Saving & Strengthening Public Health Services

AIPSN National Convention

Hyderabad

December 21-22

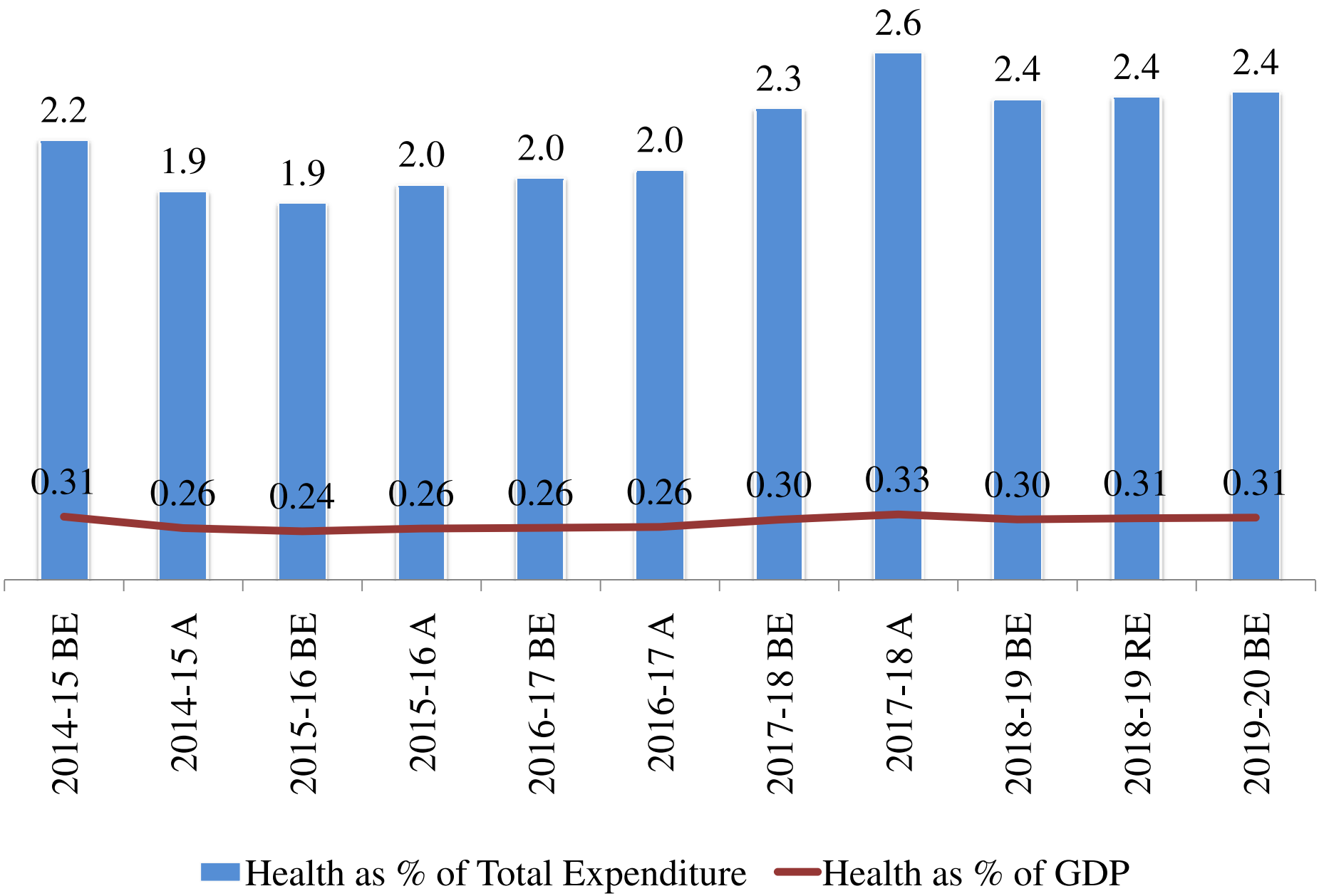
Public Services - Rationale

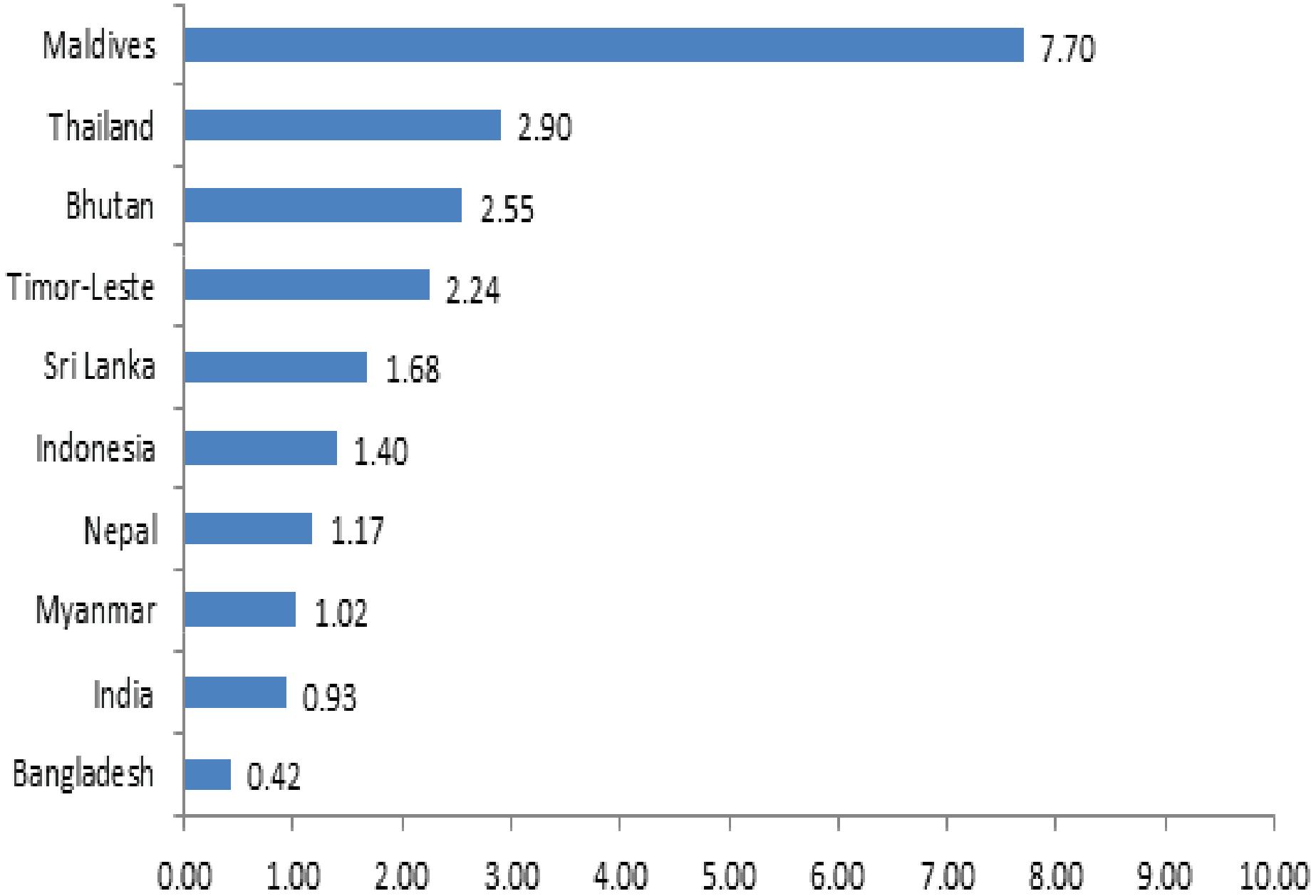
- Health fundamental to national progress as a resource for economic development
- Concerns of access and equity are addressed only within a rights framework - guaranteed by the state
- Healthcare services - market failure
- Basic services - State has the prime responsibility towards provisioning

Basic Facts – Macro Picture

- Public expenditure on Health by Centre and States (combined) 1.1% of GDP against required 4-5%
- Nearly 70% of healthcare provided by the private sector
- OOP expenditure nearly 60%; over 2% population shifts from APL to BPL every year due to high OOP expenditures
- More than 60 percent of OOP spending for healthcare is on medicines.
- Inadequacies of Infrastructure and Human Resources

Union Health Expenditure




Maldives
7.70
Thailand
2.90
Bhutan
2.55
Timor-Leste
2.24
Sri Lanka
1.68
Indonesia
1.40
Nepal
1.17
Myanmar
1.02
India
0.93
Bangladesh
0.42
0.00
1.00
2.00
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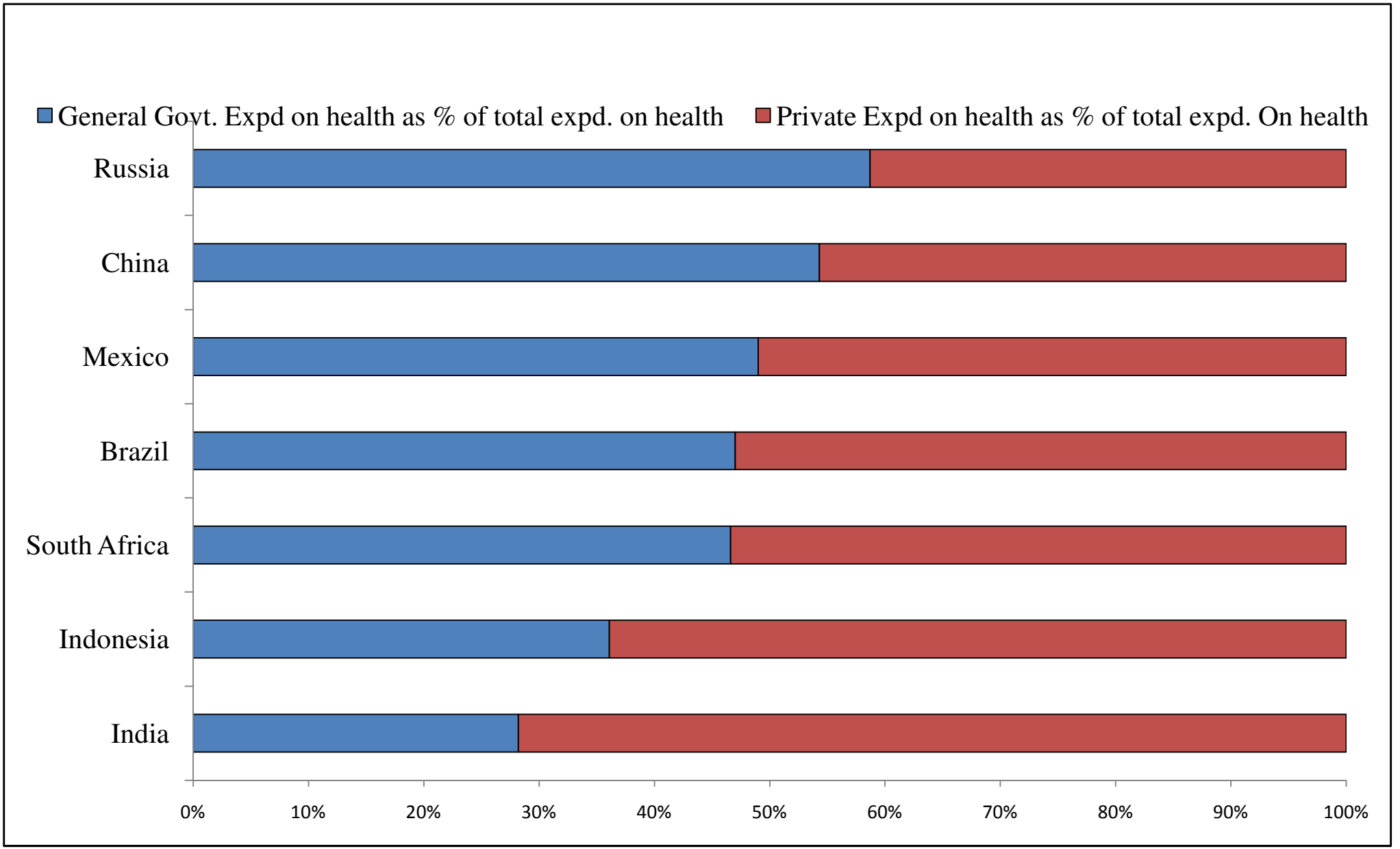
Lowest share of public expenditure and very high share of private expenditure on health in India



Is Privatisation Desirable - Evidence

- UN Report of the Special Rapporteur (2018)
  - privatisation has a negative impact on people living on lower incomes or in poverty
  - privatisation often involves the systematic elimination of human rights protections & existing human rights accountability mechanisms are clearly inadequate for dealing with the challenges
- WHO Framework of Health System:
  - accessibility and responsiveness;
  - quality;
  - outcomes;
  - accountability, transparency, and regulation;
  - fairness and equity; and
  - efficiency

Evidence

- Systematic review of studies across low and middle income countries (2012)
  - private sector delivery of health care does not come out to be more efficient, accountable, or effective than public sector delivery
  - providers in the private sector more frequently violated medical standards of practice and had poorer patient outcomes, but had greater reported timeliness and hospitality to patients
  - Efficiency tended to be lower in the private than in the public sector, resulting in part from perverse incentives for unnecessary testing and treatment
  - both sectors, financial barriers to care, and poor accountability and transparency

Average Medical Expenditure per hospitalisation case by type of hospital (Rs.)

Rural		Urban	
Public	Private	Public	Private
4290	27347	4837	38822

Availing of Services – Public or Private?

Percentage distribution of women aged 15-49 who gave birth during last 365 days by place of childbirth					
Rural			Urban		
Public	Private	Home	Public	Private	Home
56	24	20	42	48	11

Percentage distribution of cases of hospitalisation for childbirth by level of care for each social groups				
Social Categories	Rural		Urban	
	Public	Private	Public	Private
ST	57.9	15.1	46.6	48.9
SC	60.6	21.6	58.1	37
OBC	46.5	34.6	43.9	52.7
Others	50.8	37.4	36.2	60
All	52	30	43.6	52.5

Policy Orientation – Over the years

- Early decades after Independence saw –
  - development of medical colleges and tertiary care centres to generate the human resources
  - parallel investment in primary health care systems, though insufficient
  - focus on just two services - family planning and malaria control

- Decade of 70s & 80s saw –
  - Alma Ata Declaration
  - First NHP
  - Minimum needs programme – strengthening PHC

- Decade of 90s onwards –
  -Structural Adjustment Policies
  - Decreasing role of state (spending, regulation, and public ownership)
  - Declining transfer to states
  - Reduced expenditure on public health
  - Freeze in recruitments

Reduced care in government facilities – leading to privatisation

21st Century...

- **Characteristics at the turn of the century**:
  - Low public spending on healthcare (0.9% of GDP)
  - Unsatisfactory rural public healthcare system in many States leading to pauperisation of households due to expensive private sector healthcare.
  - Disparity across States in terms of availability of public resources for healthcare
  - Rising burden of non-communicable diseases (NCDs)
  - Deteriorating quality of healthcare services

• Thus, urgent need was felt to transform the public health system into an accountable, accessible and affordable system of quality services.

• In 2000, the goal of Health for All was still unfulfilled. NHP 2002 recognised this and the foundations for NRHM were laid.

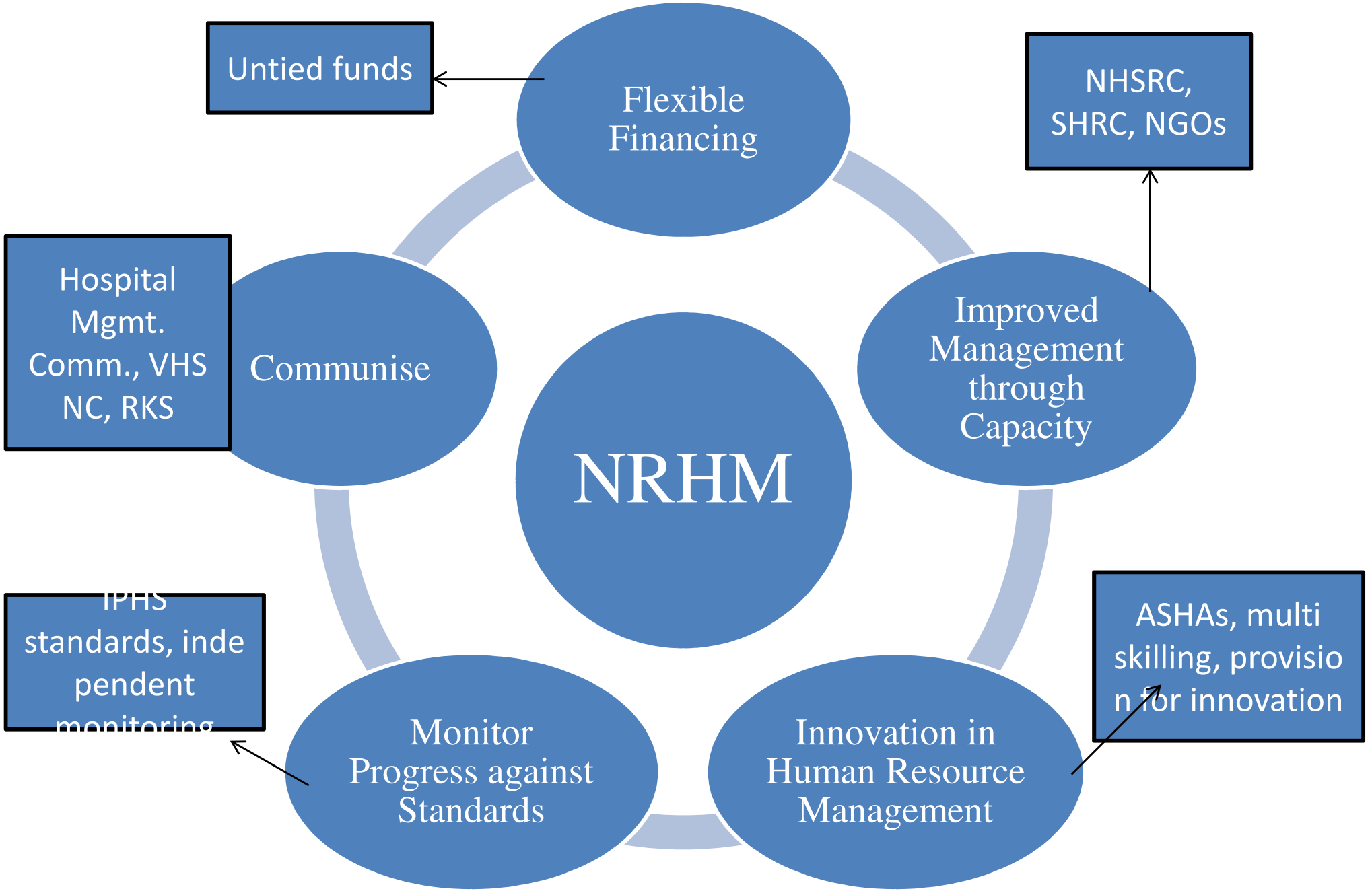
The NRHM…

- National Rural Health Mission (NRHM) introduced in 2005; The Mission sought to provide accessible, affordable and quality health care to rural populations, especially vulnerable and underserved population groups

- Key strategies:
  - bridge gaps in healthcare facilities,
  - facilitate decentralised planning in the health sector, and
  - provide an overarching umbrella to the existing disease control programmes run by the MoHFW

- In 2013, National Health Mission (NHM) – NRHM + NUHM

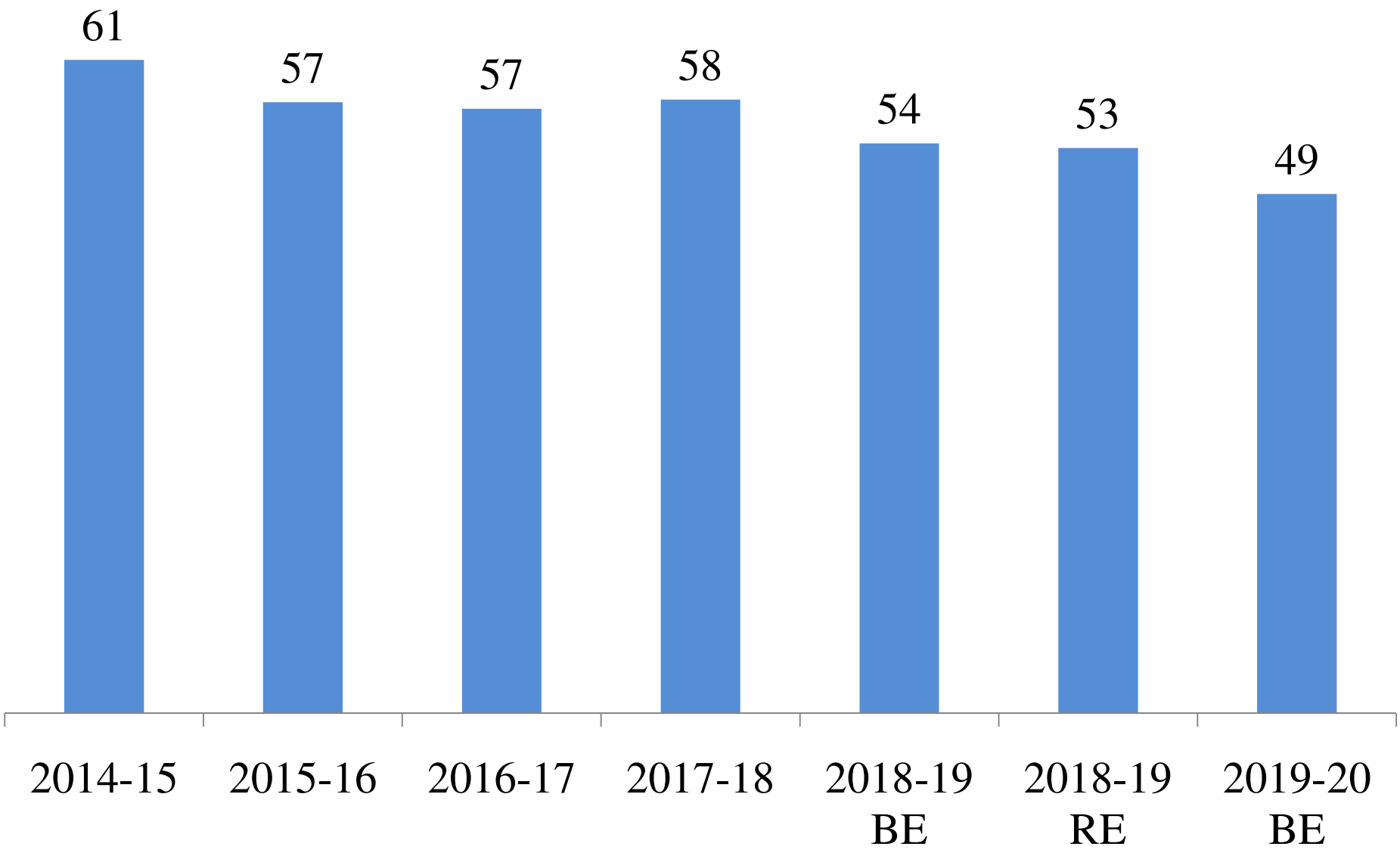
5-pronged Approach



Issues/Problems

- focus on selective healthcare approach and remained centred on programmes such as RCH, TB, HIV and vector-borne disease control
- inadequate budget outlays, further reduction in allocations
- lack of trained, regular staff for various important roles like programme management, finance/accounts and frontline service provision. Weakening capacity of the State government apparatus to effectively implement various NHM interventions
- contractual terms of employment, sanctioned vs vacant
- Allocations under NHM decided in a top-down and unrealistic manner. lack of need-based budgeting especially at the district and sub-district levels, often carried out without a survey of beneficiaries and proper analysis of unit costs on the ground.
- limited community participation in the planning processes.
- distribution of health care centres skewed – SCs, PHCs, CHCs and hospitals, increasing the footfall, sub-optimal services
- Quality of care – inbuilt mechanisms there but lack of funds exacerbates the problem

NHM as % of Union Health Budget



CAG Audit of NRHM

- Non-availability of medicine and equipments, essential medicines/ consumables such as Vitamin-A, contraceptive pills, ORS packets in select facilities

- Equipments lying idle/unutilised due to non-availability of doctors and trained manpower to operate the equipment

- ASHAs surveyed across States,
  - 83% did not have disposable medical kits,
  - 33% did not have De-worming pills

- Diversion of funds to other programmes (Andhra Pradesh, Gujarat, Jammu and Kashmir, Rajasthan, Telangana and Tripura)

- Under JSY, non-payment of incentive to beneficiaries, delayed payment to beneficiaries

- Contractualisation of labour with low remuneration

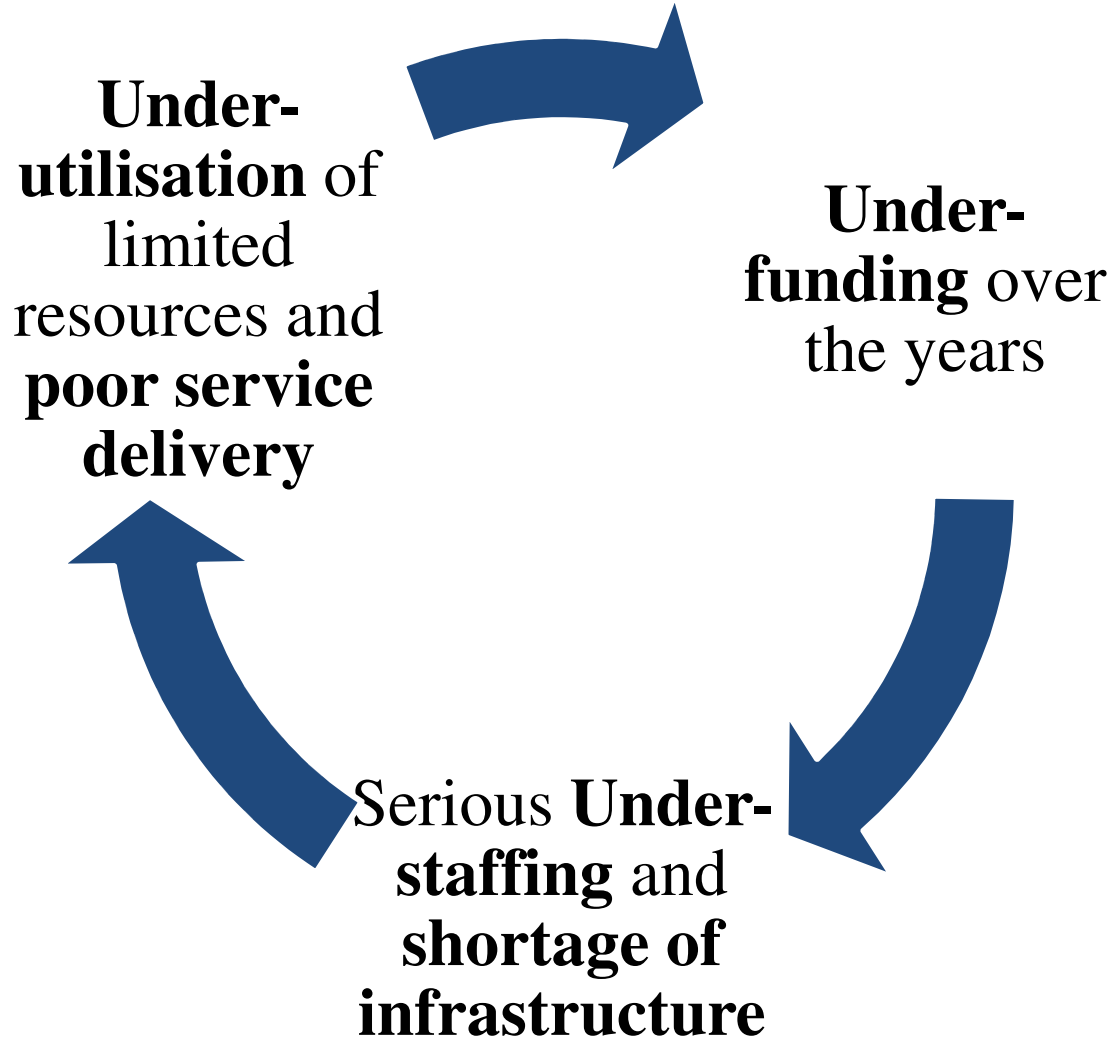
- At the all-India level, 11% of SCs; 16% of PHCs and 16% of CHCs functioning as per IPHS norms

- Shortfalls in Human Resources -
  - 85 % less physicians in position at CHCs against required
  - 74 % less obstetricians and gynaecologists in position at CHCs against required

- Delays in transfer of funds (50 to 271 days)

- Unspent balance

Problems of underfunding and under-utilisation of funds co-exist



Ayushman Bharat – PMJAY & HWCs

- The 2017 NHP had a clear thrust on insurance based model of healthcare

- Several publicly financed health insurance schemes have been launched in India such as:
  - Central Government Health Scheme (CGHS in 1954)
  - Employees State Insurance Scheme (ESIS in 1952). Primarily for Civil servants and formal sector workers
  - *Rajiv Aarogyasri* Health Insurance Scheme (RAS) in Andhra Pradesh
  - Kalaignar in Tamil Nadu
  - *Rajiv Gandhi Jeevandayee Arogya Yojana* (RGJAY) in Maharashtra
  - Chief Minister‘s Comprehensive Health Insurance scheme (CMCHIS) in Tamil Nadu and
  - *Rashtriya Swasthya Bima Yojana* (RSBY)

- Centre-State sharing ratio to be 60:40

Beneficiaries

- Expected target beneficiaries: about 10.74 crore families (approximately 50 crore beneficiaries)

- Entitlement to the scheme will be decided on the basis of deprivation criteria in the Socio-Economic Caste Census (SECC) database

  - Categories in rural area include:
    - families having only one room with kucha walls and kucha roof
    - families having no adult member between age 16 to 59
    - female headed households with no adult male member between age 16 to 59
    - disabled member and no able bodied adult member in the family
    - SC/ST households
    - landless households deriving major part of their income from manual casual labour
    - automatically included families in rural areas having any one of the following: households without shelter, destitute, living on alms, manual scavenger families, primitive tribal groups, legally released bonded labour

  - Categories in urban area include:
    - 11 defined occupational categories are entitled under the scheme

Issues & Challenges with Insurance-based Model:

- Funding priority to PMJAY means reductions or stagnation in allocations to other public sector programmes. Winding up of NHM?
- Data shows that most of the claims have been made in the private hospitals. The private hospitals largely operate in cities rather than in remote areas.
- Most reimbursements have happened for the upper quintile of population
- Urban bias – most claims from private hospital in cities
- The private sector has been demanding/negotiating higher package rates
- Exclusion: Patients from marginalised vulnerable backgrounds are turned down or their use discouraged by empanelled hospitals
- The distance of the empanelled hospital from the patient's home is also a factor that discourages beneficiaries.
- Multiple layers of intermediaries under insurance programmes- huge admin costs and avenues of profit

- Unnecessary care being induced, often with disastrous consequences on health

- Outpatient costs not covered. The cost of outpatient treatment, which the poor prefer over hospitalisation, forms 65 % of out-of-pocket expenditure in India (Brookings report, 2016)

- Most of the hospitalisation reimbursements are made by the upper income quintile

- A recent comprehensive review on various studies related to RSBY (Prinja, 2017) revealed that in majority of studies (8 out of 14) there was increase in Out of Pocket Expenditure related to RSBY.

- A WHO (2010) analysis estimated that up to 40% of health spending globally is wasted, with insurance fraud being a high contributor

Health &Wellness Centres

- Upgrade of all health Sub-Centres and all primary health centres into 1.5 lakh HWCs

- Indicative transition from selective healthcare into a comprehensive set of health care services

- Problem areas:
  - The current list of services not comprehensive enough
  - The budget allocated for upgrading the SCs to HWCs is grossly inadequate
  - The need for greater emphasis on preventive and promotive services is under-played.
  - The team of healthcare work force is not in place and not even planned for. There is neither a clear work distribution, nor the requisite training

Saving & Strengthening PHS

- Saving:
  - From the policy neglect – allocation and programmatic
  - From the discourse of inefficiency and non-accountability
  - From the onslaught of privatisation
  - From insurance-based model of healthcare

- Strengthening:
  - Increasing public provisioning
  - Comprehensive PHC
  - Ensuring decentralised planning – bottom up approach
  - Addressing the concerns of Health workforce
  - Addressing the concerns in medical education
  - Availability of affordable medicines and diagnostics

Key Concerns

- Increased responsibilities on States for financing of social sectors

- States with weaker fiscal health could witness lesser magnitudes of public spending on social sectors because of:
  - Their limited ability to mobilise own sources of revenue and,
  - Greater need for them to increase spending on core infrastructure sectors