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Study of various Governance Issues in Government Hospitals (A case of Delhi)

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Abstract

Governance in a government hospital setup has complexity as it concerns not only economic and financial dimensions, but also incorporates societal ones. This paper aims to identify factors that play a role in the governance of a hospital setting. Several key drivers of the governance reform program in India include the desire for value for money and reassurances about the way that resources are utilised. The performance of the Indian health service has been criticised over the last number of years as despite an increase in spending. It was concluded that there are several factors which affect the governance of hospitals. The probability can differ but they impact the governance surely. The government and different stakeholders has to work for effective governance.

Key Words: Government Hospital, Governance, Government hospital, Delhi, Indian health Service

Introduction

It has been a longstanding belief that governance is necessary to promote and ensure fairness, accountability and transparency within organizations. Governance in a government hospital setup has complexity as it concerns not only economic and financial dimensions, but also incorporates societal ones. Good and functional corporate governance is related to adequate corporate performance. There has been much debate in Delhi in recent times over hospital expenditure, waiting lists, Accident & Emergency crises and capacity issues in the three major hospitals of Delhi like AIIMS, Safdarjung and Ram Manohar Lohia Hospitals. This paper aims to identify factors that play a role in the governance of a hospital setting. There are many different stakeholders in the government hospital setups including clinicians, patients and administrators as well as the Department of Health. The main objective is to find to find the effect of various factors like doctor availability, medicine availability, age, income level etc. on governance of hospital. Consequently, it is an area in which the question of governance has been continually raised.

Literature Review

Berle and Means (1932) contributed the first research into this area, which resulted in the first generally accepted meaning of corporate governance. The Cadbury Report (1992) puts forth one of the most straightforward definitions whereby it refers to corporate governance as ‘The system by which companies are directed and controlled’. Julien and Rieger (2003) endorse that corporate governance is: ‘the system within an organisation that protects the interests of its diverse stakeholder groups. In essence, corporate governance

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has increased in importance and has become one of the most topical issues in business research today. Higgs Report (2003) explained the development of these codes was initially reactive in nature and was fuelled by the unexpected failure of organisations. These failures shook investor confidence in the quality of financial reporting. Subsequently, the codes have been continuously revised and built upon in order to meet changing governance needs.

Governance in the Public Sector Hospitals

The public sectors of countries in the developed world are large both in terms of their size and the financial resources needed to maintain them as they encompass many areas including education, policing, transportation and the health and social services. Ezzamel and Willmott (1993) assert that a key element of the public sector is that services are provided for the public good, suggesting that the public sector would have a higher sense of purpose in what they do than the private sector. Another difference lies in the fact that people who use public services may not be ‘willing customers’ as may be the case with health care.

Hospitals are huge economic entities that consume significant expenditure and resources. Governance in a hospital setting concerns not only economic and financial dimensions, as there is a huge societal aspect associated with the provision of health care. In turn it could be argued that hospital governance takes a more institutional approach. As the concept of hospital governance has been broadened to include both financial and non-financial elements, Eeckloo et al (2002) argue that its purpose is to enable a more integrated approach of supporting and supervising all hospital activities including clinical performance. While the previous governance focus in this setting may have been primarily concerned with managing organisational structures, infrastructure, departments and the resourcing of facilities, the hospitals of today are focusing more on managing processes and supporting care activities. Prior to the reorganisation of the health service, local politicians played a role as they were represented on the Health Boards. Now however there are no longer people involved whom the local population has mandated.

When WHO first gave consideration to the topic of clinical governance it highlighted four main dimensions of it including professional performance, resource allocation, risk management and patient satisfaction. However, subsequently many other elements have been incorporated as the concept has been rolled out into hospitals. Other elements include:

a. Patient involvement in service delivery.
b. Staffing and staff management.
c. Continuous professional development.
d. Clinical effectiveness.
e. Education and training.
f. Using available information.
g. Clear lines of accountability and responsibility for clinical care.

Even though extensive consideration has been given to the issue, no one recognised model of clinical governance is held up to be ideal. As a result, many hospitals may still face a situation of trial and error in their efforts to find a suitable clinical governance framework.

The Indian context

While there has been little or no research conducted on governance in Indian hospitals, the publication of several reports in recent years have exerted a motivational influence over the Indian governance reform program with respect to health care settings. Several key drivers of the governance reform program in India include the desire for value for money and reassurances about the way that resources are utilised. The performance of the Indian health service has been criticised over the last number of years as despite an increase in spending. A lack of patient satisfaction has also served to drive the reform program forward. Incidents such as unresolved waiting lists, the closure of hospital wards, the apparent lack of nursing staff, lengthy waiting lists and Accident and Emergency crises due in no small part to a shortfall of hospital beds, have all become familiar headlines in the press. In addition to the those outlined above, other generic issues such as the changing demographic profile of the country, an increasingly educated population and the expected higher standards that have come with the country's affluence have also contributed to the strengthening voice calling for reform.

Research Questions

The overall objective of this research was to assess the concept of governance in a hospital setting and what influences the processes and procedures of this phenomena. In particular, this study set out to answer the following questions in order to address the research objective outlined above.

1. The key drivers of hospital governance in internal environment
2. The key drivers of hospital governance in external environment
3. The main objective is to find to find the effect of various factors like doctor availability, medicine availability, age, income level etc on governance of hospital.

Research methodology

The study is conducted in the three major hospitals of Delhi. This is an exploratory research. The sample size is the three major hospitals of Delhi. Sample size is 264 including 50 doctors and sick persons. The period of study is 2013 and 2015. In order to test the dependency of the different factors on the governance of hospitals, we have used the logic regression method to study probability of the impact of different factors.

Data analysis and interpretation

Following is the analysis of data collected from the respondents. These themes were identified as the governance concept, what constitutes governance in a hospital setting, pertinent issues in the governance debate, and the role of clinical governance. These themes are studied with the help of statistical tools like regression.

Logistic regression

Logistic regression is generally thought of as a method for modeling in situations for which there is a binary response variable. The predictor variables can be numerical or categorical (including binary). Multinomial (aka polychotomous) logistic regression can be used when there are more than two possible outcomes for the response. Letting Y be the binary response variable, it is assumed that $P(Y=1)$ is possibly dependent on $\vec{x}$, a vector of predictor values. The goal is to model $p(\vec{x}) \equiv P(Y=1 \mid \vec{x})$ .Since Y is binary, modeling $p(\vec{x})$ is really modeling $E(Y \mid \vec{x})$, which is what is done in OLS regression, with a numerical response. If we model $p(\vec{x})$ as a linear function of predictor variables, e.g., $\beta_0 + \beta_1 x_1 + ... + \beta_p x_p$, then the fitted model can result in estimated probabilities which are outside of [0,1]. What tends to work better is to assume that

$$P_i = E(Y = 1|X_i) = \frac{1}{1 + e^{-(\beta_0 + \beta_1 X_1 + \cdots \beta_p X_p)}}$$

Which can be written as

$$P_i = E(Y = 1|X_i) = \frac{e^{(\beta_0 + \beta_1 X_1 + \cdots \beta_p X_p)}}{1 + e^{(\beta_0 + \beta_1 X_1 + \cdots \beta_p X_p)}}$$

$$P_i = E(Y = 1|X_i) = \frac{e^{z_i}}{1 + e^{z_i}}$$

$$where z = \beta_0 + \beta_1 X_1 + \cdots \beta_p X_p$$

Then

$$1 - P_i = E(Y = 0|X_i) = \frac{1}{1 + e^{z_i}}$$

Therefore, we can write

$$\frac{P_i}{1 - P_i} = e^{z_i}$$

Take logarithm

$$L_i = Ln\left[\frac{P_i}{1 - P_i}\right] = z_i = \beta_0 + \beta_1 X_1 + \cdots \beta_p X_p$$

that is, L, the log of the odds ratio, is not only linear in X, but also (from the estimation viewpoint) linear in the parameters. L is called the logit and hence the name logit model for models like. As *P* goes from 0 to 1 (i.e., as *Z* varies from $-\infty$ to $+\infty$), the logit *L* goes from $-\infty$ to $+\infty$.Although *L* is linear in *X*, the probabilities themselves are not.

The logit becomes negative and increasingly large in magnitude as the odds ratio decreases from 1 to 0 and becomes increasingly large and positive as the odds ratio increases from 1 to infinity.

In our case we used following logit model:

$$L_i = Ln\left[\frac{P_i}{1-P_i}\right] = z_i$$
$$= \beta_0 + \beta_1X_1 + \beta_2X_2 + \beta_3X_3 + \beta_4X_4 + \beta_5X_5 + \beta_6X_6 + \beta_7X_7 + \beta_8X_8 + \beta_9X_9 + \beta_{10}X_{10} + \beta_{11}X_{11} + \beta_{12}X_{12} + \beta_{13}X_{13} + \mu$$

Where

$$z_i = governace\begin{cases} = 1\ for\ average\ or\ below\ it \\ = 2\ for\ above\ average \end{cases}$$

$$X_1 = pharmacy03\begin{cases} = 1\ if \text{Medicine delivery time is } < 10\ mints \\ = 2\ if \text{ Medicine delivery time is } 10-15 \text{ mints} \\ = 3\ if \text{ Medicine delivery time is } 16-29 \text{ mints} \\ = 4\ if \text{ Medicine delivery time is } > 29\ mints \end{cases}$$

$$X_2 = pharmacy04\begin{cases} = 1\ if\ availability\ of\ medicine\ is\ excellent \\ = 2\ if\ if\ availability\ of\ medicine\ is\ good \\ = 3\ if\ if\ availability\ of\ medicine\ is\ fair \\ = 4\ if\ if\ availability\ of\ medicine\ is\ poor \end{cases}$$

$$X_3 = comfort\begin{cases} = 1\ if\ comfort\ is\ excellent \\ = 2\ if\ comfort\ is\ is\ good \\ = 3\ if\ comfort\ is\ fair \\ = 4\ if\ comfort\ is\ poor \end{cases}$$

$$X_4 = billing02\begin{cases} = 1\ if\ billing\ time\ is < 10\ mints \\ = 2\ if\ billing\ time\ is\ 10-15\ mints \\ = 3\ if\ billing\ time\ is\ 16-29\ mints \\ = 4\ if\ billing\ time\ is > 29\ mints \end{cases}$$

$$X_5 = doctor01\begin{cases} = 1\ if\ doctor\ is\ pleasant \\ = 2\ if\ doctor\ is\ friendly \\ = 3\ if\ doctor\ is\ warm \\ = 4\ if\ doctor\ is\ indifferent \end{cases}$$

$$X_6 = doctor02\begin{cases} = 1\ if\ explanation\ by\ doctor\ is\ excellent \\ = 2\ if\ explanation\ by\ doctor\ is\ good \\ = 3\ if\ explanation\ by\ doctor\ is\ fair \\ = 4\ if\ explanation\ by\ doctor\ is\ poor \end{cases}$$

$$X_7 = doctor03\begin{cases} = 1\ if\ addressing\ concerns\ is\ excellent \\ = 2\ if\ addressing\ concerns\ is\ good \\ = 3\ if\ addressing\ concerns\ is\ fair \\ = 4\ if\ addressing\ concerns\ is\ poor \end{cases}$$

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$$X_8 = assist_staff \begin{cases} = 1\ if\ assistance\ by\ staff\ is\ excellent \\ = 2\ if\ assistance\ by\ staff\ is\ good \\ = 3\ if\ assistance\ by\ staff\ is\ fair \\ = 4\ if\ assistance\ by\ staff\ is\ poor \end{cases}$$

$$X_9 = attitude \begin{cases} = 1\ if\ attitude\ of\ staff\ is\ pleasant \\ = 2\ if\ attitude\ of\ staff\ is\ friendly \\ = 3\ if\ attitude\ of\ staff\ is\ warm \\ = 4\ if\ attitude\ of\ staff\ is\ indifferent \end{cases}$$

$$X_{10} = regist02 \begin{cases} = 1\ if\ registration\ time\ is < 10\ mints \\ = 2\ if\ registration\ time\ is\ 10 - 15\ mints \\ = 3\ ifregistration\ time\ is\ 16 - 29\ mints \\ = 4\ if\ registration\ time\ is > 29\ mints \end{cases}$$

$$X_{11} = hh_{size} = household\ size$$

$$X_{12} = Monthly\ income$$

$$X_{13} = gender \begin{cases} = 1\ for\ male \\ = 2\ for\ female \end{cases}$$

Estimated Result

	Table 1:Average Marginal Effect[1]		
	Model 1	Model 2	Model 3
VARIABLES	Governance	Governance	Governance
pharmacy04	-0.0677**	-0.0772***	-0.0822***
pharmacy03	-0.0477		
Comfort	-0.168***	-0.174***	-0.121***
billing02	0.00385		
doctor03	-0.0892**	-0.0969***	-0.162***

doctor02	0.00392		
doctor01	0.0124		
assist_staff	0.0172		
Attitude	-0.0524		
regist02	-0.0354	-0.0525**	-0.0415*
hh_size	-0.00534	-0.00616	
Gender	0.0350	0.0488	0.0718
income_monthly			4.43e-07
Observations	219	227	136
Standard errors in parentheses			
*** p<0.01, ** p<0.05, * p<0.1			

From Table 1, gender and monthly income does not have significant effect on governance of hospital, i.e. wealthy patients will not improve governance significantly. Income level is positively related but not significant. As doctor quality decreases, governance of hospital will worsen. We have used household size and monthly income to capture the effect of poor standard of living on perception of governance. As both are expected to positively correlated with each other, we have used household size only in model 1 to avoid the problem of multicolinearity. The household size has negative but insignificant impact on governance. If we used monthly income then it has positive but again insignificant impact. So if a rich person comes to hospital then it will improve governance marginally. For perception of governance between male and female are not significant differ. So there is gender discrimination in treatment in hospitals under study. The quality of governance improves significantly if there is medical shop inside hospital. The quality of doctor, registration process, comfort level and pharma determines the overall governance of hospitals. So it is important for government to focus on quality of medical education, which must incorporate ethical sensitiveness also. In government hospitals, registration process is one of major problem, as indicated by this study also. So government must focus on this.

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This does not require radical changes in existing system, but hospital administration need to use information technology in registration process. Recently central government introduced the online registration process linked to AADHAR card in AIIMS. It will improve overall governance for patients and they can save their valuable time.

Conclusion

It is observed that as doctor quality decreases, governance of hospital will worsen. We have used household size and monthly income to capture the effect of poor standard of living on perception of governance. The gender and monthly income does not have significant effect on governance of hospital, i.e. wealthy patients will not improve governance significantly. Income level is positively related but not significant. The household size has negative but insignificant impact on governance. If we used monthly income then it has positive but again insignificant impact. So if a rich person comes to hospital then it will improve governance marginally. For perception of governance between male and female are not significant differ. So there is gender discrimination in treatment in hospitals under study. The quality of governance improves significantly if there is medical shop inside hospital. Thus it can be concluded that there are several factors which affect the governance of hospitals. The probability can differ but they impact the governance surely. The government and different stakeholders has to work for effective governance.

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