

Is worker effort higher in church-based than in government health facilities?



This brief is based on data collected in 2007 in all nine rural districts in Dodoma and Morogoro regions, Tanzania.

126 randomly selected health facilities were enrolled, including 11 hospitals, 25 health centers and 90 dispensaries. 80 of the facilities were owned by the government, 46 by voluntary agencies. 159 health workers were randomly selected for inclusion.

More than 3500 outpatient consultations were directly observed. Interviews were conducted with all health workers, all patients/caretakers, and with the in-charge of all facilities.

The research team is grateful to district officials and health workers in all the nine study districts, who participated in the study, discussed the results with the research team, and assisted in the interpretations.

A study of diagnostic effort documents low worker effort in both church-based and government health facilities. Despite a strong perception among patients about good medical quality in church-based health clinics, health workers in these clinics do not ask more history taking questions or undertake more examinations. Effort levels are so low in both sectors that there is a real danger of inaccurate diagnoses and mismanagement. However, health workers in church-based facilities are more polite and communicate more with the patients about the diagnoses.

Health worker effort is an important determinant of the quality of health care services. While equipment and medication are surely important, an accurate diagnosis is crucial for correct treatment. The accuracy of the diagnosis will to a large extent depend on the level of diagnostic effort made by the health worker during the consultation.

Church-based providers offer an alternative to government health care delivery in many African countries, and are in some areas the only providers of health care. According to popular belief, church-based facilities also offer higher quality care than government providers. Despite the importance of church-based provision of

health care, we know very little about worker effort levels in this sector. This brief reports the main results from a study aiming to compare worker effort levels in church-based and government health clinics in Tanzania.

Ownership can affect worker behaviour

Government and church-based health facilities share the objective to offer high quality services to the population. Their organizational structures differ, however, allowing church-based organisations more flexibility in staff management. As a consequence, church-based organisations may find it easier to implement effective incentive schemes. Moreover, church-based facilities are



Patients waiting in line for consultation.

to a large extent dependent on patient inflows to survive, and this may result in greater sensitivity to patients' wishes. Finally, the religious aspect may attract different types of health workers to church-based facilities. All these factors might induce differences in worker behaviour.

Perception of good medical quality in church-based clinics

Interviews with patients confirmed that there is a perception of good medical quality in church-based clinics. While closeness and habit were major reasons why patients attended public clinics, the most important reason why patients attended church-based clinics was the good medical quality (Figure 1).

Three types of health worker effort

Three different aspects of worker effort were studied: politeness, communication with patients, and diagnostic effort (see Box 1).

Health workers in church-based facilities communicate more

Health workers in church-based facilities more frequently inform the patient about their diagnosis (47 vs. 25 per cent) (Figure 2). They also more often explain the diagnosis to the patients (35 vs. 17 per cent). We found no significant difference in the extent to which health workers explain the treatment to patients. On average, only 33 per cent of the patients had their treatment explained to them.

More polite treatment in church-based facilities

Health workers in both government and church-based clinics treat most of their patients with politeness, but again, church-based facilities perform somewhat better than government clinics. Health workers in church-based clinics welcomed 90 per cent

Box 1: Worker effort

Diagnostic effort

The extent to which health workers ask history taking questions and undertake physical examinations according to guidelines. Guidelines are based on the clinical officer curriculum in Tanzania and the WHO-guidelines for Integrated Management of Childhood Illnesses (IMCI).

Communication effort

The extent to which a health worker communicates and explains diagnosis and treatment.

Politeness

Polite treatment of patients by greeting and welcoming the patient.

Effort was measured through direct observation of outpatient consultations with patients presenting with fever, cough and/or diarrhoea.

of their patients, while health workers in government clinics welcomed 72 per cent of the patients. Similarly, health workers

Figure 1: Reason why patients attended health facility.

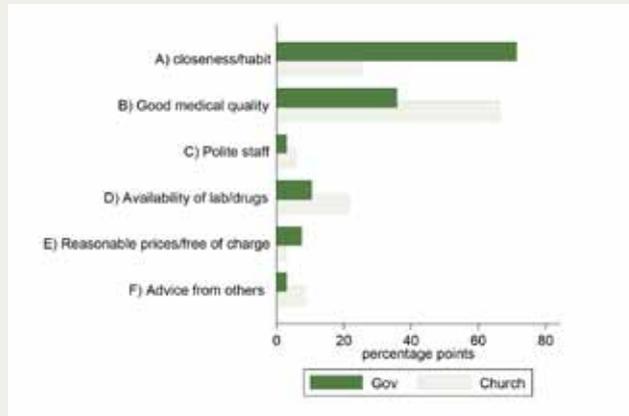


Figure 1: Health worker communication with patients.

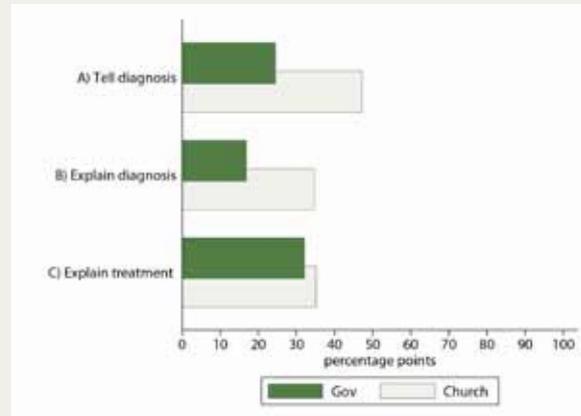


Figure 3: Politeness with patients

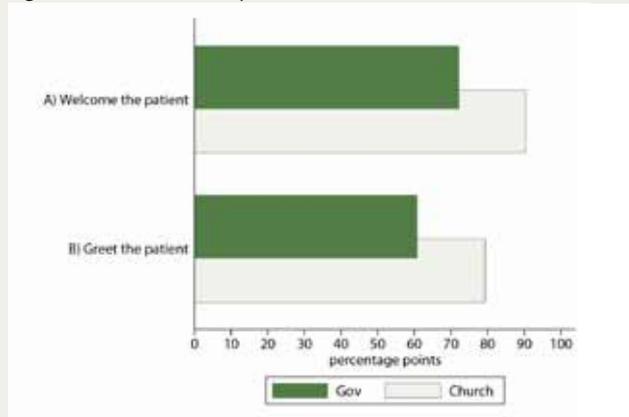
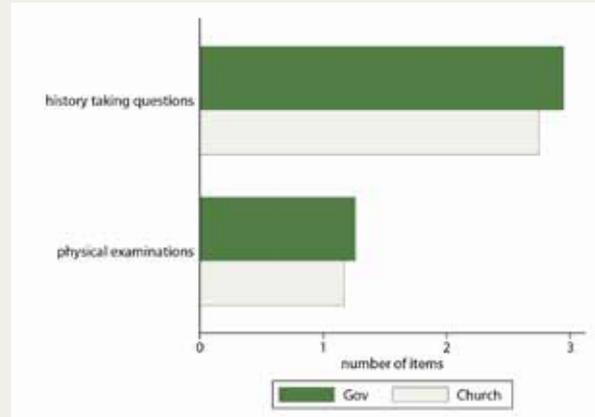


Figure 4: Diagnostic effort: Average number of questions / examinations



in church-based clinics greeted 79 per cent of their patients, compared to 61 per cent of patients in government clinics (Figure 3).

No difference in diagnostic effort

We found that health workers conduct on average almost three relevant history-taking questions, and a little more than one relevant physical examination. This amounts to 22 % of the relevant items we studied. Surprisingly, we found no difference in diagnostic effort levels between health workers in church-based and government institutions. This is surprising in light of the patients' views of high medical quality in church-based facilities (Figure 4).

Low effort could threaten patients' lives

Health workers at both church-based and government health facilities exert low diagnostic effort. There is a real danger that patients suffering from potentially life threatening disease are mismanaged in both types of facilities.

Nonetheless, patients seem to prefer church-based facilities when they seek high quality care. The explanation might be that church-

based facilities perform better on other aspects of performance that are easier for patients to observe and appreciate; health workers in church-based are more polite and communicate more with their patients.

We also find that church-based facilities have less drugs stock-out and are more likely to have a laboratory. Out of the seven tracer drugs that we studied, church-based facilities had on average six in stock, while government facilities had only four. And while 90 per cent of the church-based facilities had a laboratory, only 27 per cent of government health facilities had. These factors may all explain the perception of better quality care in church-based facilities.

Need to improve worker effort in both sectors

Despite a widespread belief that church-based facilities offer higher quality care, diagnostic effort is equally low in church-based as in government health care facilities. Policy-makers therefore need to include both church-based and government health service providers in interventions aiming to improve health worker effort.

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Health workers in facilities run by the church are better at communicating with the patients about the diagnoses, and at treating patients politely. These aspects are important for building trust between patients and providers and can influence patients' willingness to follow the doctors' prescriptions. There is a strong need to increase the level of communication about diagnoses, especially in the government sector.

The MAP project (Health Worker Motivation, Availability, and Performance) is a collaboration between NIMR (National Institute of Medical Research), CMI (Chr Michelsen Institute), University of Bergen, REPOA (Research on Poverty Alleviation), and Bergen University College.



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Subscribe to CMIBrief at www.cmi.no
Printed version: ISSN 0809-6732
Electronic version: ISSN 0809-6740