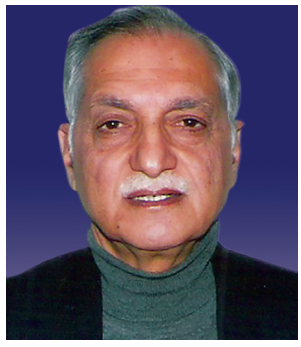
Editorial

Quality and Accreditation



India is known for the size of its population—a large country with a huge population. Till lately, India's identification was for quantity not quality. But, the quality movement in India has begun.

Irrespective of which country you look at, quality has been a problematic area and often occurred more rapidly in the better economies of the world. Most of the countries struggled initially (Japan and South Korea), but determined efforts saw them scale unprecedented heights. After World War II, Japanese products were not known for quality, they were labeled 'Cheap' in comparison to Western products. The Japanese took quality initiatives in 1950s and, today, Sony, Panasonic, Honda, Toyota, Nikon, Canon are bywords in quality. Then came the Koreans. Their products in 1980s were also labeled 'Cheap'. Today, LG, Samsung, Hyundai are well-respected, good-quality products.

India's stock in quality products and services is also evolving rapidly, particularly in hospitality and IT sectors—TAJ, ITC, Oberoi groups in hospitality, TCS, Infosys and Wipro in the IT sector are well-known for their quality services. A total of five Indian companies are the recipients of the Deming Prize making the renowned total quality management (TQM) expert, Yasutoshi Washio opined a few years ago that 'Indian manufacturing quality will overtake that of Japan in 2013.' It has not quite happened in 2013, perhaps it will in 2023—the portents are there for all to see.

Compared to the manufacturing sector, healthcare quality has always been a trouble spot. Not just in India, but all over the world. It is partially due to the fact that healthcare is notorious in shunning change and adopting modern principle of service delivery and management.

United States of America which is often used as the paragon in healthcare quality also found it tough to begin with. When a surgeon named Ernie Codman suggested what he called the 'End Result Idea', meaning codifying the results/outcomes of surgeries, the alarmed medical community at Massachusetts General Hospital (Harvard, Boston) was aghast. Doctors believed they were doing fine, they felt they knew what was best for the patient and did their best, if the patient did not do well it was not their fault. They were 'Gods'. Dr Ernie Codman was promptly banned, barred from work in penury. In 1918, the American College of Surgeons woke up to the fact that, 'All hospitals are accountable to the public for their degree of success … if the initiative is not taken by the medical profession, it will be taken by the lay public.' The seeds of healthcare quality and patient safety were sown—it would culminate in the formation of Joint Commission International (JCI).

Around this time, in the early 1920s, Walter Shewhart was propagating the use of statistical methods in quality management. He was closely followed by two others whose names were forever to remain associated with quality—Edward Deming and Joseph Juran. Deming made a massive contribution to Japan's surge as a quality producer of goods. He taught quality improvement of products, design, testing and their sales. Juran was an evangelist in the field of quality management. Juran's trilogy of quality planning, quality control and quality improvement are still followed as also the Pareto principle. All these efforts of Deming and Juran caused a great improvement in manufacturing and service sectors, but healthcare was, as usual, slow to respond. It required the efforts of Donabedian who propounded the SPO principle—structure, process and outcome for healthcare quality to apply quality management principles in healthcare. Batalden et al expressed the meaning of quality in healthcare—'combined and unceasing efforts of healthcare professionals, patients and the families and researchers, payers, planners and educators to make the change that will lead to better patient outcomes (health), better system performance (care) and better professional development'.

Healthcare quality, therefore, means exceeding the expectations of patients (customer) every time and all the time ensuring 'First Do No Harm' to the patient.

Seven pillars of healthcare quality have been described in literature which are as follows:

1. Efficacy—The ability of care to improve health.
2. Effectiveness—The degree to which attainable health improvements are realized.
3. Efficiency—The ability to obtain the greatest health improvement at the lowest cost.
4. Optimality—The most advantage is balancing of costs and benefits.
5. Acceptability—Patient preferences about accessibility, patient-doctor relationship, availability of necessary amenities, effect of care and cost of care.

6. Equity — Fairness in distribution of care and its effect on health.
7. Legitimacy — Conformity to social preferences concerning the above six points.

While there is no dearth of quality tools — ISO, TQM, Kaizen, Six Sigma and Accreditation, it is the latter which has found universal acceptance. Accreditation is a methodology approved by World Health Organization for complete evaluation of an organization and all functions and processes leading to clinical outcomes. It is usually voluntary and aims at meeting agreed upon quality standards related to essential healthcare facilities. Accreditation is also a public recognition by a national body on the achievement of a set of standard by a healthcare organization, demonstrated through an independent external assessment of that organization's level of performance in relation to the standard. Accreditation relies on establishing technical competence of a healthcare organization in terms of accreditation standards in delivering services with respect to its scope. It focuses on learning, self-development, improved performance and reducing risk. Accreditation is based on optimum standards, professional accountability and encourages healthcare organization to pursue continual excellence. Accreditation also means putting systems in place in an objective, transparent and dynamic manner, by defining those systems, ensuring ownership and implementation by stakeholders.

There are a large number of accreditation bodies — Australian Council on Healthcare Standards of Australia, JCI of USA: QHA trent of UK, HAS of France. India has National Accreditation Board for Hospitals (NABH) and Healthcare Provider, both as an organization and its standards are recognized by ISQUA, the International Society of Quality and Accreditation — the accreditor of accreditation bodies of the world. NABH is thus the equivalent of any of the top-ranked accreditation bodies of the world and its standards are so recognized.

The NABH journey started in 2005 to 2006 when the Ministry of Tourism and World Trade Organization called upon Quality Council of India (QCI) to serve as the umbrella body to spearhead quality initiatives to promote medical tourism. The constitution and the structure for NABH was laid in the year 2006, and NABH was inducted as one of the four boards and QCI. It is made in India, for India and by India.

National Accreditation Board for Hospitals and Healthcare Provider is uniquely tailored for Indian healthcare, uses highly trained, qualified and experienced assessors. Assessments are comprehensive and multidisciplinary, centered on organizational and patient safety, and continuous quality improvement is an important goal; NABH has been growing rapidly since the first five hospitals were awarded the NABH certificate by the then President of India, Dr APJ Abdul Kalam, in 2006 to 2007. One milestone followed another as in 2007 to 2008, NABH became a member of International Society for Quality in Healthcare (ISQUA), founder member of Asian Society of Quality and Accreditation (ASQUA) and the Blood Bank Accreditation program was launched. The next year, the 2nd edition of standard was released and accredited by ISQUA. The Small Healthcare Organizations (SHCO) was also launched. In 2009 to 2010, the first Blood Bank was accredited, an memorandum of understanding (MOU) was signed with Ministry of Health for AYUSH accreditation standards and Central Government Health Scheme (CGHS) mandated NABH accreditation for empanelment. The following year, dental, allopathic clinics, imaging accreditation standards were launched, NABH — I (International) came into being and an MOU was signed with Philippines. A new set of standards (3rd edition) was launched (again accredited by ISQUA) and Employees Contributory Health Scheme (ECHS) (Ministry of Defence) signed an MOU mandating NABH accreditation for empanelment.

National Accreditation Board for Hospitals and Healthcare Providers growth continues with the greatest achievement coming in 2013 when NABH joined 14 countries whose organization has been accorded ISQUA recognition. Today, nearly 300 hospitals, blood banks, clinics, imaging and dental centers have achieved NABH accreditation and nearly 700 are in the queue.

Accreditation by NABH benefits patients, hospitals, staff and third parties [health insurance companies, (CGHS), (ECHS), etc.]. Despite, the need and benefits of accreditation the progress, though fairly rapid and satisfactory, has posed challenges in India where availability and affordability of healthcare continues to remain a challenge, ahead of assurance (quality and safety). As George Santanaya opined, 'Those who speak most of progress measure it by quantity and not by quality'. The challenge of movement from quantity to quality, the maintainance of quality and the challenge of accreditation to reaccreditation (CQI — continuous quality improvement) remains. Resource constraints, process constraints, lack of public awareness, patient education and ability to understand ailment and therapy technicalities and choices as also outcomes are a hindrance to quality and safety. Lack of quality data (nosocomial infections, patient falls and drug reactions) and their objective capture and assessment is also another major deterrant. Human factors, such as contentment and complacence and a nondemanding public, cause problems first in seeking and getting accreditation and then maintaining it. Another

major factor are lack of extensive data on the question — does accreditation (quality) help to reduce costs? Even when such data are available, it is not widely disseminated and discussed. The fact is that the two absolutes — improving quality always reduces costs and reducing costs will never improve quality — are ill-understood. Failure to comprehend, this ends up compromising clinical outcomes and thus business of healthcare.

India needs to do more to promote quality and accreditation — why not a 'jago grahak jago' campaign on quality in healthcare? Hospitals still not accredited need to realize that accredited hospitals report significant improvement in leadership, infection control, medication error reduction, medical record, management, staff training and professional credentialing as also quality monitoring.

Let me conclude by quoting 'quality without efficiency is unsustainable, efficiency without quality is unthinkable'. Healthcare quality and safety in India is a long, torturous and tortuous journey but one that must be undertaken with guts, gusto and determination and accreditation (NABH) is a useful tool and ally in making this journey worthwhile and rewarding.

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