Health Care Quality in India: Challenges, Priorities, and Future

Dr. Vinod C Sugathan

Assistant Professor & HoD

PG & Research Department of Economics

Sree Narayana College, Sivagiri, Varkala.

ABSTRACT

India's health care industry offers a wide spectrum of care quality, from internationally renowned hospitals to establishments that give care of intolerably low quality. The lack of valid data on quality and the technical challenges of assessing quality provide specific challenges to efforts to improve the quality of care. Ongoing initiatives in the public and private sectors seek to enhance data quality, create better metrics and a knowledge of care quality, and create creative answers to vexing problems. We list the top priorities and difficulties facing attempts to raise the standard of care. The rapidly changing profile of diseases in India and rising chronic disease burden make it urgent for state and central governments to collaborate with researchers and agencies that implement programs to improve health care to further the quality agenda.

Keywords: care, chronic disease.

Introduction

One of the striking features of India's health care sector is the range of quality in available services. India is home to global leaders in innovation in and quality of health care such as the Narayana Hospitals, known for providing high-quality cardiovascular surgery at low cost, and the Aravind Eye Care System, whose hospitals provide a high volume of cataract surgery, as well as globally renowned medical teaching institutions such as the All India Institute of Medical Sciences, in New Delhi.1,2 Simultaneously, many Indians—especially the poor—receive unacceptably low-quality primary and hospital care.3,4 The rapidly growing burden of chronic diseases in India makes the low quality of care highly salient for health policy. The challenge of low quality in health care is not unique to India. Studies from a range of developed and developing countries have demonstrated widespread problems with providers. who make little effort to ensure that patients receive high-quality care, geographic variations in the quality of health care services, and high levels of medical errors.5–9 Efforts to improve the quality of health care services in low-resource settings, including India, have typically focused on structural constraints.10 Recent studies in low-income countries have documented low levels of provider knowledge, in both the public and the private sectors, and have found evidence of large gaps between providers' knowledge and the care provided, sometimes called "know-do gaps."11,12 In addition to providers' lack of capacity or knowledge in such settings, low quality of care could also be due to the lack of incentives in the health system or information problems in the health care market, combined with a lack of accountability among

providers and poorly functioning governance systems in the health system. It is important to understand the process of delivering health care services and the factors that can limit providers' effectiveness. A cluster of articles in this issue of Health Affairs focuses on challenges related to the quality of health care in India. The cluster includes articles that describe challenges in using data from household surveys and hospital administrative records to measure the quality of care, examine a delivery model for high-quality surgical care, and evaluate a state-run ambulance service program designed to improve access to and use of care, as well as a Data Watch article on trends in statelevel maternal and child health indicators. In addition to reviewing the state of research and evidence on the quality of health care in India, this article discusses critical challenges related to scaling up promising innovations and governance issues related to the quality of care.

Measurement Of Quality

Efforts to improve the quality of health care in India and attempts to evaluate the impact of these efforts invariably face challenges because of the lack of reliable administrative data. Of the three categories of Avedis Donabedian's measures of the quality of health care (structure, process, and outcomes),13,14 structural measures have traditionally received the most attention in the form of government surveys of health facilities and record keeping to track the availability of resources such as numbers of hospital beds and personnel and quantities of supplies. Whether these resources can be used productively in delivering high-quality care to patients depends on the process aspects of care, including the capacity of health-sector workers. Measuring the quality of the process of delivering health care and the resulting health outcomes is especially challenging, requiring methods and approaches that go beyond standard service statistics and facility surveys.

Research Methods

Recent studies in India and elsewhere that employed research methods such as observations of health care providers' performance, exit interviews of patients, vignette-based interviews of providers, and standardized patients who present unannounced to assess the experience of real patients demonstrate the potential of research methods to measure quality for a range of illnesses in primary care settings.11,12,15–20 However, these research methods of quality assessment have limitations. For example, measuring the quality of care in settings where providers are aware that they are being assessed (such as through methods of direct observation or patient exit interviews) could bias results because of the so-called Hawthorne effect, with providers changing their behvavior because they know that they are being observed or evaluated.

Using standardized patients who are incognito can help circumvent concerns about differences in the composition of the patient populations of various providers, Hawthorne effects, and know-do gaps that would be limitations with other methods.11,12,16,19 The standardized patient method is considered a gold standard for the measurement of quality. However, it is limited in the types of cases that can be presented to providers and the settings

in which the method can be used without potentially harming the standardized patient or revealing that he or she is not a real patient.

Furthermore, the research methods described above are often inadequate for quality measurement in hospitals, where the process of health care delivery is even more difficult to observe than it is in primary care settings. The limitations of the methods underscore the importance of high-quality administrative data for both policy makers and researchers trying to identify quality gaps or to evaluate the impact of efforts to improve quality. For example, the article by Kimberly Babiarz and coauthors in this issue of Health Affairs describes one of the first evaluations of the Emergency Management and Research Institute's 108-ambulance system in India; the authors report challenges in directly measuring the quality of care because of data limitations.

Promising Efforts

There are several promising efforts to create new data sources to address this specific data gap in the direct measurement of the quality of care. For example, the Indian government's proposal to increase the frequency of the National Family Health Survey—moving from a ten-year cycle to a three-year one—holds the promise of generating more timely district level data on the quality of health care and on health outcomes.

While the availability of new administrative data from hospital records and new household surveys presents unique opportunities to understand issues related to the quality of care in India, the use of new data to measure that quality is also a challenge. Two articles in this issue use data from household surveys and hospital administrative records to present findings from new data sets. Jishnu Das and Aakash Mohpal analyze a unique data set that matched 23,275 households across 100 villages to health care providers in each of the villages, to document the quality of rural health care in the state of Madhya Pradesh.4 The authors find no within-village association between residents' socioeconomic characteristics and the quality of health care providers. Importantly, the article also highlights how using quality measures based on random samples of providers will not reflect the quality of providers used by households, especially in settings with large variations in patient loads or with households whose members seek care outside of sampling areas. Another article in this issue, by Matthew Morton and coauthors, analyzes claims data in the context of hospitals' quality of care in a district in the state of Orissa.25 Although India's National Accreditation Board of Hospitals and Healthcare Providers has developed recommendations for administrative data requirements, it has not been possible to analyze the quality of care nationally using hospital data, because of a lack of availability of data from many hospitals. To address this major gap, the Government of India is considering a national-level initiative to measure hospital quality in a standardized manner. Similarly, the advent in 2008 of the Rashtriya Swasthya Bima Yojna (RSBY; the National Health Insurance Plan) in India, with its standardized reporting requirement, has the potential to significantly change this limitation. The article by Morton and coauthors reports findings from an attempt to develop quality metrics using RSBYclaims data.25 The authors find several limitations in currently available data, such as lack of completeness and mismatches, and problems with different systems of patient identification that prevent records' being linked across government programs, and they provide recommendations that could significantly improve data quality and completeness in future.

Moving Forward On

Improving Health Care Quality This cluster of Health Affairs articles examines issues central to the quality of health care in India against a background of significant ongoing reforms that create new opportunities for states to change their allocations of resources to the health sector. Given the measurement and data challenges that these articles address, it is important to note that even with improved data to clarify the problems and challenges in providing high-quality health care, the ability of national and state governments to take appropriate action to improve the quality of care is related to overall governance and accountability. In India's federalist structure, health is a matter of state jurisdiction. Although the central government has traditionally tried to influence health-sector priorities through policies and vertical programs, states are ultimately responsible for how their respective health systems function. A significant recent financial development in India was the fiscal federalism reform in 2015 that was part of the Fourteenth Finance Commission's effort to give states more control of spending. India's central government decided to increase the share of total tax revenue to be returned to individual states from 32 percent to 42 percent—an annual increase of approximately $16 billion that states will have full autonomy in deciding how to allocate.

Nonetheless, with increased autonomy as a result of the fiscal decentralization, state governments have the opportunity to respond to the needs of their respective populations and allocate resources as needed. Depending on states' ability and capacity to identify such needs and adequately address them with policy reforms, topics such as the quality of health care could receive timely attention. While multiple models of resource allocation and heterogeneity in state priorities are bound to emerge,42 we hope that policy makers and researchers in India will direct more attention to issues related to the quality of care in the health system.

Conclusion

Improving the quality of health care at the system level requires a focus on governance issues, including improving public-sector management, building institutional capacity, and promoting a culture of data-driven policies. Ideally, state and local governments and local health facilities would use data from administrative sources and household surveys for quality improvement efforts and for accountability in health care delivery. This use of evidence in making policy decisions would require institutional incentives and targeted capacity building in addition to investments in creating standardized and more reliable data sets. It is critical for governments, implementing agencies, and researchers working in India to collaborate on evidence-based approaches to improve the quality of health care and health outcomes.

Reference

1. Ahmad, I., Lakhani, M.S., Gillet, M., John, A. and Raza, H. (2001). Hypotriglycerdemic and hypochlesterolemic effects of anti-diabetic Momordica charantia (Karela) fruit extract in streptozotocin diabetic rats. Diabetes Res Clin Pract. 51: 155-161.

2. Ambike, S.H. and Rao, M.R.R. (1967). Studies on a phytosterolin from the bark of Ficus religiosa Part-I. Indian J Pharm. 29: 91.

3. Anand, R., Patnaik, G.K., Roy, K. and Bhaduri, A.P. (1995). Anti-oxaluric and anticalciuric activity of lupeol derivatives. Indian J Pharmacol. 27: 265-268

4. Anjaria, J.V., Varia, M.R., Janakiraman, K. and Gulati, O.D. (1975). Studies on Leptadenia reticulata: Lactogenic effect on rats. Indian J Exp Biol. 13: 448.

5. Anonymous (1989). The Ayurvedic Pharmacopoeia of India. Part-I and Volume-I. Ministry of Health and Family Welfare, Govt. of India, New Delhi.

6. Anonymous (1991). Bibliography of CDRI Research contributions 1951-1990. Contains information on fourteen screening studies undertaken on medicinal plants. Central Drug Research Institute. Lucknow. India. pp 56, 61, 72, 83, 89, 104, 112, 127, 169, 187, 203, 224. (Publication no- 1236, 1358, 1599, 1844, 1965, 2306, 2307, 2478, 2817, 3712, 3713, 4080, 4431, 4867).

7. Anonymous (1999). The Ayurvedic Pharmacopoeia of India Part-I and Volume-II Ist edition. Ministry of Health and Family Welfare, Govt. of India, New Delhi.

8. Anonymous (2001). The Ayurvedic Pharmacopoeia of India. Part-I, Volume-III, Ministry of Health and Family Welfare, Govt. of India, New Delhi.

9. Arora, R.K., Chawla, R., Shikha, R., Kumar, R., Sharma, A., Puri, S.C., Sinha, A.K., Tripathi, R.M. and Sharma, R.K. (2006). Radioprotection by Himalayan high-altitude region plants. In Herbal Drugs : A twenty First century Perspective. (Sharma, R.K. and Arora, R. Eds). JAYPEE Brothers, New Delhi. pp-301-325.