

Service Delivery in Hospitals The Quality Challenge

by Dr. Syed Saad Andaleeb

The control of hospital management remains strongly in the hands of physicians. These physicians must go back to what they are trained to do — tend to the sick and heal the afflicted. The administrative duties of pushing files and making managerial decisions should be left to a well-trained generation of managers.

"Quality is doing it right the first time."
"Quality has to do something for the customer"
"Quality is a journey"

HEALTH care is a vital sector in Bangladesh. It may be argued that the health of the economy is dependent to a considerable extent on the health of its most important asset — its people. Poor health is reflected in productivity losses that are lost for good. Unfortunately, the efficacy of the health care sector leaves much to be desired as it is beset with many problems. From the removal of healthy kidneys to the use of toxic intravenous saline and blood bags; from the abysmally unclean hospitals to poor interpersonal patient care; and from the lack of accountability of health care providers to insubordinate and unruly fourth class employees, the task ahead seems to be monumental.

The overall challenge for the sector is to improve access to health care, reduce the exorbitant costs, and ensure quality. To achieve this, many of the above-mentioned and related problems must be addressed systematically. The central focus, however, should be on improving service quality. This is because health concerns are extremely salient to people and the perceived quality of services has a relatively greater influence on patient behaviour (hospital choice, usage, etc.) when compared to access and cost.

In Nepal, for example, the government made substantial investments to increase access. Yet, utilisation of the facilities remained low because of clients' negative perceptions of quality.

Quality also impacts costs structures; it costs less because doing it right the first time means that resource usage is not duplicated and can be deployed for wider coverage. For example, poor service quality prevents patients from quick recovery, thereby increasing

their costs. The facilities also remain unavailable for other patients. Clearly, expanding access or reducing costs may not be enough if one's confidence in the quality of health care services is low. In fact, perceptions of poor quality may dissuade patients from using available health care services; if the system cannot be trusted to guarantee a threshold level of quality, it will remain underutilised, be bypassed, used only for minor ailments, or used only as a measure of last resort.

To understand the service quality needs of hospital patients we conducted an exploratory study in Dhaka city. We found that patients assess quality on five major dimensions. In order of importance they are: discipline (cleanliness of the facilities and staff, and a general sense of order and discipline in the hospital), assurance (skilled staff, efficient services, and procedures done correctly the first time), responsiveness (staff must be caring, helpful, prompt and courteous), communication (when patients' conditions and all medical procedures are clearly explained), and bakshish (when patients don't have to pay extra for due services). Clearly, every hospital must strive to provide and maintain a clean environment which is often paid lip service; staff skills must be ensured through continuous training; patients must be kept abreast of their condition and what procedures they are likely to undergo, along with proper instructions on medication and their potential side effects; they must be humanely treated with care, assistance, promptness and courtesy; and they must not have to pay extra for services that are due to them.

To ensure that the above needs are met, hospitals must adopt modern managerial practices and reduce service failures. Generally, these failures occur because providers do not know or do not care to know what patients want; they do not have any standards in place to deliver consistent services; they are incapable of delivering according to the standards because of human resource and management system problems; and because they fail to match performance to promises made explicitly or implicitly. Clearly, they must define and

establish deliverable standards based on feedback from patients. That will require fine-tuning of the hospital system through 1) bench-marking 2) continuous assessment of quality, and 3) using the results to make improvements where needed. It cannot be stressed strongly enough that quality is a journey and with every improvement, patients' expectations will elevate to the next level. For health care professionals, the excitement should be in the challenge to meet those expectations, win back the heart and soul of the patients and, of course, reward themselves by stemming the outflow of valuable foreign currency that can be deployed better in other sectors.

To ensure conformance to quality standards, there is also a need for modern managers to run the hospitals efficiently and effectively. The general state of apathy and unconcern that currently prevails in most hospitals, especially in public hospitals, suggests that such practices are yet to be introduced. This condition may be attributed partly to the fact that the control of hospital management remains strongly in the hands of physicians. These physicians must go back to what they are trained to do — tend to the sick and heal the afflicted. The administrative duties of pushing files and making managerial decisions should be left to a well-trained generation of managers. To this end, we strongly feel that the field of health and hospital administration must be introduced immediately in the country. We ardently hope that physicians will embrace these changes. That way they will best honour the oath they have pledged to uphold.

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Food Supplements Can Provide Immunity against Malaria

by Md Asadullah Khan

In the 1950s, international health experts thought wonder drugs and insecticides would eliminate malaria completely, just as widespread inoculation programmes have conquered small pox. By the start of this decade, the disease was on a dangerous rebound.

With symptoms of a headache, then a flulike fever and bone racking chills lasting upto an hour or more — the disease has come to be familiar to millions of people around the world. When the chills return after 24 or 48 hours, the patient knows for sure, what disease he has — malaria — and treatment can begin for the relatively lucky patient infected with — one or more benign strains of the parasite. The fever is caused by Plasmodium, the malarial parasite, one of the deadliest and most vicious on earth. As it wends its way from mosquito to man, it causes other than fever, severe damage to the spleen in perhaps 500m people a year. Of these, it kills an estimated 2.7m — most of them children under five.

One should be happy that the monsoons do bring life but one should be equally worried that they could just as easily bring death. The rains are the first sign of problems. In the dried pores and cracks lie dormant eggs of one of the hardest and greatest scourges: the Anopheles mosquito. In its guts begins the life cycle of "plasmodium falciparum", the deadliest of two microscopic parasites that cause malignant malaria with more lethal modus operandi. The other parasite "plasmodium vivax" is not as lethal as the "P. falciparum". On entering the human blood stream "plasmodium falciparum" starts reproducing at such a fantastic rate that its progeny clogs arteries and choke off the oxygen supply to the brain. The patient can die within 48 hours after the onset of the first fever, long-before a diagnosis is possible.

The epidemiologists' warning for the last few years that especially deadly types of malaria, brought on by drug resistant "P. falciparum" strains, were on the way came true in India. In 1994, "P. falciparum" made its first appearance in Rajasthan after heavy monsoon rains allowed "fulesome" breeding of the "Anopheles" mosquito. Malaria, it was learnt, killed about 2800 people in India in 1996. Many died of the malignant form of the disease — cerebral malaria. Parasites of this type cut blood supply to the brain.

Anopheles, the female type is deadlier. They suck blood from humans — to collect proteins to produce eggs and these female type of the species transmit malaria through its bite. The males feed on plant nectar. Female mosquitoes

have an excellent set of homing devices. They zero in on their victims by a variety of means: detecting infra-red radiation, carbon dioxide and chemicals that are emitted in minute quantities by the body.

Anopheles bites at night and rests indoors during the day. It can breed in everything from a cupful of water to a reservoir created by a dam. Anopheles species have adapted to human conditions marvelously. They once fed on cattle but then found humans as easy prey as their population rose. These species are found especially in the inundated parts after the floods with patches and puddles which are ideal breeding grounds for Anopheles type of mosquitoes.

As the water keep on receding more and more puddles will be formed.

As already stated, malaria, spread by the parasites *P. vivax* and *P. falciparum* breed in the Anopheles' intestines. The parasites kill red blood cells and cripple the spleen.

Shockingly, following rains in 1996 in some states of India, "P. falciparum" surfaced again claiming more than 600 lives in two districts of Arunachal Pradesh and then spreading in all directions. In late October in 1996, the wave reached Calcutta (pop. 12 million) and the hospitals were clogged with patients. Governments and medical workers were almost powerless to fight the malaria menace in India.

In the 1950s, international health experts thought wonder drugs and insecticides would eliminate malaria completely, just as widespread inoculation programmes have conquered small pox. Meanwhile, because of lack of proper surveillance, Anopheles mosquitoes that survived gained resistance to pesticides. At the same time, all four common types of the disease had started showing strength against anti-malarial drugs.

But not so any more. Researchers at Johns Hopkins University at Baltimore, Maryland in the US seem now to have discovered that rarity of modern medicine, a cheap and easy fix. Happily, Anaraj Shankar and his colleagues have found that feeding zinc or vitamin A to children seems to raise their immunity to malaria. Vitamin A's general immunity-boosting properties

have been known for a long time. As a result, it has, in the guise of cod liver oil, been used for children for decades. Zinc is also found in many foods and is needed only in trace amounts to keep the body and particularly the immune system in good order.

But detailed knowledge of its effects is only just emerging. And zinc deficiency, it is learnt, is common among children, even in such wealthy countries as Denmark.

Denmark also does not have to worry about Malaria. Papua New Guinea does. There the disease is a leading cause of death in children. In a 13 month trial that he conducted in New Guinea, which involved feeding almost 500 children vitamin A every three months, Dr. Shankar found that he could reduce the incidence of the disease by 30 per cent. Zinc did even better. In a ten-month study of over 270 children, Dr. Shankar found that those receiving ten milligrams (mg) of zinc a day had 40 per cent fewer attacks of severe malaria than those on normal, low-zinc diets. This was probably because the children taking extra zinc produced more biochemicals that affect the immune system, such as interferon-gamma. Such molecules tweak the immune system's "killer" T cells into action, and may also raise the level of antibodies to Plasmodium.

Sadly, neither zinc nor vitamin A is as good at preventing disease as are anti-malarial drugs such as "mefloquine". On the other hand, they are not so expensive. A year's worth of each of the two supplements costs roughly a dollar or 50 taka per child. A year's supply of mefloquine costs 50-100 times that. And it may, in any case, be possible to get results that are closer to those of drugs by combining the two food supplements. To find out whether the effects of zinc and vitamin "A" are, indeed, complementary, Dr. Shankar is planning to start a further trial in Ghana. And to see if food supplements can boost the effects of drugs, an international study (organised by USAID and Harvard University) was looking at the combined action of zinc and anti-malarial drugs in 1,200 children in Ghana.

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Banerjee, whose party had also supported the move in the Assembly, later spoke in the same vein. The Socialist Unity Centre of India (SUCI), a fringe Left party, also issued a statement saying their representatives in the house had signed in favour of the resolution "by mistake" and they were not in favour of Bangla.

The name agreed upon originally for the state was "Paschim Banga" but it was presented as "Bangla" in the resolution. State SUCI secretary Pravash Ghosh described the move as a "pre-political gimmick" and regretted that the ruling Communist Party of India-Marxists (CPIM) had followed

states that indulged in "rabid provincialism and went on a name-changing spree."

Banerjee alleged that although the three members from metropolitan Calcutta in the last Lok Sabha had been from her party, they were not consulted before rechristening it as "Kolkata". "Nor were our 25 councillors in the Calcutta Municipal Corporation (CMC) informed." She also stressed the need to ascertain public opinion in the matter.

After the new Lok Sabha is elected, the resolution will go before it for ratification and then to the President for his assent. The switch to "Kolkata" will come into effect as soon as the state government issues a notification to that effect in the state assembly unanimously and the Congress was a party to it.

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and said there were other pressing problems to attend to.

While supporting the resolution, Congress and Revolutionary Socialist Party (RSP) legislators and Trinamool member Shobhabandhu Chatopadhyay had underscored the need to assess public opinion.

Noted writer Annada Shankar Ray wondered about the need to change the name, saying the word "west" should have been there with the state's name, because it denoted part of an earlier whole. Eminent movie-maker Mrinal Sen averred "the sky would not have fallen on our culture had we continued with our earlier names."

Controversy Dogs Renaming of West Bengal

Krittivas Mukherjee writes from Calcutta

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THE name "Calcutta" might soon make an official disappearance, paving the way for "Kolkata," but controversy continues to dog the renaming of West Bengal as "Bangla."

Both Trinamool Congress chief Mamata Banerjee and his Congress party colleague in the last Parliament, Priya Ranjan Das Munshi, have decided to oppose the resolution on the name "Bangla" when it is taken up for ratification in the new Lok Sabha, or lower house of Parliament, to which elections are scheduled for September-October. This, despite the fact that the resolution seeking to change the name West Bengal to "Bangla" was adopted by the state assembly unanimously and the Congress was a party to it.

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Reacting to state Culture Minister Buddhadev Bhattacharya's assertion that the new name signified freedom from colonial legacy, former Police Commissioner Tushar Talukdar said that "legacy is not something that you can get rid of by simply changing a name." He called it a non-issue

and said there were other pressing problems to attend to.

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Eminent movie-maker Mrinal Sen averred "the sky would not have fallen on our culture had we continued with our earlier names." He also feared that "Bangla" may get mixed up with Bangladesh.

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Former Trinamool member Paritosh Sen said he wasn't sure to what extent the Bengali identity would actually be preserved through the new names, "but there are more important issues on our priority list."

Industrialist Harsh Neotia said "when the world knew Calcutta by its old name, where was the need to change it."

The Statesman newspaper, in an editorial, apprehended that name-changing will damage the cosmopolitan character of the city. Bengal Club president P. K. Dutta said it would still be called the Bengal Club. "If we were a politically-affiliated club, we would have ridden the wind."

Sushila Mitra, a Calcutta resident of Tamil origin who is married to a Bengali, said "I hate to call it (Madras) Chennai. Why bother with names when more important issues like development are pending?"

— India Abroad News Service

Garfield



by Jim Davis

James Bond

