PUBLIC HEALTH

Managed care

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Health activists say the health chapter of the Twelfth Plan document exaggerates the role of the private sector in providing health care.

Patients waiting to receive free medicine at the Tuticorin Medical College hospital on April 7. The draft chapter on health talks about every citizen family being entitled to an essential health package where private and NGO health providers would also be empanelled to give the families a choice.
The draft chapter on health for the Twelfth Five Year Plan document not only is grossly inadequate in its approach but exaggerates to unrealistic levels the role of the private sector in providing health care. It invokes the concept of universal health care (UHC), but, critics say, it is far removed from even the basic tenets of such health care. However, what rankles health activists is that while the chapter claims to have referred extensively to the High Level Expert Group (HLEG) on UHC constituted by the Planning Commission itself, the document proves otherwise.

The Jan Swasthya Abhiyaan (JSA), a broad front comprising several organisations campaigning for health for all, said that the chapter failed to build on the recommendations of the HLEG and “misquotes the group’s recommendations in many places and ends by proposing a plan for restructuring the country’s health system that would effectively hand over health care to the corporate sector”. The HLEG, constituted in January 2011 under chairmanship of Dr K. Srinath Reddy, produced a comprehensive report in November 2011.

The draft chapter talks about the concerns that have been plaguing the health care system. Its prescriptions are, however, problematic. It says expenditure by the Centre and the States, both Plan and non-Plan, will have to be increased substantially. “It has already increased from 0.9 per cent of GDP [gross domestic product] to around 1.4 per cent [including expenditure on rural drinking water and sanitation]. This percentage needs to be increased to 2.5 per cent by the end of the Twelfth Plan.” The draft chapter recommends only a small increase in public expenditure from the present 1 per cent to 1.58 per cent of the GDP, in contrast to the HLEG’s recommendation of a 2.5 per cent increase during the course of the Plan.

It suggests that State governments spend far more in order to reach the targets. “Since expenditure on health by the State governments is more than twice the expenditures by the Centre, the overall targets can only be achieved if, along with the Centre, the State governments expand their health budgets appropriately. Central fund should, therefore, be designed to incentivise an increase in State government spending. Efforts would be made to find a workable way of encouraging cooperation between the public and private sectors through contracting of services, and also through various forms of PPP [public-private participation], while ensuring that there is no compromise in terms of standards of delivery, and the incentive structure does not undermine health care objectives.”

The JSA, which is represented in the HLEG, has trashed the draft chapter’s recommendation that the States should spend more and that the Centre’s contribution be made conditional on the States’ contribution. But of larger concern is the proposal to restructure the health system where a transition from “the present system, which is a mixture of public sector service provision plus insurance, to a system of health care delivered by a managed network”. The chapter claims to have been inspired by the HLEG’s recommendations, but HLEG members have denied this.

The chapter says the health strategy for the Twelfth Plan must “strengthen initiatives taken in the Eleventh Plan to expand the reach of health care and work towards the longer-term objective of establishing a system of UHC in the country”. This includes access to a defined essential range of medicines, which will be entirely free for a large percentage of the population, but the list of assured services, it says, will have to be limited owing to budgetary constraints.
There are two components underlying the document’s vision of UHC: “Preventive interventions, which the government would be both funding and universally providing, and clinical services at different levels, defined as an Essential Health Package, which the government would finance but not necessarily provide.” The JSA says this means that the government will have to confine itself to providing a small package of services and primarily be a purchaser of virtually all clinical services from the corporatised private sector. Thus, it says, the government will finance with public money and bolster an already resurgent corporate sector providing medical services, adding that this will “decisively halt and eventually reverse the moderate achievements of the NRHM [National Rural Health Mission] in expanding public health infrastructure and services in parts of the country”.

The chapter also talks about making efforts to find a workable way to encourage cooperation between private and public sectors through the contracting of services and also through various forms of PPP while ensuring that the standards of delivery are not compromised and the incentive structure does not undermine health care objectives. In the case of access to essential medicines, the government may contract private chemists, and drug supply would be linked to centralised procurement at the State level to ensure uniform drug quality and cost minimisation by removing intermediaries.

It talks about every citizen family being entitled to an essential health package where private and NGO health providers would also be empanelled to give families a choice.

The document, the JSA says, is strangely silent on drug price regulation, whereas the HLEG had recommended enforcement of price controls and price regulation on essential and commonly prescribed drugs and the incentivisation of the production of drugs and vaccines in the public sector. The chapter also talks extensively about expanding the Rashtriya Swasthya Bima Yojana (RSBY), a health insurance scheme, which appears to be the central thrust of its concept of UHC. But the HLEG had underscored the inflationary dangers of insurance schemes, especially in the absence of a focus on primary level, curative, preventive and promotive services.

**RSYB expansion**

The chapter boldly recommends the expansion of the RSBY. “The present Rashtriya Swasthya Bima Yojana, which provides “cash less” in-patient treatment for eligible beneficiaries through insurance, will need to be expanded to increase access to secondary and tertiary care. Its coverage was initially limited to the BPL [below poverty line category] but was subsequently expanded to cover other categories and this process of expansion would continue. It should be the objective of the Twelfth Plan to cover the entire population below the poverty line by RSBY,” it says. Under a section titled “Innovative models of financing: Public-Private Partnerships”, the health chapter says that PPPs offer an opportunity to tap the material, human and managerial resources of the private sector for public good.

“Health has now been included with other infrastructure sectors which are eligible for Viability Gap Funding up to a ceiling of 20 per cent of total project costs under a PPP scheme. As a result, private sector would be able to propose and commission projects in the health sector, such as hospitals and medical colleges outside metropolitan areas, which are not remunerative per se, and claim up to 20 per cent of the project cost as grant from the government. Some potential models for PPP in health care, covering PHCs [primary health centres],
diagnostic centres and hospitals have been identified and can be considered,” it says. The JSA has critiqued this form of innovative financing, saying that the only eligibility requirement is the location, not any contribution to public health goals.

There are some seemingly innocuous plans such as converting and expanding the NRHM into a National Health Mission. But the ideological bias, as the JSA says, is evident in the chapter when it says “a pure public sector delivery system involves funding a large public sector health system, with little incentive for the service providers to deliver a quality product”. The JSA argues that there is global evidence to show that the best performing health systems are publicly financed and where health care is almost entirely provided by the public sector or by a combination of public sector and non-corporate providers.

“We emphasised that cherry-picking will not help. A long-term vision was needed,” said Jasodhara Dasgupta, a member of the HLEG. The HLEG had discussed the issue of insurance thoroughly and was sceptical about the outcomes. Vandana Prasad and Amit Sen Gupta of the JSA said all the initial gains of the NRHM were reversed subsequently. There is evidence to show that many irrational procedures were conducted in order to claim the money under the RSBY, they said.

The concept of UHC, as outlined in the draft chapter, is fraught with problems though it has all the politically correct terms such as “determinants of health”. It says: “UHC builds on universal access to services which are determinants of health such as safe water and sanitation, wholesome nutrition, basic education, safe housing and hygienic environment, preventive services as immunisation, maternal and child health care. To venture UHC without ensuring access to determinants of health would be strategically a mistake, and plainly unworkable. Therefore, it would be prudent to realise the goal of UHC in two steps: First is the universal provision of Public Health Care encompassing high impact, preventive interventions which the government would be both funding and universally providing within the Twelfth Five Year plan; the second would be clinical services at different levels, defined in an Essential Health Package, which the government would finance but not necessarily directly provide. The latter would take two Plan periods for realisation, but a move in terms of pilots and incremental coverage can begin in the Twelfth Plan itself.”

It does not talk about eradicating out-of-pocket expenditure, although it admits that such expenditure on health care is a burden on poor families, and a regressive system of financing, which needs to be modified to tolerable levels in the Twelfth Plan. It also admits that “public expenditure on health is only about 32 per cent of the total, which is low by any standard”. The Eleventh Plan had a more grounded understanding of the situation. It had noted that the growth of the private health sector in India had been considerable in both provision and financing. “There was a flourishing private sector, primarily because of a failing in the public sector. The growth of private hospitals and diagnostic centres was also encouraged by the Central and State governments by offering tax exemptions and land at concessional rates, in return for provision of free treatment for the poor as a certain proportion of outpatients and inpatients. Apart from subsidies, private corporate hospitals receive huge amounts of public funds in the form of reimbursements from the public sector undertakings, the Central and the State governments for treating their employees,” it had said.

It also noted that “public spending on health in India is amongst the lowest in the world [about 1 per cent of GDP], whereas its proportion of private spending on health is one of the highest. Households in India spend about 5-6 per cent of their consumption expenditure on
health [National Sample Survey Organisation, or NSSO]. The cost of services in the private sector makes it unaffordable for the poor and the underprivileged.”

On the cost of treatment by households, the Eleventh Plan document quoting the NSSO (60th Round) noted that the average expenditure for hospitalised treatment from public hospitals was less than half that of private hospitals in rural areas and about one-third in urban areas. There were inter-State variations where the cost per hospitalisation in a government hospital was the lowest in Tamil Nadu (Rs.637 in rural areas and Rs.1,666 in the urban areas) and the highest in rural Haryana (Rs.11,665) and urban Bihar (Rs.30,822). The cost of hospitalisation in private hospitals was the highest in Himachal Pradesh (Rs.14,652 in rural areas and Rs.23,447 in urban areas) and the lowest in rural Kerala (Rs.4,565) and urban Chhattisgarh (Rs.4,359).

In March, the National Working Group of the JSA had called for a national debate on UHC. The meeting was categorical that even though tax-based financing was the most successful way to finance health, resource allocation to States needed to be equitable. It also rejected what it called “the currently fashionable and politically convenient insurance schemes for tertiary illnesses”, of the Arogyashri type or the limited hospital based coverage of the RSBY type. “We are aiming for health security and universal coverage.”

The working group was also critical of the HLEG proposal for a single capitation fee that would be paid to an integrated care provider as part of a “managed care” model, stating that it was untested and potentially fraught with problems of denial of care, which would be particularly difficult to monitor in the case of a private provider.

“We point out that in the current social and economic context the only possible integrated care provider other than the government is corporate entities, and given international and national experience with these, this is not desirable. We would limit private sector participation to essentially roles that are supplementary to the public system, where costs and quality of care are subject to monitoring and equity considerations are respected,” the working group noted.

The draft chapter on health cannot be finalised with so many loose ends and imponderables, especially when the recommendations will have far-reaching consequences. The least that should be done now is for the government to take the criticisms seriously and rework the basic orientation of the chapter itself, which, in its present form, militates against the notion of health for all.
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