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QUALITY AND HEALTH SECTOR: TWO WORLDS APART?

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Contents

In recent times, the most developed countries have undergone a major process of **sanitary reforms** and changes, involving structures, approaches, operational technologies, heading toward a new definition of the concept of health service and assistance.

The origin of these changes has to be sought in the evolution of the social and economic environment, compelling the Legislator to seek a new balance in the relationship between State and citizens. The nature of that "pact" requires a deep reflection and a global re-definition, as witnessed by the present debate about Welfare State in all advanced democracies. The role of Health within such picture is crucial, as **a primary feature of the person's well-being**, getting sharp attention and giving rise to high expectations by the population.

The health expenditure by the main European countries ranges between 7 and 10% of the GDP, thus being an important voice in public budgets. It has been stated that compatible health expenditure should not exceed 10% of GDP. This target may be hard to pursue for some countries, due to long-lasting demographic trends. A longer average life, in itself a very positive phenomenon,

leads to an aging population, whose health needs are more than proportionally increased.

An "old" population is more liable to diseases and more needful of **expensive cures, with consequences** both on a macroeconomic and sanitary level. The increase in macro sanitary risk makes it difficult to respect the public expenditure constraint.

Another element to be taken into account is the **specific direction** of the striking **technical progress** in the sanitary field, often more focused on the effectiveness of therapies than on cost reductions. Thanks to new technologies applied to diagnosis and therapy, nowadays it's possible to treat a wide range of pathologies, with brilliant perspectives of recovery even from diseases so far considered incurable. The scope of effective cures has been enormously expanded, but often the technologies to be used are very expensive.

In a world characterized by scarcity of resources, this leads to major ethical problems. Is it right to employ any means to cure a single patient? By doing so, don't we steal resources to other patients equally worth assistance? In other words, which is the balance between the effectiveness of a therapy on an individual basis and the concept of social equity?

But expenditure problems are just a single part of the scenario: advanced economies have nowadays a highly demanding population. The **unsatisfaction** of citizens related to the National health system is partly due to real and documented **episodes of "malpractice"**, partly to a new consciousness: to be the owners of rights as **taxpayers**, thus having legitimate expectations and demands about the treatment they receive.

One more issue, partially linked to what above, can be underlined. We live in the world of media; the citizens have unprecedented chances to get information about every aspect of their life. For example, the new scientific and therapeutic discoveries gain a wide echo on television and newspapers, causing **an increase in people's expectations** toward Health in an ideal sense, often accompanied by a **critical stand** regarding the current state of things [1].

The health reforms of these years are an attempt to cope with a dynamic and problematic reality, characterized by contrasting thrusts, brand new challenges and opportunities. The addressed target is the search for a difficult balance between economic aspects on one side, and those ethical and social principles that inspired the birth of the Welfare State, aimed at granting sanitary assistance to all the population, on the other.

The solutions adopted all over the world by the most advanced countries are partly related to the adoption of **new "political" processes of resources allocation**, but that must happen in a wider frame, with a sort of intellectual and cultural reform. Indeed, we have to set **a new focus on the efficacy and efficiency of the service**, on internal **coherence** of health organizations, on **people's needs** and requests, on **human** and **professional relations** at all levels.

Can Quality Management tools and principles, adapted to the peculiar features of the public health sector, grant such an answer?

The **Quality approach** is a wide set of ideas and experiences developed in private firms during the last 70 years. From a historical point of view, quality definition and quality control have been applied in several contexts, according to the evolution of the critical variables of the competitive frame. The cradle of Quality Management was represented by firms committed to the production of goods; until the 50s, the concept of quality has been tied almost exclusively to **products**, to their **conformity** to detailed checklists, and later to the time **durability** of this conformity.

Afterwards, the focus was put on **customer satisfaction** (thus developing accessory services as a relevant competitive element) and on the relationship between client and supplier, eventually transposing it into the firm itself since different departments can be considered as "suppliers" and "customers" in the production chain. By then, quality was ready to enter the firm's organization, gradually turning into **Total Quality Management**. Especially from the half of the 60s on, Quality Management has proven able to provide a significant competitive advantage, deeply affecting the firm's performance, its internal and external relationships,

its organizational, administrative and productive coherence.

Given the many different contributions and approaches, it's hard to trace a single scheme about Quality Management; on the contrary, there are a certain number of significant authors, a wide range of writings, more or less homogeneous and extensively structured [2].

Anyway, they all insist both on a scientific, systematic approach to organizational development, and on the need to involve the whole business, with tools designed to improve the working processes.

In its broadest sense, Quality is a concept difficult to classify, since it is related to the goods or services issued, to all the operations carried on within the firm (R&D, design, marketing, production, data storing, etc.), but even more to a **business philosophy** affecting human relations, organizations and processes.

Accordingly, Quality is based on the development of several related dimensions:

- improvement in the system's **efficiency**, increase of productivity, cost reduction;
- focus on **efficacy**, measured through **customer satisfaction** (the client gaining a central role);
- emphasis on **continuous professional enrichment** of the workers and on the **rationalization** of the organizational structure;
- attention to **personal relationships** (co-operation at all levels, teamwork, sharing of targets and culture, good working environment, active involvement of the employees);
- emphasis on innovation and **continuous improvement**, to be obtained through both **incremental changes** and **radical breakthroughs**;
- central role of the **leadership** in setting the values and the vision, pursuing progress, and in fact establishing a true quality culture;
- **timely response** to environmental change, individuating market needs;
- quality starting from the **early stages** of production, since they are the phases when mistakes can be repaired at the lowest cost;
- partnership and co-makership with **suppliers**;

- elastic and integrated **management by processes** (instead of business functions seen as separated entities);
- attention to specification and **measurement** of the variables, based on the principle that improvements must be "weighed";
- a new **responsibility** toward community and environment.

The outcome is a flexible and organic system, customer-satisfaction oriented, highlighting the **joint responsibility of all operators**. Quality is therefore a cross-phenomenon, involving every business unit in a dynamic process of improvement.

More recently, the quality approach has been adapted to firms supplying **services**, thus showing its versatility and the general validity of its basic principles. Statistical tools for robust design [3], control of sensible data and features of the produced goods [4], provision and store management [5], have been substituted by other performance indicators, more suitable to the "immaterial" nature of service, but the global systematic corpus and the main principles have remained mostly unaltered.

The **introduction of Quality** in a service can be seen as a **cycle** comprising the following phases:

a) definition of a set of **quality standards** concerning the key aspects: customer satisfaction, business coherence and efficiency, employees performances;
b) **measurement** of the attained results for each significant standard (selecting a few to be checked continuously, and others to be followed once or twice a year);
c) awarding or correcting **action** (a quality adjustment cycle must single out the knots to untie, involve the workers in the elaboration of solutions, and last but not least apply the corrections until the problem is eliminated);
d) **repetition** of the actions a)-b)-c)-d) by the employees (quality management cycle);
e) revision and gradual **extension** of the quality management cycle, so as to comprehend roles, responsibilities, processes and praxes of the firm (creation of a Quality System[6]);
f) further step from the solution of problems to their **prevision and prevention** (developing a Quality Control

and Revision approach);
g) introduction of **Total Quality Management**; all the workers ultimately master quality tools, procedures, values and style.

The quality approach of a firm supplying services, along with a few peculiarities owed to the different nature of the output, has a wide range of analogies with businesses producing goods. The attitude doesn't change (it's still based on improvement efforts in every possible dimension, measurement culture, global involvement of the business resources), and the market structure is very similar. In fact, it's still characterized by the supply and demand rules, which in their turn determine prices, profits and, to the last extent, the success and the survival of the business in the competitive arena or vice versa.

Public health services display some relevant differences compared to what above. Firstly, as a matter of fact health is not a free competitive market: public organisations are not profit-oriented, are not liable to the risk of bankruptcy, and given the little elasticity of the supply, any increase in demand is a trouble instead of an opportunity for growth. Indeed, the prices of sanitary services are determined by political choices and public budget constraints rather than by supply and demand interactions.

Furthermore, there are peculiarities related to the users' attitude. Customers of private businesses usually have a certain number of options, and if they are not satisfied they have the chance to turn to another supplier (so, their choices directly determine the success or the failure of a firm). This choice, in the case of public sanitary services, has many limitations, not to mention that the users don't directly pay for the service received; until recently, this contributed to induce a "passive" and submissive attitude in the population ("can we complain about something that we receive 'for free', and that saves human lives?"). The lack of options (and of the chance to compare them), together with the hard comparison between cost and benefit, make it hard to quantify customer satisfaction, the more so because the customer, in this case, is not a single person.

Besides the direct beneficiary of the sanitary service, in fact, there's a family, a general doctor, a circle of friends,

a social community, each having needs and expectations about the service [7]. The requests of such categories may be contrasting, and the patient himself, unlike the buyer of a private good or service, is not able to evaluate the technical aspects of the therapy received.

This leads us to acknowledge the existence of 3 different dimensions of quality related to health services:
- quality as estimated by the "client" (in this case, the patient, his family, the general doctor and society in general);
- quality from a professional point of view (determined by the professionals providing the cures, thus regarding the medical and nursing techniques and procedures needed to supply a satisfactory service for the patient's needs);
- business quality (that is, the most efficient and fruitful use of the resources within the limitations and the guidelines disposed by Law, Authority and sanitary purchasers [8]).

Patients are very sensitive to **attention and solicitude**; as a consequence, the relationship with the doctor plays a leading role in their evaluation of the service as well as the relationships with **bureaucracy** in the supplying organization, service **accessibility**, and **time-lags** between requests, analyses, prognoses and cures.

On the other hand, the sanitary service necessarily contains a most relevant **professional element**, **impossible to measure** by the patient himself: he doesn't have the technical competences to formulate a judgment.

Finally, with the same amount of efficacy and "humanity", from a social point of view it's better to provide a treatment minimizing the consumption of resources, so as to allow the supply of the service to a wider range of needful citizens.

On the basis of what we have been saying so far, it's clear that applying a quality approach to public health is more complex than doing so in the private business sector. The strain for improvement involves different dimensions, as well as stakeholders sometimes seeking contrasting goals; the sanitary activity itself is based on cooperation by different professional groups (doctors,

nurses, managers, social assistants, administrative employees, etc.), each with their own orientation, ethical codes and assessment systems.

Is it possible to employ Quality Management in order to increase efficacy, efficiency and customer satisfaction related to health services? What is the convenience in investing precious resources to implement a quality system, right in a moment when finding such money is more difficult?

The reasons to adopt such an approach are many: firstly, service improvements reduce the costs of "scarce quality", increasing productivity and eventually **freeing large amounts of resources**.

Personnel involvement, knowledge management and inter-professional cooperation allow to enhance the workers satisfaction, crucial for an excellent service in that it motivates them to pursue the business aims. As a consequence, this prevents the expensive phenomenon of workers migrations.

A key feature of a Total Quality System is **prevention**. In the health sector it gains **a particular appeal**, resulting in a **low-cost**, **high-saving** set of policies.

The exchange of information with "customers" can make the service fitter for the population needs, involving the public in the decisions and clearly explaining opportunities and limitations deriving from the budget constraint [9]).

What's more, the extra attention to quality as perceived by the "customer" makes it possible to reduce idle expenses deriving from claims for damages and loss of reputation (which, in presence of other service suppliers, turns into a durable economic damage when the customer addresses elsewhere).

Lastly, quality represents a **competitive advantage** of increasing importance, in a sector where something similar to competition between public and private organizations is beginning to rise, which entitles the citizen with a freedom of choice so far unseen. This gradual change toward a competitive market model is making quality a more and more desirable and valuable

tool [10], since the analogies with its early field of application are growing more and more significant.

Anyway, the basic differences between the private sector and public health services remain, thus making **a specific and personalized approach to quality management necessary**. On the outset of the commercial firms experience, a "tailor-made" project is needed, based on a global scheme defining a coherent strategy to introduce the tools and make sure of their correct use.

In the case of industrial firms, improvement is attained mostly through the measurement of relevant physical features of the good, the assessment of product conformity and of its performance. In firms supplying services, output is not of a "material" kind anymore; as a consequence, the estimation is based on the user's perceptions and on the costs of scarce quality. **Public health will have to outline its peculiarity** as compared to the private sector, starting from a **definition of quality** related to its own institutional role (for instance as "**full satisfaction of the demands of those people who need the service most, at the lowest cost for the system, within the limits and the lines imposed by authority and purchasing organisations**").

On the basis of such definition, the next step will be the **assessment of the standards** for performance evaluation, minding the 3 basic dimensions stressed above (quality as estimated by the "client", professional quality, business quality), with a systematic approach comprehensive of all variables. Quality represents a breakthrough innovation for the health sector, in that it implies a change of mentality. In an ideal sense, quality culture (meant as an attitude to multi-dimensional improvement) is pretty much the same in any field of application, be it private or public. What changes from time to time is the set of tools to be shaped according to the specific sector.

Quality and health services are not worlds apart; on the contrary, concepts like efficacy, efficiency and customer satisfaction are strongly needed within the sanitary system, as features of the service that a modern and advanced country should offer its citizens; therefore, nowadays quality represents a promising field, still rich of

unexplored possibilities, and liable to substantial progress in the next future.

NOTES

[1] To reduce the gap between the "peaks" (remarkable achievements, such as a revolutionary surgical operation) and the "average" (actual standards of sanitary routine) is a key challenge for health professionals.

[2] At least three authors should be mentioned at any rate, due to the major contributions and influence displayed on the next generations of quality experts:
- P.B. Crosby, the creator of an approach based on prevention (Zero Defects logic; the attitude to "do things right the first time"; quality as "vaccine" to gain immunity from "bacteria" of mistake; measurement of non-conformity cost);
- W.E. Deming and the emphasis on statistical analysis, customer needs, leadership role (system of Deep Knowledge; Plan/Do/Check/Act Cycle; 14 points for organisational change);
- J.M. Juran, extending the concept of output to goods and services (intermediate/final), taking the clients within the firm (external/internal client) and orienting the whole business structure to satisfy their expectations (approach by projects; classification of problems according to their priority; Spiral of Progress; breakthrough theory).

[3] The creator of such method, based on the development of products capable to resist the forces altering their qualitative features, is G. Taguchi. Instead of setting a range of acceptable performances for any relevant feature of the product (i.e. the brightness of a TV screen), the firm should rate a single optimum point and act accordingly. This change of attitude brings about at least 2 substantial improvements:
- the company fine-tunes on the perception of the customer, who considers any shift from the optimum point as a drawback and a cost;
- the firm is able to track serial production problems (such as a gradual increase in the brightness of the assembled TV screens) long before the feature exceeds the acceptable range - that is, in real time.
As a result, products assembled according to robust design are more likely to meet the customers' needs, to

last longer, and to maintain the desired standard of performance in time.

[4] W.E. Deming dedicated a big share of his work to developing statistical techniques suitable for this use.

[5] The Just In Time method, for instance, allows to reduce depository stocks, which makes it possible to save space, to spare money on warehouse expenses, and to produce in accordance with the seasonal sales cycle (thus focusing on market evolution and needs).

[6] At this stage, it's possible to start the process of accreditation of the structure and introduce the audits meant to assess the service features.

[7] The compulsive hospitalization enforced by law for patients with serious mental disorders provides an excellent example.

[8] From a historical point of view, **professional quality** has been the one guiding principle of medicine for several centuries. The accepted pattern was paternalistic, based on an uneven relationship between doctor and patient; the latter was supposed to be submissive, to follow prescriptions, and to put blind trust in the doctor's decisions. Later on, a different approach began to take place, more respectful of the patient's autonomy and rights, a sort of partnership between the two subjects (through the procedure of informed consent). In this phase, **quality as perceived by the "client"** has become an important feature in service assessment. Lastly, and very recently, important innovations have been introduced such as health service "business development", for the first time making assessments about efficiency, best allocation and use of resources, social suitability, actually introducing the third dimension of **business quality**.

[9] Social consent is very important for any service provided by the State, even due to political reasons.

[10] A competitive lever under all respects.

JEL Classification of this essay: I31, L3, H51, I18, I19, L8, M