

FRONTLINE

THE NATION

Published: July 24, 2013 12:30 IST | Updated: July 23, 2013 16:51 IST

PUBLIC HEALTH

Private care?



A. Muralitharan Young mothers with their just-born babies in the Upgraded Primary Health Centre at Medavakkam, Chennai. A file photograph. The NAC has recommended investing 70 per cent of health care funds at the level of sub-centres and PHCs.

The National Advisory Council recommendations seem to be making a strong case for a major role for the private sector in the delivery of health care. By T.K. RAJALAKSHMI

THE recommendations for universal health coverage drawn up by the National Advisory Council (NAC), headed by United Progressive Alliance (UPA) chairperson Sonia Gandhi, push for public-private partnerships (PPPs) in the health delivery system but not for any inbuilt mechanisms for accountability. The NAC also seems to be making a strong case for the private sector in insurance schemes on

the grounds of “unlocking supply constraints”.

The NAC Working Group claims to have drawn its inspiration from the Twelfth Five-Year Plan’s definition of universal health coverage as ensuring equitable access for all Indian citizens in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate and quality health services (promotive, preventive, curative and rehabilitative) and services addressing wider determinants of health delivered to individuals and populations, with the government being the “guarantor and enabler although not necessarily the only provider of health and related services”.

The emphasis here, health experts point out, has been on the last clause, which places the onus of providing such services on the private sector. According to the High Level Expert Group (HLEG) on Health Coverage in India, the core principles of universal health coverage include universality, equity, non-exclusion and non-discrimination in health care; comprehensive, rational and quality care; and provision for a cashless package at the point of delivery either by government or contracted-in private providers. The word “free” health care and regulation are poignantly missing in the NAC’s vision. Shockingly, the NAC has accepted the Twelfth Plan target of public health expenditure at 1.8 per cent of the gross domestic product (GDP). The HLEG report had recommended that government expenditure on health be enhanced at least up to 2.5 per cent of the GDP.

The Jan Swasthya Abhiyan, a broad coalition of individuals and organisations working on health, feels that the NAC recommendations are contradictory and that some of the crucial propositions are unjustified. It is critical of the watered-down chapter on health in the Twelfth Plan. It had hoped that since the NAC was an independent body it would go beyond the parameters set by the health chapter in the Plan document. While the NAC recommendations wax eloquent on the rapid expansion of the unregulated private sector dominated by a large number of unqualified professionals, it is silent on the urgent need to regulate the pharmaceutical industry and diagnostic centres and on the need to put an end to capitation fees charged by private medical colleges. Clearly, the recommendations lack a holistic approach. There is no mention of the integration of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) in the universal health coverage system, which is needed because the majority of AYUSH graduates end up in allopathic practice.

As part of its proposal for a “good package of Essential Health Care”, the NAC recommends investing 70 per cent of the funds for health care at the level of the sub-centre and the primary health centre (PHC). The sub-centre is envisaged as a gatekeeper to ensure that 95 per cent of the patients are fully cared for at this level. The Jan Swasthya Abhiyan points out that there is an emphasis on “strong performance pressure at all levels of the health delivery system”. Its argument is that it is wrong to make the under-funded PHCs carry out mandatory public health functions such as ensuring the quality of water and sanitation and catering to public health emergencies and then making them compete with the private sector for “capitation” payments as examples of community-based accountability mechanisms. The experience of the Arogyasri scheme in Andhra Pradesh showed that government health services were facing a severe resource crunch, with resources being diverted to the private sector.

The NAC suggests a hybrid combination of a state-owned delivery infrastructure coexisting with insurance schemes in a highly coordinated manner. It argues that incremental outcomes would not be visible. The Jan Swasthya Abhiyan’s position on this is that even where merging does not take place, the health outcomes of the Rashtriya Swasthya Bima Yojna (RSBY) or even its financial protection role is yet to be established. The HLEG had favoured the idea of rolling back insurance into the State health budgets but did not specify how it could be done. The NAC recommends merging the state-owned delivery apparatus into the insurance schemes. The problem is that the draft fails to explain the nature of this hybrid scheme and how it would deal with issues like “induced demand” and “moral hazards”. The HLEG’s recommendations of avoiding the purchaser-provider split and insurance have also been ignored.

The Jan Swasthya Abhiyan has argued that rolling back insurance into State health budgets is feasible and desirable. This would

ensure case-based reimbursements from a district untied fund, which would include incentives to the providers. The reimbursement can be made directly through a unit of the government and there is no need for an insurance company. The Jan Swasthya Abhiyan says that since the providers are public or not-for-profit hospitals and the reimbursement packages are modest, there will be no undue incentive for oversupply.

The NAC further proposes privatisation of sub-centres and PHCs and running them on the public-private partnership model. In its appendix on strengthening health systems, the NAC says that State governments need to assign top priority to ease supply-side constraints at the primary care level, using the PPP route as part of the empanelment process for the insurance schemes. The argument behind this is that the arrival of insurance will mean that privately owned hospital infrastructure will now start to grow because it will benefit from government-financed patient flow. The Jan Swasthya Abhiyan is completely opposed to this proposal, which it says is clearly aimed at making the health system amenable to private profit at the cost of the public exchequer. It has argued that public health logic demands that public financing should help the public health system to lead the provisioning of health services.

The model of the Healthcare Social Enterprise suggested by the NAC is identical to the managed care formulations in the draft of the Twelfth Plan, with a window for opening up primary health care to corporate players. The Jan Swasthya Abhiyan says that this will enable private providers who are the owners of HSE entities to use public purchasing to provide free service and free drugs as a ploy to force out smaller providers from the market who do not fall in line and join their HSE. Even the proposal to set up a National Health Regulatory and Development Authority (NHRDA) to replace the National Clinical Establishment Act is unclear and not an improvement over the existing legislation as many of the provisions in the latter are merely repeated in the proposed NHRDA. The Jan Swasthya Abhiyan argues that the presence of a strong and reliable public health system will itself check unregulated growth of the private sector and help in preventing unethical practices.

One good aspect in the recommendations is that the NAC suggests revisiting of conditions that are at present in force for sanction of funds by the Centre to the States. These conditions have to do with non-compliance in the deployment of human resource or facility-wise performance, which stipulate a reduction in outlay up to 7.5 per cent or up to 15 per cent. It says that keeping in with the principles of universal health coverage, it may be necessary to revisit such punitive conditions. It terms the conditions as ambiguous and non-measurable but, on the other hand, proposes three sets of core conditions. It suggests more flexibility as far as programme implementation plans (PIPs) are concerned but in the same vein suggests that flexibility should be there “to move resources from one head to another provided they comply with the essential deliverables under each head that has been agreed to in the PIP with the MoHFW [Ministry of Health and Family Welfare]”.

The NAC document recognises that per capita public expenditure on health in India is among the lowest

in the world. It admits that as a proportion of the GDP, public spending on health in India is less than that of most countries of the world; yet it does not recommend enhancing of this expenditure in substantive terms. It says that the government should ensure maximum allocations in the coming years, but without stating how much, such statements are at best homilies of intent.

Printable version | Jul 24, 2013 2:18:08 PM | <http://www.frontline.in/the-nation/private-care/article4945224.ece>

© Frontline