

COMMENT

The dynamics of efficiency

MUSHTAQH ALI¹

¹Private practitioner, 9 Olympic colony, Mogappair, Chennai 600 050 INDIA e-mail: ali.mushtaqh@gmail.com

Why are Indian health delivery systems deficient in operating along the Western paradigm of appointment-driven practices with their proven "efficiency"? Is our "inefficiency" a result of people, both physicians and patients, or of the setting? Does systemic inefficiency thwart the efforts of efficient individuals? Actually, multiple factors feed into any outcome and we need to look at it in the larger context of public health services in India.

A suffering patient usually evokes a visceral empathy in the physician. But the system that creates the physician does everything to smother this reaction, which is such an integral part of healing. As a student, the future physician finds herself thrown abruptly into a melee of human suffering armed with sterile in vitro knowledge of the human body. Nothing prepares her for the emotional minefield that constitutes the basis of a physician-patient relationship. During much of her student life she comes to detest the rushed scramble of the out-patient department, as hordes crisscross the halls of the hospital desperate to reach their designated outpatient rooms before closing time. Human dignity by then has been left outside the gates of these teaching hospitals, either run privately or by the government. Added to this is the colossal ignorance among many patients of human bodily functions. The end result: simmering all-round anxiety.

Things change when students become physicians. Many of them hanker for specialisations and super specialisation, and primary care becomes the resort of the disgruntled who are left out of the specialisation mainstream. The focus by now has shifted from healing to becoming successful. And success is measured in unabashedly materialistic terms. A needy patient morphs into a golden opportunity. Others, however, continue to view their work as a collaborative exercise, where the patient's needs are of the greatest importance. With such diligence comes a good professional reputation. And before long the throngs at the clinic overflow on to the steps and the road. There is no way these patients, with hope in their eyes, can be turned away on the pretext of efficiency.

A physician who goes into private practice has no clue how she will fare. Setting up a coordinated clinic with all the paraphernalia of an office, secretaries, nurses, lab technicians, and paramedics entails a capital outlay that a fledgling physician usually cannot afford. No finance may be available that would allow her to work in comfort until the patients are willing to pay for a service that functions along this different

paradigm. By the time the practice may flourish the financiers would already be claiming penalties.

The numbers who swell a primary care physician's waiting room in India are very different from the orderly patients of western countries. The western model is perhaps evident in the dentist's office in India, which are practices based on routine check ups and timely reviews. This is one of the reasons for the high costs of private dental services. If the model is applied to the practice of a primary care physician, it will have a similarly inflationary effect on the cost of service. This is one significant reason why improving the efficiency of primary care through appointments and time slots is not possible in India.

In family care, income is incidental to service; it cannot be a precondition. Bonding between the patient and the physician is important. The patient often develops an almost filial dependence on the family physician, which may translate into a high level of anxiety and an inability to take health-related decisions. This dependence however represents the complete and abiding trust that a patient has in the doctor. And in such a relationship it is difficult for a doctor to reduce health delivery to principles of efficiency, when the bigger issues are fairness and transparency in sharing mutual concerns.

In crowded outpatient clinics in various hospitals in India, indigent multitudes throng for succour. Given the circumstances, it would be more correct to view the running of these clinics as an example of human ingenuity in the face of a deluge. With health care becoming increasingly expensive, public health delivery systems have got hopelessly crowded. Health delivery eventually focuses on servicing the greatest numbers, with the result that quality suffers. But a comparative analysis of management of health delivery systems and outcomes in patients between public and private hospitals is bound to reveal no great difference. Government hospitals, however, would score low in the public's opinion on the quality of nursing care and paramedical help. This subjective difference contributes to the poor reputation of crowded government hospitals.

Private clinics in primary care face much the same problems as government hospitals. The physician running the clinic, concerned about keeping health delivery costs low, takes on many roles: as nurse, attendant, and doctor. This model of efficiency is not to be belittled. It fills a void in a way that no efficient organisation can ever hope to achieve: it serves a small

community in a more personal manner than the large hospitals where efficiency is a byword for functioning in way that is profitable for the hospital.

The anxieties of patients during epidemics are difficult to comprehend for a physician trained in delivering health care under the western system of management. There are no models for the kind of patient visits in India, where whole families in different stages of the same disease may clamour for immediate attention. In a small community this swells into a deluge, which can never be regulated by secretaries and nurses but can only be addressed by the treating physician's attention. The exercise may seem to elevate the physician to the status of a demigod, but this again is emblematic of the

Indian physician-patient relationship. Moreover, management of everyday infections like waterborne diarrhoeal disease can never be regulated by an appointment-driven regime of efficient health care.

The management and delivery of health care in India need not be run on the same model as in the West. Indian physicians have the bigger task of attending to the demands of a much larger numbers of patients. Management expert Peter Drucker apparently has said, "There is nothing so useless as doing efficiently that which should not be done at all." Where does one start to reform the system?

Reference

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