The question “Is quality affordable?” is loaded with dynamite!

Can a person who lives on less than US $1 per day afford a high-quality cataract operation? If the answer is ‘No’, then do we offer that person poor or low-quality services? Do people living in poverty have a ‘right’ to high-quality eye or health care? If the answer is ‘Yes’, then at what price and who should pay? Should we ignore quality and focus on affordability? Or should we provide high-quality services in the hope that someone else will pay?

These are difficult questions, which policy makers, managers, and clinicians must face and try to answer.

What is quality?

How do we define and measure quality? A simple analogy will highlight the complexity of this issue: if we have a meal, how do we judge its quality? We can measure how many calories, vitamins, etc. the meal contains, or we can decide how satisfied we are with the food, and we may also take the service into account. Our degree of hunger and the price we pay for the meal may influence our level of satisfaction.

The American Medical Association defines the quality of care services as “the degree to which [these] services influence the probability of optimal patient outcomes.”

The World Health Organization offers a more comprehensive definition and divides quality in four sections:

1. **Professional performance** (technical quality), including:
   - evidence-based practice
   - clinical audit
   - development of guidelines
   - measures of outcome
2. **Use of resources** (efficiency)
3. **Risk management** (risk of injury or illness associated with the service provided)
4. **Patient satisfaction**

The different aspects of quality have been formulated into a set of six characteristics that any high-quality health programme should display. As shown in the Box overleaf, such a programme should be: safe, effective, patient-centred, timely, efficient, and equitable.

Quality can vary markedly between organisations. An ophthalmic centre in a high-income country will achieve different outcomes for patients when compared to a low-resource organisation in a low-income country. However, each organisation has a duty to maximise quality within its own resources. Quality is a ‘whole system’ concept: this means that every individual in the organisation, regardless of function or position, should be encouraged to find ways to improve quality.

It is important that we define precisely what quality means to our team or organisation.

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**Is quality affordable?**

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Maintaining clean facilities and clear access for patients contributes to the quality of care. IVORY COAST

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IS QUALITY AFFORDABLE? Continued

What are the characteristics of a good-quality eye care programme?¹

1 Safe: avoiding injury to patients
2 Effective: based on evidence of effectiveness and avoiding services that have been shown to be ineffective
3 Patient-centred: offering care which is responsive and respectful to the patient
4 Timely: ensuring that waiting time is minimal, especially for potentially serious disorders
5 Efficient: using resources wisely
6 Equitable: providing care that does not vary due to personal circumstances or characteristics.

Affordability

Affordability depends both on the price of a health intervention and on the financial means of the person or organisation paying for it. The cost of the intervention or service, and therefore its price, should be kept as low as possible through efficient business practices, e.g., high productivity and no waste (only use what is essential for quality). Health care can be paid for in several ways: by the government, by the user or family, by another party such as a private company (e.g., health care insurance), or by a non-governmental development organisation (NGDO). The ability of these organisations to pay for health care will influence the level of service.

However, if the care needs to be free to some sectors of society, who will subsidise the cost? Sometimes, a family member will pay the fees or the government may provide free health care. The more affluent in society may pay more for services, thereby subsidising services for the poor through a multi-tier pricing structure (this is similar to first, business, and economy seats on aeroplanes). Local or international NGDOs may also subsidise costs, but this is less sustainable in the long term.

Is quality affordable?

There are degrees of quality. An individual organisation or hospital should be able to identify where quality needs to improve and to decide whether such an improvement is affordable.

Affordability of quality is not only or always a question of cost. Cost-effectiveness is important, but so is the best use of resources. Offering services of poor quality is a waste of resources and may prevent uptake of services. Many improvements do not require more money or resources, but may require the team to change the way it works. It is therefore important to consider the situation as a whole.

Improvements in quality that incur a minimal cost or save money

Some small changes in structure or process can lead to a large improvement in quality. Being aware of the organisation and the way it functions will allow us to identify and address these small changes. Here are two examples:

• A cleaner noticed that the waiting room became very dirty at lunch time and took responsibility for cleaning it before the afternoon clinic. This improved patient satisfaction with the service.

• The nurse in charge of an eye unit conducted an audit into the use of theatre time. She found that if the patient was anaesthetised as the eye doctor was getting ready, then it became possible to carry out ten cataract operations in one session instead of eight. This generated more income for the hospital.

Improvements in quality that incur a higher cost

We need to decide whether these improvements will be resource-efficient in the long run, as shown by the examples below. If a costly change significantly improves quality, it may be seen as affordable in view of the long-term benefits. Conversely, a procedure may be cost-effective in itself, but it can still represent a misuse of scarce resources.

• An ophthalmologist was keen to move from extracapsular cataract extraction (ECCE) to small incision cataract surgery (SICS). Investigation of the evidence showed a marked difference in surgical outcomes between ECCE and SICS. The cost of moving from ECCE to SICS, whilst large, was felt by the hospital administration to be affordable, because it had the potential to significantly improve clinical outcomes.
Improving the patient’s experience

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When arriving at the eye care unit, patients often feel unsure of what is going to happen, anxious, and vulnerable. Many have never found themselves in a hospital setting before or have never travelled or slept away from home.

An integral part of eye care to make sure a patient’s experience is a positive one. This article offers suggestions for good, evidence-based, practice to improve this experience.

Our suggestions should necessarily be adapted to local context: resource-poor settings are particularly challenging work environments and staff may need to display more ingenuity in working towards good practice, when striving to achieve the goals of VISION 2020.

Communication
Good communication is of greatest importance in all the caring professions. It is crucial at every level – between disciplines, and between staff and patients and their families.

If the eye care team is able to inform patients, instil confidence in them, and convince them of the need for treatment or follow-up, this can actually make the difference between successful and unsuccessful outcomes. It is always important to consider the patient’s point of view.

Patient information
Accessible and correct information is the key to good communication with the patient and his/her family.

Verbal information:
- Speak in a clear and friendly manner, and avoid using medical jargon.
- The patient should not feel rushed; adapt your pace, particularly if he/she has another sensory deficit (e.g. deafness).
- You will communicate more effectively if you are friendly and approachable, rather than ‘business-like’.
- At appropriate moments in the conversation, you can check if the patient has understood the information, by asking questions such as: “Can you tell me the date and time of your next clinic appointment?” You should also ask if the patient has any unanswered questions.
- Consider potential language barriers. Interpreters can facilitate a stress-free interaction. If language has been a problem, you should make a note of it in the patient’s records. This helps to plan ahead and to make sure you include the appropriate interpreter for future appointments.

Written information:
Effective written information should help patients and their families to understand and remember a discussion, and it should contain all the important points.

A permanent written record of the information also offers another advantage; it gives all members of staff a standard set of information points that they should remember.