Similar problems, related maladies

Private and public health care delivery systems, despite their marked differences, suffer due to variable professional standards and limited accountability.

K. S. Jacob

Health care in India, at its finest, matches the standards of international best practice. The knowledge, skill and confidence of its doctors and nurses, the sophistication of available technology, quality of service and five-star hospitality compete with the best in the world. Its relatively low cost has made it an important player in the health tourism sector. However, at the other extreme, publicly funded health care services often do not meet required standards, despite many committed doctors and nurses and the ideals, effort and money contributed by the National Rural Health Mission (NRHM). The regularity with which the media highlight scandals, report clusters of “unexplainable” deaths, expose dilapidated infrastructure, depict non-functioning medical equipment, record inadequate staffing and document negligence suggests a different world. Chalk and cheese.

These different systems reflect diverse philosophies and contrasting economic models: state-of-the-art private health care and capitalism, on the one hand, and public health care services with their inefficiency and socialistic framework, on the other. While many professionals in both these systems maintain the highest professional and ethical standards, many others fail to live up to the required norms of excellence and service. One often hears horror stories of exploitation and neglect. The variable standards of medical practice within each of these systems highlight similar problems, related maladies.

Professional standards : The contractual, legal and ethical obligations of medical practice and the public nature of health services mandate licensure and regulation. However, the Medical Council of India, a statutory regulatory authority, has never seriously engaged with nor regulated medical practice. Its powers to strike off doctors from its registers, suspend and withdraw licences remain on paper.

Professional societies also have an obligation to maintain standards of medical practice. Their role in establishing diagnostic and treatment protocols is crucial. Yet these societies focus on protecting the rights of their members, with little emphasis on responsibilities related to maintaining professional and ethical standards of practice. Their relationship with pharmaceutical and hospital industries often prejudices their concerns and moves them away from the science and art of medicine. Compulsory professional development and re-certification are unheard of in India. Professional groups rarely express convictions; they often push self-interest.

Audit and accountability : The maintenance of standards in institutions demands regular audit. Such audits are crucial to medical practice as they allow health professionals to compare their services with national and international standards, identify lacunae, change policies and programmes and update their knowledge and skill. Nevertheless, regular and systematic audits of processes and procedures are rare. Audits of input in the public sector and of income in private facilities take place, but without any focus on patient outcomes and cost-effectiveness. However, holding individuals and systems accountable for faulty policies and practice should be mandatory.

Culture of silence : The medical fraternity in India has its own omerta code. Even gross misconduct, often recognised by colleagues and superiors, is met with silence, complicity and even collusion. Corrections of major violations of conduct and poor standards of service are uncommon. This is true in both the private and public sectors. Tedious procedures, long delays, ineffectual committees, political interference, inconclusive investigations and the absence of action make people hesitant to raise concerns. Instances of gross medical negligence and less-than-optimum care are often covered up, leading to perpetuation of such practices with these becoming the norm. The medical fraternity usually circles its wagons in the face of public scrutiny instead of opting for transparency, investigation and improvement.

Society in transition : India is in the early stages of transition from a feudal society to an enlightened social order. The power differentials between doctors and their patients, the unequal knowledge base, the supply-side/seller's market and paternalistic attitudes within the medical profession do not allow for the empowerment of patients. Complex decisions are often made for patients without their adequate understanding of issues, resulting in their minimal contribution to the decision-making process.

Dissimilar impacts : The lack of standard guidelines, poor execution of simple regulations and non-existent audits of medical practice play out very differently in the private and public sector health delivery systems.

The NRHM and its many innovative platforms have increased access to, and availability and affordability of health care in many rural areas. Yet, many health centres, despite improvement in infrastructure and personnel, perform poorly in providing basic health care. The lack of professional development, low professional standards of practice, poor supervision of processes and the lack of accountability in public sector hospitals result in sub-standard care. Although the Janani Suraksha Yojana has increased institutional deliveries across the country, maternal and infant mortality continues to be unacceptably high in many regions. Audits have shown a failure to adhere to recommended treatment protocols. The absence of routine institutional audits, despite being part of the system, results in a lack of accountability. Self-regulation does not work. The culture of silence and feudal social systems results in poor quality of health services.

The context of the private sector is very different. Educated and well-heeled patients demand higher quality of health care. Failure to implement professional standards under these circumstances often results in over-investigation of patients and the use of multiple, inappropriate and expensive medication/procedures. Remunerations based on commissions distort medical practice. It is easy for bias to hide out in the fog of medical jargon, technology and decision-making. It is not difficult to befuddle patients with jargon and baffle them with technology. Even discerning patients are unable to recognise inappropriate practice and curb inflated health care costs. The prevalent neo-liberal culture focusses on the trappings of sophistication, technology and hospitality rather than on the quality of medical decision-making and therapy. The absence of medical audits, despite routine and rigorous financial reviews of performance, makes for poor health care. The culture of silence renders the exposure of incompetent or unscrupulous doctors rare. Self-regulation does not work.

The choice for patients should not be between poorly functioning public hospitals and exorbitantly priced private health care. For a majority of Indians, choosing between the devil and the deep blue sea is no choice at all.

Moving forward

While many doctors work against the odds to maintain the highest professional and ethical standards, many others fail to live up to what is required of them. While one tends to blame individuals for failures, the problems in reality, are systemic. Private and public health services need regular audits to maintain professional standards and to establish individual and collective accountability. The neoliberal creed of greed in private and corporate practice and apathy in the public sector mandate regulation and supervision. External enforcement of accountability (e.g. redress through consumer courts and the Common Review Mission of the NRHM), although necessary, has not delivered and cannot deliver quality care. There is need for regulatory authorities, professional societies and institutions to implement standards through mandatory protocol-driven management guidelines, to change their culture and enforce basic minimum standards. The publication of such protocols will democratise knowledge, allow for comparisons, assure quality and curtail costs. Display of audits carried out within institutions (e.g. microbial antibiotic resistance patterns, Caesarean section rates, etc.) will inform citizens of the issues involved and allow for informed choices. A regular review of individual and institutional performance is mandatory. Continuing professional development and re-certification are necessary. Empowerment of the general population and its participation in decision-making are crucial. Grievance redress mechanisms should also be in place. There is need to strengthen governance at the institutional level.

Strong advice with a weak audit of practice will result in variability of performance of individuals, institutions and systems. Although it sounds blasphemous, the “Interest-Convergence dilemma” is obvious. The idea that doctors, despite their stated aim, would not

always support efforts to improve the lot of patients, unless it is in their own personal interest, is not hard to see. The brightest of individuals and the best of systems need a regulatory framework to produce consistent results and maximise benefits for all. A significant proportion of doctors have yet to buy into the need to follow standard algorithms related to health care. Ideals are easy; living up to them is not. The culture needs to encourage individuals and institutions to take responsibility, update their practice and be accountable. Self-righteous defence is not an option. However, there are no black-and-white victories in such battles, only incremental ones. The proverbial two steps forward and one step back. Health systems in India have a long way to go before ethical and scientific practice is the norm rather than the exception.

(Professor K.S. Jacob is on the faculty of the Christian Medical College, Vellore. The views expressed are personal.)