

Jan Swasthya Abhiyan Action Alert

Dangerous drift in health policy

In July 2012, the Planning Commission released a draft of the Health Chapter of the Twelfth Five Year Plan. This draft chapter charts a dramatic change in the core principles and strategies of health care policy and provision in India. Instead of charting a course that would fulfil the government's responsibility of providing health care, it proposes a system of "managed care" and "managed competition" in which the government will function as the purchaser of health services from organised networks of public and increasingly private and corporate health providers. In doing so, the chapter clearly **signals a plan to radically restructure India's health system with an emphasis on greater privatisation and corporatisation of health care services.**

The 'July Draft', which boldly advanced proposals that blatantly avoided or selectively interpreted the views of the consultative groups and processes established by the Planning Commission itself to guide the task of plan formulation, was immediately received with great concern and strong opposition. Even the Ministry of Health, which bears accountability for both making the Plan and implementing it, registered its sharp disapproval on the tone and content of this document. Experts and civil society organisations, including the Jan Swasthya Abhiyan (JSA), registered their deep disagreement with the intent and directions expressed in the draft chapter and these serious criticisms were widely reported in the media. As a result, the chapter is currently being reviewed and re-written.

Even as this process of redrafting is underway, it is vital to conduct an informed public debate as regards the key proposals in the Planning Commission's draft chapter. It is important because the Planning Commission's draft proposes a fundamental shift, and in many ways an ideological shift, in public policy as regards health and health care. If at all such a shift is to be proposed, it needs to be discussed and debated in the public sphere and in the nation's Parliament.

While opposition from different quarters may still re-shape the final version of the Health Chapter in the 12th Five Year Plan, the idea of and the investment in the concept of the "managed care" approach in India is unlikely to recede. On the contrary, efforts to establish these models will be actively promoted, and this will be done under the rubric of extending Universal Health Coverage (UHC) and enhancing performance. For example, in the same week as the Planning Commission's draft chapter became available, a leading financial daily published four articles, building support for managed care, but much more carefully and cautiously positioned, than the rather blunt and straightforward articulation that was presented in the July draft. In the coming weeks and months we can expect many more such defences of the managed care model to emerge, designed to create a false consensus. We know from global experience that moves to systematically weaken public systems and to privatise and corporatise healthcare, usually depend on the covert and undemocratic introduction of structural changes. Such moves count on a public that is largely uninformed of the processes and consequences of these transitions until the effects are impossible to ignore. This is especially so since the language and terms used are difficult to decipher and the goals often appear aligned to notions of 'universal access', whereas the eventual outcomes could not be more different. At this critical juncture, therefore, an informed and sustained public dialogue on the present and future of India's health system is of utmost urgency and importance.

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This brochure is an attempt to initiate such informed public discussion. Drawing on Indian and international evidence and experiences, it puts forward the JSA's understanding on four key aspects of the draft chapter and explains briefly what is at stake in each case:

1. The shift to a system of 'managed care' and 'managed competition'
2. The implications of expanding insurance schemes such as the Rajeev Gandhi Swasthya Bima Yojana (RSBY) and Public Private Partnerships (PPPs) in health care services.
3. The proposed levels of public expenditure on health
4. Approaches to strengthening public health systems

Understanding 'Managed Care'

What is managed care? How will it be delivered? What does international experience with managed care tell us?

The Planning Commission's draft Health Plan proposes a fundamental shift in the way in which health services are to be financed and provided in India, a transition to be initiated in the Twelfth Plan period and built upon and expanded subsequently. It envisages a "*shift from the present system, which is a mix of public sector service provision plus insurance*" towards "*a system of a network of health service providers at the primary, secondary and tertiary level, which is funded on the basis of a per capita payment to the network.*"

In conjunction with other proposals in this Draft Chapter, this proposal would take India along the American/Mexican path of 'managed care' -- of progressive privatization/corporatization of health care. *Managed care* (first developed in the United States, but now also promoted in some other parts of the world), "**sees the state as a proxy collective purchaser of a wide range of care processes from competing commercial providers**¹".

In India, this would mean that, over time, the government would move away from its role as a provider of health services, except for a limited number of primary, preventive interventions to act as the purchaser of healthcare. Most of the health care services will now be organised in competing, commercially viable healthcare networks. This is how the "July Draft" describes the approach:

"The principle on which the system works is that if there is a large enough pool registered with a network the likelihood of diseases of different types is known and the cost of dealing with them can be worked out, and the total cost can be covered by a per capita payment. Once enrolled, the individual's health problems are handled by the network as a whole, with proper regard to the need for preventive care and a sequence of care from primary to the higher level as needed. An important element in the system is that access to higher levels of care is through a referral system at the lower level. An effective MIS system, available to every service provider in the network, ensures rational treatment taking account of the entire history of the patient. The network can consist of public sector service providers plus such private sector providers who are contracted in on per-specified terms."

¹ The Political Economy of Health Care: Where the NHS Came from and Where It Could Lead, Julian Tudor Hart, The Policy Press, 2010: 6

Furthemore, it explains:

“The budget of individual public sector health care providers would no longer be covered by the state government. Instead, a share of the total payment to the network will be paid to each provider at each level based on the initial choice of the insured person of the preferred provider. In principle, units that do not get enough patients registered with them will be starved of funds.”

And this is what it will deliver:

*“Cashless delivery of an Essential Health Package (EHP) to all resident families ought to be the basic deliverable in all models. Since the frequency of use of services, nature of service delivery and cost of services are fundamentally different for out-patient (ambulatory) and in-patient care, the EHP should be built separately for the two. Given the fact that out-patient care is a major element of household's out-of-pocket and catastrophic expenditure on health, it would be the endeavor of the Government to first target ambulatory EHP to all citizens. **Beneficiary families would have choice to avail of a top-up package by paying a premium.**(emphasis added)”*

In order to work out network models, the chapter proposes that states be incentivised to take up different district-level “pilots,” which will have the following common elements:

To quote : “

- The use of output-based provider payment that allows government to pay providers based on what they produce as well as use payment mechanisms that drive efficiency and quality;
- Patient choice which can lead to provider competition;
- Separation of payment and provision functions;
- Purchasing services from public and private providers;
- Provider certification and independent regulatory agencies;
- Use of monitoring systems that focus on outputs and outcomes, rather than inputs; and
- Promotion of a new management culture based on purchasing and contract management.”

Why should we have objections about this radical and new model proposed by the Planning Commission? If the government is committed to financing a system that will ensure cashless access at the point of service for the citizen, why does it matter who the provider is? Isn't “patient choice” a good thing? Moreover, shouldn't the promise and prospect of incentives and strong regulation to generate such integrated networks and to manage competition be adequate to ensure against poor performance and profiteering? All that is being suggested are a few ‘pilots’ over the next few years, so why this panic? The disarming and ‘reasonable’ nature of explanations provided by the votaries of this model merit more detailed analysis.

What does the international experience with managed care tell us?

There is a significant body of evidence and experience emerging from countries with different models and at different stages in transitions to health systems with managed care and managed competition which provide lessons that we cannot afford to ignore. We highlight some of these below:

Composition and character of the health system: The first thing that a managed care approach does is to gradually but perceptibly change the basic composition and character of a country's health system. With the separation of financing and provision and the introduction of managed networks of public and private providers competing for the same patients, commercial considerations dominate health facilities and determine their survival. In other words commercial sustainability is the ultimate ‘bottom line’ to be aspired for. **Public facilities must therefore begin to work with this ‘bottom line’ at the top of their**

agendas, thereby fundamentally altering their central mandate to function as a *public* service. For example, if gaining resources and economic viability is the target, then it would make sense for the provider to concentrate on a few patients with high value diseases that provide substantial returns, then cater to a large number of poor persons with diseases which are expensive to treat and profit margins are low. Even the best public hospitals, typically, lose out to private providers with aggressive marketing strategies. Indeed, these integrated and large-scale network models play to the strengths of commercial and organisational capacities of corporate healthcare conglomerates that crowd out smaller private providers at first and then the public sector.

Range, quality and access to health services: Related to the changing character of the health system and directly linked to the system of costing and purchasing services from competing health provider networks are a number of short and long-term effects on the quality of care:

- A) In the short-term, as suggested in the ‘July draft’, different packages of services (preventive versus clinical/curative; out-patient versus in-patient, etc.) are purchased and provided in separate packages, thereby fragmenting the health system and service delivery, compromising the quality of healthcare where such divisions are unsound – medically, financially, and socially. The proposed massive expansion of RSBY would certainly deepen and further accentuate an unhealthy division between primary and secondary/tertiary health services.
- B) As the networks expand, the range of services covered by health plans under “Essential Services Packages” tend to contract rather than to expand. “Free services” become more limited, while “top up” payments and premiums are introduced to offer patients who can pay a greater range of services. The ploy is simple – offer a few basic essential services and ensnare patients, who then have to pay to access the necessary range of services. In Mexico, for instance, under this system, the clinical package includes only 200+ services in contrast to over 2000 currently covered by insurance under the RSBY scheme in India. In recent months in the UK, plans to introduce a ‘market orientation’ into its National Health Scheme (NHS), have led to a progressive reduction in publicly financed services.
- C) The public sector is increasingly ghettoised into only providing preventive and promotive services. Notwithstanding the rhetoric about preventive and promotive care being extremely important as means to reduce overall disease burden (and therefore costs for the network), the quality and span of these services -- as provided by a network organised on managed care principles -- are ratcheted down progressively as their costs are reduced to a minimum.
- D) Since the networks are paid a per capita payment for every individual registered in their system, the real profits come from “top ups” and premiums from those who can afford to pay, as well as from cost-cutting measures in the “essential package”. Patients who cannot afford ‘top ups’ are denied advanced and relatively expensive procedures. These acts of denial are often disguised as expert diagnoses that understate the severity of illness or the availability of more expensive options for patients covered only by “essential” plans. Since referrals determine a patient’s access to higher levels of care within the network, patients are at its mercy with no real choice regarding treatment options. Meanwhile, the ‘clinical judgements’ of providers, needless to add, are exceedingly difficult to monitor and regulate. Standard treatment protocols are useful aids for improvement of quality of care. However, as means of standardising for purpose of purchasing and regulation – to prevent ‘milking’ of the system by providers for profit maximisation -- they are singularly useless.
- E) As cost-cutting and profit-making come to shape the supply of health services, the effects on access and equity become more visible. This is the experience from across both developed

and developing countries that have switched to such models as quality of care becomes ever more differentiated according to income.

The story regarding people who access care from the private sector in India, especially from the corporate hospital sector, is very similar barring one fundamental difference. India has one of the most privatised health systems in the world in terms of health expenditure.. But this is the result of an unacceptable public health policy that progressively under-invested and actively, as part of structural adjustment policies, undermined the ability of the public health system to provide comprehensive health care to all. Despite this, the public health system still operates within the logic of a public system (i.e. publicly financed and provisioned). At present, the failure of health care in India is NOT a consequence of an explicit policy designed to promote a corporatised health system in the name of Universal Health Care. The public health system in India has great scope for improvement if properly supported. In contrast, a model of ‘managed care’ largely to be delivered by the corporate private sector will eventually leave no room for maneuver.

Box 1: Managed Care in the United States

Managed Care seems to be one of the United State’s most prominent exports and their model has been favourably quoted in the Planning Commission’s July Draft. But what has this meant for the character and quality of the US health system?

Roughly 28 percent of the total US population has no insurance coverage and is not part of any capitation fee-paid health plan. Another 34 percent of the population is insecurely enfranchised: were these individuals to suffer from serious illness, the insurance cover or health plan is not likely to work for them. Only 38 percent of the total population has access to a secure private “managed care plan” – these are usually college-educated, high-income employees paid for by companies or self-insured high income individuals, or well-to-do retirees who have a medicare plan with a top-up premium. (It is important to note, in the US, where the hold of health insurance companies is extensive, the difference between an insurance premium and capitation fee is not too significant.)

Arnold Rehman, former editor of New England Journal of Medicine, quoted in a recent report, had this to say about the managed care health system in the US:

"In all parts of the system, the providers of care see themselves as competing businesses struggling to survive in a hostile, economic climate, and they act accordingly. The predictable result is a fragmented, inefficient and expensive systems that neglects those that cannot pay, scrimps on the support of public health services and medical education, and has all the deficiencies in quality that are so well described and analysed in this report. It is a system that responds more to the financial interests of investors, managers and employers than to the medical needs of patients."

Costs of Care: While the managed care model is held out as ‘more efficient’, actually it reposes a greater burden on the public budget than the current system. Simply put, evidence from around the world shows that it actually costs more for the government to purchase care than to provide it, even as the range of services shrinks and out of pocket costs to patients – whether in the form of co-payments, top-ups, or private fees for services not covered – remain considerable. In the US, for instance, health care costs account for about 15 percent of the GDP, of which public expenditure is 7.26 percent of GDP (\$ 3,200 per capita). **In spite of the huge health care expenditure in the US, including substantial public expenditure, the US health system is widely acknowledged as the most expensive and wasteful in the entire developed world -- a clear consequence of the managed care model that the US has pursued. The Columbian experience with managed care has been even more disastrous. Total expenditure on health as a percentage of GDP was at 3 percent during the period 1990–1995. The reforms, initiated**

in 1993, saw health expenditure almost double to 5.5 percent of GDP by 1997, while health care coverage remained below 55 percent and actual treatment rates decreased².

Mexico is often cited as one important success story of the managed care model. While holding out the 'success' of the Mexican model, what is glossed over is the fact that the range of services available under the managed care scheme (*Sergio Popular*) includes a very limited package of care -- and covers only some 30 percent of the population with large exclusions, both of diseases and of populations. The total cost of healthcare in Mexico is 5.9 percent of GDP, and the public share is 2.8 percent of GDP (in absolute terms \$393 per capita). In contrast, India spends 4.2% of its GDP on healthcare, with 1.36 % being the public expenditure (only \$ 40 per capita). If we look at examples of countries where government hospitals and service providers provide over 95% of in-patient health care, the levels of public health expenditure required for universal health coverage are attainable. Thus Sri Lanka and Thailand both have a total health expenditure of 4.1 percent of the GDP, with Sri Lanka's public share being 1.79 % of GDP (\$80 per capita) and Thailand's public share being 3.04% of GDP (\$244 per capita). *(All figures taken from World Health Statistics for consistency -- we note that these figures for India are different from what is commonly quoted).*

Furthermore, given the design and regulation requirements of the managed care system, a high proportion of public health expenditure would go towards covering administrative costs, as well as dividends, profits and capital assets of corporate owners. This would mean that public health expenditure would show up as increasing, but the actual expenditure on people's health needs would be far less than it should be.

Box 2: Why Panic? It's Only a Pilot!

Acknowledging that a transition to a managed network of health providers will only take place over two to three Plan periods, the 'July Draft' proposes to initiate the process with the seemingly mild suggestion of experimenting with a few district-level pilots. Surely this is the most reasonable way to proceed, by learning from the ground? **The experience of marketising health systems and pushing through major changes elsewhere, however, reveals that pilots may be a less tentative step than they might initially appear.**

Indeed, across the world, many countries seem to have been similarly persuaded to take up such managed care pilots. In the UK, as a recent book on the privatisation of the famed NHS explains, pilots had a major role to play in the process:

"Another device used to head off opposition has been 'pilots'. Some of the main steps in marketisation have been introduced as pilots, sometimes with a specific commitment to evaluate them before they are 'rolled out' nation-wide, which is then ignored. The tactic was eventually used to overcome opposition to involving private companies in PCT (Primary Care Trust) commissioning. The scheme was supposed to start in just seven 'pilot' PCTs, which the Department of Health and the Treasury could evaluate to see if it offered 'value for money.' But in March 2008, when only one pilot had even begun, let alone been evaluated, Alan Johnson announced that the scheme was to be rolled out nationally." (Leys and Player 2011: 110)

In India too, hasty scale-ups in health are not a new phenomena. Indeed, as the next section on health insurance under the RSBY scheme explains, evaluation is hardly a pre-requisite for rolling out programmes that affect millions of citizens and change the character of the health system.

² http://idesal.uphero.com/docs/article/88/176_co_20100516_Colombia_privatization.pdf

Health Insurance, RSBY and PPPs

As an interim measure, as the Indian health system transitioned to managed care, the Planning Commission's draft chapter calls for the expansion of health insurance coverage to the population under the RSBY scheme and for a concerted expansion in the number of PPPs in health. In the case of insurance, the proposal is indeed most contradictory, as the chapter concedes that in the longer run it may indeed be necessary to move away from an insurance-based fee-for-service model, a point that has been emphasised in the report of the High Level Expert Group (HLEG). And yet, here, over the next five years, the Plan proposes a massive expansion in health insurance under a scheme that needs to be very carefully reviewed and evaluated rather than being immediately scaled up.

In India, only 16 percent of the population was estimated to have access to any health insurance coverage at all. The Rashtriya Swasthya Bima Yojana (RSBY) was introduced in 2007 and was intended to provide health insurance for poor families. As the draft chapter notes:

“RSBY provides for “cash-less”, smart card based health insurance cover of Rs 30,000 per annum to each enrolled family, which can enroll up to five individuals. The beneficiary family pays only Rs. 30 per annum per family as registration/renewal fee. The scheme covers hospitalisation expenses (OPD expenses are not covered), including maternity benefit, and pre-existing diseases. A transportation cost of Rs. 100/- per visit is also paid. The premium payable to insurance agencies is funded by Central and State Governments in 75:25 ratio, which is relaxed to 90:10 for the North-East region and Jammu & Kashmir. The maximum premium is capped at Rs. 750 per insured family per year.

RSBY was originally limited to BPL families but was later extended to building & other construction workers, MNREGA beneficiaries, street vendors, beedi workers, domestic workers. The scheme is currently being implemented in 24 States/UTs. About 3 crore families have been covered as on date and 38 lakh persons have availed hospitalization under the scheme till June 2012.

A key feature of RSBY is that it provides for private health service providers to be included in the system, if then meet certain standards and agree to provide cash-less treatment getting reimbursed by the insurance company. This has the advantage of giving patients a choice between alternative service providers where such alternatives are available. Several State Governments (such as those of Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu) have introduced their own health insurance schemes, which often have a more generous total cover.”

Given the rapid roll-out and reach of the RSBY, what is the problem with the proposal to continue to scale up the scheme and to use the RSBY platform to cover all BPL families in the Twelfth Plan Period?

The Planning Commission's own draft begins by stating that there is a well-established problem with any “fee for service” payment system financed by an insurance mechanism because it provides incentives for unnecessary treatment, leading to spiralling costs and premiums. The evidence, in the case of RSBY too, they admit points to this process and therefore needs to be very thoroughly studied before there is further expansion. Yet, a few paragraphs later, the **Planning Commission's draft calls for massive expansion of the current RSBY scheme across the country, even as several reports regarding its performance thus far raise serious concerns!**

Most reports about the RSBY indicate that there has been a substantial transfer of patients, particularly for some procedures, into the private system and away from the public sector. What is most worrying about this trend is that under RSBY, care is only provided for certain disease groups, often those that are more convenient and profitable for private providers. Simultaneously there is considerable denial of care in cases where provision proves inconvenient for private providers. It appears that “demand” is being actively shaped by the treatments that private healthcare providers want to supply rather than by the health needs of the insured population. For instance, in many districts from where anecdotal reports have been coming in, we find a pattern where very few life-saving caesarian sections are being performed under RSBY. Women continue to die from obstructed labour because casearian sections are not lucrative options while there is a massive increase in unnecessary hysterectomies (removal of the uterus) across all RSBY districts. There is a strong likelihood therefore that the money invested in RSBY will create – and is already creating – a new, market-oriented health system based on providers’ profitability rather than covering existing needs and the actual catastrophic health expenditures of the poor across the country.

In such a situation, the lack of robust monitoring in the present system is shocking as the task of monitoring and fraud busting is left to the insurance company, giving rise to grave concerns about widespread insurer-provider collusion. At the same time, it is very clear that there is not a single district where the RSBY has been rolled out where a District Public Health Officer is informed or can even access information about the caseloads of each disease treated under this scheme. Already, the hiatus between public health and clinical medicine is complete and growing – and is firmly linked to private sector interests.

Instead of subjecting the RSBY to the strongest, independent evaluation possible, however, the Planning Commission is pushing for its unqualified expansion as a necessary “interim measure,” using it as a model for private sector engagement in healthcare provision, and encouraging the spread of other, equally unevaluated approaches to Public-Private Partnerships as an essential plank of the Twelfth Plan Health Strategy.

Box 3: Passing off Health Insurance as Health for All

The promotion and expansion of health insurance through RSBY has yet another critical implication for both the diminishing meaning of health for all and the role and responsibility of the government in ensuring that it is truly achieved.

The International Peoples Health Assembly held at Cape Town in July 2012 had warned precisely of this form of distortion of the meaning of universal health coverage. To quote: *“While we welcome the recent upsurge of interest in the concept of universal health coverage, we oppose the idea that this be achieved through the promotion of a minimalistic insurance model that would operate within a marketized system of health care, or worse still, be used as a context or excuse to dismantle or undermine public hospitals and promote corporate interests in health care delivery. Universal health coverage must be achieved through organized and accountable systems of high quality public provision.”*

A recent article that announced that by extending health insurance coverage through RSBY to the entire state, Chhattisgarh would attain “Health Cover for All from October 2012” illustrates that such a danger is not notional. (*Economic Times*, 8 August 2012). Chhattisgarh, we must bear in mind, is a state with the highest maternal and under-5 mortality rates not only in the country but anywhere in the world! Though it has made impressive progress in the community front, it is struggling to build up a minimum number of functional public health facilities. Studies from Chhattisgarh have questioned the health outcomes or social protection being achieved by RSBY there and shown that a large part of the expenditure is going to non-priority health needs which are defined by providers.

Public Expenditure on Health

Across the board, it is well acknowledged that India has for too long had among the lowest levels of public expenditure on healthcare in the world and that the government's financial commitments in this sector must significantly improve (see Table comparing public expenditure on health as percent of total expenditure on health in India and in other regions). **One of the central goals of National Health Policy and the National Rural Health Mission has therefore been to increase public health expenditure to 2 to 3 percent of GDP.** This has been a common target – as Working Groups, the Steering Committee, the High Level Expert Group (HLEG) and even the Planning Commission's own Approach Paper to the Twelfth Plan emphasised and indeed promised a substantial push to increase public expenditure on health to 2.5 percent within the Twelfth Plan Period. **Against this stated commitment, the 'July Draft' falls well short of this mark. It puts the current public health expenditure at 1.06% of the GDP with 0.33 percent as the central share and goes on to raise it to only 1.58% of the GDP with the central share being only 0.7 percent.**

Table: Percent Public Health Expenditure

Country/Region	Public Expenditure on Health as percent of total health expenditure
India	29.20
Average of High income countries	65.10
Average of Low income countries	38.78
Average of Middle income countries	52.04
World	62.76

Source: World Bank Database (<http://data.worldbank.org/>)

Over the years states have been starved of funds through a variety of fiscal mechanisms, but even during the 11th Plan period the states actually performed better than the centre in allocation of funds for health care. The Eleventh Plan had projected an allocation of 0.87% of GDP by the Centre and 1.13% by States by 2011–12. At the end of the Plan period the allocation stood at 0.32% of GDP by the centre and 0.68% of GDP by states. The major shortfall was a consequence of the meagre Central allocation.

The Planning Commission now proposes that the share of the States would increase from the current 0.68% of the GDP to 1.08 of GDP (slightly below the 11th Plan projections). It also proposes that the central allocation would be 0.5% of GDP (well below the 11th Plan projections). **Thus while projecting a large increase by the states, it pegs the central allocation significantly lower than even the 11th Plan target. It is not clear why the states, which have relatively less scope to increase revenue are expected to increase allocations significantly, while the central allocation is pegged so low.** Further the Planning Commission's health chapter proposes that the Centre's additional contribution would be substantially conditional on the States' increased allocation. Thus if states' contribution does not increase at the "compound rate of 40% annually" as proposed in this Chapter, the Centre's contribution will also not increase and ultimately even the miserly target of 1.58% of GDP will not be reached!

What lies behind this major step back?

One of the justifications for this weak commitment is to blame it on the poor absorption capacity of the public health system to utilise the increased financing effectively. However, this is not quite accurate. Yes, in the initial years of the newly launched NRHM fund absorption was slow to put into place, but as

the Mission progressed and processes were strengthened, the utilisation and absorption of funds has also stepped up and improved considerably.

Moreover, it is vital to understand that absorption capacity in health is also a function of the size and capacity of health facilities built, the extent of human resources deployed within the system and the provision of free essential drugs and diagnostics. While a commitment to provide essential medicines and services at no cost to all citizen has been made, there has been no commensurate commitment to increase the size of the public health workforce in a reliable, long-term manner. Indeed, there is a marked reluctance to do so. This reluctance to build and deploy a strong public health workforce is taking place at a time when, after much effort, an expansion of educational institutions is taking place and states are finally generating the human resources required in the health sector. A failure to absorb them within the public system will only force these much needed skills and resources to join the private sector on adverse terms. How can the public system be expected to increase its capacity to absorb finances if there is no commitment to expanding and strengthening the very core – human resources for health – required for it to do so?

There must be a clear commitment for the deployment of central funds to pay for a substantial proportion of at least the primary care workforce and a strong public health cadre of professionals who are hired, not on contractual terms, but as regular employees. This must be accompanied by commitments by the States to increase the sanction of posts to meet the requirements of the Indian public Health Standards (IPHS). Simultaneously the forward movement in expansion of public health facilities has to be accelerated so that the shortfalls in infrastructure that exist in many states (as the Plan document states) need to be plugged. The deployment of an expanded workforce, an expanded public health infrastructure and provision of all necessary drugs and diagnostics free of cost in public facilities would result in measurable increases in service delivery and greater equity and quality in service delivery, and shall absorb funds much more expeditiously.

Contrary to the above approach of expanding, strengthening and consolidating public facilities, the Planning Commission recommends allocating more resources through demand-side mechanisms – through insurance schemes such as RSBY for instance – where funds will be converted into pay-outs that would increasingly finance private and corporate providers. This is why the proposal of the ‘July draft’ to keep funds fungible (i.e. not clearly earmarked) between supply side and demand side expenditures and between rural and urban areas, must be viewed with considerable suspicion. For corporate healthcare chains to achieve a scale of operation that is profitable, incorporation of urban areas within the system of managed care through networked systems is critical. While there is an urgent need for addressing the needs of the urban poor and for integrating rural and urban health care, this needs to be done through earmarking additional funds for urban health systems. This cannot be done by using the bait of the lucrative urban sector to attract high end private providers into a unified system. If such ‘fungibility’ is allowed, inequalities in access and quality would persist, while the responsibility for health provision would shift away from the government even as “coverage” (and not comprehensive health care) can be rapidly expanded and the private sector incentivised to serve and shape health demands.

Strengthening and Reorienting Public Health Systems

Public Health Services will have to be the backbone of any system that aspires to make available health care to all citizens of the country. For this to happen, public health service need to be expanded and strengthened to ensure that it becomes the principal provider of health care services the country. It also needs to be reoriented so that it is fully committed to the interests of the ordinary citizens, and the influence of any vested interests including international agencies is rolled back.

However, the path to ensuring accountability and effectiveness cannot be achieved by forcing the public health system to compete with private (esp. corporate) providers in a framework governed by the market, which includes the introduction of ‘hire and fire’ type of practices and ‘rationalisation’ of staff. Rather improved functioning must be ensured through a much more systematic, bottom-to-top participatory and accountable processes and mechanisms, combined with acceleration of a range of key management and organisational reforms. Such measures should seek to roll back vested interests of certain officials, significant corruption, bureaucratic inefficiency and private sector dynamics within the public system, and strongly re-establish genuine ‘public interest’ as the overriding principle that must command the functioning of the public health system. Several ongoing and proposed elements of NRHM, including HR reforms, medicine procurement policy, decentralised health planning and community based monitoring and planning of health services in certain states, can point out some of the directions that can and need to be taken to ensure such accountability and strengthening of the Public health system.

Similarly, although in-sourcing of a section of regulated private providers in a publicly funded and managed system need not necessarily dilute the essentially ‘public’ nature of such a health system, handing over the system to largely unregulated, powerful corporate networks would completely vitiate the basic public logic that is the rationale for any genuine UHC system, and would be disastrous for the health and well-being of the people of India.

This long-standing and persistent failure to invest in and empower the public health system in India has, it seems, become inseparable in the eyes of the country’s planners with the inevitable failure of the public health system itself to improve and perform as it must. As a result, the argument has taken hold that public systems are too entrenched and unresponsive, and further that with new tools and mechanisms of financing and regulation the government can catalyse and support a more dynamic, competitive and efficient private sector to provide universal access to healthcare for entire populations. The message is: equity and quality can be purchased, if only the contract is well-structured. So we are told, given the failure of public systems to deliver, we must opt to change the approach.

The fundamental issue, however, is that this is not the real choice that confronts us. As Leys and Stewart state in defense of the UK’s NHS, for us too, “*the choice is not between change and no change. It is, as in every case, all about the direction of change that we choose to pursue and the degree of commitment and creativity with which we do so.*”

The evidence and experience summarised above cautions us that the shift to managed care and managed competition is an immensely expensive and highly inequitable direction to take. But, at the same time, there is no point at all in uncritically defending the public health system and it is absolutely vital to recognise that the lack of investment is not the only – or necessarily the most important – factor that is the problem here.

We identify below a few indicative areas, which are major institutional constraints to effective and equitable public health systems. For each of these areas, there are very good examples of what has been done, and many more creative possibilities of what could be done. We must engage with these problems keeping the larger vision of a democratic and equitable society in mind.

1. Rules and guidelines, systems and capacity that allow districts to allocate financial and human resources and drugs and supplies responsive to needs as articulated by communities, and measurements of disease burden, current patterns of utilization.

2. Institutional capacity to measure health outcomes and health processes in a decentralized manner, identify communities and areas where access is inequitable and take affirmative action including additional resource allocation to reduce inequity.
3. Strategies to develop, attract and retain skilled professionals to work in rural and remote areas, with a deep sense of professional satisfaction and with appropriate set of skills.
4. Putting in place systems that ensure externally certified quality of care in all public hospitals and in public health services on an urgent basis and gradually over the entire health sector
5. Institutional capacity required for making a decision on circumstances where contracting arrangements with private providers supplements and adds value to public service delivery and closes critical gaps in assured services that public systems are committed to providing, and then drawing up such contracts and ensuring that the contractual obligations of all parties are fulfilled.
6. Institutional capacity and enabling institutional mechanisms to coordinate action on social determinants across sectors identify gaps in public service provision or public policies that impact adversely on health outcomes and initiate action on these.
7. Institutional capacity to make technology needs assessment, assess and uptake technological advances, promote research and development to meet the technological needs of the system and manage knowledge resources needed for optimal utilization of technologies and for improved functioning of health systems.
8. Institutional designs and capacity for effective regulation of drugs, food safety, clinical establishments, ensuring ethical practices and preventing conflict of interests in health care provision, choice of technology or in health policy.
9. Institutional designs and systems that, on one hand ensure accountability of service providers, reduce rent-seeking by authorities and leakages of public funds, and on the other create a positive work-climate wherein public facilities and district health societies are empowered to be responsive to local priorities and hold themselves accountable to communities.

In conclusion, greater investment and addition of human resources will be needed, but in addition the strengthening of public health systems requires major institutional innovation and capacity building at all levels of the system, including in its capacity to productively engage private sector health providers within a regulated environment. Indeed the presence of a robust and reliable public health delivery system works as one of the best regulators of private service provision and cost containment, and most importantly is the fundamental means for citizens to hold the state accountable for health rights and health equity.

One of the philosophical foundations of this approach is that healthcare is not seen as a commodity that lends itself to packaging and purchase mechanisms but rather as a relationship of trust that has to be established between a health team and the community it serves. The role of the government is to build systems that establish and protect such a relationship.

References and further reading (with special reference to understanding the international experiences that the Planning Commission is quoting)

1. Colin Leys and Stewart Player, *The Plot against the NHS*, Merlin Press: 2011 (www.merlinpress.co.uk)
2. David Ansell, *County: Life, Death and Politics at Chicago's Public Hospitals*, Academy Chicago Publishers: 2011
3. John Geyman, *Falling Through the Safety Net, Americans without Health Insurance*, Common Courage Press. www.commoncouragepress.com
4. Jonathan Engal, *Poor Peoples Medicine: Medicaid and American Charity since 1965*, Duke University Press: 2006
5. Julian Tudor Hart, *The Political Economy of Health Care: Where the NHS came from and where it could lead*. Second Edition, The Policy Press, University of Bristol: 2010. Access at www.policypress.co.uk
6. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the 20th Century*, John Hopkins University Press: 1999