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Quality standards for health care delivery and management in publicly oriented health services†

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SUMMARY

In 1999, the multidisciplinary Tavistock group prepared a generic statement of ethical principles to govern health care systems. This paper elaborates on these principles in two directions. First, it develops a set of quality standards, based on ethical principles, intended to regulate health care delivery and service management. Second, it focuses them on 'publicly oriented' (not necessarily governmental) as opposed to 'for profit' (not necessarily private) services. We propose ten principles or quality standards for these services, part of which relate to the individual patients, others to the community. They are political as well as technical, and can be used to inspire health policies, contracts issued by governments, and identification of partners by aid agencies. We analyse their application in key areas of health care by publicly oriented and for-profit health care organizations standards in developing countries, and conclude that the latter are unlikely to adopt the proposed standards. We further elaborate on the implications of the standards for publicly oriented services, focusing on care delivery and patient-centred care, family and community medicine, services management and disease control. Using these criteria for a renewed compact between authorities, health professionals and communities may help to motivate health professionals by bridging the gap between their professional and social-political identity. Copyright © 2003 John Wiley & Sons, Ltd.

KEY WORDS: quality of health care; public policy; health service management; politics

INTRODUCTION

In 1997, an editorial in the *British Medical Journal* stated the case for a shared code of ethics that might bond all health care stakeholders into a consistent moral framework (Berwick *et al.*, 1997). To elicit comments and discussion, the multidisciplinary 'Tavistock group' issued five ethical principles that should govern all health care systems (Smith *et al.*, 1999), in essence:

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1. Health care is a human right.
2. The care of individuals is at the centre of health care delivery, within an overall preoccupation for generating the greatest possible health gains for groups and populations.
3. The responsibilities of a health care delivery system include the prevention of illness and the alleviation of disability.
4. Cooperation between providers and with those served is imperative.
5. All individuals and groups providing access or services have a continuing responsibility to help improve its quality.

This paper elaborates on these principles further in two directions. First, it develops a set of quality standards based on ethical principles intended to regulate health care delivery and service management. In doing so, we aim to clarify in tangible terms the meaning of 'quality' of health care—a fashionable, but rather ill-defined policy issue. The paper focuses on primary care services, although the principles apply to other levels of care as well.

Second, it focuses these principles on 'publicly oriented' health services. Indeed, health systems are generally pluralistic, incorporating organizations ranging from private-for-profit, non-governmental (NGO), governmental, municipal, denominational, mutual aid, social security, etc. According to the framework of Giusti *et al.* (1997), we classify these organizations to their remit. 'Publicly oriented' health care organizations refer to facilities and systems whose *raison d'être* is to respond to the health needs and demands of the population. They aim to provide a service to patients, which is equitable, sensitive to community requirements and sets priorities according to need. On the other hand, 'private-for-profit' services primarily focus on financial profitability and treat corporate and health professionals' income as an end in itself. 'Publicly oriented' health services are thus defined in terms of their mission, rather than their ownership. State-operated health facilities are not automatically 'publicly oriented' as degrees of internal privatization may give rise to management for profit and the sharing of benefits amongst professionals. On the other hand, many NGO facilities are 'publicly oriented' in their calling, although private in terms of ownership. In this paper, quotation marks are a reminder that 'publicly oriented' refers to a definition based on public interest and not on government ownership.

Our proposed principles are designed to influence health care delivery and management in all services operating in the public interest, by serving as a basis for:

– management contracts between health authorities and 'publicly oriented' services;
– audits of health services, as regards the content and aspects of service to be assessed;
– statutes, objectives and benchmarks for 'publicly oriented' organizations (NGOs, municipality, government, mutual aid association, etc.);
– formulation of hypotheses in research and evaluation;
– design and teaching of health services managerial strategies.
– dissemination in and by health professional networks;
– health policy proposals for and by political bodies.

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The definition and assessment of quality standards in health care is a political as well as a technical issue. In this paper, we explore how the adoption of what might be termed 'humanistic' criteria for quality health care (and indeed for some, these might be seen as 'socialist' criteria) could have a positive influence on the development of the health sector. Indeed, they could be used as guidelines by health professionals, health care managers, policy-makers, consumers and professional associations seeking to encourage social accountability in health care within government, municipal, and NGO health organizations. The likely impact of a new service compact based on these principles, between patients, health professionals and the government on health care delivery and management is contrasted with care provided by market-based, for-profit organizations. The reasons why this sector is unlikely to adopt the proposed standards in developing countries are explored in this document.

TEN PRINCIPLES AS A BASIS FOR HEALTH CARE DELIVERY IN THE PUBLIC INTEREST

We propose ten axioms to be the basis of quality in 'publicly oriented' health care systems and services. In doing so, we were initially inspired by the Groupe d'Etude pour une Réforme de la Médecine (GERM),[‡] which defined axioms 3, 4, 8, 9 and 10 (GERM, 1971; Mercenier, 1971) and which were further developed through extensive experiences in the field over the past decades. A first set defines the individual's interest in health care:

1. Each individual has the right to access quality health care at a cost within their reach without jeopardizing the economic security of the individual and his or her family.
2. Quality care is patient-centred (Brown *et al.*, 1986; Engel, 1977) and continuous, and reduces suffering, disability, anxiety and risk of premature death.
3. Clinical practice must be effective and therefore rooted in evidence-based medicine. Decisions that are not based on scientific criteria should be acknowledged as such by the provider in an explanation to the patient.
4. Quality care enhances the patient's autonomy (Beauchamp and Childress, 1994), makes him/her less of a hostage to the disease and its treatment, and respects the decision-making capacity of patients.
5. There is a need for a balance in care between effectiveness and efficiency,[§] between the medical handling of the psycho-social dimension of care and the quest for patient's autonomy, and between rationalization of treatment and response to a patient's demand. The practitioner should strive to maintain this balance through dialogue with the patient.
6. Health professionals should use their knowledge for the benefit of their patients, before their own advancement or that of an employing organization.

[‡]*Study Group for the Reform of Medicine*.
[§]This contrasts with the Hippocratic oath, which favours effectiveness above any other consideration.

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7. Health professionals should recognize the multiple causes of ill health and actively engage in wider activities to promote good health and prevent disease.

A second set of axioms balances these individual interests with the population's collective interest:

8. Wellbeing, defined as the satisfaction of basic needs (food, housing, education and health), is a pivotal human right. Health professionals have a duty to respond to such needs in a way that entails solidarity between the rich and the poor, between the healthy and the sick, and between the moderately and the seriously ill.
9. 'Publicly oriented' health care delivery decisions should be driven by equity. In the presence of scarce health care resources, equity may demand that a limit be placed on personal health care consumption in the wider interests of universal access according to need.[§§] Conflicting health objectives should be resolved in the joint interest of the patient and the community. 'Publicly oriented' decision making in an accountable and transparent manner is needed to prioritize health care activities.
10. 'Publicly oriented' health care delivery should be holistic, culturally and gender sensitive (Brody, 1999) and should strengthen the health care capacity of individuals and their community. Collective reflection and community action are essential contributions to the development of 'publicly oriented' health system and services, and should be fostered throughout such services (WHO, 1978).

THE APPLICATION IN DEVELOPING COUNTRIES

These principles are unlikely to be applied in the private-for-profit sector of developing countries. Some independent doctors may pursue these criteria and in the industrialized world some indeed (partly) do. However, in poor countries profit is necessarily more an end in itself because of the fragile economic situation of the vast majority of health professionals. These conditions are likely to deter private-for-profit providers from adopting these principles. These arguments can be further elaborated by comparing the application of the principles in five main aspects of health care delivery, respectively in 'publicly oriented' and market-based systems: care delivery (clinical practice, family medicine, community medicine, disease control) and service management.

Care delivery

The axioms set out above that define the individual's interest in health care are stated as principles. In this sense, readers are free to accept or reject them. However, continuity of care, patient-centred care, the quest for patient autonomy, and evidence-based medicine can be argued as pre-conditions for effective care. They

[§§]Public management should aim at health sector productive efficiency, which refers to the entire health care public system and not just to one isolated institution.

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are both an end and a means. For example, when decisions about treatment are made on a shared basis, adherence is likely to increase. In other words, health care that promotes the patient's autonomy is likely to be more effective.

Clinical practice

In 'publicly oriented' health care systems, both the individual patient and the community become stakeholders in clinical decisions. At this point, owing to the scarcity of resources, the requirement that is placed on health professionals to deliver optimum quality of care needs to be matched with a concern to contain costs. Similarly, health professionals need to balance rationalization imperatives imposed by protocols of disease-control programmes with the flexibility needed in patient-centred care (with regard to use of drugs, for instance). They must strive to optimize the balance between health care provision in the community and the rights of the individual. In practice, epidemiology should play a pivotal role in clinical decision-making. An essential drug policy, epidemiological knowledge, evidence-based medicine and appropriate diagnostic and therapeutic technology are other key elements in effective and efficient health care provision.

In the for-profit sector, clinical decisions are taken on a case-by-case basis with the ostensible objective of maximizing patient benefit. Effectiveness usually outweighs efficiency, especially because of inherent incentives to over-consumption. In particular, the health professional's income and a facility's revenue are usually dependent on the volume and complexity of diagnostic and therapeutic interventions. This explains why for-profit hospitals in the USA lead to increased spending on health care, while being less efficient than public institutions (Woolhandler and Himmelstein, 1999). For the same reason, publicly financed, but privately delivered care in industrialized countries is likely to be inherently less efficient than publicly financed and delivered care (Havighurst, 1977; Silverman *et al.*, 1999)—although not all public systems achieve their potential for efficiency. Health maintenance organizations that combine the functions of both financing and provision will consider maximizing efficiency as a prime objective and therefore may be an exception. However, the improvements may be largely absorbed by the profits taken (Woolhandler and Himmelstein, 1999).

Family medicine

In our view patient-centred care, the pivotal feature of family practice, is the best mechanism for health care delivery in 'publicly oriented' first line services. Such practice is characterized by an assessment of social, family, psychological and somatic factors that may influence the health problem and its solution. It implies a provider–patient negotiation of a therapeutic and/or preventive strategy appropriate to the specific needs ('patient-centred care').

Several managerial strategies are available to progressively apply the principles of patient-centred care in developing countries, as for example:

- in order to improve skills in patient–doctor interaction, in-service training has proved effective in developing countries (Henbest and Fehrsen, 1992) as well as

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in Europe (Liaw *et al.*, 1996). It can be based on a psychological expertise in the doctor–patient relationship and the use of *aide-memoirs* to systematically explore psychosocial and psychosomatic disorders in particular patient groups.

- numerous techniques can be used to overcome problems of lack of privacy, time and health worker motivation, spanning from specific task delegation, reprogramming of health personnel time, the use of family files to restructuring the conduct of consultations.

Family practice was never a characteristic of colonial health policies. Indeed, its features were conceptualized after the colonial period. However, it did not emerge after independence in the majority of developing countries (Van Dormael, 1995) and holistic care is somehow at odds with government services preoccupied with disease control activities.

Some crucial aspects of family practice are also at odds with the profit motive. In making clinical decisions, the family practitioner faces dilemmas that lie at the very heart of patient-centred care. Does the problem need to be medicalized? Should it be treated biomedically or psychosocially? Should the patient be treated as an individual to the exclusion of all else or with reference to his or her environment (Kunneman, 1995)? Even in industrialized countries, only a minority of health professionals, usually socially and/or politically motivated doctors, address these issues with respect of their patient's autonomy. In developing countries, promoting patient autonomy may not prove feasible if health care financing is inadequate and practitioners are forced to depend on health care over-consumption for survival. Other barriers include perceived class differences between providers and patients, the varying degree of professionalism and the role of personal relationships that can all affect the feasibility of family medicine.

Consequently, shared decision making about case management, an essential element of patient-centred care, is very difficult to achieve in private-for-profit practice and 'internally privatized' government facilities in developing countries. In these situations, any attempt to increase efficiency and patient autonomy will be at the expense of profitability.

Community medicine

'Publicly oriented' and for-profit health care organizations are very different in the way they treat the interaction of professionals with the local communities. 'Publicly oriented' delivery adhering to the quality standards enters into a dialogue with local groups and other services in order to solve individual and community health problems. Resolving some patient problems (e.g. drug abuse, violence, disease due to poor sanitation) requires the participation of providers in community forums. More basically, health care services cannot be 'publicly oriented' and accountable to their clients where the government is the sole authority and if no weight is given to the voice of the community. These considerations have given rise to the discipline of 'community medicine', which is in fact family medicine revisited. Individual and family health problems are addressed whilst giving due consideration to the collective needs of the community. It is of limited interest to most private doctors because

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it involves a number of unpaid activities, mostly amongst poor patients, rather than amongst the better off—the core of their clientele in developing countries, and the delivery of 'public goods' cannot be charged to the patients. Moreover, community medicine's aim of empowering the community cuts across the grain of market-based health care delivery. In practice, private doctors tend to interact with communities primarily to recruit clients. When private doctors are paid by mutual aid associations, the 'public' or 'private' character of their practice depends to a large extent on whether they are supervised by a health professional concerned with the public interest.

Disease control

Nobody would say that government services may not deliver curative care. However, current international policies recommend disease control prioritization within the public sector together with increasing privatization of curative care on the grounds of (supposed) higher efficiency of the for-profit sector (Communication from the Commission to the Council and the European Parliament, 2002; Human Development Network, 1997; WHO, 2000). By contrast, numerous publications underline the frequent need to integrate disease control programmes into general health care services. First, case management is sometimes the only practical control procedure (tuberculosis), the most efficient one (malaria) or a vital element also to promote prevention (HIV/AIDS). Second, organizational structures requiring independent staff for each disease programme are very expensive and difficult to sustain. Third, disease control interventions need to attract general health service users and gain access to patient 'stocks' through the offer of comprehensive care in order to improve (early) detection (Unger *et al.*, 2003). Separating disease control and prevention from curative health care is therefore bound for failure. As for community medicine, the objectives and strategies are not compatible with private-for-profit organizations and providers. Health care facilities that are able to integrate patient-, family- and community-centred care with the disease control programmes must be managed in the public interest and thus be publicly oriented'.

Service management

'Publicly oriented' management should ensure access to quality health care for a defined population. This implies acting upon the quality of, and access to, care in all accessibility forms: financial, pharmaceutical, geographical, intra-institutional, cultural, psychological. By contrast, market-based management aims at securing access to quality health care only for those who can pay.

Managers of 'publicly oriented' facilities should also adopt a *systems management* approach, treating health facilities, resources and processes as complementary parts of the same system, in order to ensure flexible resource utilization, achieve economies of scale, and improve access to care (Berman and Laura, 1996; Van Dormael, 2001). Systems management as applied to the health sector is generally not relevant to market-based management because in the latter profitability primarily determines the decisions made and the investment required. Furthermore, in developing countries where the private sector has not achieved the degree of

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complexity necessary to allow it to share resources across health units, a systems management approach is particularly unsuitable.

These managers should also supervise both health care and disease control; if these activities are separated to distinct service structures the disease control objectives tend to overwhelm wider health care goals (Unger *et al.*, 2003).

The objectives of community participation in the provision of health care differ also according to the management rationale. Four different (though not mutually exclusive) objectives could be:

1. community participation is considered an appropriate method of resolving health problems identified by governments and aid agencies;
2. these problems are defined in dialogue with communities;
3. co-management of 'collective' health facilities;
4. community organization as a goal *per se*.

The last three objectives are typical of 'publicly oriented' management.

By contrast, social control upon private-for-profit health facilities may reduce profits made by investors and the income of health professionals, and thus conflicts with the objectives of market-driven management. Under these circumstances, transparency and the democratization of health facilities are simply not relevant. They are also not relevant or even unwanted for health services charged with delivering disease control programmes and managed by objectives, ignoring the broader demand for health care.

Health systems

In developing countries, health care delivery is broadly classified into one of three categories with some overlap (Green, 1987). One category is market-based and driven mainly by profitability. The other two share a mission to work in the public interest. 'Official' health services comprise primary facilities and hospitals under the control of the government or municipalities. In contrast, community-based health care organizations such as local pre-payment associations, mutual solidarity networks, village and neighbourhood committees, run their own facilities. NGOs are active in both the first and third categories.

Our proposed compact requires that if any of these sectors receive public funds (including international aid), they should abide by the ethical principles laid out above.

CONCLUSION

We have proposed ten axioms for the organization of medical practice in 'publicly oriented' health services in developing countries. These could form the basis of a new contract between the public, the health professions, health care providers and the government. Since ancient times, medical deontology has set out to inform doctors' freedom of decision making in the interests of the patient. In 'publicly oriented' health care delivery, medical practice should also take into account the collective interests of the community alongside the interests of individual patients.

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We are aware that only strong motivation—and reasonable income—can drive health professionals to adopt these standards. Improving this motivation by strengthening the social and moral status of health professionals is the greatest challenge in current health policies (Marchal and Kegels, 2003; Segall, 2003). In our opinion, the advantage of employing these criteria for teaching, research, contracting, evaluation, management and policy design lies precisely in their ability to bridge the gap between the professional and the social-political identity of health professionals. In so doing they make use of the professed ethical motivation of health professionals and politicians.

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