



Averting maternal death and disability
**Quality of care in institutional deliveries:
the paradox of the Dominican Republic:
a commentary on management**

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1. Introduction

Quality of service has two main dimensions. First, service should meet accepted standards or norms. Second, service should please clients. In medical and health services the first—the technical dimension—is dominant. This is even more true in emergency services, where there is question of life or death. However, if services are weak on the second, the human dimension, clients may avoid them altogether (perhaps resorting to home treatments) or seek less effective services elsewhere. Either of these alternatives may lead to poor outcomes.

The paper in this issue of the journal by Miller and colleagues [1] is based on a strategic assessment of the maternal health services in the Dominican Republic (DR). It provides interesting insights into the quality of obstetric care by direct observation of the process of service delivery, as well the perceptions of patients, clinical staff and other stakeholders. It shows that several management problems constrain the delivery of high quality services. In the absence of quality of care, institutional delivery alone can reduce maternal mortality only up to a point. Governments in many countries are developing strategies to increase

institutional delivery as means to reduce MMR, so this is an important limitation.

The paper raises several key management issues.

2. National norms or standards of care and their implementation

The first step in developing good quality emergency obstetric services is to develop standards of care. The DR has done this. It has detailed standards of care, written and endorsed by government. However, the assessment described by Miller et al. showed that standards were often not followed. For example, episiotomies are routinely done whether indicated or not, and without appropriate antiseptic preparation. The Gap Model of service quality, a well-accepted conceptual framework in service quality literature, identifies this as the most important gap—the gap between the specified standards and actual service delivery [2]. This gap is commonly seen in many developing country health programs. Norms and standards are developed by governments but are not implemented by the various hospitals [3].

Miller and colleagues report that stakeholders claim that implementation gaps are due to lack of resources. While this is true in many situations in developing country hospitals, routine episiotomy

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actually wastes scarce resources by doing unnecessary procedures. There appears to be widespread lack of knowledge of the standards or lack of confidence in their scientific validity. There also appears to be little, or ineffective, supervision. Supervisors have not communicated the standards well, there is no monitoring of compliance with the standards and no consequences for deviation from the standards. Many institutions falsely believe that once standards are set, professionals and organizations will automatically follow them. This paper clearly shows that this is not true and that not meeting standards for care leads to low quality of care, all too often with poor outcomes.

Behavioral scientists talk of A-B-C for sustained behavior change:

- A is antecedents—such as standards, training, supplies, etc.;
- B is behavior—working according to standards;
- C is for consequences—the results for the staff of their behavior.

If there are no consequences of the behavior then staff will not be motivated to do the right things and desist from wrong things. The experience from the DR tells us that if standards are to be implemented then they should be well communicated, compliance should be monitored and followed by positive or negative reinforcement.

3. Mismatched needs and resources

The second key management issue seen in the DR is that there is a mismatch between need for service and resources or capacities. Services are produced by the interaction of patients and staff, so matching the demand for services with capacity to deliver service is critical. When demand exceeds the capacity, there are queues and clients have to wait. But in case of EmOC services—patients will either be referred or provided with poor quality—or even unsafe—service (such as two mothers delivering on one bed). In the DR, we see first that some hospitals are both overcrowded and have a shortage of staff. Second, all women get the same degree of care irrespective of their level of need—women with normal deliveries and women with obstetric complications get the same treatment.

This over-medicalizes the normal delivery (also wasting scarce resources) on one hand, and reduces availability of expertise for complicated deliveries on the other hand. This, too, is common in many hospitals in other developing countries [4]. It occurs when there is no system of assessment and triage as well as no system of evidence-based auditing of care.

It is not unusual that senior doctors are sometimes reluctant to do the more demanding emergency procedures and surgeries at inconvenient hours. The Miller paper describes instances where patients needing the expertise of senior clinicians were treated by very junior or unskilled nurses or medical students. In rural areas, the capacity mismatch occurs because no specialists are posted there and general doctors and midwives are not trained to take care of complications. In urban areas it may occur because there are no guidelines for calling senior staff for serious cases. Posting senior doctors and specialists to peripheral small hospitals where their services are needed is a very difficult problem in many countries—developed as well as developing. It requires a strong political will and organized system of posting and transfer that is equitable enough for the staff to accept.

Maldistribution of staff between various facilities often occurs so that some busy facilities have proportionately less staff while other less busy facilities have more staff. While we have no data on this in the paper from the DR specifically, it is a common problem. We are told that some hospitals are very busy—one of them doing 1766 deliveries per month or approximately 58 deliveries per day. To provide high quality care at such high volumes is really a challenge. Overcrowding, congestion, overloading of staff all lead to a compromise of quality of care and poor results. Most public hospitals are not permitted to hire additional staff on temporary basis to meet peak demand. They cannot even redistribute staff between hospitals in proportion to the workload. Staffing levels are generally based on the number of beds rather than the number of patients they treat. Thus, mismatch between demand for services and supply of providers leads to poor quality services.

If quality is to improve, managers in the health system must have the flexibility in staffing to meet

client demand and workload. Second, the triaging function and allocation of skilled human resources according to need must be taken seriously. In simple terms, delegation of work is good but not at the expense of the quality of patient care. It should not be a means of shuffling work by senior staff as seems to be the case in the DR. Managers must ensure that senior staff are providing care to the complicated and difficult cases and also that they are monitoring the care provided by junior staff.

4. De-humanizing care

Client-friendly care is an important dimension of quality. Miller et al. show that patients do not feel that the care provided by the hospital is pleasing. Patients also feel that the staff is indifferent and uncaring. The observations by the team doing the study vividly described the de-humanizing care including lack of privacy, dignity and communication with the patients. Each interaction of client and service provider is a chance for the hospital to show that it cares for clients. In service quality literature, such interactions are called ‘moments of truth’ and are believed to be the opportunities to form good impressions in the minds of the clients about the service provider [5]. Unfortunately, hospitals in the DR are providing poor human interaction, leaving a very negative impression of the hospital in the minds of the mothers. This is a major management issue in many public hospitals and is the main reason why more and more people prefer private health services to public services in many countries.

A possible reason for de-humanized care is because the leadership of the health system at the hospital level or at the government level does not emphasize this perspective. Perhaps a client focus is also lacking in the training of doctors and nurses in the DR as in many countries. Senior doctors and teachers do not place a high priority on the human aspects of care and hence the whole organization becomes indifferent towards the clients. Over-burdening of the services because of heavy workload only adds to this problem.

5. Lack of management systems and supplies

The poor quality of care in DR is also partly due to inadequate systems including a shortage of sup-

plies and drugs in hospitals. Patients have to bring in their own supplies. Patients are often referred out from the peripheral hospitals to higher levels simply because of the lack of drugs and staff and not because of the severity of their condition. This inappropriate referral ‘system’ leads to overcrowding in urban hospitals. Even simple systems of cleaning, hygiene and waste disposal are weak in many hospitals.

Inadequate management skills of the hospital managers and lack of efforts from the central level to improve hospital management are the probable cause of this situation. Of course, inadequate budgets for drugs and supplies also contribute. Even simple supplies like antiseptics are not available in the required quantity. In a country with per capita income of more than US\$ 2000, it is unlikely that lack of resources is the only cause this unfortunate situation. Lack of good management in hospitals and the health sector in general is more likely to be the main reason.

Inadequate resources is the cause most often cited by the staff for poor quality work. While the paper from the DR does not describe the management structure of the hospitals or their financing, it is likely that a substantial part of the problem is due to a lack of systems of management, accountability of staff and inadequate financial management.

6. A way out

The paper shows that with good leadership better things are possible. In one hospital the situation is very different. There is an opportunity to learn from that hospital and its management systems to improve other hospitals. It is heartening to note that, after the assessment report, efforts are being made to improve the situation. More accountability is being introduced among the staff, more resources will be available through new projects, and adherence to norms is being stressed.

Regular review of maternal deaths to find out what changes in systems are needed, will help in improving care. Besides deaths, severely complicated cases who survived (so-called ‘near misses’) should also be audited against a set of criteria based on national norms and standards. This helps

to identify the areas of the care delivery process that need to be improved. Sanctioning those who provide poor care is needed, but those who provide high quality care should be recognized and rewarded. Health care providers have genuine problems which need to be addressed so that they all have the means to provide high quality care.

This paper shows that management failures are responsible for continued high MM ratio in the DR in spite of the fact that 97% of the deliveries take place in institutions. Poor quality care does not lower the MMR. If women with complications are not getting the required expert care then simply delivering in a hospital will not help to save their lives.

Unfortunately, the DR is not alone among developing countries in the area of poor management of hospitals. Many countries have similar problems, but because of their high home delivery rate, they feel that their high MMR is because of non-availability of institutional care. It is assumed that institutional care implies high quality care. Miller and her colleagues have shown that it is not necessarily true and that, in spite of moderately high national incomes, hospitals can be poorly managed. Unless specific measures are taken to improve it, the quality of care will remain poor as seen by example of the DR. The key management lesson from this

report from the DR is that just increasing institutional deliveries alone may be no help unless high quality care of women with complications is assured. This is a major management challenge. Agencies like the World Bank, bilateral donors and technical agencies like WHO and PAHO need to pay much more attention than they presently do to improving management of hospitals and quality of care if MMR is to decline—just providing material goods will not be enough.

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