CHAPTER 5

INTERRELATIONSHIP OF ECONOMIC/PATIENT-DRIVEN QUALITY

Recapitulation

In Chapter 4 the study has made use of the service quality dimensions to look into the expectation and perception of the customer/patient in relation to health service of the peripheral health system. The object has been to determine whether the health service is in line with patient-driven quality and achieves customer/patient satisfaction. In this Chapter it is proposed to arrive at a synthesis between the approach of economic quality and patient-driven quality.

Reconciliation of Economic/Patient-driven Quality

Quality of the health service is a broad and complex term comprising technical quality, economic quality and patient-driven quality of health service. In the context of the study two components of quality of health service have been taken up: economic and patient-driven quality of health service. But it is necessary to bring out that economic quality and patient-driven quality are closely intertwined. As the purpose of a health facility is to take care of patients it consistently endeavours to attain patient-driven quality. But it is felt that a health provider such as a health center distinguishes itself by the cost-effectiveness with which it delivers health service. Besides an interesting definition of "quality of health service" according to J. Ovretveit (1992) is "fully meeting the needs of those who need the service at the lowest cost to the organization. "Economic quality is
associated with the notion of cost. It is felt that an analysis of cost helps to give an indication whether an organization or facility is operating efficiently. If the cost of operation of a health center is high it means that the process or method for delivery of health service is not productive. It may be necessary to review the procedure to reduce cost and improve efficiency. It is felt that the cost or economic quality approach may contribute to build up a comprehensive quality system for the health service. On the other hand the implementation of the patient-driven quality system may result in preventing faulty service or negligence, thus avoiding cost relating to malpractice claim. It is becoming clear that there is a link between economic quality and patient-driven quality as they serve to reduce cost and improve service. On the basis of the findings of the study on economic quality and patient-driven quality it is intended to arrive at a synthesis of inference in respect of the state of the health service at the peripheral health system. This may help to formulate a scenario which may lead to the improvement of the health service.

Synthesis of Inference
Variation in cost: The study on economic aspect of health service has shown that there is wide variation in total facility costs for all services as well as in the cost of each specific service provided at the level of AHCs and CHCs. The variability is greater among CHCs. If this is related to patient-driven quality it is felt that it is necessary to lay down appropriate systems which may apply respectively to all AHCs and CHCs with well-established processes, protocols of
care and guidelines about resources and staff to be used for various services. The processes associated with the systems may help to address the problem of cost variation so that remedial action may be taken to avoid big discrepancy in costs. This sets up a systematic approach to ensure that the operation cost of services at the level of AHCs and CHCs are standard, reliable and with little fluctuation. It is felt that the AHCs and CHCs may be better managed to provide quality service.

Cost of Curative/Dispensary Service: The study on economic aspect of health service has brought to light that the cost of curative/dispensary and dental services represent nearly two-thirds of total cost of services at AHCs. At the level of CHCs, curative/dispensary service accounts for about two thirds of total cost. It is evident that a high proportion of resources at the peripheral health system is utilised to meet the cost of curative/dispensary service instead of supporting preventive and health promotive activities which are meant to be an essential component of the peripheral health system. Viewed from the angle of patient-driven quality it is felt that it is important for the peripheral health system to be properly planned and designed. It has to provide for a balanced distribution of resources among the various services. Although it is recognized that curative/dispensary service is important to treat diseases it is vital to orient the health service towards the preventive and health promotive side of medicine in order to halt the spread of disease and foster a healthy lifestyle to keep the population in good health.
Personnel Time Cost: The study on economic aspect of health service shows that a large proportion of total cost is due to cost of overhead personnel time and downtime of personnel. The cost of personnel time for general service as it is not linked to facility output is considered as personnel overhead time. To improve productivity at the peripheral health system it is necessary to reduce overhead personnel time and downtime of personnel. When examined from the patient-driven quality angle, it is felt that one means to reduce overhead, Personnel time is to contract out say cleaning of the health center. When cleaning work is contracted out, it may be possible to get a competitive cost which may be lower than the existing cost for cleaning the center. This may lower cost to a certain degree. It is also felt that to deal with personnel downtime there may be flexible opening hours of the center. The center is functional on weekdays from 9.00 a.m. to 4.00 p.m. and for half day on Saturdays. During such time most people are at work especially with the industrial development of the country. It is proposed that by arranging for health personnel to work in shifts, during weekdays the health center may remain open for extended hours from 4.00 p.m. to 6.00 p.m. and also run for half day on Sundays. The working population can attend the health center after work without the need for any absence from work and benefit for half day from health service during weekends. Such an arrangement may meet the convenience of patients and expands coverage of health facility to the community.
Cost Of Pharmaceuticals: The study on economic aspect of health service has shown that the type and amount of pharmaceuticals prescribed may have an impact on cost of services of AHCs and CHCs. It has been found from the study that there is widespread utilization of antibiotics which may be costly to the health service. Over-prescribing of antibiotic may lead to risk of antibiotic resistance, necessitating other antibiotics for treatment purpose. Looking at the problem from the patient-driven quality aspect it is felt that it may be useful to develop strategies to streamline use of pharmaceuticals. A form of treatment protocol may be devised where for each disease apart from antibiotics there are choices for use of other medicine. For instance to treat diarrheal disease among children besides utilising an antibiotic which is costly, alternative use maybe made of Oral Rehydration Solution (ORS) which is less costly. Such an approach may reduce cost of pharmaceuticals and contribute to the welfare of the patient.

Volume of service CHC/AHC: The volume of service provided which is related to attendance rate influences whether a health facility has high or low costs. The study has shown that some CHCs have greater volume of services and higher attendance than AHCs. Those CHCs therefore appear to be more efficient providers of health services. If this phenomenon is seen from the patient-driven quality approach it is viewed that there is need to proceed with a rationalization in the use of service at the peripheral health system level. It is suggested that consideration may be given to alter the package of service at both CHCs and AHCs so that they provide distinct and not overlapping service. For instance a
CHC may attend to community health care needs including preventive and health promotive services. The AHC may provide simple diagnostic and curative/dispensary service as well as dental service. In an area where there is a multiplicity of health facilities, for example Government hospital, private clinic and private care providers (physicians and dentists) steps may be taken to close those centers with exceptionally low utilization cost and arrange to open new centers where utilization is high. It is further felt that facilities in areas of low utilization of a health facility, the nature of the health service may be altered to minimize cost of generating health service and offer basic service. This may ensure an interconnected network between the CHC and the AHC for the general benefit of the patient.

Decentralisation and Cost-sharing: The study on patient-driven quality has shown that the patient's expectations of the health service are very high. There is rising expectation among patients who are becoming more discerning especially with development in medicine and medical technology. On the other hand health facilities such as AHCs and CHCs have to cope with increase in demand with little change in resources. For instance there may be shortage of a medicine and it may take the central Ministry of Health time to replenish the stock. In such a circumstance the physician may either refer the patient to the pharmacy of the hospital of the health zone where he may get the medicine or request the patient to purchase the medicine. The patient may naturally feel dissatisfied as he expects to get the medicine at the health center. It is important
to develop realistic expectation among the patient. If such a situation is examined from the economic quality aspect it is felt that there is need to decentralise the health service devolving financial responsibility to the health center. In the event of depletion of stock of medicine the health center may use the funds to purchase medicine from a supplier within the health zone. It is also believed that though health service is free, a system of limited cost-sharing may be introduced for say obtention of medicine. The system of cost-sharing in health care is in practice in Denmark, West Germany and the United Kingdom (U.K.). Cost sharing it is felt may help the physician to take into account the aspect of cost when prescribing medicine. This may be a way to avoid that the cost of medicine gets too high. The center may derive some revenue. In a sense through cost-sharing the health center may charge for service of low priority so that scarce resources are released for services of high priority, say child health service to lower Infant Mortality Rate which is relatively high (approximately 19.6 percent).

Responsiveness Of Service: The study on patient-driven quality has shown that there is not much satisfaction with the responsiveness of the health service of the peripheral health system. When there are many patients waiting at the health center there is a tendency for the physician or nurse to rush with the patient. The physician and nurse must spend sufficient time with the patient, listen to the patient and develop a procedure of care; lessening the anxiety of the patient and leaving a positive impression on the patient. If the patient is not satisfied he may
go to the hospital of the health zone for the same health problem. When looked at from the economic quality angle it is felt that the system of the health center must be designed to enable to physician to devote reasonable time to a patient particularly for a correct diagnosis. If the dissatisfied patient proceeds to the hospital of the health zone for the same health ailment, there may be duplication of effort involving unnecessary cost. Such cost may be avoided if the health staff of the health center are more responsive.

Timeliness of Service: The study on patient-driven quality has revealed that there is dissatisfaction with timeliness of the health service at the peripheral health system level. The patients have to queue up to get registered at the health facility. They have to wait to get medical consultation. They have to line up to obtain medicine from the pharmacy. This creates a negative perception about the health service. In order to view the problem from the economic aspect it is proposed to have recourse to the Time Price Theory (Nichols et al, 1971). According to the Time Price Theory patients pay a "time price" in terms of the earnings they forego or the lost benefit of the worthwhile activities they are unable to pursue. The rational individual may join a waiting list rather than pay for immediate private care if the utility he expects to gain from immediate rather than delayed treatment is greater than the price of immediate care. Waiting for health service therefore involves cost. It is important to organise the health service to overcome waiting time and provide timely service.
Setting For Improvement Of Service

Awareness of Cost: It is felt that the case study may help to create an awareness of cost among the physician, the nurse and other health staff. There is likely to be greater concern for cost in the provision of care. The staff may be motivated to generate cost data to achieve cost-efficiency. In the health facility there is going to be a different perspective with the effective use of resources and the adoption of ethical behaviour to maximize benefits and provide quality of health service.

Consistency of Service: The case study may be useful to promote consistency of health service. A CHC may have, for instance, a low cost of immunization service and a high cost of child care service when compared to other CHCs. The significance of the study may be to single out any incongruity in respect of any service so that corrective action may be taken for adjustment of cost in relation to the general cost trend of the CHC.

Benchmarking of health facility operation: The study helps to pinpoint the CHCs and AHCs whose costs are nearer to the respective mean costs for AHCs and CHCs. It may be possible to produce benchmarking standards which may be applied to CHCs and AHCs whose total costs of operation are above the respective mean costs for CHCs and AHCs. The standards may help to ensure that there is not much discrepancy in relation to total costs among CHCs and also among AHCs.
Strategic Planning of Health Service: In line with the tendency to collect data on cost it is felt that the study may also lead to information gathering on health problems. Such information may help in a systematic assessment of health needs for a particular region. The health facility may formulate targets for instance to lower infant mortality to a certain level. The health facility may then gear its medical interventions to cope with the health needs of the region to bring about an improvement in the level of health.

Package of Curative and Preventive Service: It has been found in the course of the study that resources are skewed in favour of curative service with limited resources for preventive service. The study may help to reorient the peripheral health system to provide for an equitable mix of curative and preventive service as prevention is a long-term measure to lower the incidence of disease.

Balance between the first tier and second tier of health service: The CHC represents the first tier of health service and the AHC is the second tier of health service. It is has been found that in certain cases a few CHCs turn out to be more effective providers of health service than AHCs. The study may lead to a rationally based balance between CHCs and AHCs with inter-complementarity between the two levels of health service.
Health Service Quality: The study has brought out that it is important to incorporate patients insight in the provision of health care. Getting feedback from patients may help to provide an appropriate service. There is need to assess viability of service. For instance treatment measures may be examined to explore alternative treatment procedures which may be less costly but equally effective. The health service must reflect the mentality that the patient comes first. In order to offer quality of service, the health service needs to provide for convenience, timeliness and promptness of service.

It is felt that the setting outlined may contribute to give a different direction to the health service of the peripheral health system. It represents a series of development which may prove useful for sustained improvement of the level of health service.