QUALITY ASSURANCE IN HEALTH AND ACCREDITATION

Dr. ALEX GEORGE Ph. D

THE CATHOLIC HEALTH ASSOCIATION OF INDIA

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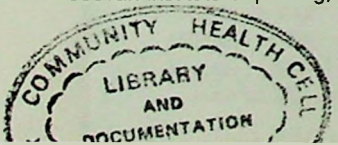

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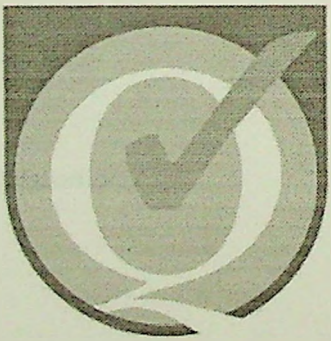
1. What is Quality Assurance ?

Quality Assurance (QA) is a system of ensuring that quality of the products and services are maintained up to certain standards. It is primarily aimed at serving the consumers/ users who in fact constitute the vast majority of the people of any country. Even producers of one commodity will be consuming many other commodities. Thus it is in the interest of all.

2. Why Quality Assurance in Health Care ?

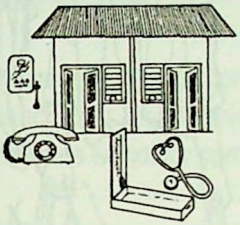
QA in health care is on the one hand meant for delivering quality care to the patients and on the other hand for helping the providers of care to work up to the professional standards of the period and thus ensure a clientele by satisfying them with quality. In the case of health, the hospitals, health centres, diagnostic centres, dispensaries and the professionals serving there are the providers and the patients are the users/ consumers.

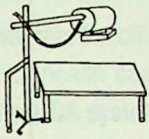


3. What are Standards of Health Care ?

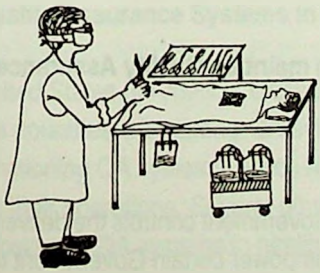
There are mainly three types of standards. Structure, Process and Outcome Standards.

- Structure Standards refer to the Infrastructure, Equipment, other Physical requirements and Personnel

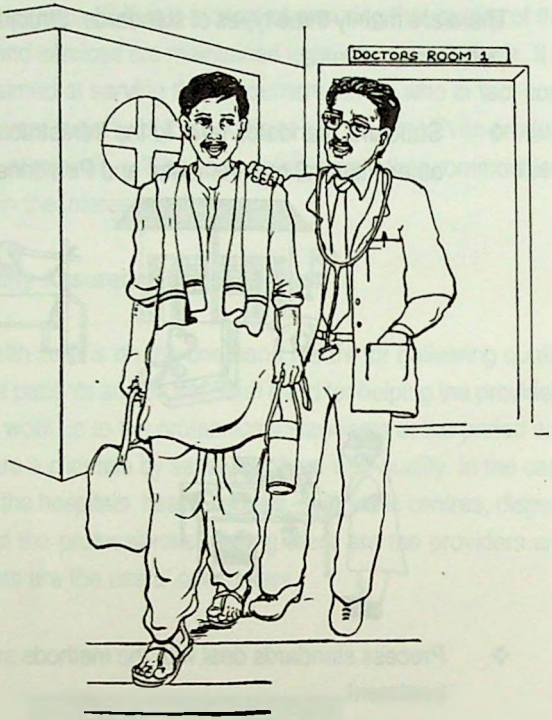




- Process standards deal with the methods and procedure of treatment.



❖ Outcome standards are concerned with the result of treatment.



Patient coming out satisfactorily after treatment

4. What are the systems to maintain Quality Assurance ?

4.1 Regulation :

In this system the Government controls the delivery of care. It will appoint and empower certain Government officials to ensure the delivery of care through a legal machinery. This

legal machinery may or may not be appealable against in the law courts of the country. Or sometimes the appeal will be only to a higher court and that too only with the permission of the legal authorities under the regulatory mechanism itself. Needless to add that such permissions are rarely granted.

4.2 Accreditation :

This is a system of self regulation wherein the different professions attached to the provision of health care and the health consumers will jointly operate a QA system.

4.3 Hospital Audit :

Hospital Audit is practised in public hospitals run by the Government. The British National Health System is a prominent example. It is operated through the participation of the different professions attached to public health care institutions. User participation in such systems is increasingly becoming the norm.

5. Quality Assurance Systems in Developed Countries

United States of America, Canada, UK, Australia, NZ are some of the countries with strong QA systems. These countries do have functioning QA systems, which have built up effective procedures for their operations. Several other prominent countries also have substantial QA systems in health care.

6. Why Quality Assurance of Health Care in India ?

- ❖ It is meant to serve affordable and feasible quality in health care to our own people.

- ❖ The Middle class & the Mass Media have been articulating this demand for a long time. They were articulating the felt needs of the people as a whole only, since the private and voluntary health sector in India has been out of any kind of controls regarding the quality of their service.

- ❖ Of late, Health Insurance companies also insist on quality standards in the institutions they recognise for service provision to their clients, so that their clients get proper medical care and thereby insurance claims could be reduced.

7. Private Sector Regulation in Several States

Tamil Nadu, Bihar, MP, Maharashtra, WB, Manipur, Nagaland, Sikkim and AP are some of the states, which have enacted or are in the process of enacting legislations to control private health care institutions. Even small voluntary institutions with few beds or no beds also come under the purview of these legislation.

8. Common Features of Private Health Sector Legislation

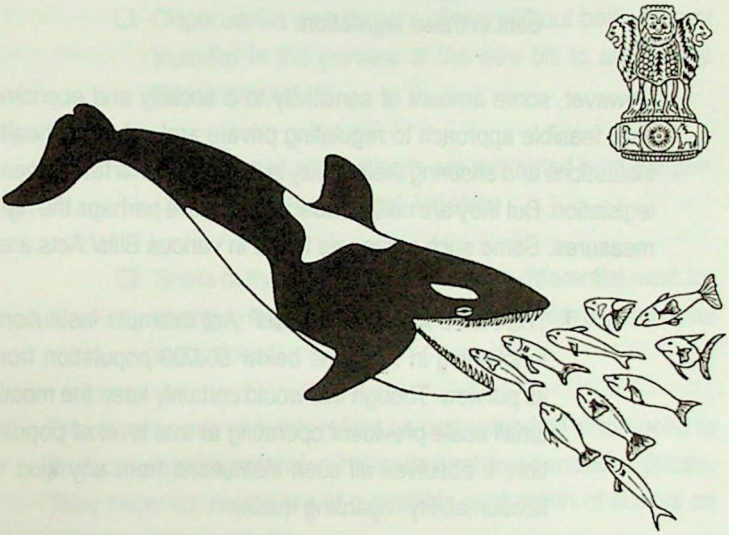
The common provisions of the legislation mentioned above are :

- ❖ The enforcement of registration and license (R & L) for private and voluntary hospitals which will be given for a specified period mostly after an

enquiry by the "competent authority"

- Expecting the institutions to maintain the R & L by functioning as per certain conditions, which are not quite clear now or are expected to be formulated later.

- Breach of provisions of the legislation or of the conditions of R & L can lead to a fine of Rs. 500 to Rs.1, 00, 000 with or without imprisonment in different states and also possible suspension / cancellation of registration / license.



Big hospitals would eliminate the smaller ones.

8.1 Other Features & implications of the Legislation:

- A lack of concern for the limitation of access to health care, which will result from the large scale closure of

small units by treating them along with the larger ones.

- ❖ A lack of sensitivity to institutions of small size delivering health care particularly in remote rural areas.

- ❖ A lack of concern for the voluntary health sector.

- ❖ A lack of understanding of the innovative Community Health experiments in the voluntary sector, which are being carried out by paramedical or lay staff with minimum support from the medical profession is also evident in these legislation.

However, some amount of sensitivity to a socially and economically feasible approach to regulating private and voluntary health institutions and ensuring their quality is also found in a few of these legislation. But they are neither adequate nor are perhaps the right measures. Some such measures found in various Bills/ Acts are:

- ❑ The Rules made for the M.P Act exempts institutions functioning in locations below 50,000 population from its purview. Though this would certainly keep the mostly small scale providers operating at that level of population, it absolves all such institutions from any kind of accountability regarding quality.

- ❑ The Rules made under the Tamil Nadu Act specifies that clinics and dispensaries having up to 2 beds will be granted Registration and License without any inspection of their premises, facilities, personnel records etc. It

defines a hospital as a place where 3 or more patients are treated as inpatients with or without surgeries or conduct deliveries along with or without OP services.

- The Bihar Bill includes a provision, which gives the powers to the State Government to relax the requirements for location, accommodation, equipment and personnel for clinical establishments in rural areas. This bill also has a clause to fully or partly exempt charitable organisations from paying registration and license fees.

- Dispensaries and doctor's clinics without beds are not included in the purview of the new bill to amend the Karnataka Act.

- Dispensaries without beds are exempted from the purview of the West Bengal Act also.

- Some of these legislation also have differential rates for charging registration and license fees from big and small institutions.

These measures certainly reflect an understanding of the need to protect the existing provision in remote rural areas and other places. They show an awareness of a possible contraction of access on account of the legislation.

However, in place of such measures, what is necessary is:

- Specification, with some flexibility, of the cluster of services ie., diseases / conditions that can be treated/

Linked with this is also the question of access and equity. Pure considerations of technical quality should not seriously affect access. Fixing up the same standards for large hospitals and the smaller hospitals, health centres and dispensaries working in remote rural areas with limited economic resources and underdeveloped social and economic infrastructure would be extremely unviable for the latter. It would lead to large scale closure of such smaller units; thus seriously affecting whatever access is available.

Issues such as appropriateness, adequacy and relevance also figure in the above discussion on conceptual categories of standards. However, though they sound apparently technical in nature they do have strong ethical bearings at the same time. Certain procedures which are appropriate, adequate and relevant according to existing scientific knowledge may also have side effects or risks attached with them. The latter bring in the ethical dimension for quality related judgements.

10.3 Development of Standards

Standards need to be prepared first in a draft form and then finalised. In the entire exercise professional experts, representatives of organisations which are going to own and implement those standards and representatives of users in the form of health consumer organisations or voluntary organisations in health need to be involved.

Standards developed will be useful if we:

- First list out the services; in this case the diseases and conditions that would be treated at institutions of different bed strengths.

- Then develop the process standards that are necessary to deliver those services.

- And simultaneously develop the structure standards that are necessary to support those processes.

Instead of such an approach, if we go by the conventional approach of setting standards we will start with setting structure standards for different sizes of hospitals without even making sure that these structure standards be even put to use. they can be used only the institutions for which we are setting the standards do actually deliver the services for which they are intended. It is for this reason that we insist that first the services for which standards are to be set in the health institutions of various sizes should be agreed upon by the concerned.

After deciding the range of services to be delivered at institutions of different sizes, the next step that is advised is to set the process standards ie. the various, diagnostic, medical and surgical procedures required to manage the particular disease, condition. Structure are to be considered mainly as a support to carrying out these procedures and not in isolation as in the conventional approach.

Some basic structural standards up to a feasible level regarding the space plan, power, water, human resources etc

needs to be specified separately. However, the primacy should remain on the process standards to treat the agreed upon range of services. Importance of structure standards, being seen essentially as a support to process standards.

10.4 Resource Raising to Implement Standards

Resources will be required for upgrading the standards even though we will be aiming at only feasible levels of quality. Certain minimum items cannot be compromised at institutions of different sizes. For raising necessary resources the institutions will need support from lead/ mother NGOs and national and international funders. It will be good if the related institutions articulate themselves through certain networks.

10.5 Forming Accreditation Councils

Accreditation Councils (AC) will be the bodies, which will implement an Accreditation System (AS). It will be a self

Accreditation Council meets

regulatory body of relevant professionals, representatives of the institutions of various sizes and User representatives, who will constitute an AS,. There could be a state/ regional AC, with branches/ chapters for districts or zones, ie., groups of districts.

10.6 Standards Implementation

The District Accreditation Council (DAC) or its members will make a visit to an Accredited Institution once in a Quarter in the first year of introducing an AS in a district/ state/ region. The number of visits could be reduced to once in six months from the next year.

The DAC will observe the actual delivery of care for various diseases/ conditions and also the structural features of quality such as infrastructure, equipment and personnel. They will give suggestions, which the concerned institution will be expected to carry out within a stipulated time. They will also play an enabling role in facilitating to organise training programmes etc., for improving the delivery of care. The release of any equipment/ instruments budgeted, as per the fund raising programme also will be supervised by them. For this purpose they will devise certain guidelines to see to it that equipment requested are actually needed and also ensure that they will be used. The presence of relevant staff or a written undertaking that the staff will be got trained within a specified time, for operating the equipment will be taken.

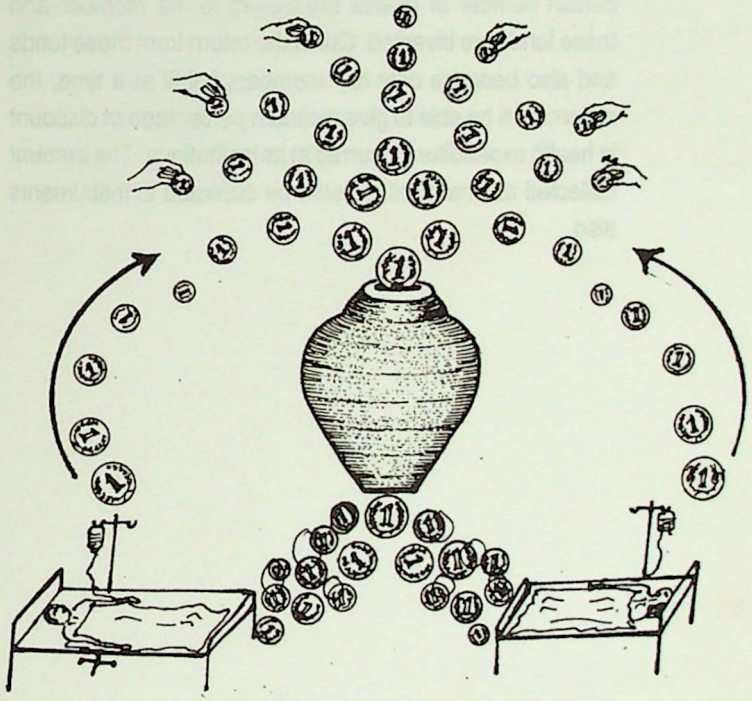
10.7 Resource Raising For Standards Maintenance

Recurrent costs after the introduction of standards will have to be met by the concerned institutions. This will necessitate them to adopt suitable financing mechanisms. Implementing Health Insurance through self - help groups, micro credit groups or adopting Co -operative Health Care systems are two options.

10.8 Setting up a Health Insurance Scheme

In insurance, pooling of risks and premia of various persons helps in proving a large amount to help those who fall ill. Supposing there are 1000 persons in a Rural Insurance scheme that we set up and each are paying a premia of Rs.10 per month. Thus the scheme will be getting 1000X 10X12 = Rs. 1, 20, 000 per year. But out of the 1000 people in the scheme only 75 may fall ill in that year. These 75 will thus get the benefit of health insurance at the rate of: 1,20, 000/ 75 = Rs.1600 per year, which is 13 times more than the annual amount paid. This is a very crude example, which is only meant to illustrate health insurance in an easily understandable manner. The provision of benefit can be increased by increasing the number persons covered by the scheme, by limiting the insurance package to a few crucial diseases/ conditions and from the returns out of the investment from the premia. Insurance scheme can be introduced only in areas where we have good rapport with the people. It is better not to be thought of as a scheme to start off

health activity in an area. Instead it can fit in better, in areas where we have a health programme, well embedded in other development programmes. Centres/ institutions having self help groups or micro credit groups attached to related development programmes will have an added advantage. Convincing the people about the need to pay regular premium is relatively less difficult if the organisers of the scheme are having good rapport with the people for



Contribute a small amount regularly to gain more for treatment while fallig ill.

whom it is organised. This is ensured in the case of well developed health and development programmes having at least a few years of association with the people for whom a scheme is planned.

10.9 Co - operative Financing

In the scheme of co- operative financing an entry fee is collected in bulk at the time of joining. In return to this fee, a certain number of shares are issued to the member and these funds are invested. Out of the return from these funds and also because only few members fall ill at a time, the scheme will be able to give a certain percentage of discount in health expenditure incurred at its institutions. The amount collected as share value could be collected in instalments also.