**Title**- Quest for quality in healthcare processes: a utopian fusion of ethical practice and financial sustainability.

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**Main Article-**

**Quest for quality in healthcare processes: a utopian fusion of ethical practice and financial sustainability**

In the 21st century, healthcare, rather than being viewed as complicated entity as it once was, is increasingly being viewed as a product that is delivered to an end consumer- the patient. While this changing perception had planted its roots much earlier in the more developed parts of the world, this idea has really taken form in the Indian scenario in the past decade or so. While this may come as a bitter pill to swallow to many, the notion is here to stay for good. Accepting both its merits and demerits, the Indian clinician needs to adapt to this systematic process of healthcare delivery or else choose to alienate themselves from the expectations of the informed customer/patient.

**BACKGROUND**

The Joint Commission International (JCI) took its first breath in 1951. In 1965, in a historic decision, the United States government decided to make it mandatory for a hospital to be JCI accredited for them to be covered under the state sponsored insurance plan. Subsequently the JCI spread its wings to Asia, Europe, the Middle East, Africa and South America.(1)

Following in these footsteps, the Quality Council of India (QCI) established the National Accreditation Board for Hospitals and Healthcare providers (NABH) in 2006. Created with the aim of streamlining the process of healthcare delivery, from the moment the patient sets foot in the hospital till the time they leave, the NABH accreditation soon became a standard of quality for both public and private hospitals.(2) As of December 2019, 664 hospitals boast of being adherent to the standards recommended by NABH.(3)

**THE NEED FOR ACCREDITATION BODIES**

# The guiding principle to delivery of healthcare has always been the Hippocratic one- do no harm. Yet medical errors are one of the leading causes of in hospital patient mortality.(4) The data pool on clinical errors is not very informative in our country. That being said a number of studies have been done which prove beyond reasonable doubt that medical errors are rampant in the Indian practice of healthcare delivery. Centre specific study by Gaur *et al* found medication errors to be as high as 25.7%.(5) Patel *et al* found this number to be 36%.(6) One has to take this as a guarded estimate as the system of reporting of medical errors in India is not a very robust one. But even if we take these numbers on face value, it leads to the dismal understanding that 1 in every 4 patients will have a medication error committed against them.

# There arises the need for a regulatory watchdog. A 2012 Cochrane review concluded that while the noticeable improvements that one may extract from audits and feedbacks may come across as small, they are important nevertheless.(7) As doctors pride themselves in being eternal students, they should make themselves more accessible to audits. Medical audits bear dual benefits- not only do they highlight the faults in existing care delivery pathways but they also create the possibility of improving upon existing non-erroneous processes.

# To understand the second benefit, one must look at medical audits from The perspective of hiring a coach. One hires a coach to get an independent and unbiased critique upon one’s skill set. Add to that a receptive *auditee* and noticeable improvements are observed in skills that the *auditee* didn’t even realize needed improvement.(8)

# The Obstructions

# The argument that usually has been made to justify the poor quality of healthcare processes in India has been of under-funding and limited resources. Before critiquing this perspective one has to admit to the partial truth that lies in this. India spends just under 1.5% of its GDP on healthcare.(9) Comparing that to the numbers that United States displays (13.39%)(10), one cannot but feel coy. But the presumption that pumping more money into the system will improve outcomes is all but a fallacious one. The United States of America is a pristine example which according to the 2019 data compiled by the Organization for Economic Co-operation and Development (OECD) is the biggest spender on healthcare in the world. Yet when compared to countries of similar economic stature, it fares extremely poorly in patient outcomes.(11) The reasons for these paradoxical findings go beyond economics and lie somewhere in the murky realms of human behavior, medical ethics and conflicting priorities on part of the clinicians.

# The Indian market makes for an interesting case analysis for at one end of the spectrum we have the public healthcare sector which is usually starved on the monetary and human resource fronts while at the other end of this spectral bazaar we have the private sector- financially driven and enough resources to give any healthcare facility in the West a run for its money. Jishnu Das and his colleagues at the World Bank did a peculiar quality audit of primary healthcare delivery in India using standardized patients and drew some unexpected conclusions from that study. As anticipated, the private sector, when compared to the public sector, fared much better on the conventional quality parameters and patient outcomes. The public sector patients were exposed to significantly higher rates of under treatment. But interestingly enough the private sector patients, while paying much higher cost, were prone to being over investigated and over treated. While under treatment lead to morbidity and mortality, over treatment lead to increased financial burden on the patients, made them more predisposed to adverse drug events and hence in some ways, also contributed to poorer quality outcomes. Lack of effort was noted on the side of public sector clinicians.(12) But if private sector patients are being over investigated and over treated, it seems like a fairly straightforward conclusion to draw that there is a certain lack of altruism in the average private practitioner.

**PATIENT**

**POOR QUALITY**

An essential observation that needs to be made here is that a large number of these private centers are accredited and are supposedly adherent to the conventional quality control parameters.

So the question arises- are these quality parameters redundant? Perhaps before arriving at such a dramatic conclusion, one needs look at all the facets of the state of affairs. The reason why most organizations are going for accreditations and clinical audits is not because they are quality driven but because they are market driven. The NABH or JCI emblem alongside the hospitals name on the banner increases their capital worth. This is not a reflection upon the accreditation agencies or even the hospitals, but perhaps upon the human condition. Given a choice between true systemic integrity or just certification of excellence, most would tend to drift towards the latter for it amounts to a much easier task. Hence, a ‘certified’ institute can choose to take either of the two paths- to either be compliance driven or be quality driven. While chasing compliance might not always translate into quality, going after quality will inevitably achieve compliance of the requisite standards.(13)

This is the point where the debate has to make a paradigm shift from economics and conventional quality indicators towards the ethical front. The capitalist nature of the market will always argue that while medical ethics make for good coffee table conversation, their application to a fiercely competitive and result oriented healthcare sector is impractical. Opposed to this cynicism, there are multiple examples where ethical models of healthcare delivery have also become prototypes of financially sustainable business models. Angeli and Jaiswal published a study pertaining precisely to this ideology where they took six organizational case studies and extrapolated the data to propose a business model for healthcare delivery to the majority of the population which reflects the base of the pyramid (BoP). Instead of viewing the second largest population in the world as a burden, they suggest looking at it as one of the largest consumer markets in the world. Value creation can be done without compromising upon patient affordability and organizational sustainability. (14)

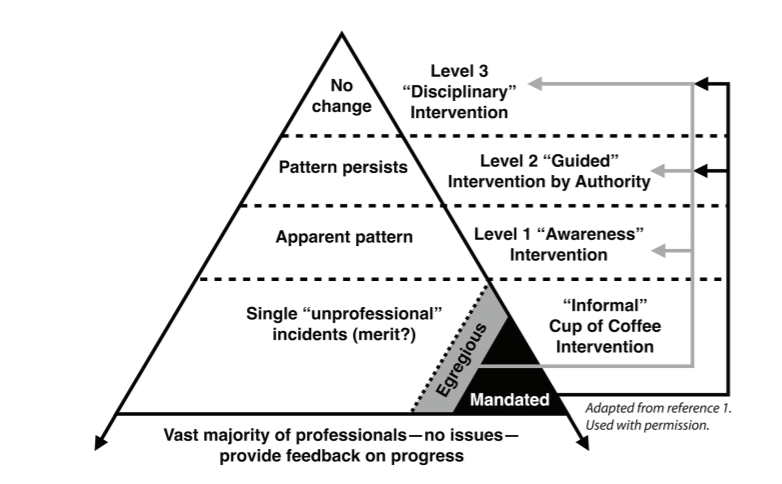
**The Solution**

# This debate of compliance vs excellence cannot be settled by extrinsic data but it is actually a call for introspection. A good analogy to understand this is the concept known as ‘clinical gestalt’. Clinical gestalt implies that a clinician can arrive at a logical (and correct) conclusion using inadequate data by employing his/her experience and power of pattern recognition.(15) It is the ‘gut feeling’ that every physician has. And if one relies on pattern recognition, one cannot but recognize a deep seated behavior that operates upon anectodal evidence rather than scientific one,(16)(17) that operates in callousness rather than attentiveness,(18) that operates in ignorance rather than knowledge.(19) While a set of quality control guidelines are easy to implement on paper, the foundation of quality in any process depends upon the one delivering it-in this case, the healthcare providers.

# Perhaps it is in recognition of this issue that the erstwhile Medical Council of India with its dying breath has delivered the new Competency Based Undergraduate Curriculum For The Indian Medical Graduate.(20) It has been welcomed on all fronts as much needed reform for the Indian medical education system, which had failed miserably to keep up with the dynamism that global medicine has progressed in the past few decades.

But like all solutions, it brings with it its own set of problems. It still employs the one size fits all approach to a highly complicated and subjective area of teaching. Its hasty implementation has also led a few authorities to question the sincerity with which the MCI has launched this initiative.(21) It obviously is a false perception that the physician that would be created as a product of the competency based curriculum would be a far superior one to the previous generations as the institutes themselves and their objectives become the biggest confounding factor to that theory.(22) Most teaching institutes would gauge their success in the number of students that pass out of their gates every year without reflecting upon the quality of the clinicians that they are releasing into the system.

Quality cannot be achieved without accountability and accountability cannot be mined out of the workforce without the complete and unflinching commitment of the organization’s leadership.(23) The guiding principle is simply what we are taught as children- actions have consequences. The highest echelons of the organization need to actively promote and in fact demand the entire workforce to behave in a professional manner. Deviation from expected behavior should receive optimum feedback and if necessary, it should be reprimanded. On the other hand, professionalism should be rewarded. An excellent example of how to provide feedback to unprofessionalism on part of the healthcare providers is the Vanderbilt disruptive behavior pyramid.(Figure 1)(24)



**Figure 1** The Vanderbilt disruptive behavior pyramid

**Conclusion**

Attainment of the requisite level of quality in healthcare processes is a task in continuum. Quality has to be viewed as a living organism which will change and grow with time. Its attainment is no menial task by any measure of imagination and the path to achieving truly excellent and error free healthcare is not only a treacherous one but also a testing one. Institutional resolve plays a vital role in making sure that the patients receive the highest quality of care, physicians behave in a professional manner and the forthcoming generations of doctors are trained in a way that quality becomes engrained into the very process of how we treat patients. For clinicians and healthcare providers, it is a call to look inwards and perhaps awaken that lost sense of morality. If healthcare is a product and the patient a consumer, we need to make sure that we are delivering what we would be satisfied to receive as a customer. Historically, organizations that have not listened to the critique of the consumer have perished. Quality has to be seen as the node of convergence for medical and business ethics. If a telecom company can aim for a Six Sigma process(25), there should be no doubt in our minds that it is imperative for the entire healthcare sector, public or private, to aim for the same.

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**Abstract-**

The economic growth of India has resulted in a larger segment of the population in getting access to healthcare. These paying consumers are increasingly becoming sensitive to the quality of the healthcare that they are provided with. In this changing scenario, where the market is being driven by a capitalist sentiment, ethical practice is being shoved out of the door. Justifications provided are that the system is overloaded, under staffed and inadequately funded and hence quality cannot be achieved. This article puts all these ideas through the churner of global and national data to propagate a singular idea- that ethics and quality not only can but in fact should always go hand in hand.