The limitations of metric-fixation in healthcare assessment standards

Considering the Indian context, ***Deepanshu Mohan*** *looks at the counter-productive nature of metric-based incentives affecting performance in the healthcare sector with some comparative anecdotes from the United States.*

The traditional wisdom on studying the impact performance of various social and economic policies in formal institutions and governance systems often relies on hard-core measurement data indicators for evaluating performance and (re)designing policies using data-centred analytical perspectives. The excessive reliance on data extraction and its validation by public policy practitioners across countries (including India) raise some vital questions on what works and doesn't work in improving access to public services like healthcare, education, policing etc. and to what extent incentives (or deterrences) decidedly solely on the basis of (pre)defined metrics may culminate into counter-productive results. As a case in point to the Indian context, this article looks at the counter-productive nature of metric-based incentives affecting performance in the healthcare sector with some comparative anecdotes from the United States.

How we can define Metric-Fixation

"What gets measured gets done" is a traditional credo of measured performance, which Jerry Muller in his book *The Tyranny of Metrics* calls the "metric fixation". The theological, almost faith-based arrogance on using a metrical canon for resolving problems with a social dimension, according to Muller, has now developed into an institutional *dogma* affecting the relationship between measurement and performance particularly in areas of public services such as healthcare, education and policing.

In his book, Muller outlines **three** tenets to the metrical canon: the *first*, involves acknowledging a set of indicators used for measuring comparative performance from standardized data while replacing judgment acquired through personal experiences and observational behavior; the *second*, involves making such metrics public to ensure *transparency* and *accountability* of public institutions, mandated to provide public services (example, education and healthcare); and *third*, managing monetary incentives and rewards, mapped directly with results analyzed from metrics in the quest to improve measured performance.

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

Arathana Hospital, Tamil Nadu. Photo credit: Mohan Mols, CC BY-SA 4.0.

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India's Health Care Assessment

If we take the case of India's healthcare system, comprising of a complex web of different medical establishments in form of clinics, hospitals, government agencies, insurance companies etc. across rural-urban areas, there are significant supply-demand side constraints circumscribing access to (primary, secondary, tertiary) medical services of a reasonable quality at an affordable rate.

Metrics of per-capita spending on healthcare, mortality rates and life expectancy (as argued here) do reflect the asymmetric state of healthcare access across states, rural and urban areas in India. 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 performance metrics alone cannot explain the systemic nature of medical concerns affecting India's demography.

In an article written last year, I argued how access to quality healthcare access in rural areas across Bihar, Madhya Pradesh, West Bengal and some parts of Rajasthan remain influenced by a common perception (amongst people in rural areas) that proper diagnosis and medical service is only available in district hospitals which are located at a much farther distance, regardless of whether a well-operational primary healthcare facility is situated nearby.

Das and Mohpal in a similar study conducted a few years ago also observed a stark divergence between "medical qualifications and knowledge" amongst doctors available (in above states) with their "knowledge and practice" (in terms of antibiotics prescribed for treatment). The study, implicitly highlighted significant methodological limitations in understanding the quantum and nature of medical problems across the country.

In other words, ensuring a 'reasonable' number of medical doctors to provide primary, secondary care to people in rural (semi-urban) areas from a metric-based assessment may not be sufficient in improving medical outcomes, as desired. 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 from metric-fixated reasoning.

In case of India, while policymakers may advise the government to keep spending more (from a lower-per capita spending) by increasing 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.

One can draw a similar case in reference to the US medical situation too. As per international standard, the US medical system (as argued here) is highly successful in diagnosing and treating most diseases. However, mortality and life expectancy rates in the US too are largely explained by factors *outside* the medical system which bear strong correlations with food consumption practices, other cultural lifestyles. The rapid rise of obesity amongst Americans (and other countries) remains connected to a widely prevalent consumerist culture of (over)eating high calorie-intake fatty foods which have increased the incidence of chronic illnesses such as Type-2 diabetes and cardio diseases.

Mapping Rewards & Punishment

For evaluating the performance of medical institutions too, a metrical cannon may be utilised in creating (limiting) incentives that may culminate into undesired outcomes. For example, according to the second tenet of the metrical cannon- medical institutions' performance can be improved through transparency and accountability by making all "hospital mortality rates public". In the US, while this practice was adopted, a recent study, shows how "public reporting of mortality rates has had no impact on patient outcomes".

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Similarly, in India's state of 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 the newly enacted Bill, doctors or healthcare facilities may face criminal proceedings under Indian Penal Code, including a cancellation of their medical license, if found guilty of medical negligence. The Indian Medical Association (IMA) raised strong objections to this clause as the IMA wants a single-window accountability for doctors to reduce the scope of harassment and no differentiation in treatment between the private sector and government-appointed doctors. Moreover, a stricter law and high criminal deterrence for punishing doctors convicted of medical negligence may prevent doctors (in public or private medical facilities) 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 remain key to addressing healthcare concerns across different geographical spaces. Remedying medical problems that surface from societal or cultural behavior require alternative methods for initiating long term (policy) solutions that go beyond any methodological individualism that is centered on a metric-fixated, one-size-fits all belief. More qualitative feedback documented to analyze the performance of existing policies and/or medical institutions help us in assessing what works and doesn't work in the domain of public-policy analysis.

The point of arguing beyond a metrical cannon is to push for other feedback mechanisms into the domain of analytical reasoning for creating improved access not only for medical services but also in areas of education and policing (argued here). A student's overall grade performance is just one of the indicators for her/his (cap)ability to do well in a given professional task. Qualitative feedback on her/his performance during the interview or training period gives employers much more informational certainty on her/his capabilities (beyond the grades scored).

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 behavioral 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, thus, is likely to distort the very rationale of designing policies for the common good.

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