Divergent Paths to Quality: A Comparative Analysis of NQAS Implementation in Public Health Facilities and NABH Accreditation in Private Hospitals of Madhya Pradesh, India

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Abstract

Background: Madhya Pradesh faces a dual challenge in healthcare: expanding access in rural areas while ensuring quality in urban centers. **Objective:** This paper evaluates the quality assurance frameworks currently shaping the healthcare landscape in Madhya Pradesh (MP), specifically contrasting the National Quality Assurance Standards (NQAS) with the National Accreditation Board for Hospitals & Healthcare Providers (NABH). **Methods:** A comparative analysis of accreditation protocols, certification data from 2024-2025, and operational checklists was conducted. **Results:** Data indicates a significant surge in NQAS certifications (>1,200 facilities), driven by "virtual assessment" models in rural areas. Conversely, NABH accreditation remains "top-heavy," concentrated (70%) in urban tertiary care centers like Indore and Bhopal. **Conclusion:** While NQAS focuses on process-driven improvements in resource-constrained settings, NABH serves as a market differentiator for the private sector. A "middle-path" policy is recommended to bridge this quality divide.

Keywords: NQAS, NABH, Public Health, Accreditation, Quality of Care, District Quality Assurance Unit.

1. Introduction

The pursuit of Universal Health Coverage (UHC) requires not just financial protection but also access to quality health services. In Madhya Pradesh (MP), the healthcare quality landscape is bifurcated into two distinct operational frameworks. On one hand, the **National Quality Assurance Standards (NQAS)**, launched by the Ministry of Health & Family Welfare (MoHFW), aims to improve care in public facilities through a cost-effective, process-driven approach. On the other hand, the **National Accreditation Board for Hospitals & Healthcare Providers (NABH)**, a constituent of the Quality Council of India (QCI), sets high-end benchmarks comparable to ISQua standards, primarily for the private sector.

This paper aims to analyze the penetration, operational differences, and impact of these two standards within the state of MP.

2. Review of Literature

The global discourse on healthcare quality, as outlined by the **World Health Organization (WHO) Framework for Quality Improvement (2023)**, emphasizes the need for context-specific accreditation models. In India, studies by **Singh et al.** have highlighted the disparity between public and private sector service quality. While private hospitals often leverage accreditation for branding and insurance empanelment , public facilities utilize NQAS to secure funding through initiatives like "Kayakalp" and "LaQshya". The divergence in these paths—one driven by market forces and the other by public health mandates—creates a unique laboratory for study in MP.

3. Methodology

This study employs a **Comparative Framework Analysis** to evaluate the two standards.

- **Data Sources:** Secondary data regarding certification status (2024-25) was collated from NHSRC reports and the NABH Portal.
- **Operational Analysis:** The study compares the specific "Checklist of Documents" required for entry-level certification in both systems to understand the operational demands placed on hospitals.
- **Geographical Scope:** The analysis covers both rural districts (Panna) and urban centers (Indore/Bhopal).

4. Results: The Implementation Divide

4.1 NQAS: The "Bottom-Up" Expansion

MP has witnessed aggressive adoption of NQAS, particularly in lower-tier facilities. Current data reveals a "pyramid" structure of quality assurance:

- **Sub-Health Centers (SHC):** ~1,062 certified facilities, representing the highest volume.
- **Primary Health Centers (PHC):** ~108 certified.
- **District Hospitals (DH):** ~42 certified. This distribution confirms that NQAS is successful in permeating the rural health infrastructure.

4.2 NABH: The "Top-Heavy" Concentration

In sharp contrast, NABH accreditation is geographically skewed. Over 70% of accredited hospitals are located in Tier-1 cities (Indore, Bhopal, Jabalpur). Furthermore, smaller private nursing homes often opt for "Entry-Level" (HOPE) certification rather than full accreditation due to high barriers to entry. Industry reports suggest a 30% failure rate for initial audits due to infrastructure deficiencies.

5. Comparative Operational Analysis: Statutory vs. Process

A detailed examination of the required documentation reveals the core philosophical difference between the two standards.

5.1 NABH: The Statutory "Gatekeeper" Model

NABH operates on a binary compliance model focused on **Infrastructure Legality and Safety**.

- **Statutory Compliance (The "Go/No-Go" Gate):** Facilities must possess a Fire NOC from the Municipal Corporation and "Consent to Operate" from the **MP Pollution Control Board (MPPCB)**. Failure to produce an AERB license for X-Ray machines is a frequent stumbling block.
- **HR Credentialing:** The focus is on verifying degrees and MP Medical Council registration for all staff , alongside explicit "Privileging Documents" that define specific clinical rights for each doctor.
- **Safety Protocols:** Mandatory Infection Control Manuals and Disaster Management Plans must be in place.

5.2 NQAS: The "Continuous Improvement" Model

NQAS focuses on **Program Implementation and Outcomes**. It is more forgiving of infrastructure deficits if the clinical process is robust.

- **Documentation Focus:** The standard requires maintenance of 18 specific departmental files (e.g., Labour Room, SNCU) containing SOPs and duty rosters.
- **Quality Governance:** Monthly minutes of the District Quality Assurance Unit (DQAU) and "Action Taken Reports" (ATR) are mandatory to prove that gaps are being addressed.
- **Outcome Indicators:** Unlike NABH's policy focus, NQAS mandates the tracking of clinical data trends, such as C-Section rates and Patient Satisfaction Indices ("Mera Aspataal").

6. Discussion: Challenges and Economic Implications

6.1 The Cost of Quality

For private hospitals, NABH is a significant cost driver. Upgrading HVAC systems and fire safety infrastructure requires substantial Capital Expenditure (Capex). While accreditation boosts branding, the Return on Investment (ROI) is not always positive in price-sensitive markets like Gwalior or Ujjain. Conversely, for government facilities, NQAS is financially incentivized through grants. However, the "cost" is paid in human resources; nursing staff frequently report that heavy documentation burdens encroach upon patient care time.

6.2 Sustainability and Manpower

A critical challenge for NQAS is the sustainability of quality post-certification. Frequent staff transfers and the absence of permanent Quality Managers in smaller facilities often lead to a decline in standards. Additionally, rural CHCs face manpower shortages, forcing reliance on rotation doctors, which hampers adherence to continuous care protocols. In the private sector, a "training drain" phenomenon is observed, where nurses trained in NABH protocols migrate to government jobs, creating a retention crisis.

7. Conclusion and Policy Recommendations

The quality landscape in Madhya Pradesh is currently bifurcated. NQAS has successfully elevated the **baseline** of care in public health facilities, creating a "culture of protocol". Meanwhile, NABH remains a hallmark of **excellence** for the urban elite.

Future Recommendations:

1. **A "Middle-Path" Policy:** Private nursing homes should be encouraged to adopt NQAS-like basic standards if they cannot afford NABH.
2. **Convergence:** Government District Hospitals should aspire for NABH accreditation to compete effectively with the private sector in tertiary care.

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