23

BIBEK DEBROY

The Indian Health Sector

Providing Choice, Competition, Efficiency and Finance

This is a volume in honour of Pradeep Mehta. Pradeep and his work have been about pushing competition, choice and efficiency, not just in India, but elsewhere too and with health education sector as one of its foci. Therefore, this paper focuses on choice, competition and efficiency in the health sector, an important one for India.

In September 2010, India's Ministry of Health and Family Welfare presented an annual report on the state of India's health, presumably the first of several such status reports. There is a self-congratulatory under-current in this report. Life expectancy has increased to 63.5 years. Infant and under-5 mortality rates have declined, with the infant mortality rate (IMR) at 53 per 1000 live births. Subject to data problems about maternal mortality ratio (MMR), that too has dropped to 254 per 100,000 live births. All these are 2009 figures. However, the Approach Paper to the Twelfth Five Year Plan (Planning Commission, 2011) mentions an IMR of 50 and a MMR of 212, both figures for 2009. A National Rural Health Mission (NRHM) has been launched in 2005, with a focus on 18 relatively backward States.

There are four problems with this self-congratulatory under-current. First, depending on the country with which one is making comparisons, India is still an under-performer in health. The IMR is 19 in China and the MMR is 45. The IMR is 17 in Sri Lanka and the MMR is 58.[1] Second, there is a 2009 country report on India's

1. Planning Commission (2011).

progress towards the Millennium Development Goals (MDGs).[2] The MDG system has a hierarchy of goals, targets and indicators and several are on health. Stated simply, in terms of progress towards 2015, India performs far better on poverty reduction and education than it does on any of the health-related indicators. To take the IMR as an example, "The trend of decline since 1990, if continued, can only take India to an IMR level of about 46 by 2015, which is far short of the target. High rate of infancy deaths in India is largely attributed to very high share (66 per cent in 2007) of neo-natal deaths."[3] Third, progress has to be benchmarked against what was expected or projected. The 11th Five Year Plan (2007-2012) had projected that by 2012, the MMR would be 100 and the IMR would be 28. On the assumption that these were then believed to be deliverable targets, there has been slippage. Fourth, all-India averages mask a lot of variation, not just in an urban/rural sense, but also in terms of divides between States. For instance, the IMR is 70 in Madhya Pradesh and the MMR is 480 in Assam.

Since the Bhore Committee of 1946, there have been 21 committees and commissions with a direct focus on health, not counting the ones that deal with pharmaceuticals or related areas.[4] The recommendations of these committees and commissions helped to shape India's health care infrastructure, policy and legislation. However, what we wish to flag in this section is their recommendations on choice, competition and efficiency on the supply-side and an end to public sector monopolies, with suggestions on financing health care. This section is not meant to be comprehensive. Nor is it meant to cover all those 21 committees/commissions. In general, the highlighted recommendations have not been accepted and no one listened.

But it is important to flag that they have been floating around and each time, we try to reinvent the wheel. Rather

2. There have been two earlier reports too. But this 2009 is the latest. *Millennium Development Goals: India Country Report 2009; Mid-Term Statistical Appraisal*, Central Statistical Organisation, Ministry of Statistics and Programme Implementation, *http://mospi.nic.in/rept%20_%20pubn/ftest.asp?rept_id=ssd04_2009&type=NSSO*

3. Ibid. Neo-natal means within the first month of birth.

4. In a collaborative exercise between the Ministry of Health and Family Welfare (MoHFW) and the World Health Organisation (WHO, India), the reports of most of these committees/commissions are available at *http://nrhm-mis.nic.in/ui/who/GOI-who-link.htm*

interestingly, as one moved through the 1960s, conceptual issues connected with financing, user fees, the use of subsidies and private sector involvement seemed to disappear from the radar. Public expenditure and public provisioning were treated as axiomatic and it was assumed that tighter monitoring would solve the efficiency problem. It is only in the post-1991 period that one is revisiting what was discussed in the 1940s and the 1950s.

The core of the delivery problem is in rural India, where primary health-care is provided through a network of 145,894 sub-centres (SCs), 23,391 primary health centres (PHCs)[5] and 4,510 community health centres (CHCs). There are population norms for such SCs, PHCs and CHCs. For instance, a population size of 5,000 must have a sub-centre, a population size of 30,000 must have a PHC and a population size of 120,000 must have a CHC.[6] A sub-centre has a lady auxiliary nurse mid-wife (ANM) and a male health worker (MHW). There is a lady health visitor (LHV) for six such SCs. The PHC is a referral unit for six SCs and has a medical officer (MO) and other staff. The CHCs are supposed to have four medical specialists (surgeon, physician, gynecologist, pediatrician), with an anesthetist and eye surgeon eventually made mandatory. In parallel with the NRHM, a National Urban Health Mission (NUHM) has now been proposed. The Ministry of Health's *Annual Report 2010-2011*, succinctly states the problem in urban India.

> However, while there is somewhat a uniform public health infrastructure in the rural areas, it is largely non-existent in urban areas except in some large urban centres and metropolitan cities that too mostly focused on reproductive and child health services. Approximately three-quarters of urban healthcare is accounted for by private health facilities and therefore, result in substantial out of pocket (OOP) expenses. The health indicators for the urban poor are as bad as their rural counterparts and much worse than the urban average. Poor environmental condition in the slums along with high population density makes them vulnerable to various

5. Figures from Ministry of Health and Family Welfare, *Annual Report 2010-11*.

6. These have been the norms since 2009. However, there are lower population thresholds for hilly and tribal areas.

> communicable and vector-borne diseases…The poor health outcomes can partially be traced to the inadequate services, like water supply and sanitation and housing facilities.

The focus thus is on public sector delivery, both in rural and in urban India, despite the statement that three-quarters of urban health care is accounted for by the private sector. However, some empirical work by Das (2011) shows that even in rural India, access is primarily through the private sector.

> Typically, households can access multiple providers, ranging from fully qualified public and private sector providers to those without any formal medical training in the private sector. In Delhi, India's capital, there are 70 doctors, most in the private sector, within a 15-minute walk of every household. In the private sector, about half are fully qualified and 10-15 per cent have no medical training, with a higher fraction of qualified providers in richer neighbourhoods.
>
> According to a recent report, across rural India, the average household can access 3.2 private, 0.3 public, and 2.3 public paramedical staff within their village. In rural Madhya Pradesh—one of the poorest states in India—households can access 7.5 private providers, 0.6 public providers, and 3.04 public paramedical staff. Of those identified as doctors, 65 per cent had no formal medical training and, of every 100 visits to health care providers, eight were to the public sector and 70 to untrained private sector providers.

The report in question is an important one, because it demolishes the proposition that there is a market failure of health workers in rural India and that the public sector must fill the void.[7] Contrary to *a priori* expectations, those four key trends are the following. First, the availability of medical providers in rural India is quite high, nearly 6 available per rural India. Second, more than 50 per cent of medical providers are private providers. However, third, the majority of medical providers have no medical qualifications and 65 per cent have no formal medical training. Fourth, most households

7. *Mapping Medical Providers in Rural India: Four Key Trends*, MAQARI (Medical Advice, Quality, and Availability in Rural India) Team; *CPR Policy Brief*, February 2011, *http://cprindia.org/sites/default/files/policy%20brief_1.pdf*

visit private doctors and doctors with no medical qualifications.[8] Ninety-two per cent go to private providers and 79 per cent go to unqualified providers.

A private market thus exists. The problem is with its quality and lack of regulation. In contrast, the public sector provisioning may not have problems of regulation, but it continues to have problems of access and quality. It is because of this lack of service quality in public sector delivery, spliced with the non-availability of drugs that patients resort to the private sector. The usual response of the government to this problem is one of euphoria about the involvement of local bodies.

> The effectiveness of a health care system is also affected by the ability of the community itself to participate in designing and implementing delivery of services. The opportunity to design and manage such delivery provides empowerment to the community as well as better access, accountability and transparency.
>
> In essence, the health care delivery must be made more consultative and inclusive. This can be achieved through a three dimensional approach of (1) strengthening panchyati raj institutions (PRIs)/urban local bodies (ULBs) through improved devolution and capacity building for better designing and management, (2) increasing users' participation through institutionalised audits of health care service delivery for better accountability, and (3) bi-annual evaluation of this process by empowered agencies of civil society organisations for greater transparency. Methodologies based on community based monitoring, which have proved successful in some parts of the country, will need to be introduced in other parts (Planning Commission, 2011).

As this quote itself admits, the experience has been quite variable.

The attitude of public sector delivery also spills over into the skills issue. Consider the figures given in the afore-mentioned status report of 2010 (Ministry of Health and Family Affairs,

8. The word "doctor" is being used in loose fashion. It does not imply the possession of a MBBS degree.

2010). The international norm is that there should be 25 skilled health workers (doctors, nurses, midwives) per 10,000 population.[9] In contrast, India has around 8 per 10,000. Of these, allopathic doctors constitute 31, nurses and midwives 30, pharmacists 11 and Ayurveda, Yoga, Unani, Siddha, Homeopathy (AYUSH) practitioners 9 per cent, respectively. These are figures from the 2001 Census and do not include community health workers, like Accredited Social Health Activists (ASHAs) recruited through NRHM. The Approach Paper to the Twelfth Plan has some additional numbers (Planning Commission, 2011). PHCs have a shortage of 10.27 per cent of the number of doctors required, CHCs have a shortage of 62.6 per cent of the number of specialists required, PHCs and CHCs have a shortage of 24.69 per cent of the number of nurses required. There is a shortage of 27.13 per cent of the number of pharmacists required and a shortage of 50.42 per cent of the number of laboratory technicians required.

These are shortages in rural health care delivery. One should not confuse an overall shortage with inequities in distribution and both problems exist. For instance, there may be too few nurses compared to the number of doctors. Health care workers are understandably concentrated in urban areas and most are employed in the private sector. Most medical and nursing colleges are in Andhra Pradesh, Maharashtra, Karnataka, Kerala and Tamil Nadu. There are few in Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh.

In ad hoc fashion, several states have also experimented with public–private partnership (PPP) models in delivering health care, outsourcing and levy of appropriate user charges.The Ministry of Health and Family Welfare (2007) has a database that collated these and other reform attempts. The challenge is to replicate and upscale them.

Since the reforms of 1991, some States have experimented with user charges—Assam, Gujarat, Haryana, Himachal Pradesh, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Tripura, Uttar Pradesh, Uttarakhand and West Bengal. Typically, such charges are imposed for diagnostic and curative services on patients above the poverty line, while those below

9. This is the context of deliveries and immunisation and is not a general figure. However, since the point being made is about shortages, this does not matter.

the poverty line are exempted and continue to receive free and subsidised services. There is a fair degree of variation in the implementation of user charges across states, ranging from the specific services that attract user charges in different states (some apply them on primary services, others on secondary or tertiary), to the degree of cost recovery to the use of such recovered funds.

Further, some of the states like Odisha, apply different rates to different geographical regions, and in some states the authority determining these charges is decentralised (as in Madhya Pradesh and Kerala). In the course of formulating the 11th Five Year Plan (2007–2012), the Planning Commission (2007) constituted a Task Force on PPP to improve health care delivery. Instead of the classic obsession with increasing public expenditure and assuming that it must be equated with public provisioning, the task force's report indicates how choice and competition can be introduced.

The report begins by accepting the inevitable, instead of questioning it, namely, the importance of the private sector, both for profit and non-profit. This does not negate the point about lack of regulation, since the quality of health care provided by the private sector varies. In general, private health care services are also more expensive than public ones, more so for in-patient services. There have been instances of such successful reform attempts involving PPP, as when services are contracted out on a temporary basis to the private sector. The government can pay an outside agency to manage a specific function, or the government facilities can be leased to private entities. Subsidies meant for the poor can be routed through private entities. And experiments also include the levy of user fees and insurance schemes. While there can be no universal template, there are two propositions that are clearly myths—first, everything has to be delivered by the public sector; second, the poor are unwilling to pay.

The usual approach to addressing health problems is one of increasing public expenditure on health, the argument being that OOP expenditure on health care is too high.

> Those who access 'free' government health services are expected to purchase medicines from private pharmacies; pay user fees for laboratory tests and of course the ubiquitous

informal fees. Those who use the private services of course have to pay considerable amounts. Significantly, those who are insured also do not get full protection. While their OOP payments are reduced, they still have to pay for ambulatory care and for excluded conditions (Ministry of Health and Family Welfare, 2010).

While this is true, this seems to be more of an insurance issue, rather than one of increasing public expenditure on health to the oft-cited figure of 3 per cent of GDP. That's the primary reason why OOP expenditure is still so high.

Can there be a satisfactory conclusion to such a paper? The lessons of competition, choice and efficiency, and transiting from licencing to regulation are obvious enough. Why have they not been implemented? In formulating public policy on health, there is still a great deal of distrust of the private sector, interpreted as the private corporate sector. For example, this is evident in attitudes towards the pharmaceutical sector which is seen as excessively profit-oriented; largely because of this, recommendations are not implemented, even when they cogently articulate directions for reform. Regulation is thus confused with control and this is reflected in over-legislation, which is rarely enforced. Since health is a State subject, many State governments have systemic problems in enforcing existing laws and regulations. To compound the problem, Government ministries and departments work in silos. Apart from regulation, competition policy instruments and consumer complaint mechanisms remain unsatisfactory; this is also the case with self-regulation.

References

Ministry of Health and Family Welfare (2010). *Annual Report to the People on Health*. Government of India, September, *http://mohfw.nic.in/showfile.php?lid=121*

Planning Commission (2011). *Faster, Sustainable and More Inclusive Growth, An Approach to the 12th Five Year Plan*. August.

Das, Jishnu (2010). "The Quality of Medical-Care in Low Income Countries: From Providers to Markets", *PLOS (Public Library of Science) Medicine*, April.

Ministry of Health and Family Welfare (MoHFW) (2007). *Health Sector Policy Reform Options Database of India (HS-PROD)*.

Planning Commission (2007). *Draft Report on Recommendations of Task Force on Public Private Partnership for the 11th Plan*, Government of India. *http://planningcommission.nic.in/plans/planrel/11thf.htm.*