Editorial

Community ophthalmology - Can excellence, efficiency, and equity co-exist?

An ideal healthcare system combines equity with quality (or excellence). Healthcare efficiency, in terms of optimal utilization of infrastructure and time, is a moral responsibility in a resource-starved country. The three E's Excellence, Efficiency and Equity, thus have high ethical relevance in the practice of community-based ophthalmology. Essentially, it translates to the delivery of the highest possible quality of eye care to the spectrum of the society with optimal distributive justice and efficiency.

Equity, however, as expressed elegantly by Rick Riodian in his book *The Red Pyramid*, does not mean that everyone gets the same, it means everyone gets what they need. In a community ophthalmology situation, using expensive multifocal intraocular lens even in patients who may not have any visual need for it at all, or performing a high-risk penetrating keratoplasty in a patient who has 6/6 vision in the other eye and can function normally, or performing a complex vitreoretinal procedure in a similar situation, do not exemplify equity. Several interventions that are considered "effective" may not be exactly "cost-effective". Cost per disability-adjusted life year may be more valid criteria to decide on effective intervention for a community.

Performing hundreds of cataract surgeries in a camp in a very short period with minimal utilization of resources, but with a high rate of complications or poor visual outcome does not meet the norm of excellence. Quality standards for cataract surgery seem lax – the World Health Organization (WHO) recommends that 80% of operated patients should have uncorrected visual acuity of 6/18 or better in the operated eye.[1] Would any of us settle for such an outcome for ourselves? Then why do we accept this quality norm for our communities? Thus, a perspectival understanding of and a balance between excellence, efficiency and equity are very critical in the planning and delivery of community-based eye care services.

The Committee on Quality of Health Care in America in its report "Crossing the Quality Chasm" recommends 6 attributes for an ideal healthcare system in the 21st century: "1. **Safe**: avoiding injuries to patients from the care that is intended to help them; 2. **Effective**: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively); 3. **Patient-centered**: providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions; 4. **Timely**: reducing waits and sometimes harmful delays for both those who receive and those who give care; 5. **Efficient** avoiding waste, including waste of equipment, supplies, ideas, and energy; and 6. **Equitable**: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status."[2] These attributes should form the backbone of all community-based eye care interventions.

There are several models of community eye care delivery in India today – general eye screening camps, fixed primary eye care facilities (vision centers), mobile primary eye care, risk-stratified screening (school eye examination, diabetic retinopathy screening), teleophthalmology-based screening and diagnosis, cataract surgical camps in make-shift operating facilities, base-hospital approach, hub-and-spoke model, etc. Each of these come with their own advantages and shortcomings. There are several excellent and time-tested models in India which embody the essence of the vital three 'E's'. Invited editorials in this Community Ophthalmology Special Issue of the *Indian Journal of Ophthalmology* describe some of these successful models.[3-12]

I believe that our wise opinion leaders and health care policymakers will distill in the concepts of excellence, efficiency and equity while formulating community eye care delivery norms beyond 2020, and help us cross the quality chasm.

Santosh G Honavar

Editor, Indian Journal of Ophthalmology, Centre for Sight, Road No 2, Banjara Hills, Hyderabad - 500 034, Telangana, India.
E-mail: editorjournal@aios.org

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