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PRIVATE MATERNITY CARE PRACTITIONERS IN PUNTO FIJO, VENEZUELA

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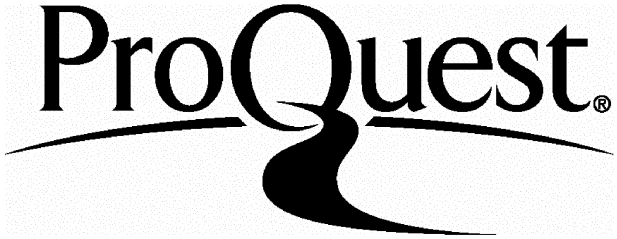

ABSTRACT

From the private practitioners' and users' perspectives, What are the key aspects involved in private maternity care in Punto Fijo, Venezuela?

The aim of this study is to identify issues surrounding private obstetric care in Punto Fijo, Venezuela as perceived by obstetricians working in private maternity care and users of these services. It is a descriptive qualitative study. Twenty open-ended, in depth semi-structured interviews with obstetricians and ten interviews of women who had recently received these services were conducted. Other methods used included informal non-participant observations and revision of grey literature.

Results suggest that doctors work mainly in both private and public sector but prefer to work in private due to better opportunities to fulfil their plans for career development and practise adequate obstetrics. They perceive obstetrics as a speciality where technology is paramount to provide good quality services. There are though differences in the way obstetrics is practised in the private sector and public sectors. These differences respond to the characteristics of the users, the relationship between them and doctors as well as the conditions and availability of resources in the private institutions. Further research is needed to explore in depth some of the issues appearing in this research specially those concerning the excessive use of some obstetrical procedures and the apparent lack of regulatory mechanisms to control the activities of private obstetric care sector.

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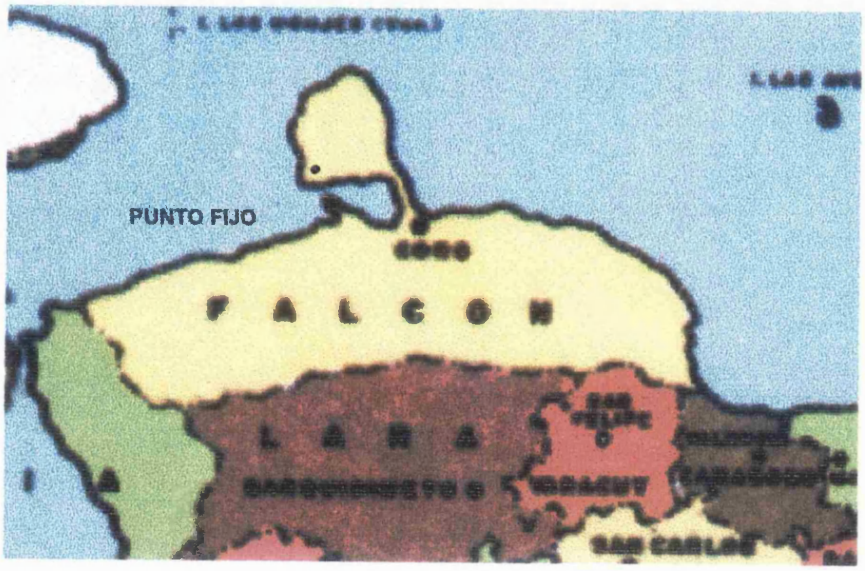
LIST OF ABREVIATIONS

I.V.S.S.	VENEZUELAN INSTITUTE OF SOCIAL SECURITY
M.S.A.S.	MINISTRY OF HEALTH AND SOCIAL WELFARE
G.D.F.	GOVERNMENT OF THE FEDERAL DISTRICT
PAHO	PANAMERICAN HEALTH ORGANISATION
D.M.I.	MOTHER AND CHILD HEALTH DIRECTORATE/MOH
O.C.E.I.	CENTRAL OFFICE FOR STATISTICS AND INFORMATION

LIST OF FIGURES AND MAPS

MAP OF REPUBLIC OF VENEZUELA

MAP OF FALCON STATE



CHAPTER ONE

INTRODUCTION

1.1 SUMMARY OF THE REPORT

This report presents the relevant information obtained from a qualitative study aimed at elucidate the major aspects of private maternity care in Punto Fijo, Venezuela from the perspectives and views of a group of doctors and patients selected to participate. It presents the results, discussions and derived conclusions for those interested in the topic either as a source of information on the issues covered or as starting point for further research.

The introduction outlines the context in which the study was carried out, and states the aims and objectives together with background information to justify its conduction. In the second chapter the reader is presented with information and past and present literature on topics that support the information presented as result of this research. It also presents information and discussion about the research methods selected and used.

Chapter three gives complete and detailed information on the methods used in the context of the study and discusses their limitations. Chapter four leads the reader

through the findings followed by the interpretation and discussion of their implications in Chapter five. Finally the final conclusions and recommendations derived from the study are presented in Chapter six.

1.2. BACKGROUND TO THE STUDY

Maternal Mortality. A reason for concern

In Venezuela there has been an increase in the number of maternal deaths reported during the last five to six years, despite the high rate of institutional births registered which is more than 90%. Although low for the standards in many developing countries, this rise in the number of maternal deaths has awakened the public health community as the matriarchal structure of the Venezuelan Society implies that the death of a woman has major social and economic implications. These circumstances generated a lot of pressure to elucidate the causes of the problem and more important to find appropriate and effective solutions. In 1995 The Maternal and Child Health Directorate of the Venezuelan Ministry of Health launched a proposal in association and with technical support from UNDP and PAHO oriented at the implementation of special measures to reduce the magnitude of the problem in the country (DMI-OPS-PNUAD, 1995).

Particularly in the Falcón State, the Maternal Mortality Rate in 1995 was 44.9 per 100,000 live registered births. Although the total number of deaths was low

creating difficulties to interpret these figures, it is important to mention that there was an increase of 22.40% in Maternal Mortality between 1992 and 1994, which is well above the national average increase during the same period of time (6.13%) (Godoy O., Montiel L., Sanchez C. et al., 1996).

The Venezuelan Health System is currently undergoing the worst crisis of its history. The collapse of the major public health care providers, like the Ministry of Health and The Venezuelan Institute of Social Security, has created a situation where an increasing number of people have turned to the private health sector in search of solutions to their health problems.

Reform of the Health System

Currently there are proposals for a complete reform in the way the health sector is financed and administered. The proposals also include changes in the way that the different providers of health care will work. Although there is very little or almost non-existent information on how this "new system" will work, one of the features that has been mentioned is the increase in the participation of the private health sector in the provision of health services in most areas of health care.

Considering the information previously mentioned it is paramount to understand the characteristics of the private health sector, how it works and the benefits and pitfalls that have been reported from experiences in other countries.

This study aims at describing a topic within the vast issue of private health care by gaining insight on the views of doctors working in the private sector and users of this type of services in an attempt to contribute with the already existing knowledge in the topic.

1.3. REASONS FOR UNDERTAKING THE STUDY

Personal reasons

After graduating as a paediatrician in Venezuela I had the opportunity to work in the private sector in two interesting areas. As a private practitioner I worked in activities related with Primary Health Care, providing a healthy baby clinic, applying immunisations, development follow up, and when necessary special paediatric care. Starting to work in the private sector was difficult due to the need to acquire appropriate resources to provide adequate care.

The parallel activity that I developed was an antenatal course for mothers to be in which I instructed women on issues concerning pregnancy, birth and baby/child care. During this experience I got interested in the activities of private obstetricians based mainly on the observation of issues that emerged from this activity. First was the level of 'ignorance' that most women attending the course had about pregnancy and childbirth, the misconceptions about antenatal care and, the little

conscience about the power that they as women could have on their bodies. Most of these women were educated and belonged to well-of social classes.

I started to informally collect data on the mode of delivery they had had, and noticed that most patients ended up having caesareans. I then took notes of the medical reasons for these procedures according to what the women were told by their doctors. Some of the answers were, I quote "After four hours of pain the doctor decided to practise a caesarean because I had only reached a dilatation of four centimetres". Others would say: " although I was thirty seven weeks pregnant the doctor decided to induce labour because the baby was already mature according to the ultrasound indicators, but as the induction did not evolve properly I had to have a caesarean". All this caught my attention but unfortunately at the time I did not have the time to organise a proper research protocol.

Once at the Institute of Child Health I found that the work of private obstetricians was a topic of interest for other professionals, and that it constitutes an important subject for research within areas like epidemiology, health services management/financing and health policy.

Because of the fact that in Venezuela there is an undergoing Reform of the Health Sector where the role of the private sector is still unclear, I saw this as a good opportunity to study the subject in more depth.

CHAPTER TWO

LITERATURE REVIEW

This literature review aims to explore and record previous research addressing the issues related with private maternity care within the context of obstetricians' and users' perceptions. Medline and Popline databases were used to initiate the search as well as BIDS and previous known articles.

The libraries of the Institute of Child Health and the London School of Hygiene and Tropical Medicine were visited. Information was also obtained locally in Venezuela from the Ministry of Health (Mother and Child Health Directorate), and at the Central Office for Statistics and Information.

2.1. PRIVATE HEALTH CARE

2.1.1 General Issues

The concept of Private Health Care involves a vast number of terms and definitions that extend to a wide range of disciplines associated with health economics, financing and organisation of health services which go far beyond the scope of this report. This particular study concerns health care providers within a specific

branch of the medical profession (gynaecology and obstetrics), mentioned here as one speciality as it is so that it is delivered in Venezuela.

The concept of private health sector care refers to those parts of the health care system which are not under the direct control of the government. There are two implicit characteristics of the private health care that help to understand some of the issues surrounding it. First is the obvious dimension of ownership, and secondly control, the latter one is very important due to the deeper and complex implications it has. It implies that the private sector functions according to different objectives and norms than the public sector. This concept also reflects the fact that private health care providers may seek profits, choose which services to provide, and determine their own levels of quality of care, as well as inputs and costs (Bennet S., 1997). There are some positive issues though, as some would argue that private providers can significantly augment the total quality of health care available, and because of the before mentioned 'freedom' can also be a source of innovation in both the for-profit and non-for-profit private health care sectors. They may result in more efficient, higher quality services and greater patients' satisfaction (Berman P., 1997).

In many industrialised countries the growth of the private health sector has been positive suggesting that it is possible to organise a health care system in such a way that both public and privately owned providers can contribute to efficient and equitable health care. It is important to have in mind that the concept of ownership may not be determinant when modified by appropriately structuring the health care market, in terms of financing, service delivery and demand. However, in situations

where there is entire or almost entire private provision and financing of health care it can lead to very high costs. An example of this is the health system in the United States, considered one of the most expensive health systems in the world (The Economist, 1998).

The importance of what has been mentioned relies on the fact that the private health sector has grown in many parts of the world. There are problems associated with this growth that have to be studied carefully, specially those related with the growth of health care providers and its implications.

Many authors have described the problems associated with the growth of the private sector in developing countries as consequence of the different environments in which they operate (Nittayaramphong S. and Tangcharoensathien V., 1994), (Newbrander W., 1997), (Fielder J. 1996). For both public and private sector providers there are external and internal factors that determine their performance. The external factors to the providers include the public demand for services, societal expectations of providers, and the regulatory framework within which minimal standards for the provision of health care are laid down. The internal factors include the organisations' or individual providers' objectives and its management structure and culture (Bennet S., 1994). How these factors are defined in each country where the private health sector has grown determine the type and extent of the problems.

2.1.2. Problems associated with private for-profit health care providers

One of the principal characteristics of private for-profit providers is that they are primarily motivated by making money. According to Roemer cited in Bennet (1997), their orientation means that private providers are unlikely ever to perform for the good of people, and can never contribute to the public health goal of the state.

Bennet et al. (1994) describe five main problems associated with private for-profit health care providers. The concern for profit is often regarded as beneficial to the customer due to the assumption that the supplier will be made sensitive to the preferences of the consumer, and so provide a better service. The reality is that in health care this situation is complicated as the heath professional temporarily holds the knowledge, power and responsibility for the patient's health. The private provider may use this power to maximise profits, for example by supplying more health care than it is required (Bradford G., 1991).

Contrary to public health that is concerned with preventing disease and promoting health, improve medical care, promote health related behaviours and controlling the environment, the concern for profit may lead private practitioners to fail to promote preventive practices, which reduce morbidity with the resultant increase in consultations. On the other hand the private sector tends to be separated from the public sector and while the latter tends to standardise with respect to activities, staffing and procedures, this is not usually the case of the private sector providers. They are unlikely to be integrated with the Ministry of Health's information system or to the structure of the referral system and often are unevenly distributed, located where there is willingness and ability to pay. In addition because they do not pass

information in their activities to the public sector, planning and forming public health strategies can be particularly difficult.

The large difference of income between public and private workers may lead to 'brain drain' by which trained personnel may leave the public sector to work full time in the private sector creating shortages in government facilities. They can also work partially in both, public and private usually neglecting their public sector duties. Finally, because private for-profit providers often work in isolated conditions without peer review on their work (formal or informal) there can be decay in medical skills with consequent repercussion on professional ethics (Bennet S., 1994). Other problems mentioned are increased inequity in access and use of health care (Berman P., 1997).

2.1.3. Obstetrics and the private health sector

A lot of information was found in relation with private health care in general but very little on the associations between this type of health care and obstetrics, specifically in the areas of concern of this research. Nevertheless as a way to illustrate some of the issues surrounding the research question, a review of evidence encountered in relation to specific obstetric practices within the context of private care are mentioned.

How obstetric practices may be affected by whether obstetricians work in the public or private sector? The literature showed little evidence except for specific obstetric

procedures, like caesarean section rates, that escape the objectives of this study. However, the evidence found is so striking that is worth mentioning as a way to illustrate the range and nature of the problems surrounding private obstetric care.

In 1985, WHO published a set of recommendations to be relevant to perinatal services world-wide. These recommendations highlight the importance of proper antenatal care and the rights that a woman should have in making her own decisions about this care. The roles of social, emotional and psychological factors are also listed as fundamental to understanding proper perinatal care. "Birth is a natural process, but even 'no risk pregnancies' can give rise to complications". As key factors for success, the recommendations mention the change and transformation of health services and staff attitudes and the redistribution of human and physical resources (WHO, 1985).

Obstetricians, like no other specialists, have the responsibility to care for two patients that have to be considered simultaneously. Sometimes what maybe an advantage for one may be to the disadvantage of the other. The advances observed in obstetrics in recent years have benefited both but there are arguments about whether the risks that some of those techniques involve in relation to the real benefits in reducing perinatal mortality (Dunn P., 1976). In relation with labour, specifically the active management of labour implies features like hospital environment, elective premature delivery, amniotomy, augmentation of uterine action, analgesia and sedation, foetal monitoring, supine and lithotomy position, caesarean delivery, episiotomy, clamping of the pulsating cord, and the use of ergometrine with cord traction. These practices are so frequently and widely used

that have become part of the 'ritual' of modern delivery, and are accepted by doctors and patients (Dunn P., 1976).

Some obstetric procedures, carried out as part of hospital routines are necessary for efficient functioning. They represent a challenge to the professional working in maternity units firstly because they have to make decisions to introduce and maintain only those that have been shown to do more good than harm. Secondly, they must decide how to apply those routines flexibly taking into consideration the needs of each individual childbearing woman. Literature showing evidence of association between private practice and these obstetric procedures is scarce. Evidence of a higher rate of labour induction has been found in the private medical sector than in public academic hospitals, without other medical explanation being reported (Price M. and Broomberg J., 1990).

As mentioned before an exception is the amount of data in which the high rate of caesarean sections observed in many parts of the world is related to the type of health service in which a woman is attended.

2.1.3.1 Considerations on Caesarean section

Caesarean section, consists on an operation of delivering the baby through incisions made in the abdominal and uterus. It has an enormous potential for the preservation of life and health, probably greater than any other surgical operation.

There are unequivocal indications for caesareans, such as placenta previa or transverse lie, but there are other 'ambiguous' indications (foetal distress, prolonged labour) which are by no means clear. The variation observed in the criteria to use this major operation suggests that the obstetrical community is uncertain as to when a caesarean section is indicated. It also suggest that other factors, such as socio-economic status of the woman, the influence of malpractice litigation, women's expectation, financial considerations and convenience may sometimes be more important than obstetrical factors in determining the decision to operate (Enkin M., Kersey M. and Chalmers I., 1989). WHO recommendations suggest that there is no justification for any region to have a caesarean section rate higher than 10 – 15% (WHO, 1985).

In the last thirty years, caesarean section rates have been rising in many parts of the world especially in many Western countries. In the United States the rate of caesarean sections rose from 4.5% of deliveries in 1965 to 17.9% in 1981. This rise in the number of caesareans was similar for all age groups, except teenagers, and for all regions of the country (Placek P., Taffel S. and Moren M., 1983). By 1985 an estimated number of 851,000 live births were caesarean deliveries accounting for a rise to 22.7%. In this study the rise for teenagers and mothers aged 20 to 29 was five to six times as high in 1985 as in 1965, and four times for mother aged 30 and older (Taffel S., Placek, P. and Liss T., 1987).

In developing countries, caesarean rates have also increased. Although the situation is largely unknown because of lack of reliable data, some recent studies from Latin America suggest that there has been an increase. This has to be

considered carefully as results from research suggest that in the context of developing countries, caesarean delivery could be accompanied by a greater mortality risk, a higher number of complications and poorer acceptance than previously estimated (De Muylder X., 1993).

Several factors have been mentioned as contributors to the increase of caesarean section rates around the world. These range from obstetricians' personal choice (Al-Mufti R., McCarthy A. and Fisk N., 1996); obstetrician individual practice style (Goyert G., Bottoms S., Treadwell M. and Nehra P., 1989); unequivocal obstetrical indications such as placenta previa or transverse lie, or less academic criteria like diagnosis of dystocia and foetal distress (Enkin M., Keirse M. and Chalmers I., 1989).

In the United Sates a study comparing Caesarean rates in low risk, nulliparous women attending private physicians and clinics describes rates of 13.2% and 10.7% respectively showing that private patients giving birth to their first child were significantly (OR 1.32; $p<0.001$) more likely than clinic patients to undergo caesarean section delivery if dystocia, malpresentation or foetal distress was diagnosed (Haynes de Regt R., Minkoff H., Feldman J., et al., 1986).

A study conducted in Brazil by Barros, Vaughan and Victora (1986) showed a high rate of caesareans among low risk mothers (33%) compared to those at high risk (27%). These women (low risk group) had more antenatal controls irrespective of gestational age and also had a better family income; factors suggesting that issues others than medical are responsible for the high rate of caesareans observed.

Another study in Brazil which examined nine hospitals showed that in all hospitals the rate of caesareans was high, but 75% were carried out in private patients compared to 40% to insured and less than 25% to indigent patients (Janowitz B., Nakamura M., Lins E. et al., 1982). In Chile the caesarean birth rate was 37.2% in 1994. Murray (1997) described the higher rate of caesarean registered in patients attended by the private insurance sector 59% compared to 28.8% for those attended by the National Health Fund. In South Africa a study showed that women who delivered under the care of fee-per service practitioners had higher rates of caesareans and labour inductions than those delivering in central academic hospitals which are public and free of charge (Price M. and Broomberg J., 1990). In Punto Fijo the figures found in three of the clinics selected for this study range from 66% to 78%.

Among other issues that need consideration is the evidence from studies that have shown that the type and number of interventions to which a woman is submitted during pregnancy and labour is associated with social-class. Hurst and Summey (1984), looked at how obstetrical interventions in childbirth vary according to the socio-economic status of the birthing woman. Their results are striking as they showed that caesarean sections are more frequently practices to women in higher socio-economic classes, which are usually patients considered in low risk. They concluded that caesarean rates are closely associated with social class characteristics probably following an 'inverse care law': the lower the social class the higher the medical risk and the lower the intervention rate (Hart J., 1971). In 1977, Chard and Richard also suggested that a form of 'inverse care law' applies in obstetric care as a result of research in which they proved that the amount of

medical care that women receive in labour and delivery varies inversely with the actual need for that care.

The lack of information about the obstetricians' view and perceptions about their work within the private sector enhances the importance of this study and calls for further research into other issues also related with this topic.

2.1.4. Relationship between users and providers in the private health sector

In general, knowledge about private providers has only begun to emerge over the last few years (Mc Pake B., 1997). For specific aspects like the relationship between users and providers in the private sector the information available is also scarce, specially areas concerning views and perceptions of professionals about their performance in the private sector. Little was found.

However it is important to keep in mind that the behaviour of both providers and users depend on the structure of the existing health system and the predominant pattern of 'public-private mix' (Mc Pake B., 1997).

Research done in England showed that women use private care services more than men and the reasons for this were mainly better care/attention, privacy and flexibility for choice (Wiles R., 1993). Another study, also in Britain found the use of private health care to have connotations within racial and social issues in specific population groups (Thorogood N., 1992).

Nevertheless the perceived advantages of private care may not be completely evident in the relationship between doctors and patients, as it continues to be inevitably unequal in terms of power and status and unlikely to become a 'mutual relationship' (Wiles R. and Higgins J., 1996).

2.2. HEALTH SYSTEM IN VENEZUELA

2.2.1. Structure of the Health System

The Venezuelan health services are highly complex because of the many organisations involved in delivering care. There are five main health sector institutions supported by the government:

- The Ministry of Health and Social Welfare (M.S.A.S.), responsible for the provision of preventive care in health centres and health points around the country. Curative medicine is also provided in large hospitals. The care is usually free of charge, and when available drugs are also provided for poor patients.
- The Venezuelan Social Security Institute (I.V.S.S.), covers civil servants for health care including hospitalisation.
- The Government of the Federal District (G.D.F), provides preventive and curative medicine for patients living in Caracas, capital of the country, and its surroundings.

- The Social Welfare Institute of the Ministry of Education (I.P.A.S.M.E.) provides mainly curative medicine in health centres and health posts for employees of the Ministry of Education.
- The Health Services of the Armed Forces, provides all health-related care for members of the army and their families.

There are also more than 70 other institutions in the public and private (for profit and non-profit sub-sectors). With exception of the I.P.A.S.M.E. and the I.V.S.S. patients have freedom to choose any of these health facilities in an unrestricted way.

Although not yet entirely implemented, the pattern of 'public-private mix' that has been proposed in Venezuela is that described by Mc Packe (1997) as the one which mainly exists in countries with relatively higher GNP per capita. This pattern usually incorporates a major role for an insurance sector including the social security sector. As it has been described for other countries like Mexico, within these pattern of provider's mix, there has been a substantial growth in the extent of out of pocket payments leading to a substantial share of care being offered in private for profit facilities.

2.2.2 Reform of the health sector.

Following the global tendency to reduce the size of the state that dominated the 1980s and that of the 1990s in which the prevailing concept is that of the 'capable state', Venezuela introduced a process of decentralisation that was accompanied by a growth of the private health sector. There was a widespread adoption of autonomous hospitals or hospitals trusts, the establishment of private practice in government facilities and the renting out of hospital space for non-clinical facilities (Bennet S., Mc. Packe B. and Mills A., 1997). The current proposal for a reform of the health system that includes the incorporation or extension of the participation of private providers makes it easy to predict a further increase of the private health sector.

At present, the Ministry of Health has the largest network of resources. In late 1992, it operated 3,797 outpatients units, 615 of them in urban areas. The country had 609 hospitals, 298 in the public sector (190 operated by the Ministry of Health) and 311 in the private sector. The number of physicians increased from 28,400 in 1987 to 32,616 in 1992 (from 1.55 to 1.65 per 1,000 population) (M.S.A.S., 1995). Despite these figures the geographic distribution of health resources is extremely uneven and coverage by the public sector has decreased in recent years. During the 1980s it was estimated to be 90% of the population. However, the 1991 social survey found that in the event of acute illness or injury, 34.0% of respondents had sought treatment at a private institution (PAHO, 1995).

2.2.3. Private health care in Punto Fijo

There are four large private clinics operating in the area offering a wide range of clinical and surgical specialities including gynaecology and obstetrics, hospitalisation and diagnostic facilities. These clinics are, Policlínica de Especialidades (51 beds), Policlínica Paraguaná (27 beds); Clínica Falcón (24 beds); and Clínica Cardón (~15). Several outpatient units can be found around the city either managed by individuals or groups of doctors offering consultations, minor surgery, diagnostic services and laboratory.

Thirty-four Gynaecologist/Obstetricians are registered at the Regional Medical Association (Colegio de Médicos del Estado Falcón) and currently work in Punto Fijo. Private doctors of all specialities are available for patients who can afford to pay their fees. Prices vary in different parts of the city according to the type of facility, its reputation and doctors' own decisions.

The average fee for an antenatal care consultation is around US$ 14 and US$ 26 (Bs. 8000 to Bs. 15,000). The cost of a vaginal delivery varies from Bs. 500,000 to Bs. 600,000 (US$ 875 and US$ 1050). Caesarean sections are usually more expensive than vaginal delivery, particularly if surgical sterilisation is to be carried out at the same time. For comparison, the official monthly minimum wage of an unskilled worker is the equivalent of US$ 175 (Bs. 100,000). A doctor's monthly salary in the public sector can vary from Bs. 500,000 to 1.500.000 (US$ 870 – US$2600), depending on the type of activities developed, years of experience within the public sector and level of seniority.

2.2.4. Data on Punto Fijo and Falcón State

The Falcón State is located in the Northwest part of Venezuela. The Paraguaná Península is located in the extreme North cost, in front of the Caribbean Sea. Punto Fijo belongs to the Carirubana District, and is characterised by a very hot and dry weather during most of the year, with average year temperature of 27,3 °C (O.C.E.I., 1995).

The total population of Falcón for 1995 was estimated in 699,232 inhabitants, 499,301 urban and 199,931 rural. Birth rate per 100 inhabitants was 28,64. The total number of live births was 20,025, out of which, 19,883 were attended by doctors. A total of 19,736 were attended in health institutions, 18,447 were attended in public hospitals and 1,289 in private clinics (O.C.E.I., 1995).

There are in total 16 hospitals around the state, 4 belong to the Ministry of Health. The total number of beds is 1,192 of which an estimated number of 98 are dedicated to obstetric care. There are 1,197 doctors, 465 professional nurses and 1897 auxiliary nurses (M.S.A.S., 1995). Out of the total number of births (live births + stillbirths) reported by sources of the Ministry of Health, the number of vaginal deliveries was 11,314 and caesareans accounted for 2,442. The average rate of caesareans in the public sector was 9.09% (DMI/M.S.A.S., 1995).

The total number of Maternal Deaths in 1995 was 9, with a Maternal Mortality Rate of 44.9 per 100,000 registered live births (M.S.A.S., 1995). Between 1992 and

1994 an increase of 22.40 % in Maternal Mortality was registered compared with an increase in the same period of time for the whole country of 6,13% (Godoy O., Montiel L., Sanchez C. et al., 1996).

2.3. LITERATURE REVIEW ON METHODOLOGY

The goal of qualitative methodologies is to develop concepts that help us to understand social phenomena in natural settings, giving emphasis to the meanings, experiences and views of all participants. In health care settings they can reach aspects of complex behaviour, attitudes, and interactions which quantitative methods cannot proving to be extremely useful in examining clinical decision making, by probing and exploring both the declared and the implicit or tacit routines and rules which doctors use. Because of these features they have become very useful in the study of health and health care. They can be applied to study subjects such as the organisation of health services, interactions between doctors and patients, and the changing roles of health professions (Pope C. and Mays N., 1995).

2.3.1. Qualitative Research

Evidence of research involving doctors' and patients' perceptions or any other issues related to private practice in Venezuela was not found. Most of the

research done to study private obstetric care concentrates on the use of quantitative methods in order to measure specific issues and their implications. Because of the aim of this study, the use of qualitative methods is ideal. In depth responses to open-ended questions help us to learn more about what respondents are thinking and feeling about the topics discussed and to understand consequent behaviour. This together with the nature and sensitivity of the topic justify the use of qualitative methodologies for this study as they help to reach deeper understanding of previously unexplored or poorly understood topics (Britten N. and Fisher B., 1993).

One key characteristic of qualitative research is its emphasis on discovery and less emphasis on hypothesis testing and evaluation. It is often referred as **"hypothesis generating"**, whereas quantitative research is characterised by hypothesis testing. (Murphy E. and Watson B., 1992). While quantitative methods rely on reliability (that is, consistency on re-testing) through the use of tools such as standardised questionnaires, qualitative research methods score more highly on **validity** by getting at **how** people behave and **what** people mean when they describe their experiences, attitudes and behaviours (Pope C., and Mays N., 1995).

Qualitative research is concerned with the process of research rather than the outcome. It is **Iterative**. Researchers use this to try to understand more of the individual's meanings, rather than the researcher's. Asking how individuals construct his/her world and attempting to understand her/his through in depth questioning, gives great insight into the chosen object. Research can go backward

and forward making adjustments and changes as the study progresses (Rudestan K. and Newton R., 1992).

The main problems associated with qualitative research concern those related with **validity** and **generalizability**. One approach to increase the validity of qualitative data is to triangulate data collection methods. **Triangulation** is term used to describe validation of data by gathering information from more than one source. It can be achieved either by **data triangulation**, in which different data sources are used (i.e. different age groups of informants, key informants, etc.) or by **methodological triangulation**, in which multiple data collection methods are used to study a single problem. Sample sizes employed in qualitative research are smaller than those used in quantitative work. This has implications for the generalizability of the findings. What is explored is the range of opinions, beliefs, attitudes and experiences. Therefore numbers become immaterial; generalizability exists when a framework is formulated which, with evidence, explains the diversity uncovered by the process (Hudelson P., 1994).

2.3.2. Qualitative Interviews

Interviewing is a well-established research technique. It is a conversation in which the researcher encourages the informants to relate, in their own terms, **experiences** and **attitudes** that are relevant to the researcher problem. Interviews in qualitative research are not bound by a rigid questionnaire designed to ensure that the same questions are asked to all respondents in exactly the same way

(Walker R., 1985). In a qualitative research interview the aim is to discover the interviewee's own framework of meanings and the research task is to avoid imposing the researcher's structures and assumptions as far as possible (Britten N., 1995).

2.3.2.1. Semi-structured interviews

Semi-structured interviews were the method selected to undertake this study. This type of individual interview is conducted on the basis of a loose structure consisting on **open-ended** questions that define the area to be explored, and from which the interviewer or interviewee may diverge in order to pursue an idea in more detail (Brittten N., 1995). It is based on the use of an **interview guide** that consists on a list of questions or topics to be covered during the interview. However, the exact order and wording of the questions may vary from respondent to respondent. The interviewer may still follow leads and new topics that emerge but the interviewer guide is a set of clear instructions concerning the main question under investigation. The researcher needs to remain open to the possibility that the concepts and variables that emerge may be different from those that might have been predicted at the outset (Britten N., 1995).

The specific type of semi-structured interviews used were depth/focused, which aim at obtaining a complete and detailed understanding of the topic under study as possible. Depth interviews involve preparing an interview guide, and assume

enough prior explanation of the topic to know what the relevant questions are (Hudelson P., 1994).

Strengths of semi-structured interviews

Because semi-structured interviews demand from the researcher the preparation of an interview guide, he/she can estimate how best to use the time available for the interview. This is especially appropriate in projects dealing with people who are used to efficient use of their time and may not be willing to spend time in open-ended, everyday conversation with the researcher. On the other hand, for the interviewee the use of an interview guide by the researcher transmits the idea that the researcher knows what he/she wants from the interview. As before mentioned the interview guide can still be flexible enough to allow both the informant and researcher free to follow new leads. Also because the same core list of questions are asked to each respondent, the data from these interviews are easier to systematise (Hudelson P., 1994).

Weaknesses of semi-structured interviews

Developing an interview guide requires sufficient time to explore the topic of interest beforehand in order to know what are the relevant issues and questions that should be covered (Hudelson P., 1994). Bias can be introduced by the way in which the interviewer is perceived by the interviewee and the effects of

characteristics such as class, race, sex and social distance on the interview. Lack of rapport between researcher and informant can also limit data collected (Britten N., 1995).

STUDY QUESTION, AIM AND OBJECTIVES

STUDY QUESTION

From the private practitioners' and users' perspectives, What are the key aspects involved in private for profit maternity care in Punto Fijo, Venezuela?

STUDY TYPE

Descriptive study, using qualitative methodology

AIM

To describe and analyse private maternity care as it is currently delivered in Punto Fijo, Venezuela, from the perspectives of obstetricians and users.

OBJECTIVES

- To identify the reasons why practitioners opt to work in private sector maternity care
- To explore how private practitioners see and conceptualise their work
- To identify what obstetricians see as the main differences in clinical practices between work in the private and public sector
- To explore the obstetrician/patient relationship within the private sector
- To describe private obstetricians views about their role in the new proposed reform of the health system

CHAPTER THREE

METHODOLOGY

3.1. STUDY QUESTION AND STUDY TYPE

From the private practitioners' and users' perspectives, What are the key aspects involved in private maternity care in Punto Fijo, Venezuela?

Study Type

Descriptive Study, using Qualitative Methodology

3.2. TRIANGULATION

In this study only one method of data collection was used, however in order to reduce the chances of bias as well as increase validity, a purposive sampling strategy was used. The idea was that participants would differ from one another in such a way that variation becomes a source of important information by looking at themes across all respondents.

I also kept a diary (log-book) in order to record my own perceptions and impressions during the process of data collection so that I could review my own performance and insight into the research question. In addition I took notes on different subjects that although not entirely related to the research question would enable me to understand and represent the context of the findings.

3.3. SAMPLING

3.3.1. Subjects

Medical professionals currently providing private maternity care and registered in the Regional Medical Association.

Mothers who received private maternity care and had a baby in the six months previous to the start of the study.

3.3.1. Sampling strategies

Subjects were selected in three ways

Key Informant

Key informants are individuals who possess especial knowledge and who are willing to share it with the researcher. They have access to the culture under study in a way that the researcher does not. The key informant is someone with whom the researcher develops a special relationship of information exchange. They can also be useful for pre-testing more structured data collection techniques to be used by other respondents (Hudelson P., 1994).

A key informant was identified from the stage of proposal. This particular person is a doctor that has lived and worked in the area for more than thirty years. Apart from working at different levels of public health institutions, he has also been involved in activities of the Local Medical Association and other activities related with medical professionals.

Purposive Sampling

A list of the Gynaecologist/Obstetricians working in the area was obtained from the Regional Medical Association (Colegio de Médicos del Estado Falcón). Registration is a compulsory requisite for doctors to start medical practice both in the public or private sector. Doctors were chosen from the list by Purposive

Selection, using Maximum Variation Sampling Strategy. It consists in selecting the individuals in such a manner that they differ in certain characteristics decided in advance. It helps identify common patterns that emerge from great variation of particular interest and value (Patton M., 1987).

The characteristics chosen to construct the sample were:

- Years of experience in terms of the time since they graduated as obstetricians
- Working either solely in the private sector or in both public and private
- Places of work, in a large local private clinic or at independent surgeries

Convenience Sampling

Originally users would be selected by purposive sampling, asking doctors to provide names and addresses of women who had received their services within the last six months or had their babies at a private institution. This strategy had to be changed so I asked two local paediatricians to go to their surgeries at the time when they were doing 'well baby clinic'. Once there I asked mothers who were in the waiting area if they agreed to participate and had received private maternity care during the six months preceding the study.

3.4. METHODS

3.4.1. Ethics

Ethics Form-Obtaining approval

The proposal for this study was evaluated by the Ethics Committee at CICH (Centre for International Child Health/Institute of Child Health) and approved by communication signed on the 26 of June 1998, after the handing of the Ethics Form distributed by the course organisers beforehand.

Ethics-Gaining Access

Gaining access to doctors is known to be a difficult task. Working with doctors implies interfering with busy timetables and complicated work organisation. The Key informant advised me on this respect at the beginning of the research when I was still preparing the strategy to start the data collection process. He reminded me that "in the private practice time equals money and doctors can react negatively to your request to spend a few minutes to complete an interview".

In general I had the impression that because of the fact that I am a doctor, this aspect of access was somehow facilitated. On the other hand, having the reference of the Key Informant, who is a well-known personality and considered an

authority within the health professionals, also permitted a less restricted access to doctors and their time.

Ethics-Obtaining Consent

An introductory letter was presented to each doctor before the interview. A consent form which doctors were asked to sign before the start of the interview accompanied the letter. The letter contained information regarding:

Professional background of researcher

International studies currently being carried out

Main Objectives of the study

Explanation of Methodology (especially concerning tape recording)

Assurance of confidentiality and anonymity of results

Advanced gratitude for their participation

Voluntary nature of participation

Logistics

Once at each clinic I localised the doctor's consultation room. Introduced myself to the secretary and asked to see the doctor. Some would see me personally and set a time for the interview, others would give me an appointment to come and see them in a more convenient time. Despite this, long hours waiting to see doctors was the usual. Some doctors were late arriving to the appointment; others would

ask me to wait until the number of patients they had in the waiting room was lowered. Others simply made me wait for them to finish and then let me in.

After finishing with the doctors working in the large clinics, I continued interviewing those doctors working independently around the city. This was difficult because of the limitations to find addresses and coincide with the doctor's consultation hours.

Refusal to participate

Only one doctor refused to participate. Although this was not openly expressed, I tried to contact him in several occasions without success. I attended the appointments but was never able to do the interview due to reasons explained by the secretary as: "the doctor is busy" or "had an emergency call".

Methods Used

Tape-recorded, open-ended, semi-structured interviews with twenty doctors and ten mothers were conducted in a period of six weeks. There were 15 male doctors and five females. Four of the mothers interviewed were hospitalised after having had their babies. The rest were interviewed at the paediatricians' surgeries. Two initial pilot interviews were carried out in order to develop the interview guide. This guide consisted in a list of themes which was used during interviews.

In addition to the interviews I decided to make notes on informal unstructured observation on some issues like existence of health related information in the waiting areas; number of patients waiting to see doctors; conditions of the facilities in the waiting rooms and others. I also looked at other material in order to support the findings. An example of these materials consisted in the birth records kept in the neonatal units of each of the clinics selected.

Interview format

Myself conducted all the interviews in a semi-structured way, using open-ended questions. Personal introduction of myself as well as wording of questions was slightly different each time. This helped me to evaluate the atmosphere while starting with the wider and less compromising questions and also allowed to create a sense of a "guided conversation" rather than an interview and follow a 'flexible agenda' (Britten N., 1995).

Interview Guide themes

The doctors' Interview guide included the following themes:

a) Doctor's professional experience

- Years since graduated as obstetricians
- University at which they obtained their qualifications as obstetricians

- Reasons to choose obstetrics as career
- Reasons to settle in the area

b) Working either solely in private or both public and private

- Advantages and disadvantages of the private practice
- Differences perceived between obstetric practice in private and public

c) Doctors views on reasons why patients choose private services

- Patients' ways to cover costs of private obstetric services
- Relationship between doctors and patients

d) Obstetric practices (# deliveries/month; % of caesareans; others)

e) Opinions about role of the private sector in the proposed new health System to be implemented in the country in due course

Women's interviews included:

- Reasons to select obstetrician
- Reasons to select clinic
- Experiences on private obstetric care
- Relationship with obstetrician
- Complaints about private obstetric care

- Modes of financing obstetric care
- Suggestions

Site of Interviews

All interviews with doctors took place at the doctor's surgery or consultation room. Doctors would maintain their position as consultants (them on one side of the desk and me opposite to them).

Some of the interviews with mothers were carried out in a small room to which I was given access. Others were conducted in the paediatricians' waiting rooms. In most interviews mother were accompanied by their babies.

Interview Style

Most interviews would start and finish in a very smooth way. However at the beginning there was always a sense of formality that smoothed as the interview progressed. Doctors looked more relaxed and started to talk more openly and freely. The length of the interviews varied with most interviews lasting between 40 and 45 minutes. Two interviews lasted for approximately one hour and the shortest lasted 25 minutes.

Tape-recording

All interviews were tape-recorded using an audio-recorder. As explained before, the introductory letter contained information on the methodology to be used and the need to use a tape-recorder. Once the doctors had finished reading the letter and expressed the consent to participate either verbally or signing the letter at once, the tape-recorded was turned on and discretely placed in a convenient place as to make it discrete but also to reduce the chances of failure.

Establishing Rapport

I was concerned about the reaction of doctors towards my condition as a doctor. Despite being advised by different people about the difficulties that accompany research dealing with medical professionals, I was confident that I would get a positive response from the doctors. After introducing myself and explaining the objectives of my research I started the interviews by asking the more general questions. This was positive as I felt doctors liked the idea of talking about themselves. At the end I was convinced that being a doctor helped to consolidate the trust and enthusiasm that the majority of doctors reflected in their willingness to participate in this research.

Recording Information

During the interviews I kept the Interview guide with me so that I did not forget any of the topics covered. I also kept my Log-book with me but avoided taking any notes until the interviews were finished and I had gone out of the doctor's office. Once outside I would write some of my personal impressions about the interview.

Difficulties Encountered

The main difficulties encountered to pursue this research were related with the logistics and access due to the busy nature of the doctors' day-to-day activities. Making appointments with doctors was difficult as well as the sense that although everything seemed to be going all right, unpredictable things could occur that would interfere with the interview being carried out. Example: Doctors coming late because they were attending an emergency call.

One main difficulty was also related with transport and distances. Public transport is poorly organised making it difficult to use them and try to be on time. The more convenient alternative (taxis), were expensive. Distance from clinic to clinic, as well as from the place where I was staying to each of the clinics was usually longer than expected.

I found disturbing being asked to enter the doctors' offices to conduct the interviews after having seen many women waiting for the doctors the waiting area. Some of these women were in advanced stages of pregnancy and had been there

for long periods of time. Waiting for some doctors took as long as three and four hours in the extreme cases. This was exhausting as not all clinics offer the same facilities of comfort for the patients. As mentioned somewhere else in this report, Punto Fijo is characterised by its intense hot weather. The fact that I was somehow competing with patients to see the doctors made me fell uncomfortable in these kind of situations.

Another difficulty appeared when I asked doctors to provide the names and addresses of women to be interviewed as doctors usually keep their patients' records within their offices. Apart from this, each doctor has its own patient's record in which the information varies. Some don't have details that would enable me to contact the subjects in an easy way. As explained before these circumstances led to change in the strategy to select participants.

Interviewing mothers who had their babies with them was difficult, as the babies' cry or move distracting them. I tried to avoid this as much as possible while being aware of the situation in order to make the interviews run smoothly.

Feed-back to participants

Some doctors asked for feedback on the results of my research. They showed a great deal of interest in the topic as well as desired to know the final results. I intend to send a copy of this report to the Key informant to be distributed amongst those interested.

3.5. ANALYSIS

Data analysis for each doctor and mother interviewed was done using 'Framework'. This method of analysis of qualitative data involves a number of distinct though highly interconnected stages that although systematic and disciplined, rely on the creative and conceptual ability of the analyst to determine meaning, salience and connections (Ritchie J. and Spencer L., 1994).

According with this method I started by familiarising with the data by sifting and sorting of all material. This process was facilitated by the fact that I made all transcriptions of the interviews, then read the transcript several times. By doing this I started to identify the key issues and emergent themes present in the data. I started to categorise the data by recording the range of responses to different questions as well as concepts and themes. After doing this, indexes were created. This stage was difficult, as it requires the use of intuition and judgements about the meanings, relevance and importance of issues, and implicit connections between ideas. The indexes were then applied to the transcripts while I also started to select those passages that could be included as quotas in the results, allowing me to illustrate the ideas and concepts to be presented. The following step is called charting in which 'charts' are devised with headings and subheadings from the thematic framework using a thematic approach. This is done by looking at each theme across all respondents giving a better picture of the data as a whole and facilitating the search for associations.

It was at this stage that I had to discharge some information contained in the data, which I thought, was not relevant to the research question. This was difficult and I had the sense of "loss and doubt", and despite reading form the literature that this was something perfectly accepted I found it challenging. As expressed by Lincoln and Guba (1985) "the task of data reduction" is part and parcel of quantitative analysis, but "the art of naturalistic data processing is far from well developed" (Rudestam K. and Newton R., 1992).

The final step is called mapping and interpretations. For this it is necessary to be aware of the key objectives and features of the analysis itself. The question set in this research contains issues that can be included into two categories, Contextual, that consists in identifying the form and nature of what exists, and Diagnostic as it examines the reasons and causes of what exists. Having this in mind the results were structured in a way that could be presented making 'sense' in accordance to the aims of the research (Ritchie J. and Spencer L., 1994).

3.6. LIMITATIONS OF THE METHODOLOGY

3.6.1. Sensitivity of issue under study

A study involving doctors working in private can affect the interests of those involved because of the sensitivity of certain topics. Having to talk about aspects related with financial, professional and personal issues in front of the researcher

and knowing they were being recorded can generate discomfort and suspicion about the research objectives, interfering with the way doctors answered to the interview and introducing bias.

3.6.2. Skills of researcher

For a good interview to take place the interviewer has to be aware of many things simultaneously. Not only has to try to keep a fluent and pleasant 'conversation' with the interviewee but also maintain within the rules of the appropriate interview technique. While doing the transcriptions I became aware of my own pitfalls hearing how often I asked close or leading questions, or interrupted the interviews at certain points to introduce my own opinion about what the interviewee was saying.

3.6.3. Characteristics of subjects

Doctors tend to be straightforward in answering questions, probably because of the way they usually answer to patients' health related questions. Open-ended questions require the interviewee's willingness to talk freely and openly about the issues being asked. This might have been aggravated by the busy nature of these professionals and the fact that most interviews took place during working hours interfering with their activities (Britten N., 1995).

3.6.4. Effects of interview sites

Because all interviews took place at the doctors' consultation rooms and surgeries during working hours, a sense of being interfering with important activities or creating discomfort either to the patients or to the doctors was present at some moments. Some interviews were interrupted by telephone calls, enquiries from secretaries and patients. This could have been avoided by carrying out the interviews at the doctors' homes, as recommended by the literature (Britten N., 1995). This strategy was not considered due to the potential difficulties that may have involved.

CHAPTER FOUR

RESULTS

4.1. INTRODUCTION

The aim of this study was to describe and analyse the key issues related with private obstetric practices in Punto Fijo, Venezuela from the obstetricians' and patients' perspectives. The results show that there are aspects of the private obstetric practice in which there seems to be common views and opinions among practitioners whilst there are others where views and experiences vary, either slightly or in opposite directions from doctor to doctor. Doctors' attitudes and practices are presented in relation with the different issues covered by the interview.

Key issues arising from the doctors' answers to the interview fall into four main dimensions that include all the topics covered by this study. Within and across those dimensions, there are sub-categories of issues that emerged upon close reading of the transcripts of the interviews with the obstetricians. I found that the amount of information collected was immense forcing me to reduce it leaving only those relevant to the study question.

The four main categories that emerged from this study are:

- **Personal issues**: These are elements of doctors' attitudes and views of the private obstetric practice that are directly related to the practitioner's life, choices and way of thinking.

- **Professional concerns**, relate to those aspects of doctors' own perspectives and views about private obstetrics related specifically with gynaecology and obstetric as a profession.

- **Economic and financial matters**, refer to those aspects of private obstetric care related with the profitable nature of the activity.

- **Work related issues** are those that accompany the day-to-day activities of doctors working in private.

4.2. PERSONAL ISSUES

- **Years of experience**

The doctors interviewed had differences in the number of years that they had worked as obstetricians in the area ranging from less than five years to more than

thirty. Most worked in Punto Fijo since they finished their training as obstetricians and have stayed there for all of their professional's trajectory.

- **Reasons to choose obstetrics**

Amongst the reasons to choose obstetrics as a medical speciality doctors mentioned a wide range of motives. The multidisciplinary nature of this medical speciality allows them to develop a wide range of activities from gynaecological/obstetric surgery, fertility and more medical specialities like endocrinology. The inherent nature of the speciality that deals mainly with uncomplicated patients and where the final outcome is usually positive seemed to be a common factor influencing doctors' decision.

A past positive experience working in the obstetric/gynaecological field, either as undergraduate students, their admiration for motherhood and the work with women and children were related with their choice of career. For doctors who have been obstetricians for a longer period the lack of specialists in obstetrics that prevailed in Punto Fijo by the time they finished their training lead them to choose this speciality due to the good job opportunities that they would find.

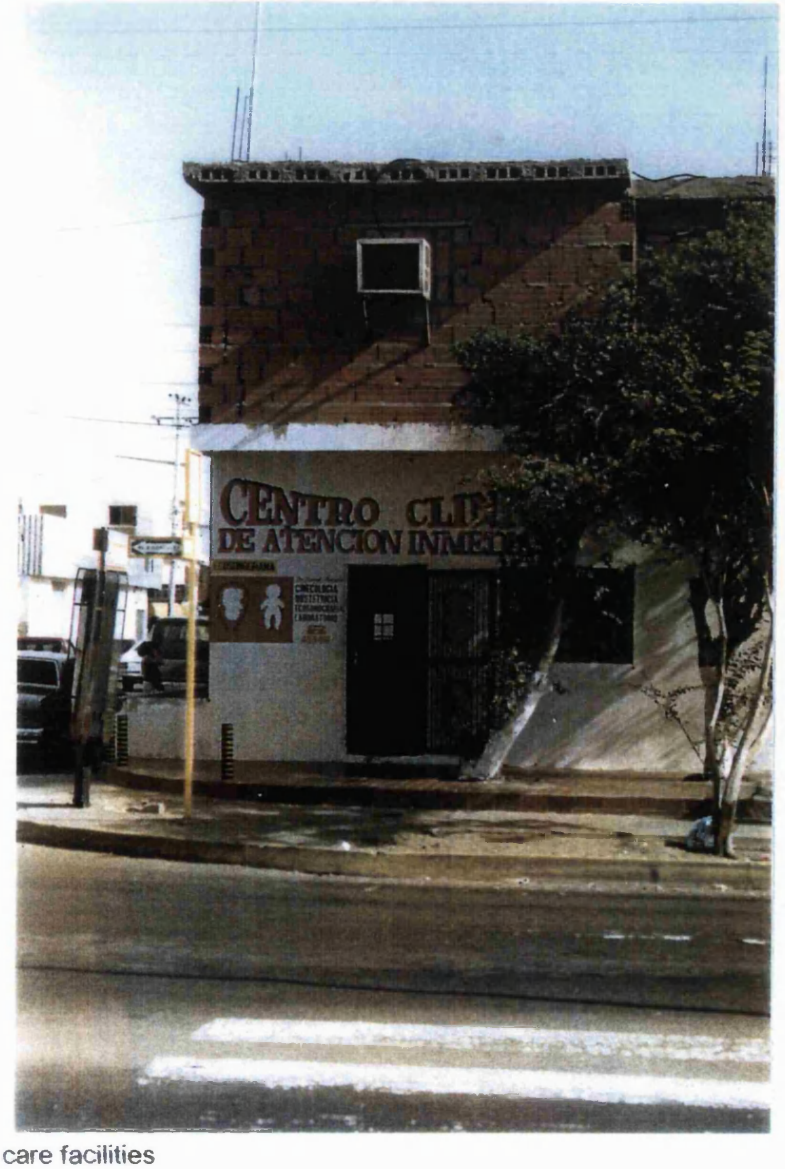


FIGURE ONE: Different types of private care facilities

- **Places of work**

Among the doctors interviewed a few work solely in the private sector while others share their professional activities between the public and the private sector. In this group of doctors some work for the Hospital Calles Sierra that belongs to the Venezuelan Social Security Institute (IVSS), the largest Hospital in the area. Some doctors work on a permanent job condition while others work as deputies due to the difficulties they encounter to find vacancies in the public sector. These tend to be the youngest and newest doctors in the area. The rest work either at the Hospital de Judibana (M.S.A.S.) and others at the Health Centre where they mainly deliver Primary Health Care. Some doctors also expressed that they work for some Non-Governmental Organisations like the IPASME and the Red-Cross, that are non-for-profit organisations. As expressed by a young doctor who explained the difficulties related with finding jobs in the public sector:

"Jobs in the public sector are difficult to find. You have to belong to a certain political party or to have good personal relations with the people involved in the administration of public services."

The motives to settle in Punto Fijo as an attractive place to work responded mainly to family and personal interests. Younger doctors have come to the area for family reasons and attracted by the better opportunities of career development and economic benefits of the area, compared to other cities in the country.

FIGURE TWO: Private facilities

Nevertheless they have found a very competitive environment where starting a professional career has not been easy.

There were divergent criteria in relation with the proposals for the health sector's reform in which the private sector will have an active role as provider of services. Some doctors expressed their ignorance and lack of information about the way in which services will be organised and administered. There were optimistic views based on their believe that the already existing infrastructure and resources of the private sector could support and help to solve the deficiencies of the public sector. Less optimistic opinions stated that because of the profitable nature of the private sector and the costs involved in the management of health services, strict compromise from the government authorities is needed to comply with payments and fees, otherwise any agreement made would have to be withdrawn.

A doctor who only works in the private sector said:

"I do not think it will work. I think those are only 'hot towels' to give people hope and acceptance of the situation."

4.3. PROFESSIONAL CONCERNS

- **Self Management**

Working in the private sector offers the opportunity to develop a professional career according to the professional's own plans and expectations. By functioning like 'little entrepreneurs' they are able to manage their own activities and timetables as well as make the medical decisions over patients according to their own criteria and experience. However, because of the individual way in which they work they are forced to make a lot of sacrifices due to the absence of a 'team work' which also means that all the responsibility for the patients' well being relapses on the doctor as an individual. For these reasons doctors feel that they have a greater responsibility to the patient in private than in public as in the public institutions the responsibility is shared by the group of doctors assigned to a department or service.

A doctor who had previously expressed his discontent with the experience of working in the public sector mentioned:

"Working as an obstetrician in private is an art. One has to develop skills to identify the patient that needs more attention. One should never underestimate a patient. This is something you learn with time, to dedicate each patient the time according to her needs."

- **Opportunities for career development**

The work in the private sector allows doctors the opportunity to develop their career as obstetricians or gynaecologist in what they refer as a 'proper manner'. By having access to the newest technology and resources that are available in

private institutions and that they consider necessary to provide appropriate maternity care, doctors feel that the private sector gives them the opportunity to practice better obstetrics. They can develop skills and keep up to date with the newest theories and protocols to treat patients. Showing an ironic expression a doctor expressed his conviction about the reason for not working in the public sector:

"Here in Punto Fijo I don't think there is a doctor working privately that does not have his/her own ultrasound equipment. In the hospitals they are still measuring the uterine height with the metric ribbon. Procedures like foetal monitoring, methods to analyse amniotic fluid or special laboratory tests are not available in public. That is the only thing they do...to measure the uterine height... That is medieval obstetrics!"

At the public hospitals there are limitations in the use of technology due to budget shortages and lack of resources.

A different perspective to these arguments was mentioned by the recognition of the existence of differences in the type and variety of pathologies observed and treated by obstetricians in private compared to those seen in public hospitals. The socio-economic characteristics of patients together with the volume of people that attend to the public institutions imply that at the hospitals the number of high risk patients observed is larger and there is a wider range of obstetric pathologies to be observed so offering more opportunities to gain experience in treating complex obstetric cases. It is at the public hospitals that doctors deepen their knowledge

and experience, learn skills and develop criteria in dealing with complicated patients and their problems.

One female doctor who has worked for many years in both sectors and is currently a senior consultant in one public hospital said:

"In the public sector is where you really learn. Everyday there is something new to see so it is there that we gain experience."

- **The practice of obstetrics in the private sector**

There were divergent arguments concerning the practice of obstetrics within the private sector and the possible differences that might exist between the private and the public sector in this respect. Some doctors were insistent that the clinical criteria were similar in both sectors whilst others openly recognised the existence of differences. The reasons mentioned for these differences include the internal organisation of public institutions, the availability of human and non-human resources, patients' ability/willingness to pay for services and, the demands that patients' or their families make.

The existence of hospital protocols, norms and conducts that have to be followed by all doctors working in a service or department mean that procedures and conducts necessarily change between public and private. Doctors in the private sector work individually, making their own decisions, which are usually based on

their personal criteria, sometimes 'subjective'. In the doctors' opinion, the number of caesareans practised in private in comparison to that of public is an example of this situation. Many expressed their knowledge and awareness that in general they were performing more caesareans in private than in public.

Some would refer to the issue in relation with what is considered in the literature whilst others would mention what is done in public hospitals

A doctors who works as a lecturer at the university said:

"In public things are done according to what is written in the books, or the way we were told by our professors at the university. Here in private there is more subjectivity and that is shown in the reality that more vaginal deliveries are attended in public hospitals whilst in private more caesareans are performed."

The percentage of caesareans estimated to be performed by doctors ranged from saying that they would be higher than the number of vaginal deliveries to as much as 60, 70 and 80%. They recognise that the number of caesareans they are performing is high and argue a variety of reasons that include family pressure, justification of surgical procedures not recognised by insurance companies (surgical sterilisation) or patients' fears to certain obstetrical procedures like forceps.

"Sometimes we feel the pressure of the family, they ask us to stop the woman from suffering in labour and we have to indulge them. There is a doctor here that makes fun saying that there is an indication for caesarean called "Family distress".

"Here in private we have a high rate of caesareans, but this is due, for example, to cases where the patient wants to get surgical sterilisation, then we have to please those patients, by doing a procedure without the existence of a proper obstetric indication."

"In Punto Fijo doctors are doing too many caesareans, and this is specially truth in private. I had my training in Caracas, and there we used forceps as an obstetric procedure to facilitate vaginal deliveries. But here if you say the word forceps is like fighting with Jesus Christ. It is something not to be even mentioned."

Data obtained from the neonatal units of the clinics support the information provided by the doctors. These tables show the number and percentages of caesareans performed at the clinics where the interviews took place, during the years 1996 and 1997. This information was obtained from the neonatal units of each clinic with the permission and consent of the clinics' authorities.

Table 1. Number of births and percentages by mode of delivery reported in each clinic, 1996.

Clinic	Total	Vaginal deliveries		Caesareans	
	#	#	%	#	%
Policlínica de Especialidades	371	125	33.6	246	66.3
Políclinica Paraguana	224	61	27.23	163	72.76
Clínica Falcón	108	34	31.48	74	68.52

Table 2. Number of births and percentages by mode of delivery reported in each clinic, 1997.

Clinic	Total	Vaginal delivery		Caesareans	
	#	#	%	#	%
Policlínica de Especialidades	414	132	31.88	282	68.11
Policlínica Paraguaná	235	62	26.38	173	73.62
Clínica Falcón	74	16	21.62	58	78.37

The availability of technological resources and equipment in the private institutions allows doctors to routinely do procedures, which are not provided in the public

facilities. An example is the controversial number of ultrasound scans performed in pregnant women as part of the antenatal control. Most doctors mentioned the theoretical indication of three scans during pregnancy in uncomplicated cases but recognise that they do one on every monthly consultation in order to reassure the mother and themselves that everything is going well. As expressed by a young doctor:

"I like to do a monthly scan because I like to see the baby. I am a human and I can make mistakes. A small malformation or detail can go unnoticed and that would be disastrous!"

Another example of procedures done on a routine basis to mostl patients in the private sector include episiotomy and enema. In the case of the episiotomy all doctors practice it on every primipara and when sometimes regardless of parity. For the enema they mentioned it as a rule in order to avoid the risk of "contamination" of both baby and surgical area. The reasoning behind these practices were for some the experience and satisfaction with results. For others the arguments were based on scientific evidence like decrease in the risks of perineum tearing, avoidance of long term complications like urinary incontinence and others.

The presence of a woman's partner during labour raised different opinions. Some doctors expressed their agreement and recognised the advantages in terms of support for the women and involvement of the father, although they mentioned that

it can add pressure to the situation, especially if problems are encountered. Some would mention that non-medical persons should not be allowed to witness medical procedures and that this is in fact contemplated in the Medical Federation of Venezuela, statements a rules for the practice of medicine. In the public sector such 'concession' is inconceivable.

- **Professional performance and the relationship between doctors and patients**

Doctors refer to the users of private health services as "exclusive". First of all the number of patients that can afford to pay for private maternity care is much lower than the number of patients that use the public services. They are usually low risk patients as they are better nourished and probably less exposed to potential risks during pregnancy. Apart from that they tend to be better educated, more conscious about the need for early antenatal control and once in the care of the doctors, are more likely to comply with the doctors' indications and recommendations. Doctors feel that the patient in private is more open and receptive to health education messages and it motivates them to do this kind of activities.

According to doctors, patients select their obstetricians on the basis of trust, confidence, understanding, the security of getting a good service, professional experience, responsibility, tranquillity and the reassurance that the doctor they have chosen will accomplish with the main objective of giving them a healthy baby.

"Patients want a good obstetrician, they want a person who is actualised, that possess the equipment to provide a good service and that treats them well."

"There is an expression that people uses here in Punto Fijo..."That doctor took care of my pregnancy...he cared for my baby"...It is as if they value you for caring for something as precious as their babies."

Obstetric practices can be influenced by the relationship that is established between the patients and the doctor, in which the later perceives the patient as having the right to demand because there is a payment involved. Doctors expressed that sometimes decision making is modified by the pressure or demands that the users of private services impose over doctors.

"Sometimes you have the husband, the grandmother, the aunt of the patient and even the one who will be the Godmother asking you to act faster in order to stop that woman from suffering."

In the public sector patients are somehow resigned to the conditions and treatment that they get and there seems to be no mechanisms by which them or any form of pressure group can interfere with the current problems. On the contrary the patients in private demand from the doctor to the point in which they can influence decision making in relation with the procedures needed.

"Despite the constant strikes and the mistreatment that patients get in the public sector they don't complain. It is as if for them that has become a routine. They then look for a solution in the private sector but for some it represents a big sacrifice in terms of money."

4.4. ECONOMIC AND FINANCIAL MATTERS

- **Private practice as a source of income**

"For pure economic reasons you have to work in private. In order to complement your earnings in the public. Only doing so you can have the status and an income in accordance to your professional position."

The work in the private sector offers doctors the benefit of a better income. This not only represents a reason to work in the private sector but a constant incentive to continue despite the difficulties, as it allows them to have the economic level to keep the social status that they "deserve for being doctors". Because of the low pay that doctors receive in the public sector they turn to the private in search of the economic benefits that enable them to maintain a living standard in accordance with their professional status. Some doctors expressed that if the conditions were different in the public sector and especially if doctors would get a better remuneration for their work, they'd rather only work in the public sector.

A doctor recognising the great difficulties he encountered to start and settle in a private clinic mentioned:

FIGURE THREE: Obstetrics services are offered for the 'clients' to shop-around

"If things were different in the public sector one could work more comfortable and do things better, just like it happens in other countries, where doctors simply don't need to work in private."

Working as obstetricians in the private sector represents for some doctors the only way to "survive" economically. It is a need in order to guarantee a source of income. This was specially truth for those young doctors that only recently started a work in the public sector either under contract or permanently:

"In this country if you don't work in the private sector you don't survive"

For some doctors the income they receive from their work in private is complementary and allows them to have economic affluence and to be well of. These doctors were mainly those either working only in private or those with a long trajectory as obstetricians within the public and private sector who have already reached a certain professional and personal status.

- **Implications of a profitable activity**

There are implications in terms of costs of the private obstetric practice that affect not only doctors but also patients as users. Because it is mainly a for-profit activity,

economic and financial factors appeared related to a varied range of aspects directly or indirectly associated with the work in the private sector.

Implicit costs for doctors

For doctors to start and maintain a private practice implies expending large amounts of money. They have to be stakeholders or to have a share of the clinics where they work in order to have access to the facilities and benefits that those institutions offer. Apart from that they have to buy medical equipment, materials, office furniture and stationery, and pay for auxiliary personnel. Some doctors have to pay monthly instalments as part of the clinic's policies or pay for the rent of their consultation rooms. These make it difficult especially for those starting their career.

In addition because there are new technologies being developed everyday as well as new procedures and practices, doctors experience a constant pressure to keep up to date with these advances. These are translated into more expenditure, a continuous worry about economic issues in the context and reality of a country where the ability and willingness to pay for medical services is restricted to certain sectors of the population.

A doctor who described his ordeal in trying to buy a second hand ultrasound machine said:

"A big disadvantage of work in the private sector is that you have to think in investment. You have to invest in equipment, personnel and apart from that the development and appearance of new technologies is overwhelming in the sense that one has to keep actualised. That means money".

Costs for patients

The counterpart in cost related issues concerns the patients. Doctors are aware that the use of sophisticated technology and specialised procedures to patients in the private sector increases the costs of health care.

"Unfortunately private practice is business. If the patient has no means to pay for the services, even if you want to help you can't, because even if you do not charge the patient for your work as a professional the clinic cannot exonerate patients from paying for the services they received."

Competitiveness

Because of the difficulties encountered to start and maintain an adequate number of patients to guarantee coverage of the costs involved in running a private practice, doctors feel that the environment between obstetricians working in Punto Fijo is very competitive. This affects the way patients are treated and also the relationship between obstetricians. Competitiveness, individualistic performance and "egoism" are amongst the characteristic of the work in private as described by doctors. The existence of an "elite" means that for some doctors it is very difficult

to have access to a perceived decreasing number of patients and an ever-growing number of doctors. Competitiveness amongst doctors plays an important role in maintaining an appropriate number of "clients" to suit their own interests and conveniences.

"We are too many specialists competing for a limited number of patients. There are many Hospitals training specialists without proper research on needs for professionals at the national level so there are approximately 67 obstetricians graduating and entering the market every year. It is just too much."

"For example, you have a patient that is complaining: "doctor I have this little pain here, Why don't you do a scan to see that the baby is ok?"...You have to do it because if you don't do it because you consider it unnecessary she will go to the doctor next door and ask for it. That is how it is!"

- **Strategies developed to deal with economic issues**

"This is business. Here the mandate is the law of money and depending on that you do more or less."

In the day-to-day activities, doctors have developed strategies to deal with the economic constrains that encompass private practice to both doctors as providers and patients as users. These include issues related to the provision of services, decision making and relationship between the user and the provider.

"It is difficult to manage the public opinion about the work in private. People sometimes do not judge on the basis of professional standards. It is easy to criticise and say: "that doctor is a thief". People's idea is that sometimes you decide what to do on the basis of what makes money. Sometimes I just avoid hospitalising a patient so that they don't think that I am interested in the economic benefits of that situation."

Some institutions have introduced policies to increase the access of patients to the services they offer. In Clinica Paraguaná patients have the possibility of having their babies using facilities specially adapted for these called "social cases". Examples of these strategies include the creation of semi-private rooms, limitations in the provision of items that are not entirely necessary for the medical treatment, and only increase the costs of services. Unfortunately for both doctors and patients the way in which the private sector works means that only those who have the resources can have access to private services despite the fact that resources both human and material are available. Patients who can afford to go to private, either because they have the money or possess a private insurance coverage, perceive that the solution to their medical problems is not only appropriate but also effective. On the contrary when a patient is unable to pay the doctors find themselves in the difficult position of having to refer these patients to the public sector.

"Sometimes patients cannot receive the surgical treatment in private because they lack the economic resources. These may be interesting cases that are lost. You loose the patient and that is sad."

This is more preoccupying in situations when the procedure needed is neither available in public hospitals, but the patient cannot receive it under private care due to lack of resources to pay for its cost. Sometimes decisions and conducts can be conditioned to the cost of procedures and the patient's ability to pay for whatever is required.

- **Financing the costs of private obstetric care**

There are variations in the way patients cover the costs of obstetric care in private. They can be divided into several categories. First, is the patient that pays the whole cost of obstetric care from "out of pocket money". These are the minority. Other patients have a private insurance scheme that usually covers the entire or a high percentage of cost for surgical procedures and hospitalisation, but not those related with antenatal controls and technical or diagnostic procedures.

Due to the high prices of deliveries and surgical procedures the majority of patients go to the private sector for antenatal care and pay for its costs including laboratory, scans, and other procedures, but at the end of the pregnancy go and deliver at the public hospitals. Some doctors working in both public and private said that sometimes they control the patient in private and then attend the patient during labour at the public hospital if they are on call.

4.5. WORK RELATED ISSUES

"In public doctors work "with their nails" due to the lack of resources seen in the hospitals. Without proper resources you can not develop the speciality in an integral manner."

- **Better working conditions**

Doctors expressed their preference to work in the private sector due to a combination of factors that do not exist in the public sector, which give them satisfaction. The quality of facilities in the private care institutions and the support of a better trained auxiliary personnel give them confidence to comply with the requirements of the day by day work.

The conditions in which doctors work in the public sector compared to those in private affects the relationship between doctors and patients. They mentioned the inherent characteristics of the users of both services. Patients in private are more educated, come early in pregnancy, accept their recommendations and usually establish a good relationship with them. In public they have to see a large number of patients on each consultation. This workload limits the time dedicated to each patient and compromises the quality of care. Finally, the physical environment is nicer at the private clinics than in hospitals.

- **Organisation of services**

In their private surgeries doctors can organise consultation rooms on accordance to their personal taste and requirements. They can decide on timetables, organisation of consultations, personal information given to patients, availability to patients to their own convenience, etc.

They can also participate in the decision making of the institution where they provide their services. In one of the clinics where doctors were interviewed they voted the creation of an independent body (AGOPE, Association of Gyneco/obstetricians of the Policlínica de Especialidades). This consists of an internal organisation of work by rotations, in order to deal with emergencies and surgical procedures allowing them to plan their activities as well as guarantee that their patients will get the best of attention. These clinics also have contracted doctors to work as residents, these are specialist doctors that can solve emergencies and provide attention to patients if required during hours when most specialist doctors are not within the institution (nights and weekends).

To deal with the activities in both work places doctors have to adapt their activities, unfortunately in detriment of those in the public sector. When asked how to manage a hypothetical situation where he would be needed in both places a doctor said:

calificaron el ataque de "acto inhumano y de barbarie".

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FIGURE FOUR: Competitiveness forces doctors to use strategies to increase demand for their services

"Well, the advantage is that in public there is more flexibility. You can leave the place and everybody understand as they do the same".

Another strategy used by doctors to attract and facilitate the access to private obstetric care is the provision of extended timetables out of regular working hours offering more flexibility to patients, specially those that have to work. Due to the better organisation of services in private patients can find rapid and effective solution to their medical problems. There are no waiting lists and as long as they can afford to pay for the services required, they get the best possible attention.

The existence of a well organised private sector means that in many cases patients attending the public institutions have to be referred to the private sector when a special procedure or treatment is needed. This is of course, if the patient can afford to pay for the services needed.

- **Availability of resources**

Doctors emphasised the importance of the quality of care that patients receive in the private sector's clinics. Clinics are equipped with the technological resources that allow the doctors to provide appropriate services and for patients to have access to those advantages. On the other hand the availability of specialists in areas like genetics, fertility as well as the complementary diagnostic services like laboratory, x-ray and ultrasound allow them to provide a more complete and

reliable service. They have the sense of doing things appropriately whereas in public they express their frustration for not being able to do things in a correct manner.

"In the private health care system you know that your patients are getting all they require. That gives you satisfaction and the tranquillity of having done a good job."

- **Characteristics of the relationship between users and providers in private sector maternity care**

Another aspect mentioned by doctors in relation to the quality of medical care is the personal treatment that patients get from doctors, nurses, paramedics and auxiliary personnel. In the public sector's institutions patients are treated in manners considered by some doctors as "inhumane". On the contrary in private the patients have more privacy, and usually get more time to deal with their inquiries.

"In public not all doctors treat patients appropriately, they see them as livestock, doctors do not dedicate them enough time."

"When patients come here they complain about the treat they get in public institutions, basically they refer to not being examined in a proper manner, or having only their abdomens measured. Here they feel relaxed as one can talk to them, show their baby on the scan's monitor and reassure them that everything is under control. They definitely come here looking for quality."

- **Current situation of the public sector**

The current situation of the public sector's institutions represents not only a reason for doctors to work in the private but also for patients to seek in private care the solution to their health problems. The capacity of hospitals has been saturated and some have collapsed due to lack of resources to provide care. Public hospitals have been the victims of corruption, robbery, mismanagement and disorder. As expressed by a doctor who worked for more than thirty years in a public hospital:

"When I was senior specialist at the Hospital I fought and got a magnificent ultrasound machine. We used to take good care of it, only three people were allowed to handle it within the department. What happened?... Someone took it. It was robbed!. Nowadays there is a big disorder in the public hospitals. The services are completely deteriorated."

At the moment there is a collapse of public institutions and hospitals are undergoing the worst crises in the history of the country, with frequent employees' strikes and shortage of resources. Despite having a good number of well-trained doctors and nurses, there is little that can be done to improve the working conditions and the quality of care that the patients receive.

"We all know the situation of public hospitals. The quality of care is a disaster. Patients do not get what they need and deserve. The reasons for this are the lack of resources, the volume of patients demanding public services and the poor remuneration that doctors receive."

- **Public Health implications**

There is a big gap between the information on the activities in the private sector and what public authorities get to know. Information about patients treated in private is usually retained within the doctors' own consultation rooms or at the clinics' data base systems. This aggravates the situation of the public sector as health authorities do not get a clear picture of the epidemiological patterns in the area making planning and managing more difficult and complicated.

"It worries me that the information about what I see in my surgery does not reach the health authorities. This means that sometimes important cases and pathologies are not included in their statistics."

- **Special features of the area**

The presence of the Oil Company in the area has played a major role in the development of the private health sector. First because there is a constant affluence of people moving in and out of Punto Fijo. The company employs a large number of professionals and technicians that constitute the group of people that demand the existence of a private health sector. On the other hand the Oil Company has a good policy of medical insurance coverage for its employees, which guaranties a volume of patients with ability to pay the costs of private health care.

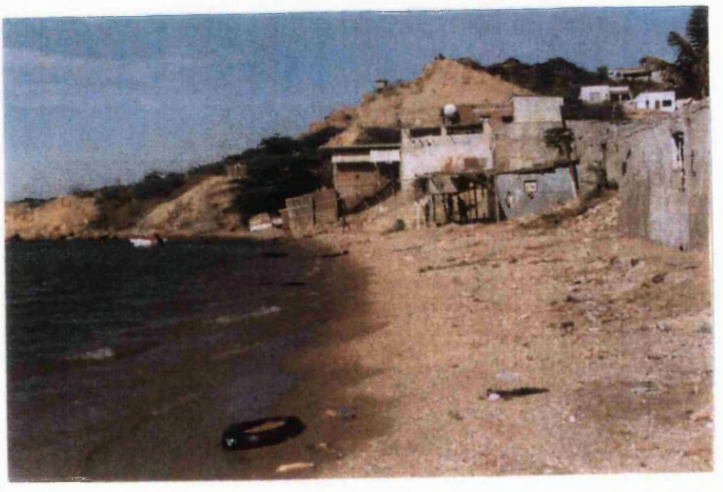

FIGURE FIVE: Gaps in living conditions across different social classes

"Here in Punto Fijo we have the great advantage of the Oil Companies. They offer good coverage for health care to their employees. The coverage can cover up to ten million Bolivars. Not all people can afford to pay for such a good insurance."

There have been some negative effects like the existence of a kind of monopoly to which certain insurance companies are already reacting due to the relatively high costs of medical care compared to other areas in the country.

"We have a problem with the insurance companies, they tell patients to go somewhere else because the costs of services here are expensive compared to other cities."

Unfortunately for the public health sector the advantages of having the Oil Company in Punto Fijo have not been reflected in the conditions of the health infrastructure. Despite the large number of local employees that by law have to comply with monthly contributions to the Social Security System (IVSS Instituto Venezolano de Seguros Sociales), the existence of a centralised system means that the resources obtained barely reach the local level. These together with the fame of the public sector of being corrupt and bad administrator of funds have contributed to the current situation of the public sector institutions.

"The Venezuelan Institute of Social Security (I.V.S.S) has been for long time one of the greatest den of vice and corruption. It has played a fundamental role in the deterioration of health services. There is a high level of bureaucracy that keeps thousands of employees just because of political influence. At Hospital Calles

Sierra there is only one small lift that is usually damaged, but there are six lift operators working under contract."

4.5. INTERVIEWS WITH PATIENTS

The interviews with mothers were characterised for more homogeneous responses to the issues being asked. Four main topics were identified:

- **Choice of Clinic and Doctor**

Patients select the clinic of their choice on varied criteria. Some prefer a place that is convenient in terms of proximity to the place where they live or work. For others the reasons were the clinic's reputation, the presence of a preferred professional or by word of mouth recommendations. In relation with their choice of obstetrician, most women alleged that their doctors had been recommended by another person in their families or by a friend. Most women agree with the relationship they have with their obstetricians. They find in them a person they can trust personally and professionally.

"I trust my doctor with my eyes closed. I know I am putting my life in good hands. Even more... my baby's life!!"

- **Reasons to use the private sector**

Patients expressed their satisfaction with the services they receive in the private sector. They feel relaxed, reassured by their doctors. They can count on their

doctors and call them whenever they need attention and always get a response. Some patients had had the personal experience or a reference from a known person about the conditions of the public sector's institutions and go to the private because of the "fear" of the service offered in the public sector.

"I am afraid of going to a hospital. I think if I go there I would die".

- **Complaints**

Some women disagreed with the high costs of services but mainly in relation with administration costs of the clinics. When asked about the doctor's payment they considered fair for the responsibility implicit in obstetrical care. They affirm that the quality of care in private clinics is superior to that in the public sector but some disagreed with the treatment received from some of the nurses while being hospitalised.

Another common complaint refers to the way in which doctors organise their consultation hours. Patients are given an appointment but the order in which the doctor sees them is determined on a first-come-first-served basis. For some of them waiting could take hours, even in the last weeks of pregnancy. They found this unfair considering that they pay for the services.

Among the recommendations that patients made to their doctors were: the reduction of appointments per session in order to avoid long waiting hours, the

selection of women who are advanced in pregnancy to be seen first. Better organisation by doctors so that they can arrive on time and not leave the consultation room in emergencies or other unplanned activities.

No complaints were expressed about the medical decisions or procedures received. The answers to these issues were always responded with a remainder of the unconditional trust in their doctors' experience and good will.

"I trust my doctor. Everything he's done I am sure was for my benefit"

- **Paying for the costs of private obstetric care**

Most of the patients interviewed had a private insurance policy that covered between 80 and 100% of costs related with hospitalisation, surgery and baby care at the clinic. One patient described how she was attended by her doctors at the public hospital because of lack of insurance but had attended antenatal care in private and paid with out of pocket money. Another received the benefits of being a "social case" at one of the clinics, receiving private care without all the "luxuries" involved.

"I was allowed to be a 'social case'. Because I am not covered by any insurance the clinic offered me a service without details and the luxury they usually offer and it made it cheaper. That was very important for me as I was very scared of having to go to the hospital".

CHAPTER FIVE

DISCUSSION

"Doctors owe a duty of loyalty to their patients' interests that requires them to elevate their conduct above that of commercial actors".

Frances Miller

The findings of this study suggest that the views and perspectives of doctors and patients about private obstetric care in Punto Fijo reflect the characteristics that are inherent to private medical care in general and those related to the concept of modern obstetrics. These are interconnected and include issues responding to the special circumstances of the context in which they occur. As mentioned by Mc Pake (1997), the failures of the private sector depend on the pattern of private sector provision predominant in each country.

5.1. BEING AN OBSTETRICIAN: A PERSONAL CHOICE OR A RESPONSE TO A PUBLIC NEED

The decision to work as obstetricians in the private sector depend on internal and external factors (Bennet S., 1994). Choosing to be an obstetrician on the basis of this speciality's own nature, because personal interests or to fulfil local needs for these type of professionals, have to be analysed having in mind the 'private-public mix' that exists in Venezuela, as well as the context of health policy in the country. Then, the concept of 'regulation' acquires great importance.

In Venezuela there are no rules or norms to decide neither on the number of professionals and specialists that graduate from the national universities every year nor on the distribution of these human resources around the country according to the regional or local needs for this type of professionals.

It makes necessary to ask the question of what is the attractive that this speciality offers to professionals in terms of the benefits they receive by working in the private health sector. Are there hidden economic interests? How much profitable is Obstetrics/Gynaecology in comparison to other clinical specialities?.

What is definitely certain is that the activities carried out by these professionals are usually expensive, specially if considered in relation to the monthly wages or salaries that workers receive in Venezuela. For example, considering the number of caesarean sections that were found and if the cost of a caesarean section is

equivalent to a doctor's monthly salary at a public hospital, Is not it incentive enough to attract doctors to do this speciality? Unfortunately the results do not give enough evidence to support any assumption about the before mentioned question but they open space for further research into them.

Another point for consideration is the personal decision of doctors to work in public or private. Why is it that the majority of doctors despite the recognition of better income and working conditions in private want to work in the public sector? There may be strong reasons not clearly identified in this research to explain this situation, however the recognition of the existence of 'flexibility' of the public sector that allows them accomplish with both public and private sector activities deserves serious considerations. As mentioned by Bennet (1994), one of the problems associated with private care is the decision of doctors to work in both sectors in order to increase their income, as this usually goes in detriment or neglect of the public sector by doctors.

5.2. THE "GOOD OBSTETRICIAN"

"It might appear that (some doctors) consider that the 'best' health care is one where everything known to medicine is applied to every individual by the highest trained medical scientist in the most specialised institution".

Halfdan Mahler
WHO Director-General 1973-88

The opportunities for professional development within the private sector that was expressed by doctors can be examined from different perspectives and using a variety of arguments.

The perceived 'freedom' experienced by doctors working in the private sector is related to the lack of control mechanisms by the governmental health authorities. First, the path that doctors choose to fulfil their expectations and plans for career development may not be appropriate to the health needs of the population as a whole. This is important to consider as some authors argue that more than the number of physicians/population ratio and beds/population, it is the type of specialists in relation to the population needs that should be considered (Long M., 1994).

Secondly, the fact that doctors seem to be 'consciously' aware of the alarming discrepancies between what they consider appropriate obstetrical practices and what is actually done should call the attention on the potential unveiled reasons behind. The evident lack of monitoring by health authorities could explain them but also the absence of internal audits or peer-regulation mechanisms that would make these situations 'visible' and analysable by the obstetric community as well as the public.

Two other issues emerge from the topic of obstetric practices. First, is the question about the motifs behind the doctors' decisions to perform a large number of procedures on their patients. Is it in the patients' interest or are these procedures performed to increase their income? (Bennet S., 1994). This argument leads to the

question of the relationship between doctors and patients within the so-called **'fiduciary ethic'**. This concept refers to how the vulnerability of patients and the wide disparity in knowledge that commonly exists between doctor and patient create tremendous potential for exploitation and distrust (Bradford G., 1991). Doctors are in the position of making recommendations to patients about the need for services that they will themselves provide and from which they may derive income. Within the private obstetric care the extent to which the **fiduciary ethic** guides the behaviour of physicians and how often it has been abused or used to disguise other motivations is difficult to know due to the differences in criteria about what appropriate obstetric care means (Dunn P., 1976).

Secondly, is the perception and concept that doctors have about obstetrics as a medical speciality where the use of sophisticated equipment and state-of-the-art technology is considered to be not only appropriate but 'better'. Their comments and criteria reflect some disrespect and neglect for the traditional obstetric skills and 'art' of what is considered one of the oldest professions of human kind (Dunn P., 1976). The use of sophisticated technology as a proxy for good practice and the 'irony' with which they refer to the way obstetrics is practised in public institutions, reveal a view of pregnancy, labour and birth as "medical" subjects and not a as part of a natural process.

Professor G.L. Kloosterman, cited by Dunn (1976) says:

"Spontaneous labour in a healthy woman is an event marked by a number of processes which are so complex and so perfectly attuned to each other that any interference will only detract from their optimal character. The doctors always on

the look-out for pathology, and eager to interfere, will much too often change the physiological aspects of human reproduction into pathology." To this Dunn (1976) replies: "Alas, when this happens, such complications may be, and often are interpreted as justification for the original intervention rather than as the undesired result of it".

A case for concern derives from the doctors' opinion in relation with the activities that they develop in the private sector, as well as the type of pathology and patients which in the majority belong to low risk groups. If as it was expressed, the majority of patients that use the private obstetric care receive mainly antenatal care and then go to the public institutions for surgical procedures or attendance of labour, then two issues have to be considered. First, is the effectiveness of antenatal care in reducing maternal morbidity and mortality in the population, which has been recently questioned (Mc Donagh M., 1996), and secondly, the fact that surgical procedures and all services that require hospitalisation are usually those that account for the higher costs of health care. So, are doctors benefiting from highly cost effective activities while leaving the public sector with the more resource-consuming ones? That seems to be the case.

Although out of the scope of this study another issue arising from these findings is the possible existence of an **'Inverse Care Law'** in obstetric care in Punto Fijo, by which those with the greatest need for obstetric care are receiving the less and vice-versa (Hart J., 1971).

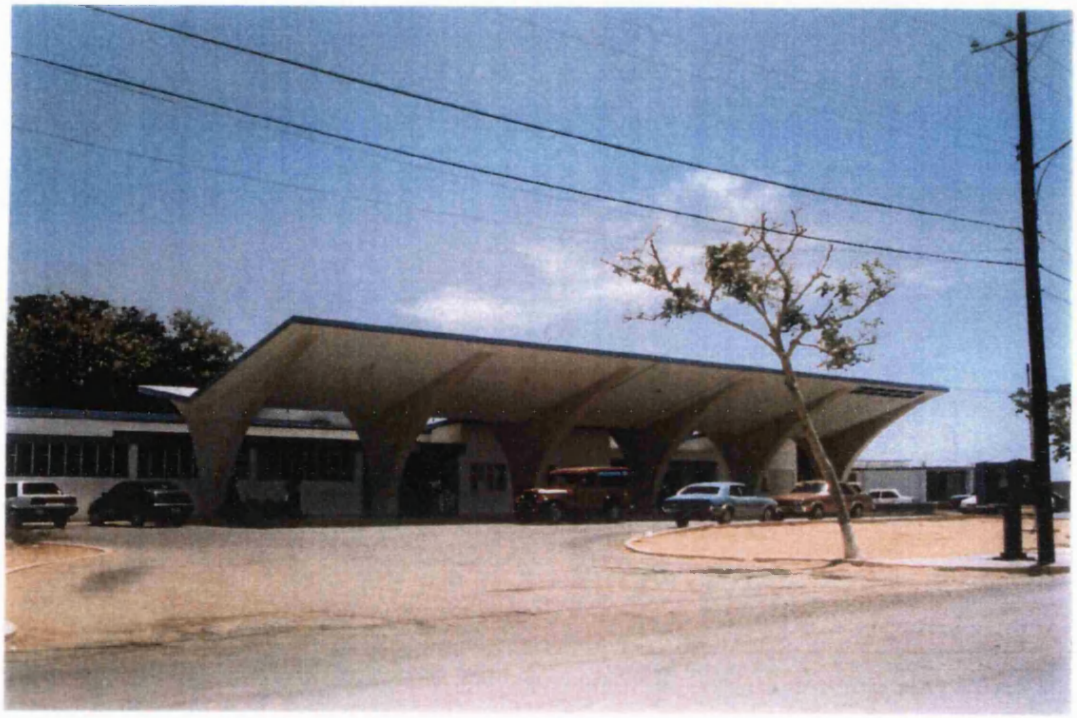

FIGURE SIX: Public Hospitals

5.3. PUBLIC OBSTETRICS VS PRIVATE OBSTETRICS. THE ISSUE OF QUALITY

The issue of quality of care is one that has to be looked at carefully as perceived 'higher quality' was mentioned by doctors as a reason to work in the private sector and by patients to seek this type of service. Issues included in the concept of quality of care were also recognised as those accounting for the main differences between obstetric care in the public sector and the private sector.

The complexity behind this argument relies on the meaning of quality of care. For doctors quality seemed associated with obstetric procedures and the offer of appropriate technology while for patients the reasons were mainly related with the amenities offered by the private sector and personalised care that they receive.

In the context of a competitive market, quality as an attractive offered by the private sector acquires another dimension. Doctors and private institutions have to use a series of strategies to attract patients and, patients respond to these according to their preferences. Newspaper adverts, offer of services provided shown at the front door of surgeries serve the patients' wish of 'shopping around' in search of the ideal obstetrician.

5.4. MOTIVATION TO WORK

Doctors' perception of the medical profession as one associated with 'high status' was revealed by their motivation to work in private due to the better chances of having an income that would allow them to live to such standard. The conditions in which they work and the characteristics of the patients they attend in private may also contribute to enhance this 'motivating' factor.

The conviction that they provide services of higher quality as a motive of satisfaction at work also denotes the doctors' perceptions about obstetrics.

5.5. RELATIONSHIP BETWEEN DOCTORS AND PATIENTS

The perceptions of doctors and patients about the relationship between them generate concern. The absolute trusts that most patients manifest on their doctors without almost any concern or complaint about performance is preoccupying. One reason to explain this could be the lack of knowledge that patients have about appropriateness in obstetric care, as well as about the benefits and risks of some obstetric procedures. The fact that doctors recognise the influence that patients' demands can have on their medical decisions aggravates the situation, as there seems to be room for doubts about whom holds the authority in the relation doctor/patient.

Although in a different context and type of health system, research has shown that women tend to use private care more than men for reasons such as encountered show that 'better care/attention', 'privacy' and 'convenience' (Wiles R., 1993). In the case of obstetric care in Punto Fijo the same reasons could be leading not only to prefer private care but also to dangerously accept their doctors' decisions as 'unequivocal'. More information about women's perceptions on their bodies and their reproductive health could help elucidate some of these concerns.

5.6. CAN THE PRIVATE SECTOR HELP TO IMPROVE THE CURRENT SITUATION OF THE PUBLIC SECTOR?

To answer this question considerations should be made on the fact that the majority of doctors interviewed currently work simultaneously in the public and private sector. Some of them have done so for many years and have witnessed the decay of public institutions. Therefore it should not be unfair to suggest that somehow they are responsible for the chaotic situation of public hospitals. Then, How could possibly the private sector contribute to solve the serious problems of the public sector ?.

The degree of participation of the private sector as provider of care has increased in recent years, and what the current proposal for reform seems to do is increase further the participation of private providers by financing private sector provision for

FIGURE SEVEN: The oil company. For good and for bad.

the under-served. Some authors would argue about what would be the best decision that policy makers should take and consider as one option the relocation of investment in the public sector in order to make it more competitive (Mc Pake B., 1997). In the context of the historical background of the health system in Venezuela any decision has to be considered with extreme caution.

5.7. PUNTO FIJO, THE GOLD MINE FOR PRIVATE OBSTETRICIANS

The reality of a place where demand for private obstetric care is high brings about the question of the extent to which the situation described in this study could be detected somewhere else in the country. Punto Fijo is not the only city where there are oil activities, therefore this situation would probably apply to other cities with high number of employees from the oil industry.

At the moment doctors seem aware of the advantages of this particular area, but also of the risks and consequences that this 'bonanza' can imply specially because insurance companies seem to be acting to protect their interests too.

Further research after the process of decentralisation is completed could reveal the trend in use of services. Will the public sector institutions do better? Will it be able to compete fairly with the private sector? I suggest that doctors, and in this case obstetricians will play a key role specially if they decide to advocate for a more

equitable health system rather than worrying about maintaining their interests within the private sector.

CHAPTER SIX

CONCLUSIONS

According to the doctors interviewed in this study the reasons why they opt to work in the private maternity care sector are mainly to have better opportunities for career development, a more organised and motivating working environment and the possibility of offering high quality health care services. Better remuneration appears to be a major advantage obtained from working in the private sector.

Doctors perceive obstetrics as a medical speciality where the use of technology and sophisticated procedures play a major role in determining the quality of obstetric care. They seem to neglect and disagree with some of the traditional skills and tools that characterise this profession.

The main differences between the practice of obstetrics in the private and public sectors lay on the availability of resources (especially technology, laboratory, special tests and sub-specialists), the characteristics of users of each health sector and the relationship between doctors and patients. Finally there are differences related to the organisational structure and culture predominant in each type of health care.

Obstetricians in Punto Fijo are not yet clear about what would be required from them in the new health system proposed. There has not been enough detailed information from the government health authorities. However, opinions varied between optimism and total eskepticism towards whether in such severe situation of the public sector institutions there is anything that the private sector can do.

RECOMMENDATIONS

- Further research in order to widen the information obtained in this research, specially concerning doctors' perceptions about specific obstetric practices and the way that they are currently being performed.

- Although against the nature of the 'market' concept, a regulatory system should be proposed at both external level by the government health authorities and internal level, at the places where private doctors work. This could be done through the introduction of medical audits within private institutions or by peer-group revisions on performance.

- Policy makers should be made aware of results of studies like this one in order to allow them take the appropriate measures to change the status quo. A good

way to start would be through the universities, by regulating the number of specialists graduating and so helping to regulate the 'market'.

- Health education guided to improve the knowledge of women in all aspects of reproductive health, especially those concerning obstetric interventions during pregnancy, labour and childbirth. The idea would be to increase awareness of the risks and consequences of such procedures and empower women to negotiate with their doctors on the decisions made on their bodies.

- The marked differences in the characteristics of patients that attend the public sector and those that use private health care suggest the existence of a 'two-class system' in the way obstetric care is delivered. In this respect a call for advocacy amongst obstetricians to contribute with the necessary inputs to improve the conditions of the public sector as a mean to achieve the desirable goal of a more equitable health system.

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APPENDICES

Punto Fijo, July 1998

Dr.....
Address.....

Dear Colleague:

I am currently pursuing a Master Course in Mother and Child Health at the Centre for International Child Health/Institute of Child Health, (University College London). The reason of my visit to Venezuela responds to the need to pursue a research project as part of the before mentioned course.

It is for this reason that I am approaching you in order to ask your valuable participation in my research project. The objectives aim at describing the current situation of maternity care services within the private sector in Punto Fijo Estado Falcón, as they are currently delivered. The research methodology proposed consists on an interview of approximately one (1) hour. For reasons of scientific rigor this interview must be recorded for later transcription and analysis.

The results obtained in this research will be presented to the University authorities as part of the course evaluation process. Nevertheless, I would like to inform you that confidentiality and anonymity of results will be guaranteed at all times.

If you agree to participate, please sign the annex to this letter.

Thank you very much for your important co-operation

Looking forward to working with you

Dr. Elizabeth Sáenz -Martínez

MD;Paed;MSc PHDC

Consent Form

I.....agree to participate in the research project as proposed to me by Dr. Elizabeth Sáenz-Martínez and declare that I understand and accept the conditions that it implies.

Signature Date

REPUBLICA DE VENEZUELA

MINISTERIO DE SANIDAD
Y
ASISTENCIA SOCIAL

No. 03

Caracas 13 de Marzo de 1998.

Doctora
Elizabeth Sáenz M. de Martínez
Becaria CONICIT / BRITISH COUNCIL
Londres, Inglaterra.

Estimada Dra. Sáenz de Martínez:

Es grato dirigirme a usted a fin de comunicarle que he aceptado ser Monitor de su Tesis de Grado para optar a la Maestría de Salud Materno Infantil que actualmente realiza en UCL / Center for International Child Health, Londres, Inglaterra, titulada "Prácticas de los Proveedores de Salud en el Sector Privado en Salud Materna, Punto Fijo, Estado Falcón, Venezuela".

Cuente usted, con el apoyo que le brindará esta Institución a su importante trabajo que será de gran utilidad para el país, así como también que se realizarán los trámites necesarios para facilitar su labor a nivel regional.

Reciba mis más altas consideraciones y estima, por el esfuerzo que realizas. Saludos, quedo de usted, atentamente,

REPUBLICA DE VENEZUELA
Dirección General Sectorial de Salud
DIRECTOR
Dirección de Atención a la Madre, el Niño y el Adolescente
MINISTERIO DE SANIDAD Y ASISTENCIA SOCIAL

Dr. Luis A. Gazzotti L.
Jefe de la División de Crecimiento y Desarrollo
Dirección de Atención a la Madre, Niño y Adolescente

LAGL/bnt.
Marzo 1998.