



## LEARNING FROM LESS SUCCESSFUL QUALITY CIRCLES IN INDIAN HEALTHCARE

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### ABSTRACT

**Purpose** – The purpose of this paper is to highlight the challenges that Quality Circles in Indian Healthcare are facing and identify the gaps in their functioning. These could help in flagging the probable pitfalls for currently active Hospital QCs and those which are being newly instituted.

**Design/methodology/approach** – Data for this study was collected through interviews and questionnaires administered in 16 hospitals across India which are registered members of Quality Circle Forum of India (QCFI).

**Findings** – The results reflect that to enhance the sustenance and growth of QCs, factors related to Top management support, trainings and cultural compatibility are most critical.

**Originality/Value** – This study provides insights into what could be the factors which could lead to ineffectiveness in the functioning of Hospital QCs and render them inactive. Published results on QCs in Indian healthcare have been rather scarce and this study could trigger more research in this area.

**KEYWORDS** : Quality Circles, Healthcare, India

### INTRODUCTION

Quality Circles emerged as a miracle drug for growth of organizations in Japan during the 1960s and slowly spread to the world in over more than 70 countries (*Fundamentals of Quality Circles*, 2008) Eventually over the next three decades they were tried and tested by organizations across the US, UK and many other parts of the world with mixed results. Quality Circles came to India only in 1982 and were first popularized in the manufacturing industry. The service sector was a late adopter of QCs and so were healthcare institutions. Though, healthcare QCs are yet in a nascent stage, the chapters under Quality Circle Forum of India (QCFI) have grown to 33 which are actively propagating QCs in the country across different industries including hospitals. QCFI represents India in the 13 member International Committee that has been set up for organizing International conventions on Quality Concept Circle, annually (<https://qcfi.in/qcfi-chapters-2/>)

The basic philosophy of QC circles is timeless and has universal application. QC circle activities have been introduced and promoted in both manufacturing and service sectors. According to Kaoru Ishikawa, "Quality does not mean the quality of product but also of after sale service, quality of management, the company itself and the human life." (*Fundamentals of Quality Circles*, 2008, 3) JUSE (Japanese Union of Scientific Engineers) defines "QC circle activities as those which are carried out by a small group of first-line employees who operate autonomously in solving problems found with their work, products and services. These activities aim to promote:

- self and mutual development of their members,
- contribute to building a pleasant and vital workplace,
- improve customer satisfaction and
- contribute to the society." (*Fundamentals of Quality Circles*, 2008, 9)

This study was carried out as an All-India Observational study of Quality Circles functioning in Hospitals. Universal Sampling was used to identify hospitals with Quality Circles registered with the Quality Circle Forum of India (QCFI). A total of 16 hospitals out of a total 26 consented to participate in this study. 41% of QC members working in the identified Hospitals were included in this study based on random sampling. The Hospital heads and QC members were interviewed and were administered a questionnaire with the objective of collecting data specific to functioning of their Quality Circles. Both active and inactive quality circles were included in the study to identify, describe and analyze the

factors which are imminent to ensuring the success of Quality Circles.

In a database of 64 respondents, 52% were Male and 48% Female. A total of 48% of the respondents had been members of QCs for 5 years or more. About 27% were members for a duration of 1-2 years and about 17% had been QC members in the bracket of 2-5 years. Work profile of respondents were in Administration (31%), Doctors (22%), Nursing (16%), Quality Department (11%), Pathology Lab (9%), Engineering, Maintenance & Stores (8%), and Pharmacy (3%).

### Review of relevant literature

Researchers have pointed out that many organizations tried Quality Circles in the 1980s and botched them. In these organizations, upper-level managers acted as though they believed the source of poor quality was the worker. In fact evidence shows that 95 percent of all defects are caused by dysfunctional work systems, processes and policies (Walker, Terry, 1992) In earlier studies, some of the reasons identified for weak execution of Quality Circles have been:

- "Circles not meeting regularly, rather met on ad hoc basis when they had something to discuss.
- Staff shortages
- No changes from the previous changes suggested
- Perceived bias from Senior Management towards certain circles in providing resources and support
- The perception that it is not voluntary and imposed by Senior Management led to resistance.
- Transfer of Staff
- Demands of patients making it difficult to find time for meetings." (Lees, Dale, 1989)

In certain studies it has been noticed that Quality circles may bring about a change in the balance of power. In most organizations, managers at all levels exert more expert power than non-managers because they control the flow of information which is needed for decision making. The introduction of Quality Circles may require that managers release information which is needed for decision making which before was confidential. Similarly, QCs represent an alternate channel of information which may result in the manager being by-passed." (Brennan, 1992)

### Factors which led to ineffectiveness of Quality Circles

The findings of this research highlighted that the probable reasons for Hospital QCs becoming inactive included:

- **Lack of guidance from facilitator in the initial years**  
Some QCs couldn't show satisfactory progress especially in the initial years due to not enough guidance and mentoring by the facilitators.

**Trainings were superficial**

Responses from respondents reflected that though 86% of QCs underwent trainings, they were not effective and 61% found the trainings to be either average or fair.

- **Long work days for attending meetings and executing projects**

When QC meetings were held after work hours with no clarity of agenda, QC members often found it inconvenient to attend them. Similarly, when project implementation required more stay backs they lost motivation to continue with their membership of Qcs.

- **Focus on only project implementation and cost saving**

QCs which focussed only on project implementation and cost saving without also prioritizing the well-being and growth of the QC members were seen to be fizzle out in the long term.

- **Shift of focus to other quality systems such as NABH, ISO, JCI etc**

In hospitals where there was a shift towards quality systems such as NABH, ISO, JCI etc. it was found that QCs often faced reduced focus as senior management invested more time in streamlining processes as per the chosen quality system guidelines.

- **Judgemental attitude of Non-QC Members**

Respondents who were QC members pointed out that on many occasions they felt discouraged due to judgemental attitude of Non QC members who were critical of the projects being done by them.

**Study of key factors related to functioning of currently active Hospital Qcs**

**Table 5.23 - Calculation of the percentage of opinions chosen by respondents on the likert scale for the factors related to functioning of their QCs**

	0 - Poor	Average - 1	Fair - 2	Good – 3	Excellent – 4
Identification of problems	00	(5.6%)	(11.15)	(66.7%)	(16.7%)
Punctuality of meetings	(1.9%)	(9.3%)	(25.9%)	(44.4%)	(18.5%)
Attendance	00	(9.3%)	(22.2%)	(61.1%)	(7.4%)
Motivation	(1.9%)	(7.4%)	(18.5%)	(57.4%)	(14.8%)
Trainings	00	(33.3%)	(27.8%)	(31.5%)	(7.4%)
Effectiveness of QC co-ordinator	00	(7.4%)	(25.9%)	(57.4%)	(9.3%)
Senior Management Support	00	(11.1%)	(24.1%)	(46.3%)	(18.5%)
Quality of solutions	00	(3.7%)	(16.7%)	(61.1%)	(18.5%)
Recognition by Senior Management	(3.7%)	(9.3%)	(22.2%)	(51.9%)	(13.0%)
Recognition by colleagues	(1.9%)	(7.4%)	(27.8%)	(51.9%)	(11.1%)
Achievements of your QC	(1.9%)	(7.4%)	(18.5%)	(55.6%)	(16.7%)

Taking the benchmark as a cumulative of the options Good and Excellent (likert scale values 4 and 5) it was found that the factors for functioning of currently active Hospital QCs can be ranked in the following sequence (Highest (most effective) to Lowest (least effective):

1. Identification of problems (83.4%)
2. Quality of solutions (79.6%)
3. Achievements of QC & Motivation (72.2%)
4. Effectiveness of QC coordinator (66.7%)
5. Attendance & Senior Management Support (64.8%)
6. Punctuality and Recognition by Colleagues (62.9%)
7. Recognition by Senior Management (59.2%)
8. Trainings (38.9%).

**CONCLUSION**

Reasons for Hospital QCs becoming inactive included many facets which need to be watched out for such as need for more involvement of higher management, support from Non-QC members, focus on other Quality Systems, Shortage of

- **Pressure from Management when QC deadlines are missed due to everyday routine work**

When QC projects were in implementation phase, at times the QC members found it difficult to balance the execution of QC projects and also meet the deadlines of their everyday routine work. This created a tension and pressure which led to dissatisfaction amongst the members.

- **Lack of enthusiasm due to non-recognition of projects and biases by senior management**

Over a period of time QCs which were not evaluated by senior management and did not receive feedback were seen to lose memberships. Also, if QC members sensed biases from senior management in providing resources or selection for competitions and conferences, they began to lose enthusiasm for participation in QC activities.

- **Shortage of Manpower**

In hospital set-ups where there was a shortage of manpower, frequency of QC meetings and attendance in them dropped. This led to eventual inactivity and ineffectiveness of Qcs.

- **Cultural incompatibility**

Certain QCs were started in a hurried manner without the proper orientation of employees and establishment of QC steering committee, Facilitator and Deputy Facilitator. Over a period of time such QCs tended to lose direction.

- **Deficiency of funds and resources**

In hospitals where QCs did not receive project approvals and there was a deficiency of funds and resources, QC members lost their interest and belief in the purpose of the QC activities.

- **Data fudging**

Some QCs cited that they have noticed data fudging by presenters during presentations and this was discouraging for them.

Manpower funds and resources, training needs not met and unplanned / infrequent meetings.

In the effectiveness of functioning of Hospital QCs it was found that Identification of problems (83.4%) and Quality of solutions (79.6%) was ranked highest while lowest ratings were for Recognition by Senior Management (59.2%) and Trainings (38.9%).

Though Senior Management was found to be supportive of QC projects in giving approvals and providing resources, it was seen that they were not prompt in recognizing the efforts of QC members (59%). Similarly, non QC members and other colleagues also did not recognize the efforts of QC teams (62.9%). This result is also similar to the findings in the Indian Context from a study by (Singh A, 1989) which considered the key factors for success of QCs and found that "Senior Management support and acceptance by middle and junior

management were the most important factors contributing to the success of QCs in Indian Organizations. Lack of cooperation from the middle and first line managers was identified as the primary reason for failures of QCs in this study.

Limitation of this study is the sample size of hospitals studied. Also, except one with some similarity, no other studies in specific to nature of Quality Circles in Hospitals of India was found in recent times and therefore this study has been more of an exploratory and observational nature. However, this study could be of value for existing and newly instituted hospital QCs and may also be useful as a beacon for further research.

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