

## Policy Recommendations

Although the health care sector in India actually consisted of public, private forprofit and nonprofit institutions, governments could remain noncommittal about the private forprofit and nonprofit sectors. Various factors allowed the noncommittant policy posture. Firstly, the yearning for a National Health Service and hence a postponement of policy formation on the role of private sector. Secondly, the size of private health care sector was relatively small. The situation has changed significantly. The private health care sector is growing rapidly over the last two decades. The country has experienced fundamental changes in its dominant approach to the role of public sector. Public sector is yielding to privatisation in most areas of the economy. Clearly there is an urgent need to spell out a comprehensive policy about the private health sector. At the least, governments have a responsibility to define rules of the health care market to facilitate the growth in private health sector and assure consumer confidence. Thus the first policy lesson is as follows.

1. Develop and adopt a set of comprehensive policy towards the private forprofit and nonprofit health care institutions.

Available evidence from within India and the industrialised countries suggest that the private HCIs, particularly the proprietary ones have a comparative advantage in delivering ambulatory care. The only limitation appears to be the tendency of private proprietary clinics to locate in economically developed and urban areas. This may be the reason why in the rural areas PHCs, ANMs and MPHWS continue to play a significant role in provision of ambulatory care. Even then only 8 - 25% of people resort to the PHC, ANM or MPHWS for ambulatory care. In other words, private doctors are the major source of ambulatory care in the rural areas as well. Private hospitals also appear to have more maternity patients. This situation is likely to continue in the medium term, since a lot of the proprietary hospitals and nursing homes are essentially practice facilities of obstetricians. These coupled with the experience that public financing is essential for accessibility of health care facilities to poor, we arrive at the following recommendations :

2. Ambulatory medical care is best provided through a net work of family physicians (FP), who would usually be self employed doctors but can include ambulatory care services by other institutions as well. Steps to develop such a network will include the following:

- i. Definition of the package of basic ambulatory care and family physician services.
  - ii. A capitation fee based scheme of enrollment with FPs with some provision to allow for annual review of choice of FPs by the covered families.
  - iii. Public funding of FP service coverage at least for families who can not afford to pay.
3. In the short and medium-term, private hospital and nursing home capacity should be used to increase the incidence of institutional deliveries in the country. Raising the incidence of institutional deliveries vis-a-vis home deliveries would help reduce maternal mortality rates. Public funding of institutional deliveries by women from poor families, in private HCIs will facilitate health sector reform by providing incentives for private HCIs to adopt standards and assure quality of maternity services, as well as build experience in public financing and private provision of healthcare services.

Keeping aside the reproductive and child health (RCH) services and public health programs, the range of clinical services, available in the private and public sector HCIs was not very different. Ideally, one would expect the public sector HCIs to offer a limited range of well defined clinical services consistently across all HCIs, if standard range of services are well defined, and the same is implemented. However, availability of clinical services in public sector appears to be determined by what doctors working in public sector have to offer rather than what the health authorities should provide. Hence our next policy recommendation is about definition of the standard range of services and consistency in availability of those services.

4. Public health authorities should explicitly define standard range of services based on local burden of diseases, and availability of cost effectiveness of interventions to be delivered by the public health care institutions. Governments should review the job descriptions, cadre strength, recruitment systems and posting policy to improve consistent availability of predefined services through all public HCIs. This, we believe, will help in better targeting of public subsidies to the poor.

There is preponderance of evidence that forprofit private health care institutions tend to be less accessible to the poor. This tendency of forprofit HCIs to avoid poor patients continues even in an environment of comfortable revenue realisation from large government programmes like the Medicare and Medicaid in the US. Public and nonprofit HCIs tend to be more accessible to the poor and provide a wider range of services to meet public health needs. In fact, from the accessibility-to-poor point of view, public and nonprofit health care

institutions appear to behave more alike than the private forprofit HCIs. Another argument in support of private forprofit health care has been the quality of care. Available evidence does not support this hypothesis as well. The patient exit interviews in this study gave better scores to private HCIs on interpersonal aspects and to public sector HCIs on technical aspects of care. The overall level of patient satisfaction with private and public sector HCIs was similar. Yet another argument usually advanced in support of private provision of health care through forprofit HCIs is that they are "more efficient". However, research studies comparing the relative efficiency of private, nonprofit and public HCIs do not support this hypothesis. There is preponderance of evidence that private forprofit HCIs are less efficient compared to nonprofit HCIs. Although India has a mixed health care system, paucity of nonprofit health care institutions is a major handicap. There are three policy implications of this situation.

1. In the near and medium-term, the public sector hospitals will have to respond to the hospitalisation needs of the poor. This would mean upgrading and expansion of first referral hospital facilities in the public sector. The First Referral Health Systems project in Andhra Pradesh and few other states have program components to upgrade and expand the first referral hospitals in the public sector. More work is needed to estimate requirement of hospital stock in view of current and future levels of disease burden and hospital service requirements.
2. Encourage development of nonprofit health care facilities in the long run. Actually this later objective is best pursued through social movements. It will be difficult to achieve sustainable growth of nonprofit health care institutions through government policy. Limited role of government policy towards nonprofit HCIs will be to provide a signal about the desirability of voluntary action. The range of nonprofit HCIs promotion policies would include (a) legislative mandate for incorporation of nonprofit HCIs for different purposes related to health care, (b) legislative recognition of the special needs of health insurance organisations, (c) land and capital grants to nonprofit HCIs, etc.
3. Government programmes encouraging nonprofit HCIs will inevitably attract opportunistic nonprofit institution building in addition to spontaneous voluntary action. Hence the nonprofit HCI promotion policy should be accompanied by development of appropriate regulatory mechanisms for the nonprofit sector. These would include model code of transparency in governance of civil society institutions, and standards of accounting practices for nonprofit institutions. Clearly, some of these policy measures require action outside the health sector. For example standards of accounting practices can be prescribed under the income tax rules that provide for registration of nonprofit institutions.

Suppose, we wanted the private HCIs to grow, in any case, and provide most of the hospitalisation requirement in the country. We found that patient revenues are the primary source of maintenance and expansion of private hospitals. Experience from the US suggests that sustained growth of private health care institutions requires substantial growth in patient revenues. Aggregate growth of patient revenue in turn is linked to existence of government programmes to pay for healthcare costs. In the US, introduction of Medicare and Medicaid were significant contributors to growth of private forprofit healthcare institutions. These programmes were characterised by federal mobilisation of resources for Medicare through compulsory social security collections and increased allocation of federal budget for the Medicaid program. There appears to be an impression that the solution to resource constraints in the public health sector is to encourage the private health sector. It is believed that private provision of healthcare will some how reduce the health expenditure burden on the government. However, it clear from experiences of similarly placed country like the US is that substantial increase in consumption of healthcare by the needy is feasible only if the state has a proactive policy to allocate the required resources. In other words, whatever be the delivery mechanism, increased allocations to health sector requires state intervention. Funds for healthcare services can be raised through social security collections like the employees state insurance scheme and higher allocations from the general revenue. Thus our next set of policy recommendations focus on health system infrastructure to assure healthcare consumers of a certain minimum standard of care and further assist them with information to facilitate their choice of providers. These recommendations are about creation of the quality system subsystem of the health system.

1. Substantially increase allocations for healthcare services by;
  - i. Streamlining and expansion of fiduciary social security services and
  - ii. Substantial increases in allocation of government expenditure to health sector.
2. Establish rate setting policies and authorities to set fair rates of healthcare service charges. These rates will facilitate purchase of healthcare services by the government from private forprofit and nonprofit providers. It will well recognised that health care institutions both forprofit and nonprofit have a motivation to maximise revenue by exploiting the rate structure and payment systems. Hence, the rate setting mechanism should provide for research programmes to monitor impact of rate setting decisions and take appropriate remedial action from time to time.

We have noted that the private forprofit HCIs do not fare any better than the public or nonprofit HCIs in terms of efficiency, quality of service, or

accessibility to the poor. There is preponderance of evidence tilting the scale in favour of public and nonprofit HCIs regarding equity, efficiency and quality of service. This might lead to an erroneous impression that there is no role for private health sector. We have already noted that the private, mostly proprietary, health care facilities have a comparative advantage in delivering ambulatory care. In respect of hospital services also, private HCIs have some advantages as well. Private HCIs are quick to respond to the demand for services. We have seen earlier that growth of private HCIs, mostly forprofit, in AP shows strong correlation with the index of infrastructure development (Figures 4.1 and 4.2). Capital is quick to flow in to the health sector in times of high demand and equally quick to flow out during slumps in demand for health care. This explains the higher density of private HCIs in economically developed districts and regions. Quick response to demand is an important and useful feature of the private HCIs. A health system without any private providers would not survive long in view of its slow response to changing demand. Thus private HCIs is a very desirable component of the health care system. That means governments have a responsibility to facilitate a competitive healthcare service market. The need for active state intervention is all the more important since the healthcare sector is usually characterised by market failures largely on account of information asymmetry between the consumers and providers. For example, it is difficult for consumers to evaluate technical quality of health care. Hence the need for a healthcare quality assurance system. The following set of recommendations essentially ask for creation and sustenance of the quality of care subsystem in the health sector. These measures should be applicable to public private forprofit as well as nonprofit health care institutions.

1. Streamline existing state licensing mechanisms for healthcare professionals.
2. Create state licensing mechanisms for healthcare facilities of all kinds including group practices, nursing homes, hospitals, diagnostic facilities and etc.
  - i. It will be desirable to study and review state licensing rules and regulations in different parts of the world and prepare a model healthcare facility licensing law for Indian states.
  - ii. Develop national network of institutions to contribute towards development of standards and specifications for different aspects of the healthcare facility licensing process. The workshop on private health sector in Andhra Pradesh (Mahapatra and Nagarjuna, 1998) suggested that the mechanisms for development of minimum standards should have the following essential features:
    - a. The standards development should be done by an organisation with adequate research and documentation on the subject.

- b. Standards should be developed by professional and research teams following wide ranging consultation among various stake holders.
  - c. The minimum standards should be specified on the basis of size and service offering. In other words both bed size and service offering of the hospital should be taken into consideration to arrive at the minimum required facilities. Marginal modification to standards may be allowed on the basis of location features like urban, rural and remote areas. Substantial deviation on the basis of rural urban character of the hospital should not be allowed. Instead appropriate restriction in range of service may be made.
3. Encourage voluntary accreditation in addition to the state licensing mechanism. The workshop on private health sector in Andhra Pradesh (Mahapatra and Nagarjuna, 1998) suggested the following desirable characteristics of an accrediting institution.
- i. A non profit organisation, so that it does not have a profit motive behind the accreditation process.
  - ii. Should not be representing a particular interest group.
  - iii. The accreditation set up should not fully depend on the accredited hospitals for its financial sustenance. In that case there will be pressure on the accrediting institution to liberally grant accreditation so that its revenue can be maximised. On the other hand hospitals seeking accreditation should also pay for part of the cost to ensure that the process is voluntary and the hospital appreciates the value of accreditation service. The accreditation set up can be funded jointly by the hospitals seeking accreditation, through accreditation related fees, and major users of accreditation information like insurance companies, large corporations who may use accreditation status as a criteria for empanelling of hospitals to provide medical care for their employees, and the government.
  - iv. The organisation should have the capacity to develop standards.
4. The workshop on private health sector in Andhra Pradesh (Mahapatra and Nagarjuna, 1998) suggested the following incentives to encourage accreditation:
- i. Institutions responsible to provide medical care to their respective clientele and having a need to out source the same in part or full may be persuaded to empanel hospitals and nursing homes possessing valid accreditation for the concerned service. These institutions would include;
    - a. Large employers both in public and private sector,

- b. Central Government Health Scheme,
  - c. Insurance companies providing coverage for medical conditions,
  - d. Employees State Insurance (ESI) scheme,
  - e. and such others.
- ii. Build public awareness by taking up information, education and communication (IEC) campaigns through mass media and other forums.
  - iii. Require information on accreditation status and factor it into the decision making process while considering requests for any direct or indirect state subsidy like tax concessions etc. Where the subsidy precedes setting up and / or operation of a hospital or service, a condition may be imposed by the concerned government requiring that the beneficiary institution will obtain and maintain accreditation within a certain period of time.
5. Establish a program for development, periodic updating and dissemination of clinical practice guidelines (CPG).
  6. Establish a program of research on measurement of medical outcomes which will help in the long run, use of risk rated medical outcome data for comparison of technical quality of care by health care institutions.

We would expect the public sector to offer a smaller but more consistent range, if they were implementing something like an essential clinical package (World Bank 1993 p112-118). However, we found the range of general clinical services in public sector as varied as in case of the private HCIs. Availability of clinical services in public sector appears to be determined by what doctors working in public sector have to offer. This is mainly because the state does not yet adequately define the cadre strength of entry level medical officers by specialty. Hence the following recommendations.

1. Essential clinical package definition:
  - i. Immediate priority is to explicitly allocate existing cadre strength of entry level medical officers in first referral hospitals among the five commonly required specialties namely, (a) General Medicine, Obstetrics and Gynaecology, Paediatrics, General Surgery and Orthopaedics.
  - ii. Explicitly define the essential clinical package of services. Reorganise staffing in public HCIs commensurate with the essential clinical package.

