



“Quality Of Health Care In India: Challenges, Priorities, And The Road Ahead”

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Abstract

India's healthcare system varies from excellent to terrible. The absence of trustworthy quality data and the technical challenges of gauging quality are stumbling blocks to efforts to enhance care. Accessibility enhancements, new ways of measuring a treatment's effectiveness, and novel takes on old problems are all in the works. In this article, we provide a high-level overview of the primary obstacles to enhancing healthcare quality this issue of Health Affairs focuses on the results of prior initiatives to evaluate and improve healthcare quality in India, and in light of the current situation, we think it's necessary to emphasize those results. To combat the growing prevalence of chronic diseases, healthcare reform efforts in India require coordination between the federal and state levels of government, as well as universities and non-profits.

Introduction

One of the best things about India's healthcare system is the wide variety of high-quality services it provides. The All India Institute of Medical Sciences in New Delhi, the Narayan Facilities (known for its affordable and high-quality cardiovascular surgery), and the Aravind Eye Care System facilities are just a few instances of India's great healthcare infrastructure (known for their many cataract procedures) (Le et al., 2016) (Khanna T , Rangan VK, 2011). Access to quality secondary and higher education is shrinking in India, especially for the poor. (Scott & Jha, 2014) (Das & Mohpal, 2016)^{3, 4} India has a rapidly increasing chronic illness burden, making the poor quality of care a major problem for health policy.

The problem of subpar medical care is by no means unique to India. (Berendes et al., 2011) Medical mistakes, geographical differences in the quality of health care, and the problem of physicians not taking necessary precautions to prevent injury to patients have

been the subject of much study in both developed and developing nations(Newhouse & Garber, 2013).

In low-resource settings like India's, efforts to enhance healthcare quality have generally focused on reducing institutional impediments(Das & Hammer, 2014). Evidence of large "know-do gaps," or disconnects between provider knowledge and the care offered, has been uncovered in recent studies of low-income countries(Das et al., 2015)(Mohanalan et al., 2015).Poor care might originate from a number of causes, such as clinicians' reluctance to accept blame, inefficient health system governance frameworks, inadequate financial incentives, and market informational barriers. This is on top of the fact that providers typically lack the skills and expertise necessary to effectively serve in these kinds of environments. It is critical for clinicians to be aware of the procedures involved in providing healthcare and the issues that may restrict its effectiveness.

Health Affairs has published a number of pieces in this issue that focus on the issues plaguing India's healthcare system. Statistics on Maternal and Infant Mortality in the U.S. Perhaps it's something you'd consider a subset of Data Watch. What characteristics of a surgical treatment are considered to be successful? Criteria for evaluating the success of a publicly financed ambulance service in its mission to expand health care access for its community members. The article summarises the existing state of knowledge on the quality of healthcare in India and looks at the challenges associated with expanding the use of innovative technologies and addressing governance concerns in this area.

Measurement of Quality

In India, improving healthcare quality and gauging the success of current measures are impeded by a lack of reliable administrative data. Structure, method, and outcomes are the three dimensions upon which Avedis Donabedian bases his assessment of healthcare quality(Goi, 2016)

(Dandona et al., 2016). The government has traditionally placed a premium on structural metrics, such as the number of hospital beds, staff members, and supplies, while conducting surveys and maintaining records of healthcare institutions. There are several factors that affect the efficiency with which these resources are employed to give high-quality treatment to patients, but probably the most crucial is the knowledge and experience of medical professionals. It is difficult to evaluate the efficacy and influence of healthcare services on patients' health since data and surveys are rarely acquired during service delivery.

Research Methods

In a number of recent studies conducted in India and elsewhere in the world, research methods used to establish whether or not primary care is useful in treating various diseases have been shown to be trustworthy. Clinical observations, patient exit interviews, vignette-based provider interviews, and standardised patients who randomly showed up were some

of the study methodologies utilised to evaluate actual patients' experiences. However, these quality rating studies do have certain caveats. Patients' responses may be distorted if they are aware they are participating in a study (a phenomena known as the Hawthorne effect), in which people adjust their behavior because they are being observed or examined (via surveys of customers and close observation of ongoing events).

Employing dummy patients, or "standardised patients," can help alleviate issues associated with multiple-provider variation in patient populations, the Hawthorne effect, and knowledge gaps that would otherwise be present when using other methods. Quality evaluation is only as good as the standard patient evaluation method used. However, there are limitations on when this process can be used without putting the standardised patient in danger or making it evident that they are not a genuine person.

Furthermore, it is more challenging to witness the process of providing healthcare in hospitals than in primary care settings, hence the aforementioned research methods are sometimes insufficient for assessing quality in hospitals. High-quality administrative data would be valuable for detecting quality gaps and gauging the efficacy of initiatives to raise the bar on quality, but this data is impossible to acquire using present methodologies and is consequently ignored. This issue of Health Affairs features an article written by Kimberly Babiarz and colleagues in which they discuss the results of an early assessment of India's 108-ambulance system by the Emergency Management and Research Institute. Despite this, the authors acknowledge that direct measurement of care quality is unfeasible owing to data restrictions.

“Promising Efforts”

In order to fill this specific informational vacuum in the direct assessment of care quality, there are a number of worthwhile initiatives under way to generate new data sources (Morton et al., 2016).¹⁵ For instance, the Indian government has proposed reducing “the frequency of the National Family Health Survey” from once every ten years to once every three years¹⁶ (Rao et al., 2011). This has the potential to drastically reduce the amount of time it takes for jurisdictions to amass information about healthcare quality and patient outcomes.

Hospital records and new household surveys that have been available recently have shed light on care quality issues in India, but this data is not easily used to assess care quality. New data sets based on hospital administrative records and household surveys are presented in two papers in this issue. Jishnu Das and Aakash Mohpal utilized a recently created data set that connected 23,275 families in 100 villages with neighboring clinics to assess the quality of medical care in rural Madhya Pradesh, India. The authors conclude that there is no correlation between the median income and the quality of local physicians. This research demonstrates that quality ratings taken from random samples of providers may not

adequately represent the quality of providers engaged by households if patient loads abruptly shift or if members of the household seek treatment outside of sampling zones.

In similar work, Matthew Morton and colleagues evaluate the quality of hospitals serving a specific region in the Indian state of Orissa by analyzing patient claims data.²⁵ The National Accreditation Board of Hospitals and Healthcare Providers of India is not permitted to use hospital data in its evaluations of care quality in the country, despite the existence of standards for administrative data. The government of India plans to address this disparity by implementing a nationwide initiative to standardise hospital quality measurement.

The Rashtriya Swasthya Bima Yojana (RSBY) national health insurance system has been in place in India since 2008 and may alleviate the stringent reporting requirements in the country. The goal of Morton and his colleagues in utilizing RSBY claims data to set quality standards was discussed.²⁵ The authors note several problems with the current data, such as gaps, inconsistencies, and problems with different patient identification systems, which prohibit records from being linked across government programmes. Reviewing the data, they provide ideas that might greatly enhance its future quality and coverage.

Strategies to Improve Quality

India has a critical shortage of doctors with the British medical degree of MBBS or above. This is because it is more challenging to hire and retain talented public sector workers in these areas.

It appears that over 75% of patients in rural India are treated by someone without any medical training (Das & Mohpal, 2016). Since the quality of care provided by certified medical professionals is not notably higher than that supplied by informal providers, it is unclear whether just expanding the number of certified medical professionals would alleviate the problem in such rural parts of India (J, 2015).

If the existing supply of informal caregivers in rural regions is equipped with the means and incentives they need to deliver better care, there is the possibility for an instant increase in treatment quality. However, there is a lack of hard evidence showing how collaborating with providers in the unorganised sector could enhance the quality of care.

The Liver Foundation and local academics in West Bengal launched a pilot programme in 2013 to train providers in the informal sector on a wide range of medical and health topics over the course of nine months (Mohan et al., 2016). The intervention significantly improved case management, a measure of treatment quality, and also enhanced adherence to best-practice checklists, another measure of treatment quality.

Residents of the Indian state of Bihar are attempting to utilize telemedicine and social franchising to establish a vast network of medical clinics in the state's rural areas and facilitate communication with unofficial, private doctors. Tens of thousands of unpaid caregivers were trained and integrated into the system with relative ease, but the initiative

fell short of its intended aims of enhancing care quality and population health(Cousins, 2016).

Lessons Learned

The lessons we learn from each of these situations will be invaluable as we work to improve quality and make decisions based on the best available data. Given this, it's obvious that improving the standard of care given by the market's informal providers would be a lengthy and difficult endeavour. The second takeaway is the importance of conducting pilot studies to prove the efficacy of innovative approaches to improving healthcare quality before implementing them on a larger scale. After hearing about the initiative's success in West Bengal, the governor agreed to the Liver Foundation's suggestion to implement the program in other states. The government will train seven thousand clinicians once a week for six months as part of this project(Mohanan et al., 2014).

Efforts in the Formal Care Sector

The quality of care provided by informal caregivers in rural areas has been enhanced by a number of large-scale, consistently conducted actions by governmental and commercial entities.

Public Sector: Researchers in India are now evaluating the success of many state-level government programs designed to improve healthcare quality (especially for pregnant women and small children). With the help of experts and foreign funding, two of India's largest and healthiest states have begun implementing strategies like nurse mentorship and direct monitoring of infants. Bihar and Uttar Pradesh are the two states at discussion here. Since 2012, more than 8,000 documented deliveries have been logged, and an assessment of these efforts is currently underway. Large-scale social accountability mechanisms to monitor and improve rural healthcare service performance are also being implemented and evaluated by the government of Uttar Pradesh. These types of programmes demonstrate a growing willingness on the part of state governments to adopt innovative methods for improving healthcare and, more importantly, to evaluate these methods thoroughly. Progress in health industry governance is also demonstrated by measures to improve assessment support, increase accountability, and finance better data.

Private Sector: It's not unlike how unstructured ideas from the private sector can greatly improve healthcare delivery. There is much that health care administrators in the private and public sectors may take away from the work of pioneers like India's Aravind Eye Care System. According to the article published in this issue of Health Affairs¹ by Hong-Gam Le and colleagues, the system extensively utilised task shifting to execute high-quality cataract surgery at a low cost. To a large extent, non-medical personnel were responsible for pre- and post-operative care. There is a price to pay for efficiency improvements like having non-

medical staff talk to patients about their surgery options and not making doctors change gloves and gowns between patients. While these procedures may have been effective within the highly regulated Aravind Eye Care System, expanding their use beyond this setting could put patients and their satisfaction at risk. Before opting to export their healthcare system, expand it to incorporate new medical services, or deploy it countrywide, Indian officials want to see more data.

Since the private sector is responsible for the bulk of healthcare provision in India, partnering with private providers strategic significance in health issues. Despite significant discussion of the possibility of public-private partnership projects to reduce healthcare costs and improve patient outcomes, broad adoption of such programs has not resulted in the anticipated financial advantages or improvement in health outcomes (Miller G, 2014).

One such method the private sector may help improve healthcare quality is through contracts that include performance incentives for providers (Mohanam M, Miller G, Donato K, Truskinovsky Y, 2016). In spite of the fact that health care is typically not included in performance incentive schemes, a growing number of governments in middle- and low-income countries are testing out PBCs to improve healthcare delivery. In spite of the fact that health care is typically not included in performance incentive schemes, a growing number of governments in middle- and low-income countries are testing out PBCs to improve healthcare delivery..

Furthermore, studies on the effects of incentive programmes for providing health care inputs have shown mixed results (Morton et al., 2016). The study indicated that the rate of postpartum hemorrhage decreased by 20% after obstetric care providers in the Indian state of Karnataka were randomly allocated contracts with performance incentives based on inputs. (following recommendations for obstetric treatment provided by the Government of India and the World Health Organization). The research also found that incentive spending was lower for input-based contracts than for output-based contracts, indicating that these reductions may be realised with less effort. However, accurate administrative data on the supplied inputs is necessary to put input-based contracts into practise. Extensive fieldwork was conducted for this research and provided the basis for the data presented here. Morton and co-authors predict that in the coming years, state and federal governments will devote significant resources to enhancing the quality of administrative data.¹⁵ Many Indian governments have made progress toward better health management information systems, which is encouraging.

Scaling Up

Quality improvement also addresses the related and critically important problem of scaling up initiatives to improve quality, which are often developed in limited, controlled settings. In the case of innovations that fare well in lab conditions but fall flat in the real world, this is of paramount importance. Understanding market demand, the innovations' potential or

required evolution during deployment, and the reactions of the key market players are all essential for a successful expansion of these technologies (providers and patients). Successful extension of these innovations requires an understanding of market demand, the ways in which they may or must alter throughout deployment, and the responses of the primary market players (providers and patients). Better health care for families via experimentation, initiative, collaboration, and delegation (AIDED) projects (Bradley et al., 2012) application to policymaking in India is possible. This model requires implementing organisations to adapt dynamically to a complex context, which is not always predictable. Given the limited resources available in countries like India, it would be prudent to require proof of performance before expanding successful experimental ventures. Even if the efficacy of a novel programme has been proved, it is prudent to carefully evaluate the consequences of expanding its use. In order to keep successful, innovative programmes from being shut down owing to political economy concerns or shifting trends in the objectives for global health, solid empirical evidence on programme effectiveness should be provided.

Moving Forward On Improving Health Care Quality

In light of recent changes, individual states in India have the rare chance to reevaluate how they spend health money, and these articles from Health Affairs provide critical analysis of the current challenges facing India's healthcare system. Examining the federal and state governments' abilities to improve healthcare quality in light of the measurement and data problems described in these articles is essential. Although we now understand more fully the difficulties inherent in delivering high-quality medical care, the situation has not altered. The federal government is responsible for the health of the Indian population. Despite the federal government's efforts to centralise control of the states' health care systems through law and vertical programmes, the states retain ultimate control over these systems.

2015 saw the Fourteenth Finance Commission's plan to give states more control over their own budgets take front stage in India. India's federal government planned to provide the states an additional \$16 billion each year, or a rise from 32% to 42%, of the country's total tax revenue. Allotted funds in each state would then be used in ways that are well-liked by those living there. Concerns have been raised that the health sector may receive less assistance than in the past under the current administration after federal promises of money for the National Health Mission, a programme to address the health needs of neglected and disadvantaged population groups in India, failed.

Nonetheless, fiscal decentralisation has given state governments more leeway to meet the needs of their constituents and distribute resources as they see fit. Whether or whether pressing issues, such as healthcare quality, get immediate attention depends on the ability of individual states to identify these demands and respond appropriately through policy changes. The way various administrations prioritize topics varies. It would be fantastic if the

medical community's intellectuals and decision-makers in India prioritized improving the quality of care.

Conclusion

The public sector needs better management, more institutional capacity, and a culture of data-driven decision making in order to provide better health care to all Americans. Health care quality and provider accountability on a national, state, and local level can all benefit from data obtained from administrative sources and household surveys. Investments in the construction of standardised and more trustworthy data sets, as well as institutional incentives for using evidence in policymaking, are necessary. Healthcare and health outcomes in India may be greatly improved if the government, implementing organizations, and researchers all work together to find and evaluate viable techniques that are backed by evidence.

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