Curing our hospitals

To keep patients safe, we must transform the quality of our healthcare system

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India's healthcare system faces the important and often competing challenges of expanding access, ensuring affordability and guaranteeing quality. As matters stand, small private hospitals, clinics, pharmacists and quacks are the mainstays of healthcare provision in both urban and rural centres. The renewed focus and increased spending by the government to revamp the public sector health delivery system may tilt the balance back towards public sector healthcare, but a large structural shift in healthcare-seeking behaviour is usually very slow and cumbersome.

In theory, the private sector responds more fully to patients' needs because it provides greater autonomy and flexibility to the healthcare provider. Multiple healthcare providers competing on quality and price allow the patient to choose the best quality of healthcare they can afford and the invisible hand of the market achieves system-wide efficiency.

In practice, however, greater flexibility without any regulatory oversight results in the quality of care provided falling short of even a basic minimum standard of quality. The scale of this quality problem is enormous even in high-end urban medical centres, leave alone rural health clinics. Inappropriate treatment, malpractice, excessive use of certain procedures and negligence are rampant.

The root cause of the problem is that the quality of healthcare (also price) is extremely difficult to measure and the consumer is unable to verify the quality. Attempts to objectively measure it always result in esoteric, multi-attribute healthcare quality metrics which are difficult to create and even more difficult for the patient or the caregiver to understand.

In choosing their hospital, clinic or quack, patients and their caregivers typically rely on 'perceived' quality which is often far removed from actual quality. In a market where unscrupulous low quality providers have a competitive advantage in both price and perceived quality, high quality providers find it extremely hard to recover the costs required to provide high quality healthcare.

Most developed countries, therefore, regulate the provision of healthcare and pharmaceutical products through central government-run agencies. In some ways, the clinical establishments registration and regulation Bill is attempting such a regulatory structure. However, the risks of well-designed but poorly executed healthcare regulation are extremely high in India. The national and state regulatory councils would lack trained and motivated personnel to enforce the regulations, especially in remote areas. And a slow and needlessly complex regulatory agency

can choke the private sector and deny any kind of healthcare to some segments of the population. The risks of decentralised corruption within the regulatory agencies are even higher.

A voluntary accreditation programme for health providers is another way to improve quality. The National Accreditation Board for Hospitals & Healthcare Providers (NABH) is a powerful attempt at this. But while NABH's accreditation efforts can help improve quality in larger private hospitals and clinics, they are unlikely to have a significant impact on the quality of care in small private clinics or rural healthcare establishments.

Accreditation results in high quality of care only if the patient cares about the accreditation, or accreditation becomes a precondition for healthcare providers to receive payments from insurance or third party payers. NABH has attempted this through preconditions for empanelment by the Central Government Health Scheme and other insurance companies, but with limited success. Healthcare in India is still largely paid out-of-pocket and the leverage of the insurance companies or payers is still relatively small.

A prime cause of our inability to ensure higher quality in healthcare provision is the excessive fragmentation of our healthcare provisioning system. This makes monitoring, regulating, or improving quality very costly. The infrastructure investment required for collecting quality performance data from small owner operated clinics is extremely high at present.

This does not, however, mean that quality can be achieved only when a few large hospital chains own all the clinics, or when there is a plethora of franchise clinics. It requires a few coordinating agencies, or orchestrators, who can guarantee higher compliance to quality standards and better reporting of clinical performance metrics.

One way to achieve this would be to couple the desired quality improvements with access to critical inputs - which the coordinating body can provide to hospitals, clinics and rural health establishments at a much cheaper cost than what they can otherwise obtain. Examples of such inputs would be very cheap sources of capital; heavily discounted medicines or hospital equipment; well-trained paramedical staff at subsidised rates.

The poor quality providers will not have access to these inputs at the same prices as their high quality counterparts and will not be able to compete unless they improve quality and can get access to these subsidised inputs. The coordinating agency needs to be organised as a public-private partnership; a for-profit or a government-run model will not be effective and sustainable for this role.

One can never predict how complex systems such as healthcare will react to a new regulation, new information flows, or new incentive structures. Perhaps the regulatory Bill will work, or NABH programmes will achieve national scale, or doctors and the Medical Council of

India will ensure better peer-review and thus self-regulation will emerge. What is critical, though, is that we end the gridlock on healthcare quality regulation and make some difficult choices - else we face an inevitable decline in our nation's health.

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