Source of money	Provider of services	
	private	public
private	1	2
public	3	4

Source: (Romer, 1991.p.118).

In the table the cell number one refers to both source of money and provider of service as being private. It is very common to see in every country where personal health services are provided by private personnel and are paid by own expense privately. Cell number two denotes that the services are provided by the public entities such as personnel in government health centers and hospitals for which private payments are made. It can be seen in the market oriented transitional countries like Thailand and the Philippines where the charges are made for service provided in the government facilities especially for the drugs dispensed. Those countries have some exemption for making charges. In the cell three the service is provided by the private providers and the payment are made by the governmental financing program directly or indirectly via intermediary agencies. It is usually found in developed countries where social security system has been well established. The cell four means that the services are provided by government personnel and are funded publicly. It is the symbol of socialism found in Cuba and former USSR. In some Scandinavian countries hospital services are provided publicly, and are funded publicly totally irrelevant to private system (Roemer, 1991). Most of the developing countries in Asia have all the patterns with varying degree of involvement.

There are other brief definitions of private sector among which one definition describes the private sector as **all those organization and individuals working outside the direct control of the state.** Among private sector there are different kinds of providers applying the different principles of cure for disease and illness, ranging from modern medicine to traditional medicine (Aljunid, 1995; Roemer, 1991). But obviously the western medicine was taking a predominant role in provision of health care to the population. And then the provision of western medicine may be divided into two different categories depending on the purpose of provision: for profit and not for profit. For profit private providers include general practitioners in-group or solo practice and doctors working in private clinics and hospitals (Aljunid, 1995).

Recently there was a growing national and international interest in private sector provision of health care in developing countries. With the changes in political, and social, economic sectors in the developing countries in the late of 1980 the government's role of involvement in development changed in every aspect. The health sector is also the place where the government has to reconsider its role in the light of resources problems. Therefore the limiting resources to maintain the existing public health system, the increasing demand from growing population for more quality services that has escalated cost with highly sophisticated medical technology are the driving forces to expand and utilize the private resource in a wider extent to cope with changes and popular demand. So the trend of health care is changing from the directly provided, publicly funded, centrally controlled, government dominant system to more limited, decentralized, self-funded system and development of private market that will make the reduction of burden on government (Newbrander, 1997; Bennett, 1997; World Bank, 1993).

2.3. 2. Role of private providers in Asian countries

After defining private sector in cell one, role and distribution of private sector in developing countries are different from developed countries where market oriented system is more fully developed and regulated. Developing countries also reveal wide-ranging pattern of distribution with different level of involvement in health care system. MacPake proposed some generalization and categorization for the purpose of defining issue and strategies. It was suggested to identify three pattern of public - private mix in developing Asia. Pattern one denote those countries in which low or moderate involvement of formal private for profit sector especially in medical service provision but more substantial involvement of non-governmental organization (NGO). The distribution of public is proportionate to that of NGO. Major involvement is from informal private sector that constitutes unregistered practitioners, traditional healers, and unlicensed drug sellers. Regulation of private sector is not feasible. This is the common feature of poorest nation. In contrast to pattern one, the pattern two has more important role played by formal private for profit sector but private provision are still found in the lower level of health system. Public sector is overloaded with tertiary care in which the private sector involvement and capability are limited. This is also another spectrum of poorest nations in Asia. In pattern three the insurance system come into action with coverage as wide as possible undertaken by government and private company. Involvement of private for profit sector is under the arrangement of those social security systems. Capability of regulation by government is much better than other. The role of unregistered sector is usually marginalized. The service provision by private sector is seen in the whole spectrum of health system. These are

general categorization but it can vary with country depending on the urban and rural situation (MacPake, 1997).

Extent of involvement of private sector in health system in Asian developing countries is found to be substantial reflecting the magnitude of problem, which can affect the performance of the whole system. Table 2.3 cited the comparison of proportion of private physicians among Asian as an example of extent of private involvement in health provision.

Table.2.3. Proportion of private physicians to total physicians in some countries

No.	Country	Private physicians as percentage of total physicians
1	Pakistan	32
2	Oman	43
3	Indonesia	6
4	Papua New Guinea	25
5	Thailand	18
6	Malaysia	57
7	India	73
8	S Korea	86
9	Myanmar	65

Source: (Hanson & Berman, 1998, NHP in Myanmar, 1996).

Quality of care problem in different pattern of private involvement might need specific focus on the country situation. Although there are limited amount of information in this sector, available data showed that the private providers are heavily used in Asian countries. In Malaysia among every 100 ill persons 5.2 visits were made to the private clinics as compared to 2.1 visits to health centers, 1.4 visits to government hospitals, and 0.4 visits to traditional practitioners. Another study showed

that 32.5% of adults above 18 years of age utilized the public services, 22.2% sought treatment at private clinics, and 33.6% used self-medication and 11.7% visited traditional healers. In Indonesia Berman et al (1987) showed that in Western Java among the 3322 treatment contacts, 12.8% were made with private providers (doctors and paramedics), 16.8% with public providers and the rest with traditional healer or self treatment. In 1986, the private sector accounted for 63.2% of the total health expenditure of Indonesia. Similarly Thailand, India, Philippine, China and Papua Newguinea demonstrated that the private sector is growing and important healthcare providers besides the government and indigenous healers. In some studies private providers were utilized more frequently than the government services (Aljunid, 1995; Zwi & Brugha, 1998; Thaver & Harpham, 1997). These evidences indicate that the private sector is taking a significant role in health care provision to community in conjunction with public provision. And also the fact that we have to note is mix of public providers in private provision. Most physicians who are working in public sector have to do general practice in their out-of-office hour as a measure of remuneration to compensate for their low salaries (Roemer, 1991).

It is clear that the quality of care in developed countries where health care market is well developed, has been a matter of issue for a long time as compared to developing countries. But there are some studies, which dealt on the quality of care issue and performance of the private sectors in Asian countries. Many studies showed that patient perceived the quality of care given by private providers to be higher than public services and they preferred the private providers to public services. And contributing factors leading to choice of private providers are personalized service,

better facilities, accessibility in terms of location, convenience of working hour, and shorter waiting time (Aljunid, 1995; Zwi & Brugha, 1998).

2.3.3. Recent findings of quality of care in private providers

Despite patient's preference, quality of care was found to be deficient when the professionally defined criteria were used to assess the quality of care in private providers. In a study (1994) done in Mexico the private care for the management of children with diarrhea and acute respiratory infections in a rural area was found to be inferior to that provided by public sector. The private physicians in the rural Mexico made more inappropriate use of antibiotics, less education on continued feeding and improper rehydration (Bojalil et. al, 1998). Similar finding was also found in a study of rural Malaysia in 1995 in which the main weaknesses were demonstrated. It was shown that there are use of untrained support staffs, poor quality of preventive care, poorly equipped emergency facilities and uncertain quality of diagnosis based on X-ray and ultrasound (Aljunid & Zwi, 1995). Some studies in Asian countries showed inappropriate prescription of drug like use of non -essential drugs, polypharmacy, excessive use of injection, irrational use of antibiotics and potentially harmful drugs. In some conditions of public health importance like tuberculosis, leprosy, diarrhea and acute respiratory infections, the providers did not follow the standard guideline (Aljunid, 1995; Zwi & Brugha, 1998).

Up to now it is evident that the private sector is playing a significant role in the heath care sector and substantial number of population seek health care preferably in private physicians. Although most consumers in developing world perceive quality of care in private providers are better than public provision, some evidences indicate

the deficiency in quality of care provided by private provision. This can lead to adverse effect on individual benefit, community benefit as well as public benefit creating health, and social and economic problems.

2.3.4. Identification of problems in quality of care provided by private providers

Involvement of private providers in health care provision has pros and cons that implicate the health system as a whole as well as for the patient. The fees for service make the providers diligent and attentive to the patient. Where there is the competitive market, the providers will try to produce quality service to retain the patient. The providers have freedom to make professional judgement for the best of the patient. This sovereignty of work circumstance fulfills and encourages the morale of the providers. For the patient they can make choice among the providers and freely consult with other providers at the same time. The significant advantage is the convenience in time because the consultation can be made after working hour for the ambulatory treatment. Despite the advantages, there are problems accrued from private provision. The most significant issue in recent time is the supplier-induced demand that is the deliberate provision of excessive service beyond the need of patient in order to increase the income. Sometimes it can lead to potentially fatal and harmful procedure producing undesirable outcome. The provider may hold on the patient without referral when it is necessary for the economic concern. The profit-oriented nature of private provision may be attributable to maldistribution of health manpower because the providers try to stick in the location where the prospect of profitability is good. The another irrational point is that the provider especially physicians who are trained by public finance making private profit only. Sometimes they use the highly sophisticated technology to impress the patient instead of simple,

less expensive, useful technology, making the waste of resources. The privates provision only centers on the private goods that are almost personalized service scarcely comprised of preventive and promotive activities. The patient may make wrong choice based on the faulty criteria in determination of provider because of the poor knowledge in private sector. These are the general problem ensued from the private provision of health care (Roemer, 1991).

After being familiar with Donabedian structure, process, outcome model and findings from some studies, we can figure out possible problems by using the 3 by 3 table with columns showing dimension of quality of care and rows showing structure, process, and outcome.

Table 2.4.' Three by three model with possible problems in quality of care.

(Adapted from Jun, M., et al. 1998)

	Technical dimension	Interpersonal dimension and amenities	Social dimension
Structure	1. Use of unqualified staffs 2. Use of faulty diagnostic equipment. 3. Use of drug with uncertain efficacy 4. Lack of proper registration of patient	1. lack of decency of facility 2. crowded waiting room 3. inadequate lighting and ventilation 4. lack of standardized facility 5. no recreation facility	

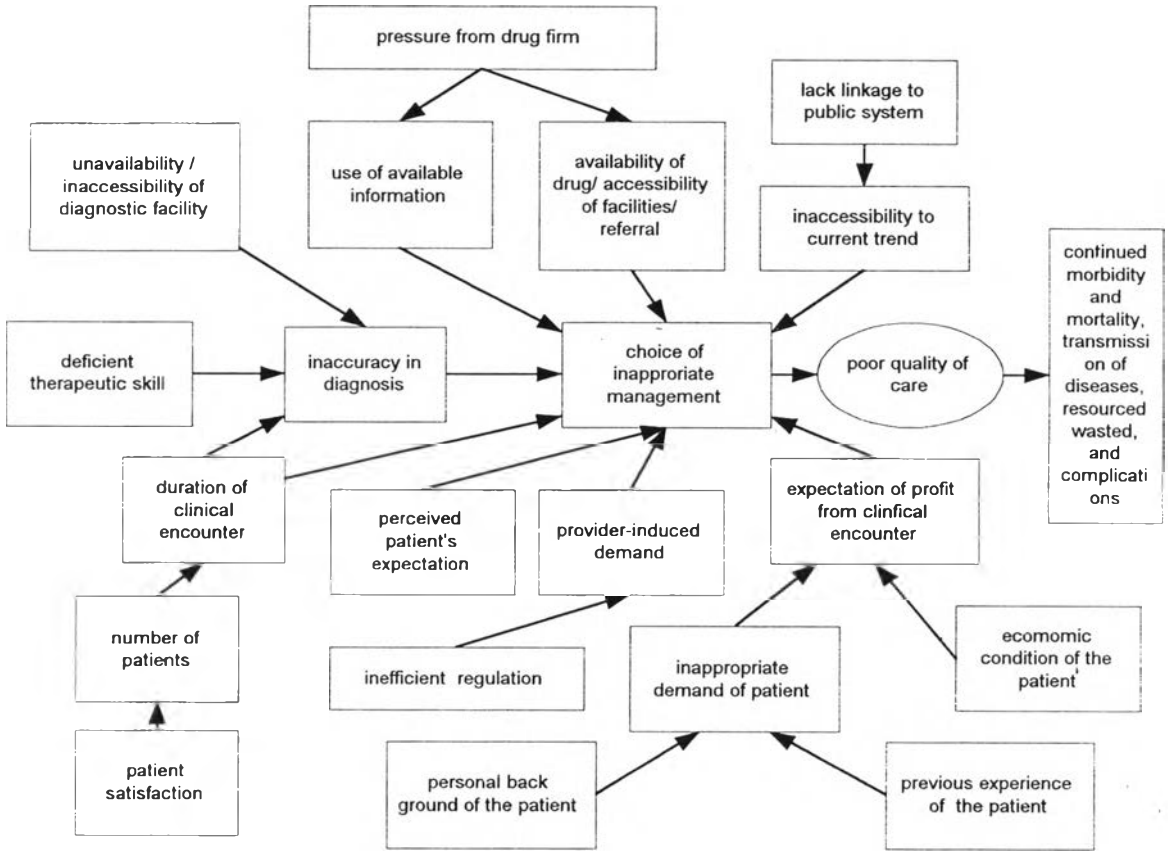
		in waiting room 6. lack of privacy	
Process	1. inefficient diagnostic skill and acumen 2. Prescription of drug irrationally. 3. failure to follow the standard guidelines 4. Technically intensive service profile.	failure to educate the patient about illness very short duration of clinical encounter discrimination on patients according to social status	1. high cost
outcome	1. wrong diagnosis 2. uncontrolled illness 3. adverse consequences of irrational drug use 4. late referral 5. prolong morbidity 6. increased morbidity 7. increased disability 8. increased mortality	1 lack of patient satisfaction 2.lack of mutual trust and respect between providers and patients 2. low utilization of private sector	1. low acceptability and affordability to community due to high charges 2. finding alternative care 3. wastage of money, time and life 4. adverse effect

			on health status of community

There appeared many possible problems in each cell resulting from intersection between dimension, and structure, process and outcome model. Problems in quality of care are diverse and somewhat interrelated. While the quality of care problem may range from structure to outcome, from technical to social, for the sake of public the emphasis should be placed on the technical aspect of quality in the places where there are significant gap between the knowledge of providers and patient. The patient can easily judge the external appearance of health care setting whereas they can not assess the quality of care and service produced and consumed immediately at the place of production. So we cannot estimate extent of quality problems in the process that can be readily overlooked in the absence of regular monitoring system, especially in developing countries where the public health system is failing in personal services the because of reduced demand resulting from low acceptability. Failing public system forced the people to seek care in private sector where regulation is inadequate and above-mentioned problems are prevailing. The problems in the technical dimension can be obviously cited and imagined. For example a patient who are presenting with cough resulting from common cold may be wrongly diagnosed as a pulmonary tuberculosis case because the x ray machine lack maintenance, unqualified radiological technician and unskilled physician leading to false diagnosis and wrong treatment not following standard guideline, might finally end up with drug side effects and waste of money and unnecessary suffering. This is the imaginary example of extreme condition of poor quality of care in every spectrum of dimension especially seen in poor developing countries.

2.4. causes and consequences of quality of care

Figure 2. 1. Quality of care and its influences

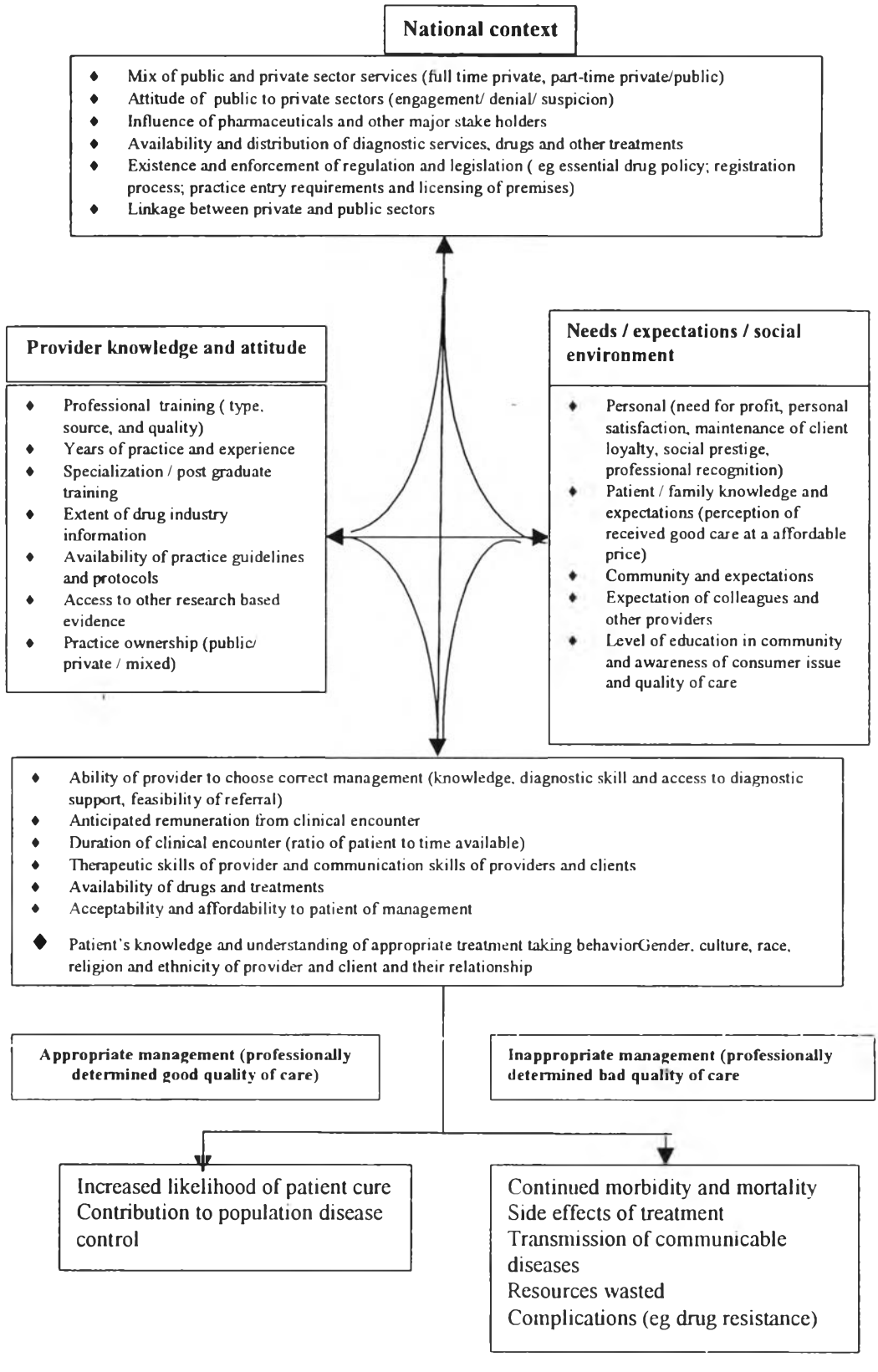


Following causal web outlined the complex factors involving in the mechanism leading to how good or bad in quality of care. For more clarification of complex factors I would like to use and adapt a model presented by Ruari Brugha and Anthony Zwi (1998).

2.5. why do they exist / happen?

In the figure 2.2 we can see the relation among different factors controlling the provider decision in the clinical encounter and resultant quality of care, which determine the cure of disease making it free of transmission especially in conditions of public health importance.

Figure 2. 2. The model showing causes and effects of quality of care



Source; adapted from (Rurai Brugha and Anthony Zwi, 1997.p.110).

There are 4 main groups of influences. **Macro-context** factors are occurring in the national level and in the health system. In the developing countries **the mix of private and public sector** services are usual finding and long lasting view reflecting the inadequate income and salary in the public services. Majority of public doctors has to work as private physicians in the evening hour or morning to get extra income blurring the demarcation between private and public sector. It makes benefit by contributing the experience and knowledge acquired from public service and government hospitals. **Linkage between private and public sector** also becomes smooth in some ways making **referral** process prompt when necessary. Previously in some African countries the private activities of public physicians were controlled and banned through legislation (Roemer, 1997). Although public doctor are engaging in the private activities, some sort of **denial or suspicion** demeanor are still occurring between private and public sectors especially the former deals with latter. It can lead to unfavorable climate for collaboration of disease control activities. **Influence of pharmaceutical company and major stakeholders** can not be ignored. They can determine availability of resources such as drugs and equipment. And also making **marketing and dissemination of information** might alter the management behavior of providers.

Existence and enforcement of regulation and legislation has a strong influence for provider behaviors and quality of care. In developed countries every physician need to re-certify regularly to validate their license every specified period according to law. The important requirement for re-certification is to have an activity of continuing education for a prescribed duration (Abbatt & Mejia, 1988). Government will and enforcement of law to protect the consumer right (e.g. by setting

minimum requirement of qualification of staffs, facilities and standard of equipment) also play a crucial role in regulating the behavior of private providers. Regulation by making official monitoring on private providers also contained malpractice and improves the working condition of private sector. Health Policy making level need to realize the true situation in which mix of private and public happen and community preference of private health care and potential capability of private sectors.

Need and expectations patients and their families are also influential. In developing countries patients especially in rural area, believe that injection has more therapeutic effect than tablets. They are not satisfied with prescription of tablets only. The providers also perceive their desire and give the injections inadvertently to achieve the loyalty of customers. These needs and expectation usually come from the previous experience and modified by the pressure of family members and sometimes peers. Sometimes they are very much insistent in what they want and making irrational demand. For example a patient with gonorrhea might insistently request the loading dose injection of penicillin.

Sometimes although they are expecting what they want, doctors can explain and educate what should be and what can be done to convince them needing time and communication skill. It is reasonable in less crowded time but in a clinic with long list of waiting patients provider can only try to expedite the throughput of patient ignoring the need of education. Acquiring increased number of customers might be the symbol of patient satisfaction rather than assurance of quality of care because time availability for a patient reduced with increased number of patients.

It is clearly difficult to speculate the behavior of a provider under such influences inter-acting each other like desire to keep professional prestige and dignity and perception of patient's expectation and desired remuneration from clinical encounter.

Most patients in developing countries are people from low socioeconomic status and hardly know the consumer and quality of care issue. Therefore they are really ignorant of what they need and what should they get in compared to developed countries.

Apart from patient and macro context influence the significantly effecting force is **provider knowledge and attitude** that make a critical decision during clinical encounter. Professional training, type, quality and source of training. Specialization, duration and experience are also determining the provider knowledge and attitude. Physicians who are aware of public health problems and potential hazards of ignoring national or internationally recognized guideline can give assistance in national disease control program making his behavior in more positive way.

Accessibility to various kinds of information and opportunity to get continuing education is an essential necessity to improve provider knowledge making up to date. There are discrepancies between knowledge and practice, (Thaver, 1997; Brugha & Zwi, 1998) the change strategies may not work without knowledge reinforcement. Acquiring knowledge with active participation and through problem identification and

problem -based learning may not only enhance the knowledge but also result in sustainable practice of self-learning.

In places where discrimination between gender, race, religion and ethnicity prevail, it can produce difference in distribution of quality of care. By studying those factors playing in action in production of quality of care it becomes obvious that the quality issue in health sector is quite complex issue involving various stakeholders and forces.

2.6. What are the priority problems?

While the identification of problems surfaced many areas in which the quality of care in private physicians is requiring improvements, the prioritization is needed for intervention. From 3 by 3 table total problem areas were nine showing three dimensions and three categories. Significance of each problem can vary with existing context of the health system that is unique for the individual countries. But understanding of general characteristics of each country might be helpful in dealing with the problems. Each country can be grouped into three namely to public-oriented, welfare oriented and private oriented. But different picture can be seen in different economic development of the country that can be classified as developed, transitional, and poor (Roemer, 1991; Mcpake, 1997).

In contrast to that classification, some prefer to divide according to level of income so as to make more clarified categorization as higher income, middle income and lower income countries (Brugha & Zwi, 1998). In those low and middle-income countries, the infectious diseases continue to exist as the most prevalent health

problems demanding plenty of resources and all-out effort (WHO, 1998). Although substantial achievements had been made during the past decade, recent economic crisis in East Asian countries made the every country in difficult situation to face the scarcity of resources in every sector. That is the fact leading to utilize the available resources efficiently and effectively. At that time the private sector was also growing with the capability of implementation in every level of health sector. However still there was a gap of knowledge about the quality of care and behavior of private provider especially private physicians who are most favorite source of health care in the community. Despite limited studies about private sector, available evidences showed deficiency in quality of care in the management of conditions of public health importance according to evidences already cited.

From the extensive consideration of causal web and conceptual model mentioned above, we can see the contributing causes are multi-factorial and complex and inter-acting each other from national context to patient factors. From the professional point of view the quality of care in the process of management in specified conditions of public health importance found to be feasible to intervene. Whereas the private physicians are distributed out of formal public health systems, they have line of communication to public registration systems and might be monitored by other regulations. Despite the presence of regulation the enforcement become questionable due to resource constraint. Patients and their families are also independent actors acting under the influence of wide range of factors like social and economic condition. They might require long range plan to implement to come up with changes in those sectors in co-operation with other non-health sectors. If feasible, multifaceted approach is the best way to achieve the sustainable improvement and changes. Where there are limitation and constraint in resource and

management, the only feasible way to approach is the provider part that is the important determinant to achieve quality care of which the interpersonal dimension is found to be satisfactory (Thaver & Harpham, 1997).

Before we can consider the intervention to proceed, the reference to causal web should be reviewed again to find out the sequence of causes leading to core problem, inappropriate management interchangeably with poor quality of care. There are eight causes directly linked to inappropriate management. I would like to categorize these into three to understand easily. Among them the factors contributing to profitability are provider-induced demand, perceived patient expectation and expectation of profit from clinical encounter. Unsurprisingly this is the strongly motivated factor for doing general practice even by public physicians in a condition where the salaries are very low to cover the cost of living. The general practice becomes a major earning for lucrative income that is many times more than public salaries (Ferrinho et al., 1998). The other important factor is technical quality of the physician, which may be inefficient attributable to no more refreshing of clinical skill and knowledge years after graduation. With the explosive development of science in every sector the knowledge today might be readily outdated tomorrow. The rest is the resource factor, which determine the availability of drug and equipment. Out of three major causes identified, the most rational to implementation is assumed as provider knowledge problem according to feasibility, sustainability, effectiveness and acceptability. Improvement of knowledge is essential for proposed change in practice.

2.7. What could we do to improve the problem situation?

The model developed by Brugha and Zwi (1998) explained the interaction of macro context, provider knowledge, and expectation from the patient and their families leading to provider's behavior for the decision making in clinical encounter. According to this model we need to consider all the factors in the strategies that is responsive to the needs, motivations and expectation of providers, patients and their communities in the contexts in which they live and work.

For the improvement of practice in developed countries the most effective way was found to be the practice enabling strategies (e.g. practice visit and patient education) and reinforcing strategies (reminder and feedback) combined with predisposing or disseminating strategies (Davis et al. 1995). The intended change and improvement of quality of practice also require the active participation and implementation by professional in the development of guideline as well as the shared perception of the need and successful translation and achievement of sense of ownership (Brugha & Zwi, 1998).

2.7.1. Interventions in developing countries

It is clear that the interventions in every setting whatever it is in the developed or developing countries require the multi-faceted approach that is simultaneously dealing with those issues in various influences. Brugha and Zwi (1998) proposed the model of intervention as follows:

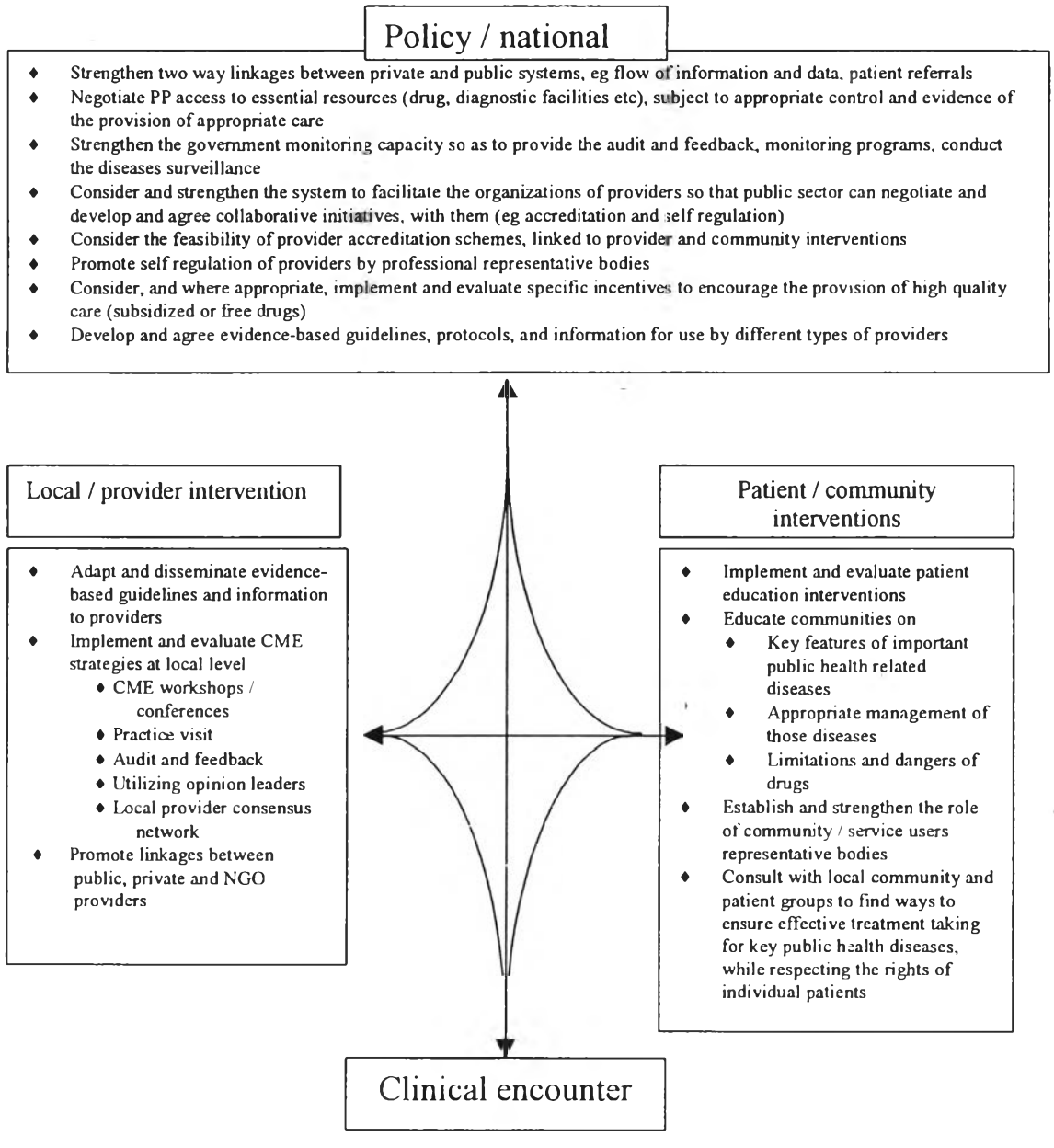
2.7.1.1. Provider training intervention

The dissemination of scientifically sound information on which to base the clinical decision is the crucially important to the appropriate practices and decision making for the clinician as well as policy makers and health care manager. But the adaptation to the local context and different level of health provision are also essential. Intervention such as in-service training, large seminar, face to face interventions, intervention using the interactional educational workshops combined with feedback and the use of peer review committees were found to be effective in the improvement of practice in government provider in some developing countries like Mexico (Brugha & Zwi, 1998).

2.7.1.2. Multi-faceted interventions involving providers, patients and communities

Brugha and Zwi described that provider perception and experience on the expectation of patient and community is more important influence than the skill and knowledge of providers from experiences in Ghana. In Indonesia experience there was significant improvement in practice of providers after application of educational method, interactional group discussion (IGD) in which the single 90-120 minutes discussion involving both providers and service users to reduce the inappropriate use of injection.

Figure 2. 3. Model showing various interventions for improving quality of health care provision by private sector.



Source: (Brugha and Zwi 1998. Page 114).

All the available evidences showed that the approaches involving the providers, patient and community are more likely to be effective than single targeted approach (Brugha & Zwi, 1998).

2.7.1.3. Policy and regulatory intervention

The effectiveness of policy and regulatory intervention has been reported in World Bank (1993) and the shift of government intervention from major service provision in health sector to financing and regulation has been recommended in World Bank Report (1997). There are different types of regulations dealing with the registration and licensing, reporting and notification of diseases. In some countries, there are regulations on the investment of diagnostic facilities such as radiographic machine, CT scan and magnetic resonance imaging (MRI). One of the significant roles of regulation in every country is to maintain the medical ethics and to control the malpractice. Sometimes the regulation prohibits the private practice of public doctors in some African countries. In some developed countries, the regulation is applied to control the location of clinic (Aljunid, 1995).

Brugha and Zwi (1998) also noted the intervention using the accreditation and self-regulation to improve the practice of providers might be possible in combination with incentives such as fast-track access to diagnostic services, opportunities for continuing professional development and training, and access to drugs and other treatment at a subsidized rate. Where there is an organization representative to the professional and providers the involvement of such organization in regulation of providers is more acceptable and feasible. However, the alternative organization that can recheck the activities of the professional organization might be needed. Through that organization the opportunity of better communication among providers and between providers and community can be improved by establishing the linkage for audit and peer review, organization for group continuing medical education,

consensus building and working with local opinion leaders to promote the appropriate quality of care specific local context.

The licensing through regulation is the easiest form to maintain and improve the quality of care because it deals with the structural aspect of quality of care. However the specific organization is required to manage the licensing activities and for the enforcement of the regulation (Newbrander, 1998)

2.8. How do these solutions work?

2.8.1. Provider training intervention

Provider knowledge is the most important resource in every health system. Development of knowledge has started since the beginning of the mankind. With the development of science and technology the growth of knowledge is expanding rapidly needing specialization in different area of diseases and illness (Roemer, 1991).

To maintain the skill and performance in provision of quality health care, continuing medical education is the main component for a health system. It has become an international discipline and integral phenomenon for the health professions (Davis, 1998). Thus the need for continuing education has been recognized for a long time. Socrates and Plato considered the education as a life long process (Abbatt & Mejia, 1988).

2.8.1.1. What is continuing education of health workers?

Continuing education of health workers was found to be defined as all the experiences, after the initial training, that help the health care personnel to maintain or learn competence relevant to provision of health care. The definition indicated that the continuing education includes all the experiences, not just refresher courses, extends from the completion of the initial training until retirement (Abbatt & Mejia, 1988).

Most private physicians in developing countries had few opportunities to continue their learning process that is indispensable for a physician. It has been a professional ethics to improve the practice and to continue learning throughout the life. The life long professional development become essential for a physician to adapt the increasing knowledge and change health trend and disease spectrum (Breedlove, 1998).

Therefore it is obvious that the training of providers can improve the knowledge and the finally practice despite multiplicity of influences on the practice. Without knowledge base the improvement of practice is unlikely to change. Whereas there is no substantial evidence that indicate the deficient knowledge in private physician in developing countries, we can not assure of satisfactory quality of care in those whom have never had a continuing learning since the graduation from medical school. A study in Karachi reported that 65% of the sample had no affiliation to any professional organization. 30% of them were neither getting nor subscribing any form of medical literature (Thaver & Harpham, 1997). This finding denoted that private

physician accessibility to knowledge is questionable in the condition without provision of continuing learning.

By providing the training of provider based on philosophy of continuing education, the physician can get aware of current situation of prevalent disease problem and their trend and modern line of management for the fulfillment of community benefit. The benefit of continuing education can not be substantiated in every situation. But in certain conditions that have following criteria were found to produce successful outcome (Abbatt & Mejia, 1988).

Teaching was designed to solve a specific problem recognized by the health workers.

The learner shared in the identification of the problem and the need to find a solution.

The learning method emphasized participation by learners, a favorable environment, and small- group methods.

The learners were involved on the evaluation of the outcome of the educational experiences. (Abbatt & Mejia, p. 17. 1988).

2.8.1.2. Different types of intervention in continuing education

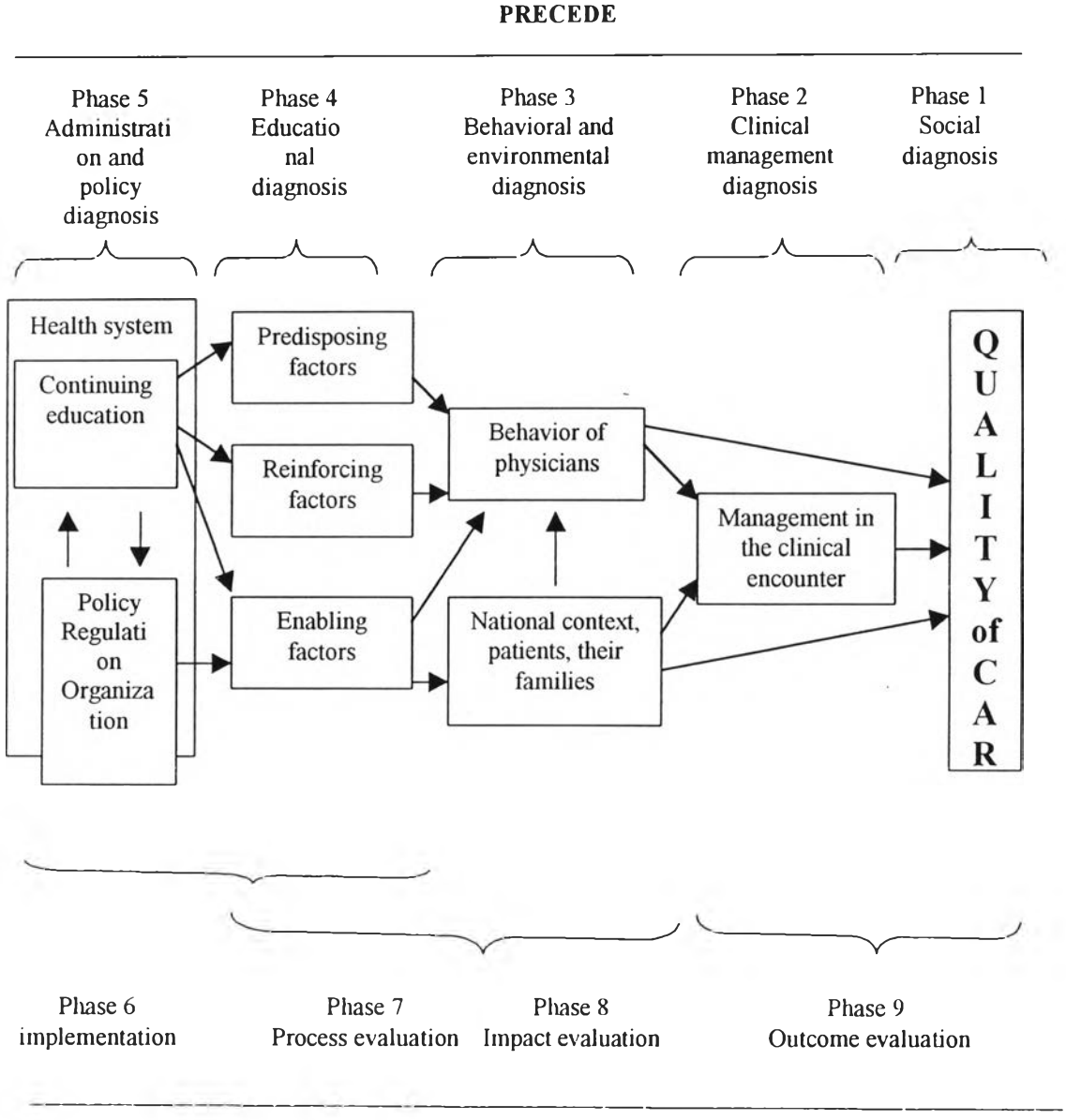
The educational interventions have to be carried out for continuing education of the all the professional in every field. Educational interventions for are any attempts to persuade the professional to modify their practice performance by communicating the information (Davis, Thomson, Oxman, & Haynes, 1995).

The classification of the continuing medical education was based on the factors described in the Green's **precede- proceed model** of health promotion. These factors includes predisposing factors i.e. communicating or disseminating information, the enabling factors i.e. facilitating the desired change in the practice site, and reinforcing factors i.e. using the reminder and feedback. All the interventions use single approaches or combined approaches (Davis, Thomson, Oxman, & Haynes, 1992).

2.8.1.3 Conceptual model for continuing education

The quality of care in private physicians is the ultimate outcome of the process that occurred in the clinical encounter as a result of behavior of the private physicians. The continuing education intervention program can modify the behavior of the physician by providing the predisposing, enabling and reinforcing influences for the motivation to change.

Figure 2. 4. Conceptual model for continuing education program to improve the quality of care in private physicians.



Source: adapted from (Kaplan, Sallis, Patterson, 1993, p. 57.)

To implement and to evaluate the continuing education program the Precede-Proceed model developed by Green and Kreuter in 1991.

The modal has altogether 9 phases, i.e. 5 PRECEDE phases and 4 PROCEED phases. Phase one is the social diagnosis phase in which the quality care issues and

influences are examined from the different perspectives. The phase two is the epidemiological diagnosis phase in original model but it can be modified as the physician and patient interaction diagnosis phase in which the decision of management of the patient takes place. Phase three is originally the behavioral and environmental diagnosis that can be used without changing. The phase four was taken as the phase of educational diagnosis in which various methods of approaches are determined to implement depending upon the results of diagnosis in previous phases.

Phase 5 is the phase of administration and policy diagnosis phase in which the continuing education program was planned and organized. The **PROCEED** phases are the implementation, process evaluation and impact evaluation and outcome evaluation phases. These are the steps to launch and operate the education program and to evaluate the effectiveness of the program.

In this model the continuing education program are planned by using predisposing influences that increase the motivation for change. These factors are the dissemination and communication of information by using the seminar, conference, workshop, small-group discussion and provision of guidelines, protocol. Enabling approaches are reduction of barriers to change created by societal forces and system, i.e. outreach activities like academic detailing by pharmacist, practice facilitation by nurses and provision of patient education materials. Reinforcing factors are approaches using the social feedback that encourages or discourages the behavioral change. It consists of feedback from audit and reminder following chart reviews (Davis, Thomson, Oxman, & Haynes, 1992).

2.8.2. Multi-faceted intervention

Multi-faceted intervention involving the provider, patient and community might be effective because it can modify the practice of provider by realizing the true expectation of patient and community. The discrepancy between the perceived expectation of patient and real expectation can become clear by using the multi-faceted approach. It is expected that the sustainability of the approach is better than single targeted approach (Brugha & Zwi, 1998).

2.8.3. Policy and regulatory intervention

The commonest form of interactions between the government and private providers is regulation. Most regulations have to deal with the registration and licensing of the physicians and clinics. Some developed countries make mandatory requirements for assessment of the competence of physicians. Regulatory interventions to maintain the standard and quality of private providers have been developed in United States and Western countries.

Need of recertification with snapshot assessment of competence has been established since 1969 in United States. It is a voluntary process but most physicians must get certified every seven years to have a status of being " board certified". Up to now the United States is the only country that requires the recertification throughout the life of most specialists. In other developed country like Canada there is no examination program but the continuing program is planned and the credit was accounted for recertification. In Australia the participation in continuing medical education and credit system of education is mandatory. In United Kingdom it is voluntary (Bashook & Parboosingh, 1998).

The requirement and need of recertification and continuing education of physicians in developing countries has not yet been established with regulation. The most continuing education programs are in the form of activities, usually sporadic involved by few professionals and sponsored by private enterprises for commercial interest (Abbatt & Mejia, 1988). Although there are annual conferences on research and current issues, the involvement of the private providers are not much as compared to those of public providers.

Involvement of government in health sector is larger than in other sectors. Government involvement may be in the form of legislation and regulation apart from provision of services. Most legislation are intended to protect the benefit and right of population from health problems. Some legislation are directed to the health personnel and their licensure and to control their malpractice and behaviors. Government drug policy can effect the availability of drugs in private sector as well as in public sectors. Government law can control structure of the private facilities especially in the import of technologically sophisticated machine and equipment. Another important area where the government involvement is pronounced is the financing of the health care system. In some countries the government is providing the health services as well as purchasing for the insurers (Roemer, 1991; Brugha & Zwi, 1998). While there is a lot of legislation and regulation, the enforcement is very costly and requires excessive resources. Influence of legislation can vary with the contexts and situation. In urban area the control of private sector is relatively easy as compared to rural area. Enforcement in developed countries where there is less unregistered providers is more efficient than in poor countries that have to rely on unregistered providers (Bennett, McPake & Mills, 1997).

2.9. Which intervention should we make?

Up to now, it is evident that quality of care issue in private providers is rather complex and multi-factorial involving various stakeholders depending upon types of health system. Unsurprisingly the solution may not be a simple one. Consideration on provider influences, patient and community influences and the influences from national context are inevitable. Combination of interventions targeting the various sectors is required to achieve the sustainable solution.

For countries with a poor economy, the ability of government involvement in control of health sector is limited and localized. The financing and development of health insurance system can not be implemented except the some social security system and payment for some medical expense for some employers (Roemer, 1991). This is also small number as compared to large population. Generally the poor developing country cannot tackle the problems of private sector by legislation alone.

Intervention directed to the change of community perception and belief require coordinated effort of various sectors in addition to the health sector. The implementation might take place after prolong planning and preparation. The effect of intervention may result quite long time after implementation. Thus community-oriented intervention should be planned for the long term.

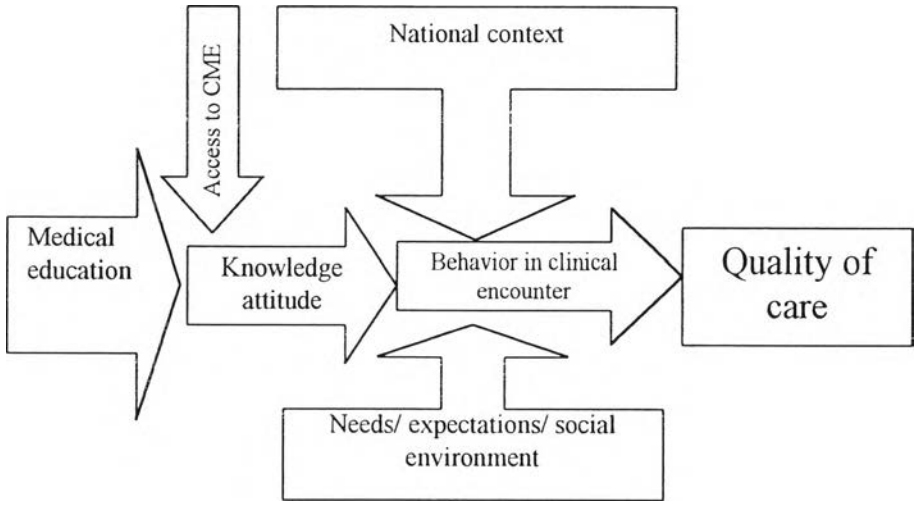
The provider directed approach is the most rational among the intervention in the context of developing poor countries. In the health care provision in those countries, the providers especially the physicians are playing the crucial role in the determination of the quality of process of care making the decision of management of

the patients. There are some evidences showing the powerful influence of the physician upon the expectation of the patients and it indicates the potential for client education.

2.10. Conclusion

The most immediate factors influencing the decision of physicians in the clinical encounter have been shown in the figure 1.2 among which **the providers' knowledge and attitudes** are more feasible to approach and intervene rather than the national context and needs, expectation and the social environment factors. As described in the model the knowledge and attitudes depend on the professional training, years of practice and experience, specialization and postgraduate training, extent of drug industry information and marketing, availability of practice guideline and protocols, access to the other research-based evidence and practice ownership. Out of those, training is evidently powerful measure that may lead to change of knowledge and attitudes.

Figure.2.5. Site of action of continuing education



Therefore **continuing medical education**, which comprises the provision of information, treatment protocol and guidelines, and may enhance the access to research-based evidence through the education channel.

Continuing education program can also promote the personal and rapport among each other and with public sector. It can also produce the awareness of the current issues prevalent in the community and recognition of the quality of care given by them. The need of improvement can be convinced and participation in the control of diseases, preventive and promotive health care provision might be achieved in long term. Themselves and public health personnel concerned may expect these sequences of positive change in the practice of private physicians under the assumption of full motivation with active participation. By improving the quality of care through the continuing education the most desirable goal i.e. the professional prestige can be attained.

All those reasons indicates that the continuing education program is the choice of intervention to improve the quality of care in private physician for the sake of long term effectiveness and to achieve the national disease control objectives with use of human resources efficiently within organizational and managerial capability.

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