

treatment cost audits in medical institutes: neuroeconomics of affordable healthcare



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Introduction

While the majority of private hospitals and medical institutes record patient history yet the details about chronology and information about treatment protocols administered is scanty. Similarly, the records of consumables brought by patients at the time of surgery or revenue lost to patient's investigations sent out to private labs are usually not available. The Govt of India recently issued a notification, "Cost records shall be maintained on regular basis in such manner as to facilitate calculation of per unit cost of production or cost of operations, cost of sales and margin for each of its products and activities for every financial year on monthly or quarterly or half-yearly or annual basis." This is a telling comment on the state of revenue records in India, making it difficult to ascertain the compliance to procedures critical to implementing good and economical patient care. 'The cost records shall be maintained in such manner so as to enable them to exercise, as far as possible, control over the various operations and costs to achieve optimum economies in utilization of resources' said the noting. Such records have an enormous implication for delivering affordable health care for Medical Institutes in a resource starved economy like India. This commentary is, therefore, an effort to create awareness about the link between retrieval of real time cost records and delivery of patient care for poor in public hospitals.

Empowering Institutes and hospitals by Quality Management

Information about health care services in medical institutions collected over a period of time can be a goldmine for doctors, care providers and law makers alike, provided that the information is collected systematically. While the health care system is often perceived in India as overloaded with patients no data is available about how judiciously are doctors allocated for various medical activities. The collection of correct revenue has low

priority in such hospitals even though it directly impacts neuro-economics of human resource management. Quality managers in hospitals are often asked an eternal question whether a doctor should concentrate on treating a patient or filling up a form, unmindful of the implications of quality tools on efficient management of resources. Unless the real time inventory and revenue information about expenditure incurred in delivering healthcare by way of human resources deployment, preventive maintenance, financial losses due to delays in procurement of drugs and consumables or prescription of branded drugs remain open to cost audits, the policy makers would not be able to apply their administrative skills to maximize the returns from government investments. The cost of treatment for poor patients shall therefore continue to be met out of pocket.

Modelling the private hospitals professional management of resources

Although private medical centers are often argued as epicenters for supplier induced demands, they have management skills from where govt hospitals can learn a lot for professional management of resources. Let us look at the private medical centers where it is almost impossible to generate profits if the real time management of outside referrals, equipment costs and salary for doctors is not calculated on the basis of number of patients seen or hours of surgery performed. A separate department, in such centers, controls inventory in a manner which is auditable, verifiable and archivable such that the preventive maintenance saves health costs thus maximizing profits. As public hospitals are not required to generate profits, if Govt ensures increased hours spent per doctor for patients or transfer them to rural centers, on a rotational basis, it may reduce both health care delivery costs as well as patient crowding in such centers. It was recently revealed in an editorial that a doctor does not hold more than 3-4 hour duration OPD twice in a week or 1-2 day surgery per week (Pangariya, 2014, *Ann Neuro*) in top Medical institutes raising the issue

of under utilization of such highly skilled workforce whose training costs are especially subsidized by Govt of India. Some argue that in the absence of data about comparison between the patient-doctor ratios in private versus govt hospitals, the policy intervention remains minimally effective. Others blame it on absence of economic analysis of costs of health care delivery in public health care systems versus revenue generated. Many thinkers believe that this information can not be efficiently audited by Chartered Accountants, instead a skilled economist is a requirement in public hospitals. In private hospitals, reduced doctor patient ratio results in profits while even with increased doctor patient ratio in public hospitals, the efficiency remains low. The private sector hospitals are often perceived as better equipped in terms of money and men as compared to public hospitals, however, the new salary structure in govt hospitals, especially medical institutes, coupled with large number of 'on roll doctors' makes per hour calculation of salary very competitive with private centers, if normalized to allowances, leaves, conferences and assistance in the form of paid residents provided to Medical Institutes. Often the absence of Junior and Senior residents in private centers make the job of doctors very challenging which is not the case in such Govt Medical institutes, thus making the case for treatment and cost audit of the resources more significant in the context of considering redeployment for rural health care.

Cost audits for better govt spending

Unless the computerization of health care delivery is undertaken it is impossible to track the efficiency of health care delivery or the money lost by the Institute to outside referrals by public hospitals. Recently, the Health minister, Sh J P Nadda noted that medical institutes should strengthen the lab facilities such that patients are not referred outside medical institutes. However, an appraisal of costs borne by patients in govt hospitals, by way of number of investigations and prescriptions has never been undertaken, resulting in perpetuation of dissociation of current health care system from cost audit feed

back. It is often difficult to ascertain how much of that money, camouflaged as prescription of branded medicines, returns back as conference and charity caskets usually made to allow doctor's conference travels. With implementation of cost audits coupled with mandatory prescription of generic drugs, it is possible to use the same funds for affordable health care delivery and nationwide rural health reform. These funds are otherwise being used to either escalate costs of health or launch clinical trials. Whether it is overburdening of doctors or under utilization of human resources can only be analysed by economic audit in the form of cost and treatment audit analysis. Recently, a report published in BMJ explained how the use of branded drugs in Indian Medical Institutions burdens the poor patients, a case which was similarly highlighted in a famous 'Satyamev Jayte' TV show by an actor turned social activist, Aamir Khan.

General trends

One needs to note that the present structure of the healthcare industry in India does not encourage any records for cost audits. Keeping treatment revenue records in a auditable fashion and complying to NABH (National Accreditation Board

for Hospitals) standard guidelines are in the best interests of doctors, patients and insurance companies, therefore, implementation of cost audit can consequently easily reduce health care costs. Such practices can be best led by meritorious doctors who should be allowed to lead institutes regardless of seniority or discipline. This alone can ensure transparency and advancement of medicine.

VIP patients and Conference management

It is often argued that a good policy aiming to transform the medical healthcare remains prisoner to influential patients who take doctors' advice on variety of issues including policy, audit and prescriptions without question. Even though International guidelines restrict personal or policy benefits from patients, it is generally believed that professional ethics demand declaration of such conflicts of interest by individuals who plan to bring new policy issues. The same applies to judiciary deliberating cases of doctors in Medical Institutions. With growing cases of corruption in Indian medical field, ethical practices pertaining to handling of VIP patients also need to be included in Medical ethics guidelines. As Govt of

India subsidizes health care costs through affordable medical education, unlike West, it is important that such cost audit policies and related reforms are implemented without interference from patient lawmakers and auditors. Some thinkers have postulated the recruitment of younger and healthy lawmakers, including interdisciplinary MCI panelists in order to bring new changes that can benefit poor patients.

Cost audits of treatment continue to be mooted as an essential tool to curtail the pharma sponsored conferences, as most of money comes from prescriptions or referrals of consulting physicians. As there are a large number of conferences held in various medical fields, Govt of India is learnt to have ordered the ban the holding of such conferences in five star hotels. If conference sponsorship is completely banned and instead the cost of organizing such conferences is completely funded by Govt, the health care costs can be drastically cut down sizing down graft in health care.

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