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1.0 Introduction

Service Industry has grown leaps and bounds during the last few decades; in many developed countries, services have gone past manufacturing in terms of revenue and employment. In U.S.A., service sector constitutes nearly seventy-two percent of its GDP. IIE (1999).

If we look at the last decade in particular, Health sector has done real wonders. Initially this sector was mostly under government control, expect few private clinics, all major hospitals specially in India were government owned, maintained and controlled, but today, this sector is experiencing tremendous growth with many corporate entering this sector. The health services are not different from other businesses in the service sector. Professionalism in this segment has brought it at par with others hence loosing its image of being a Noble profession. The doctors are no longer considered a social worker.

In all field of this sector, cardio-vascular, orthopaedics, urology etc. there has been tremendous development. Heart,
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Kidney, Eye transplant is a reality today. It has opened hopes for hundreds of thousand patients. There has been phenomenon progress in the field of radio-diagnosis and pathology, which are the base of treatment, because these two sectors help in diagnosing the illness. And developments like Ultra sound (Sonography), MRI, Cad scan etc, have really made diagnosis very simple and accurate. Today, surgery is performed through keyhole, through robotic hands. Information technology has also played a big role in this sector; through transcription doctors in one part of the world can treat a patient in other part. Even operations are being done through video conferencing. One can access the profile of a patient in any part of the world through Internet.

According to World Health Organisation report (1997), half a century ago, most people died before reaching the age of 50 years. However, life expectancy now is much higher. Global average life expectancy at birth reached 65 years in 1996. India has made significant progress in the past several decades in improving the health and well being of its people. Over the past 40 years, life expectancy has risen by 17 years to 61 years, and infant mortality has fallen by more than two-thirds to 74 deaths per 1,000 live births. (The World Bank Group and Health Sector Development and Disease Control in India. 2005).
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We have also seen growth in the availability of this service; with participation of private sector this segment has grown a very high pace. In big cities like Delhi, Mumbai, Chennai and Kolkata there are hundreds of hospital and clinics, which are working round the clock, in serving patients. Commercially, it is one of the best growing service industries. The estimated value of Indian healthcare industry is close to Rs. 1,00,000 crores, and is expected to grow steady at the rate of 15 per cent annually. Cfore (2002).

1.1 Grey area of health sector

In spite of great achievements, as discussed above, all is not well with the health sector. India continues to lag behind in this sector even today after over five decades of independence. World Health Organisations norms say, population to bed ratio should be 1:300 (1 bed per 300 people), but in our country, this ratio is 1:1000. Although India has approximately 13,000 hospitals, which have adequate facilities but for a country of above one billion people it is not great news. Even their distribution is not uniform. The divide is not only rural-urban but also geographical. In states like Maharashtra, there are above 3000 hospitals and Kerala has about 2000 but states like Haryana or Himachal have less than 100 hospitals.
The remarkable growth that we are witnessing in private and public hospitals, in the urban areas, has been good and bad both for the consumers. It is good because choice is more, but bad, due to absence of compliance of strict regulation and quality standards, an abundance of choice also gives a free run to dubious health facilities run by urban quacks. According to Balagopal, C (2004) in India about 80 per cent of the products used in the healthcare sector does not have any standards and would not be used elsewhere in the world.

According to one study, one can pay dearly for choosing an incompetent doctor. The study has given following facts, according to which:

- 40% of patients with chronic conditions do not get the treatments recommended by the medical literature.
- 20% of patients with chronic conditions get the wrong care.
- 30% of patients with acute conditions get the wrong care.

Example: Only 44% of women with breast cancer receive breast-conserving surgery (lumpectomy) even though 75% of women are eligible for it. Another study has found that medical errors kill between 44,000 to 98,000 people a year.

In a landmark report to President Clinton, W.J., the Advisory Commission (1997) on Consumer Protection and Quality in the
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Health Care Industry called for a "national commitment to the measurement, improvement, and maintenance of high-quality care for all Americans." As part of that effort, the Commission called for the creation of a Forum for Health Care Quality Measurement and Reporting "to develop and implement effective, efficient, and coordinated strategies for ensuring the widespread public availability of valid and reliable information on quality."

Report documents reveal some of the existing quality problems in the health care system and identify current strategies that have proven effective at improving quality outcomes, increasing confidence and often reducing health care costs. It also underscores why a national effort is needed to improve the quality of health care.

1.2 Role of Quality in Health Service Sector

The development of quality has occurred gradually through steady evolution. This "evolution" has occurred through the "eras" of inspection, statistical quality control, quality assurance and strategic quality management. Increasingly, quality has been linked with profitability, defined from the perspective of the customer and is included in the strategic planning process. So, business quality is also viewed as an aggressive competitive weapon.
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1.2.1 Quality in Health Care

Quality in health care has also developed recently although consensus about standards of practice and care has been with us for a very long period of time. The Ministry of Health has conducted an evaluation of the various strategies and programmes related to quality activities in the Ministry since the mid-1980s and the findings will be discussed at this meeting. This will be helpful for us as we plan our agenda for quality in health for our country into the next millennium.

Today we have progressed from the perception that "quality is difficult to define" to a situation where "quality can and should be measured, and reported, for the benefit of the health care providers, patients and the public". We need to understand and promote the concept of "public accountability in health care". Accountability is about the willingness of health care providers to share information about their performance with those who need to know or who have an interest in this information. Are the health care providers in our country ready for this? What information should be provided? How do we ensure the accuracy and validity of this information? How do we ensure that this information will be useful and will be understood by those who are interested in it?
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According to Donabedian (1980), quality of health service can be defined as 'That kind of care which is expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that altered the process of care in all its parts'.

1.2.2 The Measurement of Quality

During the last 30 years research has demonstrated that quality can be measured Brook, R.H. (1983).

Those who believe that they are ready to be compared within an information-rich environment may be more ready for public disclosure than those who feel disadvantaged by doing so. Measurement and disclosure can be a difficult combination and will not be constructive if misused. Information about performance may differentiate between winners and losers.

What information should be made available? What information would be meaningful? Should we measure health promotion efforts, clinical outcomes, patient satisfaction, individual functional status, compliance to standards or some combination of these? Will those who are interested in this information be able to comprehend and use it?

The strength and credibility of any public disclosure programme depends on the quality of the data collected through
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the performance measurement process. Performance measurement in health care is new and still evolving. We need to organise a system and develop indicators that truly measure what was intended to be measured, and there is a need to evaluate these indicators to be sure that they meet these objectives. Issues of data integrity need to be addressed. Suleiman, A.B. (1998).

"I am not clear whether there is a broad public interest in performance information in health care although a great deal has been expressed about it by certain quarters in the country. This is probably the start of the realisation that the basis for accountability is not as strong as we would like it to be.

1.2.3 Translating Quality & Performance Measurement

Defining and measuring the quality of care in long term care facilities is a multidimensional and complex issue with several pitfalls, Berg, K. (2002).

Easily Understood Information for Decision-Making

(Decision-making - Between Performance Data and Easily Understood Information)

There is a big gap between performance data and information that is easily understood. While those in health care tend to
question the ability of the lay public to understand health care performance data, there is need to face, that those in health care barely understand what health care performance data mean. It will be part of our responsibility and challenge to develop the data, interpret it into information that can be understood and used by those in health care as well as those interested in it.

The Principle of Accountability

Accountability is being emphasised not only because the public should have access to information about quality, but also because accountability may be required for licensing and accreditation purposes or because of requirements of the health care financing system. Accountability in health care should at the minimum help accomplish the following:

a. develop the documentation of the use of health care service
b. identify the basis for critical actions taken
c. evaluate differences in outcomes
d. develop an information base that can help support decision-making

The practice of medicine concerns about various medical treatments or procedures, variations in medical practice and concerns about the cost of health care have been frequently and
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widely discussed including in our local media. Consumers have frequently expressed their concerns about obtaining value for their investment in health care. We will need to accept that increasingly in the future, methods for assessment of quality, information on quality of care will be used to shape the market forces in health care and will be on the agenda in the new health financing system. However, a lot more needs to be done before this can really be in place.

In the drive to institutionalise quality as a way of life in the public sector, TQM has been given special emphasis. In doing so, public agencies are encouraged to be customer-oriented and conforming to identified standards of quality in their operations. The public sector is perceptively shifting to a more customer-driven focus. It has now become more proactive, more aware and more able to understand fully the philosophy of 'doing things right the first time and every time', by identifying standards of quality and conforming to them. (In the end, it is the user who helps to determine the products and service quality the organisation must deliver).

Some advocates say that creating a work environment of high quality is even more important than improving productivity and it is incorporated in TQM. Rather by improving the quality of work life, the productivity would rise as well. Indeed, studies seem to show that improving the quality of work has led to;
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- decreased absenteeism and turnover
- greater job satisfaction
- greater commitment in the organisation and its goals

1.3 Objectives of Research

1. To understand the health service industry in general.
2. To understand the concept of quality as applicable to health care industry.
3. Define quality indicators from doctors, patients/attendants point of view.
4. Study perception of Doctors, regarding quality on different dimensions such as qualification dimension, behavioural dimension, background dimension, physical factors dimension, and perception dimension.
5. Study perception of quality among doctors on different demographic variables like city, experience, status, gender and qualification.
6. Study perception of Patients/attendants, regarding quality on different dimensions such as Qualification dimension, behavioural dimension, background dimension, physical factors dimension, cost dimension, location dimension and perception dimension.

Study perception of quality among patients/attendants on different demographic variables like city, income, status, gender and qualification.
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1.4 Scope of the Study

The study would be of immense help to doctors in understanding their patients. What makes a patient choose a particular doctor or nursing home?

It would also be useful to promoters of health care industry, in understanding, what product attribute should be promoted to attract patients/attendants.

It will also be helpful to academia that are interested in the study of health care industry in general and quality aspects of health care industry in particular.

1.5 Limitations

Despite the honest and enthusiastic efforts of the researcher, survey research study has limitations and shortcomings of their own. There are many limitations like limitations of methods, time, cost etc. Researcher has tried his level best effort to minimise, if not eliminate the limitations. This study has a fair amount of shortcomings. Some major limitations can be summed as follows.

1. The study was restricted geographically to three cities Delhi, Aligarh and Amroha only, the sample of 208 Doctors and 238 Patients / Respondents was chosen on the basis of standard sampling procedures and scientific methods. It could be concluded that result represents the
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population. Even then generalization of result for whole India may not be possible.

2. Every possible precaution was taken while constructing the questionnaire, help of many senior Doctors and Psychologists was sought in constructing it, but even then there may be certain shortcomings in the questionnaire.

3. Every possible care was taken while administering the questionnaire. Researcher tried his best that all questionnaires should be administered in his presence so that doubts can be removed immediately.

4. Cooperation of respondents was a serious problem, as it is in all survey-based researches. It was difficult to arouse interest of the respondents; they also had doubts about the utility of the study. Many of them had the feeling it a waste of time, and of no use for them.

5. Administering of questionnaire was difficult to illiterate respondents, as they were unable to understand many things. The questionnaire had to be translated in Hindi or Urdu. In some case that may have caused distortion in the message.