

Quality Health Care for the Numerous: The Challenge of Numbers

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Abstract: The delivery of health care on a continuous basis in a progressive manner to a group of population located geographically in a certain area is a challenge by itself. Once initiated several quality issues including enhancement / expansion of services does arise. The number of beneficiaries / recipients is a crucial factor. In current times, health delivery cannot be confined to government / public sector alone as was the case for substantial period in the past. At the same time, corporate / private parties need to be monitored in relation to the practices and cost eventually payable by the patient. The uninsured need to be attended / included in the gamut. Mechanisms of partnership (PPP: public-private partnership) with a realistic approach require to be initiated / strengthened / consolidated. The degree and success is determined by continuous inputs / review / corrections. Cost control / containment has been an important consideration in developed countries' health policy as well. In matters of health there has been heterogeneity in Southeast Asian countries health policy approaches; however there have been many similarities in terms of patients / disease / issues profile as well. There is much that health policy makers, academicians, clinicians, health authority can do in the changing times more so from experiences obtained in other regions of the globe. Quality in health care is a continuous process and changes noted in the practices, feedback, outcome, cost effectiveness require to be periodically fine-tuned.

Key words: Quality. Health Care Delivery. Universal Access. Health Policy.

INTRODUCTION

The level and tier of health care has several components. The regional, environmental, spatial aspects from amongst the many influence the planning, delivery, cost and quality of health care in a given region at a certain point/phase of time. When dealing with quality in health care issues, it becomes necessary to consider the, dimension of numbers, clinical situations/ disease profile, the setup (s), partners, and Indicators.

DIMENSION OF NUMBERS

Population size indicates the numbers in different age groups that need to be attended. South and East Asia is occupied by densely populated countries¹. Despite the population stabilization programmes, it is anticipated that another equal of the existing population may be added by the year 2030. As it is the current population poses a challenge by sheer numbers belonging to different age groups and distributed in metros cities, hinterland and rural areas.

The **changing demographic profile** needs to be clearly understood. It has been rightly said that Asia is aging attributable to two factors.

1. **Better life span** both in males and females, rising from erstwhile 50 to 60+ differing in different countries. Old age² is characterized by multiple organ system disorders and has elements of chronic disease increasing complications with necessities of rehabilitative measures and care in institutional setups. Taken together, this increases the need for multiple visit attention by different members of the medical, paramedical and rehabilitative calling for care in larger necessities / requirements and adding to service volume
2. There have been some accomplishments in **reduction of IMR (infant mortality rate)** and maternal mortality rate; but still much more needs to be done. Name based tracking of pregnant women and children for Ante Natal Care and immunisation will add to accurate data from across India.

CLINICAL SITUATIONS/DISEASE PROFILE

Asia has seen a continuous change in *the* profile with predominance of infectious/ diseases of under nutrition combined with the newer ones pertaining to lifestyle and aging.

- a). **Tropical diseases** like vector borne malaria have shown difficulties in control / eradication and morbidity / mortality may continue unabated in certain countries. Likewise, dengue / leptospirosis³ continue to affect large numbers of the population quite often on a seasonal basis particularly the months of June to October coinciding with monsoon.
- b). **Non-communicable diseases** sometimes termed as diseases of affluence

(perils of plenty) notably diabetes mellitus, hypertension, coronary artery diseases⁴ are rising in numbers with occurrence of difficulties in control and development of complications (catastrophic health payments) requiring tertiary/ super speciality care with modern technology gadgets and equipments. These have assumed the dimension of public health problem/epidemic.

- c). **Lifestyle diseases** such as HIV has been a scourge; strategic intervention has resulted into closeness to a plateau phase with several patients receiving anti retroviral therapy with reduced hospitalizations and marginally improved quality of life. Cancers attributable to dietary/ environmental factors show a demonstrable rise and demand, complex measures of chemotherapy / surgery / radiotherapy emphasizing the role on prevention for which substantial research funding is being utilized. Sound mental health is a matter of concern and the numbers clearly indicate rise in demands of psychiatry / counseling services.
- d). **Emerging diseases** such as swine flu, avian flu (facilitated by increase international travel and necessitating quarantine measures pose a challenge and demand extensive services from laboratory diagnosis, indoor services and ICU care in case of complicated situations (catastrophic health payment).
- e). **Environment related problems:** rising pollution of the environment⁵ through industrial exhaust, vehicular traffic and the effects of "Global Warming" are now visible. Flash floods, snowing, un-seasonal rains and such calamities / eventualities pose enormous demand on emergency management services and disaster management with multi agency efforts including those of immediate care and long term relief and rehabilitation. Further incidence of malaria, malnutrition, gastro intestinal diseases are anticipated to get out of control if nations do not adhere to combine all round measures in reducing the effects of global warming.

THE SETUP(S)

The modern equitable health care delivery system has as its objectives i.e. (a) adequate access; (b) sound efficiency; (c) standard quality; (d) legitimate control of cost accompanied with patients / relatives' - attendants' satisfaction. The fundamental equation is the balance between service volume and the total health spending. The demographic transitions noted above apply to individuals in a social context and under economic realities. In countries/ regions where health care setup is still at its nascent stage, the backlog shall have to be doubled in the coming 5-7 years. Conventionally there have been academic medical centers/medical schools/medical teaching institutions in large cities/state capitals which have served the purpose for substantial period of time. Coupled with these, the corporate hospitals, trust hospitals have also grown up essentially in metropolitan and large cities leaving tier 2

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cities and tier 3 towns relatively deprived/backward of medicare/health care facilities. The frenzy of fast urbanization has been enormous and cuts across all major quality of life indicators. The cities may fall well short of delivering a basic standard of living including health for their residents. The urban transformation in its scale and speed has been enormous and the slow pace of parallel development of structure such as water supply, sewerage, drainage, transport and housing shall put severe pressure on the civic body. The urban landscape forces millions of people to live under pathetic conditions (ghettos/slums) which may tend to be affected by water logging during monsoon resulting in diseases causation and spread. The WHO has launched a project called 1000 Cities, 1000 Lives offering portion of public space for physical exercise, making families friends, community health checkup, having local healthy food. The WHO launched this campaign primarily as urbanization in emerging as a major challenge for public health relating to water, environment, non-communicable disease and their risk factors-tobacco usage, unhealthy diets and communicable diseases like open Tuberculosis. In short, the setup shall have to be in (a) Metro cities; (b) vulnerable areas within the cities necessitating urban health mission programmes and (c) rural, away from hinterland relatively isolated areas having the necessity of basic health infrastructure.

Whereas in the larger cities, super speciality, high technology care, high end investigations can be carried out, it is necessary that secondary hospitals (peripheral urban health care) are developed in the above mentioned urban pockets and there need to be at least primary health unit with 30 beds in rural setup with out-patient department, provision for indoor-patient services, operation theatre, emergency/obstetrics services with a basic backup of pathology/radiology/blood bank and pharmacy services. *Tele-medicine*⁶ services can give a diagnostic advisory back up in relation to nature and urgency of treatment elsewhere.

It has been underscored that over the next 30 years virtually all population growth would be in urban areas, thereby signaling that this most defining change of urbanization is here to stay and the consequences thereof need to be anticipated from the angle of strategic planning and in particular reference to health. It thus becomes obvious that improvement in the quality of health care may have to be differential comprising of :-

- (a.) modernization and technological updating of super speciality centres / medical schools in the metropolitan / large cities,
- (b.) creating special health care provision in urban pockets (ghettos / slums) arising due to the amazing speed of urbanization without a parallel progress in infrastructural development. These efforts need to be in the nature of urban health improvement programme.
- (c.) development of medium size hospitals and related facilities in tier 2 cities and tier 3 towns,
- (d.) basic primary health care and / health facility in rural part of the country as pointed out. All the above being networked through a carefully planned referral system and networked through telemedicine⁶ / surveillance programme.

PARTNERS

Though government have been conventionally the main provider/ facilitator, it is the private sector that has now engaged in chains of hospitals at metropolitan/large cities and medical establishment needs to be undertaken in tier 3 towns and rural hinterland. In an effort for the public health care system attempting to adapt to population needs, the public-private partnership mode has to be initiated, consolidated and strengthened differentially on sound assessment.

The two most crucial issues are the reach and access. The health care provider and facilitator needs to reach the hinterland/remote part of the country so that access of citizen for urgent care, primary care/preventive care (vaccines) and checkup becomes facilitated. The overall success and the quality of health care can be judged by the availability of health care facility to the recipient in the remotest part. It shall become obvious and clear that (a.) creation (existence) of health care; (b.) enhancement to acceptable levels and (c.) addition of conveniences public health facilities in accordance to the changing times are progressive steps in the assessment of quality of

health care.

Hospital sector especially super speciality services continue to be an area of interest to private equity investors. Nationwide, private hospitals chains to the neighbourhood clinic are the line of percolation. Health "industry" appears to be rapidly latching onto multi dimensional revenue potential for health care with corporate health insurance coverage and payment potential as the key factors. There is already a lurking fear that patients become a conduit for doctors to bill money from insurance companies⁷. Threat to primacy and autonomy of the medical professional has to be averted. Though the time taken to stabilize the operations can be long, the private sector needs to be monitored. The problem of rising health cost has become key US domestic policy issue. The need for the Independent Payment Advisory Board⁸ to report on health care costs, access, quality and utilization and further recommend regarding ways of slowing the growth in private national health care expenditures, comparative-effectiveness research (CER)⁹ as a means of reducing health care cost without compromising the quality of care speaks for itself.

INDICATORS

Under National Rural Health Mission (NRHM), the Central Government has financed the addition of one lakh skilled health care providers to the public health work force. However, much more needs to be done in this direction to address the issues related to availability and quality of human resources. The Union Health Budget has increased from Rs. 8000 crores in 2004-05 to over Rs. 21,000 crores¹⁰. The Report¹⁰ includes the challenges and policy options which required a national consensus

It is stated that enhanced quality of health care contributing to better quality of life and broadly resulting in furthering the objectives of Millennium Development Goals (MDG) appears to be a natural logical sequence. Much has been said about translational medicine, broadly meaning that the results of biomedical research (*bench*) be transferred to the place of care (Outdoor-indoor critical care, OT, preventive and rehabilitative services) *bedside*. Further corollary is to see the *application* in its widest and most extensive form so that the meaningful benefits are accrued to numerous, i.e. bridging the gap between translation and application.

Undoubtedly certain issues pertaining to health care are universal. Within a given region there may exist heterogeneity, for instance in East Asia; the evolution and approaches in Japan, Korea (North and South), Singapore may be different towards financing and delivery of health care and yet there may be commonalities in relation to countries in South East Asia. The achievements of medicine in technology, diagnostics, imaging, indeed have been spectacular. Citizens all over the world have been recipients of excellent care related to the application of these developments. The quality of health care has an immense potential for further development. The scope is wide and the canvas large. However, the need to deliver service that has been barely existing and the need to have reassuring basic health care is indeed crucial. The gaps have to be bridged, the tempo has to be accelerated, the balance has to be struck for the goals of health care to the numerous being fulfilled.

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