New Directions for Public Health Financing

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The World Bank's recommendations on financing of health care, with the emphasis on primary health care services need serious consideration.

RECENTLY, the World Bank published a document, 'Policy and Finance Strategies for Strengthening Primary Health Care Services', suggesting a need to streamline the expenditure on public health care. Against its backdrop, it was thought necessary, given the diverse mechanisms of catering health services across the country, to bring forth experiences of various states and evolve a broad consensus regarding the future means of public health financing. Besides participants from major states of the country, representatives of national and international health and financial organisations and of few select NGOs working the field of health also attended the workshop. Deliberations centred around four themes, namely, the extent of privatisation of health services, the underprioritising of primary health services *vis-a-vis* tertiary health institutions, re-evaluation of financial allocation in public expenditure on health, and seeking new means to mobilise resources for health services.

Speakers from various states highlighted the steps undertaken by their state governments to improve health services and health financing. In Andhra Pradesh, the state government has emphasised on privatisation of the health sector. Recently one primary health centre was handed over to a corporate hospital. Likewise, village mandals, i e, local level committees for each 1,000 population, are made responsible for the functioning and presence of doctors in their sub-centres or PHCs. However, the glamour of tertiary care is so strong that most doctors recruited in rural areas tend to leave villages and opt for speciality/ super speciality training. There is a need to have community awareness about the fact that good health could be achieved through active community participation and is not something which can materialise from state efforts alone.

Rajasthan has undertaken various steps to improve its health delivery system. It was pointed out that to ensure the availability of funds to hospitals, the state government will be setting up hospital committees which can raise financing from the banking institutions on government guarantee. It would be considered a useful step if auto financing scheme goes a step further and the money instead of coming to the treasury could be retained by the institutions themselves to plough back for their maintenance and development.

The Rajasthan government has not only started contracting out cleaning services in the public hospitals but also began a system of local contractual appointment for doctors and paramedics. The system is very useful for remote rural areas, especially for districts like Kotra, Jhadol, which doctors never visited in last 20 years. Under the scheme in last two months 175 medical doctors were given contractual appointments. The doctors seeking employment in this way, approach the district collector office to meet a committee of chief medical officer, health officer and the district collector. This committee gives appointment order to any doctor if s/he agrees to the terms and conditions of the state government. It is a major policy decision which the state government has taken for some limited districts. Based on its success the government may expand it to paramedics also. There are other provisions for doctors as well. For instance, they can also work after retirement or can get ad hoc or contract appointments. Further, there are few areas and schemes which emphasise community participation and NGOs role. These include VIKLAPA for family welfare and 'Swasthaya Karmi' to increase the outreach services and cover remote areas. The community participation is the crux of the entire sector. The state government would like to see that the community becomes self-sufficient regarding the planning of health services.

Representatives from Karnataka suggested that the distinction in the government budget between non-plan and plan expenditures should be replaced by non-essential and essential ones. This may lead to an improvement in the deicision-making. Further, taking into consideration the 73rd constitution amendment, the local bodies powers especially financial decentralisation up to the level of local bodies should made use of to improve PHC services. It opined that the social marketing of cond oral pills, ORS, must be done by the pri sector and not by fair price shops.

In Punjab the process of struct adjustment started when the state govern itself was thinking about issues like effectiveness and cost recovery. By and the state government has managed to the health expenditure stable. Neverthe the state faces numerous problems regar its health system. Firstly, there is a infrastructure at the PHC level. Secon due to law and order problem in Pu ANMs decline to stay at sub-centres. sequel there is an over saturation at district level. Since hardly anyone is avail at the sub-centre level, people prefer to the sub-district or district level. Thir there is paucity of drugs due to low h budget. The latter is around 2.8 per ce the state budget. With such a low bud it is difficult to sustain even the exis infrastructure. The state governmen considering to start a separate mainten unit so that the existing infrastructure be taken care of. The state governmen also taken decision against expansion effort would be rather to consolidate current level of annual expenditure drugs which is Rs 2,000 at the sub-ce level, Rs 15,000 at the PHC level, Rs 20,000 at the CHC level. It is diff to provide efficient services due to availability of drugs and low quality services in the government sector. private health care sector in Punjab is d extremely well. Experience also shows there is more demand for outdoor serv The state is burdened with providing in facilities. About 47 per cent of in-pat do not pay for any service. Some ha pay for diagnostic services like X-ray, test, etc. Punjab has always charged kind of user fees but it forms a signific minimal part of the entire budget. The government is planning to increase rates and in this regard a memorandum been already cleared by the cabinet.

The Punjab government is trying to in the private sector both in promotive preventive health care. A regional ins is being initiated jointly by the governments of Punjab, Haryana Himachal Pradesh. Punjab has had experience in pay clinics which functio the evening and charge the patient. the earlier system, of the total am collected at pay clinics 50 per cent were by the doctor concerned and the rest to the treasury. In the proposed syste per cent would go to the doctor and th would be used for the development o institution.

The Punjab government has also tried out e contracting of the cleanliness services the hospitals in Jalandhar. Punjab, too, ces problems regarding the placement of octors in rural areas. Most doctors want a ural posting only in order to get an admission a postgraduation course. For that they ormally choose a place close to the city. s a result, in the border areas of Ferozepur nd Gurdaspur, scarcity of doctors persists.

With regard to the referral system, it was uggested that Punjab could have something ike a card system so as to ensure an equitable istribution of health facilities at the various evels. At present district and sub-district evels hospitals are overcrowded while most f the PHC and sub-centres remain nderutilised. In a democratic setup it is ifficult to push people towards a desired eferral system. However, an incentive could e provided through user fee for those going y the systematic referral.

Punjab government does not have much xperience with NGO functioning and ommunity participation. There are many eligious organisations, who are coming rward to donate building, machinery and ther equipment; only they want government octors to run the hospitals. They are ready o contribute large amounts for medicine ecause they have an international network o mobilise resources. Owing to the excellent acilities people prefer going to these ospitals. Keeping this in view, the state overnment in the current annual plan has ade budgetary provision to provide support o these hospitals by increasing the supply f doctors.

In the open discussion it was pointed out hat budgetary allocation to tertiary level ealth institutions which are affiliated to edical colleges in the country is determined y the criteria of bed requirements led down y the Medical Council of India. Nurses trength is determined by the Nursing Council f India. Therefore, disease pattern does not ecome a criterion to spend on these nstitutions. Doubts were raised about the ontention that private tertiary care was eeded because there is currently a short- r medium-term fiscal problem. Private ervices are needed because they are more ost-effective than the public sector. The ata in World Development Report mentions hat except for the US, in most European ountries 17 per cent of the tertiary health xpenditure is publicly funded.

It was also opined that to depend upon rivate sector for secondary level referral ervices is a utopian thought. In fact, there s no piece of legislation in this country hich regulate even the most unimportant ispensary operating in the corporate sector. suggestion was made to begin co-operative ospitals in other states, considering their uccessful operation in Maharashtra. It was reminded that the main difference between private and government sectors is that the former is mainly oriented towards curative aspects. The preventive and promotive aspects like IEC activities, are all done by public sector only.

However, based on the experience of Gujarat, a contrary view point was also expressed. In Gujarat, for instance, some charitable trusts have set up non-profit hospitals and they serve as a bind between the public sector and the private commercial sector. Such hospitals are located in almost all the major towns and cities of Gujarat and have undertaken several projects pertaining to promotive and preventive aspects like detection of cancer, TB, leprosy, etc. Moreover, the problem of retaining doctors in rural areas is lesser in Gujarat.

Primary Health Care and District Health Systems

The second session began with certain observations of the chairperson. He observed that instead of increasing people's dependence on a fragile public health system with inadequate funds, other available alternatives should be kept in view. There is a strong need to spell out operational aspect of health policy and design a complementary policy on medical education. The whole question of bringing down planning from the current level requires decentralisation beyond district level. Uptil now the district level has been considered important because firstly, a district has sufficient amount of capabilities required for formulating and implementing plans, secondly, a district is reasonably large to be viable for planning and thirdly, a district is not an isolated unit but an aggregate of sub-centres, PHCs and community health centres. Therefore, the adequacy of health programmes as well as peoples' participation and awareness generation, needs to flow from the district to the lower levels. The World Bank document, which was the focus of discussion in the workshop, reflects a similar vision.

In the discussion following the presentation, the issue of shortage of doctors in rural areas was addressed. In Maharashtra one year rural posting prior to postgraduation, either M D or M S, has been stipulated by the state government to overcome the problem. However, in the state, the CHC level is the weakest link. Therefore, efforts are on to strengthen this weakest link.

In Assam there is a need to increase assistance from the central government and international donors to overcome its low budgetary outlay on health. The Assam government has started the system of user charges to mobilise resources for the local hospitals in the state.

The participants from Himachal Pradesh explained the steps undertaken by the state government to overcome the shortage of doctors in remote areas. These included: (i) opening up of 5,025 ayurvedic hospitals and dispensaries; (ii) appointment of 5,100 'adhikaris' at ayurvedic hospitals in remote area; (iii) initiation of a scheme called 'Vikas Me Jan Sanyog' (peoples participation in development). Under this scheme 20 per cent of the funds is contributed by the people while remaining 80 per cent is provided by the government. As a result, people are coming forward to construct hospitals, sub-centres, ayurvedic hospitals, etc; (iv) proposing to increase the state health budget from the current level to 6.8 per cent; (v) rationalising the structure of health services so as to provide referral health care to the people. It has been decided that at the three zonal level hospitals, the state must have the services of 14 specialists, of which there will be 11 specialists at the district level hospitals and at least four specialists at the PHC level; (vi) an all-India open recruitment to supplement the requirement of doctors, which arises in case of inaccessible areas in the state. In this regard, the willingness of the doctors to serve in these areas is questionable. The system of posting contract doctors has miserably failed. Most contract doctors vanish after collecting their salary, leaving the message that they have gone to a neighbouring village. But they turn up after one year to collect their annual year salary and to disappear again. To overcome this problem, efforts are being made to make paramedical staff available at these places; (vii) since it was observed that the doctors after spending three or five years in the immediate rural vicinity of cities and towns, return seeking admission in medical colleges the state government has now strictly specified the remote rural areas to which doctors will be posted; (viii) encouragement is being given to private institutions to take over health care. Some good institutions are being allowed to start nursing courses. Fifty per cent of the seats in these courses will be government seats. Recently, the state government in collaboration with Apollo group of hospitals, has formed a trust to start a medical college. Further, there are 24 NGOs in the state which have been identified for Grameen Swasthya Karya Karta (rural health volunteer) scheme. In this scheme the NGOs will train women above 30 years to be a link between the government functionaries at the village level and the NGOs.

In Gujarat due to scarcity of staff at smaller municipalities in the state, the national programmes are not receiving proper attention. The state government started certificate courses in radiology and paediatrics to solve the scarcity of doctors but were objected to by the medical council.

In order to fill the vacant positions of doctors, every Monday and Wednesday open interviews for specialists are being conducted, but hardly anyone is coming forth. Incidentally in Gujarat, the number of postgraduate seats are more than the number of students passing MBBS. Thus, no graduate doctors are available for PHC level hospitals in Gujarat. Presently, the expectations from doctors are far too many. It is presumed that the doctor, besides having excellent clinical know-how, is an expert on finance, administration and public relations. Further, inadequate infrastructural facilities at PHCs, e g, pucca buildings, toilets, etc, deter doctors from working in these areas.

It was pointed out that issues of equity and efficiency are important for the success of primary health care system in the country. Certain basic requirements, namely, infrastructure, sufficient nursing staff, employment stability for the doctors, clarity in policy deciding upon the transfers of doctors, etc, ought to be fulfilled. The issue of the structure of public financing is also important. In the period of liberalisation there is a need to experiment with various financial options. In Kerala, for instance, an innovative idea of setting up of hospital development committees has been tried. All the funds are entrusted to the hospital development committees which include revenues from user charges, visiting fees, the out-patient ticket fees, etc. These committees have their bank account and can decide on the allocation of funds. However, 10 years later, the accountant general has raised objection against the scheme, calling it contrary to the Indian Constitution. According to him, all the funds should have gone to the state treasury. At present, the state government is sorting out ways to answer the objection.

Generally a government circular takes at least six months to one year to reach to the primary health centres. Many times a circular regarding a health programme reaches much after the week is over. It happens because of the convulated procedure of dispatching the circulars. Like other appointments, viz, IAS officer, revenue inspector, tehsildar, block level development officer, etc, an orientation training at the time of posting of medical officer in the rural areas should be initiated. Besides, a refresher course after every 2-3 years may be useful. It is also necessary that despite very good development indicators, the preventive strategies in Kerala should take care of the disconcerting factors like the presence of large number of smokers, high alcohol consumption next only to Punjab, increasing drug addiction, impact of cable TV on health in terms of breakdown of family conversation, and industrial pollution, etc. All these issues are going to be crucial in the next 10 to 15 years. It should be conveyed that government is not solely responsible for health of its citizens but each individual is equally responsible for his/her health. The government should provide basic support services, otherwise over the next 5 to 10 years the health system would collapse under the weight of rising demands.

Raising people's awareness regarding their own health and thus increasing community participation has resulted in success of some innovative programmes in Kerala. For instance, it was announced by the state that 25 per cent of the total collections from Indira Vikas Patra would be earmarked for early detection and prevention of cancer. The response from the public was enormous. As against a planned collection of Rs 10 to 12 crore under the scheme, Rs 76 crore were collected out of which 25 per cent of that was earmarked for cancer control and early detection programmes. In fact, it was equivalent to 10 years of sanctioned budget. This suggests that there is a lot of scope to mobilise resources through community participation. We are still not able to find meaningful way of assessing the efficiency of public hospitals in terms of quantitative and qualitative parameters and some effort has to be made in this direction.

In the open discussion it was pointed out that the working of the medical system is counter-productive in encouraging doctors to go to rural areas because of the non-availability of training to induct fresh medical graduates from the urban and curative-oriented education. Further, the reporting among different levels of medical functionaries at PHC and CHC levels also needs careful scrutiny. The issue of non-functioning of the referral system, and thinking of ways to discourage people from bypassing the lower level facilities and possibility of introducing card system to be discussed. It was also emphasised the health planning board could play important role in looking at the adequ of existing health facilities in their respe districts.

Regarding financing of health meas it was argued that financing innova should look not only at health insurance also at other mechanisms like leasing equipment, increasing access to credit by medical sector. The rating or grading of hospital or nursing home should not confined to public sector. Both the sec should be included in such grading and procedures including waste manage procedure, food safety, hospital infec control should be considered. Licens system in improving the availability doctors in rural areas should be tried Simultaneously, the importance of wo literacy and health education from sch level onwards should be given due prio

In Tamil Nadu, it was noted, that t is surplus of doctors who desired to w in rural areas. This was because the s government allows private practice in r areas. The monetary incentive is so str that most doctors working at PHC level not want to return to tertiary le institutionals. As a result the state governm has devised three separate levels recruitment, namely, primary health ce service, taluka-district service and teach service.

The entire discussion, it was remark was emphasising on innovations. In process the desirable part of the exis system was being overlooked. For insta it was suggested that the current rural he system could be strengthened by utili

nearly half million anganwadi workers. It was mooted that in order to improve rural orientation whether the current MBBS course of 4.5 years could be extended to 5.5 years with an additional one year to serve in the rural areas. It was possible that the neglect of rural orientation in medical curriculum owes to Medical Council of India which is managed by people who themselves do not have any rural orientation.

Re-Evaluating Financing Priorities

In the discussion following the overview presentation on the above theme, it was opined that in fixing priorities in the health sector, means would have to be devised to optimise returns from public expenditure. There cannot be any second opinion that preventive and promotive aspects in the primary health care system need to be stressed more. Currently, the per capita spending on primary health care in rural areas, especially per sub-centre and on drugs, is very low. There is, thus, a need to re-emphasise these priorities in the rural areas. A community volunteer based system, like the one existing in Indonesia, could also be tried. In discussing preventive and promotive aspects, the role of other departments, especially the water and sanitation department, should be taken into account. While 50 to 70 per cent of the diseases are regulated through preventive measures, the budget on provision of clean water and sanitation comprises merely 1 per cent of the total outlay. We should learn from China wherein each water supply scheme, 5 per cent of the amount is reserved for sanitation, health and hygiene education.

The role of efficiency and cost reduction measures in enhancing resource availability and thus quality of care was emphasised. For instance, the factors like excessive use of hospital beds, unnecessary emphasis on expensive medical procedures, purchase of costly equipment not so commonly used, etc, should be avoided. Moreover, the cost awareness among medical professionals could be enhanced by training them in health economics. Co-operative health care schemes, on similar lines of Indonesia and Thailand, could be initiated in India. Besides the aspects of equitable access as well as sustainability of the health system are also important to reckon with.

It was recognised that the constitutional barrier in retaining funds at the point of collection should be overcome. In Tamil Nadu, for instance, there was no scarcity of funds but a better management was required. To improve managerial ability the Tamil Nadu government has started five days management programme for the doctors. Further, the expenditure or budget should not be computed in per capita terms but should be based on number of out-patients and in-patients. It was also suggested that a committee needs to be appointed to have a fresh look at public health education material in the country.

One of the ways to overcome the low budgetary allocation to health care sector is to pressurise government to shift its emphasis from certain sectors like power generation. These sectors could be entrusted to private sector. It was pointed out that private motivation through user charges may not operate in hilly and tribal areas. Therefore, in these cases public funding should emphasise health facilities and NGOs should also be encouraged. Also, it should be checked that in the transmission of user fees from a local hospital to a central authority, the number of intermediary authorities should be curtailed for administrative convenience.

The available evidence on the need for resource mobilisation indicates that the demand for health care has to be price elastic. This denotes that real issue is the quality of services. There is a need to adopt inter-sectoral approach and appropriate mechanism has to be devised to establish these linkages. It was highlighted that the prevalence of unregulated private sector in the health care was leading to bad quality of care in private nursing homes on one hand while on the other it was resulting in high earnings for the practitioners. Therefore, it is essential that the government should lay down minimum standards and guidelines to monitor the private sector.

One viewpoint drew attention to the fact that even the tertiary sector runs short of funds and there is scarcity of drugs and consumables. Thus, it is not clear the extent to which the funding for the tertiary sector can be reduced. It was cautioned that if the financing mechanism of earmarked taxation for health care is to be adopted, it should be ensured that the powers to levy the earmarked taxation are also vested with the tier of government for whose expenditure the levy is aimed at. Also there is a need to estimate the amount indirectly spent by the government in providing tax concessions to health schemes of private companies. On the basis of the experience in Gujarat, it was suggested that by charging the patients in special wards slightly above the recurrent cost, additional finance could be generated to provide for poor patients. Also, to avoid duplication of facilities, it should be ascertained that there are no other institutions like charitable or trust hospitals which provide a comparable quality of care.

There is a need to look into the current level of investment in the pharmaceuticals and whether the number of formulations could be restricted in our country. Moreover, there should be wider emphasis on generic drugs rather than limiting it to a few successful experiments.

To improve the resource availability in the health care sector, some more measures were suggested. These included: (1) tax holiday for investment in health sector in backward regions; (2) fiscal incentives for encouraging indigenous manufacturers of medical equipment; (3) initiating hospital audit; and (4) cutting down hospital stay days by means of day surgery and better technology. It was suggested that we should also incorporate in our health planning the adverse health outcomes of development. It was pointed out that using new taxation for financing health care may lead to excessive burden of taxation. It was also suggested that there is a lot of information available in the ANM register which if compiled and computerised could provide tremendously useful information base.

In the last session, the recommendations regarding public health financing basically emphasised the actions which were considered necessary within the framework of the World Bank report. Accordingly, some modifications and additions were made in the original table of the World Bank report. The recommendations emerging from the workshop asked for more involvement of private sector and experimentation with private contracting of public health services, autonomy of hospitals to retain user fees with them, increasing community participation through NGOs, and the necessity for raising more finances through innovative mechanism including user fees, insurance and other suitable taxes. The aspects like cost reduction and improved efficiency and quality in health care through reallocation of resources from tertiary to primary care, reinforcing referral system through appropriate incentives, improved management practices and development of MIS systems in health care, placement of doctors in rural areas through appropriate policy measures were also sighted. The need for upgrading the training skills of various institutions, working both in public and private sectors, was also felt. It was decided that a number of issues in finance and budgetary analysis need attention for further research, which may be supported by central and state governments. The recommendations of this workshop indicate a new direction to the state and central governments to enhance their resources. In due course of time it is expected that these recommendations will be incorporated in policy implementation by the government of India.

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