EDITORIAL:
QUALITY IN HEALTH CARE

Quality Assurance (QA) in health care is both a necessity and a responsibility. It is necessary so that the public obtains maximum benefit from current medical knowledge and investment in health, and objectives are appropriately set against changing public expectations resulting from improvement in education and socio-economic circumstances. On a more selfish note, QA promotes business and protects practitioners from possible litigation.

But the profession should regard QA as a responsibility, implicit in the social contract that every practitioner enters into when he takes out a licence to practice. It is a safeguard against professional obsolescence, abuse or neglect. Because doctors make far-reaching decisions on health care matters, whether with regard to individual patients or entire health programmes, and because they can influence other decision-makers, the onerous role of the medical profession in QA cannot be over-emphasized.

Quality in health care means different things to different people. To medical practitioners, quality means the extent of compliance with the current state of the art as practised by outstanding colleagues in the profession. In nursing, a holistic approach towards the needs of the patient is always emphasized. There is said to be quality in nursing when both physical and non-physical needs of the patient are adequately met, when care is continuous and when self-reliance of the patient is restored and maintained.

Governments are more interested in the politics of health care, e.g., equal accessibility, and the safety and cost-effectiveness of technologies used. They would like to protect the public from fraudulent or dishonest practices.

Patients, on the other hand, tend to relate quality to their personal experiences. Thus they would emphasize such elements as prompt services, technical skills of practitioners, accuracy in the administration of care, regard for human dignity, effective communication, physical comfort and cost.

As a concept, quality in health care is therefore multi-dimensional. One cannot look at it purely from the point of view of the medical practitioners. Nor should one measure quality only by cure, case fatality or complication rates. High technology, high cost medicine may be impressive; but when it is provided at the expense of much more basic needs of the large majority, one cannot honestly say that there is quality in health care. Similarly, when one focuses only on a patient's pathology and ignores his other needs and expectations, one is addressing only part of a much more complex problem.

Quality care can be described in many ways. It must be **safe** – safety measured as the relative risk and severity of an adverse outcome. It must also be **effective** or beneficial to the individuals. But benefit must be related to the total cost of care in terms of money, manpower and other

resources, as well as to time. In other words, it must be **efficient.** This aspect of health care is sometimes neglected because the resources used belong to others. **Acceptability** is an important characteristic of quality care. It relates to the perception of recipients and is thus critical to the success of any intervention. The technology used must also be appropriate not only to the health problem but also to ethical norms and socio-economic circumstances. QA requires adequate knowledge and the right attitude to enable practitioners to make proper judgement and the right decisions, and sufficient skills to carry out the necessary procedures. In other words, practitioners must possess the requisite **competence.**

In other words, quality is a multifactorial attribute. Quality is not only safety and effectiveness of care. It transcends exclusively medical considerations. But many of us are guilty of such a narrow interpretation, contributing indirectly to the current inequities, imbalances and deficiencies.

Many developing countries are going through an unprecedented growth of health services in both public and private sectors. Demand for basic care by the poor and the not-so-well-educated is increasing day by day. In the face of increasing workload, there is a tendency to cut corners. For those who can pay, there is the alternative, highly lucrative, private sector. If profit is the dominant consideration in the private sector, abuses are likely. Unnecessary investigations may be ordered, and there may be over-treatment and over-prescribing. Some may practise defensive medicine, subjecting patients to avoidable risks or incurring unnecessary costs. In all these situations, there cannot be quality in the care provided.

Quality is also an ethical issue. A practitioner can be charged for neglect of professional duties. A negligent practitioner thus faces double jeopardy – discipline by his peers, and litigation in a court of law. Cases seeking redress in the court are usually those with severe adverse outcomes. Minor instances of defective care are difficult to prove and go unreported. At the most, the victim may complain to the press or send an anonymous letter to the Malaysian Medical Council. Or the mass media may carry out an investigative reporting, as it has done on other professions. It is in its own interest as well as that of the public that the medical profession takes a more serious view of quality in the practices of its members. The initiative must come from every member of the profession and the commitment must be total and universal.

Like any other attribute, quality in health care cannot be judged out of context. It must necessarily be related to prevailing accepted health practice norms, to what is possible under a particular situation and to expectations. As an objective however, it is not as elusive as it may seem. Quality in health care can be described, measured and compared, provided it is clearly defined and its parameters are specified. The public has a right to quality care and they are demanding it. Quality care is possible even under the most basic of primitive conditions. It is a function of human commitment rather than technique. Expensive facilities or equipment do not guarantee quality, nor is quality beyond the reach of the most peripheral health service or the lowest health worker.

What options are open to the profession? Should QA be voluntary or mandatory? There are no ready answers. Those against mandatory compliance would argue on the basis of professional autonomy and the right to make personal choices, confidentiality and the stifling effect of rules. Laws are easy enough to enact, but policing them can be difficult. Most modern approaches use group judgement and peer review in QA programmes.

The Ministry of Health Malaysia has just started a QA programme for services under its care. To start with, it involves comparative studies of outcomes. Beginning with gross measurement, it is expected that as the programme progresses, more refined techniques will be developed. By disseminating the information to all institutions, it is hoped that low achievers will strive to improve their performance.

For unorganized services, e.g., individual private clinics and private hospitals, professional organizations such as the Malaysian Medical Association, Society of Private Practitioners, Federation of Private Hospitals and similar bodies, they should play an active role in ensuring quality in health care. They should endorse the need for QA and provide guidelines on how quality can be achieved. They should play a promotive role and provide the forums for discussing quality issues.

This article started with the statement that QA is both a necessity and a responsibility. In the final analysis, however, quality is about people, an obsession, a source of pride, mastery of basics but diligence with details. Quality is assured when high purpose is matched by intense pragmatism, steadfast interest and a burning desire to do the best. Of course there is a price for quality, namely time, energy, attention and focus. This price is never too high for the recovery of self-respect.

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