

SUMMER TRAINING REPORT

ON

AN ASSESSMENT OF THE QUALITY OF HEALTH CARE IN INDIA
AND
IMPROVING GLOBAL HEALTH : FOCUSING ON QUALITY AND SAFETY

DATE 17TH APRIL 2020 TO 28TH JUNE 2020

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“ACADEMIC YEAR, 2019-2021”



ACKNOWLEDGEMENT

Vast gratefulness with most profound appreciation for the assistance and backing are reached out to accompanying people who somehow have contributed in making the examination conceivable.

Dr.Pankaj Gupta president of IIHMR University, Jaipur for giving us golden opportunity to carry out the research based summer training project.

Dr. P.R Sodani Pro-President and Dean Institute of Health Management at IIHMR University, Jaipur for his support and giving long period of time for research project.

Dr.Sandesh Sharma mentor, and advisor, for his help, guidance, direction, important remarks, recommendation and arrangement that profited this much in consummation and achievement of this study sharing his inside and aided in the analysis of information and its measurable statistics.

I am overpowered in the humbleness and appreciation to pursue my significant to every single one of the people who had helped me in this project. I might want to communicate my unique gratitude to my parents and friends for their consistent good help.

ROLL NO

0979

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An Assessment of the Quality of Healthcare in India

Abstract

Indian human services give a wide scope of nature of care. Endeavours to improve the nature of care are testing a direct result of the absence of information about current circumstance and how nature of care changes in most recent couple of decades. Creating countries have been concentrating on applicable framework, innovation, infection control, and wellbeing results as far as passing and handicap balanced life years, to a great extent overlooking the administration quality perspective from the patient's perspective. We summarise what is the position of quality of care in India compared to the standardized requirement. To establish current knowledge of patient safety, see the present situation and quality of care in India. Study helps to establish a current knowledge of quality and the gap racing in the scope of improvement for quality of care.

Introduction

A quality of healthcare can be defined as one that is assessable, appropriate available, affordable, effective, integrated, safe and patient related.

Good quality of healthcare means that providing patients with the services in an exceedingly competent manner having good communication, having cognitive processes and cultural sensitivity. The quality of healthcare given by a health professional can be judged by its outcome, the technical performance of care and by interpersonal relationship.

In practical terms poor quality can mean (a) too much care; providing unnecessary test medication and process associate with the side effects and even risk, (b) too little care, providing an indicative diagnostic test or a surgery that is important or (C) wrong care; giving medication that react with other medicine. (schuster, McGlynn, & Brook, 2005). The rapidly growing burden of chronic diseases in India makes the low quality of care highly salient for health policy.

The three dimensions that are important for measuring the quality are

1. Structural quality it evaluates health system characteristics specially in the form of Government survey of health facility and keeping the record to track availability resources such as no of beds available, quantities of supplies etc
2. Process quality- It asses interaction between clinicians and patient.
3. Outcomes evidence for the change in the patient health status.

Quality can also be measured to determine with their care meets professional standards.

It has been shown that there is no universally accepted definition of Quality of care outcome of pregnancy and utilisation of maternal health care services are studied to reflect lack of quality (Karvande, Sonawane, Chavhan, & Mistry, 2016)

It has been seen that the quality of healthcare in India differs for primary and public sector, urban and rural, inpatient and outpatient, maternal and child health. So in this we will discuss here about how the quality changes accordingly.

Objectives

1. To identify aspects of perceived quality which have large effects on patient satisfaction.
2. To identify the unmet health and healthcare needs of population and making changes to meet those unmet needs.
3. Improve access and reduce inequity.
4. Increase the focus on health promotion and prevention, screening and early intervention.

Review of literature

Inpatient and outpatient

Patients' recognition is huge as it impacts their 'wellbeing looking for conduct including use of administrations, looks for contribution in issues legitimately identified with them, empowers the specialist co-op to live up to their desires better, and gives applicable data to the approach producers to improve the quality. Except the hospital infrastructure for inpatient and outpatient satisfaction all the other perceived quality dimension have a positive and statistical significant effect the effect of the perceived quality dimension on general satisfaction does not significantly differ between inpatient and outpatient except staff behaviour which is significantly lower for outpatient compared with inpatient (Sharma & Narang, 2011).

Waiting time of more than 30 minutes significantly lower in patient satisfaction. (Rao, Peter, & Roche, 2006). Patients with higher waiting time were less satisfied with health care quality. It is found that weak support for waiting time and its effect on overall satisfaction with clinical quality (Mehra, 2016). Curiously, among IPD (Inpatient Division) patients, the factors 'relational and indicative part of care,' 'office,' and 'wellbeing faculty direct and medicate accessibility' alongside 'medicinal services conveyance' were fundamentally related though 'money related and physical access to mind' was not, in this way inferring when the patient must be conceded into the emergency clinic, the budgetary and physical openness took a secondary lounge while for

OPD(Outpatient Office) patients, 'Human services conveyance' and 'monetary and physical access to mind' were generally huge.

Rural and urban

Majority of the population living in the rural area, where the health services were provided within 1 mile but the doctors or paramedical staff visit is less. Rising prices, changing disease patterns, and growing use of advanced technology for diagnosis and medicine have done it virtually difficult to imagine any single company assisting without some type of institutional organisation .In the last two decades, there has been a growing concern over the administration of the healthcare delivery policy in India. In the year 2012, a mere 1.3% of the GDP was allotted to public health. As per the Government of India's National Rural Health Mission Document, only 10% of Indian have some form of health insurance and mostly this is inadequate (Kumar & Mishra, 2019)

The NRHM (2005-12) seeks to implement efficient healthcare to rural people during the country with special focus toward 18 states, which should weak public health notices and/or weak support. These 18 states are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh,

Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Odisha, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh. PPP can implement a solution in the achievement of health-related goals. However, the administration is also taking due care in operating with the special sector to ensure sufficient health services in rural regions. Overall low levels of medical training among healthcare provider; in rural Madhya Pradesh. (Das, Holla, Mohanan, jabak, & Chan, 2012). Right judgments were uncommon, off base treatment was generally recommended and adherence to clinical agendas was higher in private than in open facilities. Association between human services suppliers and normalized patients were brief (3.6 minutes), with low degree of history taking and assessments and an accentuation by the supplier on offering prescription to the patient. There was little supplier - quiet correspondence. Only 33% of the suppliers verbalized a conclusion, right or off base. At the point when determinations were enunciated, near half weren't right, and just 12.2% were completely right

(Das, Holla, Mohanan, jabak, & Chan, 2012).

Urban setting showed a higher level of trained healthcare providers but similarly large quality deficits with equally poor adherence to checklists.

Public and private sector

India's health system is a mix of public and private health-care providers. An early survey of rural household found that public provider accounted for 8 out of 100 visit to a health care provided by unqualified practice providers account for 70 out of every hundred visit and in urban household 70% of all visit where to private sector providers and remaining 30% where evenly divided among public healthcare centre and hospital out of which 31.5 % provider have minimal or no training 43.6% who have some type of training and 24.8% provided with bachelors of medicine and bachelor of surgery degree (Das, Holla, Mohanan, Jabak, & Chan, 2012)

General human services framework is supported through broad tax collection or open area medical coverage, though private social insurance is paid for all through out-of-pocket (OoP) consumption or through private health care coverage.. (Singh, et al., 2018) Private facilities were utilized more often for health care related to accidents and non-communicable diseases (NCDs) whereas public facilities were commonly used for infections, gastrointestinal obstetrics, and gynaecological and respiratory problems (Singh, et al., 2018)

The private sector is the various important sources of healthcare services in India, contributing alike to 80% of all duties, according to the government's statement. (Kumar & Mishra, 2019) Quality improvement initiative have been taken by government of India states of Bihar and up with worst health indicators are now collaborating with researchers and external domains to implement strategies such as nurse monitoring and direct observations delivery with more than 8000 delivery is observed since 2012 this increase the openness to adopt method to improve quality private sector majority of the healthcare in India is obtained in private sector than in public sector field. Experiment in state of Karnataka randomly assigned obstetric care provides to receive contracts with performance initiative based on either input or health outcome and research found that what type of contract reduces the rate of postpartum haemorrhage by 20%.

Maternal and child health

Infant mortality rate of 65 per thousand live but compared to 44 in India is almost 1.5 times higher among with rural household than urban. (Deorarl & Livesleey, 2018)

Globally the maternal mortality ratio has declined by 47 percent over the past two decades in India after the launch of NRHM had established effective integration and coverage of health services.

The states of Kerala with MMR as low as 61 is striving to further down where as state such as Bihar and Jharkhand have MMR of 274 and 245 respectively. Poor availability of trained HR for health and social determinants of health has been identified some of the issue for achieving universal health coverage by 2022. (Karvande, Sonawane, Chavhan, & Mistry, 2016)

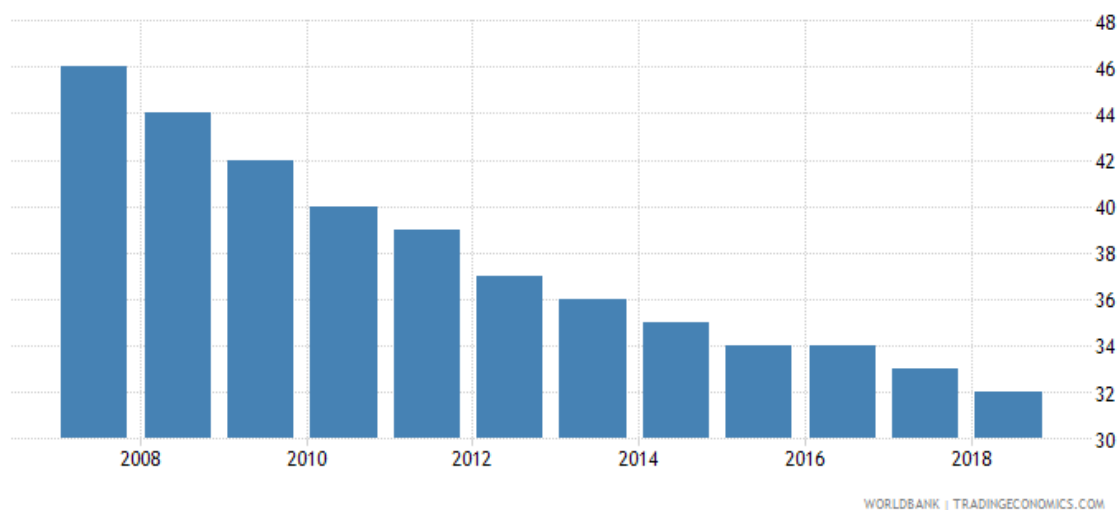
Nurses not doing partograph that is useful to register referral is not actually done. (Kilaru, Karachiwala, & Mattheus, 2010) . Early augmentation of labour at the time of delivery. (karvande, sonawane, Chavhan, & Mistry, 2016) . No screening for HIV during pregnancy. With rising institutional birth in India the question arises on the quality of care about 30% of institutional delivery where augmented with oxytocin and 62 % woman left health centre in less than 6 hours. (Kilaru, Karachiwala, & Mattheus, 2010)

To understand how the quality of health care has been changed or improved from the last few decades. We will take into consideration the burden of diseases .As for the quality, the outcome is important. So will discuss this for better understanding of the quality of health care in India This disease burden can be divided into communicable and non- communicable diseases. Communicable disease like Malaria, Tuberculosis, Leprosy, HIV Non-communicable disease like- Vascular diseases, cancer, asthma and COPD. (Kumar & Mishra, 2019)

Tuberculosis

Tuberculosis is a burden to all over the world but majority of its burden is because of India. Almost 30% patients are found in India. Along with the disease burden India accounts for the drug resistance TB that can be fatal. Be in the studies it has been seen that most of the deaths that cause due to the TB, is not because of the drug resistance Tb; this happens because of the patient received care too late or not receiving care at all.

Also according to WHO TB has surpassed the death burden of HIV and malaria. A 1992 joint audit of TB control exercises demonstrated that in spite of the presence of a national program, TB patients were not being precisely analyzed, and most patients didn't finish the treatment. This survey prompted the Changed National Tuberculosis Control Program (RNTCP) being begun a pilot premise in 1993, trailed by enormous scope usage in 1997. By December 2004, 545 areas with a populace of 94.2 crore had been secured.



India tuberculosis death rate- per 1,00,000 populations

The following graph suggest that death rate due to Tuberculosis has been decreased to a greater extend in the last ten years.

TB Patients Notified Public Sector (2019)	TB Patients Notified Public Sector(2018)	TB Patients Notified Private Sector (2019)	TB Patients Notified Private Sector(2018)
1725920	1613504	678895	542390

But from the above table it has been seen that the number of patients increases.

In March 2017 the Government of **India** (GoI) announced that the new aim with regard to **TB in India** was the elimination of **TB** by 2025. For this national strategic plan (NSP) has also been developed by the Government of India. The Vision of a TB free India with zero deaths, disease and poverty due to tuberculosis.

The Goal is to achieve a rapid decline in the burden of TB, mortality and morbidity, while working towards the elimination of TB in India by 2025.

The requirements for moving towards TB elimination in India have been arranged in four strategic areas of

Detect, Treat, and Prevent & Build. There is also across all four areas, an overarching theme of the Private Sector. Another overarching theme is that of Key Population

MALARIA

Malaria fever has been an issue in India for a considerable length of time. The financial misfortune because of the loss of man-days because of intestinal sickness was assessed to be at Rs. 10,000 million every year in 1935.

At the hour of autonomy in 1947, of a populace of 330 million, around 75million individuals were evaluated to be contaminated with intestinal sickness consistently, and the immediate mortality because of the ailment was assessed at 0.8 million for every annum. The execution of urban jungle fever conspire (UMS) in 1971-72 and the changed arrangement of activity (MPO) in 1977 improved the intestinal sickness circumstance for 5-6 years. Jungle fever cases were

As indicated by the World Intestinal sickness Report 2014, 22% (275.5m) of India's populace lived in high transmission (> 1 case for every 1000 populace) regions, 67% (838.9m) lived in low transmission (0–1 cases for each 1000 populace) territories and 11% (137.7m) lived in jungle fever free (0 cases) areas.[7] In 2013, 10.88 million cases were recorded, with 128 million tests being directed on the presumed cases with *P. falciparum* causing 53% and *P. vivax* causing 47% of the contaminations. The rate of intestinal sickness in India represented 58% of cases in the South East Asia Area of WHO.[7] reduced to around 2 million. As indicated by the World Intestinal sickness Report 2017, in the year 2016, the greater part of the populace (698 million) was in danger of malaria fever. As indicated by the Report, India represented 6% of all malaria fever cases on the planet, 6% of the passings, and 51% of the worldwide *P. vivax* cases. The Report evaluates the absolute cases in India at 1.31 million (0.94-1.83 million) and passing at 23990

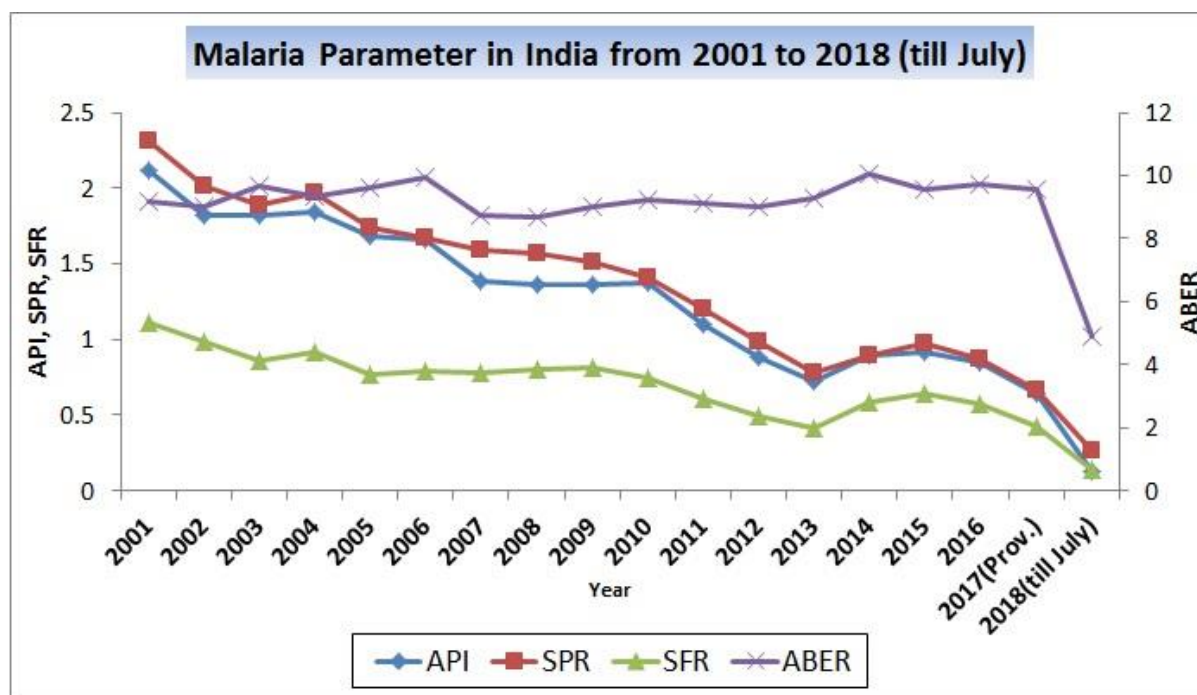


Figure: 3

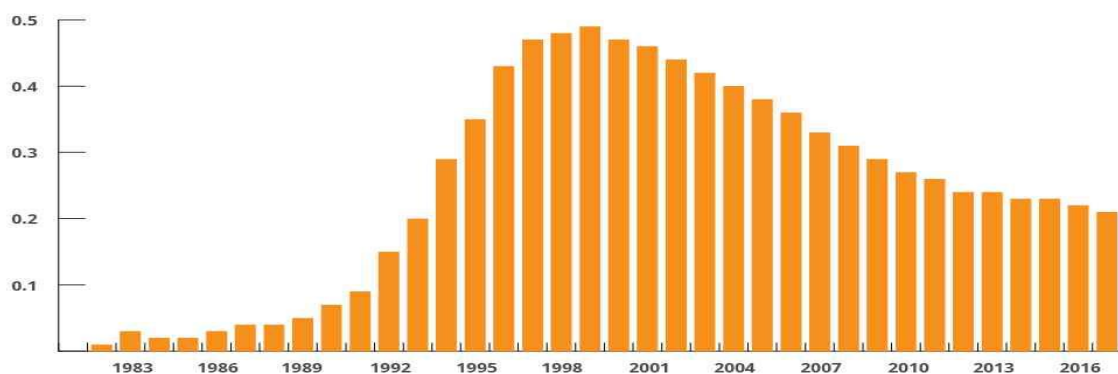
From above graph it has been estimated that API, SPR, SFR has been gradually declining after 2007. But an increase in SFR in 2014- 2015. It has been seen that API, SPR, SFR are below 0.5 per 100 population in 2018. This shows the better care of health care towards malaria has been seen in last few years.

HIV

Late information from the National Guides Control Association shows that the quantity of new HIV cases in India has fallen fundamentally since the pinnacle of the pestilence in India in 2005. Be that as it may, the pace of decrease has likewise eased back as of late. New enrollments of HIV cases in India have dropped from 1,30,000 of every 2005 to 88,000 out of 2017. There were 2,40,000 Guides related passings in 2005 while there were 69,000 out of 2017. In any case, new HIV contaminations declined just 27% somewhere in the range of 2010 and 2017 – or from 0.10 per 1,000 uninfected populace in 2005 to 0.07 in 2017 – leaving far to go for NACO's objective, which is to accomplish a 75% decrease by 2020 from 2010

levels.

Adult HIV prevalence in India in 1981-2017



Scroll.in

Source: HIV Estimation 2017, NACO

Leprosy

Uncleanliness, otherwise called Hansen's sickness, is a constant irresistible infection brought about by *Mycobacterium leprae*. The ailment predominantly influences the skin, the fringe nerves, mucosal surfaces of the upper respiratory plot and the eyes. Uncleanliness is known to happen at all ages running from early stages to mature age. The worldwide disease circumstance has changed essentially in the course of the most recent four decades after the presentation of multidrug treatment (MDT) in 1982 with a decrease in commonness from more than 5 million cases in the mid-1980s to under 200,000 toward the finish of 2016. The program in India likewise observed a decrease from a pervasiveness pace of 57.8/10,000 of every 1983 to under 1/10,000 before the finish of 2005 when India pronounced to have arrived at the World Wellbeing Association (WHO) focus of end as a general medical issue. Post 2005, significant changes in the program were made by the National infection annihilation program (NLEP) and the worldwide uncleanliness program, which may have influenced the new case identification (NCD), inability, and kid disease patterns, which keep on indicating no considerable relapse (Rao and Suneetha, 2018).

In India, the National Disease Destruction Program (NLEP) is the halfway supported wellbeing plan of the Service of Wellbeing and Family Government assistance, Administration of India. While the NLEP methodologies and plans are planned midway, the program is executed by states and association domains (UTs). India has prevailing with the usage of MDT in bringing the national predominance down to "disposal as a general medical issue" of under 1/10,000 in December 2005 and considerably further down to 0.66/10,000 of every 2016. Before the finish of Walk 2011–2012 prevailing with regards to accomplishing end at the state level in 34 states/UTs out of the complete of 36 states/UTs. Just the province of Chhattisgarh and the UT of Dadra and Nagar Haveli were yet to accomplish disposal. It was felt that the significant reason for concealed cases is low willful detailing in the network because of an absence of mindfulness just as the proceeding with dread, shame, and oppression uncleanliness. The SPARSH Disease Mindfulness Battle (SLAC) was propelled on 30th January 2017 and is a program expected to advance mindfulness and address the issues of shame and separation. The reality remains that India keeps on representing 60% of new cases detailed all around every year and is among the 22 "worldwide need nations" that contribute 95% of world quantities of disease justifying a continued exertion to cut the numbers down. In the year 2007, new cases distinguished in India were 137,685, and after nine years in 2016, the number remained nearly the equivalent at 135,485, a critical increment over the 127,326 new cases identified in 2015. This expansion in new cases is ascribed by NLEP to their ongoing methodology of inventive Sickness Case Location Crusade (LCDC), which brought about the recognition of 34 000 new cases in 2016 from profoundly endemic pockets, which represented 25% of yearly new cases.

NON COMMUNICABLE DISEASES

India like most rapidly growing economies is facing a looming epidemic of non-communicable disease. Results from several large studies on the burden of disease and their trends have formed the basis of mapping the epidemiological transitions it is clear that while elderly population disproportionately suffer and die from NCDs, the younger populations continue to suffer and die from communicable diseases- in the age group 0–14 years, 81% of all deaths are due to communicable causes, while in the age group 40–69 years, 73% of all deaths are due to NCDs. The middle age group, i.e., 15–40 years being the age of most physical activity, injuries contribute to almost 1/3rd of all deaths while communicable and non-communicable conditions contribute roughly equally to the remaining deaths. primary health care settings in rural South Rajasthan suggest that while communicable diseases (diarrhoea, TB, and pneumonia) and maternal–neonatal conditions (antenatal care, contraception) are major reasons for seeking care for people up to 49 years of age, non-communicable conditions become the major reason for those 50 and above. An analysis of the clinic footfall across a spread of 4 years showed that 57% of the patients (50 years and above) seeking care were for NCDs like COPD, hypertension, diabetes, and skin diseases.

Study suggests that NCDs are increasing in prevalence among adults in rural as well as urban areas.

Methodology

To particular technique that measures the quality is the technical process quality refers to if take care is provided skilfully and whether the right choice is made in diagnosis. A service is considered appropriate if increase life expectancy pain relief improve functional capacity exceed it expected health list example mortality and morbidity in cal diagnosis

The second metre to determine whether care meets the professional standards it can be done by quality indicator that describe a process of care that should occur for a particular type of patient on clinical circumstances and then evaluating whether patient care is consistent with the indicators.

The present study is done to see the current situation of the healthcare and what progress has been done in terms of quality.

Review of literature

Quality of healthcare in India challenges priorities and the road ahead

Research method -observation of health care provider performance exit interviews of patient standardized patient to measure the quality

Promising approach to create new latest source to address the specific data gap in the direct measurement of the quality of care

Data set 23,275 household across hundred villages in rural healthcare in state of MP using quality measure based on the random sample

Result- limited availability of formally trained healthcare provider with at least a bachelor's degree in rural area there for 75% of the country population lives where provide does don't have a formal medical education quality of care at the system level required focus on the government issue including public sector management building and institutional capacity.

Toward patient centred healthcare service in India a scale to measure patient prescription perception of quality

Research method- Primary health centre community health centre district hospital female district hospital in UP.

Research design- cross sectional survey of health facilities and patient at clinic

Better staff and physician interpersonal skill facility infrastructure and availability of drugs have a the largest effect in the patient satisfaction and public health facilities

Study- Qualitative study total of 17 facilities from 28 history which include 28 district hospital 25 female district hospital 28 community health care centre 36 primary health care centre 1869 patient and 611 inpatient

Result- Patient satisfaction and perception of quality of public health facility are on average only marginally favourable living much room for improvement for outpatient doctor behaviour has larger effect followed by medical availability hospital infrastructure and staff behaviour medical information

For inpatient staff behaviour has largest effect.

Longer waiting time has a large negative effect on both the outpatient and inpatient and improvement and improvement in one are likely to strengthen the other

Quality of health care services in rural area the user perspective

- 500 patients were reached at the human services places. It was seen that 'Human services conveyance' and 'money related and physical access to mind' essentially affected the discernment among men while among ladies it was 'social insurance conveyance' and 'wellbeing staff direct and sedate accessibility'. It was not only the budgetary and physical access that was significant however the way of

Conveyance, what was most shocking was the finding that the general nature of medicinal services administrations is seen to be higher in Essential Social insurance Places than in Network Human services Communities (CHCs). Budgetary and physical openness of the administration that is related with the result, infers that the ease structure and relative closeness of these offices are most significant elements with no affiliation being appeared with any of the other mooted segments Strangely, among the IPD (Inpatient Office) patients, the factors 'relational and indicative part of care,' 'office,' and 'wellbeing faculty direct and medicate accessibility' alongside 'social insurance conveyance' were altogether related.

study configuration cross sectional review of wellbeing office and patient at facility result relationship between understanding fulfillment and endorse quality measurement 117 offices from 28 locale emergency clinic 25 female area medical clinic 28 network social insurance place 36 essential human services community in UP

In urban and rural India standard patient study showed low level of provided training and use quality gap

The objective the quality of care derived by public provider of primary health centre in rural and urban area to address the gap

Data collection method -gold standard in quality measure

Data size 926 clinical interaction between 305 medical care providers in rural and urban India and 22 on announced standardized patient

Conclusion-

A large portion of the rural healthcare in India is provided by people without formal training.

Urgent call to better integrate quality measures.

Result brief consultation time and poor checklists resulted in treatment that were inconsistent and with treatment guidelines.

what does quality of care for maternal health provider for to enable state in India

Focus on exploration of quality component related to practice health challenges focus on marital health through a pilot research conduct in 2012 to 2013 into state of Bihar and Jharkhand

Method -Qualitative data from October 2012 to 2013

Result -study finding identify quality such as appreciation of PPP clinical guidelines in form of wall poster in health facilities.

Conclusion- frontline health provider perspective about quality and safety adequate health infrastructures from health management information system introduction of evidence-based education and training with supportive supervision contribute parallel effort.

Discussion

As per HAQ (Healthcare Access and Quality) index, 2016; India rank 145 from 180 countries.

India lags behind Sri Lanka, Bangladesh, Bhutan and Nepal

As we observed various parameters to describe the quality of healthcare. India has done various efforts to improve the healthcare

Suggestion

India has an elaborative healthcare delivery system for rural areas but the system is not able to deliver quality care. For providing good quality care, we need to have sufficient resources, medicine and equipment

Doctor patient interaction time should have to be increased for better diagnosis and treatment thus result in better outcome.

Need of qualified Doctors or atleast trained healthcare staff in rural area.

Clinicians and health plan can use information on quality to determine where to focus their effort to provide better care. Policy maker can also use information about quality of care to determine the impact of public and private changes in the healthcare market place.

India is capable of setting up a quality measurement system that can provide multiple participants in the health care system with the information they need to ensure delivery of high quality care. In the light of changes that the healthcare system has been experiencing, a strategy to measure and consequently to improve quality is needed now.

Conclusion

The quality of care that has been provided in India differs from hospital, cities and state; frequently it does not meet to the professional standardized. There is good reason to proud of our health care system, but some area need to have more improvement. India is responsible for many important advances in health care technology, and state-of-the-art care is available in both large and small communities throughout the country. But the same quality of care is not provided at all.

(Kwan, et al., 2018)

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Improving global health: focusing on quality and safety

Objective of course

Lesson 1: Burden

1. Comprehend the terms trouble, mischief, preventability and what they mean for human services uniformity.
2. Recognize the likenesses and contrasts in estimating quality in high and low-pay nations.
3. Recognize quality estimations explicit to walking care.
4. Talk about the recurrence of drug mistakes as one proportion of value
5. Summarize the prevalence of tuberculosis across the world, particularly in India.
6. Explain why the number of new cases of tuberculosis has been increasing in many countries, especially India.
7. Describe how the private and public health sector treats tuberculosis patients in India.
8. Identify strategies and innovations that can help improve tuberculosis treatment and adherence, as well as long-term strategies.

Lesson 2: MEASUREMENT

1. Understand quality variation across health care systems and geographies.
2. Discuss categories of health care resources and how they are allocated based on geography, disease frequency, political factors, and more.
3. Understand global health care quality indicators.
4. Compare how countries with and without large scale healthcare data infrastructure can Measure and understand quality.

Lesson 3: STANDARDS

1. Understand the role of the legal regulations in creating and measuring quality.
2. Identify the ways in which accreditation, staffing ratios, compensation, deterrence, and negligence impact health care quality.
3. Discuss practitioner licensing across geographies.
4. Compare patient compensation for health care mistakes across geographies.

Lesson 4: IMPROVEMENT

1. Understand the Plan Do Study Act framework for implementing and evaluating health care quality standards.
2. Identify key characteristics of health care leadership.
3. Understand the role of accountability in health care quality.

Lesson 5:IT AND DATA

1. Understand a Health Information Exchange.
2. Discuss the role information technology plays in gathering, storing, and analyzing health care data.
3. Identify the role and utility of electronic health records.
4. Understand how health data is gathered, stored, and shared across geographies.

Lesson 6:Management

1. Understand the role that managers can plan in implementing and improving quality and patient outcomes.
2. Identify the ways in which the quality of management itself can be measured.
3. Discuss the Virginia Mason Hospital system as an example of management and improving health care quality.
4. Discuss the example of the Jawaharlal Institute of Postgraduate Medical Education (JIPMER) and its role in improving quality.

Lesson 7:PATIENTS

1. Comprehend the importance of patient-focused consideration.
2. Distinguish manners by which the patient experience can be estimated and subsequently improve wellbeing results.

3. Examine process enhancements that can prompt better patient-focused consideration.
4. Get emergency clinic and specialist evaluations on the web.
5. Distinguish the effects that online networking can have in forming mentalities about a medicinal services supplier
6. Describe reasons for disparities in healthcare quality between low/middle-income countries and high-income countries.
7. Identify the features of a high-quality delivery facility and factors that matter most to women when choosing a delivery facility.
8. Explain primary causes for low quality of care in delivery facilities.
9. Discuss how information on women's delivery preferences and use-patterns can be used to understand facility quality.

Lesson 8:

1. Describe possible reasons that healthcare has been slow to embrace the science of quality improvement.
2. Discuss the three eras of the healthcare quality movement.
3. Identify four categories of improvement sciences that could be applied to the healthcare quality movement.
4. Explain the triple aim and the IOM six aims for healthcare improvement.
5. Discuss health care reform in Mexico as an example of government influencing health outcomes.
6. Understand the role the World Health Organization plays in measuring and contributing to health outcomes.

Course content

Lesson 1: Burden

Introduction - by David Bates a professor of medicine at Harvard medical school. This lesson going to outline how to think about patient safety but because of medical error in the hospital setting and in the outpatient setting

Cause, Burden and harm-

adverse effect has been discussed here at was just isn't hospital acquired infection and pressure surgical complications deep venous thrombosis 10 to 25 per cent of patient coming to the hospital result in happened something bad to them as a result of hospitalization.

Preventability

all the event discussed above can be prevented by different approaches

Infection can be prevented by handwashing adverse drug event it can also be preventable falls by taking precautions pressure ulcer bivariate of technology available and finding the risk patients surgical by identifying the correct side the DVT by giving anticoagulant.

High income and low income countries

Notably the risk of adverse drug event is lower because of the fewer medication in low and middle income countries. But additional is the birth related injuries.

Ambulatory care

In ambulatory care also patient safety is an issue the big issue is adverse drug reaction, diagnosis related error ,lab follow up ,surgical issue.

Medication error

Is an error in the process of giving medication

the most powerful intervention for reducing medication error frequency and reducing the number of preventable adverse drug event is a computer rising prescribing.

Tuberculosis background and burden

1.5 million people dying with TB today besides its a curable bacterial infection the drug resistance TB in India has been a major issue all over .The globe problem here is the execution of what to do and how comprehensively and effectively can be done.

Treatment of TB

The drug resistance TB is given for 6 month of antibiotics to start with isoniazid and rifampicin, ethambutol and pyrazinamide.

Public sector care for TB in India

The relative sensitive talking about India because of the highest burden 25 to 30% of TB of all countries National health policy in India promising to spend 2.5% of GDP on TB and national finance minister plays that India will eliminate TB by 2025

Private sector care for TB in India

Improvement in post diagnosis TB care

This is given by dots and small pill box came in a unique way to TB.

Lesson 2: Measurements

public-private variation

It was found that the public and the private sector has a variation.

In public sector the doctors are much more knowledgeable and ink rabbit it is found that most of the doctors are are contained or unqualified. The time given by the doctors pin private clinics is about 3 to 3.5 minut and in public health centre is about 1.5 minute and no physical examination

Geographic variation

It is found that in South health care facility is much good than in North

HR

Know do gap can be smaller if the doctor spend more time with patient

Resource allocation

Surveillance

In patient care

HCQ indicator of focus

Lesson 3: Standards

Introduction

will discuss about the market to assess the quality improvement at a government and public entity can do in financing and delivery healthcare the strength and the weakness of these appropriate and this issue are all around the world

1. Legal system and regulation
2. Accreditation
3. Staffing ratios
4. Defective medicine

Lesson 4: improvement

Introduction

Around measurement and around making improvement a part of job.

1. Leadership
2. System issue
3. Building will
4. Implementing data

Lesson 5: IT and data

Definitions: Health Information Exchange (HIE)

The Promise of Health IT

Health Information Exchange and Electronic Health Records

Evidence and Implementation

Global Perspective

1. Promise of health it
2. Health information exchange and electronic health record
3. Evidence and implementation of it
4. Global perspective towards it

Lesson 6: Management

1. Role of Management
2. Management in Healthcare
3. Measuring Quality of Management
4. Why Middle Managers?

Actionable Items

Other Industries

Example: Virginia Mason

Lesson 7: patients

importance of patient-centred care patient experience and patient centred care is important for improving patient outcome the main importance of patience interpret and question is closed because they are key component of quality of care.

1. Assess effort
2. Social media
3. Doctors rating
4. Rating hospital
5. The lancet commission on global health
6. Women's experience in delivery
7. Quality in maternal and newborn care
8. Importance of quality in

global health 9. Process improvement 10. Consequences 11. Key Determinants 12. Ambulatory care 13. Measuring patient experience

LEARNING METHODOLOGY USED-

Video lectures and reading material by Harvard University through online course on edX.

DURATION

The period of course is of 24 hours

PROGRAM SCHEDULE

The program is scheduled from 17th April 2020 to 28th June 2020.

KEY LEARNING OF THIS COURSE

1. Understanding the burden of diseases like tuberculosis and its impact on overall other countries.
2. Very important to help people that creating know how to communicate the message to explain that having a clinical degree makes them better at delivering the message and listening as well.
3. To improve the quality and the patient safety first making of commitment set a goal according to the priority and show it up every day and that too for all the department and not only for the academic but also include sanitation worker engineer each department.
4. For institution to create a blame free culture and organisation to start of sharing the information for that are taking the medical insurance in chemical try to take insurance so that the people who are ham can be compensated.
5. With different needs and expectations and identify and responding according to the next concert and expectation.
6. Patient experience and then measuring rights and understanding what people go out of healthcare that deliver is therefore really important.