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Asymmetric state of healthcare access across states, rural and urban areas. However, a closer look and its validation by public policy practitioners raises some vital questions on what doesn't work in improving access to public services like healthcare, education, policing, and to what extent incentives decided solely on the basis of metrics may culminate in counter-effects in the quest to improve measured performance.

All these three tenets of using (data-centric) metrics are considered essential by policymakers and politicians to marry "good intentions to managerial techniques". "Measure, monitor and remunerate", as the Trinitarian formula thus becomes panacea for tackling all problems, including those with a social dimension, influenced by norms and cultural practices. However, one can identify counter-effects of such metric-based incentive pattern in India's medical system.

India's healthcare system comprises of a complex web of medical establishments in the form of clinics, hospitals, government agencies, insurance companies, etc. There remain significant demand-supply constraints, circumscribing access to (primary, secondary, tertiary) medical services of a reasonable quality at an affordable rate across these areas.

Metrics of per-capita spending on healthcare, mortality rates and life expectancy do reflect the asymmetric state of healthcare access across states, rural and urban areas. However, a closer analysis on identifying some causes and reasons for the proliferating incidence of communicable/non-communicable diseases or a weak doctor-patient relationship, etc., reflect how such commonly studied healthcare metrics alone cannot explain the systemic nature of medical concerns affecting India's demography.

It has been argued as to how access to quality healthcare in rural areas in Bihar, Madhya Pradesh, West Bengal and some parts of Rajasthan remain influenced by a common perception that proper diagnosis and medical service is only available in far-away district hospitals, regardless of whether a well-operational primary healthcare facility is situated nearby.

Ensuring a 'reasonable' number of medical doctors to provide primary and secondary care to people in rural areas from a metric-based assessment may not be sufficient to improve medical outcomes. One also needs to incorporate social and cultural factors into the domain of analytical reasoning to get to the root of the problem. For example, water, sanitation treatment and their use bear strong correlation with individual/group lifestyles and choices and their overall quality of life which is rarely captured in metric-fixed reasoning.

While policymakers may advise the government to keep spending more to increase the number of medical facilities in rural and urban areas, ultimately, the reduction in chronic ailments (such as diabetes, typhoid, etc.) or water-borne diseases require substantial changes in socio-cultural practices with graduated (policy) measures.

To evaluate the performance of medical institutions, too, a metrical cannon may be utilised in creating (limiting) incentives that may culminate in undesired outcomes. In West Bengal, the adoption of the West Bengal Clinical Establishment Act in 2017 intends to streamline healthcare regulations with procedures on medical licensing, generic drug pricing, adjudicating and accounting for criminal offences related to medical practice.
According to this Act, doctors or healthcare facilities may face criminal proceedings under Indian Penal Code, including cancellation of their medical licence, if found guilty of medical negligence. The Indian Medical Association (IMA) raised objections to this clause as IMA wants a single-window accountability for doctors to reduce the scope of harassment, and one that applies to both private and government doctors. Moreover, a stricter law and high criminal deterrence for punishing doctors convicted of medical negligence may prevent doctors from treating patients in a serious medical condition.

What can be done?

A system incorporating periodic agency feedback on effects of medical practices and solutions, mapped with group (or individual) socio-cultural practices, is key to addressing healthcare concerns across different geographical spaces. Remedying medical problems that surface from societal or cultural behaviour requires a different set of methods for initiating long-term solutions that go beyond any metric-fixated healthcare initiative. Qualitative feedback on performance of existing policies and medical institutions helps assess what works and doesn’t work.

Feedback mechanisms beyond the metrical cannon can help not only in healthcare but also in other areas such as education and policing. A student’s overall grade is just one of the indicators of her capability to perform in a professional role. Qualitative feedback on her performance during the job interview or training period gives employers a better understanding of her true capabilities.

Data-driven performance measures and indicators are surely beneficial for identifying schemes of reward and punishment; still, diagnosis of individual/group/institutional performance warrants us to incorporate professional experiences, values and group behavioural attributes to initiate longer term (social) changes. An overt reliance on metric fixation sans a systemic process of monitoring and reward and punishment; still, diagnosis of individual/group/institutional performance warrants us to incorporate professional experiences, values and group behavioural attributes to initiate longer term (social) changes. An overt reliance on metric fixation sans a systemic process of monitoring and documenting qualitative feedback during cycles of a given policy implementation is likely to distort the very rationale of designing policies for the common good.

(The writer is Assistant Professor of Economics, Jindal School of International Affairs, Sonepat, Haryana)
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