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**EFFECTIVENESS OF PRIMARY CARE PROVIDED AT
MIDWIFERY PRIVATE CLINICS: NAKHONSAWAN PROVINCE**

SUMALEE KITTIPOOM

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สมิณันท์ทนาย

จาก

บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล

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**SUMALEE KITTIPOOM: EFFECTIVENESS OF PRIMARY CARE
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A descriptive study was conducted to determine the effectiveness of primary care provided at midwifery private clinics in Nakhonsawan Province. The sample consisted of nine clinics in three Amphurs which were random selected from fifty-five clinics in thirteen Amphurs with multi-stage sampling technique. A total 540 clients were recruited from nine clinics (sixty cases per clinic). Observation form, interview and self directed questionnaire were used to collect the data. The data were analyzed by SPSS program using percentage, frequency, mean and standard deviation.

Results of the study revealed that all of the midwifery private clinics were provided by professional nurses. Eight of them graduated with a Bachelor's degree in nursing and one, with a Master's degree. Six of them worked at community hospital, two at regional hospital and one was retirement. The average years of nursing experience were 22.44 years. The average working time of clinics were 5.22 and 10.44 hours on weekdays and weekends, respectively. There were on average 13.33 and 21.89 cases per day visited the clinic on weekdays and on weekends. The reasons for choosing those clinics were curable illness (67.8%) and the close vicinity to their home (60.2%). Most clients came to clinics with problems of respiratory system, presenting of fever (21.8%), and sore throat, common cold or cough (19.8%). The second most common problem was musculoskeletal system with chief complaints of back pain, muscle pain or arthralgia (12%). The most common drugs used were analgesic (paracetamol 45%) and antibiotics (amoxicillin 21.3%) for 3-5 days of treatment. After 5-7 days follow up, the clients indicated that their illness recover (61.5%) and cure (34.1%). Only 3.1% and 1.3% reported the same and worsen, respectively. In terms of cost of service, it was found that the average service fee was 68.31 Baht per visit and 8.72 Baht on traveling expense. More than eighty percent (87.9-93.8%) of the clients were satisfied with the nurses' services in terms of gentleness, convenience, friendliness, sufficient time spent for suggestions, and counseling. Regarding the clients' expectation, 96.6% indicated that they would revisit the clinics next time if they were sick.

In conclusion, the findings of the present study clearly reflect the nurses' role in providing effective primary care in private practice or independent role to clients in community. The results should be applied and adjusted for the primary care policy by The Nursing Council of Thailand for the greatest benefit of the people.

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สุมาลี กิตติภูมิ: ประสิทธิภาพของการให้บริการสุขภาพระดับปฐมภูมิของสถานผดุงครรภ์เอกชนจังหวัดนครสวรรค์ (EFFECTIVENESS OF PRIMARY CARE PROVIDED AT MIDWIFERY PRIVATE CLINICS: NAKHONSAWAN PROVINCE). คณะกรรมการควบคุมวิทยานิพนธ์: ยุวดี ภาฯ, กศ.ค., สมจิต หนูเจริญกุล, RN. D.S.N. 107 หน้า ISBN 974-04-0995-4

การวิจัยนี้เป็นการวิจัยเชิงบรรยาย เพื่อศึกษาถึงประสิทธิผลของการให้บริการสุขภาพระดับปฐมภูมิของสถานผดุงครรภ์เอกชนจังหวัดนครสวรรค์ กลุ่มตัวอย่างเป็นสถานผดุงครรภ์เอกชนที่เปิดดำเนินการโดยพยาบาลวิชาชีพ ซึ่งได้จากการสุ่มตัวอย่างแบบหลายขั้นตอน (multistage-sampling technique) จากสถานผดุงครรภ์เอกชน 55 แห่ง 13 อำเภอ ได้จำนวนสถานผดุงครรภ์เอกชน 9 แห่งใน 3 อำเภอ และประชาชนผู้มารับบริการในสถานผดุงครรภ์นั้นๆ แห่งละ 60 คน รวมทั้งหมด 540 คน เก็บรวบรวมข้อมูลโดยใช้แบบสอบถาม แบบสัมภาษณ์ และแบบสังเกตการให้บริการ สถิติที่ใช้ในการวิเคราะห์ข้อมูล ได้แก่ การแจกแจงความถี่ ร้อยละ ค่าเฉลี่ยและส่วนเบี่ยงเบนมาตรฐาน

ผลการวิจัยพบว่า สถานผดุงครรภ์ทั้งหมดที่ศึกษามีพยาบาลวิชาชีพเป็นผู้ดำเนินการ จบการศึกษาระดับปริญญาตรี (8ราย) ปริญญาโท (1ราย) รับราชการในโรงพยาบาลชุมชน (6ราย) โรงพยาบาลศูนย์ (2ราย) และเกษียณอายุราชการแล้ว (1ราย) ระยะเวลาในการปฏิบัติงานด้านการพยาบาลโดยเฉลี่ย 22.44 ปี เปิดดำเนินการนอกเวลาราชการเฉลี่ย 5.22 ชั่วโมงในวันราชการ ส่วนวันหยุดราชการเฉลี่ยวันละ 10.44 ชั่วโมง มีผู้รับบริการในวันราชการ 13.33 ราย และวันหยุดราชการ 21.89 รายโดยเฉลี่ย เหตุผลของการมารับบริการของผู้รับบริการที่สถานผดุงครรภ์ คือ รักษาหาย (67.8%) รองลงมาคือใกล้บ้าน (60.2%) สำหรับปัญหาสุขภาพที่มารับการรักษามากที่สุด คือ ระบบทางเดินหายใจที่นำมาด้วยอาการไอ (21.8%) รองลงมาเป็นอาการไอ เจ็บคอ มีน้ำมูก (19.8%) ระบบที่รองลงมา คือระบบกระดูกและกล้ามเนื้อซึ่งมาด้วยอาการปวดกล้ามเนื้อ ปวดหลัง ปวดข้อ(12%) ยาที่ใช้รักษาเบื้องต้น ได้แก่ ยาแก้ปวดคลอไรด์ (พาราเซตามอล 45%) รองลงมาเป็นยาปฏิชีวนะ (อะม็อกซิซิลลิน 21.3%) โดยส่วนใหญ่ระยะเวลาที่ให้ยาปฏิชีวนะจะเป็น 3-5 วัน ในเรื่องของปัญหาสุขภาพของผู้ใช้บริการหลังเข้ารับการรักษา 5-7 วัน จะมีอาการดีขึ้น (61.5%) หาย (34.1%) คงเดิม (3.1%) แย่ลง (1.3%) ค่ารักษาพยาบาลโดยเฉลี่ย 68.31 บาท ค่าเดินทางโดยเฉลี่ย 8.72 บาท ผู้รับบริการมีความพึงพอใจในด้านความสุภาพอ่อนโยน ความสะอาดที่มารับบริการ ความเป็นกันเอง การให้เวลาและการให้คำแนะนำร้อยละ 87.9-93.8 และมีความตั้งใจจะกลับมาใช้บริการอีกร้อยละ 96.6 ผลการศึกษาแสดงให้เห็นถึง การมีศักยภาพของพยาบาลในการดูแลสุขภาพเบื้องต้นประชาชนในชุมชนได้เป็นอย่างดี และเป็นการประกอบอาชีพอิสระ (Independent or private practice) และสามารถนำมาเป็นข้อมูลเพิ่มเติมของสภาการพยาบาล ในการผลักดันให้เกิดการปรับเปลี่ยนนโยบายของการบริการสุขภาพระดับปฐมภูมิที่มีประสิทธิภาพ และก่อให้เกิดประโยชน์สูงสุดแก่ประชาชนอย่างแท้จริง.

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CHAPTER I

INTRODUCTION

Background and Rationale

World Health Organization (WHO) (1998) defined human rights for health as “ the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition ”. According to the concept of “ human-centered ” development under the 8th National Economic and Social Development Plan (1997-2001), human is a determining factor for the achievement of all aspects of the “human-centered ” development. Human health development, therefore, is a fundamental and key determinant for human potential development (NESDB, 1998).

Although public health centres, as primary care settings, have been established nationwide. There are still many health care problems, for example, in the rural area many clients do not follow steps in the referral system. The referral health system policy means the clients should receive health service at the primary care office in the community such as health centres at the first contact when they have health problems. If the health problems are complex or difficult beyond the primary care health personnels’ knowledge, skill, or facility, they should be referred to the higher care service level called the secondary health care, such as community hospital or general hospital in that region. If they need very intensive or subspecialty medical care, they go further to the tertiary level. Usually, the clients in the rural areas do not follow these steps i.e., they bypass the health centres and go directly to the general or

regional hospitals at first contact. A study by Pongsuphap and Preeda Taearrak indicated that the majority (70-80%) of these clients' health problems could be treated in the primary care units (Pongsuphap, Y., 1999: 95; Preeda Taearrak, et al., 2000: 23). This situation has an impact on the big hospitals as secondary and tertiary care levels, which makes these hospitals crowded with patients. The quality and standard of care in these hospitals can not be developed. Moreover, most of the health care services still focus on "disease care" not "human care" and lack of "holistic care". Consequently, the costs of national health expenditure are rising. It was estimated that health care cost was about three hundred billion Baht per year and it increased about 10% per year. In contrast, a number of the Thai population still died early from preventable causes such as heart diseases, cancer, accidents and AIDS (Nittayalumpong, S., et al., 1999: 34-36; Preeda Taearrak, et al., 2000: 1; Prawade Wasi, 2000: 8). This is not cost-effective in the health care system in view of health economics. In addition, there were thirty percent of the Thai population who do not have access to basic health care (Health Care Insurance Department, Ministry of Public Health, 1995).

Recently, it has been well accepted that the key to achieve people's good health is the efficiency of its primary care service. Primary care is widely perceived as the backbone of the national health service system (Starfield, 1994: 1129). It is the first level of contact with individuals, the family and the community in the national health service system. It brings health care as close as possible to where people live and work, and it contributes the first element of a continuing, comprehensive and coordinating health care process (Starfield, 1994: 1129; IOM, 1994 cited by Hanna, 1996: 339).

Health Centre is a subdistrict or village level first-line health service unit, covering a population of about 1,000 to 5,000 people with health staff including a male health worker, a midwife and a technical nurse. Services provided at this level include health promotion, disease prevention and simple curative care (Wibulpolprasert, S., 1999: 195-197). However, there are many problems in terms of the quality and standard of services at this level, because it does not meet clients' expectations. Dissatisfaction of clients at this service level is composed of complaints about personnels' manner, short service time, inconvenience, lack of skills, equipment, quality and supply of drugs (Laeoprapai, B., & Sirirasamee, B., 1988: 105-110; Pongsuphap, Y., 1999: 2, Sawangdee, Y., et al., 2000: 160; Supatra Srivanichakorn, et al., 1999: 10; Taweekiat Boonyapaisancharoen, 1993: 30). Other factors determined the health services used were numbers of visits to clinics, distribution, and location of the service units, clients' satisfaction, convenience, type of services, quality of treatment (Aday & Andersen, 1975), and accessibility (Darunee Jamjuree, 1999: 77).

A midwifery private clinic providing service by professional nurse has become the alternative choice for clients, especially in rural areas. According to a study of Noonin and colleagues (2001: 86-106), most of the clients (>90%) were satisfied with the care provided by professional nurses at nine midwifery private clinics in the Southern part of Thailand. In addition, the study concluded that professional nurses who provided primary care service were accessible, affordable and effective. The Nursing Council of Thailand reported that most of the desired-health personnel providers at the primary care unit were professional nurses (Boonthong, T, et al., 2000: 55-56), and the study by Preeda Taearrak and colleagues

(2000: 39-62) also supported that professional nurses were the first primary care service health provider (63.7%).

In Thailand, there are limited studies on the effectiveness of private clinic care services. Three studies were conducted at medical clinics provided by doctors (Nittayalumpong, S., et al., 1999; Ophakin, P., 2000; Sanpirom, S., et al., 1993) and only one study was conducted at nine midwifery private clinics which provided primary care by professional nurses in the Southern part of Thailand (Noonin, N., et al., 2001: 86-106). The other parts were not mentioned. The researcher is interested in investigating the effectiveness of primary care at midwifery private clinics in Nakhonsawan Province in the lower Northern part of Thailand. Nakhonsawan is a province located between the Northern and the Central part, and it is divided into 13 Amphurs and 2 Sub-Amphurs. The public health services are composed of one large regional hospital, twelve community hospitals and one hundred eighty-five health centres. In addition, in 2001, there are fifty-five midwifery private clinics staffed by professional nurses which were recorded on the list (Nakhonsawan Provincial Health Office, 2000).

The purpose of this descriptive study was to determine the effectiveness of primary care provided at midwifery private clinics in Nakhonsawan Province. This study could expand the knowledge of primary care system in Thailand and could provide data for The Nursing Council of Thailand to drive and adjust the national health policy about professional nurses' roles in primary care service.

Conceptual Framework

The research framework in this study is derived from three concepts; primary care, independent nursing practice and effectiveness of care.

Primary Care

There are two terms, which usually cause confusion and sometimes are used interchangeably but actually they are different in definition, origin, and philosophy. These are “ Primary Health Care ” (PHC) and “ Primary Care ”(PC). PHC was coined by the WHO and UNICEF in 1978 and is known as the Alma-Ata declaration, whereas PC was born in the United State of America (USA) when the role of the pediatric nurse practitioner was extended as a physician extender on the health care team in 1965 (Barnes, D., et al., 1995: 8-9). WHO defined PHC as “ essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible through their full participation and at a cost that the community and country can afford ” (WHO, 1981). On the other hand, in 1978, the Institute of Medicine (IOM) defined primary care as having the functions of improved accessibility, continuity, comprehensiveness, coordination, and accountability (Institute of Medicine, 1978). More recently, the IOM re-examined early definitions of primary care as a first step toward projecting the future of health care in the United States. The revised definition of primary care includes many elements originally introduced but added a focus on the family and community contexts in which care should be provided: *Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community* (Institute of Medicine,

1994: 16). Central to this definition is the patient-clinician partnership that is formed and the specific description of each person in this relationship. Moreover, McGivern (1990) defined PC in sense of advanced practice of nurse practitioners as “ delivery of a complex set of services, which include the first contact and the maintenance care. It assumes responsibility for referral to distinct services in response to the client needs and cultural values ”. In brief, the principles of PHC tend to be publicly driven, universally available regardless of payment source, client directed, community participates, focus on preventive health care, and professional role as facilitator or consultant. By comparison, the elements of PC tend to be driven by private-for-profit sector with a primary focus on treatment and restoration, and is provider directed and the professional roles as experts or providers. Barnes and colleagues (1995: 8) had suggested that PC could fit within the broader philosophy of PHC as a component rather than as a replacement. In addition, The Nursing Council of Thailand (1999) had modified the definition of the primary care concept for Thailand. Primary care is defined as the basic health care service, which provides care to all stages of people’s health status from well-being people to people at risk to sick people. The service provides continuing and holistic care that includes health promotion, disease prevention, primary treatment and rehabilitation and is based on people and family self-care development, folk knowledge and community participation. It also connects to other resources and services with referral patients for appropriate care. The scope of primary care can be served by professional nurses who are the back bone of health services and “ already constitutes up to 80% of the qualified health work force in most national health systems ” (Burndtland-Director General, WHO, 1999). In addition, nurses are well prepared to assess and manage health problems of the people in the

community independently and it has for a long time in the history of nursing professional development.

Independent Practice

The independent or private practice means that nurses by themselves can provide health care services at their clinics and take responsibilities for their services. The characteristics of independent nursing practice include nurse ownership, financial/legal responsibility and full accountability for the quality (Aydelott, Hardy & Hope, 1988 cited by Synder & Mirr, 1995: 253-267; Keller, 1975 cited by Stewart, 1989: 438). According to the American Nurse Association (ANA, 1986), this private practice means “Nursing Autonomy” more than just practicing in an institute because nurses have their own decision making and responsibility in providing care (Sheehy & McCarthy, 1998: 35). In addition, Keller (1975) also defined private practice as the practice of nursing within a business framework that is partially or wholly owned and operated by the nurse providing service. In the survey about reasons for choosing private practice of the clinical nurse specialist (CNS) in USA, many of them believe that “autonomy”, often is regarded as the hallmark of a profession, which will be more effectively achieved in private practice (Kinlein, 1977 cited by Hamric, A.B.& Spross, J.A., 1989: 437). Moreover, “job satisfaction” has been studied as a way to help improve the quality of the workplace for nurses, as well as the quality of health care. The improvement of quality in both areas may lead to a decrease in nurse turnover. Decreased turnover improves productivity and efficiency in the delivery of health care (Hupcey, 1993: 181). There were many studies about the factors that influence nurse practitioners job satisfaction resulting from external factors related to autonomy, a sense of achievement, and patient care activities which increased

satisfaction (Bullough, 1974; Koelbel, et al., 1991; Linn, 1975; Sultz, et al., 1984; Tri, 1991) which ultimately would increase the effectiveness or improve the outcome of care.

Effectiveness of Care

The effectiveness of care can be evaluated in term of outcomes of care, which is defined as the result of care that can be measured with many indicators. Jennings, et al (1998: 381-388) had reviewed the outcome literature published since 1974 from medicine, nursing, and health services research and classified outcome indicators into three groups as patient-focused, provider-focused, and health care organization-focused categories. The main focuses of outcomes of care in this study are the patient-focused outcomes and health care organization-focused outcomes.

The patient-focused outcome category comprises two subsets of indicators. One is a diagnosis-specific indicator, and the other is a holistic indicator. By definition, diagnosis-specific indicators measure a disease state or physical condition and are measured at a discrete level providing information about changes in a patient's condition. These indicators show whether illnesses, diseases, or injuries are improving or worsening and are specific to the condition or disease being evaluated, such as laboratory values, results of tests or clinical signs and symptoms. They do not address the patient as a whole person with illness, disease, or injury. By contrast, holistic indicators extend beyond disease boundaries to show how well the person is living with a particular problem, regardless of laboratory values. These indicators measure a person's responses or adaptation to an alteration in health and are measured at a global level to provide objective and subjective information about domains. Holistic indicators relate to specific diseases, but the person's response, not the illness, is the

focus. These indicators include overall measures of health status/health-related quality of life, the person's functional/performance status, self-reports of knowledge or satisfaction, and symptom management (e.g., pain, fatigue, nausea) (Jennings, et al., 1998: 381-388). In this study, the researcher measures the clients' outcome as patient-focus outcomes that is comprised of two indicators; diagnosis-specific indicators and holistic indicators. The diagnosis-specific indicators in this study include outcome of care as cure, recover, the same or worsen of health problems. The holistic indicators include clients' satisfaction and expectation to revisiting the clinics at the next time.

The health care organization-focused outcomes show quality of care delivered by the institution as a whole. The example indicators are access to care, cost of care, length of stay, morbidity and mortality. In this study, the researcher also measures the clinics-focused outcome as cost of service.

In conclusion, the framework of this study is derived from three main concepts; primary care, independent practice and effectiveness or outcome of care. The primary care concept provides the scope of nursing practice at the level where people reside. This practice includes health promotion, disease prevention, primary treatment, rehabilitation and are holistic in nature. Professional nurses could provide this scope of practice independently with the people in community and other health care providers. To fully respond to these health care needs of the people especially in remote areas, nurses organized and ran their own private clinics in which they have accountability for the financial and legal responsibility and the outcome of care. However, this private practice should be evaluated for the effectiveness of care so that they can be integrated into the National Health Care Reform of the country.

Objectives

The objectives of this study are to:

1. Investigate the primary care service provided by professional nurses at midwifery private clinics including the reason for running the clinic, the health assessment, the care activities, the problems and the obstacles to health care service.
2. Investigate the clients who attended the clinics including health problems, the cost of service, the reason for choosing the clinics, the clients' satisfaction, the outcome of care and the expectation to revisiting the clinics.

Research Questions

The research questions of this study are:

1. For the primary care service provided by professional nurses
 - 1.1 What are the nurses' activities that are provided by the professional nurses to their clients?
 - 1.2 What are the nurses' reasons for running their own midwifery private clinics?
 - 1.3 What are the nurses' health service problems and obstacles?
2. For the clients who attended the clinics
 - 2.1 What are the clients' reasons for choosing these midwifery private clinics?
 - 2.2 What are the chief complaints or health problems of clients who come to these clinics?
 - 2.3 How much is the service fee?
 - 2.4 What is the level of clients' satisfaction?

2.5 What are the outcomes of care and the expectation to revisiting the clinics?

Significance of the Study

The expected outcomes and benefits of this study are to:

1. Provide basic information to health care policy committees for developing optimal health service delivery that meet clients' need.
2. Provide the results of the study to develop the efficient primary care service that improves clients' satisfaction.
3. Provide the results and suggestions about the private primary care practice of professional nurses.
4. Promote the concept and extended role of professional nurses in private primary care practice to general clients' acceptance.
5. Provide the results and suggestion for expanding the practice of professional nurses under The Professional Nursing and Midwifery Act B.E.2540.
6. Provide the base line data for further primary care research.

Scope of the Study

This is the study of the effectiveness of the primary care service provided by professional nurses at midwifery private clinics. The sample of the study is the midwifery private clinics, which are owned by professional nurse providers and the clients who come in nine presently active midwifery private clinics in Nakhonsawan Province. The duration of the study is from March to May 2001.

Definition of Terms

Midwifery Private Clinic is defined as a clinic that provides primary care and is owned by professional nurse that practice privately under The Professional Nursing and Midwifery Act B.E.2540 and Sanatorium Act B.E 2541.

Health Service Activities are defined as the actions related to practice with clients such as taking the history of clients' illness, physical examination, provisional diagnosis, drug prescription, minor operations and procedures, consultation, teaching, disease prevention, health promotion, referral and home visit etc.

Clients' Health Problems are defined as symptoms and / or signs of illness that bring them to the midwifery private clinic.

Cost of Service is defined as the service fee, transportation charge and other clients' expense upon receiving service from the clinics per visit.(Baht)

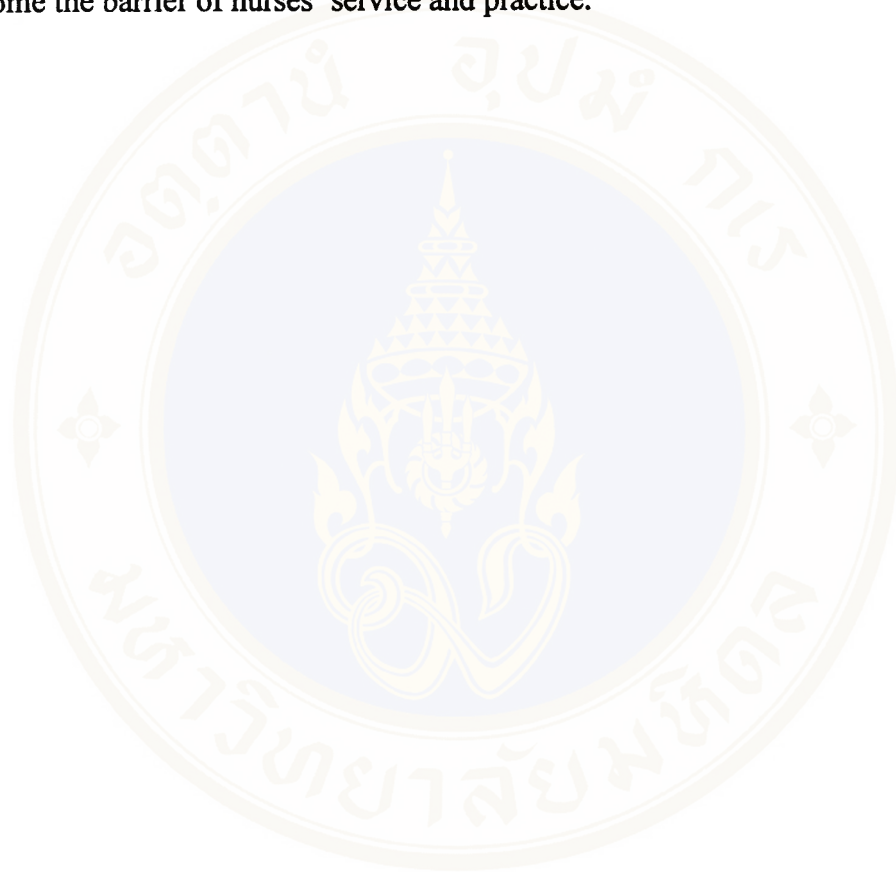
Effectiveness of Primary Care is defined in three dimensions; clients' satisfaction, the outcome of care, and the expectation in using services next time.

Clients' Satisfaction is defined as the feelings or comments of clients about their services categorized by the nurses' relationship and characteristics, treatment and service fee, which are rated as good, uncertain (not sure) and bad.

The Outcome of Care is defined as the result of care as in the feelings of clients' health problems 5-7 days after the last visit to the clinic. They answer the question as "cure", "recovery", "same" and "worsen". Cure means they felt that their problems disappeared. Recovery means they felt that they got better. Same means they felt the problems did not change. Worsen means they felt that the problems were worse than before or they had complications.

Clients' Expectation to Revisiting the Clinic is defined as the clients' willingness to receive the service again in the future if they have the health problems, by answering the question as “ yes ” or “ no ”.

Nurses' Problems and Obstacles are defined as the main problems that become the barrier of nurses' service and practice.



CHAPTER II

LITERATURE REVIEW

This chapter presents a literature review of various published research or articles that are classified as the following:

1. Level of Health Service System in Thailand
2. Primary Care Service
 - 2.1 Definition
 - 2.2 Characteristic of Primary Care Provider
 - 2.3 Primary Care Unit in Thailand
3. Primary Care Provider in Thailand
 - 3.1 Nurse
 - 3.2 Doctor
4. Effectiveness of Service

Level of Health Service System in Thailand

Health service systems in Thailand are classified into five levels according to the level of care as follows (Wibulpolprasert S, 1999: 195-197);

1. Self-Care Level. Services at this level include the enhancement of people's capacity to provide self-care.

2. Primary Health Care Level. The primary health care services include those organized by the community for providing services related to health promotion, disease prevention, curative care and rehabilitative care, using medical and health

technologies that are appropriate to community's needs and culture. Service providers at this level are Village Health Volunteers (VHV's) or other private sector volunteers who will normally have a linkage with other government health service programs.

3. Primary Care Level. This level of care includes medical and health services provided by medical and health personnels at various health units as follows:

3.1 Community Health Posts. A community health post is a village level health service unit established in remote area, covering a population of 500 to 1,000 people and staffed by just one community health worker (an MoPH permanent employee). Services provided at this level include health promotion, disease prevention and simple curative care.

3.2 Health Centres. A health centre is a subdistrict or village level first-line health service unit, covering a population of about 1,000 to 5,000 people with health staff including a male health worker, a midwife and a technical nurse. The MoPH is now in the process of assigning additional staff (a dental auxiliary, a professional nurse, and a health specialist) to each large health centre. Services that are provided at this level also include health promotion, disease prevention, and curative care. Health centre staff run health programs according to the standard procedures established by the MoPH, under the technical supervision and support of the community hospital.

3.3 Health centres of municipalities, outpatient departments of public and private hospitals at all levels, and private clinics. At these facilities, outpatient care is provided by doctors and other health professionals.

4. Secondary Care Level. Health care at this level is provided by medical and health personnels with various degrees of specialization. General and specialized

facilities include the following:

4.1 Community Hospitals. A community hospital is located in a district or subdistrict with 10 to 120 inpatient beds, covering a population of 10,000 people or more. Medical and health personnels give more emphasis on curative care, as compared to those at primary care facilities.

4.2 General or Regional Hospitals and other large public hospitals. A general hospital in this category is equipped with 200 to 500 beds, while a regional hospital has over 500 beds and medical specialists in all fields.

4.3 Private Hospitals. Most private hospitals are run as a business entity with both full-time and part-time staffs, and the clients are required to pay more money for convenient services.

5. Tertiary Care. Health services at this level are provided by medical and health personnels, a number of whom are medical specialists. Tertiary care facilities include 1.) general hospitals, 2.) regional hospitals, 3.) university hospitals, and 4.) large private hospitals (generally with over 100 beds and medical specialists).

In addition to services at the five levels mentioned above, there are other health services outlets such as private pharmacies and non-MoPH public hospitals, such as those under the Bangkok Metropolitan Administration. The classification of health facilities mentioned above is rather rough since actually tertiary care facilities also provide primary care. Moreover, self-care in nursing must be integrated at all various levels but the intensity depends on the level of self-care and dependent care deficit.

Furthermore, the midwifery private clinics staffed by professional nurses are one of the private clinic groups in primary care level that are mainly located in rural

areas. However, in the general sense of people, especially in urban areas, the private clinic means care is provided by the doctor.

Primary Care Service.

1. Definition of primary care.

The term Primary Care (PC) was born in the USA when the role of the pediatric nurse practitioner was extended as a physician extender on the health care team in 1965 (Barnes, et al., 1995: 8-9). In 1990, McGivern defined PC in sense of advanced practice of nurse practitioner as “ delivery of a complex set of services, which include the first contact and the maintenance care. It assumes responsibility for referral to distinct services in response to the client needs and cultural values ”. Furthermore, the definitions of primary care have included first-contact care (White, 1967 cited by Davis & Gilliss, 1998: 117) and longitudinal responsibility for a patient, including integration of both health and disease services (Alpert & Charney, 1973 cited by Davis & Gilliss, 1998: 117). The Institute of Medicine (IOM) defines primary care as having the functions of improved accessibility, continuity, comprehensiveness, coordination, and accountability. (Institute of Medicine, 1978). More recently, the IOM re-examined early definitions of primary care as a first step toward projecting the future of health care in the United States. The revised definition of primary care includes many elements originally introduced but added a focus on the family and community contexts in which care should be provided: *Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community* (Institute of Medicine,

1994: 16). In brief, in USA, the elements of PC tend to be driven by private-for-profit sector, with a primary focus on treatment and restoration, and are provider directed and professional role as experts or providers.

In Thailand, Boonyaphisancharon, T. (1999: 65) defines primary care as the first contact care that combines social service and technical service together. The service should be holistic, continuity, and integrated care provided by the competent health care provider who is developing a partnership with patient, family and community. Aree Wanlayasaewee and colleagues (1999: 87-88) added to the definition that primary care involves the target and optimal size of responsible population for care. Health care providers should have efficient communication skills even at or out of the office place. Moreover, Preeda Taerarak and colleagues (2000) focused on characteristics of services that cover physical, mental and spiritual of individual patient and also the community. However, The Health Care Reform Project of Thailand also included these characteristics to the definition of primary care service. It includes availability, accessibility, acceptability, holistic care, and continuous care to the people and community (Supratra Srivanichakorn, et al., 1999: 6). Moreover, primary care service should provide an integrated health care system that is possible with these conditions: 1) located in a community, 2) gives service to optimal number of clients, 3) works as the quality health team, 4) has a suitable working place, 5) provides regular service, 6) provides consultation of the referral system to the client (Boonyaphisancharon, T., 1999: 68-69). Finally, The Nursing Council of Thailand (1999) had modified the definition of primary care concept for Thailand. Primary care is defined as the basic health care service that is provided to all stages of people's health status from well-being people to people at risk to sick

people. The service provides continuing and holistic care that include health promotion, disease prevention, primary treatment and rehabilitation and is based on people and family self-care development, folk knowledge and community participation. It also connects to other services by referring patients for appropriate care.

In conclusion, the definition of primary care is the accessible first-contact care focusing on the holistic care concept which covers health promotion, disease prevention, rehabilitation, chronic care and primary treatment with an optimal expense and provides a proper referral system.

2. Characteristic of Primary Care Provider.

The characteristics of a primary care provider as mentioned by Preeda Taearrak, include: (Preeda Taearrak, et al., 2000: 11-12)

1. Skills in physical and mental health assessment, diagnosing health problems and providing a medical treatment to clients with common health problems, emergency conditions, included managing the referral system properly.

2. Giving service in a holistic care manner.

3. Combining various dimensions of health care including treatment, prevention, rehabilitation, restoration and promotion of health to individuals, family and community.

3. Working together with the community and creating an effective communication and consultation system.

4. The provider's concept of health should be well being in physical, mental, social and spiritual. The understanding of community health status is also required.

The professional nurse should be the first choice to be a primary care provider,

because of various reasons such as nurses are the major part in the health care team, working at all levels of care, in shorter time and with a lower cost of production. Moreover, a study done by Preeda Taearrak, et al. (2000) involved interview and survey with health experts, health personnel, and health consumers about who should be primary care providers. Most of people in various groups agreed that professional nurses should be the appropriate providers. This result was congruent with the study done by The Nursing Council of Thailand (Boonthong, T., et al., 2000: 55-56).

3. Primary Care Unit in Thailand.

There are many primary health care units in Thailand as classified into government and non-government or private sector. The government sector includes community health posts, health centres, health centres of municipalities and urban health centres. Furthermore, the private sector includes medical clinics, midwifery clinics and pharmacy stores.

3.1 Health Centre.

The health centre is the most closet unit to the clients especially in rural area that provides care by health personnel including health worker, midwife and technical nurse. Presently, there is enforcement in assigning additional staff such as professional nurse or dental auxiliary (Wibulpolprasert, S., 1999: 162). The main task is integrating primary health care service in and out of the office and covering an estimated 1,000–5,000 clients per area (Boonreang Chuchaisangrat, 1996: 91; Pookpun, J., 2000:2). They work under the District Health Organization and work collaboratively with the District Health Committee. The health centres are nationwide covering every village in Thailand, although many clients do not like this service. In fact, most of care provider lack basic knowledge and skill (Taweekiat

Boonyapaisancharoen, 1993: 30; Leoprapai, B. & Sirirasamee, B., 1988: 105-110; Pongsuphap, Y., 1999: 2, Sawangdee, Y., et al., 2000: 160; Supratra Srivanichakorn, et al., 1993: 112). The subsequence is the clients seek to receive service at far away hospitals. The distribution of health care units do not match with the people's needs, resulted in crowded and overutilization of some health care settings.

3.2 Health Centres in Municipalities/Bangkok

3.2.1 Health Centres in Bangkok

They are first contact units for the client in Bangkok. Most of the clients are underserved and poor people (Viroj Tangchareonsatean, 1996: 1). The percentage of service is divided into promotion/prevention and treatment, equal to 75% to 25% respectively (Boonthong, T., 2000: 22). The proposed health care providers consist of doctors, dentists, professional nurses, pharmacists and social workers. At present, there are only 23 centres out of 61 centres that have doctors working. However, there are professional nurses working in every centre. There are also health centre branches distributed in all areas in Bangkok. There are 81 units in which only one nurse takes care and provides service in "Nurse-run health centre" manner (Boonthong, T., et al., 2000: 53-54). In a survey done by Supratra Srivanichakorn, et al (1996), it showed that the visiting rate per client was very low as 0.3 hit/year in 2537 B.E. The average number of clients was 60 people/day. The main task was primary treatment more than prevention and promotion service.

3.2.2 Health Centre in Municipalities

There are many health centres in municipalities distributed in Tampol and district parts of Thailand, which provide service care for people in urban areas and out of Bangkok. They work under the division of Ministry of Interior and are support by

the Ministry of Public Health. The main task is sanitary. The primary care just takes a little part of service including vaccination, prevention program and outpatient treatment (Supratra Srivanichakorn, et al., 1999: 51). There are also a few clients receiving service care at the center, i.e., 65, 14 and 7 cases/day in large, medium and small municipalities health unit respectively (Pornthep Sririvanarangsarn, et al., 1998: 86). There are many problems about the health service in these centers, such as limited resources, uncleared health policy, personnel role in efficient management, coordination, low salary, and lack of adequate support (Pornthep Sririvanarangsarn, et al., 1998; Supratra Srivanichakorn, et al., 1993: 112).

3.3 Urban Health Centre

This centre is the outpatient, small health office service that provides comprehensive health care. The comprehensive health care is characterized as simple general treatment care, disease prevention, health promotion, with no specialty care and only outpatient services that located in urban areas (Supratra Srivanichakorn, et al., 1999: 47). The prototype of this service was “ Ayutthaya Urban Health Center ” which was developed by The Health Care Reform Project in 2532 B.E. The differences of these services from others are the integrated-continuity-holistic care and home-visiting care. Due to the clients’ acceptance and popularity, this model expanded to other provinces such as Nakornrachasrima, Khon-Kaen, and Songkhla (Pongsuphap, Y., 1999; Supratra Srivanichakorn, et al., 2000). The concept of these types of services brings about primary care service in connection to the general and regional hospitals.

3.4 Pharmacy Store

Thai people usually buy medicine from drugstores, and have self-treatment.

In rural areas, 31.7% of people do in this manner as compare to 17% of people in urban areas (Wibulpolprasert, S., 1999: 213). The variety and quality of services are the problems of these stores, therefore the people take health risks and non-cost effectiveness (Supratra Srivanichakorn, et al., 1999: 56).

3.5 Private Clinic

In Thailand, there are many private clinics, which provide care by various types of health personnels such as doctors, dentists, nurses, or midwives. From 2531 B.E. to 2540 B.E. there was a three-time rise of clients seeking services at private clinics (Division of Health and Plan, 1997 cited by Nittayalumpong, S., et al., 1998: 59). At present, there are 8,497 clinics distributed though out Thailand, which include 5,483 medical clinics, 1,582 first level midwifery clinics and 1,432 second level midwifery clinics (Medical Registration Division, 1999: 42). Presently, services to people in private clinics include health promotion, disease prevention, treatment and rehabilitation which depends on the facilities of the individual clinic. Some clinics provide services to both inpatients and outpatients, whereas others provide only outpatients. The office hours are either full-day opening or part-time opening (Nittayalumpong, S, et al., 1999: 23). The major purpose of opening private clinics is for commercial service, a few are free social service. According to the Ayutthaya's Project, the private doctor clinics had shown that the services lacked continuity of care, disease prevention, health promotion and community care services. They also practiced over treatment, with a less efficiency referral system and less communication with clients. The consequence was the patient shops for treatment from clinic to another clinic (Sanphirom, S., 1993: 2). The same results were shown by Nittayalumpong and colleague' s study in 1999 (Nittayalumpong, S., et al., 1999:

23). The main defect of private doctor clinics was lack of integration of prevention and treatment in health care. One study conducted in a rural area found that the professional nurses at private clinics provided integrated health care at affordable prices and was effective care (Noonin, N., et al., 2001).

Primary Care Provider in Thailand

1. Nurse

In Thailand or other countries, there are professional nurses who provide primary care both in government hospitals and in private clinics. The author would like to discuss only the professional nurse in Thailand as compared to the nurse in USA.

In Thailand, by the Act, the professional nurse could provide only nursing practice in government hospitals or government health sections. In the study by WHO and the Nursing Department of Ministry of Public Health in 1970, they studied the tasks and activities of professional nurses in general hospitals. They found that upcountry nurses spent 45% of their working time on technical procedures and basic medical care that was beyond their responsibility according to the law. The problems of shortage of the doctors and mal-distribution of doctors in rural areas increased in severity. Thus, there was alertness for including this extending role of professional nurses by a conference organized by The Nursing Association of Thailand in 1972 (Nursing Association of Thailand, 1972: 649-656). The training course of the Nurse Practitioner (NP) was established in 1973-1974 with the objective to produce NP who could provide basic medical care, basic medical treatment and screening skills to patients (Pensri Phichaisanit, 1977: 1-2; Raweewan Chanwate, et al., 1985: 9). The following study had found the patient's satisfaction was up to 99% with the NP

(Penchan Monaiyapong, et al., 1982). In addition to the survey of physicians' and nurses' role, the conclusion was in agreement that production and practice of NP to work in an area that had no doctor or in common or emergency situations did not go beyond the law (Yuwadee Luecha, et al., 1977; Raweewan Chanwate, R., et al., 1985).

In 1989, The Health Care Reform Project of Thailand had launched the pilot project named " Ayutthaya Urban health Center ". The proposed project was to provide holistic primary care service in an urban area by a doctor. As a result of the success of this first service, the second established health center was named "Pompetch Health Center ". The second center faced the problem of lack of full-time doctors to work continuously. They utilized the nurses to work instead of the doctors. The clients' acceptance and directed-service to community needs are the result of this project (Onchoenjit, S & Pantong, U, 2000: 80). The distinguished tasks by the nurses that differ from the doctors were the home visit care service. The activities of home visiting care service included health care consultation, health education, good communication with the patients and relatives, facing the patient's real life and behavior and making a good relationship together (Nipon Sermpnich, 2000: 850; Surakiat Archananuphap, 1999: 83-84).

Like in the USA, over the past century, various social, political and economic forces within American society have shaped the roles of advanced practice nurses. Consequently, nurses needed to have more knowledge and expertise in particular areas. This advanced practice in nursing also involved nurses' role in primary care. In reality, it encompasses multiple types of nurses in advanced roles in the USA. These roles include Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA) and Clinical Nurse Specialist (CNS). Each of

these roles was developed individually at different points in the past century. The need for NP was increasing because of the influence from many factors such as the shortage of primary care physician (which was critically severe in the 1960s and 1970s), the growing concerns about unmet needs in primary care, the increasing of health care budget, the policy of disease prevention more than curative and the rights of equal access to health care for all consumers (Fitzpatrick, 1998: 106-107). There is the regulation to clearly identify the qualifications and the role of NP, that they must graduate with a master degree in nursing and choose their major to be NP. NPs are educated in order to practice independently and interdependently in collaborative practice arrangements (Hamric, et al., 1996: 33; Hanson, 1996: 338). As primary care generalists, NPs employ a population-based perspective to care for individuals, families, and communities. NPs have major roles in health promotion, disease prevention, service coordination and acute and chronic disease monitoring (Sheehy & McCarthy, 1998: 126). The average of health cost provided by NPs was less than the physician by about 20-24% (Avorn, 1991; Brown & Grimes, 1993; Nichols, 1992; McGrath, 1990 cited by Gallagher, 1996: 30; Salkever, et al., 1982 cited by Mundinger, 1994: 213). Furthermore, NPs had equal quality of primary care to that of physicians (Mundinger, et al., 2000: 59-68), and most private insurance companies and health maintenance organizations cover the services of NPs (Aiken, et al., 1993: 172; Mundinger, 2000: 212).

Therefore, the main different characteristics of primary care provided by NPs in the USA as compare to Thailand is the independent or private practice under laws and level of education. NP in the USA earns a Master's degree level, works independently and prescribes medications in almost every state under the law

(Pearson, 2001: 7). In addition, the nurses in Thailand can practice in coordination with the physician under laws and earns at least a Bachelor's degree. In reality, some basic medical care in private practice by nurse presently is illegal.

2. Doctor

Physicians are the people who are prepared to give medical care to people including primary care. Though, there is one branch of medical specialty training called " General Practitioner " or " Family Medicine ", but in fact, less physicians choose to be trained in this specialty. In Thailand, the numbers of general practitioners (GP) are decreasing in contrast with other specialists. In 2522 B.E, GP were 79.19% of the total number of doctors, and they decreased to 55.39 % in 2542 B.E (Thai Medical Council, 1999 cited by Preeda Taearrak, et al., 2000: 25.). World Bank had suggested that in developing country the number of GP should be more than 75%. The reason was if the specialists were the main primary care providers the health cost would be too high (WHO, 1993 cited by Aree Wanlaysiaewee, et al., 1999: 48). In rural areas, the problem of deprivation of doctors at community hospitals is still important (Nittaylumpong, S., 1998: 42). The data from Health Policy Department of Ministry of Public Health demonstrated the difference between the ratio of doctors to people in various parts of Thailand, in the North 1:5,824, the Northeast 1: 10,805, the South 1: 5,510, the Central 1: 4,042 and Bangkok 1: 1,000 (Division of Health Policy and Plan, 1995). This problem is a barrier to the development of better health care service. If the health system depends on only doctors to be the key health provider in the future, it will take a long waiting time at least 10 years-for producing a doctor (Nittayalumpong, S., 1998: 42). So, the alternative good choice for health providers should be the professional nurses as the primary care providers who, really,

practice in primary care service at the present time and are more than doctors in comparison (Boonthong, T., et al., 1999; Aree Wanlaysiaewee, et al., 1999: 48; Preeda Taearrak, et al., 2000).

In the USA, there are “ nurse practitioners ” (NP) work in primary care as substitutions to the physician. The popularization of NP is accepted more than the physician. The lower cost of service and the equally good health outcome are the real reasons to permit NPs’ practice alone in primary care settings (Cooper, et al., 1998: 790-791).

Effectiveness of service

There are many concepts in the evaluation of the effectiveness of service among various studies. Gibson, et al. (1979 cited by Sompongsa, S., 1999: 28) had found that the indicators of the effectiveness of an organization included productivity, efficiency, satisfaction, adaptiveness, and development. The classification of evaluation of the effectiveness of nursing service proposed by Donabedian (1980 cited by Loeken, et al., 1997: 732) had three assessments: (1) the process assessment – a measure of humanness and informativeness, (2) the structure assessment – measure of accessibility and continuity, (3) the outcome assessment – measure of quality of care, cost of care and thoroughness.

The effectiveness of the task is considered by the means of success in the expected outcome (Suwihan, P., 1990: 33; Kaewying, K., 1996: 94). In the health service, effectiveness means that the results of the task that can be decreased or solved or to develop better health care (Tongrhor Dechtai, 1997: 277). In primary care, the effective outcome refers to those people who are in good health status, have equal

access to receive care, and pay for health care service at an appropriate cost.

The other indicator for service effectiveness is clients' satisfaction. The word "satisfaction" is defined in different points of view. The American Heritage Dictionary of the English Language (2000) defined satisfaction as the fulfillment or gratification of a desire, need or appetite. Vroom (1964: 99) mentioned that attitude could replace satisfaction. Since the two words mean what resulted from the participation of a person in one particular thing. Positive attitude represented satisfaction, while negative attitude represented dissatisfaction. The other view as pointed out by Powell (1983 cited by Sompongsa, S., 1999: 28) defined satisfaction as the ability to lead one's life with happiness and enjoyment and free from the feeling of depression. Furthermore, Locker & Dunt (1978: 283) mentioned about the relation of understanding of the result of care and expectation of clients, while Risser (1975) described the previous experience of customers about the expected service that they had perceived. In addition, Donabedian (1980 cited by Ryden, et al., 2000: 237) asserted that clients' satisfaction was a significant indicator of the quality of care because it revealed the provider's success at meeting their value and expectation for which the client was the ultimate authority.

From the above meaning, it can be concluded that satisfaction means the positive feelings or favorable feelings of a person towards some things that met his need, reduced tension, made him feel happy and free from anxiety.

Therefore, clients' satisfaction can be defined as an evaluation of the quality of health care, which comes from the viewpoint of the recipient. The quality as perceived by the healthcare recipients was recognized. As a result of this focus, measurement of client perceptions has become absolutely important in the health care

service (Strsser & Davis, 1991 cited by Dansky, 1997: 166). Perceptions drive clients to select, use, and return to health providers (Dansky, 1997: 166). So, clients' satisfaction with health service is an important consideration. According to Pascoe (1983, cited by Ryden, et al., 2000: 237), the evaluation process included a cognitively based evaluation and effectively based response.

Many researchers proposed the dimension of clients' satisfaction. By 1975, Aday & Andersen described clients' satisfaction as convenience, courtesy of providers, medical information, quality of care, and cost of care (Aday & Andersen, 1975). Whereas Ware, et al. (1978) added the art of care, technical quality of care, finances, physical environment, continuity of care, and outcome of care. So, in 1988, Eriksen developed the measurement of patient satisfaction with nursing care that is composed of the art of caring, technical quality of care, physical environment, availability, and continuity of care and efficacy.

Furthermore, Chang (1997) had reviewed earlier studies of patient satisfaction with nursing care in the hospital setting and performed content analysis of published instruments and identified the dimensions and indicators of patients' perceived structure, process, and outcomes attributed to nursing care. These dimensions were: (1) physical environment, (2) availability of service, (3) technical skills, (4) art of care, (6) explanation of care, (7) continuity of care, (8) specific outcomes of care, (10) overall quality, and (11) future intent of the patient.

In addition, clients' satisfaction results from experiencing a service quality to encounter and to compare the encounter with what is expected. They are satisfied or impressed with the service that meets their desire or expectations. If the service is not reaching their expectations, they will get dissatisfied. Moreover, the measurement of

the effectiveness of nursing service should also include clients' satisfaction and clients' expectation of revisiting the clinics. If they fail to satisfy the client with their service, they will not make a visit again. In contrast, if the service that the clients perceived is beyond their expectation or experience, they are likely to come back again in the future. Therefore, this study includes clients' satisfaction, outcome of treatment, and clients' expectation of revisiting the clinics, as the indicators for service effectiveness provided by professional nurses at the clinics.

Moreover, in health care service dimension, the effectiveness of care can be evaluated in term of outcome indicators. There are many articles about outcome indicators in various dimensions since 1974. Jennings, et al (1999) performed an extensive review of the literature and conducted to classifying outcome indicators. According to the study, three categories of health care outcome indicators were proposed as patient-focused, provider-focused, and health care organization-focused indicators. First, the patient-focused outcomes category composes two subsets of indicators: one, diagnosis-specific, the other is holistic. The diagnosis-specific indicators typically focus on specific aspects of illness by showing the status of a disease process or patient problem. In contrast, the holistic indicators extend beyond disease boundaries to show how well the person is living with a particular problem. These indicators include the person's functional status, health status, mental status, and quality of life. Second, the provider-focused outcomes category addresses aspects of provider practice that affects patient outcomes. Providers can be either professionals or significant others such as family caregivers. Common indicators include medication prescription rates, appropriateness of treatment, technical proficiency, and sentinel events. Third, the health care organization-focused outcomes

category is the most global outcome indicators that show quality of care delivered by the institution as a whole. Frequently these indicators are expressed as rates such as mortality rate, morbidity rate, infection rate, and medication errors. These indicators also represent a business orientation such as cost of care and access to care.

Summary

In conclusion, the literature review has shown that the primary care is the key to success in health service system strategy to enhance good health and quality of life to the people. It is because of the facts that primary care focus on the holistic care and the integrated health care covers physical, mental, emotional, and social functions. In addition, the prevention of disease, health promotion, rehabilitation, and appropriate referral to higher care are also the characteristics of primary care. The other outstanding features of primary care are centered on patient-provider relationship and humanity more than technology or complex equipment. The midwifery private clinic is one of the health care units that might help demonstrate their potential to be the effective primary care provider. In fact, at present, belonging to the nursing's act, the professional nurse cannot provide independent primary care. In reality, especially in rural areas where there are no physicians, these midwifery private clinics are the first place to serve the primary medical care for a long time ago. Because of inadequate studies concerning the effectiveness of these midwifery private clinics in Thailand, there is a need to conduct this study. This research outcome will provide significant actual data to The Nursing Council of Thailand. It can extend the role of the professional nurse in primary care services especially in primary medical care. The ultimate goal of health for Thai people is expected.



CHAPTER III

METHODOLOGY

This descriptive study describes the effectiveness of primary care as provided at midwifery private clinics in Nakhonsawan Province.

Subjects and Settings

Subjects

The target population in this study was the midwifery private clinics, which are owned by professional nurses. The professional nurses who provide health services and the clients who receive the health service from these midwifery private clinics were included.

The sample populations mentioned above are located in Nakhonsawan Province. Data was collected in a three-month period from March to May 2001.

Multi-stage sampling techniques were used in selecting the sample by:

(1) Three Amphurs were randomly selected from the total of thirteen Amphurs, and two Sub-Amphurs of Nakhonsawan Province,

(2) Three Tambols were randomly selected from each sampled Amphur. There were nine Tambols included in the total sample,

(3) One midwifery private clinic was purposely selected within each Tambol. There were nine midwifery private clinics included in the total sample. The criterion used in selection was based on characteristics of nurses who owned the clinic.

The inclusion criteria included:

- finished a Bachelor degree in nursing or higher degree,

- licensing for nursing or nursing & midwifery,
- willingness to participate in this study.

(4) The clients who attended the sample midwifery private clinic were a sample of another group. Sixty clients who had no hearing loss, were able to communicate in Thai and were willing to participate in this study were purposely selected from each clinic during the data collection period.

Setting

This study was conducted at nine midwifery private clinics in 3 Amphur, which are Muang, Lad-yao, and Tak-fa at Nakhonsawan Province. They provided primary care by professional nurses. Nakhonsawan is a province located at the northern part of Thailand and is 237 kilometres from Bangkok. The public health services in Nakhonsawan are composed of one large regional hospital, twelve community hospitals and one hundred and eighty-five health centres. Moreover, there are fifty-five midwifery private clinics staffed by professional nurses. The midwifery private clinics operate every day. During weekdays, they work from 5.00-8.00 p.m. Furthermore, during weekends, they operate between 8.00.a.m.-8.00 p.m.

Instruments

In this study, the researcher used the instruments developed by Noonin, N., et al., (2001) for their study on “ Effectiveness of primary care provided at midwifery private clinic in the Southern part of Thailand ”. The questionnaires were revised and validated by an expert group (see Appendix B). The questionnaires were designed for two groups of the sample, the professional nurses and the clients.

I.) The professional nurses questionnaires

There were two forms developed for collecting data from the professional nurses.

1. Nurses' demographic and characteristics of midwifery private clinic data form. This form is composed of two parts.

Part I is concerned with nurses' demographic data as related to age, gender, usual working place, basic educational level, highest educational level, continuous education/special training, and the number of years of experience in practice after finishing basic nursing.

Part II is concerned with the characteristics of the clinic including type of clinic, opening hours, duration of practice in years, observed or admission beds and clients' chart. Also, there are opened-ended questions regarding the problems, the obstacles and the reasons for opening clinic.

2. Health service activities form. This form was designed for collecting data about the care activities that are provided for the clients. It consists of history taking such as chief complaint or health problem and health history, physical examination, diagnosis, nurses' activities, and the appointment date.

II.) The clients questionnaires

There were 3 forms for collecting the data from clients.

1. Demographic data form. This form is composed of two parts.

Part I included clients' demographic data such as age, gender, religion, educational level, occupation, family's income, and home location.

Part II is concerned with the data related to their visit such as the number of visits, costs of service, the distance between home to clinic, traveling method

to clinic, and chief complaint or health problem.

2. The clients' outcome questionnaire. This questionnaire is concerned with the clients' condition 5-7 days after the last visit to the clinic and the client's expectations of revisiting to the midwifery private clinic.

3. The clients' satisfaction questionnaire. The questionnaire was designed to receive feedback from the clients about their satisfaction with services provided by nurses. It consists of 15 items categorized into 3 topics: nurse characteristics (1-5 items), nursing intervention (6-11 items), and service charge (12-15 items). These were 3 levels of measurement for each item: Good: indicates that the client was satisfied, Not sure: indicates that the client felt neutral or uncertain, Bad: indicates that the client was not satisfied.

Validity and Reliability

The instruments in this study were examined for content validity by four experts from The Nursing Council of Thailand (see Appendix C). All questionnaires were reworded appropriately for the study sample. All these instruments were designed for factual data and had been already used in research by Noonin and colleagues (2001), "Effectiveness of primary care provided at midwifery private clinics in the southern part of Thailand", so they were not assessed for the reliability coefficient.

Protection of Human Subjects

The human rights of the subjects were respected in this study (see Appendix A). All eligible subjects were individually approached to participate in the study. The researcher or the research assistant explained to all subjects about the study objectives, the data collection processes, the expected research outcomes, subject rights, the type

of questionnaires/interview, length of time for completing the questionnaires, and the right to refuse to participate in the study or withdraw at any time. The subjects who agreed to participate were informed and assured that the data would be kept confidentially, the subjects name would not appear in the report or in any other place or the results would be reported as a group data only, not as an individual.

Data Collection

The steps and methods of data collection were as follows:

1. Preparation.

1.1 The researcher sent a formal letter from the nursing department, the Faculty of Medicine Ramathibodi Hospital to the Head of the Nakhonsawan Provincial Public Health Office to explain the objectives and procedures of the study and to request numbers and names of midwifery private clinics in Nakhonsawan Province.

1.2 Three Amphurs and nine Tumbols were randomly selected to have midwifery private clinics.

1.3 After receiving the names and the numbers of midwifery private clinics, the researcher purposively selected one midwifery private clinic that met the inclusion criterias described above, from each Tumbol in three Amphurs. Totally, there were nine clinics included in the study.

1.4 The researcher prepared a research assistant who is a professional nurse for assisting in collecting data. The aim of the preparation was to make sure that the research assistant understands the study objectives, the instruments, the data

collection processes, and the sample inclusion criterias. She was prepared for collecting data from the sample clients.

2. Data collection.

After permission from the Faculty of Graduate Studies, Mahidol University, and The Nursing Council of Thailand, data was collected by the researcher/the research assistant, as follows:

2.1 The professional nurses group

2.1.1 The researcher contacted the professional nurses who owned the clinics by sending a formal letter from the Dean of Faculty of Graduate Studies, the chairman of National Nursing Research, and The Nursing Council of Thailand to explain the research objectives and procedures and asking for their cooperation.

2.1.2 The professional nurses, who agreed to participate in the study were informed by researcher with more additional information about the study objectives, the benefit, the data collection processes and the rule of human rights protection of the subjects. Moreover, they were informed and assured about confidentiality and no impact from the results of the study to their private practice in the clinic.

2.1.3 The researcher collected the data related to the professional nurse who owned the clinics. Each of the professional nurses completed the nurses' demographic and characteristics of the clinic data form by themselves. The researcher, with the nurse permission, quietly observed the nurse's activities while performing care to the clients at the clinic. The details of all the activities were completed in the health service activity form by the researcher only.

2.2 The client groups

2.2.1. All eligible subjects who met the inclusion criteria were approached by the research assistance after encountering the nurse's activities and explained about the protocol of protection of human subject as previously described.

2.2.2 The clients, who agreed to participate in this study, read and completed the questionnaires by themselves or the research assistant read the questionnaires verbatim to any participants experiencing difficulty in reading. Reading the questionnaires by the research assistant was done to ninety-five percent of the clients. However during this procedure, the research assistant provided more clarification if needed.

2.2.3 For the clients' outcome questionnaire and the clients' satisfaction questionnaire, the research assistant asked the clients to complete these questionnaires at home and mail them back to the researcher within 5-7 days after the visiting date. Again, the research assistance assured the rule of human rights protection of the subjects and it would not affect the services at their next visit. If the clients were infants or babies, their parents or relatives would answer the questionnaires.

However, if the researcher did not receive the questionnaires from the clients within two weeks after receiving treatment then the researcher contacted them and asked them to return the complete questionnaires via mail for at least two times.

2.2.4 Data cleaning, completing and coding was done for the analysis.

Data Analysis

The data from the questionnaires, structured interviews and structured observations were coded and number and entered into a counter data base program and

carefully double-checked for errors. The Statistical Package for Social Sciences for Windows Program (SPSS/ FW) version 7.5 was used for analysis.

I.) The following data was presented in frequencies and percentages:

1. Nurses' demographic data such as gender, basic educational level, highest educational level, continuous education/ special course, and usual working place.

2. Clients' demographic data such as gender, religion, occupation, family's income, educational level, home location, and traveling to clinic.

3. The chief complaints or health problems of the clients.

4. The health service activities about history of illness, doing a physical examination, diagnosis, health care services and appointment.

5. The clients' outcome and expectation to revisiting the midwifery private clinic.

6. The clients' satisfaction.

II) The following data was presented in range, mean and standard deviation:

1. Nurses' demographic data such as age, the number of years of experience practice after finishing basic nursing.

2. Clients' demographics such as traveling time to clinic, and the distance between home to clinic.

3. The cost of service

III.) The open-ended questions about reason, problems and obstacles of opening the midwifery private clinic were analyzed in categories and its frequency.

CHAPTER IV

RESULTS

This descriptive research was conducted to describe the effectiveness of primary care provided at nine midwifery private clinics in Nakhonsawan Province. The findings are presented in the following four parts with tables and descriptions.

I. The midwifery private clinics.

- The characteristics.
- Professional nurses' demographic data.
- The rationales or obstacles of running the clinic

II. The clients.

- Demographic data.
- Visiting characteristics.
- Chief complaints or health problems.

III. The health care service.

- Health assessment.
- Nurses' activities.
- Medication used in midwifery private clinics.

IV. The effectiveness of primary care service.

- Clients' satisfaction.
- Outcomes after health care services and expectation to revisiting the clinics.

The midwifery private clinics.

The characteristics.

Table 1 describes the characteristics of the midwifery private clinics. All of the clinics were opened everyday. Most of them (88.9%) opened in the evening on weekdays (5.00-8.00 p.m.), and only one of them opened all day (8.00 a.m.-8.00 p.m.). Their working hours on weekdays ranged from 2 to 12 hours with the mean of 5.22 hours (S.D.= 3.42), while the mean of working hours on weekends was 10.44 hours (S.D.= 3.28). On weekdays, the number of clients ranged from 5 to 30 cases (mean = 13.33, S.D. = 9.85), while on weekends, it ranged from 7 to 40 cases (mean = 21.89, S.D. = 12.18). Most of the sampled clinics (88.9%) did not have a health record of the patients, with one exception who had the Kardex health record. All of them did not have beds for overnight stay except a bed for temporary observation.

Table 1. Characteristics of midwifery private clinics (n=9)

Variable	Frequency	Percentage
Opening day		
Everyday	9	100
Working hours period (weekday)		
2 hours	1	11.1
3 hours	2	22.2
4 hours	3	33.3
5 hours	1	11.1
10 hours	1	11.1
12 hours	1	11.1
	(Range = 2-12 Mean = 5.22 S.D. = 3.42)	
Working hours period (weekend)		
2 hours	1	11.1
10 hours	2	22.2
12 hours	6	66.7
	(Range = 2-12 Mean = 10.44 S.D. = 3.28)	
Period		
Morning and evening (5-8 p.m.)	8	88.9
All day (8 a.m.-8 p.m.)	1	11.1

Table 1. Characteristics of midwifery private clinics (n=9) (cont'd)

Variable	Frequency	Percentage
Number of clients in weekday (case) Range = 5-30	Mean = 13.33	S.D. = 9.85
Number of clients in weekend (case) Range = 7-40	Mean = 21.89	S.D. = 12.18
Health record		
Yes	1	11.1
No	8	88.9

Professional nurses' demographic data.

There were nine professional nurses who owned the sampled clinics in this study. The professional nurses demographic data is described in Table 2. All of them were female (100%). Their ages ranged from 28 to 62 years. The mean and standard deviation of age was 44.8 years and 11.3 years, respectively. The largest group of them had finished basic education at a Bachelor's degree (55.6%), while the remainders were Diploma (33.3%) and Certificate (11.1%). Among them, only one had completed a Master's degree in nutrition. Almost half of them (44.4%) had finished nurse practitioner program training. Most of them (66.7%) worked in community hospitals, the others (22.2%) worked in regional hospitals and only one of them worked full time at her clinic. Their practical experience after finishing the basic nursing program ranged from 9 to 40 years, with an average of 22.44 years (S.D. = 10.78). Moreover, they ran their private clinics for 14.4 years in average.

Table 2. Demographic of professional nurses (n = 9)

Personal characteristic	Frequency	Percentage
Gender		
Female	9	100.0
Basic educational level		
Certificate	1	11.1
Diploma	3	33.3
Bachelor's degree	5	55.6
Highest educational level		
Bachelor's degree	8	88.9
Master's degree	1	11.1
Continuing education		
None	1	11.1
Nurse practitioner	4	44.4
Special course	1	11.1
Others	3	33.3
Working place		
Community hospital	6	66.7
Regional hospital	2	22.2
None	1	11.1
Age (years)		
Range = 28-62	Mean = 44.78	S.D. = 11.30
Number of years of experience practice after finishing basic nursing (years)		
Range = 9-40	Mean = 22.44	S.D. = 10.78
Number of years of opening clinics (years)		
Range = 1-35	Mean = 14.44	S.D. = 13.20

The reasons and obstacles of running the clinic.

The professional nurses were asked to list the reasons and obstacles to open the midwifery private clinic by open-ended questions. Content analysis was utilized to derive the common theme from the professional nurses' descriptions.

Midwifery private clinics were set up with three main reasons. First, financial reasons which included the usage of free time productively (5 cases), the way to earn additional income (4 cases), and need of counseling the client out of the government office hour (1 case). Second, social service reasons that composed of helping people who live in remote areas, which are far from the hospitals (4 cases), playing nurse's

role in providing health education to people (3 cases), sharing in activities of their home town (2 cases), well known by people while working in the hospital (2 cases), and having social relationship with local people for a long time (1 case). The third, reason at private practice consists of encounters with more experience (2 cases), and serving as an office for counseling, etc (2 cases).

The obstacles and problems of midwifery private clinic could be classified into four groups. First, government and act barriers that include 1) Lack of regulation supporting some medical procedures done by nurses, such as injections, suturing, taking out stitches, and intravenous fluid infusion, meanwhile these procedures were acceptable when done by nurses in the hospitals. 2) Drug allowance by nurses used in the clinics was similar to that being allowed to be used in health centres, which appeared to be inadequate. 3) Services provided in midwifery clinic was limited to only mother and newborn care, which did not exist in real situations. 4) Setting up clinic was the responsibility of the other health personnel who did not really understand the clinic's task and process of setting up, which was very complicated and inconvenient. Second, uncertain time of service, because there was no regular office hours in some clinics, clients were not able to see the nurses, which gave a negative impression to the client to come again or continue following up. Third, performing unpleasant tasks. Some of them were forced to do some procedures that were unnecessary but it was supportive to the clients' faith. Fourth was miscellaneous group such as clients were not able to follow the advice given by nurses, and loss of follow up leading to ineffectiveness of treatment, ect.

The clients.

Clients' demographic data.

Five hundred and forty clients were included in this study. Table 3 described their demographic data. The majority of clients (64.6%) were female. Their ages ranged from 1 to 97 years. The mean age and standard deviation were 33.94 and 23.67, respectively. The majority age group of the clients (25.7%) was 21-40 years and 24.8% of them were 41-60 years, while the smallest group (3.1%) was 16-20 years. All of them were Buddhists (100%). The largest group of them had finished study at primary school level (47.6%). The major occupation was agriculture (25.9%). Fifty percent of clients (263) had no occupation, they were students, elderly, housewives, babies or monks. All of them (263) spent money from their family income which most of them (16.5%) had a family income of 1,001-3,000 Baht per month. Regarding to the clients who had their own income, the majority of them (15.2%) had 3,001-5,000 Baht per month.

Table 3. Clients' demographic (n = 540)

Variable	Frequency	Percentage	
Gender			
Male	191	35.4	
Female	349	64.6	
Age(years)			
0-6	111	20.6	
7-15	54	10.0	
16-20	17	3.1	
21-40	139	25.7	
41-60	134	24.8	
More 60	85	15.7	
	(Range = 1-97	Mean = 33.94	S.D. = 23.67)
Religion			
Buddhism	540	100	

Table 3. Clients' demographic (n = 540) (cont'd)

Variable	Frequency	Percentage
Educational level		
Illiterate	35	25.0
Student	99	18.3
Primary school	257	47.6
High school	36	6.7
Diploma	8	1.5
Bachelor's degree or higher	5	0.9
Occupation		
Agriculture	140	25.9
Merchant	40	7.4
Government	7	1.3
Employee	90	16.7
Student	93	17.2
Housewives/Elderly	101	18.7
Others (Baby/Monk)	69	12.8
Client's income (Baht/month)		
No income	263	49.6
Less than 1000	6	1.1
1000-3000	80	14.8
3001-5000	82	15.2
5001-7000	29	5.4
7001-10000	35	6.5
10001-20000	26	4.8
> 20000	14	2.6
Family's income (Baht/month)		
Less than 1000	12	2.2
1000-3000	89	16.5
3001-5000	77	14.3
5001-7000	40	7.4
7001-10000	21	3.9
10001-20000	19	3.5
> 20000	5	0.9

Visiting characteristics.

Table 4 summarizes the visiting characteristics of the clients. Out of the total 540 studied clients, about half (52.2%) of their home location were in a different Tumbol from the midwifery private clinics, while the remainder (47.8%) was in the same Tumbol. Average distance from the clients' home to the clinics was 6,448.85

meters (S.D. = 6,960.67), ranging from 10 metres to 80 kilometres. More than 60% came by motorcycle. The clients spent 2 to 120 minutes with the mean of 13.98 minutes (S.D. =10.93) traveling to the clinics. About 78% of the clients had previous visits to the clinics for more than two times. The most common reason for visiting these clinics were good outcome of treatment (67.8%) and location close to home (60.2%). The minor reason was the nurses who owned clinics were well known to them (5.4%). The average cost of care was 68.31 Baht (S.D. = 39.03), ranging from 0 to 320 Baht. In addition, the travel expense ranged from 0 to 160 Baht with the mean of 8.72 Baht (S.D. = 12.49). Most of the clients (93.1%) knew that the care providers are nurses, while 37 cases of them (6.9%) were not recognized.

Table 4. The clients' visiting characteristics (n = 540)

Variable	Frequency	Percentage
Home location		
Same Tumbol with clinics	258	47.8
Different Tumbol with clinics	282	52.2
Distance from home to clinics (metre)		
0-2000	152	28.1
2001-4000	97	18.0
4001-6000	76	14.1
6001-8000	66	12.2
8001-10000	70	13.0
>10000	79	14.6
(Range = 10 – 80,000	Mean = 6,448.85	S.D. = 6,960.67)
Transportation to clinics		
Motorcycle	361	66.9
Car	105	19.4
Walk	38	7.0
Bus	20	3.7
Bicycle	15	2.8
Others	1	0.2
Traveling time to clinics (min)		
0-10	312	57.8
11-20	157	29.1
21-30	60	11.1
More 30	11	2.0
(Range = 2-120	Mean = 13.98	S.D. = 10.93)

Table 4. The clients' visiting characteristics (n = 540) (cont'd)

Variable	Frequency	Percentage
Reason for visiting*		
Near	325	60.2
Famous	29	5.4
Cheap	269	49.8
Nurse characters	209	38.7
Good service	229	42.4
Good outcome	366	67.8
Others	78	14.4
Number of visiting		
First	80	14.8
Second	38	7.0
Third and over	422	78.1
Cost of care (Baht)		
0-50	194	35.9
51-100	277	51.3
101-150	54	10.0
151-200	14	2.6
>200	1	0.2
	(Range = 0-320	Mean = 68.31
		S.D. = 39.03)
Transportation expense (Baht)		
0-20	502	93.0
21-40	29	5.4
41-60	3	0.6
> 60	6	1.1
	(Range = 0-160	Mean = 8.72
		S.D. = 12.49)
Care provider's status		
Known	503	93.1
Unknown	37	6.9

* Note More than one answer was possible.

Chief complaints or health problems .

Data in Table 5 describes the chief complaints or clients' health problems who visited the clinics. The results show that the most common chief complaints were dealing with the respiratory system, this composed of fever (21.8%) and cough/sore throat (19.8%). The second most common chief complaint was musculoskeletal/dermatologic system, which composed of muscle pain/arthritis/arthralgia (12.0%) and

urticaria/rash (4.8%). The other systems were gastrointestinal system which composed of abdominal pain/flatulence (9.5%), mother/child which composed of contraception (3.5%), EENT system which composed of conjunctivitis (1.9%), cardiovascular system which composed of hypertension (2.0%). In the miscellaneous group, some clients complained about headache/dizziness (11.6%), vertigo (8.3%), anorexia/fatigue (6.6%), palpitation (3.3%) and insomnia (2.7%).

Table 5. Chief complaints or health problems of clients* (n = 540)

Chief complaints*	Frequency	Percentage
1. Respiratory system	244	45.1
Fever	118	21.8
Fever with pharyngitis	97	17.9
Fever with tonsillitis	21	3.9
Cough/sore throat	107	19.8
Common cold	12	2.2
Asthma/Dyspnea	7	1.3
2. Gastrointestinal system	99	18.3
Abdominal pain/Flatulence	51	9.5
Nausea/Vomiting	20	3.7
Diarrhea	16	3.0
Dental pain/Aphthous ulcer/Gingivitis	12	2.2
3. Musculoskeletal/ Dermatologic system	141	26.1
Muscle pain/Arthritis/Arthralgia	65	12.0
Urticaria/Rash	35	4.8
Wound infected	14	2.6
Abscess/Furuncle	13	2.4
Sprain	5	0.9
Others(Gout/Fungal infection/Chickenpox)	9	1.6
4. EENT system	13	
Conjunctivitis	10	1.9
Allergic Conjunctivitis	3	0.6
5. Mother/ Child	34	6.3
Contraception	19	3.5
Antenatal care	5	0.9
General infant problems	2	0.4
6. Accident	8	1.5
7. Cardiovascular system	16	3.0
Hypertension	11	2.0
Ischemic heart disease	5	0.9

Table 5. Chief complaints or health problems of clients* (n = 540)(cont'd)

Chief complaints*	Frequency	Percentage
8. Miscellaneous	211	39.1
Headache/ Dizziness	63	11.6
Vertigo	45	8.3
Anorexia/Fatigue	36	6.6
Palpitation	18	3.3
Insomnia	15	2.7
Stress/ Anxiety	10	1.9
Fever cause	5	0.9
Leukorrhea	5	0.9
Menopause	5	0.9
Numbness	5	0.9
DM	4	0.7

*Note. More than one answer was possible.

The health care services.

Health assessment

By the researcher's observations, the health assessment started with history taking of clients' problems. The data in Table 6 shows that around five hundred twenty-nine clients (98%) were interviewed for present history, and 28.9% for past history. General physical examination had been performed by nurses to 95.9% of clients. Other procedures were; taking blood pressure measurement (53.9%), heart-lung auscultation (47.4%), eye/ear/nose examination (41.3%) body temperature measurement (40.2%), and body weight/height measurement (4.3%). During the observation period, the researcher found that the nurses performed blood pressure measurement in every case who received contraceptive injection. The majority of nurses' diagnosis was made according to symptoms in 308 cases (57%). Only 232 cases (43%) had been diagnosed according to the disease.

Table 6. Frequency and percentage of health problem assessment in midwifery private clinics (n = 540)

Health problem assessment	Frequency	Percentage
Taking history*		
Past history	156	28.9
Present history	529	98.0
Physical examination*		
General Examination	518	95.9
Blood pressure	291	53.9
Heart-Lung Auscultation	256	47.4
Eye/ Nose/ Ear Examination	223	41.3
Temperature	217	40.2
Abdominal Palpation	130	24.1
Weight / Height	23	4.3
Diagnosis		
According to symptom	308	57.0
According to disease	232	43.0

* Note: More than one category was possible.

Nurses' Activities.

The nurses' activities in midwifery private clinics are presented in Table 7. The majority of activities (3.9%) were intramuscular injections. The injected-medication that nurses performed continuously from the hospital was insulin (1 case). The prescribed-injected-medications by nurses were contraceptive injections (16 cases), vitamin B₁₂ (1 case) and tetanus toxoid (3 cases). The others were on IV fluids, taking out sutures wound/stitches and acupuncture (0.9% each), while removal of foreign body was the lowest (0.2%).

While the nurses provided the activities in their clinics, they also gave health teaching to their clients. The most common of their health teaching were the method of taking medication (96.3%) and clients' self care practice (88.1%). Noticeable the referral mode was the least activity (0.9%). After the care activities finished, most of the clients (82.4%) did not have the follow up appointment, while 17.6% of them did.

Table 7. Frequency and percentage of nurses' activities (n = 540)

Nurses' activities	Frequency	Percentage
Injection	21	3.9
Continue treatment from hospital	1	0.2
Prescribed by nurse	20	3.7
On IV fluid	5	0.9
Taking out suture wound/ Stitch	5	0.9
Acupuncture	5	0.9
Urine Pregnancy Test	2	0.4
Remove foreign body	1	0.2
Health teaching*		
Self Care	476	88.1
Using Medication	520	96.3
Referral	5	0.9
Appointment		
Yes	95	17.6
No	445	82.4

* Note: More than one category was possible.

Medication used in midwifery private clinics.

Table 8 summarizes the medications that the nurse prescribed. The most common type of medication used was analgesic/antipyretic drug; paracetamol in 243 cases (45.0%) and ASA in 9 cases (1.6%). The second type was antimicrobial; amoxicillin in 115 cases (21.3%) and penicillin/lincocin/ampicillin in 69 case(12.8%). The third type was antacid/antiflatulences; alum milk/cimetidine/air-x/ magesto in 97 cases (18.0%), ultracarbon and sodamint each in 8 cases (1.5%). The other types were NSAID that were composed of diclofenac in 80 cases (14.8%), antihistamine that was composed of chlorpheniramine/piriton in 76 cases (14.0%), vitamins/mineral that was composed of vitamin Bco/B₁₋₆₋₁₂/B₆ in 51 cases (9.4%), mucolytic/cough suppressant that composed of dextromethophan in 41 cases (7.6%), minor tranquilizer/anti-depressant that was composed of diazepam (2mg) in 34 cases (6.3%), antiemetic that was composed of motilium in 33 cases (6.1%), muscle relaxant that was composed of norgesic/muscol/mydocalm in 24 cases (4.4%), cardiovascular/ antihypertensive drugs

that was composed of propranolol in 24 cases (4.4%), and contraceptive drug/hormone that was composed of contraceptive pills in 18 cases (3.3%).

Table 8. Frequency and percentage of primary medications which were used in the midwifery private clinics

Primary medication*	Frequency	Percentage
1. Analgesic/Antipyretic/Antispasmodic	260	48.1
Paracetamol	243	45.0
ASA	9	1.7
Buscopan	8	1.4
2. Antibiotic	249	46.1
Amoxicillin	115	21.3
Penicillin / Ampicillin/Lincocin	69	12.8
Cloxacillin	19	3.5
Erythromicin	14	2.6
Co-trimoxazole	14	2.6
3. Antihistamine	220	40.7
Chlorpheniramine/Piriton	76	14.0
Dramamine	60	11.1
Actifed	30	5.5
Brompheniramine	24	4.4
Atarax	15	2.8
Cyproheptadine	15	2.8
4. NSAID	179	33.1
Diclofenac	80	14.8
Brufen	67	12.4
Piroxicam	19	3.5
Indomethacin	7	1.3
Ponstan	6	1.1
5. Antacid/Antiflatulence	119	22.1
Alum milk/Cimetidine/Air-X/Magesto	97	18.0
Ultracarbon	8	1.5
Sodamint	8	1.5
M. Carminative	6	1.1
6. Vitamins/Mineral	107	19.8
Vitamin B co./ B ₁₋₆₋₁₂ / B ₆ / B ₁₂	51	9.4
MTV	41	7.6
Vitamin C	9	1.7
FeSO ₄ /FBC/Folic acid	6	1.1
7. Mucolytic/Cough suppressant	81	14.9
Dextromethophan	41	7.6
Bromhexine	24	4.4
M.Tussis	12	2.2
Ambroxol	4	0.7

Table 8. Frequency and percentage of primary medications which were used in the midwifery private clinics (cont'd)

Primary medication*	Frequency	Percentage
8. Minor tranquiliser/Antidepressant	50	9.2
Diazepam 2 mg	34	6.3
Lorazepam	8	1.5
Tranxene/Amitriptylline	5	0.9
Xanax/Frisium	3	0.5
9. Cardiovascular/Antihypertensive	37	6.9
Propranolol	24	4.4
Reserpine	9	1.7
Isordil	2	0.4
Hydralazine	1	0.2
Digoxin	1	0.2
10. Antiemetic	37	6.9
Motilium	33	6.1
Dibendox	3	0.6
Plasil	1	0.2
11. Muscle relaxant	24	4.4
Norgesic/Muscal/Mydocalm	24	4.4
12. Contraceptive drug/Hormones	20	3.7
Contraceptive pills	18	3.3
Premarin	2	0.4
13. Bronchodilator	17	3.1
Salbutamol	7	1.3
Bricanyl	10	1.8
14. Antifungal	16	3.0
Ketoconazole	11	2.0
Vervax	2	0.4
Cotrimazone cream	2	0.4
Metronidazole	1	0.2
15. Topical steroid	14	2.5
Triamcinolone acetate 0.1%	8	1.4
Betamethasone valerate	2	0.4
Prednisolone cream	4	0.7
16. Herbal Remedies	14	2.6
Thai herbal	14	2.6
17. Antidiarrhea	14	2.6
ORS	7	1.3
Immodium/Lomotil	7	1.3
18. Eye preparation	10	1.8
Ophthalmic solution	10	1.8
19. Mouth preparation	8	1.7
Kenalog in orabase	7	1.3
Glycerine borax	1	0.4

Table 8. Frequency and percentage of primary medications which were used in themidwifery private clinics (cont'd)

Primary medication*	Frequency	Percentage
20. Vaccines	4	0.7
Tetanus toxoid	4	0.7
21. Diuretic	3	0.6
HCTZ/Moduretic	3	0.6
22. Miscellaneous	92	17.1
Cinnarazine	42	7.8
Flunarazine	9	1.7
Cafergot/Bellergal	9	1.7
Dexamethazone	9	1.7
Laxative drug	8	1.5
Betadine solution	5	0.9
Oral hypoglycemic agent	5	0.9
IV fluid	5	0.9

* Note More than one primary medication used in one person

Medication type across health problems.

Most common clients' health problems and medications prescribed by nurses according to these health problems are presented in Table 9. The most common clients' health problems were fever (21.9%), cough/sore throat (19.8%) and muscle pain/arthritis/ arthralgia (12.0%). The medications that nurses prescribed for fever were paracetamol (91.5%), amoxicillin (66.1%), penicillin/lincocin/ampicillin (31.4%), chlopheniramine (22.0%), and actifed/decolgen (20.3%). The medications for cough/sore throat were paracetamol (89.7%), amoxycillin (58.9%), penicillin/lincocin/ampicillin (41.1%), dextromethophan (26.2%), and bisolvon (19.6%). For problems about muscle pain/arthritis/arthralgia, the medications were diclofenac (95.4%), alum milk (40%), muscol/mydocalm (27.7%), piroxicam (18.5%), and diazepam (12.3%).

Table9. Medications prescribed by nurses according to common health problems

Health Problems	Medications	Number (%)
Fever (n=118)	Paracetamol	108 (91.5%)
	Amoxicillin	78 (66.1%)
	Penicillin/Lincocin/Ampicillin	37 (31.4%)
	Chlopheniramine	26 (22.0%)
	Actifed/Decolgen	24 (20.3%)
Cough/Sore throat (n=107)	Paracetamol	96 (89.7%)
	Amoxicillin	63 (58.9%)
	Penicillin/Lincocin/Ampicillin	44 (41.1%)
	Dextromethophan	28 (26.2%)
	Bisolvon	21 (19.6%)
Muscle pain/Arthritis/Arthralgia (n=65)	Diclofenac	62 (95.4%)
	Alum milk	26 (40.0%)
	Muscol/Mydocalm	18 (27.7%)
	Piroxicam	12 (18.5%)
	Diazepam	8 (12.3%)

The effectiveness of primary care services.

The effectiveness of primary care services were reported in two parts. The first part was the clients' satisfaction and the second part was the outcome and expectation to revisit the same clinic.

In this part, the 540 clients were asked to complete the questionnaires by themselves and return them by mail to the researcher within 5-7 days after this visit. As a result a total of 387 questionnaires were returned, the response rate was 71.7%.

Clients' satisfaction.

Data from the clients' satisfaction questionnaire is shown in Table 11. More than ninety percent of clients were satisfied with the nurses' gentleness and the convenience in service. In addition, more than eighty percent of clients were satisfied with friendliness (88.9%), health counseling and time spent (88.1%), willingness (87.9%), medication (87.3%), dependable (85.5%), health care service (85.3%),

greetings (85.0%), skillfulness (84.5%), waiting time (82.7%), and confidently (82.4%). The minor dissatisfaction was costly service fee which was reported by only 3.6% of the respondents.

Table 10. Frequency and percentage of clients' satisfaction (n = 387)

Variable *	Good n (%)	Not sure n (%)	Bad n (%)
1. Gentleness	363(93.8)	11(2.8)	5(1.3)
2. Skillfulness	327(84.5)	51(13.2)	1(0.3)
3. Willingness	340(87.9)	34(8.8)	4(1.0)
4. Friendliness	344(88.9)	28(7.2)	4(1.0)
5. Dependable	331(85.5)	41(10.6)	3(0.8)
6. Health service	330(85.3)	39(10.1)	3(0.8)
7. Spend time	341(88.1)	32(8.3)	5(1.3)
8. Health counseling	341(88.1)	26(6.7)	7(1.8)
9. Physical examination	296(76.5)	73(18.9)	6(1.6)
10. Medications	338(87.3)	27(7.0)	7(1.8)
11. Greeting	329(85.0)	43(11.1)	3(0.8)
12. Convenience	351(90.7)	23(6.0)	5(1.3)
13. Waiting time	320(82.7)	48(12.4)	7(1.8)
14. Services fee	289(74.7)	68(17.6)	14(3.6)
15. Confidence	319(82.4)	57(14.7)	2(0.5)

* Note More than one response.

Outcomes after health care service and expectation to revisit the clinics.

The clients reported that they recovered from their health problems in 238 cases (61.5%), got cured in 132 cases (34.1%), remained the same in 12 cases (3.1%) and got worse only in 5 cases (1.3%). Among the expectation on returning back, 374 cases (96.6%) of the clients reported that they would revisit the same clinic but only 13 cases (3.4%) reported they would not. The details are shown in Table 11.

Table 11. Frequency and percentage of outcome and expectation to revisiting the midwifery private clinics (n=387)

Variables	Frequency	Percentage
Outcome		
Cure	132	34.1
Recover	238	61.5
Same	12	3.1
Worsen	5	1.3
Expectation to revisiting		
Yes	374	96.6
No	13	3.4

CHAPTER V

DISCUSSION

This research aimed to study the effectiveness of primary care services provided by professional nurses at midwifery private clinics in Nakhonsawan province. The discussion of the results of this study will be presented in the following order:

- characteristics of midwifery private clinics and professional nurses.
- characteristics of clients.
- reasons for establishing midwifery private clinics.
- problems and obstacles in opening midwifery private clinics.
- chief complaints and health care activities.
- effectiveness of services provided at midwifery private clinics.

Characteristics of midwifery private clinics and professional nurses.

There are altogether nine midwifery private clinics in this study that have been established according to the Sanatorium Act B.E.2541 enabling professional nurses to set up private clinic to provide health care services in accordance with their educational level. For example, professional nurses who have received the first level license of nursing and midwifery can provide health care services as specified by the Sanatorium Act. The findings of the study (Table 1) revealed that all the clinics in this study were midwifery private clinics. Most of the clinics were located in the residential area close to the clients' home. As for provision of services, 88.9% opened

at a certain time everyday. Almost all of them were opened in the morning and evening during weekdays and almost all day on weekends. There was only one clinic which opened 8 a.m.-8 p.m. daily. The service time is similar to a report by Noonin and colleagues (2001: 91). The average numbers of clients who sought services were 13 and 21 cases per day during weekdays and weekends, respectively.

Most of them did not have a health record of the patient, with one exception, who had the Kardex health record. This finding is similar to a study by Noonin and colleagues (2001: 91) which found that only one clinic had Kardex health record, the other six clinics had just a record book, and the last two have no records at all. The reason for unavailable health records of clients was explained by nurses that most of the clients were regular patients whom they knew so it was unnecessary to keep records. Besides, most of them came for treatment of their diseases which, according to nurses' concept, required no health record such as common cold, fever, cough, or headache. However, in the researcher's opinion, a health record is important data that nurses must record for all of the clients' data. There are several benefits of these records; 1) the records will be the chronicles of clients' illness, 2) it is legal to keep records, and 3) it represents the nurse profession's accountability and responsibility. From the above reasons, nurses should recognize the significance of keeping the patients' health records.

According to the Sanatorium Act B.E. 2541, admission for in-patient care is not permitted to midwifery private clinics. However, there were beds for clients who need close observation after drug injection or intravenous fluid infusion, which required less than 5 hours. This finding differs from Noonin and colleagues (2001: 91), which reported the lack of beds for temporary patient care at the sample clinics in

the Southern part of Thailand.

For nurses who provided services, all of them were professional nurses. Five of them (Table 2) graduated with a Bachelor's degree in nursing, three with a nursing diploma, and one with a master degree in nutrition. During their work, most of them (Table 2) had continued their study such as nurse practitioner (4 nurses), specializing in short-course training on emergency nursing, critical care nursing, and health counseling, etc. Thus, this is the evidence to show that the nurses in this research have studied continuously for enhancement of their knowledge and skill. The standards of primary care will be provided to the clients from the training of the nurses. The nurses in Noonin's research (2001: 92) also had continued their study as this finding.

Most of them (88.9%) worked as government officials in the hospitals and they had different working experiences. For instance, one of the nurses is a nurse director, one was a former nurse director, one is a head ward nurse, two are head of health promotion units, three are emergency room nurses, and one is a health promotion personnel. Their years of experience ranged from 9 to 40 years after graduation, with the mean of 22.44 years. The nurses' experience in this study is longer than the nurses in Noonin and colleagues' study (2001: 92) which is in the range of 5-14 years.

In addition, the sampled nurses had provided primary care services at clinics for 1-35 years, with the mean of 14.44 years, which was considered long enough to have competence to practice independently. This is supported by Benner's level of efficacy which states that nurses who work in a clinic for 2-3 years will be equipped with enough knowledge to provide services, make decisions, and solve problems. If their experience is longer than 5 years, they will be able to solve immediate problems



correctly, have good perception, and have high analytical skills, all of which make them become accepted and trusted by the clients in the community.(Benner,1984 cite by Somchit Hanucharunkul, 1999 : 18, Orasa Panpakdee, 1994 : 32).

Characteristics of clients

There were 540 clients who participated in this study. Most of them (64.6%) were females (Table 3). This is in accordance with the findings of other studies that most of those who seek medical services from both public and private hospitals are females (Charoenyut, C., 1979; Noonin, N., et al., 2001; Pangprasit, S., 1993; Prakunkongchai, P., (1993); Sawangdee, Y., et al., 2000; Tunpumiprated, J., 2000; Weerapong, J., 1999). This also supports the conceptual framework of Andersen (1995 : 1-10) that gender is a factor affecting use of services at a health center. Gender is an indicator of the differences in initiation and continuous handling of the environment, as well as a determinant of self-care efficacy (Orem, 1985: 42). Moreover, Waldron (Waldron cited by Benjaratanaporn, P., 1990) explains that females are interested more in their own health than males. Because of this reason they tend to report that they are sick and seek more treatment (Apakuppakun, N., 2001: 62; Nadee, K., 1998: 35).

In addition, 25.7 % of clients were between 21-40 years old. This yield supports the studies on use of health services in public and private hospitals (Pholpuem, S., 1993; Sawangdee, Y., et al., 2000; Tunpumiprated, J., 2000; Weerapong, J., 1999). At this age, according to developmental stages and life experiences, the clients were expected to have good tolerance with problems, understanding problems well and well use of reason. In other words, the older a

person is, the better he or she is able to assess the situation, make decision, choose health care plan, and understand the illness and treatment (Phavilai, J., 1992 : 38).

All of the sampled clients were Buddhists, and almost half (47.6%) completed primary school, while 25.0 % had no formal education (Table 3). This finding is in contrast to clients in Noonin's study (2001) in that most of the clients completed secondary school (23.1%) and 3.0% had finished higher than Bachelor's degree. The other present findings showed that the three largest age groups of the clients were 0-6, 21-40, and 41-60 years. These included pre-school children and adults. For the adult subjects, most of them worked in agriculture (25.9%) and did not pursue education after completing compulsory education. Support to the findings from previous studies (Chaipayom, A., 1999; Rodin, S., 1997; Sawangdee, Y., et al., 2000; Weerapong, J., 1999), it revealed that most of the clients at both public and private hospitals completed primary education and were farmers. Furthermore, the other large group of clients were students (17.2%). In the researcher's opinion, the office hours of these clinics make it available for the students to come without missing their classes.

In terms of income, most of the clients had low income with less than 5,000 Baht per month in 80.7% Similarly, most of the clients in Noonin and colleagues' study (2001: 93) also had an income of less than 5,000 Baht per month in 50.1%. Thus, it would say that, most of the people with low income seek their health care service from the midwifery private clinics.

As for the reason for seeking treatment at clinics, the findings (Table 4) revealed that 67.8% of the subjects chose " could cure the disease ", 60.2% chose "close to home ", and 49.8% chose " low cost ". This result is similar to the result by Noonin and colleagues (2001: 94) that found that " close to home " is the most

important reason for clients to come to the clinics in the Southern part of Thailand. Considerably, though the clients knew that the service providers were not physicians, they still used the services. It was found that 78.1% of the clients used the services more than two times (Table 4). Some said that, “ My whole family will come here ”, while others said that, “ There is only one clinic in the community that they can depend upon. It is convenient and we don't have to travel far ”. Moreover, the medical cost was not considered high as the average cost of 68.31 Baht per visit. The average travel expense was 8.72 Baht per visit and the average traveling time was about 13.98 minutes. Those who came to seek treatment lived about 0-2,000 meters away (28.1%). Most (66.9%) came by motorcycle, which made the travel more convenient. However, Noonin' s study (2001: 94) found a little bit lower average cost which was 50.91 Baht per visit and the average travel expense was 0.27 Baht per visit.

During the interview, some of the clients said that although they had the government health insurance cards but they preferred to seek treatment at these clinics. This finding confirmed the reasons that convenient to travel, it not too long of a wait, not absent from work, and lower cost make the people seek treatment from midwifery private clinics. Therefore, these clinics were the most appropriate primary care service for the people within their residential area.

Reasons for establishing midwifery private clinics

Based on the finding of this study, it was found that one main reason for establishing a midwifery private clinic is to spend free time wisely (55.6%) and to create more income independently (44.4%). Most of the subjects indicated that they did not work at a private hospital and did not have to travel and to take a risk of having

accidents as they could work at their homes. There was only one subject who had to travel as far as 15 kilometers to work because there were already too many private clinics in her residential area.

Other reasons included helping people who lived far away from a public health center and fully using time to provide health care knowledge and advice to others. The nurses explained that if they worked in a private hospital, they would not have much chance to practice these functions because there were many patients. Moreover, they had lived in that area for a long time and created a bonding with people in the community. Once they had started their services, they could not stop because the patients continuously sought help from them. In the study, there were some nurses who had been providing such services for longer than 30-40 years and they had a larger number of regular patients than nurses with less experience. However, for one nurse who had provided services for only 1 year, she had about 5 to 10 patients per day and she said it was worth because the cost of expenditure was not high and since she worked at her home, she did not have to waste time traveling. Moreover, she could work independently to her fullest potential which clearly reflected nursing autonomy.

Problems and obstacles in opening midwifery private clinics

In contrast to the law, there is a need that nurses at midwifery private clinics provide general health service added to maternal and child health care. So, their actual services were not the procedures that were supported by law, such as drug injections, dressing wounds, intravenous infusions, etc. although these were their main activities while working at a hospital. The professional nurses can practice these medical

treatments or procedures beyond the permission by The Professional Nursing and Midwifery Act B.E.2540 and that of Ministry of Public Health B.E.2539 only under supervision or responsibility of physician (cited by Kongja, D., 1998: 124-129). The private independently medical practice or procedures provided by nurses at these clinics are a violation. As being seen, the real situation and the regulation are not congruent. Nursing professional leaders should bring this issue to the consideration of the authority.

The data from the open-ended questionnaire gave information that the process of establishing a midwifery private clinic was very complicated and troublesome. There were some clinics, which provided services without a proper license. If there was a pending legal case, these nurses would be considered working illegally and they might be punished by law.

The attitude and belief about health care of the layperson is another barrier in providing care. For example, many people believe that injection medication or intravenous fluid therapy is the indicator of good care because it expedites the recovery. It was found that 45.6% of the services provided at these centers included injections. Even though nurses tried to explain that an injection was as equally effective as pills. Although injections were more costly and painful, the patients still needed them. This may be explained by the fact that 25.9% of the subjects were farmers who had to work hard everyday, so they might not want to be sick for a long time. Furthermore, they believed that an injection was the right thing to do as it lead to fast recover. The other obstacle in operating a private clinic is the limited allowance of various drugs used. Nurses are a knowledgeable people who always give proper advice on medication to the patient. In comparing with drug stores, the clients

may not receive advice. If nurses were allowed to use more variety of drugs, the effectiveness of the medication might be yielded.

It is worth noting that when poor patients had to take antibiotics for 3 to 5 days, they would not have enough money to buy the medicine at one time. Some had to buy the medicine day by day, and others got free medicine from the nurses who realized that if they did not take the medication in a full dose, the medicine will not be effective, which may lead to deterioration of the patient's condition.

Chief complaints and health care activities

The findings revealed that most important health problems which made the patients come to seek treatment at these midwifery private clinic was respiratory tract infection, followed by musculoskeletal system, skin problems, and gastrointestinal system (Table 4). This is congruence with the findings of a national survey conducted in 1990 and 1995 which found similar results (The National Statistic Institute, 1992 and 1997). This finding is similar to the study at the midwifery private clinics in the Southern part of Thailand (Noonin, N., et al., 2001) which found the same rank for respiratory system. In addition, Pholpuem (1990); Nittayalumpong and colleagues (1999); and Sawangdee and colleagues (2000) conducted a study at private medical clinics and had found the same results that respiratory system infection ranked first. The other health problems that were similarly from the mentioned studies were gastrointestinal system and skin problems. It could be concluded that these health problems were neither serious nor complicated and that nurses were competent to treat them. These types of care are under the boundaries that were described by The Professional Nursing and Midwifery Act B.E. 2540. Moreover, these clinics are

opened after working hours, so they could help relieve the workload of the outpatient department of a public hospital. This enables the hospital to develop and improve the quality of care in another area.

Concerning initial medication used, the present study found that the largest groups of drug used were analgesics such as Paracetamol (45%), ASA (1.7%) and Antispasmodic (Buscopan) (1.4%). Regarding antibiotics, the most often prescribed drugs were Amoxicillin (21.3%), Penicillin/Ampicillin/Lincocin (12.8%) and Cloxacillin (3.5%), while Chlopheniramine/Piriton (14%) and Dramamine (11.1%) was the most frequently prescribed antihistamines (Table 5). This finding was similar to Noonin and colleagues (2001) which found that the most frequently used drugs at midwifery private clinic in the southern part of Thailand were Paracetamol (47.2%), Amoxicillin (21.4%) and Chlopheniramine (20.8%). When cross tabulating tables was done between chief complaints and medications used (Table9), the result showed that the nurses prescribed medications in concordance with the clients' health problems although there is no regulation allow them to prescribe medications independently. Another interesting finding was that, in four clinics, dexamethasone, a type of steroid, was used, while two others prescribed NSAID (diclofenac, brufen) and medications for heart disease and hypertension (propranolol, reserpine, HCTZ/moduretic). These drugs were beyond the scope allowed for nurses by the regulations of the Ministry of Public Health B.E. 2539. This is totally beyond the nurses' authority. This finding supports the findings of Boonthong, et al study (2000) which specified that provision of primary care by nurses at health centres exceeded the scope specified in the regulation of the Ministry of Public Health B.E. 2539 by 22.34%. It was also noticed that steroids were prescribed for four patients to treat

rashes, allergic reaction, and blisters in this study. These groups of nurses had been working with physicians for a long time, so they had a chance to see that this drug group was effective for certain problems. However, it is the researcher's belief that in a case of serious or complicated chronic illnesses, the prescription and use of steroids, NSAIDs or some cardiovascular drug should be under close supervision of an expert physician. As these days the patients' right have been proclaimed, nurses should be very careful about the standard of services they provide.

In terms of health assessment provided at midwifery private clinic, the findings (Table 6) revealed that the nurses would usually perform physical examination in a systematic manner starting with taking a health history (98%), which tended to be current history than past history. As most of the patients (78%) were local people who had used the services for more than two times, the nurses could remember their past history. However, if the nurses could not remember the patients' history, they would ask questions regarding both present and past history. As for other activities, nurses assessed the patients according to their problems. For example, if the patients had a cold with a cough and sore throat, the nurses would measure the temperature, blood pressure, and auscultation the lungs and heart sounds. If the patients had a stomachache or bloated stomach, the nurses would palpate it and perform percussion (24.1%). If the patients came for a contraceptive injection, the blood pressure would be measured and an appointment would be made for the next three months. Regarding follow-ups, there were both specified and unspecified date of appointment based on the symptoms of the individual patients. In general, when the patients received the medication, the nurses gave advice concerning the method of taking the medication, the adverse effects and the continuity of drug use. Five cases in

this study had health problems beyond the nurses' capability. They were recommended to seek medical treatment at a hospital. However, the nurses did not refer the clients to the hospital in a documented paper.

Additionally, some patients came for other services such as stitching/dressing wounds (0.9%), on IV fluids (0.9%), and removal of foreign body (0.2%), as shown in Table 7. Some patients needed continuation of care for chronic conditions such as diabetes mellitus, hypertension, and allergic disease. These patients explained that they chose to come to the clinic instead of going to a hospital or buying the medicine at a drugstore because it was convenient, they did not have to wait too long, and they were satisfied with provided physical examination. Furthermore, nurses gave recommendations on self-care practice. In cases of diabetes mellitus and high blood cholesterol, the nurses recommended them to have a blood examination at a hospital.

However, no other continuing services such as immunization of DPT, OPV, MMR, and Hepatitis B were found at these clinics. This may be because these services were provided by the government free of charge in public hospitals and schools. Nevertheless, 4 cases (0.7%) of tetanus immunization were found because the patients had been bitten by a dog and there was no free service provided at both public and private hospitals. The patients decided to come to the clinic to save traveling time and expense.

In conclusion, the findings of the present study were in accordance with the scope of provision of primary care services studied by Boonthong, et al (2000). Those health care services were health examination, health status assessment, and holistic treatment. Nurses could provide services to the patients by making decision and ensuring that the patients were safely taken care of. For illnesses and emergency

cases, nurses could conduct diagnosis, initial treatment and follow-up. If the patients required treatment beyond the nurses' capability, they would be referred to a public hospital. However, all the midwifery private clinics studied did not have a systematic or qualified transferal service because there was no written document. In most cases, the nurses would call the hospital they were working for to inform the hospital about the patients. This finding showed that though the nurses work at private clinics independently they still have accountability in good nursing practice in terms of health care networking with other health service institutions. Health care networking means the coordination between the health care workers in either any levels or any sectors. This is different from the findings of Nittayalumpong and colleagues (1999) which discovered that 47.3 % of the private medical clinics issued a written referral document and 14.2 % conducted a very close follow-up, 54 % with an occasional follow-up, and 31.8 % with no follow-up.

Findings indicated that the patients with chronic health problems (HT, DM, arthritis) chose to receive treatment at a midwifery private clinic with the reason that it was convenient, did not involve a long waiting time, and the prices of the medicine were the same. They also mentioned the fact that nurses would try to offer further advice on health issues and encourage them to go for a regular follow-up at a hospital. One nurse said that she always asked the patients to keep their hospital appointments, but the patient chose to buy the needed medicine from a drugstore instead. Thus, it might be better if she is the one, who can prescribe these medicines to the patients, because she can add useful advice to make patients maintain their conditions. Therefore, the roles of the nurses in taking care of chronic patients in the community

were in agreement with the characteristics of provision of primary health care. (Suntrarawadee Thianpichet, S. & Urai Hathakit, 2001).

Effectiveness of primary care in midwifery private clinics

Clients' satisfaction.

The analysis of the results revealed that more than 90 percent of the patients who used services at these midwifery private clinic were satisfied with the services they received in terms of politeness and caring treatment by the nurses. In addition, more than 80 percent were satisfied with the nurses' services in other aspects including friendliness, time spent talking during treatment, providing information concerning illness and self-care, willingness to help, and dependability (Table 10). This yield supports the findings of Noonin and colleagues (2001), who studied the effectiveness of primary care in midwifery private clinics in the Southern part of Thailand and found that among 360 clients, 90% were satisfied with greeting, gentleness, friendliness, and willingness to help giving advice on healthcare. Nurses' career behavior is usually emphasized in nursing education.

One explanation for this outcome may be stated that these nurses were local people and had been working at a hospital in that area from 9 to 40 years, so they knew the patients and their families very well. Also, the people in the communities knew the nurses and their services. Therefore, the clients trusted the nurses and the services they received. Moreover, it was found that during the treatment, the nurses would spend a longer period of time talking to the patients, giving advice on illness and healthcare. Those who suffered from illness were the patients who needed knowledge and advice from health care providers the most. Besides, the patients

would feel that they could more readily trust and accept the health care team members that they were knowledgeable in terms of diagnosis, treatment, as well as understanding the patients' worries and concerns better than others (Nugent, 1988: 50). These are the roles of nurses who are care providers, educators, and counselors. These professional nurses can perform independently (Somchit Hanucharunkul, 1999: 19-20). This is similar to the findings of a study conducted in the USA to investigate the performance of nurse practitioners. It found that nurses would provide more advice to promote the patients' healthcare than doctors (Brown & Grimes, 1993; Moody, et al., 1999). Moreover, Sawangdee and colleagues (2000) found that the doctor did not provide explanation about the illness and allowed little time for questions and answers. This finding is similar to other studies by Aeuwattana, A. (1999); Ophakin, P. (1999: 8-9); Rodkasem and colleagues (1999), and Zip Kin and colleagues (1984 cited by Kochanum, M., 1994: 99).

Furthermore, it was also found that the subjects were satisfied with the convenience of the services received. This could be because the clinics were located in the community and most of the subjects lived within the distance of 0-2,000 meters away from the clinics (Table 4). For the convenient factors, there are a number of previous studies which explored the satisfaction of the services received from a public health center and found that convenience is an important factor that brought the clients to the health center such as Isarapaijit, W., (1999) who conducted a study at Sukhothai Hospital, Mustafa& Haff (1996 cited by Chaipayom, O., 1999: 29) in Trinidad and Tobago. However, if the clients had to wait for a long time before receiving treatment, they would be unsatisfied (Dansky, 1997: 165-177; Likun, P., 1996). Therefore, this

led to conclusion that the total amount of time spent waiting for the provider was the most significant predictor of clients' satisfaction.

In terms of medical expenses, it was found that clients spent 68.31 Baht per visit on average. If they were poor people or monks, the nurses would not charge a fee. In addition, if the patients were unable to pay for their treatment at that time, they could come back and pay later, with no record. So, they are pleased with the flexibility of payment. Moreover, the charge at these midwifery private clinics was less expensive than that of medical private clinics which averaged 139-197 Baht per visit (Nittayalumpong, S., et al., 1999; Sawangdee, Y., et al., 2000).

Moreover, the medication the nurses prescribed was appropriate and satisfactory for the patients (87.3 %). One of the subjects in this study stated that, "The quality of the medicine does not differ from that prescribed by a pharmacy or by a private medical clinic, and I don't have to pay for the transportation to buy the medicine in the city". Another one said, " Sometimes I come just to buy medicine, but the nurses still asks me about my condition or performs an examination or gives advice, and I will not receive these services from a drugstore ". Especially when compared to the average cost at an outpatient public hospital, which charges 255-532 Baht per visit (Pannarunotai, S., 1997 cited by Nittayalumpong, S., 1999: 106). It could be concluded that the expense for care led to the satisfaction in chose health service by the people.

As for traveling expenses, it was found that more than half of the subjects (66.9%) used a motorcycle as their means of transportation, followed by riding a bicycle and walking (19.4% and 7.0%, respectively). The average traveling expense was 8.72 Baht (S.D.=12.4), with the highest expense equaled to 160 Baht and the

lowest was none (Table 4). This is incongruent with the findings of Noonin and colleague (2001) which found that the average traveling expense was 0.27 Baht. Regard for the minimal traveling expense in Noonin's study, only nine subjects had traveling expense, the other 351 subjects had none. Also, she did not count the expense for the clients who used motorcycle.

Outcomes after health care services and expectation to revisit the clinics

Based on the results of this study, it was found that 5-7 days after receiving the services from a midwifery private clinic, 61.5% of the patients reported that their conditions improved, 34.1% fully recovered, 3.1% remained the same, and 1.3% had worsened conditions (Table 11). For most of those who reported a full recovery, they sought treatment for a common cold, sore throat, and diarrhea. For most of those who reported an improved condition, they previously suffered from a stomachache, headache, or tonsillitis. Those who reported that their conditions remained the same were the one who had hypertension, diabetes mellitus and knee pain. Finally, those who said their conditions became worse were those who had tonsillitis and a stomachache.

The explanation is that these patients had a mild illness that was not serious and required a short time for recovery and cure. For instance, they suffered from a respiratory tract infection accompanied by a fever or cough (21.8% and 19.8%, respectively), followed by muscle/skin problems, and muscle pain (12%), so they could be treated effectively. Moreover, as it was convenient to travel to the clinic, the patients could receive immediate treatment that led to rapid recovery. In addition, nurses would give other advice on how to take care of themselves such as using a cold

pack when having a fever, eating soft food to accompany medication, or taking a full dose of antibiotics. This may have resulted in a faster improvement or recovery. As for the patients whose conditions remained the same, they suffered from chronic illnesses such as hypertension, diabetes mellitus that required a long-term treatment, which could be life long.

Regarding the clients' expectation of returning to the clinic the next time they were sick, 96.6% indicated that they would come back. The reasons that the subjects expected to return could be divided into the three following categories: (1) Nurses' service: good treatment, good manner, responsibility, provision of advice, warm welcome, and continuous treatment. (2) Location: close distance, convenience, and time saving. (3) Treatment: effective, good quality of medicine, appropriate medicine, and improved condition.

The findings of the present study clearly reflected the nurses' role in providing primary care, however, only 3.4% said that they would not come back because the treatment was not effective, the medication was not strong enough, they had a medical insurance card, and their symptoms were too severe. Nurses could make use of their own potential in offering primary care, by giving advice on healthcare, and acting as a health counselor in the community especially in rural areas. Moreover, the service fee was cheaper than that of the doctor and the clinics are mostly located in the heart of the community, so the patients could save time and money needed to travel. In some cases, nurses were ready to provide a home visit if the patients could not come to the center by themselves. They said that the patients were well known to them and they wanted to be dependable to the people in the community.

In summary, these midwifery private clinics could respond well to the health care needs of the people in the community. The primary care services provided covered a variety of healthcare services including primary medical care, health promotion, prevention of diseases, and health rehabilitation, including follow-ups of chronic patients and referral services. In addition, these centers were located closely to the patients' residence, so it was convenient for the patients. As Charas Suwanwela (2001) once said, the services provided were “ both close to home and close to the heart ”. Being close to home means it is a service accessible to everybody, while being close to the heart means reliability and trust that the patients have for the nurses. Therefore, it can be finally concluded that by providing health services at the midwifery private clinics, the nurses can create and maintain a mutually good relationship with the residents in the local community.

CHAPTER VI

CONCLUSIONS

Conclusions

This study is a descriptive research, which describes the effectiveness of primary care provided at midwifery private clinics in Nakhonsawan Province.

The sample population was selected by multi-stage sampling technique as follows, (1) Three Amphurs were randomly selected from the total Amphurs in Nakhonsawan Province. (2) Three Tambols were randomly selected from each sampled Amphur. (3) One clinic was purposive selected within each Tambol. There were a total of nine clinics included in the study. Sixty clients were collected in each clinic to combine into a total of five hundred and forty cases. Data was collected in a three-month period from March to May 2001.

The criterias used in selection the samples were categorized as:

The clinic: owned by the professional nurse, who had a license for nursing or nursing and midwifery and willing to participate in the study,

The client: who had no hearing loss, able to communicate in Thai language and willing to participate in the study.

The instruments were composed of structured observation forms, structured interview forms and the questionnaires. These instruments were designed for two groups of sample.

1. The professional nurse group

- 1.1 The professional nurse questionnaire was divided into two parts.

Part one was the characteristics of the clinic and part two was the demographics and characteristics of the nurses.

- 1.2 The observation form designed for collection of the health service activities that were provided to the clients.

2. The client group

- 2.1 The clients' demographic questionnaires,

- 2.2 The outcome of the clients' questionnaires concerning the condition 5-7 days after their treatment and the expectations of revisiting the clinic,

- 2.3 The clients' satisfaction questionnaires.

The researcher conducted the interview with the clinics' owner and completed the observation forms of the health service activities. The research assistant managed the data collection in the clients groups. The clients who can read completed the questionnaires by themselves, those who had problems in reading were assisted by the research assistant. After receiving the health service, the clients took the outcome and clients' satisfaction questionnaires for completion at their home and were instructed to send them back to the researcher 5-7 days later.

Data analysis was performed by SPSS F/W version 7.5. The main results were:

1. Characteristics of the clinics and the nurses' demographic data.

In each of the nine clinics, they were staffed and operated by one professional nurse who opened the clinic everyday. Only one clinic opened a full day between 8 a.m.- 8 p.m., all of the rest opened only at non official work hours which

was the period 7-8 a.m. and/or 5-8 p.m. The average service time was 5.22 hours on weekdays and 10.44 hours on weekends. The majority of the clinics did not keep the clients' records except one who had kept in card-files. All of the clinics had no bed for admission service except for short observation period.

All nurses' providers were the government's employees who worked in government hospitals except for one who had retired. Four nurses had finished the nurse practitioner course while the others were trained for some special short courses. The mean of number of years of experienced practice after finishing basic nursing was 22.44 years while the number of years opening the clinics was 14.44 years.

2. The clients' demographic data

The majority of clients were female (64.6%) aged 21-40 years (25.7%) and all of them were Buddhists. Most of them had finished primary school level in 47.6% and were agriculturists (25.9%), and had a monthly income ranging from 3,001-5,000 Baht.

The average of the distance from home to clinics was 6,448 meters with time spent traveling to the clinics was 13.98 minutes, which was mainly by motorcycle (66.9%). The average cost of traveling was 8.72 Baht.

The reasons for the clients for revisiting the clinics were good outcome of treatment (67.8%) and near home (60.2%). The coverage cost of service fee was 68.31 Baht per visit. Most of the clients (93.1%) knew that the health care providers were nurses.

3. Chief complaints or health problems of clients

The majority of chief complaints were related to the respiratory system with the presenting symptoms of fever and cough / sore throat were 21.8% and 19.8%

respectively. The other important systems involved the musculoskeletal/dermatologic system—presented with muscle pain/arthritis/arthralgia was 12%, the gastrointestinal system—presented with abdominal pain/flatulence was 9.5%. Moreover, the symptom of headache/dizziness was 11.6%.

4. The clients' health care service and the nurses' care activities in the clinics

Either taking present history of illness (98%) or past history (28.9%) was the main approach of the nurses. According to their physical examination, the parameters measured were temperature measurement, heart-lung auscultation, blood pressure measurement, examination of ear/nose/eye in 40.2%, 47.4%, 53.9%, 41.3% respectively. The provisional diagnosis was made according to symptoms in 57%.

The nurses often provide information, guidance and counseling to the patients related to health problems including self-care (88.1%) and medication use (96.3%). The other usual activity was drug injection (45.6%). In some clients who had more serious problems, the nurses would provide initial care before referring them to the hospital.

Most of the nurses (82.4%) did not schedule the clients for follow-up, but suggested them to return to the clinics if they were not feeling better or experiencing some complications.

5. The clients' satisfaction

More than 90% of clients were satisfied with nurse's gentleness and convenient service. Other nursing services which the clients were satisfied more than 80% were; politeness, friendliness, dependability, eagerness to help, time spent on talking, health advice, medication, greeting, waiting time and confidence.

6. The outcome of treatment

After receiving treatment, the clients reported that they were recovering from the illness (61.5%), cured (34.1%), and same (3.1%). The other (1.3 %) felt worse.

7. The expectation of returning to clinic the next time

Most of the clients (96.6%) would like to revisit the clinics again if they were sick.

Recommendations

This study demonstrated the effectiveness of primary care provided by the professional nurses in private practice from the high rate of responses of good outcomes from treatment, clients' expectation to revisiting the clinics and clients' satisfaction. Although the sample was only in three Amphurs of one province, it should reflect one part of the primary care services of the Thai health system. From the study, the researcher would like to propose some recommendations.

The Nursing Council of Thailand

1. Use the results of this study as another information to support the extended roles and responsibilities of the professional nurse in primary care services especially in primary medical care.
2. Accumulate this study result as evidence to make change to the policy or acts that are related to nursing practice. Nurses can be the effective primary care providers and can run private clinics independently.
3. The results of this study should be used as another support in revising the laws related to the scope of primary medical care provided by nurses.

4. Propose the evidence that nurses should be utilized in the Health Care Reform Project as primary care providers in the community.

The Professional Nurse

1. Nurses should develop their knowledge and skill in primary care practice.
2. According to the primary health care philosophy, the nursing practice in midwifery private clinics should be concentrated in disease prevention, health promotion, long term care and follow up of the clients with chronic illness.
3. The nurses should keep all the clients' records or files of visiting at the clinics. The record is one of the indicators of quality service and legal issue.

Nursing Education

1. The present undergraduate-nursing curriculum should focus on the primary care content because of the health care revolution trend and the change of the socio-economic situation.
2. The postgraduate continuous education should include short course training in primary care to enhance nurses' knowledge and skill in providing comprehensive primary care.
3. The nursing faculty in cooperation with The Nursing Council of Thailand should develop new nursing practice guidelines in primary care practice.

Nursing Research

1. Studies should be replicated in other parts or provinces of Thailand for comparison. The outcome will give the large picture of primary care practice by professional nurses.
2. The other factors, which influence the clients' selection the clinics (i.e., health insurance, 30 Baht card), should be the objective of further studies.

3. Future studies with the same research design in private clinics run by nurse midwives and other health workers should be compared.

Health Care Policy

1. The new “ 30-baht Health Program ” of the government should include the midwifery private clinics into the primary health care network like medical clinics or private hospitals.

4. The midwifery private clinics provided by nurses should be selected as the primary care network of the government service.

5. The midwifery private clinics should be selected into the health insurance network.

4. The development of clinical practice guidelines of common diseases may utilize data from this study as additional information.

BIBLIOGRAPHY

- Aday, L.A. & Andersen, R.M. (1975). Access to medical care. Ann Arbor: Health Administration Press.
- Aeuwattana, A. (1999). Client's satisfaction toward health care service at the outpatient department of Amnaatchareon. Master's Thesis in Science (Public Health), Faculty of Graduate Studies, Mahidol University.
- Aiken, L.H., et al. (1993). Nurse practitioner managed care for persons with HIV infection. Image: Journal of Nursing Scholarship, 25(3), 172-177.
- American Nurses Association. (1993). ANA definition of advanced practice registered nurses. In: Kansas City: American Nurses Association.
- Andersen, R.M. (1995). Revisiting the behavioral model and access to medical care: Does it matter?. Journal of Health and Behavior, 36(3), 1-10.
- Apakuppakun, N. (2001). Program evaluation on satisfaction of clients and health teams at family medicine clinic department of social medicine, Hat Yai Hospital. Chulalongkhon Journal of Nursing, 13(2), 57-65.
- Avorn J, Everitt D.E., Baker MW. The neglected medical history and therapeutics choices for abdominal pain: a nationwide study of 799 physicians and nurses. Arch Intern Med, 151, 694-698.
- Barnes, D., et al. (1995). Primary health care and primary care: A confusion of philosophies. Nursing Outlook, 43(1), 7-16.

- Benjaratanaporn, P., (1990). The difference of health seeking patterns among middle age and aging people in Thailand. Master's Thesis in Arts (Population and Social Research), Faculty of Graduate Studies, Mahidol University.
- Berger, A.M., et al. (1996). Advanced practice roles for nurses in tomorrow's health care systems. Clinical Nurse specialist, 10(5), 250-255.
- Boonthong, T. (2000). The directions of nursing care system congruent with the expected Thai health service system in the future (2nd Ed). Bangkok: Siriyudkarnpim.
- Boonyapaisancharoen, T. (1999). The integrated health care system. In Y. Pongsuphap (Ed). The new alternative health service system (pp 45-53). Bangkok: Komol-keemthong Foundation.
- Brown & Grimes. (1993). A meta-analysis of nurse practitioners and nurse midwives in primary care. Nursing research, 44(6), 332-339.
- Bullough, B. (1974). Is the nurse practitioner role a source of increased job satisfaction?. Nursing Research, 23, 14-19.
- Chang, K. (1997). Dimensions and indications of patients' perceived nursing care quality in the hospital setting. Journal of Nursing Care Quality, 11(8), 26-37.
- Chaipayom, O. (1999). Clients' satisfaction towards health care service at the outpatient department, Siriraj Hospital. Master's Thesis in Science (Public Health), Faculty of Graduate Studies, Mahidol University.
- Charoenyut, C. (1979). Factors determining the utilization of alternative source of care in rural area. Master's Thesis of Art (Medical Social Sciences), Faculty of Graduate Studies, Mahidol University.

- Cooper, R.A., Laud, P., & Dietrich, C. L. (1998). Current and projected work force of nonphysician clinicians. JAMA, 280(9), 788-794.
- Dansky, K.H. & Milles, J. (1997). Patient satisfaction with ambulatory health care services: Waiting time and filling time. Hospital & Health Services Administration, 42(2), 165-177.
- Davis, L.L. & Gillis, C.L. (1998). Primary care and advanced practice nursing: past, present & future. In C. M. Sheehy, & M. C. McCarthy (Eds.), Advance practice nursing: Emphasizing common roles (2nd ed., pp 114-136). Philadelphia: F.A. Davis company.
- Doughty, S. (1989). The CNS in a nurse- managed center. In A. B. Hamric & J. A. Spross (Eds.), The clinical nurse specialist in theory and practice (pp 415-433). Philadelphia: W. B. Saunders.
- Eriksen, L. (1988). Measuring patient satisfaction with nursing care: A magnitude estimation approach. New York: Spring Publishing.
- Fitzpatrick, E.R. (1998). Analysis and synthesis of the role of the advanced nursing practice. Clinical Nurse Specialist, 12(3), 106-107.
- Gallagher, S.M. (1996). Promoting the nurse practitioners by using marketing approach. Nurse Practitioner, 21(3): 30, 36-37, 40.
- Hamric, A.B. & Spross J.A. (1989). The clinical nurse specialist in theory and practice. (2nd ed). Philadelphia: W.B. Saunders.
- Hanna, D.L. (1996). Primary care nurse practitioner. In A.B. Hamric, J. A. Spross & C. M. Hanson (Eds.), Advanced nursing practice: An integrative approach (pp 337-350). Philadelphia: W. B. Saunders.

Herpcey, J.E. (1993). Factors and work settings that may influence nurse practitioner practice. Nursing Outlook, 41(4), 181-185.

Institute of Medicine (1978). Report of a study: A manpower policy for primary health care. National Academy of Science, Washington, DC, May 1978.

Institute of Medicine (1994). Defining primary care: An interim report. Washington, DC, National Academy Press.

Institute of Population and Social Research (IPSR). (1988). Health care utilization pattern of the people by residence and region: morbidity-mortality differentials 1988. Institution of Population and Social Research. Mahidol University.

Isarapaijit, W., et al. (1999). Patient's satisfaction toward nursing service, Sukhothai Province. The 11th nursing convention "Transition to the 21st century of Thai nursing". Bangkok: P.Vatin printing.

Jennings, B.M., Staggers, N. & Brosch, L.R. (1999). A classification scheme for outcome indicators. Image: Journal Nursing Scholarship, 31(4), 381-388.

Kassirer, J.P. (1994). What role for nurse practitioners in primary care? The New England Journal of Medicine, 330(3), 204-205.

Kinlein, L. (1977). Independent nursing practice with clients. Philadelphia: J. B. Lippincott.

Kochanum, M. (1994). The relationship between selected factors and the utilization of medical service at health center among people in rural Surathani Province.

Master's Thesis in Science (Public Health), Faculty of Graduate Studies, Mahidol University.

- Koelbel, P.W., Fuller, S.G., & Misener, T.R. (1991). Job satisfaction of nurse practitioners: An analysis using Herzberg's theory. Nurse Practitioner, 16(4), 43-56.
- Koernen, B.L. & Cohen, J.R. & Armstrong, D.M. (1985). Collaborative practice and patient satisfaction. Evaluation & the Health Professions, 8, 299-331.
- Kongja, D. (1998). Nursing Law. Bangkok: Yudtharindkarnpim.
- Leoprapai, B. & Sirirasamee, B. (1988). Health status of people and health care service in rural areas (Report). Nakhonprathom: Institute for Population and Social Research, Mahidol University.
- Likun, P. (1996). The strategic issue for reducing patient waiting time and improving satisfaction with services at the out-patient department of the first affiliated hospital, Kunming Medical College. Master's Thesis in Health development program. Faculty of Graduate Studies, Chulalongkhon University.
- Linn, L.S. (1975). Expectation VS realization in the nurse practitioner role. Nursing Outlook, 23, 166-171.
- Locker, D. & Dunt, D. (1978). Theoretical and methodological issues in sociological studies of consumer satisfaction with medical care. Social Science Medicine, 12(7), 283-292.
- Loeken, K., Steine, S., Sandvik, L., & Laerum, E. (1997). A new instrument to measure patient satisfaction with mammography. Medical Care, 35, 731-741.
- Lundeen, S.P. (1985). Nurse-managed centers offer more to patient, nurses. The American Nurse, 17(4), 22.

McGivern, D.O., Mezey, M.D., Glynn, P.M. (1990). Evolution of primary care roles. Nurse Practitioner, 17(3), 163-168.

Medical Registration Division. (1999). Annual report of private clinic and hospital in 1999. Bangkok: Ministry of Public Health.

Mezey, M.D., & McGivern, D.O. (1986). Nurse, nurse practitioners: The evolution of primary care. Philadelphia: J. B. Lippincott.

Moody, N.B., Smith, P.L., & Glenn, L.L. (1999). Client characteristics and practice patterns of nurse practitioners and physicians. Nurse Practitioner, 24(3), 94-103.

Mundinger, M.O. (1994). Advanced practice nursing: Good medicine for physicians? The New England Journal of Medicine, 330(3), 211-214.

Mundinger, M.O. (2000). Health outcomes among patients treated by nurse practitioners or physicians. JAMA, 283(19), 2521-2524.

Mundinger, M.O. et al., (2000). Primary care outcomes in patients treated by nurse practitioners or physicians. JAMA, 283(1), 59-68.

Nadee, K. (1998). Health-seeking behavior of the elderly receiving first service at King Mongkut Prachomklao hospital, Petchaburi Province. Master's Thesis in Nursing Science (Adult Nursing), Faculty of Graduate Studies, Mahidol University.

National Economic and Social Development Board (NESDB).(1998). Summary of the 8th National Economic and Social Development Plan, 1997-2001. Bangkok: Meka Press.

- Nichols, L.M. (1992). Estimating costs of underusing advanced practice nurse. Nursing Economics, 10(5), 342-351.
- Nittayalumpong, N., et al. (1999). The present and future of medical private clinics in Thailand. (1st Ed). Bangkok: Komol-keemthong Foundation.
- Nittayalumpong, N. (1998). Health Care Reform of Thailand. (2nd ed). Bangkok: Folk Doctor Press.
- Noonin, N., Konggumnerd, R. & Wangsajuntanon, T. (2001). Effectiveness of the primary care provided at midwifery private clinic. Thai J Nurs Res, 5(1), 86-106.
- Nugent, L.S. (1988). The social support requirements of family caregivers of terminal cancer patients. The Canadian of Nursing Research, 20(30), 45-58.
- Onchoenjit, S., & Pantong, U. (2000). Family nurse practitioner. The Songklanakarintr Journal of Nursing, 20(1),78-85.
- Ophakin, P. (1999). Factors related to primary care service at medical private clinics: Strategic plan. Office of Health Care Reform, Ministry of Public Health.
- Orem, D.E. (1985). Nursing concepts of practice. (3rd ed.). New York: Mc Graw-Hill.
- Pangprasit, S. (1993). Factors affecting medical service utilization of insured person at the Ayutthaya hospital according to the Social Security Act B.E. 2533.
Master's Thesis in Science (Public Health), Faculty of Graduate Studies,
Mahidol University.
- Pearson, L. (2001). Annual legislative update of how each state stands on legislative issues affecting advanced nursing practice. Nurse Practitioner, 26(1), 7-16.



- Phavilai, J. (1992). The study of health perception, self-care behavior or health state of the post cardiac valvular replacement patients. Master's Thesis in Nursing Science (Adult Nursing), Faculty of Graduate Studies, Mahidol University.
- Pholpuem, C. (1993). The determinants of private medical service utilization in Bangkok. Master's Thesis in Arts (Population and Social Research), Faculty of Graduate Studies, Mahidol University.
- Pongsuphap, Y. (1999). The development of family medicine: The Ayutthaya health urban center. (2nd ed). Nonthaburi: Health Care Reform Project.
- Pookpun, J. (2000). The effectiveness of part-time health care service at health centers in Nonthaburi Province. Master's Thesis in Science (Public Health), Faculty of Graduate Studies, Mahidol University.
- Prakunkongchai, P. (1993). Out patient satisfaction for government hospital health service: A case study of Nakhonsawan Province. Master's Thesis in Arts (Population and Social Research), Faculty of Graduate Studies, Mahidol University.
- Risser, N.L. (1975). Development of an instrument to measure patient satisfaction with nurses and nursing care in primary care settings. Nursing research, 24 (1), 45-52.
- Rodkasem, J. et al. (1999). Patient's satisfaction toward nursing service, Kampanget hospital. The 11th nursing convention "Transition to the 21st century of Thai nursing". Bangkok: P.Vatin printing.
- Rudy, D. R. (1995). Advanced practice nurses should they be independent?. Arch Fam Med, 4, 14-16.

- Ruppert, N. (1995). Advanced practice nurses: should they be independent?. Arch Fam Med, 4, 674.
- Ryden, M.B., et al. (2000). Development of a measure of resident satisfaction with the nursing. Research in Nursing & Health, 23, 237-245.
- Sanphirom, S. (1993). An evaluation of the referral system between private clinic and government hospital: A case study of Pranakhonsri-Ayutthaya Province. Master's Thesis in Science (Public Health), Faculty of Graduate Studies, Mahidol University.
- Sawangdee, Y., Israbhaakdi, P. & Sanpuwan, M. (2000). Problems and suffering experienced by patients obtaining services at health care facilities. Institute Population and Social Research. Mahidol University.
- Schaffner, J.W., Beymer, P.L., & Wiggins, J. (1995). Utilization of advanced practice nurses in health systems and multispecial group practice. JONA, 25(12),37-43.
- Sheehy, C.M. & McCarthy, M.C. (1998). Advance practice nursing: Emphasizing common roles. Philadelphia: F. A. Davis company.
- Shoultz, J. & Hatcher, P. A. (1997). Looking beyond primary care to primary health care: An approach to community-based action. Nursing Outlook, 45(1), 23-26.
- Sompongsa, S. (1999). Health information system reform for improving health center effectiveness in Sakonnakhon Province. Doctoral's Thesis in Public Health (Health administration), Faculty of Graduate Studies, Mahidol University.
- Starfield, B. (1994). Is primary care essential?. LANCET, 344(22): 1129-1133.

- Stewart, P. (1989). The CNS in private practice. In A. B. Hamric & J. A. Spross (Eds.), The clinical nurse specialist in theory and practice (2nd ed., pp. 435-455). Philadelphia: W. B. Saunders.
- Sullivan, E.M. (1992). Nurse practitioners & reimbursement. Nurse Health Care, 13, 236-241.
- Sultz H.A., Henry, O., Bullough, B., Buck, G.M., & Kinyon, L.J. (1984). Nurse practitioners: decade of change-part IV. Nursing Outlook, 32, 158-163.
- Synder, M. & Mirr, M.P. (1995). Advanced practice nursing: A guide to professional development. New York: J. B. Lippincott.
- Tunpumiprated, J. (2000). Factors affecting utilization health center service of people in Tumbol Wanghin Tak Province. Master's Thesis in Public Health, Faculty of Graduate Studies, Chaingmai University.
- The American Heritage Dictionary of the English Language. Forth Edition. (2000). New York: Houghton Mifflin Company.
- Tri D.L. (1991). The relationship between primary health care practitioners' job satisfaction and characteristics of their practice settings. Nurse Practitioner, 16(5), 46-55.
- Vroom, V.H. (1964). Work and Motivation. New York: John Wiley & Sons.
- Ware, J.E. & Davies-Avery, A. & Stewart, A.L. (1978). Measurement and measuring patient satisfaction. Health & Medical Care Service Review, 1(1), 1-15.
- Weerapong, J. (1999). The relationship between factors of curative service provided at health centers in Nakhonsawan Province. Master's Thesis in Science (Public Health), Faculty of Graduate Studies, Mahidol University.

- WHO. (1998). 50 years of international public health: Health as a human right. WHO: Geneva.
- WHO. (1978). Primary health care: Report of the international conference on primary health care. Alma-Ata, USSR, 6-12 September 1978. WHO: Geneva.
- Wibulpolprasert, S. (editor). (1999). Report of Thailand Health Profile 1997-1998. Bangkok: Ministry of Public Health.
- Wichaidit, M. (1996). A study of nursing service management in the out-patient department, St. Louis hospital. Master's Thesis in Science (Public Health), Faculty of Graduate Studies, Mahidol University.
- จรัส สุวรรณเวลา. (2544, 12 กันยายน). “เสนอเพิ่มอัตราค่าล้างรองรับ 30 บาท”, หน้า 6. มติชนรายวัน.
- คารุณี จามจรี. (2542). ความเป็นผู้นำกับบทบาทการบริหารพยาบาลเพื่อสู่ ศตวรรษที่ 21. วารสารกองการพยาบาล, 26(2): 74-87.
- ทองหล่อ เดชไทย. (2540). หลักการบริหารงานสาธารณสุข. นครปฐม: สถาบันพัฒนาสาธารณสุขอาเซียน มหาวิทยาลัยมหิดล.
- ทวีเกียรติ บุญยไพศาลเจริญ. (2536). แนวคิดในการพัฒนาการให้บริการสาธารณสุขระดับปฐมภูมิ. ใน การประชุมสัมมนาอัยแพทยศาสตรศึกษา ระบบการสนับสนุนแพทย์ทั่วไปและแพทย์ทั่วไปในการพัฒนาระบบบริการสาธารณสุขไทย; 17-18 สิงหาคม 2536. (หน้า 27-32). ม.ป.ท.
- นิพนธ์ เสริมพาณิชย์. (2543). บุคลากรทางการแพทย์กับเวชปฏิบัติปฐมภูมิ. คลินิก, 16(12): 848-851.
- บุญเรียง ชูชัยแสงรัตน์และคณะ. (2539). การพัฒนาของสถานีนอนมัยในเขตพื้นที่ทั่วไปและพื้นที่เฉพาะ. รายงานวิจัย. กรุงเทพมหานคร: โรงพิมพ์องค์การสงเคราะห์ทหารผ่านศึก.
- ประเวศ วะสี. (2543). สุขภาพในฐานะอุดมการณ์ของมนุษย์. (พิมพ์ครั้งที่ 4). กรุงเทพฯ: บริษัทพิมพ์ดี.

- ปรีดา แต่อารักษ์และคณะ. (2543). ข้อเสนอการพัฒนาระบบบริการสุขภาพระดับต้นของไทยในการปฏิรูประบบสุขภาพแห่งชาติ และใน(ร่าง)พ.ร.บ.สุขภาพแห่งชาติ. นนทบุรี: สำนักนโยบายและแผนสาธารณสุข สถาบันวิจัยระบบสาธารณสุข.
- พรเทพ ศิริวนารังสรรค์, อำนวย กาจีนะ, อรสา ไฉวินทะ, สุมากรณ์ แซ่ลิ้ม, และกรรณิกา เรืองเดช. (2541). บทบาทของเทศบาลต่อการพัฒนางานสาธารณสุข. นนทบุรี: สถาบันวิจัยระบบสาธารณสุข.
- เพ็ญจันทร์ ส.โมไนยพงศ์, อารีณา ภาณุโสภณ และสุจินต์ วิจิตรกาญจน์. (2525). พยาบาลกับกฎหมายวิชาชีพ. ภาควิชาพยาบาลศาสตร์ คณะแพทยศาสตร์ โรงพยาบาลรามารชิบดี มหาวิทยาลัยมหิดล.
- เพ็ญศรี พิชัยสนิทและคณะ. (2520). พยาบาลสาธารณสุขเวชปฏิบัติของไทย. ภาควิชาอนามัยแม่และเด็ก คณะสาธารณสุขศาสตร์ มหาวิทยาลัยมหิดล.
- ยุคดี ภาษาและคณะ. (2520). การสำรวจทัศนคติของแพทย์และพยาบาลที่มีต่อบทบาทของพยาบาลเวชปฏิบัติ. รายงานวิจัย. ภาควิชาพยาบาลศาสตร์ คณะแพทยศาสตร์ โรงพยาบาลรามารชิบดี มหาวิทยาลัยมหิดล.
- รวิวรรณ ชาญเวชช์, วันดี เสวตมาลย์, และเพ็ญจันทร์ ส. โมไนยพงศ์. (2528). การติดตามผลการปฏิบัติงานของผู้สำเร็จการอบรมพยาบาลปฏิบัติทั่วไป. รายงานวิจัย. คณะแพทยศาสตร์ โรงพยาบาลรามารชิบดี มหาวิทยาลัยมหิดล.
- วิโรจน์ ตั้งเจริญเสถียร. (2539). ทุกข์ สมทัย ในระบบสาธารณสุขและหลักประกันสุขภาพไทย. กรุงเทพฯ: สถาบันวิจัยระบบสาธารณสุข.
- . สุกสิทธิ์ พรรณารุโณทัย และวินัย ลิสมิทธิ. (2541). ทรัพยากรสาธารณสุขกับการกระจายอำนาจด้านสาธารณสุข โอกาสสร้างหลักประกันสุขภาพถ้วนหน้าของประเทศไทย. วารสารวิชาการสาธารณสุข, 9(1): 15-25.
- สภาการพยาบาล. (2543). คุณภาพวิชาชีพ. กรุงเทพฯ: บริษัททีไอซ์.
- สภาการพยาบาล. (2541). กฎหมายกับการประกอบวิชาชีพการพยาบาลและผดุงครรภ์. พรจันทร์ สุวรรณชาติ(บรรณาธิการ). นนทบุรี: เคอะเบสท์กราฟฟิคแอนด์ปริ้นท์.
- สมคิด รอดอินทร์. (2540). ความสัมพันธ์ระหว่างปัจจัยบางประการกับการมาใช้บริการด้านสุขภาพที่สถานีอนามัยของประชาชนจังหวัดสิงห์บุรี. วารสารสาธารณสุขมูลฐานภาคกลาง, 12(5), 20-22.
- สมาคมพยาบาลแห่งประเทศไทย. (2515). ประมวลการประชุมพยาบาลแห่งชาติ ครั้งที่ 3. วันที่ 30 ตุลาคม- 3 พฤศจิกายน พ.ศ. 2515.

- สมจิต หนูเจริญกุล. (2540). แนวคิดของการปฏิบัติการพยาบาลขั้นสูง. สารสภากาพยาบาล 12 (2):1-13 .
- สมจิต หนูเจริญกุล. (2542). การพยาบาล: ศาสตร์ของการปฏิบัติ. กรุงเทพฯ: มปท.
- สุนทราวดี เขียวพิเชฐ และอุไร หัตถกิจ. (2544). การบริการสุขภาพระดับปฐมภูมิกับการศึกษาระดับบัณฑิตศึกษา. ใน การประชุมวิชาการระดับชาติ ครั้งที่ 1 เรื่อง การจัดการศึกษาเพื่อการพัฒนาปฏิบัติการพยาบาลขั้นสูง; 22-24 สิงหาคม พ.ศ. 2544.
- สุพัตรา ศรีวิเศษชากร. (2536). แพทย์เวชปฏิบัติทั่วไปในประเทศไทย: สถานการณ์และแนวทางการพัฒนา. ใน การประชุมสัมมนาอ้อยแพทยศาสตรศึกษา ระบบการสนับสนุนแพทย์ทั่วไปในการพัฒนาระบบบริการสาธารณสุขไทย; 17-18 สิงหาคม 2536. (หน้า 27-32). ม.ป.ท.
- สุพัตรา ศรีวิเศษชากร. (2539). ระบบบริการเวชปฏิบัติทั่วไปในประเทศไทย: สถานการณ์และข้อเสนอต่อการพัฒนา. (พิมพ์ครั้งที่ 1). กรุงเทพฯ: บริษัท ดีไซร์
- สุพัตรา ศรีวิเศษชากร, นพวรรณ ดวงหัตถ์, และวันทนีย์ จำเพ็ง. (2543). การพัฒนาระบบบริการเวชปฏิบัติครอบครัว. รายงานการประชุมวิชาการ; 21-22 กรกฎาคม และ 18-19 สิงหาคม 2542. ขอนแก่น: โรงพิมพ์คลังนานาวิทยา..
- สุพัตรา ศรีวิเศษชากร. (2542). อะไรคือ เวชปฏิบัติครอบครัว ระบบบริการปฐมภูมิ และบริการด่านแรก. ใน พงษ์พิสุทธิ์ จงอุดมสุข และทัศนีย์ สุรกิจโกศล(บรรณาธิการ), เวชปฏิบัติครอบครัว บริการสุขภาพที่ใกล้ใจและใกล้บ้าน: แนวคิดและประสบการณ์. (หน้า 9-23). นนทบุรี: สำนักงานโครงการปฏิรูประบบบริการสาธารณสุข.
- สุรเกียรติ อาชานานุภาพ. (2542). เรียนรู้ผู้ป่วยเบาหวานจากการเยี่ยมบ้าน. คลินิก, 15 (2), 83-84.
- สำนักงานสาธารณสุขจังหวัดนครสวรรค์. (2543). รายงานประจำปี. ม.ป.ท.
- สำนักงานประกันสุขภาพ กระทรวงสาธารณสุข. (2538). (ร่าง) พระราชบัญญัติประกันสุขภาพและมาตรฐาน การให้บริการสาธารณสุข พ.ศ.....
- อรสา พันธุ์ภักดี. (2537). บันไดความก้าวหน้าของการปฏิบัติการพยาบาลผู้อ่อนแอของผู้ชำนาญการทางคลินิก. การประชุมวิชาการพยาบาลผู้ชำนาญการทางคลินิก: มิติใหม่ทางการพยาบาล. (หน้า 31-33). วันที่ 9- 11 มีนาคม พ.ศ. 2537. ภาควิชาพยาบาลศาสตร์ คณะแพทยศาสตร์ โรงพยาบาลรามาริบัติ.
- อารี วัลยะเสวี, พงษ์พิสุทธิ์ จงอุดมสุข, สงวน นิตยารัมภ์พงศ์, เขวลักษณ์ ปรปักษ์ขาม, และ นฤมล ศิลารักษ์. (2543). (ร่าง) รูปแบบระบบบริการสุขภาพที่สอดคล้องกับสังคมไทยในสองทศวรรษหน้า. กรุงเทพมหานคร: สำนักพิมพ์มูลนิธิโกลดคิมทอง.



APPENDIX A

Consent to participate in research study

คำชี้แจงและพิกัดสิทธิในการเข้าร่วมการวิจัย

(กลุ่มพยาบาลวิชาชีพ)

เรียน เพื่อนพยาบาลร่วมวิชาชีพที่นับถือ

ดิฉัน นางสาวสุมาลี กิตติภูมิ นักศึกษาพยาบาลปริญญาโท ภาควิชาพยาบาลศาสตร์ คณะแพทยศาสตร์ โรงพยาบาลรามาริบัติ กำลังทำการศึกษาวิจัย เรื่อง ประสิทธิภาพของการดูแลสุขภาพระดับปฐมภูมิในสถานผดุงครรภ์: จังหวัดนครสวรรค์ ผลที่ได้จากการวิจัยครั้งนี้จะเป็นข้อมูลพื้นฐานที่สำคัญที่จะนำเสนอต่อสภาการพยาบาลเป็นแนวทางในการผลักดันการออกกฎหมายคุ้มครองการบริการการรักษาพยาบาลในสถานผดุงครรภ์ต่อไป

หากคุณ..... เข้าร่วมการวิจัยครั้งนี้ ดิฉันขอให้คุณช่วยกรุณาตอบแบบสอบถามส่วนที่ 1 เป็นข้อมูลของสถานผดุงครรภ์ และข้อมูลส่วนบุคคล ซึ่งจะใช้เวลาในการตอบประมาณ 10 –15 นาที หากไม่เข้าใจในแบบสอบถาม สามารถสอบถามรายละเอียดจากดิฉันได้โดยตรง สำหรับส่วนที่ 2 แบบบันทึกการสังเกตการให้บริการนั้น ดิฉันใคร่ขออนุญาตเข้าบันทึกการให้บริการในขณะที่ท่านทำการรักษาพยาบาลผู้ให้บริการ โดยจะไม่มีมีการแสดงความคิดเห็นหรือการกระทำใดๆที่จะเป็นการรบกวนสมาธิของท่านแต่อย่างใด

ในการตอบแบบสอบถามและการรักษาพยาบาลนี้ คำตอบของท่านจะมีค่าอย่างมากต่อการวิจัยครั้งนี้ ข้อมูลทั้งหมดจะเก็บเป็นความลับ นำเสนอผลการวิจัยเป็นข้อมูลโดยรวมและไม่มี การระบุชื่อแต่อย่างใด การเข้าร่วมการวิจัยครั้งนี้จะเป็นไปตามความสมัครใจของท่าน ไม่ว่าท่านจะเข้าร่วมการวิจัยหรือไม่ก็ตาม จะไม่มีผลต่อการเปิดให้บริการรักษาพยาบาลแต่อย่างใด หากท่านสมัครใจเข้าร่วมการวิจัยในครั้งนี้แล้ว เกิดเปลี่ยนแปลงใจภายหลัง ท่านมีสิทธิ์ที่จะขอยกเลิกการเข้าร่วมวิจัยได้ตลอดเวลาที่ท่านต้องการ โดยไม่มีข้อแม้ใดๆทั้งสิ้น และไม่มีผลต่อการเปิดให้บริการรักษาพยาบาลเช่นกัน

ในระหว่างเข้าร่วมการวิจัย ถ้าท่านมีข้อสงสัยใดๆดิฉันยินดีตอบข้อสงสัยของท่านตลอดเวลา และเอกสารนี้จะทำสำเนาเป็น 2 ฉบับ เก็บไว้ที่ผู้วิจัย 1 ฉบับ และเก็บไว้ที่ท่าน 1 ฉบับ

ขอขอบคุณมากในความร่วมมือ

สุมาลี กิตติภูมิ

ยินดีเข้าร่วมในการวิจัย

หลักสูตรปริญญาโท โรงเรียนพยาบาลรามาริบัติ

ลงชื่อ.....วันที่.....

โทร 2011673, 01-4804501

(กลุ่มผู้ให้บริการ)

ดิฉันชื่อ สุมาลี กิตติภูมิ นักศึกษาพยาบาลปริญญาโท ภาควิชาพยาบาลศาสตร์ คณะแพทยศาสตร์ โรงพยาบาลรามาธิบดี กำลังทำการศึกษาวิจัย เรื่องประสิทธิผลของการดูแลสุขภาพระดับปฐมภูมิในสถานผดุงครรภ์: จังหวัดนครสวรรค์ เพื่อนำความรู้ที่ได้ไปใช้เป็นแนวทางการปรับปรุงการบริการดูแลรักษาพยาบาลได้อย่างเหมาะสมต่อไป

ในการวิจัยครั้งนี้ใคร่ขอความร่วมมือ ในการตอบแบบสอบถามทั้งหมด 3 ส่วน โดยเรียงลำดับจากส่วนที่ 1 ถึงส่วนที่ 3 ดังนี้

ส่วนที่ 1 เป็นแบบสอบถามข้อมูลพื้นฐานส่วนบุคคล

ส่วนที่ 2 เป็นแบบสอบถามผลของการรักษาพยาบาล

ส่วนที่ 3 เป็นแบบสอบถามความพึงพอใจ

ซึ่งส่วนที่ 1 จะใช้เวลาตอบประมาณ 5-10 นาที ส่วนที่ 2 และส่วนที่ 3 ดิฉันใคร่ขอให้ท่านนำกลับไปตอบที่บ้านหลังจากที่ท่านรับการรักษาจากสถานบริการแห่งนี้แล้ว 5-7 วัน และเมื่อตอบเสร็จแล้ว ขอความกรุณาส่งกลับคืนให้ดิฉันทางไปรษณีย์ ซึ่งจะมีชื่อและที่อยู่ของดิฉันพร้อมซองจดหมายติดแสตมป์เรียบร้อยแล้ว

การตอบแบบสอบถามนี้ไม่มีถูกหรือผิด ข้อมูลที่ได้ทั้งหมดจะเก็บเป็นความลับ และนำเสนอผลการวิจัยเป็นข้อมูลโดยรวม การเข้าร่วมการวิจัยครั้งนี้จะเป็นไปตามความสมัครใจของท่าน ไม่ว่าท่านจะเข้าร่วมการวิจัยหรือไม่ก็ตาม จะไม่มีผลต่อการให้บริการรักษาพยาบาลแต่อย่างใด หากท่านสมัครใจเข้าร่วมการวิจัยในครั้งนี้แล้ว เกิดเปลี่ยนใจในภายหลัง ท่านมีสิทธิ์ที่จะขอยกเลิกการเข้าร่วมวิจัยได้ตลอดเวลาที่ท่านต้องการ โดยไม่มีข้อแม้ใดๆทั้งสิ้น และไม่มีผลต่อการให้บริการรักษาพยาบาลที่ได้รับเช่นกัน

ในระหว่างเข้าร่วมการวิจัย ถ้าท่านมีข้อสงสัยใดๆดิฉันยินดีตอบข้อสงสัยของท่านตลอดเวลา และเอกสารนี้จะทำสำเนาเป็น 2 ฉบับ เก็บไว้ที่ผู้วิจัย 1 ฉบับ และเก็บไว้ที่ท่าน 1 ฉบับ

ขอขอบคุณมากค่ะ

สุมาลี กิตติภูมิ

นักศึกษาระดับปริญญาโท

คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี

APPENDIX B

Instruments

ข้อมูลชุดที่ □□□□□

ส่วนที่ 1 ข้อมูลสถานบริการ

1. ที่อยู่ เลขที่.....หมู่บ้าน..... ตำบล.....

อำเภอ.....จังหวัด.....

ประเภทสถานบริการ

สถานผดุงครรภ์

สถานพยาบาลและผดุงครรภ์

2. วันและเวลาที่เปิดทำการของสถานบริการ

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7. มีแฟ้มประวัติผู้ใช้บริการ

มี

ไม่มี

8. ปัญหาและอุปสรรคในการดำเนินการของสถานบริการ

.....

.....

.....

ข้อมูลชุดที่ □□□□□

ส่วนที่ 2 แบบบันทึกการสังเกตการให้บริการ

1. ปัญหาสุขภาพ/อาการที่มารับการรักษา.....
.....

2. การซักประวัติความเจ็บป่วย

อดีต.....
.....

ปัจจุบัน.....
.....

7. การมาขอรับการดูแลต่อเนื่อง

7.1 ทำแผล

7.2 ฉีดยา

7.3

8. การนัดครั้งต่อไป.....

ส่วนที่ 1 ข้อมูลส่วนบุคคลของผู้ใช้บริการ

คำชี้แจง ให้ท่านเติมคำลงในช่องว่าง หรือ (ใส่เครื่องหมาย ✓ ลงใน หน้าข้อความที่เป็นความจริงทุกข้อ)

1. ชื่อ..... สกุล.....

2. ที่อยู่ปัจจุบัน เลขที่..... หมู่ที่..... ตำบล.....อำเภอ..... จังหวัด

3. เพศ 1. ชาย 2. หญิง

14. ค่าใช้จ่ายในการไปรับการรักษาพยาบาลในครั้งนี้ เป็นจำนวนเงินเท่าใด

14.1 ค่าเดินทาง.....บาท

14.2 ค่ารักษาที่สถานบริการเรียกเก็บ.....บาท

14.3 อื่น ๆ (ระบุ).....บาท

15. ท่านทราบหรือไม่ว่า ผู้ให้บริการในสถานบริการแห่งนี้เป็นพยาบาล

1. ทราบ

2. ไม่ทราบ

ข้อมูลชุดที่

ส่วนที่ 2 ผลของการรักษาพยาบาล

โปรดอ่าน : หลังจากที่ท่านรับการรักษาที่สถานบริการแห่งนี้แล้ว 5 - 7 วัน โปรดตอบแบบสอบถามชุดนี้ทุกข้อ แล้วกรุณานำส่งตามที่อยู่ปรากฏ จักขอบพระคุณยิ่ง

คำชี้แจง ให้ท่านเติมคำลงในช่องว่างหรือใส่เครื่องหมาย ✓ ลงใน ที่ตรงกับความคิดเห็นของท่าน

1. ผู้ตอบแบบสอบถาม

1.1 ผู้ให้บริการ

1.2 อื่น ๆ (ระบุ.....เช่นญาติ, เพื่อนบ้าน เป็นต้น).....

2. หลังจากที่ท่านรับการรักษาที่สถานบริการแห่งนี้ความเจ็บป่วย หรืออาการของท่านเป็นอย่างไร

1. หาย

2. ดีขึ้น

3. อาการเหมือนเดิม

4. อาการแย่ลง

3. ถ้าท่านเจ็บป่วยหรือไม่สบาย ครั้งต่อไป ท่านจะมาใช้บริการรักษาที่สถานบริการแห่งนี้หรือไม่

1. มา เพราะ.....

2. ไม่มา เพราะ.....

ส่วนที่ 3 ความพึงพอใจของผู้ใช้บริการต่อพยาบาล และการให้บริการในสถานบริการ

คำชี้แจง ในแต่ละคำถามให้ท่านใส่เครื่องหมาย ✓ ลงในตารางที่ตรงกับความคิดเห็นของท่าน

ข้อความ	ดี	ไม่แน่ใจ	ไม่ดี
ท่านพึงพอใจต่อพยาบาลและการให้บริการเหล่านี้หรือไม่			
1. ความสุภาพและอ่อนโยนของพยาบาล			
2. ความชำนาญในการรักษาของพยาบาล			
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15. ค่ารักษาพยาบาล			
15. ความมั่นใจในการรักษา			

APPENDIX C

LIST OF EXPERTS CONSULTED ON VALIDATION OF

THE INSTRUMENT

The content validity of questionnaires were determined by four consulting experts included

1. Associate Professor Preeyakorn Chutangkorn
Faculty of Nursing,
Khon Kaen University.
2. Assistant Professor Suwanna Chantharaprasert
Department of Community, Faculty of Nursing,
Burapha University.
3. Lecture Dr. Yupin Angsuroj
Faculty of Nursing
Chulalongkhon University.
4. Mr. Prasong Manaying
Pimai Hospital, Nakhonratchasrima.

BIOGRAPHY



NAME	Mrs. Sumalee Kittipoom
PLACE OF BIRTH	Lampang, Thailand
INSTITUTION ATTENDED	Chaingmai University, 1978-1982 Bachelor of Science (Nursing and Midwifery) Mahidol University, 1999-2001 Master of Nursing (Adult Nursing)
RESEARCH GRANT	The Nursing Council of Thailand
OFFICE POSITION	1982-Present, Ramathibodi Hospital Faculty of Medicine, Mahidol University. Position: Nurse 6