QIDS

Quality Improvement Demonstration Study

A DOH-PhilHealth-UCSF-UPecon Partnership

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Has quality of care improved?
Comparing Results from the Baseline and First Quarterly Surveys (Part II)

Apart from a doctor's skills, good quality of care also means keeping patients satisfied. Satisfaction includes giving the patient confidence, that the proper diagnosis and treatment have been offered, and that they were given sufficient time and attention to hear their concerns. In assessing the quality of hospital care in its study sites, QIDS uses a multidimensional metric that encompasses three aspects to determine the overall quality of care. Earlier we described the first aspect of care: doctors' skills at evaluating and caring for the patient's illness. We used a novel instrument known as *clinical vignettes* and gave this to doctors in all of the QIDS study sites (see QIDS Research Bulletin Part I).

To measure satisfaction we administered the Patient Satisfaction Questionnaire or PSQ-18 in all of the sites as well. The PSQ-18 is an internationally recognized metric developed by Ware, Snyder, and Wright in 1976. The PSQ-18 has been validated, shown to be reliable and widely adopted for research purposes. The PSQ-18 is designed to draw a patient's perceptions regarding technical quality, interpersonal manner, communication, financial aspects of care, time spent with doctor, and accessibility of care. Patient responses to the 18 questions are used to compute an index for patient satisfaction, ranging from 0-100.

> An example of a PSQ-18 question is: *"How strongly do you agree or disagree with this statement: Doctors are good about explaining the reason for medical tests".*

The third aspect we measured is case load or actual number of patients seen by doctors for outpatient care and number of admissions. This captures the ability of doctors to balance the amount of time seeing one patient with their efficiency to see an adequate number of patients. When doctors see too many patients, quality of care provided to each individual could suffer. On the other hand, doctors seeing too few patients means that they are not providing enough services for the time and cost required to have them staff the facility. Seeing too few patients may also indicate that patients do not want to see doctors who do not provide good quality services or that they want to seek a better care alternative in the area. We measure case load information in hospitals using periodic facility surveys conducted by the QIDS research team. The inclusion of case load in the QIDS overall quality measure serves another important purpose. It is used to monitor possible inappropriate responses to financial incentives by hospitals to the policy interventions. A potential adverse response to intervention A, the arm of the study where insurance coverage is increased, would be the prioritization of treatment to children over older patients. Informing hospitals that their total case load, regardless of patient age, is part of the quality metric might mitigate this potential adverse response.

Table 1 shows the provincial averages of the PSQ-18 index and case load scores for both the baseline and the 2005 second quarter survey rounds. The table shows that case load scores have a wider range compared to patient satisfaction scores. The data also show that quality can change quickly over time compared to case load. This is to be expected – after all, it is much easier to change the way one deals with patients rather than change the number of patients who come to the hospital.

Table 2 looks at the combined measure incorporating vignettes, patient satisfaction, and case load. Here, we see that the bonus group of hospitals has the least number of hospitals whose quality deteriorated over time. While it is too early to make predictions on the impact of the bonus intervention on quality, these data are in support of the hypothesis that providing incentives for good performance could actually improve performance. We will continue to monitor these trends to see if the pattern holds up and to check if one intervention selectively changes any of the three measures of quality that we are observing.

Table 1. Patient Satisfaction and Case Load Scores, by survey round

Province	Patient Satisfaction		Case Load	
	Baseline	Second Quarter, 2005	Baseline	Second Quarter, 2005
Bohol	71	75	100	100
Capiz	77	75	100	100
Cebu	70	72	92	92
Eastern Samar	78	63	92	92
Iloilo	76	70	100	100
Island Provinces	75	75	100	100
Leyte	72	70	88	88
Negros Occidental	74	74	100	100
Negros Oriental	74	74	58	58

Table 2. Number of Hospitals,
by intervention and change in overall quality index

Intervention	Same	Improved	Did Not Improve
Access (n=10)	5	2	3
Bonus (n=10)	7	2	1
Current (n=10)	6	1	3

The Quality Improvement Demonstration Study (QIDS), which is jointly being undertaken by the Department of Health (DOH), Philippine Health Insurance Corporation (PhilHealth), University of California San Francisco (UCSF), and the UPecon Foundation, attempts to evaluate policy interventions implemented under the DOH Health Sector Reform Agenda. QIDS is funded by the US National Institutes for Health and PhilHealth.

Specifically, QIDS evaluates the impacts of three policy interventions of interest to PhilHealth: expanding access to PhilHealth benefits for the most vulnerable populations (Intervention A); targeting bonuses for high quality care that leads to better health outcomes (Intervention B); and the current benefit program. In the QIDS project, these three interventions were randomly assigned to 30 district hospitals in the Visayas and Camiguin. To determine which intervention results in the greatest health benefits, QIDS is carrying out evaluations at baseline, every quarter and at the end-of-project. There are surveys of hospitals, physicians, exiting patients, patient follow home and random households.

The members of the editorial team are: John W. Peabody (UCSF), Orville Solon (UPecon), Elizabeth Butrick (UCSF), Stella Quimbo (UPecon), Jhiedon Florentino (UPecon), Marife Bacate (UPecon), and Mitch Abdon (UPecon).

Comments may be sent to Rm. 342 Economics Bldg., University of the Philippines, Diliman, Quezon City or qids_01@yahoo.com.