Providing quality healthcare

Health Care Quality

1. 0 Background To The Study

The Client enters the health care delivery service with needs, concerns and expectations, requiring various interventions. Identifying and providing appropriate care to meet these needs in a cost effective way without compromising the standard of care is one of the challenges facing health care providers today.

Other challenges facing them include consumer's demands, professional demand for excellence, high cost of healthcare and demographic shifts. In order to provide quality care that meets the client's need and increase his satisfaction the client's views must be respected and his preferences taken into consideration. Studies to identify clients' preferences have shown that providing physical comfort adequate and timely information, coordinated and integrated care, emotional support, respect for clients' values and rights are powerful predictors of client satisfaction (Gerteis, 1993; Potter and Perry, 2001).

Other studies also showed that irrespective of cultural background and beliefs, providers' behavioural attributes such as showing respect, politeness, provision of privacy and reduction in clients' waiting time influence clients' satisfaction with care (Population Report, 1998).

Clients satisfied with the care they received have been found to pay compliments, comply with instructions, keep clinic appointments and recommend the hospital to friends and family members (Larson and Ferketich, 1993; Kotler and Armatrong, 1997, in contrast, those not satisfied

have been found to complain, take legal actions, change providers or even leave the orthodox health care services for complementary therapies or alternate medicine (Luthert, 1990; World Bank Report, 2000; Jegede, 2001).

These activities have affected the health care delivery system. In recent times, several changes have also emerged. This includes a change in the stereotyped image of the patients. Historically the patient had been viewed as a passive recipient of healthcare in a paternalistic relationship with the caregiver. This is no longer the case, as today the client is a well-informed consumer with a strong negotiating power of choice, which he uses to his advantage (Melville, 1997, Alagba 2001).

This position was strengthened by the Consumers' Bill of Rights of 1965 and the Patients' Bill of Rights of 1975 (smelther and Bare, 2000, Alagba, 2001). The Bills emphasized Client satisfaction with services provided more so as satisfaction has been accepted as a major indicator of quality care. Furthermore, as consumer of the services the client is in the best position to say if a service has met his needs or not. The client's perception of care is therefore of paramount importance to any provider.

However, in spite of all these, healthcare workers' care alone may be inadequate to meet all the client's needs. Client-centered care required that healthcare delivery system provide client-friendly hospital policies, adequate number of professionals, safe and clean environment, appropriate equipments and functional laboratories. These facilities provided at affordable prices are necessary to complement healthcare workers' efforts and guarantee client's satisfaction.

Unfortunately the major hindrance to the achievement of this goal is the high cost of healthcare services, for example, Stanhope and Lancaster (1996), Potter and Perry (2001) reported that there was a great hike in health care delivery system in United States of America.

Then the health care costs inflation was said to have been higher and faster than the consumer price index between 1950 – 1980, and in 1993 it was said to have increased twice above the national inflation index. This hyper inflation, Stanhope and Lancaster (1996) further stated led to consumers' outcry and great demands for cost effective healthcare services.

Chapter Two

Literature Review

- Concept of Satisfaction

Several authors have defined the word satisfaction severally, for example Webster's dictionary defines satisfaction as " the fulfillment of a need or demand and the attainment of a desired end". The Oxford Advanced Learner's Dictionary defines it as " the feeling of contentment felt when one has or achieves what one needs or desires". Satisfaction can also be simply defined as a sense of contentment emanating from perceived needs met.

These definitions suggest the need for needs identification and goal setting before satisfaction can be attained. It would also appear that satisfaction is subjective with only the individual attesting to his/her satisfaction. In today's provider-client relationship the onus lies on the providers to strive at client satisfaction.

Studies to identify the antecedents of client satisfaction have shown that client satisfaction is one of the results of the provisions of good quality service; consequently it has become an important quality indicator (Filani, 2001; Vuori, 1987). The need to provide quality care is based on several factors including the principle of equity. Clients and consumers who pay for services are entitled to value for money paid.

Satisfaction is also found to depend on client's expectations. Each individual has an expectation of the outcome of an interaction, a relationship or an exchange. Positive outcome engenders client satisfaction. This view is well articulated by Kotler and Armstrong (1997) who stated that " when a client's expectations are not met, the client is dissatisfied, when it is met the client is satisfied and when it is exceeded, the client is delighted, and keeps coming back". Consequently service providers should assess clients' expectation at the inception of a relationship in order to consciously plan to satisfy the client.

Sometimes clients may not be sure of what to expect, it becomes necessary for service providers to develop an expectation of good quality in the client so that they can insist on it. Otherwise the client may be satisfied with relatively poor services (Shyer and Hossan, 1998).

This is not in the interest of the client or the service providers. Therefore counseling the client and informing the public on what constitutes appropriate care or service should be seen as efforts to develop and sustain client satisfaction. This is especially important in the light of current reforms in the health care delivery system.

Recently, certain forces have occasioned reforms in the healthcare delivery system; these forces include population demographics such as increasing number of the aging population, cultural diversity, changing patterns of disease, technology, economic changes and clients' demand for quality care (Smeltzer and Bare, 2000). These forces demanded that care providers developed innovative ways to meet clients' needs and increase clients' satisfaction.

Today healthcare is viewed as a product to be purchased and patients hitherto seen as passive recipients of healthcare have metamorphosed into empowered consumers. As consumers the clients command the attention of providers and healthcare managers who have a duty to ensure their satisfaction. This view was supported by the British Government when dealing with the National Health Service (NHS) inability to cope with problems increasing demand on it by the aging population, the advancements in medical technology and the rising expectations of healthcare users (Melville 1997).

Also like consumers it has been noted that healthcare clients are getting increasingly associated with rights, power and empowerment. Their present status enables them to take control of their circumstances and achieve their own goals. Adams (1990) observed that it also enables them to work towards the maximization of the quality of their lives. Using their power, clients demand for good quality healthcare: their demand is supported by the World Health Organization, Alma Ata declaration of 1978, and the constitution of the World Health Organisation (1966).

The latter, stated that, “ good health is a right of all people”. This is interpreted to mean a right to availability, accessibility and affordability of good quality health care. It follows that healthcare should be provided in a way that is acceptable and satisfactory to the consumer, who also has the power of choice.

Literatures abound on the clients’ power of choice (Rogers, 1993, Melville 1997). However, suffice it to note that the client as a consumer uses this power to select between alternatives and chooses what gives him/her best satisfaction. This fact was also noted by Alagbe (2001), who citing the Law of marginal utility stated that “ Consumers are rational and have the ability to measure the utility or satisfaction they derive from each commodity consumed, and given a total rationality consumers elect a combination of goods and services that will maximize their satisfaction”.

This stresses the fact that consumers choose what will give them maximum satisfaction. The power of choice has numerous benefits for clients, including the fact that the client is frequently consulted by the provider or producer (Melville 1997). This also creates a relationship of partnership rather than the paternalistic one that had characterized the healthcare delivery system.

The goal before all healthcare providers is to develop and maintain a client-centered service in order to provide quality service and ensure client satisfaction, more so as clients are becoming more knowledgeable and health conscious (Smeltzer and Bare 2000).

Their interest was stimulated and sustained by the television, internet, newspapers and magazines other communication media and by political

debates. Their increasing demand for quality care based on this increase in knowledge was however catalyzed by the consumers' awareness campaigns of the 1960s and 1970s, which subsequently led to the formulation of the Patients' Bill of Right. This will be reviewed later following a review of the historical background of consumerism.

Historical background of consumerism

The early 1960's saw the American public agitating for quality service for every dollar spent. Most business executives regarded the agitation as transitory threats. The consumerists however continued and became extremely vocal in their criticisms and protests against escalating cost of services without corresponding improvement in the quality of goods.

According to Alagbe (2001) in 1962, the American consumer movement received a major boost with a presentation to the congress of the consumers' Bill of Rights; by President John F. Kennedy the bill contained four items namely, that the consumers should have:

– The right to safety: This refers to protection against products hazardous to health and life.

– The right to be informed: This refers to protection against fraudulent, deceitful or misleading information in advertising or elsewhere and by also providing people with facts necessary to make informed choices.

– The right to choose: This refers to assurance of reasonable access where possible to a variety of products and services at competitive prices with

government regulations to assure satisfaction, quality and service at fair prices.

– The right to be heard: This refers to the right of redress with the assurance that the consumer's interest will receive full and sympathetic consideration by government's expeditious actions.

Based on this the American Hospital Association in 1972 published a list of rights for hospitalized patients. The patients' bill of rights was devised to inform patients about what they should expect from a caregiver-patient, and a hospital-patient relationship.

The patients' bill rights

The patients' Bill of Rights have strong implications for the healthcare worker, who is involved in independent, dependent and interdependent care of the patient. The care giver (Doctor, Nurse, Physiotherapist etc) form the most central and important part of the patients' stay in the hospital. The care giver respecting patients' right will ensure his satisfaction with care. Every healthcare worker therefore has a responsibility to ensure that the client's right as enunciated by the Bill of Rights is always respected.

The bill includes that, a patient has the right to considerate and respectful care. This implies that health services providers should consider such facts as individual preferences, developmental needs, cultural and religious practices and age differences in their care of the patient. S/he also has the responsibility of ensuring that their assistants offer the same level of care.

The patient has the right to obtain from his physician, complete current information concerning his diagnosis, treatment and prognosis, in the terms that the patient can reasonably understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate and reliable person on his behalf. He has a right to know by name the physician, responsible for coordinating his care.

The patient has the right to receive from his physician the information to give informed consent. Some patients may not want to know everything about them, so the care giver has the responsibility to explain to the client that it is their right to know all, as it is a legal requirement. This helps the patient appreciate his responsibility for his health. The average client also appreciates the honesty of these explanations in the long run, because he is being treated as a partner with decision power.

The patient has the power to refuse treatment to the extent permitted by the law, and to be informed of the medical consequences of his action. It is difficult for healthcare workers to understand why clients refuse treatment that can benefit them, but this is a reality. Often, explaining in simple language the purpose solves the problem. If after the explanation of purpose and procedure, the patient still refuses, the care giver should remember that such action is the patients' right. However, good planning of care that includes the patient in planning has tended to reduce the problem of refusing therapy.

The patient has the right to consideration of his privacy. The patients' right to privacy is readily violated on busy wards especially where there are no

curtains as is the case in most government hospitals in many third-world nations because of the current economic crunch.

Healthcare workers as patients' advocates should ensure that their rights to privacy are respected. Efforts to ensure clients privacy should include having discussions with clients conducted in private areas not at their bedsides for all to hear. Also patients' conditions should not be discussed in the hearing of other patients. Class assignments must not identify a patient by name or position.

The patient has a right to expect all communications and records pertaining to his care to be treated as confidential. Patients' charts should not be left to be read and discussed by unauthorized personnel. Laboratory result should be well documented and stored. Healthcare workers need to remind other aids that patients records are confidential and not to be discussed at home with friends and relatives.

The patient has a right to expect that within its capacity, a hospital must make reasonable response to the request of a patient for services. Nurses are often in charge of coordinating services for the patient such as x-rays, appointments with specialists, such as physiotherapist, etc. these should be available and provided in the order that is convenient for the patient. Also in the event of a transfer, the nurse should emphasize this to the reference hospital.

The client has the right to obtain information as to any relationship of his hospital to any other healthcare and educational institutions or hospital personnel. Sometimes hospitals are affiliated to or are owned by some

religious organizations and universities; this has implications for the client care. He therefore has a right to be informed about it.

The patient has the right to be advised if the hospital proposes to engage in, or perform human experimentation affecting his care or treatment. He has the right to refuse to participate in such research projects. Most clinical trials take place without the clients' knowledge, or even when explained the language may be too technical for the client to understand.

After explicit explanation, a client should be asked to sign a separate consent in addition to his consent for care if an experimental therapy is proposed to him. He can also withdraw at will without any reprisals. The patient has a right to refuse permission to any one to touch his body. His basic responsibility is to himself and not to the advancement of science or learning.

A patient has a right to expect reasonable continuity of care. Healthcare must to continuous and of the same quality. A change in shift should not result in negligence.

The patient has a right to examine and receive an explanation of his bill, regardless of the source of payment. In places where bills are paid by third parties and insurance, it is easy to assume that clients should not care about charges. The client has a right to receive explanations and demand for rational charges.

The patient has a right to know what hospital rules and regulations apply to his conduct as a patient. Some hospital rules are very restrictive, however, if

they are written down and given to patients, the patients are more likely to remember them. Patients' have the right to be properly informed; having the booklets to review at his leisure time and reminding them of these rules will help compliance.

It is important that a client has access to the bill of rights as the consumer's access to the bill of rights ensures that he is able to demand for his rights.

However as the patients' advocate, the healthcare worker has a responsibility of ensuring that these rights are respected as provided. These rights ensure that the consumer/client's basic needs are met. To guarantee this, Haskel and Brown (1998) recommended that hospitals should create a culture that focuses on patients.

This, they argued will allow health workers to respond to patients' needs and even go beyond their expectations. The Health care system determines the quality or services provided. Unfortunately today, healthcare financing is more economy driven than patient-centered. (World Bank Report, 2000). This portends a danger for client care and needs to be examined.

- Healthcare systems

This can be defined as the organ that organizes and funds health care services. Its goal is to provide an optional mix of access, quality and cost. Kielhorn and Schulenburg (2000) identified three basic models of health care system. These are the " Beveridge" model, the public-private mixed model and the private insurance model. The differentiating factor appears to be the funding and the coverage.

- Beveridge Model

This is funded through taxation and usually covers everybody who wishes to participate in the state. Countries using this model include United Kingdom, Canada, Demark, Finland, Greece and Norway;

In this model healthcare budgets compete with other government spending priorities such as education, housing and defence. Consequently budget cuts and run away inflation lead to high costs of healthcare services. One of the resultant effects is shortage of healthcare professionals, like doctors, nurses, physiotherapists etc. Regrettably this is feared to have affected the quality of healthcare.

For example, Ferlman (2000), after a poll conducted on 2, 000 adults for the British medical association reported that, the number of people satisfied with the health service dropped to 58% as compared with 72% percent in 1998. The population who were " very dissatisfied" or " fairly dissatisfied rose from 17 percent to 28 percent This result may not be unconnected to the decline in the quality of healthcare services.

- Public Private Mix Mode

This model is funded primarily by a premium-financed social mandatory insurance, it has a mix of private and public providers, which allows for more flexible spending on healthcare. (Kielhorn and Schulenburg, 2000). Participants are expected to pay insurance premium into competing non-profit funds and the physicians and hospital are paid through negotiated contracts.

The funds can also be supplemented through additional voluntary payments. Countries that use this model according to Kielhorn and Schulenburg (2000) include France, Germany, Australia, Switzerland and Japan.

- Private Insurance Model

This model exists exclusively in its pure form in the United State of America (USA). Healthcare there is funded through premium paid into private insurance companies. The health insurance is not mandatory, so most often people with low income and high-anticipated healthcare cost, like people with chronic diseases are often unable to afford insurance.

This makes healthcare in this system selective and non-equitable. An estimated 15% of the population in USA where this model is practiced are said to be unable to have any insurance cover. (Kielhorn and Schulenburg, 2000).

Any of these three basic healthcare funding models are utilized by most healthcare organizations to fund the healthcare delivery system. However due to the global changes occasioned by various factors healthcare organizational developments became necessary, in order to contain costs and ensure quality care. (Stanhope and Lancaster 1996: Yoderwise, 1999).

The United Kingdom Health System

In a bid to provide free healthcare services for all UK residents, National Health Service (NHS) was founded in 1948. Funds for running the NHS was got through general taxation and this fund is administered by the department of health. Essentially, consumers of healthcare services do not pay at the point of receiving the services.

Apart from the NHS, Private healthcare providers also exist in the UK but the consumers of their services either pay at the point of service or through insurance.

The NHS: Considerable changes have occurred in the structure of the NHS over time. There is however no considerable differences in the structure and functions of the NHS among the countries which make up the UK. In England for example, the department of health in collaboration with other regional bodies or agencies take charge of the overall strategy while the local branch of a particular NHS takes the key decisions about local healthcare.

The secretary of state for health is the minister overseeing the NHS and he reports to or is accountable to the Parliament. The overall healthcare management is the duty of the department of health, which formulates and decides the direction of healthcare.

England has about 28 strategic health authorities which are concerned with the healthcare of their regions. They are the intermediary between the NHS and Department of health.

Types of trusts

Local NHS are called Trusts and they provide primary and secondary healthcare. England has about 300 Primary care trusts and these altogether receive ¾ of the total NHS budget.

NHS Trusts: these are responsible for specialized patient care and services. They run most hospitals in the UK. There are different types of NHS trust:

– Acute trusts providing short term care e. g. accident and emergency care, maternity, x-rays and surgeries etc; Care trusts; mental health trusts and ambulance trusts.

Foundation trusts: ownership of these trusts is by the local community, employees, local residents. Patients here have more power to shape their healthcare based on their perceived health needs to their satisfaction.

Private Healthcare

This sub-sector of the UK healthcare system is not as big as the NHS and does not enjoy similar structure of accountability as the NHS. They may be similar to the NHS in service provision but are not bound to follow any national treatment guideline and are not saddled with responsibility of the healthcare of the larger community.

Regulation and inspection of healthcare system in the UK are carried out by a number of designated bodies. Some of these are the national institute for clinical excellence; the healthcare commission; the commission for social care inspection and the national patients' safety agency.

Community Satisfaction with Healthcare System

World Bank (2000) identified three basic types of healthcare organizations providers in the healthcare system. These are: the market or for profit co-operations, the government, and the not for-profit organizations. The last group includes the mission hospitals run by religious and non-governmental organizations. For them their main objective is to provide quality care for the citizens. Although scarce resources often limit their efforts, they are reported

to be providing quality care to clients within their means. (World Report, 2000).

In Government run systems especially in many resource-constrained nations, the main complaint is the failure of the Government run systems, which are supposed to be the most equitable and cheapest system for providing care, is being run down for ideological reasons in some countries, (World Bank, 2000). This jeopardizes the availability of healthcare services to the individual, resulting in the client's non-satisfaction with one.

Lastly, are the for-profit co-operations. These, according to World Bank (2000) have problems of care and affordability, which parallel their profit. The affordability is noted to be most acute in the market-listed companies. This is because the prime objective of these groups entering the health market is to make profit from the sickness the most costly and least affordable healthcare providers. Unfortunately while share holders are getting profit the clients for whom health care is provided are receiving poor quality care.

World Report (2000) documented declining care and increasing dissatisfaction with healthcare in most countries. The greatest dissatisfaction was reported in the market-based systems and when market placed systems replaced state funded ones.

The market system in the USA, which was supposed to help the citizens, is criticized for deliberately exploiting them. Critics argued that the strong competitive measures encouraged, have destroyed the ethics of USA's

hospitals' Samaritan culture and the professionals of the healthcare providers.

Patients were reported to have had to suffer as a result. Equity was also said to have become a problem, as healthcare is no more available to all citizens. This was attributed to the effect of the market systems on the health care delivery service.

The market based systems are also reported to have wide spread incidences of denial of care of patients, mis-use of patients for profit and neglect of the frail and vulnerable (World Bank, 2000). These were said to have occurred when profits were being earned and shared by corporate bodies to shareholders. Information from the market place were said to have revealed receptive marketing, and mis-information which covered up the misdeeds of the corporate bodies.

In response proponents of the market system defended their policies and argued for its usefulness, and value in healthcare reforms. For examples Samuel (2000) argued that competition, a fall out of the market system encourages efficiency, reduces costs, enhances responses to consumer demands and favours innovations.

Consumer empowerment, he stressed is one of the dividends of competitive healthcare systems. He added that introducing competition would provide consumers the freedom to choose between different services and different delivery mechanisms that meet their needs. It is also expected that this would increase their satisaction.

Competitive pressures, Samuel (2000) pointed out will break down self-regulatory practices by service providers, developed essentially to serve their interest, so that clients interest will eventually be served. While the above argument is appreciated, it is also observed that the problem of equity is more profound here, as it appears that only the few that can afford quality care can get it. In the light of the what Alma Ata declaration of 1978, all nations have a responsibility and an obligation to attend to the health needs of all their citizens.

It is obligatory to make healthcare available, accessible, affordable and acceptance to all. These places on the government of every nation the responsibility to ensure that there is equity in health care services distribution. In order to ensure this, countries like the United Kingdom entirely funded the National Health Service (Kielhorn and Schulenburg, 2000). As a result, even in the face of health care cuts and shortages the NHS clients were found to be very supportive of the system. (Walsh, 1999).

In most other countries, clients have reacted to the healthcare system and services provided in various ways. In some places, they have responded with an observable move away from conventional medical care. This trend, most argue, can be traced to the high cost of the latter.

There is also the argument that clients' expectations are no longer met through conventional healthcare services. This is said to be so especially for clients with less serious disorders. For example, Manga (1993) found that clients were considerably less satisfied with medical physician's management of their low back pain than chiropractic management of the

same ailment. These observations, were also corroborated by Cherkin and Maccomak, (1989) and Harris Poll, (1994).

Processes of a health service system

The processes of a healthcare service system refer to the actual performance of the activities of care. Stanfeld (1992) identified two components of the processes. These are the activities of the providers of care and the activities of the population.

Activities of health care providers

Every interaction between an individual or community and a care provider begins with need or problem identification. Starfield (1992) stated that the problem recognition implies an awareness of the existence of situations requiring attention in a health context.

Diagnosis, planning and intervention follows after that assessment, is carried out. Evaluation is done intermittently and the end of the intervention to determine if the original diagnosis, plan and interventions were appropriate and adequate for the recognized need.

In nursing, models of care such as the nursing process are utilized to facilitate systematic and scientific provision of quality care and client satisfaction. Also care provided is guided by established institutional standards of care. Effective assessment of client’s needs and its resolution is expected to have an outcome of client satisfaction. It is therefore important that the healthcare provider’ intervention should be client centered, in order to achieve the set goal.

Activities of the client

People decide whether or not, and when to use the health care system (Starfield 1992). It is in coming in contact with the health care system that clients recognize what services are offered and the quality of the services offered. The clients' experiences enable them to form their opinions, deciding if they are satisfied or not (Starfield 1992).

The caring process involves the performance of the activities of car